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NHS

Our Case for Change

Making Gloucestershire's NHS Maternity Services Fit for the Future

Why do we need a case for change?

A 'case for change' presents the rationale for developing services that are fit for the future. This document sets out the Gloucestershire NHS Maternity Services Case for Change.

It explains the current and future needs of our local maternity population, existing services, the challenges facing maternity care in Gloucestershire, and why change is needed. It does not present solutions for a maternity service redesign, but together with the maternity health needs assessment, it provides the foundation for the codesign of a maternity service that is the very best it can be: a service that consistently delivers safe, equitable and high-quality care for every woman[1], baby and family. To achieve this, we must ensure everyone in the county has an equal chance of a healthy pregnancy and postnatal period, and consider how our service model supports us in reaching that goal.

Over recent years, our maternity services have faced significant changes, including an increasing number of complex[2] pregnancies, new national policy, changes in women's choices, and workforce pressures. These challenges are not unique to Gloucestershire. There is a national focus on improving maternity care, driven by findings from recent independent investigations and reports such as the Ockenden Report, along with the commitment to implement the upcoming recommendations of the National Maternity and Neonatal Investigation, due later in 2026. At the same time, the NHS 10-Year Plan encourages a stronger focus on wellbeing, prevention, and supporting people to maintain their health and independence – particularly during pregnancy and the crucial early years.

The feedback to our Gloucestershire 5-Year Plan engagement in 2025/26: Getting ready for the Future NOW! confirmed that a set of principles developed with input from local people and communities 10 years ago still held true to help guide the development of health and care services and support for the future:

- A greater amount of the budget should be spent on supporting people to take more control of their own health
- There should be a greater focus on prevention and self-care
- We should develop joined up community health and care services
- We should bring some specialist hospital services together in one place
- We should focus on caring for people with the greatest health and care needs.

Approximately 80% of people who participated in the survey also agreed that services and support that people use most frequently should be available as close to people's own homes as possible and that it is reasonable for people to travel further for services they don't need as often, perhaps once or twice a year, including more specialist care.

The local 5-Year Plan engagement responses also identified supporting parents and families, and health education and prevention in early years, as a priority.

We have looked carefully at how our services are performing and how well they are meeting the needs of our changing maternity population. This has been done alongside listening to the experiences of women and families, the insights of staff, and understanding the clinical, demographic and societal changes happening both locally and nationally. It is clear that our current service was not designed for the needs of today's population, nor the needs we expect in the future.

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[1]Note on terminology: This document uses the terms 'women' or 'mothers' throughout. These should be taken to include people who do not identify as a woman, but who are pregnant or have had a baby.

[2]Pregnancies may be considered 'complex' for a variety of reasons including pre-existing health conditions, age, social factors, or other factors affecting the pregnancy such as twins. Complex pregnancies will require additional input and specialist care.

What is our vision for the future of our maternity service?

Our vision has been developed with our Maternity Service Review project group and board. Members include Gloucestershire Maternity and Neonatal Voices Partnership (MNVP), clinicians and managers from Gloucestershire Hospitals NHS Foundation Trust (GHT), NHS England Regional Maternity Team, NHS Gloucestershire Integrated Care Board (ICB), and Public Health at Gloucestershire County Council.

Gloucestershire's maternity service needs to be fit for the future to meet the changing needs of the population, codesigned with women, birthing people, and stakeholders.

This means:

Delivering safe, equitable, personalised, high-quality care for women, babies, and their families

Reducing inequalities in access and outcomes across protected characteristics and particularly ethnicity, inclusion health groups, deprivation and urban/rural status

Providing good outcomes and experiences for women and the best start in life for babies

Ensuring high levels of staff engagement, satisfaction, and wellbeing

Providing a service that provides value for money and meets the needs of all women in Gloucestershire while continuing to provide choice

Joining up care across professional groups e.g. midwives, health visitors, and GPs, and between services e.g. maternity services, family hubs, perinatal mental health, health visiting, social care, and voluntary and community sector organisations, to make it easier for women to get the right help and support when it is needed.

Current state: Maternity services in Gloucestershire

The services we provide

NHS maternity services in Gloucestershire are commissioned by NHS Gloucestershire ICB and provided by Gloucestershire Hospitals NHS Foundation Trust (GHT). Health visiting and the specialist perinatal mental health service is provided by Gloucestershire Health and Care NHS Foundation Trust (GHC). General Practitioners work alongside maternity services to support women during and after pregnancy.

These services include **antenatal care** (care during pregnancy), **intrapartum care** (care during labour and birth), and **postnatal care** (care for the mother and baby after birth).

The maternity services include the following:

Midwifery-led care:

Routine antenatal and postnatal care across Gloucestershire's six districts, and intrapartum care for low-risk women at home or in a midwifery-led birth unit.

Consultant-led care:

Antenatal, intrapartum and postnatal care, including outpatient clinics and day assessment unit, for higher risk women requiring additional monitoring. These clinics are supported by a range of specialist midwives (for women with additional or complex health or social needs, and include tobacco dependency, substance and alcohol support, safeguarding, bereavement, and perinatal mental health), other health care professionals, a regional Maternal Medicine Network (specialist care for women with significant pre-existing or pregnancy-related medical conditions) and a regional Fetal Medicine Network (specialist care relating to fetal medicine).

Maternity triage and advice line:

Triage is a 24/7 in-person assessment service at Gloucestershire Royal Hospital, and is available along with a maternity advice phone line for women who are more than 16 weeks pregnant or are recently postnatal and experiencing non-emergency or concerning symptoms.

Maternity ultrasound:

Routine antenatal scans for all pregnant women and additional scans for women with higher risk pregnancy.

Local neonatal unit:

For babies more than 27 weeks' gestation requiring specialist neonatal care.

These services are primarily concentrated in Gloucester and Cheltenham, with limited satellite provision for ultrasound and some consultant-led clinics across the rest of the county.

