



Royal Berkshire
NHS Foundation Trust

Title:	Report for Reading Borough Council ACE (Adult Social Care Children Services and Education Committee) on 18th March 2026
Agenda item no:	
Meeting:	Maternity Clinical Governance and ACE (Reading Borough Council Adult Social Care Children Services and Education Committee)
Date:	23 rd February 2026
Presented by:	Sarah Bailey, Interim Director of Midwifery
Prepared by:	Sarah Bailey, Interim Director of Midwifery

Purpose of the Report	<ul style="list-style-type: none"> • Purpose of this report is to share information with Reading Borough Council ACE Committee on the following: • The Trust have been requested to attend the committee with a paper and presentation on the following: • Summary of the national MBRRACE report findings • Local data on inequalities in maternity care (including info on global majority women) • Local progress on reducing inequalities across maternity care <ul style="list-style-type: none"> ○ Including translation services
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Report History	<ul style="list-style-type: none"> • Maternity Clinical Governance 13/03/2026
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What action is required?	
Assurance	
Information	
Discussion/input	
Decision/approval	The Committee is asked to approve that this paper can be shared externally

Resource Impact:	NA
Relationship to Risk in BAF:	NA
Corporate Risk Register (CRR) Reference /score	NA
Title of CRR	NA

Strategic objectives This report impacts on (tick all that apply)::			
Provide the highest quality care for all			√
Invest in our people and live out our values			
Deliver in partnership			√
Cultivate innovation and improvement			
Achieve long-term sustainability			
Well Led Framework applicability:			Not applicable <input type="checkbox"/>
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>	3. Culture <input checked="" type="checkbox"/>	4. Governance <input checked="" type="checkbox"/>

5. Risks, Issues & Performance	<input type="checkbox"/>	6. Information Management	<input checked="" type="checkbox"/>	7. Engagement	<input checked="" type="checkbox"/>	8. Learning & Innovation	<input type="checkbox"/>
Publication							
Published on website	No	Confidentiality (FoI)	Private	Public	yes		

1 Executive Summary

Providing this report to share information on the Trusts current position on inequalities in maternity care for women and babies. This is to be shared with the Reading Borough Council ACE Committee.

The 2025 MBRACCE report highlights inequalities in maternal outcomes, with higher mortality rates for Black and Asian women and those living in deprived areas. RBFT serves a diverse population and monitors perinatal outcomes closely.

RBFT Q1-Q3 2025/26 rolling rate is 4.91 per 1000 births, this is slightly higher than the 2023 national comparative rate of 4.84 per 1000 births. This rise has prompted a deep dive by a multidisciplinary strategy group. This will involve further medical review of all the cases, thematic analysis.

Recent data has shown a rise in perinatal mortality and in 2024/25 this was higher among Black women.

Neonatal outcomes for term babies admitted to neonatal services remains below national targets and maternal outcomes are stable with further ethnicity data analysis planned.

