Department of Health & Social Care

From Baroness Merron
Parliamentary Under-Secretary of State for Women's Health and Maternity

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End Inequality in Baby Loss campaign group
Sands
By email to: campaigns@sands.org.uk

19 August 2026

Dear Sands #EndInequalityInBabyLoss campaign group,

Thank you for your correspondence of 8 May to the then Secretary of State, and for the petition handed to the Prime Minister's Office on 11 May, about inequalities in baby loss. Your petition has been passed to this department, and I am replying as the Minister for Maternity. I am sorry that you have not received a more timely reply and thank you for your patience.

I was very sorry to read of the deaths of Vaishali's daughter, Jaya, of Bhavna's and Vijay's son, Joshan, and of Amber's and Darren's twins. I would like to offer them my sincere sympathies for their losses. I was also very sorry to learn of the shocking and unacceptable experiences each of the families has endured.

I recognise the support your open letter has received, and I am grateful to each of you for the work you have done to raise awareness of inequalities in baby loss. Every woman and baby has a right to receive safe, equitable and personalised care.

I want to reassure you that we are committed to ensuring the voices of women and families are at the heart of improving standards.

It is unacceptable that there are stark inequalities in healthcare for women and babies. It is a priority for the Government to ensure all women and babies receive the high-quality care they deserve, regardless of their background, location or ethnicity. We know that addressing inequalities includes taking action before women reach maternity care and after they return home. It also includes working to improve women's and babies' experiences and outcomes.

For too long, women and babies have experienced poor care and avoidable harm during pregnancy and childbirth, and this must end now.

We must fundamentally reset the current maternity and neonatal service, which is seen to protect itself above its duty to protect women and babies during one of the most vulnerable times in their lives. That is why we commissioned the national independent investigation into NHS maternity and neonatal care, to bring together findings from past reviews, local

investigations of selected trusts, and evidence from thousands of women, families and staff into a single set of recommendations.

Baroness Amos published the final report and recommendations of the investigation on 30 June. Her investigation found that women and families are not being listened to, there is a lack of accountability when things go wrong, and racism and discrimination are driving inequalities in outcomes. She found a system that is fragmented, overly complex and too slow to learn.

On 24 June, the independent report into Nottingham University Hospitals NHS Trust exposed serious and sustained failures in maternity and neonatal care. There was evidence of abhorrent mortuary practice, a systemic failure to listen to women, a lack of accountability across senior leadership teams, and clear evidence of racism and discrimination. No woman, baby or family should ever have to go through the harrowing experiences detailed in Donna Ockenden's final report.

We are determined to break the cycle of recommendations that do not deliver the change that we know is needed. That is why the Government has announced the appointment of the first-ever Maternity and Neonatal Commissioner. This was one of Baroness Amos's urgent recommended actions, and we accept that this is a crucial first step for us in overseeing systemic improvements to care and outcomes, and earning back the trust of women and families. This role, which will be discussed urgently with the National Maternity and Neonatal Taskforce, will have a relentless focus on driving improvements in maternity and neonatal care, including co-chairing the Taskforce.

We will translate the recommendations from Baroness Amos's investigation and Donna Ockenden's national recommendations into a single national action plan to drive systemic and sustained improvement across maternity and neonatal care. The National Maternity and Neonatal Taskforce, which is composed of family representatives, clinicians and other experts, and chaired by the Secretary of State, will oversee the development of this action plan, which will be published by the end of the year. Once published, the Taskforce will hold the system to account for implementing the action plan and improving outcomes and experiences for women, babies, families and staff.

We are also taking immediate action to make sure maternity care is safe for all women and babies. We will implement new standards for maternity triage across the country, tackle the 'postcode lottery' in care, invest £41million to improve maternity and neonatal safety, and take further action to tackle unacceptable inequalities affecting Black, Asian and disadvantaged women from all backgrounds.

The Government is committed to setting explicit targets to close the maternal mortality gap. We are taking an evidence-based approach to determining the targets, ensuring that they are centred on women and babies. We have also launched an inequalities dashboard to bring together a range of information on inequalities. This will allow NHS trusts to see data relating to inequalities and track the progress of initiatives in real time. It will enable the identification of areas where Black and Asian women, and women from socioeconomically deprived backgrounds, experience the greatest inequities in care and health outcomes.

We are currently rolling out the Perinatal Equity and Anti-discrimination Programme, which will be available to all NHS trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination by improving the experiences and outcomes of ethnic minority groups and those from deprived communities and supporting staff to work in environments free from discrimination and racism.

In addition, NHS England has worked closely with stakeholders, including integrated care boards (ICBs), trusts, voluntary sector partners and national bodies such as the Office for National Statistics, to develop the *Ethnicity Recording Improvement Plan*. The plan sets out five areas for action by ICBs and healthcare providers that are essential to improving ethnicity recording practice, accurate recording and robust analysis to understand inequalities between groups. The plan is available at www.england.nhs.uk/long-read/ethnicity-recording-improvement-plan.

NHS trusts also provide cultural competency training for maternity staff as part of the core competency framework, which sets out clear expectations for trusts. It ensures that training to address significant areas of harm is included as a minimum core requirement and is standardised for every maternity and neonatal service.

Tackling the underlying problems is fundamental to ensuring that all women and babies receive the care they deserve, and we are committed to improving outcomes for all women and babies.

I hope this reply is helpful.

All good wishes,

BARONESS MERRON

cc campaigns@sands.org.uk