There is a choice of options for place of birth. The full range of choice is not currently available due to temporary closures, but would consist of:

- One alongside midwifery-led birth unit (AMU): Gloucester birth unit in the Women's Centre at Gloucestershire Royal Hospital.
- Two freestanding midwifery-led units (FMU): Stroud Maternity Unit (birthing suite and 6 postnatal beds) at Stroud General Hospital, and Cheltenham Birth Unit (birthing suite) at Cheltenham General Hospital.
- Home birth.
- A consultant-led unit in the Women's Centre at Gloucestershire Royal Hospital (intrapartum care in a delivery suite, and a combined antenatal/postnatal maternity ward).

Cheltenham birth unit and the postnatal beds in Stroud maternity unit have been temporarily closed since 2022, both due to midwifery shortages and to support safety, including the quality standard of 1-1 care in labour across services in Gloucestershire. In November 2025, the home birth service was suspended following safety concerns raised by staff. This decision was made after careful consideration to ensure the safety of mothers, babies, and staff. Work is underway to reopen Cheltenham birth unit and the home birth service.

Our workforce

Since 2022, Gloucestershire has faced midwifery staffing challenges impacting on safety, with the workforce not fully recruited to permanent posts. Focused recruitment and retention efforts have led to significantly improved levels of staffing (although this consists of a high number of newly-qualified midwives), and staff are supported by a new leadership structure.

There has been increasing pressure on the obstetric workforce (doctors) with the changing trends towards increased medical intervention, including caesarean births. This has led to a review of the obstetric workforce supported by NHS England, and obstetric staffing levels have subsequently been increased since 2022[3].

Performance of our services

GHT maternity services have been on an improvement journey over the last few years, overseen and supported by GHT's Board, the ICB, and NHS England's Maternity and Neonatal Improvement Support Team Programme.

Care Quality Commission (CQC) inspections

2022

An inspection of all GHT's maternity services by the CQC in April 2022 led to a rating of 'inadequate', with a section 29A Warning Notice issued for safe care, workforce, and governance processes and systems.

2023

In April 2023, the CQC reinspected the maternity service at Gloucestershire Royal Hospital only, again rating them as inadequate, with a section 29A Warning Notice. A separate CQC inspection in December 2023 of Stroud Maternity Unit led this part of the service to be rated as 'requires improvement'.

2024

In March 2024, the maternity service at Gloucestershire Royal Hospital only was reinspected and again rated as 'inadequate' (the CQC report was delayed and published in January 2025), and the Trust was served a section 31 Warning Notice over concerns relating to: learning from incidents; the provision of safe care; workforce; and governance processes.

[3]Since 2022, investment in the obstetric workforce has enabled new posts, including a 7-day Registrar presence in triage, additional consultant cover for unscheduled care, dedicated 24/7 obstetric and gynaecology on-call roles, and strengthened governance. However, further consultant expansion is required to meet rising clinical complexity.

Maternal and neonatal death reviews

As part of the work to improve quality, experience and safety following CQC inspections, two external reviews were commissioned in 2024 to identify what more GHT could learn from seven maternal deaths (2017–2023) and 44 neonatal deaths (2020–2023). The reviews made a number of recommendations and highlighted some failings in care. GHT has undertaken a substantial programme of work to identify where improvements have already been made and where further action is needed. A robust plan is in place to address any outstanding areas for improvement. The Trust also engaged with the families involved in these reports to acknowledge failings, listen to their experiences and concerns, and ensure they felt confident in the steps the Trust was taking. See more information here.

Progress

There has been some good progress in maternity services. Specific improvements include:

- Increased staffing levels: reduced vacancies in midwifery since 2025, and additional obstetrician posts created and recruited to since April 2022
- New leadership structure and strengthened governance
- Improved staff induction process for agency staff
- Electronic access to maternity notes for women and families (2023)
- Following latest best practice for risk assessment and reducing major bleeding after birth
- Improving blood clot risk assessments
- Strengthening the internal Freedom to Speak Up service
- Providing a range of support for families and staff.

Despite pressures, the 2025 CQC survey focusing on women's recent experiences positions Gloucestershire Hospitals Trust as performing 'Better Than Expected' in labour and birth, highlighting staff dedication and quality of care, whilst underlining the need for consistency of antenatal information and sustained improvement in postnatal experience.

Future state: Changing needs of our population

The maternity health needs assessment provides a comprehensive overview of the demographics and clinical characteristics of Gloucestershire's birthing population. The full needs assessment can be viewed here, and below is a summary of the key findings.

Although there have been a number of improvements to the maternity service, the findings from the needs assessment reveal that we face significant challenges, including health inequalities, inconsistent experiences of people using services, changes in women's choices, and increasing levels of clinical complexity, while needing to operate within a finite financial envelope.

A changing birth rate

The trend in live births in Gloucestershire overall follows the national picture: in 2016 there were 6,739 registered live births, but the rate has decreased since then to just over 5,800 in each of the years 2022-2024.

Birth numbers are expected to **remain stable until around 2032, before a projected modest increase** with district-level variation. This pattern will require adaptable planning for workforce, estate, and community-based services.

Changing demographics

Gloucestershire has a mix of urban and rural areas, and although it is generally affluent and is among the 20% of least deprived counties nationally, there are pockets of significant deprivation. Gloucester and the Forest of Dean have above-average levels of deprivation compared with England as a whole, and these two districts include 12 neighbourhoods ('Lower Super Output Areas') which are in the most deprived 10% nationally, accounting for 3.1% of the county's population. The general fertility rate in 2023 did not vary strongly by national deprivation deciles in Gloucestershire – meaning that births were distributed fairly evenly across the deciles.

Nearly a quarter of births in Gloucestershire in 2024/25 were to women who identified as having an ethnicity that was not white British, with the majority of these being in Gloucester, followed by parts of Cheltenham. 11.8% of women who birthed in Gloucestershire in 2024/25 did not speak English as their first language.

Health inequalities remain a defining issue and are expected to shape future maternity need and provision. Women from deprived areas and ethnic minority communities already experience disproportionately poorer outcomes and greater barriers to care. Future service design will need to focus on reducing inequality of outcomes between our different demographic groups and prioritise culturally sensitive and accessible care.