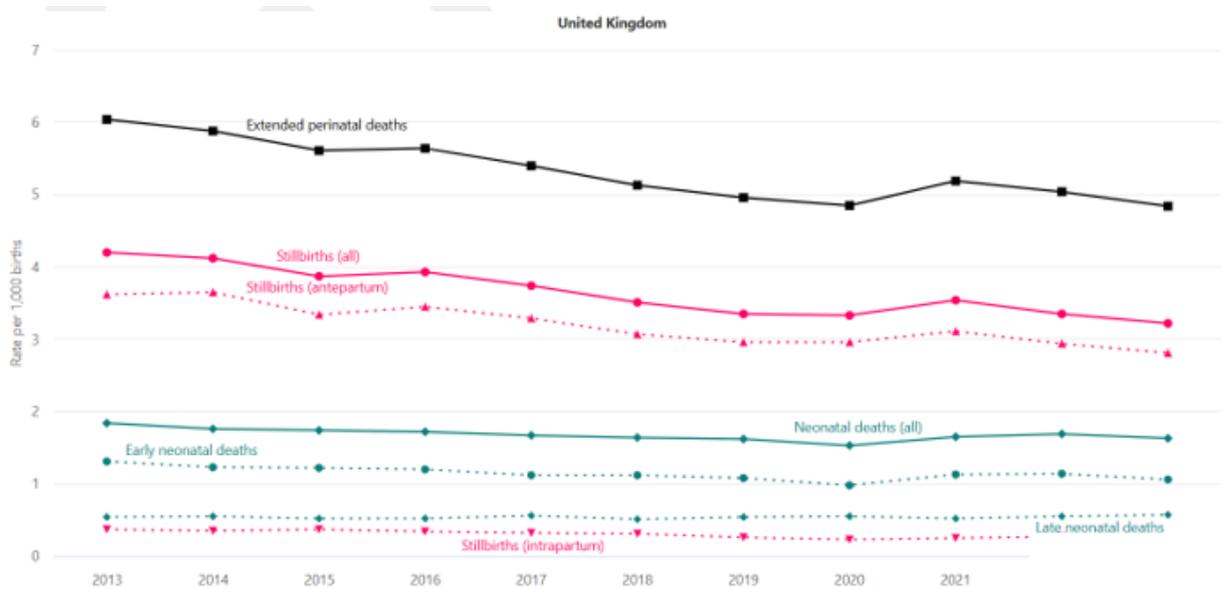
There has been extensive work to improve inequalities within the last 12 months, including continuity teams, cultural competence training, improved interpretation, targeted community engagement. Ongoing work includes Maternal Care Bundle implementation, maternal outcomes by ethnicity/deprivation and strengthens community partnerships.

2. Key Issues

2.1- MBRRACE (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK)

- Recent MBRRACE- UK (2025) report continues to highlight inequalities in maternal and neonatal outcomes across the UK. Key findings include:
- Maternal mortality rate remains higher for black ethnic backgrounds who are 3.7 times more likely to die during pregnancy or 6 weeks postpartum than white women.
- Women from Asian backgrounds are 1.8 times more likely to die.
- Women in the most deprived areas face mortality rates more than twice as high as those in least deprived areas.
- Leading cause of death is cardiac disease, mental health related causes and thrombosis with recommendations emphasising earlier recognition and escalation pathways and culturally competent care.

- National five times more survey highlights the lived experience of Black women, including lower levels of trust in maternity services, higher rates of feeling dismissed or not listened to, barriers to culturally appropriate information and challenges navigating communication and continuity of care. These insights reinforce the importance of culturally safe care and accessible communication.
- Across the United Kingdom from the MBRRACE report there has been a decrease overall in perinatal mortality.



Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

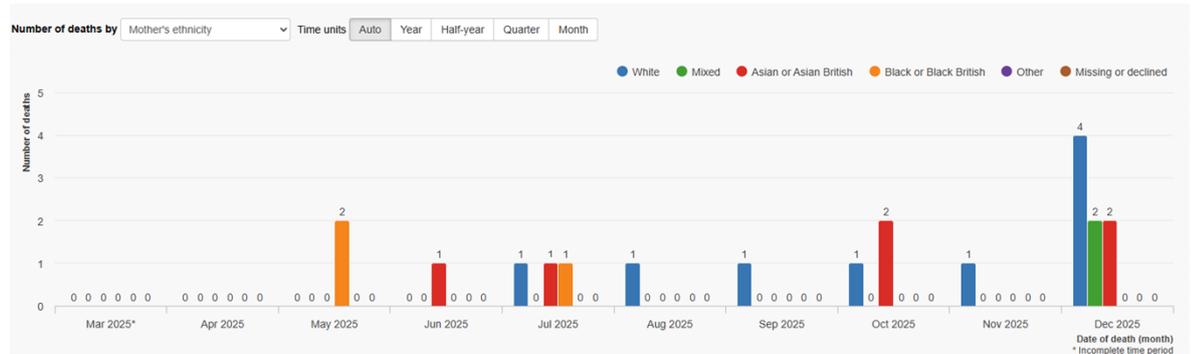
2.2 Local Context at RBFT

The Trust provides care for over 5800 women a year who book with the Trust for pregnancy care, with 4800 babies being born under the care of the Trust. Ethnicity breakdown of the women/birthing person who book with the Trust is 64% White, 22% Asian, 8% Black, 1% mixed Black/White, 3% other, 2% unrecorded. Care is provided in a large geographical area, which has areas of deprivation, with 12 areas among the most 20% deprived in England.

