The Health and Social Care Alliance Scotland (the ALLIANCE)

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Healthcare Improvement Scotland – Maternity Care Standards ALLIANCE response

07 November 2025

Introduction

The Health and Social Care Alliance Scotland (the ALLIANCE) welcomes the opportunity to respond to Healthcare Improvement Scotland's consultation on the draft Maternity Care Standards[1]. As recent events have made clear, robust, person centred and rights based standards are essential to achieving equitable, compassionate and high quality maternity care for all women in Scotland[2].

Our response draws on lived experience evidence from 'Trauma, Abandonment and Isolation' – a 2023 joint research report by Engender and the ALLIANCE which captured the voice of more than 200 women about their experiences of maternity care in Scotland during the COVID-19 pandemic. While many of these accounts were pandemic specific, they also revealed long-standing systemic challenges within maternity services, including inconsistent communication, lack of continuity, limited mental health support, and unequal experiences of care. Additionally, our response includes experiences shared during a focus group facilitated by the ALLIANCE, on behalf of Healthcare Improvement Scotland.

The ALLIANCE welcomes the ambition and overall direction of the draft standards, which mark a significant and positive step towards more consistent and person centred maternity care across Scotland. We particularly welcome the strengthened focus on continuity of care across the maternity pathway, more considered integration of mental health and wellbeing, the attention to bereavement and loss support, and the commitment to improving access to unscheduled and urgent care. Together, these elements demonstrate a welcome effort to ensure that maternity care reflect the holistic needs of women and their families.

The ALLIANCE welcomes the Standards' acknowledgment of the gendered nature of health and healthcare. Our work consistently finds that women often fear their concerns will not be taken seriously, and that gender inequalities continue to shape access, diagnosis, and treatment across the health system. Tackling these inequalities requires an explicitly gendered

and intersectional approach that recognises how women's experiences are affected by overlapping factors such as disability, race, and socio-economic status.

At the same time, however, the ALLIANCE identifies several critical gaps that must be addressed to ensure women and birthing people's rights are fully realised in practice.

First, the ALLIANCE strongly advocates for the creation of a standalone standard on communication, recognising that effective and accessible communication underpins every aspect of safe, equitable maternity care. Without accessible information, women and birthing people cannot meaningfully exercise their right to health or make informed choice. A standalone standard would embed inclusive communication from the outset, ensuring high quality information in formation such as BSL, Braille, Easy Read supported by staff trained to communicate across diverse needs.

Currently, we have concerns regarding the accessibility of the Standards in their draft form. The current materials are lengthy, not accessible to those who use BSL, highly technical in parts and use language that is not easily understood by the wider public (for example, "triumvirate leadership"). In particular, the ALLIANCE are concerned at how the lack of accessible documentation will leave many groups underrepresented and skew participation in the development of these Standards. This echoes findings from the ALLIANCE's More than Words: Communication for All campaign[3], which calls for accessible communication to be embedded as a basic standard across all areas of health and social care. We recommend that going forward Health Improvement Scotland provides accessible and inclusive material for all women.

Second, the absence of abortion and limited reference to miscarriage are significant omissions. Decisions around continuing or ending a pregnancy are central to reproductive rights and should be reflected within a rights

based maternity framework. Alignment with the Scottish Government's Miscarriage Care in Scotland delivery framework should be ensured.

Finally, the standards should explicitly acknowledge the lasting psychological impacts of COVID-19 on those who were pregnant, gave birth or experienced loss during that period. Isolation, disrupted care and the absence of partner support were described as deeply traumatic, with ongoing effects on mental health and family planning decisions. Recognising these experiences would help ensure services remain sensitive, trauma-informed and responsive to continuing need.

The ALLIANCE further recommends the additional priorities to strengthen the draft Maternity Care Standards;

- Inclusion of care partners throughout full maternity care pathway
- Integrating ongoing lived experience feedback loops
- Greater emphasis on intersection and trauma-informed training
- Ensuring accessible complaints process and information

Question 2: Do you support Standard 1: Principle of care as currently written? (Scaled Question)

Scaled Response: Slightly support

Please tell us why you think this?