Local data shows inequality of outcomes in the county among those from deprived areas and/or ethnic minority communities:

- Higher stillbirth and neonatal mortality rates among women in the most deprived deciles and/or among ethnic minorities.
- Babies in the most deprived areas are significantly more likely to be born preterm.
- Asian and British Asian women are more likely to experience third- or fourth-degree perineal tears.
- Women who are of Black, Brown or Mixed ethnicity are more likely to have a postpartum haemorrhage.

National data continues to show persistent inequalities, with higher rates for both stillbirth and neonatal mortality among families from deprived areas and/or ethnic minority communities as follows:

- Despite an 8% decrease in stillbirth rates for babies born to mothers from the most deprived areas (from 4.60 per 1,000 total births in 2022 to 4.23 per 1,000 total births in 2023), these rates remain much higher than those for babies born to mothers from the least deprived areas (2.46 per 1,000 total births).
- Inequalities in neonatal mortality rates by socioeconomic deprivation widened in 2023. Rates increased for babies born to mothers from the most deprived areas (from 2.38 per 1,000 live births in 2022 to 2.50 in 2023), a rate now more than double that of babies born to mothers in the least deprived areas, where the rate decreased from 1.18 per 1,000 live births in 2022 to 1.03 in 2023.
- Stillbirth rates decreased in 2023 for babies of Black and White ethnicities but increased by 9.8% for babies of Asian ethnicity, compared to 2022. Babies of Black ethnicity remain more than twice as likely to be stillborn than babies of White ethnicity (Black: 5.84 per 1,000 total births; White: 2.71 per 1,000 total births). The MBRRACE (2025) report does not identify a single explicit cause for this increase in stillbirths in Asian babies, but it is likely part of a broader pattern of ethnic and socioeconomic inequalities in perinatal outcomes.
- Neonatal mortality rates decreased in 2023 for babies of all ethnicities compared to 2022. However, babies of both Asian and Black ethnicity continue to have much higher rates of neonatal mortality than babies of White ethnicity (Asian: 2.35 per 1,000 live births; Black: 2.28 per 1,000 live births; White: 1.50 per 1,000 live births).

Other inequalities experienced nationally by Black, Brown and Mixed ethnicity women include:

- **Miscarriage rates are 40% higher in Black women, and Black ethnicity is now regarded as a risk factor for miscarriage.**

- **Public Health England's 2020 report found that prematurity (preterm birth) is a major cause of long-term infant morbidity. Black mothers, particularly those of Black Caribbean background, are twice as likely to give birth before 37 weeks.**

- **UK studies show that women from ethnic minority communities are more likely to suffer from common mental health disorders, yet are less likely to access treatment.**

Women experiencing social exclusion and/or severe and multiple disadvantage (SMD) (those who face multiple challenges such as domestic abuse, homelessness, substance misuse, and mental health issues) face significantly greater risks in pregnancy than those without these experiences. These women are at the highest risk of severe maternal morbidity and maternal death, reflecting both heightened need and the systemic barriers they encounter.

These intersecting inequalities highlight the importance of ensuring maternity provision for these women is trauma informed, flexible and aligned with current guidance so that women receive appropriate and equitable care, and improved outcomes. It is also essential to improve interagency collaboration between maternity services, other healthcare services, social care, Family Hubs and voluntary and community organisations to support women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.

Maternal age is linked to increasing clinical complexity in pregnancy, but older mothers can also have greater socio-economic status and access to care. The average maternal age continues to rise, with the average maternal age in England being 30.9 years in 2024. In that same year, nearly two thirds of all births in the county were to people aged over 30. Women over the age of 35 are more likely to experience pregnancy-specific complications, such as gestational diabetes and pre-eclampsia, which increase the risk of adverse maternal and neonatal outcomes. Therefore, maternity services must adapt to manage more complex pregnancies safely and equitably, with appropriate staffing, training, and infrastructure to support personalised and responsive care.