2.21 Perinatal Mortality (stillbirth after 24 weeks of pregnancy and neonatal death up to 4 weeks of age)

- Perinatal mortality rates are monitored and reported to the Trust board, this is broken down into ethnicity and social deprivation indices.
- Cases of perinatal death are reviewed under the Perinatal Mortality Review Tool, a robust multidisciplinary review with external panel members and representation from Maternity Neonatal Voice Partnership. On review there is a large proportion of cases that there is no care issues identified that would have changed the outcome. Due to increased complexities of women in care and fetal complications sometimes intervention will not change the outcome. For cases where care issues have been identified there is further scrutiny through the Trust's safety process. All families receive a full copy of their report and opportunity to discuss the findings with senior midwifery, obstetricians and the neonatal team if required.
- RBFT Q1-Q3 2025/26 rate is 4.91 per 1000 births, this is slightly higher than the 2023 national comparative rate of 4.84 per 1000 births. This rise has prompted a deep dive by a multidisciplinary strategy group. This will involve further medical review of all the cases, thematic analysis. The review will also focus on ethnicity and deprivation. From the deep dive themes identified will be actioned and monitored, through the Trust board. This will be a strategic objective for this next financial year with actions identified monitored through board. Nationally, all Trusts are awaiting perinatal mortality figures for 2024, which will be the new comparative rate.

- At the end of Q4 2024/25, it was identified through quantitative review of perinatal deaths that occurred in 2023-24 that the perinatal mortality rate for Black women was 6.19 per 1000: 3-fold higher than for White women. Perinatal mortality rates for women from Asian, Mixed and Other ethnic groups were not significantly different to White women
- The cases of black women were reviewed to identify themes. A main theme was that black women were less likely to contact the hospital immediately when they notice reduced fetal movements. The MNVP and midwifery team are working with local communities to understand what challenges there are for women to report earlier.
- In the current rolling year, Q1-Q3, number of deaths in relation to maternal ethnicity



- The Trust have a maternity bereavement service which offers and provides ongoing support for bereaved families.
- The Trust is fully compliant with Maternity Incentive Scheme, and Saving Babies Lives Initiative, which focus on implementation of tools to improve perinatal and maternal outcomes.

2.22 Neonatal Outcomes

- The Trust monitors number of term babies admitted to the neonatal unit. The Trust since 2025 has completed a quality improvement project to reduce admission rates. The Trust's admission rate is below the national target rate. In 2024/25 women of ethnic minority background did not have an increased neonatal morbidity risk based on term admissions to the neonatal unit. 2025/6 data will be analysed at the end of the Q4.

2.23 Maternal Outcomes

- The Trust is currently monitoring data on for following maternal outcomes, which the Trust are not an outlier for.
 - Unsuccessful attempt at instrumental deliveries leading to caesarean.
 - Maternal death
 - Return to theatre post caesarean
 - Intensive care admissions
 - Haemorrhage post birth of over 1500mls
 - Severe vaginal tears from vaginal delivery
- These outcomes are currently not broken down into ethnicity, and this is planned for the coming year with the introduction of the Maternal Care Bundle. The Maternal Bundle is to be implemented by March 2027, so this action will align with this implementation.
- In January 2026, NHS England launched the Maternal Care Bundle, this is a national programme designed to reduce maternal morbidity and mortality through consistent

implementation of evidence-based care. The main themes are based on the MBRRACE findings, venous thromboembolism, prehospital and acute care for pregnant women, epilepsy in pregnancy, maternal mental health and obstetric haemorrhage. The Trust is currently reviewing services to benchmark against this new care bundle. It is expected that all Trusts are compliant by March 2027.

2.24 Local progress on reducing inequalities across maternity care

Workforce and Culture

- All maternity team had cultural competence training.
- Full appointed of a perinatal befriender post in 2025, who works with those requiring additional support, socially isolated, complex social needs.
- New mental health midwife in post, working with perinatal mental health team and mental health lead consultant, provision of additional support for women and families with additional mental health needs.
- Midwifery working in maternity hubs provided by Reading Borough Council.
- 2025 campaign for Safe Sleeping, recognition that not all parents can afford new cots, mattresses. Connected with local charities, with easy referral routes for midwives.