The ALLIANCE believes that implementing a holistic, person centred approach as outlined in Principle 1 is essential to realising women's human rights and improving both experiences and outcomes across the maternity pathway.

We agree that all maternity care should be high quality, personalised, integrated, and coordinated, promoting choice and shared decision making. Our joint research with Engender found that many women felt their maternity care fell short of these principles. Participants frequently reported not being listened to, taken seriously, or actively involved in decisions about their own treatment or birthing choices. One participant summarised the situation starkly;

> "Pregnant women were forgotten about and treated like second class citizens with their rights taken away".[4]

While many experiences were pandemic specific, they also revealed long-standing systemic issues in Scottish maternity services. Centralised models, reduced in-person care and inflexible processes often left women feeling anxious and out of control. These experiences demonstrate the need for flexible, empathetic and rights based practice that builds trust and respect.

Our findings also highlight how gender inequality and ableism continue to shape women's experience of maternity care. In a separate research project, Engender found that disabled women and women with learning disabilities reported paternalistic interference in reproductive decision-making[5]. We therefore welcome Principle 1's focus on embedding individualised, person centred approaches that respond to each woman's or birthing person's specific needs.

The ALLIANCE strongly welcome Standard 1.5, which commits to delivering high quality, accessible, and tailored information to support informed choice. During the pandemic, 48% of participants in our joint research with Engender said they did not have the information they needed about vaccination in pregnancy, and one in five reported that information was not provided in accessible formats. Findings from the ALLIANCE's More than Words: Communication for All campaign[6], which calls for accessible communication to be embedded as a basic standard across all areas of health and social care, indicate that only with high quality and accessible information can women make informed choices about the support and service they receive.

We also welcome Standards 1.7, 1.10 and 1.11 which strengthen continuity and integration across the entire maternity pathway. Our research showed that maternity care often focuses narrowly on delivery, with limited attention to antenatal preparation and postnatal support. This fragmentation left needs such as breastfeeding support and pain management overlooked. Ensuring continuity of care through a consistent midwifery relationship, as set out in Standard 1.7, would help address these gaps and promote safety and confidence.

The ALLIANCE welcomes the Standards' commitment to a human rights based approach to maternity care. Standard 1's focus on participation and empowerment reflects our recently published research and development of a suite of resources[7] focused on improving rights based policy and practice in health and social care. These tools, including a practical rights based decision making flowchart, could be used alongside Healthcare Improvement Scotland's equality and impact assessments to strengthen implementation and ensure that rights are embedded in everyday decision making across maternity care.

Finally, Standard 1.8, with its clear emphasis on partnership provides a crucial mechanism for translating these principles into practice and

ensuring that care remains integrated, continuous, and grounded in dignity throughout the maternity journey.

Do you have any changes you would like to propose to standard 1: Principles of care?

Stronger integration of mental health

Standard 1 could more explicitly embed mental wellbeing as a core component of safe, high quality maternity care – recognising that emotional safety and psychological support are integral to physical outcomes. Our research with Engender highlighted how mental health was often treated as secondary to physical care needs, despite participants describing intense anxiety, isolation and distress throughout pregnancy, birth, and the postnatal period. This could include explicit reference to early identification, proactive communication about mental health and ensuring all staff apply trauma-informed principles in routine interactions.

A more considered and inclusive approach to tailored information

The ALLIANCE would welcome a more considered and inclusive approach to tailored information and communication within Standard 1. Tailored communication should be recognised as a fundamental component of high quality, rights based, person centred maternity care. The Standard should explicitly state that communication must meet the needs of all women, including disabled women, those with sensory loss, learning disabilities or for whom English is not a first language. Information should be available in a range of formats – such as BSL, Braille – and developed in collaboration with those who use these formats to ensure genuine accessibility.