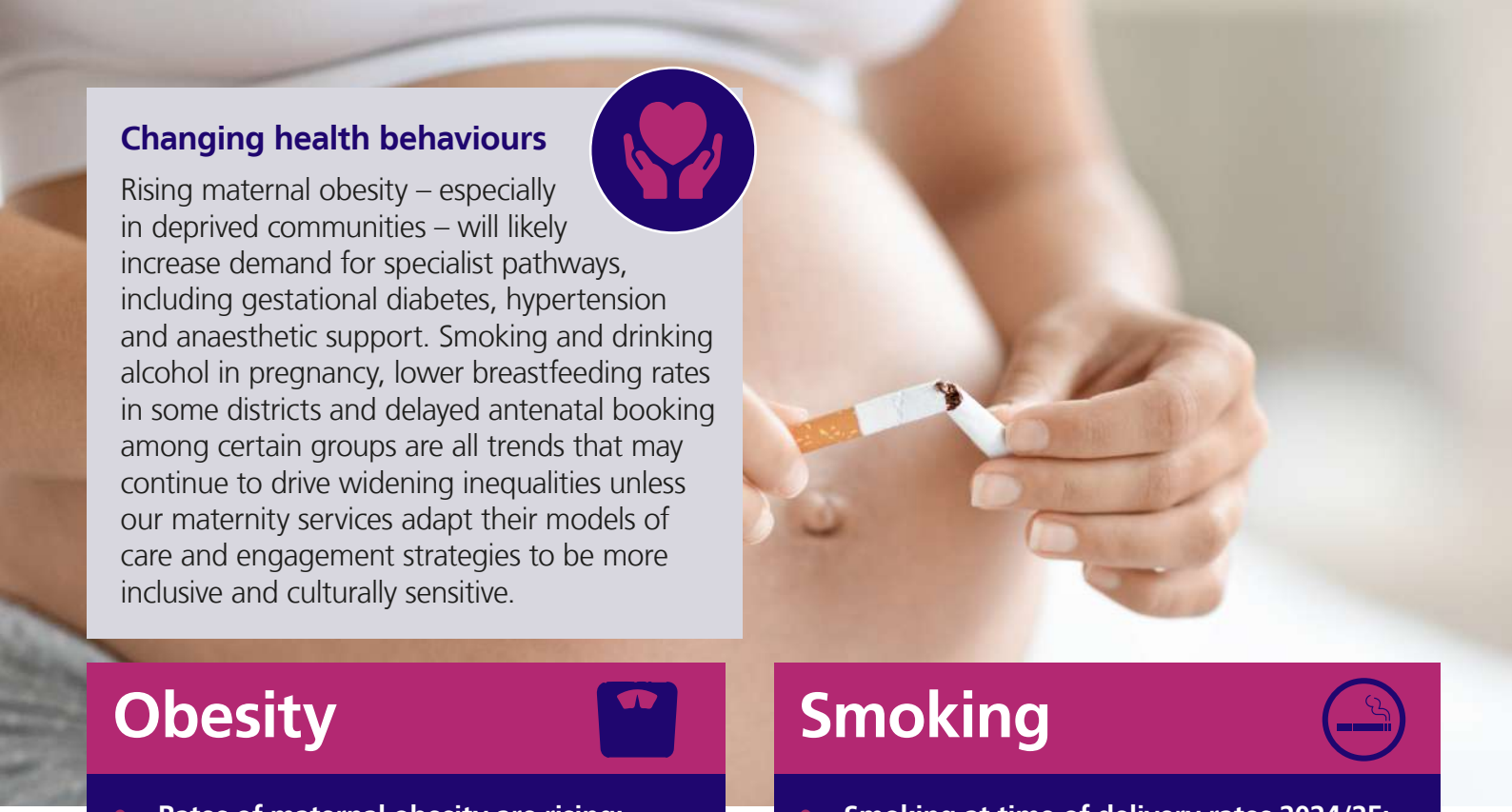
Data modelling based on Johns Hopkins algorithm forecasts that **both low-complexity pregnancies and high-complexity pregnancies will increase by 2040 in Gloucestershire**: **low complexity by 5.11%, and high complexity by 6.68%**[4]. The birth rate is also forecast to increase by then. However, these figures show that high-complexity pregnancies are projected to increase slightly more than low-complexity pregnancies.

More women are now entering pregnancy with multiple long-term conditions and will require consultant care, and this trend is projected to continue. These births are likely to be both more complex and require more medical input, including anaesthetics.

[4]Note – currently the data does not include confidence intervals, so it is not known if these differences are significant. The variance will be reviewed in further work to see if there is a statistically significant difference

Provision of antenatal education

Although there has been some online antenatal education introduced by the NHS in Gloucestershire, there is very limited NHS-led, face-to-face antenatal education, and feedback from some women indicates that having a face-to-face option available would be beneficial. This identifies the importance of understanding the needs within the diverse populations, and to coproduce potential solutions with women and the multi-disciplinary team in the maternity service. It is important to align the antenatal education offer with the Family Hubs model of care to ensure that groups are localised for families and support joint multi-professional working.

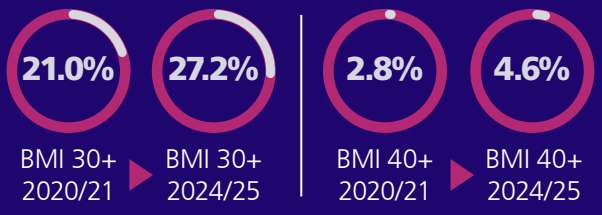


Changing health behaviours

Rising maternal obesity – especially in deprived communities – will likely increase demand for specialist pathways, including gestational diabetes, hypertension and anaesthetic support. Smoking and drinking alcohol in pregnancy, lower breastfeeding rates in some districts and delayed antenatal booking among certain groups are all trends that may continue to drive widening inequalities unless our maternity services adapt their models of care and engagement strategies to be more inclusive and culturally sensitive.

Obesity

- **Rates of maternal obesity are rising:**



- **Particularly prevalent in areas of higher deprivation**
- **Higher risk of maternal complications (gestational diabetes, hypertensive disorders, prolonged labour, caesarean section) and adverse neonatal outcomes (stillbirth, premature birth, childhood obesity).**

Smoking

- **Smoking at time of delivery rates 2024/25:**

- **Although higher than the national average, the local rate has been steadily declining in line with the national average**
- **Rates are highest in the most deprived areas**
- **Increases risk of complications such as low birth weight, premature birth and stillbirth, and long-term consequences for child development.**

Breastfeeding

- **Rates are lowest in Gloucester and the Forest of Dean, and among white British women.**

Alcohol

- **Heavy or regular drinking can cause fetal alcohol spectrum disorder (FASD), and the most serious type of harm called fetal alcohol syndrome (FAS). Children with FASD can have learning difficulties, problems with behaviour, physical disabilities and mental health problems, while those with FAS usually have severe mental and physical disabilities. While there is no local data available about the prevalence of FASD or FAS, studies show that Britain has one of the highest prevalences of FAS in the world.**

Inequalities in outcomes

As we have seen, these demographics and health behaviours feed directly into adverse maternal and neonatal outcomes such as higher rates of stillbirth, neonatal and maternal mortality, full-term neonatal admissions, preterm birth and maternal morbidity – patterns unlikely to reverse without significant targeted intervention. As the maternity population in Gloucestershire continues to diversify and age, the complexity of pregnancies is expected to increase, placing greater pressure on obstetric, fetal medicine and anaesthetic services.

Support for women who experience health inequalities in maternal and neonatal outcomes will need to focus on proactive and preventative measures, and support into early childhood, through interagency collaboration between maternity services, other healthcare services, Family Hubs and voluntary and community organisations.

Importance of preconception care

Preconception care is essential for improving outcomes for both mother and baby, particularly through proactive interventions for those with pre-existing health conditions and/or experiencing health inequalities. However, access to high-quality preconception care is inconsistent, making it vital to consider how it can be delivered more equitably.

