Department of Health & Social Care

National Maternity and Neonatal Taskforce: meeting note

19 May 2026, 2pm to 3pm, 39 Victoria Street, London

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Overview

The Secretary of State for Health and Social Care, the Rt Hon James Murray MP, chaired the second meeting of the National Maternity and Neonatal Taskforce. The purpose of this meeting was to create a shared understanding of the current state of maternity and neonatal care ahead of the publication of recommendations from Baroness Amos' Independent National Maternity and Neonatal Investigation and Donna Ockenden's report of her Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust.

The Secretary of State reflected on his new role and the importance of him chairing today's meeting given the extent of issues with maternity and neonatal care. He emphasised the importance of involving the voices of families in this work. He also welcomed Michelle Welsh MP in her new role as Maternity and Neonatal Adviser to the Secretary of State.

The chairs of the expert reference groups provided feedback from the first meetings of their groups.

A senior maternity and neonatal analyst from DHSC presented a paper on maternity and neonatal data, summarising the recent trends in outcomes and experience.

Duncan Burton, Chief Nursing Officer for England, presented a paper on current national maternity and neonatal improvement activity in NHS England.

Expert reference group feedback

The majority of the expert reference groups supporting the Taskforce held their first meetings ahead of the second Taskforce meeting. The expert reference groups chairs reflected on these first meetings, which focused on discussing their Ways of Working Charter.

Several of the expert reference group chairs fed back about the breadth of experience and expertise. They shared questions raised by their groups, including considerations on how the expert reference groups will work together to develop the action plan (and noting the intersectionality between groups); the importance of critically assessing Baroness Amos's recommendations ahead of action plan development; the relationship between expert reference groups and the Taskforce; and the need to take action and make a real difference, avoiding the recommendations sitting on a shelf. One of the groups had openly discussed the importance of psychological safety.

Members indicated their welcome for the continued commitment and leadership of the Secretary of State, the Rt Hon James Murray MP, by chairing the Taskforce. The importance of hearing the experiences of bereaved and harmed families was stressed, as the statistics and data do not show the full extent and breadth of the impact and trauma.

In response to expert reference group questions about accountability, members agreed that it would be the responsibility of the Taskforce itself to own and drive forward the national action plan, and that expert reference groups should feel able to challenge and hold the Taskforce to account. Once Baroness Amos' final report is published, it is anticipated that some work will be needed to assess the recommendations including any areas of further exploration the Taskforce would like to cover.

There was a further discussion about Taskforce membership, including a suggestion for the NHS National Medical Director to join the Taskforce.

It was agreed that the DHSC team would work with expert reference group chairs to identify areas of cross-collaboration and how to facilitate this engagement. Following the meeting, DHSC ran a combined event on 7 July for all expert reference group members and Taskforce members to begin developing the cross-collaboration.

Maternity and neonatal data

A senior maternity and neonatal analyst from DHSC analyst presented a paper on the key statistics in maternity and neonatal care. It was noted that this data is not representative of all outcomes, but they can be used to monitor and learn where things are going wrong or going well, and where we can make improvements. The statistics also do not account for the individual experiences of families.

The paper covered publicly available information of data and trends in maternity and neonatal services, including adverse outcomes for mothers and babies, service user experience, maternal demographics and the mode of labour and delivery.

Members noted there are some gaps in the data available that would be helpful for identifying priorities. For example, robust national data on the reasons behind choice of mode of delivery are not currently available. There is also a data time lags between events happening and data being collected and analysed, which the Taskforce should be mindful of when developing the action plan.

The Taskforce discussed how this data can be used to support with decision-making for services. For example, Trusts are having to adapt in real-time to the rising rates of caesarean sections, which impacts on experiences and how services need to be organised.

National maternity and neonatal improvement activity - roles and national interventions

Duncan Burton, Chief Nursing Officer for England, presented a paper summarising the main current national improvement activity in maternity and neonatal services. It highlighted the main interventions in workforce, safety, equity and personalised care, aimed at improving outcomes, reducing inequalities and strengthening the experience of women, babies and families. This covered some of the interventions introduced by NHS England's three-year delivery plan, which brought together many of the recommendations from local reviews into East Kent (2022) and Shrewsbury and Telford (2022). He advised that this information had been provided to Baroness Amos' national investigation. Duncan

Burton also noted that the paper was not exhaustive of all the interventions currently in place across all Trusts, as work is done at a local level which also drives improvements.

Duncan Burton described barriers to consistent implementation of national interventions. For example, accounting for variations across units and communities and adapting to changes over time. There are also issues with assurance and ensuring the balance of proportionate assurance mechanisms and ensuring sufficient time for improvement activity locally. These barriers will all need to be considered as part of the action plan.

The Taskforce concluded that, although there has been some progress, significant issues still exist and change is not always experienced by women and families. They noted that the data we have on outcomes and experiences does not currently always connect to the initiatives introduced. A number of specific issues were raised including workforce and midwifery graduate roles, how well the Perinatal Mortality Review Tool (PMRT) was working, the accuracy of data collection tools, alignment between maternity and neonatal services, issues with assurances and accountability of Trusts' implementation, lack of bereaved families' voices and involvement of wider community health.

Members discussed gaps in data sets and how they can be filled. For example, data is not currently collected on bereaved parents of pre-24 weeks pregnancy loss. The data could also be broken down by protected characteristics to focus on the impact on groups. Overall, it was felt there needs to be a much stronger link between the data and families' experiences and choices, with rising rates of c-sections given as an example where we don't fully understand what lies behind that. Some of the key challenges presented by data could be looked at from a family perspective to gain better understanding.

Baroness Merron closed the meeting by proposing the next meeting allows more discussion time; and thanking members and speakers for their attendance and continued commitment.