Additionally, the ALLIANCE recommends that the commitment to providing considered, inclusive and tailored information explicitly extends to mental health. During the focus group we facilitated for Health Improvement Scotland, one participant who experienced postnatal anxiety explained that she did not recognise what she was experiencing as she had no knowledge that postnatal anxiety existed. While awareness of, for example, postnatal

depression is more established, there remains limited understanding and public awareness of other conditions. Ensuring information on mental health is provided would help women to recognise concerns, seek timely help and feel confident that mental wellbeing is an integral part of maternity care.

Question 3: Do you support Standard 2: Leadership and culture as currently written?

Scaled Response: Slightly support

Please tell us why you think this?

The ALLIANCE supports the intent of Standard 2 and its emphasis on collective and compassionate leadership as the foundation of safe, person centred maternity care. Our joint research with Engender demonstrated that the systemic challenges in maternity care – such as fragmented communication, lack of continuity, and uneven quality of support – are often symptoms of structural and leadership level issues, rather than an individual failing. Ensuring strong, visible leadership at every level is therefore essential to delivering consistent and integrated care across the antenatal, intrapartum, and postnatal pathway.

We particularly welcome the Standard's alignment with the ALLIANCE Health and Social Care Academy's[8] Five Ambitions for the Future of Health and Care, and specifically the ambition to "Lead Courageously"[9]. Courageous leadership is about more than management; it means being willing to challenge entrenched systems, share power and make decisions that prioritise rights, dignity, and wellbeing. This type of leadership must exist at every level and include space for reflection and learning across teams. It requires openness, accountability, and a commitment to tackling inequalities, even when that demands cultural or systemic change. Crucially, courageous leadership should also extend to women themselves. They must be recognised as leaders in their own care, empowered to make informed decisions and supported to shape the culture of maternity services.

Creating a culture of effective leadership to encourage openness and continuous improvement also depends on building an environment where both staff and women feel safe to raise issues and give feedback without fear. Open communication and visible accountability are key to learning and improvement. Evidence from the ALLIANCE's 'Investigating

Knowledge and Understanding of the Right to Health'[10] found that complaints mechanisms across health and social care are often inaccessible or difficult to navigate, particularly for those facing communication barriers.

Maternity services should therefore provide information on rights and feedback pathways in multiple formats and languages, ensuring that every person can participate safely and confidently in shaping their care.

Do you have any changes you would like to propose?

Accessible Complaints Process Information

The ALLIANCE recommends that Standard 2 include explicit commitments to ensuring feedback and complaints processes are clear and accessible to all, so that every woman, birthing person, and member of staff knows how to raise a concern and that their voice will be heard and acted upon. Our research, *Investigating Knowledge and Understanding of the Rights to Health*, found that many people experience significant barriers to raising concerns or navigating complaints systems. Information about how to give feedback or make a complaint should be communicated in plain language and multiple inclusive formats.

Question 4: Do you support Standard 3: Clinical effectiveness as currently written?

Scaled Response: Slightly support

Please tell us why you think this?

The ALLIANCE supports the intent of Standard 3 and welcomes its focus on developing safe, compassionate, and well-functioning multidisciplinary teams. We particularly welcome the recognition that staff wellbeing, reflective practice and psychological safety are essential foundations for high quality, person centred care.

Our joint research with Engender found that women's experience during the pandemic often reflected both the pressures faced by maternity staff and the fragmentation of teamwork across services.

Participants expressed empathy for midwives and clinicians who were clearly overstretched, but also described how those pressures sometimes resulted in poor communication or insensitive interactions. Inconsistent advice and frequent staff changes undermined confidence and a sense of safety. As participants reflected;

> "The hospital staff seemed busy and short staffed, and I found support from them was lacking"[11]
>
> "Lack of staff on maternity ward at Aberdeen maternity hospital was detrimental after my c-section"[12]

These findings illustrate that the quality of teamwork and care cannot be separated from the conditions staff work in. When teams are overstretched or unsupported, women feel the impact immediately. Measures that promote compassionate teamwork, continuous learning and trauma-informed practice will help staff respond more effectively to the diverse needs of women.

