

# MATERNITY SERVICES

# NINE ACTIONS

## WE COULD TAKE TOMORROW

From 14 Inquiries to **Nine** Actions

Drawn from 14 major maternity inquiries and almost 900 recommendations, including Cumberlege, Kirkup, Ockenden (Shrewsbury), East Kent, Morecambe Bay, Amos and Nottingham.

<p><b>1 ONE NATIONAL RECOVERY PLAN</b></p>  <p>Replace hundreds of recommendations with one mandatory national maternity safety programme covering staffing, listening, escalation, investigation, training, leadership and transparency.</p>	<p><b>2 NAME ACCOUNTABLE LEADERS</b></p>  <p>Every Trust Chair and Chief Executive should sign a public maternity safety covenant. If they cannot assure safety, they should say so.</p>	<p><b>3 PUBLISH A LIVE SAFETY DASHBOARD</b></p>  <p>Real-time reporting of staffing, serious incidents, stillbirths, neonatal deaths, emergency Caesarean response times, complaints, inequalities and family feedback.</p>
<p><b>4 FUND SAFE STAFFING</b></p>  <p>Agree and fund minimum safe staffing levels. Midwives, obstetricians, anaesthetists, neonatologists and sonographers are safety interventions, not optional extras.</p>	<p><b>5 TRIGGER EARLY INDEPENDENT REVIEW</b></p>  <p>When families repeatedly raise the same concerns, an external review should begin automatically. No more waiting for campaigners to exhaust themselves.</p>	<p><b>6 SEPARATE LEARNING FROM BLAME</b></p>  <p>Create psychological safety for staff to speak up, while holding leaders accountable for suppressing, minimising or ignoring concerns.</p>
<p><b>7 MAKE INEQUALITY MEASURABLE</b></p>  <p>Record outcomes, complaints, escalation delays, interpreter use and experience by ethnicity. Measure it. Publish it. Act on it.</p>	<p><b>8 CONTINUITY OF CARE</b></p>  <p>Wherever possible, provide care through a small, dedicated team with a named midwife. Continuity builds trust, improves communication and helps spot deterioration sooner.</p>	<p><b>9 HELP MIDWIVES CREATE MEMORIES... NOT NIGHTMARES</b></p>  <p>Give staff the time, support and resources to deliver the kind of care they came into the profession to provide.</p>

**WE DO NOT LACK KNOWLEDGE. WE LACK EXECUTION.**

 <p>None of these ideas is <b>new</b>.</p>	 <p>None requires another <b>inquiry</b>.</p>	 <p>None waits on another <b>review</b>.</p>	 <p>The NHS already <b>knows</b> what to do.</p>
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SAFER MATERNITY SERVICES • SAFER FUTURES • BETTER FOR EVERY FAMILY

Nine Actions for Safer Maternity Services from **Roy Lilley**