Strengthening preconception care should involve integrated, preventative approaches that support individuals before pregnancy, especially those at higher risk of poor outcomes. This period offers a crucial opportunity to identify and address factors that can influence pregnancy and birth outcomes, many of which – such as obesity, smoking, managed and unmanaged chronic conditions, poor mental health, and exposure to domestic abuse – are already present before conception.

Increased demand for ultrasound in pregnancy

There has been an increase in demand for ultrasound scanning in pregnancy, driven by policy changes, which has resulted in demand outstripping current capacity. There is a plan in place to address this, and further work is needed to ensure equitable access. This trend is likely to continue as screening expectations evolve, and as maternal complexity increases.

More consultant-led care

Gloucestershire has seen a shift away from midwifery led births towards consultant-led births since 2019. Despite the temporary closure of Cheltenham birth unit in 2022, this trend mirrors the national picture. More women are giving birth in the consultant unit (an increase from 70.6% of women in 2019 to 82.4% in 2024), and fewer in midwifery-led birth units, as the requirement for consultant-led care has increased.

Caesarean section rates are rising (from 28.5% in 2019/20 to 43.4% in 2024/25), now slightly exceeding spontaneous vaginal births for the first time, and emergency caesarean sections are increasing more rapidly than elective caesareans (10.9% increase in emergency caesarean sections from 2019/20 to 2024/25, compared with 4.0% increase in elective caesarean sections).

The exact reasons for these changes are not fully understood nationally, but are likely to be linked to shifting demographics, including more women giving birth later in life, higher rates of obesity, and a growing prevalence of pre-existing health conditions. This is in addition to change in guidance to ensure women have an informed choice on mode of birth including caesarean section. A growing emphasis on informed choice is likely to influence future patterns

of care further, and a recent review of maternity infrastructure by NHS England suggests that specialist care need will continue to rise (NHS England, 2025).

Induction of labour rates are also rising both locally and nationally. The rate has increased in Gloucestershire from 27.5% in 2021/22 to 33.2% in 2024/25, similar to the national average rates.

Several factors are likely to have contributed to this, including developments in national policy and clinical guidance. These rates are likely to continue to rise as maternal age, obesity and multiple long-term health conditions increase.

Reduction in midwifery-led births

The number of midwifery-led births (birth units and home births) is decreasing, from 28.8% (1669 babies) of all births in the county in 2019 to 16.3% (874 babies) in 2024.

Gloucester birth unit had the most midwifery-led births in the county in 2024, with 13.2% (705 babies) of all births (down from 16.5% (958 babies) in 2019), while Stroud maternity unit had 1.7% (93 babies) (down from 4.2% (242 babies) in 2019), so is now under-utilised. The number of births in Cheltenham birth unit was declining prior to its temporary closure in 2022 (298 in 2019, 233 in 2020, and 141 in 2021), so it is likely that – based on the declining usage of Gloucester and Stroud birth units since 2022 – this decline in Cheltenham would have continued, had it remained open.

Postnatal care

For most midwifery-led birth units, the standard level of care is for women to have a short recovery time (usually within 6 hours) in the room where the birth took place, and then to go home for follow-up support from community midwives. Postnatal beds in Stroud cannot provide the level of specialist care required if a woman needs to stay in hospital following a birth. This is currently provided at the Gloucester site.

Post-operative care for caesarean births is distinct from routine postnatal care and requires additional resources (e.g. increased length of stay) and expertise. Current maternity ward staffing models do not necessarily reflect the complexity of post-operative care. This includes the need for surgical midwifery/nursing skills to manage wounds, monitor complications, and administer an increasing range of medications. With increasingly complex operative births (predominantly as a result of previous caesarean sections and/or maternal comorbidities), a review of postnatal post-operative workforce skills and bed capacity will be required.

Postnatal outcomes and experiences vary significantly by level of deprivation, underscoring the need for consistent, high-quality early postnatal care. Systemwide work has strengthened handovers between maternity, health visiting and general practice, and bereavement support has been expanded to cover 7 days a week. In the future it will remain important to ensure safe and seamless transitions between maternity, health visiting and primary care, especially with changing demographics, and there is a need for better postnatal support for women including around breastfeeding, bereavement and mental health.

Mental health

Around one in four women experience a perinatal mental health condition, and referrals to the Specialist Perinatal Mental Health (PMH) Service continue to grow. However, persistent under-representation of women from deprived and/or ethnic minority groups suggests that improving access and culturally sensitive pathways should remain a priority into the future. As awareness increases and birth trauma recognition expands, demand for specialist perinatal mental health support is expected to rise further.

What women and staff have told us they want from maternity services

Feedback from women

A wide-ranging insight programme involved nearly 900 service users, families, staff and community groups. It also included targeted engagement with Polish, Black and South Asian communities, and a review of Care Quality Commission (CQC) survey results, Patient Advice and Liaison Service (PALS)/Complaints and Friends and Family Test (FFT) survey data.

The insight gathered reveals an inconsistent experience of maternity care in Gloucestershire. Antenatally there are difficulties accessing appointments, inconsistent information, challenges in communication, and a lack of continuity of midwifery care. Intrapartum (labour and birth) experiences are often positive – particularly around staff kindness, compassion, and responsiveness, alongside skilled care and safety – yet some women report feeling pressured into interventions, receiving insufficient explanation of procedures, and variation in service availability (including birth units and home birth cover). Postnatally, many families rely on partners and private/community services due to inconsistent breastfeeding support, variable ward staffing, and limited mental health follow up. Digital record systems such as Badger Notes are widely criticised for usability and reliability.