We particularly support Standards 3.6, 3.9, 3.10, 3.11 and 3.12, which focus on open communication and joint learning. Evidence from our research showed poor communication across community, hospital, and specialist teams, often resulting in confusion – for example contradictory advice on pain management, breastfeeding or discharge planning. Strengthening communication cross these interfaces is vital to ensure continuity of information and safety.

The ALLIANCE also welcome the Standard's emphasis on professional development but is concerned that that increased training and Continuous Professional Development (CPD) could initially reduce time for direct care. Training must therefore be properly resources, scheduled and supported, not added to existing workloads. This investment will enable safer and more efficient practice.

The ALLIANCE strongly supports the commitment to multidisciplinary and interdisciplinary working. Collaboration between midwives, obstetricians, anaesthetists, mental health professional and third sector partners is essential to address physical, psychological and social needs holistically. This joined up approach is key to delivering person centred and equitable services.

Do you have any changes you would like to propose?

Resourcing and Workforce Capacity

Cultural change and multidisciplinary collaboration are essential, but they cannot be achieved if midwifery and obstetric teams continue to operate under overstretched conditions. Participants in our joint research with Engender described staff who were under significant pressure, which in turn, affected communication, compassion and consistency of care.

To make Standard 3 viable, there must be sufficient staffing, protected time, and leadership support to enable teams to engage in reflective

learning, supervision, and CPD. Without these resources, even the most well-intentioned ambitions risk becoming unachievable.

Better training in perinatal mental health and trauma-informed care

We recommend that Standard 3 include explicit reference to improved and ongoing mental health training for all maternity staff, ensuring they can recognise, respond to and refer appropriately for perinatal mental health concerns. The inclusion of mental health professionals within multidisciplinary team would further strengthen collaborative working and ensure psychological wellbeing is addressed alongside physical health and not treated as a secondary concern.

While we welcome the reference to vicarious trauma in Standard 3.8, we recommend embedding explicit trauma support for staff. In recognition that midwife teams can also be mothers, have experienced their own loss, or had traumatic birthing experiences. The link exhibited between staff morale and capacity to women's experiences underlines this importance to ensure staff are properly supported in their own experiences to ensure high quality support for women.

Equality, Rights and Intersectional training

We recommend that Standard 3 should more clearly recognise that high-performing teams must be equipped to respond to the needs of women with diverse life experience. Findings from the focus group we facilitated for Health Improvement Scotland revealed the lack of awareness around topics such as substance abuse, domestic abuse and mothers who are notified that their child will be removed from their care at birth.

The same standard of training should also be extended to providing high quality and tailored care to women with sensory loss. One participant in the focus group revealed that during their time in hospital, their glasses were placed on a top shelf which was unreachable. Consequentially, the participant could not alert staff that they needed assistance using the emergency care button because they could not locate it.

Training in equality, rights, intersectionality, stigma, cultural competence, sensory awareness and inclusive communication would help reduce the unequal impact of maternity outcomes linked to disability, ethnicity, socioeconomic status, or migration background. This should be treated as an ongoing component of professional education rather than an optional add on.

Question 5: Do you support Standard 4: Core care: antenatal, intrapartum, and postnatal assessment and care?

Scaled Response: Slightly Support

Please tell us why you think this?

The ALLIANCE recognises the importance of Standard 4 and its focus on ensuring that all women receive compassionate, high quality care across the full maternity journey. The whole-pathway approach outlined rightly reflects that high quality antenatal, intrapartum and postnatal care is essential not only to reducing maternal and perinatal mortality, but also to support physical recovery, emotional wellbeing and long term health for both parent and baby. Ensuring consistent access, continuity of care and integration of mental health and social support throughout this pathway will be key to achieving these aims.

Standard 4.3, which commits to personalised care planning across the entire pathway, has clear potential to improve the quality and coordination of care. When implemented effectively, such plans can ensure that services reflect each woman's individual circumstances, preferences and support network.