Targeted Support

- Development and launch of Easy Read English Leaflets aimed for non-English speakers and neuro-diverse population.
- Continuity of Care team, Blossom, in areas of deprivation in Reading, provide full continuity of care pathways for women in these areas (RG2 7. and RG2 8., Whitley.) Second team to be launched in April 2026, Orchid for central reading postcode.
- Poppy Team, continuity of antenatal and postnatal care for women and families who have complex social factors across Berkshire. Factors can be those who live in deprived areas, known to social services; this can be child protective services or adult, mental health problems, domestic abuse, teenage pregnancy, substance misuse, non-English speaking, those who may be recent migrants to the UK, unemployment; including that of the supporting partner.
- Young parenting classes.
- Word ski- new interpretation service across the Trust. Within maternity have Word ski on wheels, which allows for face-to-face interpretation at the press of a few buttons to a face-to-face interpreter. 24/7 service.

Community Partnership

- Easy English Classes, supported by Reading Borough Council in collaboration with Maternity.
- New inclusion midwife introduced January 2026, aim is to work with local community groups to engage and understand challenges. Met with Utulivu and Reading Community Learning Centre. Have developed engagement plan with these organisations. Will be attending the Break Free conference. Moving forward will engage with other community groups, places of worship.
- Maternity and Neonatal Voice Partnership work on engaging with black community groups in 2025 in recognition of findings that black women more likely to book pregnancy late and therefore miss important early screening. Increased booking by 10 weeks from 65% of black women to 80%.
- Working with community groups and Berkshire Healthcare to utilise health bus for important messaging in targeted community areas across 2026.
- Midwifery working in maternity hubs provided by Reading Borough Council.
- 2025 campaign for Safe Sleeping, recognition that not all parents can afford new cots, mattresses. Connected with local charities, with easy referral routes for midwives.

2.25 Survey of Black Women's experience

- In 2025, completed a detailed survey of black women who had used our services within the last six months. Questions used were the same as the Five X More national survey.

All women had a face-to-face appointment with a black midwife. 35 women interviewed
Findings were:

Finding	Action
Many women seeing GP first before contacting maternity services	Work by MNVP has supported direct contact
Required clearer information on blood tests for screening	Screening information has been improved with clear information and video.
Continuity of care in the antenatal period	As well as introduction of new continuity of care team, another project running to improve antenatal care for all women
Unsure how to get mental health support	New mental health midwife improving information – different languages
4 women felt discriminated	This was explored individually and actions taken. All maternity team had culture competence training. There are clear mechanisms for raising concerns, Call for Concern, PALs and complaints. Maternity working with Call for Concern team to increase use in Maternity.
3 women delay in getting pain relief in labour	Reviewed by anaesthetic team as involved epidural analgesia, Anaesthetists reviewing all response times for an epidural to develop any further actions
How to get support for themselves and baby	Postnatal Steering Group reviewing information given to all women at discharge.

3. Next Steps

- Complete Maternal Care Bundle benchmarking, develop local action plan.
- Work with informatics to provide a maternal outcome report for ethnicity.
- Analyse data at end of Quarter 4 2025/2026 for term babies admitted to neonatal services.
- The MNVP and midwifery team to continue work with local communities to understand what challenges there are for women to report reduced fetal movements earlier.
- Deep dive by a multidisciplinary strategy group into perinatal mortality rate. This will involve further medical review of all the cases and thematic analysis. The review will also focus on ethnicity and deprivation. From the deep dive themes identified will be actioned and monitored, through the Trust board.

3. Conclusion

Within the last 12 months there has been a huge amount of work in improving on reducing inequalities for maternity care. It is recognised that there is continuous work which has been identified in the next steps. The most important aspect being engagement with community groups, which will continue with the support of the Maternity Neonatal Voice Partnership and the newly appointed inclusion midwife.

4. Attachments

No attachments