Key improvement priorities consistently emerge:

- **Strengthened communication at every stage:**
  improved communication; clearer and consistent information about procedures, delays in care, pain relief, and what to expect through labour, aftercare and postnatally once home; information about support services and resources.
- **More reliable and accessible antenatal and postnatal care:**
  improved access/appointment system; more compassionate care; more regular postnatal checks especially around wound care; better postnatal staffing levels on the wards; better postnatal emotional and mental health support, including birth debriefs; personalised, consistent and compassionate postnatal care.
- **Improved inclusivity, cultural sensitivity and equity of access:**
  better access to support services including antenatal classes, breastfeeding support groups, and mental health support, that is easily accessible to diverse communities and people from all parts of the county.
- **Continuity of care:**
  consistency of midwife and appointments to build trust and provide a sense of familiarity and reassurance.
- **Enhanced breastfeeding support:**
  more support with breastfeeding and identification of tongue-tie.
- **Better digital tools:**
  more accessible and reliable digital tools (due to issues with BadgerNet) that enable improved access to information for women, and improved communication between women and health professionals.

A key consideration going forward is how to maximise the impact of insight, working with the Maternity and Neonatal Voices Partnership (MNVP) to develop future maternity services that are personalised, accessible and equitable.

Feedback from staff

A wide range of ideas and feedback was provided from staff working in maternity as well as from those who work closely with maternity colleagues, such as Family Hubs staff, GPs, those in the perinatal mental health team, and health visitors.

The key points include:

- **Staff wellbeing and support:**
  GHT needs to prioritise staff wellbeing by improving working conditions and reducing stress and workload.
- **Communication and collaboration:**
  Clear dissemination of new information, guidelines and systems, and issues and concerns, is required. Improve clarity of roles and more collaborative working across maternity staff, health visitors, GPs and voluntary sector/community organisations, such as through joint monthly meetings and training sessions between midwives and local health visitors.
- **Resource allocation and system flow:**
  A review of working practices would ensure effective use of resources and reduce waste. Streamlining processes and reducing paperwork would allow staff to focus on providing quality care for women and babies and enable more efficient flow through services.
- **Care and services:**
  Focus on providing individualised care. Provide improved postnatal care including breastfeeding support and care on the wards.
- **Midwifery-led care:**
  Support midwifery-led services to be more cost effective and deliver good outcomes.
- **Innovation and new ways of working:**
  Encourage innovative ideas and new ways of working, e.g. the HOME pilot for managing hypertension. Reviewing the role of Maternity Care Assistants would enable them to better support midwives.
- **Information sharing:**
  Referral via BadgerNet has been helpful, although there are reports of challenges in terms of reliability, speed of updates and women being able to access their notes, appointments and general information.
- **Continuity:**
  Greater continuity of midwife would support women, particularly the most vulnerable.
- **Birth trauma:**
  More support needed for those who experience traumatic birth.

From current to future: Challenges we need to address

Based on what we understand about the performance of Gloucestershire's maternity service along with the insight and needs and outcomes of our maternity population, the following key challenges have been identified.

1. Rising levels of complexity

The number of women having consultant-led pregnancies and births, including induction of labour and caesarean births, is increasing.

Several factors are contributing to this rise in consultant-led pregnancies and births:

- **The number of women experiencing clinically complex pregnancies is increasing.** This reflects a range of contributing factors, including an increase in maternal age, higher rates of obesity, a greater prevalence of mental health conditions, and more women living with multiple long-term health conditions. As a result, a growing proportion of women require consultant-led medical care during their pregnancies. This shift has significant implications for maternity services, with more women needing specialist input and oversight throughout their pregnancy and birth.
- **Developments in national policy and clinical guidance** reflect the latest evidence regarding safe and effective care throughout pregnancy and birth. These developments have identified risk factors that could contribute to adverse outcomes for both mothers and babies. As a result, there has been an increase in the number of planned inductions, requiring more specialised care and increasing dependency needs.
- **Shifts in choice and informed decision making are also having an impact.** Coupled with information from new national guidance, changes in the way women are accessing information from a variety of sources to inform their choice has had an impact on women's decision-making regarding birth choices. This has led to greater demand for specific interventions, including inductions and elective caesareans.

It has also resulted in an increasing but still relatively small number nationally and locally of births referred to as 'outside of guidance', i.e. women requesting home or midwifery-led births when this would not usually be recommended by a health professional. This has resulted in an identified need to review local guidance and policies to ensure they follow national guidance and support staff adequately.

Health behaviours and mental health issues can impact on the long-term health of women and the next generation.

Smoking rates and alcohol use in pregnancy, rising levels of obesity, and perinatal mental health issues, are associated with risks of complications for women and babies perinatally as well as long-term health issues. They also have the potential to impact on the health and wellbeing of the next generation. This highlights the importance of embedding prevention through preconception care and optimising opportunities to improve partnership working between maternity services, other healthcare services, social care, Family Hubs and voluntary and community organisations to improve immediate and long-term outcomes. It is particularly crucial for women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.

The NHS 10-Year Plan includes a shift towards wellbeing, ill-health prevention, and maintaining health independence, recognising that improving outcomes for pregnancy and the early years requires proactive measures rather than reactive care. In addition, the Plan highlights giving

every child the best start in life with a focus on the first 1001 days. The local 5-Year Plan engagement response identified supporting parents and families, and health education and prevention in early years, as a priority. To achieve this, maternity services must:

- Explore the provision of preconception care for those women with existing medical conditions or risk factors.
- Work collaboratively with Family Hubs and Neighbourhood Health Services that integrate health, social care, and community support to look for solutions to improve health and wellbeing.

2. Inequalities in access to care, outcomes and experience

Outcomes are poorer for people from ethnic minority and/or deprived communities.

National and local data shows that women from ethnic minorities and/or deprived communities experience poorer outcomes, including increased risks of stillbirth, neonatal mortality, preterm birth, and maternal death, and require culturally sensitive care. These women may experience several practical barriers to accessing care including communication/language, transport, and digital exclusion.

Access to maternity care in Gloucestershire is inequitable, with wide variation depending on where women live and their personal circumstances. For example, some parts of the county have limited availability of maternity services such as routine ultrasound scans. These service inequalities can disproportionately affect those without access to private transport or with complex social needs, ultimately reducing their access to information and therefore their ability to make informed choices about their care.

Wider socioeconomic factors such as unemployment, low educational attainment, domestic abuse, homelessness, digital exclusion, and limited access to transport further hinder engagement with maternity services. These intersecting challenges emphasise the need for targeted enhanced service provision and resources for these women, to support a reduction in health inequalities and disparity inequality of outcomes.