Evidence from our joint research with Engender indicated, however, that current maternity provision in Scotland too often prioritises the delivery period, with antenatal and ongoing postnatal care receiving significantly less attention and resource. Participants repeatedly described a narrowed focus on intrapartum care and urgent postnatal needs, with limited or cancelled antenatal appointments and minimal community follow-up after discharge. Some reported being unable to access any antenatal or postnatal services at all. This fragmentation left many feeling isolated, unprepared and unsupported, particularly for first-time parents, who spoke of anxiety and a lack of confidence in recognising labour or newborn health concerns.

We note positively the inclusion of Standard 4.2, which integrates mental health into assessment and care planning. Many participants in our research described experiences of distress, anxiety or trauma that went unrecognised or unaddressed within their maternity care. Embedding mental health awareness into routine planning is therefore vital to early intervention, prevention and recovery.

Our evidence also highlights that fragmented antenatal and postnatal care risks widening health inequalities. Accounts from both our joint research with Engender and the ALLIANCE facilitated focus group for Healthcare Improvement Scotland illustrate how women with financial means were often able to access private antenatal or scanning services, while others were left without reassurance or adequate information. Access to consistent, high quality NHS antenatal care should therefore be regarded as a core equity measure, directly linked to improved maternal and infant health, life expectancy and overall population wellbeing.

Do you have any changes you would like to propose?

Modernise and diversify antenatal education to ensure inclusivity and cultural sensitivity

The ALLIANCE recommends that antenatal education better reflects Scotland's diverse families with the commitment to ensuring all antenatal education is inclusive, up-to-date and co-designed with women from diverse backgrounds. Education should recognise different family structures and experiences of disability, to ensure everyone feels respected and represented. Participants in our research raised concerns that antenatal education material and online classes they were directed to in the absence of in-person classes were often outdated, heteronormative, lacked cultural relevance and included stigma concerning breastfeeding.

Recognition of the social and relational value of antenatal care

We recommend that Standard 4 more explicitly recognise the social and relational value of antenatal care, particularly in preventing mental ill-health

and improving parenting confidence. Participants in our joint research with Engender and focus group for Healthcare Improvement Scotland described antenatal appointments and classes as critical opportunities not only for medical monitoring but for building trusted relationships with midwives, peer support networks, and wider community connections. These networks help reduce isolation and improve continuity of care, though they should complement rather than replace other health and social care services.

Question 6: Do you support Standard 5: Unscheduled and unplanned care as currently written?

Scaled Response: Slightly support

Please tell us why you think this?

The ALLIANCE supports Standard 5 and its focus on ensuring women can access timely, safe, and person centred unscheduled and additional care whenever they have an urgent concern about their pregnancy.

We especially welcome Standards 5.3, 5.5 and 5.6 which emphasise the ability to access timely care in relation to maternity triage, unscheduled care and within any clinical care setting. Additionally, the ALLIANCE also welcomes Standard 5.1 specifically in relation to providing clear information to women about their local maternity triage unit.

Our joint research with Engender found that during the pandemic many women experienced serious difficulties accessing urgent or unscheduled care. Participants described confusion about who to contact, unanswered calls and lengthy delays in receiving reassurance or assessment. One woman explained:

> "I discovered I was pregnant within the first month of lockdown, notified GP but got zero appointments. I then miscarried, again notified GP but again got zero appointments of follow ups".[13]

This account illustrates how the absence of clear, accessible routes to care can lead to preventable trauma, loss of trust and long-term mental health consequences. Participants also consistently referenced the lack of information on who to contact in case of emergency. Ensuring that every women/birthing person knows who to contact and how to access urgent help is a cornerstone of safe maternity care.

We also welcome Standard 5.2, which embeds the principle that women should be able to self-refer to maternity triage services and be treated as experts in their own experience (as expanded on in Standard 2). Alongside

these experiences, our research showed that fear of being dismissed, or uncertainty about what symptoms warranted escalation often delayed help-seeking. Enabling direct access empowers women to seek timely care and reinforces a person centred, rights based approach.

Standards 5.1 and 5.4, which emphasise clear, standardised information and coordinated communication across services, are critical to restoring trust. Our report underscores the need for consistency across NHS Boards in unscheduled care pathways. During the pandemic, inconsistent application of guidance and varying local rules left many women confused and anxious.

Do you have any changes you would like to propose?

Inclusion of care partners and supporters in unscheduled or additional care

We recommend that Standard 5 explicitly commits to enabling the presence of chosen care partners wherever possible in all forms of unscheduled and additional care. Their inclusion is not only a matter of compassion but of dignity through the support and communication provided by care partners, reducing fear and anxiety at moments of acute vulnerability. This principle should apply across all care settings.

Participants in our joint research with Engender highlighted the distress caused by having to attend appointments and procedures alone during the pandemic. This included routine scans, managed miscarriage and abortion care. Many described these experiences as deeply traumatic and isolating. While such restrictions were COVID-specific, they revealed the lasting importance of ensuring that unscheduled and additional care pathways recognise the emotional as well as physical dimensions of safety throughout maternity care.

Strengthening trauma-informed practice across emergency and urgent care

The ALLIANCE recommends that Standard 5 include a clear commitment to maternity-related trauma-informed training for all emergency and urgent-care staff. Our evidence highlights that emergency or unplanned care for pregnant women can often take place outside maternity specific environments, such as emergency departments, ambulance service, or general hospital wards. Staff in these setting may not be as familiar with the physical, psychological and emotional complexities within maternity care surrounding pregnancy, miscarriage, or birth trauma.

This training should ensure that staff can respond with empathy, respect and sensitivity to women who have experience pregnancy loss, trauma, or fear during unscheduled episodes of care. Trauma-informed practice is central to improving both patient safety and emotional wellbeing and must be embedded consistently across the wider health system – not only within maternity wards.

Ensuring equity of access

Our joint research with Engender highlighted how language barriers, disability, and digital exclusion meant that some women could not reach timely help during COVID-19. To make Standards 5.1 and 5.3 fully effective, 24/7 unscheduled care must include translation services, accessible communication formats and reasonable adjustments for disabled people. This would ensure that unscheduled and unplanned care is accessible and available to everyone who requires this service.

Question 7: Do you support Standard 6: Mental health and wellbeing: women and babies as currently written?

Scaled Response: Slightly support

Please tell us why you think this?

The ALLIANCE supports Standard 6 and its emphasis on ensuring that women receive timely, high quality mental health care and wellbeing support throughout the maternity pathway. Emotional and psychological health are inseparable from physical safety, and maternity services must not only promote but guarantee access to appropriate mental health assessment and support from pre-conception throughout pregnancy, birth and the postnatal period.

We particularly welcome Standards 6.3, 6.4 and 6.5 which commit to professionals being proactive in identifying, discussing and responding to mental health needs while also supporting women to recognise changes in their own wellbeing. This shared responsibility approach acknowledges that women are experts in their own experience, while ensuring that the onus does not fall solely on them to reach a point of crisis before support is offered.

Our joint research with Engender found that mental health and wellbeing were among the most significant areas of unmet need during the pandemic, affecting both antenatal and postnatal stages. Only 25% of participants said their mental health has not been affected while pregnant or trying to become pregnant, and 62% reported that it had. Yet, when asked whether they were offered any mental health support, only 31% said ‘yes’, while 62% said ‘no’. These figures reflect a system that too often left women to identify and manage their own distress rather than receiving proactive support from services. One participant reflected;

> “A confusing time – never sure if the feelings were normal after giving birth or as a result of the worry re: the pandemic. A difficult time which I look back on and think I definitely should have reached out for more help.”[14]

Another added;

> “I think with hindsight I was probably suffering from anxiety, but didn’t recognise it and didn’t seek support for it - I didn’t know what it was and thought it was a normal part of becoming a parent.”[15]

We welcome the significance placed on Standard 6.2, which ensures that women’s mental health and wellbeing are regularly assessed in line with national pathways by staff who are trained and supported to act on concerns. Our findings, informed by our joint research and the focus group facilitated on behalf of Health Improvement Scotland, highlighted structural gaps. Whereby the absence of integrated perinatal mental health care pushed women into seeking support independently, often turning to third sector organisations or private providers because statutory maternity services could not meet their needs.