Women from ethnic minority communities, living in areas of deprivation, or experiencing complex social challenges, are less likely to be referred to, or to access, specialist support services like perinatal mental health care. Stigma and mistrust of services may prevent some women from seeking help. As a result, these populations are at higher risk of poorer outcomes.

Some work has been done by the Local Maternity and Neonatal System in Gloucestershire to create an equity action plan focusing on reducing health inequalities and improving outcomes for women from ethnic minority communities and those living in areas of higher deprivation. However, more needs to be done to reduce inequality and ensure that all women have access to the right care and that care is culturally sensitive. Future service design will need to:

- Focus on reducing inequality of outcomes between different demographic groups
- Ensure accessible care

- Demonstrate greater cultural sensitivity, be anti-racist and anti-discriminatory in its design and delivery
- Tackle the systemic factors contributing to poorer maternal outcomes among ethnic minority communities.

Support for women who experience health inequalities in maternal and neonatal outcomes will need to focus on proactive and preventative measures and support into early childhood, through interagency collaboration between maternity services, other healthcare services, Family Hubs and voluntary and community organisations.

People's experience of, and access to, maternity services is inconsistent.

There has been an increasing spotlight on maternity services over recent years, with a number of national investigations and reports giving recommendations on the quality and safety of maternity care. These include the Ockenden Report, Reading the Signals (East Kent), and the National Maternity and Neonatal Investigation that is currently underway (February 2026) – and as part of the latter, Gloucestershire is one of 12 services under review. Gloucestershire Hospitals Trust has had an inadequate CQC rating since 2022 and is working through an improvement journey with the support of the Maternity Services Support Programme, Gloucestershire ICB and NHS England's regional team.

Women in Gloucestershire have shared that their experiences are inconsistent, particularly around communication, postnatal care on the ward, feeding support, and support for mental health issues including birth trauma.

Ensuring a culture of care, inclusion and compassion, appropriate staffing, skills, and expertise in maternity care is crucial for safe, high-quality services and positive experiences for women.

3. Resource constraints

The current workforce model and utilisation of facilities is not designed to meet the changing needs of women. This has increased costs significantly without the same improvement in outcomes.

Workforce

Although there has been some recruitment to consultant posts and Gloucestershire is currently recruited to full establishment for midwives, maternity staffing challenges persist nationally and locally:

- The current Gloucestershire midwifery workforce, with a high number of newly qualified staff, has less experience and specialist skills, for example around home birth and high dependency care.
- The current community midwifery workforce model does not reflect the needs of women, particularly those with more complex health and social needs. The community midwifery caseloads require review so that they are tailored to the level of inequalities and the demographics of different communities across the county. This will ensure equity of provision of maternity care so that improved safety, quality and continuity of care can be provided, reducing staff burnout, dissatisfaction, and workforce loss.
- Increasing complexity of women, changes in national policy and guidelines, and changing choices, means there are not enough permanently recruited obstetricians to meet the rising demand for specialist care and there is also additional demand on theatre staff, including anaesthetists.

Theatre capacity

There is increasing pressure on theatres and post-operative postnatal beds as caesarean section rates rise. Caesarean sections are likely to become more complex as the numbers continue to increase and the surgical challenge and risk of complications increase. Theatre capacity and usage, and post-operative care capacity, should be reviewed.

Birth units

Of the two freestanding midwifery-led birth units in the county (in addition to the alongside midwifery unit in Gloucester), Stroud is open for births, but Cheltenham has been temporarily closed since 2022 to ensure the provision of 1:1 care in labour. For the same reason, Stroud's postnatal beds are temporarily closed.

The number of births in birth units is decreasing – and was reducing even prior to these closures – and current utilisation is low. 14.9% of all births in the county in 2024 were in birth units, down from 25.9% in 2019. In 2024, Stroud maternity unit had 93 births, and the usage of Cheltenham birth unit was declining prior to its temporary closure, with 141 births in 2021. The configuration of staffing and services needs to be considered to meet the changing needs and choices of women, and to reduce inequity in provision.

Financial sustainability

Since 2020, the NHS in Gloucestershire has increased the spend on maternity services from £31 million in 2020/21 to £57 million in 2025/26, an 84% increase despite a reducing number of births. This includes payments to out of county providers of £2.5m in 2020/21 and £4.9m in 2025/26. This significant increase in spend is in response to the changing birth trends and levels of need and complexity amongst women. It is crucial that maternity services deliver high quality, safe and equitable care whilst also providing as much value as possible, and the Government set out a three-year settlement for the NHS in Autumn 2025 which allowed for overall real terms growth of 2.4% per year to 2028/29. Our aim is to ensure that services deliver consistent outcomes and experience whilst keeping within the available resources.

This means looking at opportunities to reshape the way we deliver care to be more productive and provide better value for money, and targeting resources where the health needs of the population are greatest, in order to reduce inequalities in outcomes, in line with the NHS 10-Year Plan.

Whilst we seek to provide health and care closer to where people live, it may be appropriate (clinically and economically) to deliver some services through more central locations in the county and for these to be more streamlined. This may include reviewing how support services are provided as well as how organisations make better use of the estate.

In the public responses to the recent local 5-Year Plan '[Getting ready for the future NOW!]' engagement, approximately 80% of people agreed that services and support that people use most frequently should be available as close to people's own homes as possible and that it is reasonable to travel further for services they don't need as often.