Continuity of care also emerged as central to positive mental health outcomes. Participants who had consistent midwifery relationships reported feeling better supported and more able to discuss distress. We therefore see a strong link between Standard 6 and Standard 1’s emphasis on continuity, recognising that sustained, trusting relationships enable early identification and responsive mental health support.

The ALLIANCE also welcomes Standard 6.6, which recognises the need for flexibility in how mental health support is offered, and Standard 6.9, which highlights the importance of safe, calming environments and partner involvement. Ensuring that care partners are informed and included when women required additional mental health related care can significantly reduce isolation and anxiety, strengthening recovery and family wellbeing.

Do you have any changes you would like to propose?

Shift from “promoting” to “ensuring” mental health support

The overarching standard statement currently focuses on promoting positive mental health. Given the scale of unmet need identified in our joint research with Engender, the ALLIANCE recommends that this be reframed to focus on ensuring that women receive high quality mental health care across all stage of maternity pathway. Mental health should be treated as a core component of safe, effective maternity care and not as an optional or aspirational add-on. This commitment should also explicitly embed an intersectional approach, recognising that some groups face disproportionate risks of poor mental health and barriers to support. Ensuring consistent standards and equitable access is essential to achieving fairness and improved outcomes to all women.

Strengthen recognition and response to trauma

The Standard would be strengthened by a clearer and more explicit commitment to trauma-informed practice across all sub-standards. We recommend that Standards 6.2 and 6.4 include specific references to maternity-related trauma and on ensuring sensitive follow-up for women who have experienced pregnancy loss, abortion, or birth-related trauma.

Participants in our joint research with Engender described the long-term emotional effects of isolation and fear during the pandemic as well as distress linked to miscarriage, fertility treatment, and baby loss. These experiences underline the need for trauma awareness to be embedded.

Additionally, women who have experienced miscarriage, termination or stillbirth should receive the same level or proactive mental health assessment and follow up. Standard 6.2 could more clearly reflect this principle by explicitly including all women who experience pregnancy, regardless of outcome, within the scope of perinatal mental-health assessment and care.

Extend equity commitments to disabled women and those with lived experience of trauma

We welcome the recognition within the draft Standards that Black and minority ethnic women experience disproportionate mental-health risks and barriers to support. We recommend extending this same level of explicit consideration to disabled women and those with lived experience of trauma

Integrate social and environmental supports as a part of a holistic public health approach

We welcome Standards 6.4 and 6.5, which promote wellbeing and enable early intervention but believe this should recognise the broader social and environmental determinants of mental health. Participants highlighted how community supports such as antenatal classes, baby groups and peer networks play a vital role in preventing isolation and improving mental wellbeing. Strengthening reference to community connection, social prescribing, and non-clinical support would reflect a more holistic public health approach to maternity mental health.

Question 8: Do you support Standard 7: Loss and bereavement as currently written?

Scaled Response: Strongly support

Please tell us why you think this?

The ALLIANCE strongly supports Standard 7 and its focus on ensuring that women, birthing partners, and families who experience pregnancy or baby loss receive compassionate and continuous care.

Our joint research with Engender found that many participants who experienced miscarriage, stillbirth or termination received little of no follow-up or emotional support, reflecting a wider lack of integrated mental health provision across maternity service. One participant shared;

> "Following the stillbirth of our son at full term we were given a Sands leaflet in an envelope from the hospital, that was all. We then had to fight with the NHS for counselling which was eventually given 8 months after the death of our son in July 2020. Following a missed miscarriage in February 2021 we were given the same leaflet- I find this appalling that at two extreme ends of the spectrum of baby loss this is the support given by NHS".[16]

Accounts such as this illustrate that women and families were often left to navigate bereavement alone, with minimal communication or psychological support. The ALLIANCE particularly welcomes Standard 7.11, which proposes the appointment of a strategic bereavement lead. This will be critical to ensuring oversight and consistency across all settings where pregnancy or baby loss may occur, embedding shared learning and improvement nationwide.