The outcomes that we want

Benefits of developing services that are fit for the future:

Expected Benefits		
Benefit	**Measure**	**Stakeholder**
(What is the benefit?)	*(What is the measure?)*	*(Who benefits?)*
Reduction in inequalities of outcomes between those who experience health inequalities the most and the least. Outcomes include reduction in inequalities in preterm births, stillbirths, small for gestational age, perineal tears, postpartum haemorrhage, neonatal and maternal readmissions, and neonatal and maternal mortality	Metrics on GHT's inequalities dashboard and the national inequalities dashboard comparing differences in these outcomes for those who experience health inequalities	Women and families
Improved and more consistent experience for women	Care Quality Commission annual maternity survey, Maternity and Neonatal Voices Partnership feedback. Targeted engagement to obtain feedback from underserved communities MNVP insight	Women and families
Improved staff satisfaction	Staff survey, vacancy rates, mandatory training completed, staff absence	Staff working in maternity services Women and families
Increase in spend on maternity services limited to the annual net cost uplift factor as issued by NHS England / Department of Health and Social Care	Annual accounts	Wider NHS services and taxpayers

Conclusion and next steps

Ensuring the future sustainability of Gloucestershire's maternity services will require a model that responds to the changing clinical and demographic needs of women, supports informed choice where this can be delivered safely, and delivers equitable, personalised access to high-quality care.

We need to balance the challenges we face of health inequalities, increasing levels of clinical complexity and resource constraints, whilst operating within a finite financial envelope. This means thinking differently about how the maternity service is designed and delivered, and focusing on where we can have the greatest positive impact on experiences and outcomes for women, babies and families.

By designing services that reduce inequalities in outcomes, meet the needs of our diverse communities, are financially sustainable and create the right conditions for staff to provide safe and compassionate care, we can build a maternity system that is both resilient and truly responsive to the women and families it serves.

Further conversations and engagement are now needed with women, clinical staff and wider stakeholders, to share the Case for Change and research about what works elsewhere, and codesign potential solutions for a maternity service fit for the future.

Glossary

Antenatal

The period of pregnancy before birth, including all care and appointments provided to pregnant women during this time.

Antenatal education

Information and classes designed to help women and families prepare for labour, birth, and early parenthood.

BadgerNet / Badger Notes

The digital record system used in maternity services to store pregnancy notes and enable information sharing between women and clinicians. BadgerNet is for staff, and Badger Notes is the app for women.

Birth unit (Midwifery-led unit – MLU)

A unit run by midwives for women with low-risk pregnancies who want a birth with minimal medical intervention.

- **Alongside midwifery-led unit (AMU)**: A midwife-led birth unit located next to a consultant-led unit.
- **Freestanding midwifery-led unit (FMU)**: A birth unit run by midwives that is located away from a consultant-led unit.

Caesarean section

A surgical procedure to deliver a baby through an incision in the abdomen and womb.

- **Elective**: planned in advance.
- **Emergency**: carried out during labour when concerns arise about the health of mother or baby.

Care Quality Commission (CQC)

The national regulator for health and care services in England. It inspects and rates NHS services, including maternity care, for safety and quality.

Complexity (low / high)

A way of categorising pregnancies based on health risks:.

- **Low complexity:** minimal health concerns and typically suitable for midwifery-led care.
- **High complexity:** more health risks, often requiring a consultant-led care and closer monitoring.

Consultant-led care

Medical care provided by consultants and specialist nurses for women with higher risk pregnancies or complications.

Consultant-led unit

A hospital-based unit where care is led by consultant obstetricians, suitable for women with higher-risk pregnancies

Continuity of care

A maternity model in which women see the same midwife or small team of midwives throughout pregnancy, birth, and the postnatal period.

Deprivation (IMD Deciles)

A measure of socioeconomic disadvantage using the national Index of Multiple Deprivation. Areas are ranked from 1 (most deprived) to 10 (least deprived).

Delivery suite

The part of a consultant-led unit where women give birth with medical and specialist support available.

Equity action plan

A local plan setting out actions to improve access, reduce inequalities, and achieve fair outcomes for all women and babies.

Family hubs

Local centres providing joined up support for families, including health, early years, wellbeing and parenting services.

Fetal medicine

A specialist service that supports pregnancies where the baby in the womb has diagnosed or suspected health conditions

Fetal medicine network

A regional network of specialists who support pregnancies where the baby has diagnosed or suspected health conditions.

Friends and Family Test (FFT)

A national survey asking patients whether they would recommend the service they received to friends and family.

Gestational diabetes

A type of diabetes that develops during pregnancy and usually resolves after birth.

General fertility rate (GFR)

Birth rate per 1,000 females aged 15 to 44 years.

Governance

The processes and systems used to ensure safe, high-quality healthcare, including oversight of risks, incidents and improvements.

High dependency care

Specialist monitoring and treatment for women who require a higher level of medical support during pregnancy, labour or after birth.

Home birth
Giving birth at home with support from midwives. Suitable for some low-risk pregnancies.
Induction of labour
A process used to start labour artificially, often due to medical reasons or developing risks in pregnancy.
Integrated Care Board (ICB)
The NHS organisation responsible for planning and funding local health services, including maternity care.
Intrapartum
The period of labour and birth.
Local Neonatal Unit (LNU)
A hospital unit providing specialist care for newborn babies who are premature or unwell.
Maternal Medicine Network
A regional network of specialists who support women with significant pre-existing medical conditions during pregnancy.
Midwifery-led care
Care delivered by midwives for women with uncomplicated pregnancies, focusing on natural labour and birth.
Multiple long-term conditions
When someone has more than one chronic health condition, such as diabetes, hypertension or asthma, which can affect pregnancy.
Neonatal mortality
The number of babies who die within the first 28 days of life.
Ockenden Report
An independent review into maternity services in England, highlighting improvements needed to ensure safe, high-quality care.
Patient Advice and Liaison Service (PALS)
A service that helps resolve concerns, complaints or questions about NHS care.
Perinatal mental health (PMH)
Mental health conditions occurring during pregnancy or within the first year after birth.

Postnatal
The period after birth, usually described as the first six weeks.
Section 29A / Section 31 Warning Notice
Formal notices issued by the CQC when serious concerns are identified in NHS services, requiring urgent improvements.
Severe and multiple disadvantage (SMD)
Multiple challenges such as domestic abuse, homelessness, substance misuse, and mental health issues.
Ultrasound (Maternity Ultrasound)
Scanning in pregnancy that uses sound waves to check the baby's development and wellbeing.

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