We also welcome Standards 7.1 and 7.10 which recognise the vital role of care partners and their need for tailored information and support. Including partners within bereavement care is essential to acknowledging the shared impact of loss.

The ALLIANCE supports Standards 7.5 and 7.11 for their focus on continuity and coordination. Fragmentation across maternity and mental health services often left families without clear pathways or follow-up. Seamless referral and joined up communication between maternity, mental health and bereavement support services are crucial to providing compassionate, person centred care.

Do you have any changes you would like to propose?

Separate and sensitive setting for miscarriage and loss care

The ALLIANCE recommends that Standard 7 includes a commitment to ensuring that bereavement and miscarriage care are delivered in separated and tailored environments to particular forms of maternity care. This commitment should also include provision of flexible options for care in settings that minimise trauma, including the option to be signposted to external or specialist bereavement support outside NHS facilities.

Our joint research with Engender highlighted the distress caused by the co-location of early pregnancy and miscarriage services alongside general maternity units;

> "Early pregnancy advice unit being co-located with general maternity services is appalling. To leave my scan knowing I had miscarried to be immediately faced with babies and pregnant women was harrowing".[17]

Recognising that hospital and maternity setting may themselves be triggering for some women is essential to ensuring that bereavement care is truly person centred and respectful of individual needs.

Do you feel like anything is missing from the standards?

While the ALLIANCE welcomes the ambition and scope of the Maternity Care Standards, several critical areas are missing or underrepresented. Addressing these omissions will be crucial to ensuring that the standards reflect an inclusive, person centred, and rights based approach which ensures access to high quality care across the full maternity pathway.

Abortion and miscarriage

The ALLIANCE believes that abortion should be explicitly included within the Standards. The complete absence of reference to abortion and the brief mention of miscarriage represent significant omissions. The experiences of, and care required for, both abortion and miscarriage are intrinsic to comprehensive and equitable maternity care.

If abortion has been deemed outside the scope of these Standards, this should be explicitly stated at the outset, along with the omission's rationale.

Abortion is healthcare, access to abortion is a human right, and those who choose not to continue a pregnancy must be offered the same standard of care and dignity as those who do. The Standards' stated focus on rights and choice should therefore encompass the decision not to proceed with a pregnancy.

We would also encourage closer alignment with the Scottish Government's Miscarriage Care in Scotland: Delivery Framework, which sets out principles of trauma-informed and inclusive care. Women have multiple and complex experiences of pregnancy and integrating this framework would strengthen consistency across policy areas and reflect the importance of safe and separate spaces for those experiencing miscarriage as referenced in Standard 7.

Integrating standalone standard on communication

The ALLIANCE strongly advocates for the inclusion of a standalone standard on communication within the Maternity Care Standards. Evidence from our joint research with Engender and accounts from participants in the focus group we facilitated for Health Improvement Scotland clearly emphasise that effective communication is the foundation of high quality maternity care. As detailed in earlier answers, effective communication is a human right and a core determinant of safety, experience and outcomes.

A standalone communication standard would also ensure staff are equipped and supported to communicate effectively, through training and reflective practice. This means not only knowing how to share information clearly, but also how to actively listen, respond empathetically and identify when additional support may be needed. Communication should be viewed as a two-way process, integral to building trust, shaping care plans, and recognising when a women or birthing person may require further assistance even if they have not expressed it directly.

Equally, a communication standard should recognise that information sharing does not only happen in professional or clinical setting. Peer networks, voluntary and community groups, and digital spaces are vital channels through which many women access information and support. These sources should be acknowledged and leveraged in developing information outputs that are inclusive and accurate.

Embedding accessibility as a core expectation would help remove the piecemeal approach that currently exists and give due weight to the range of communication and information needs across maternity care. We recommend that the Standards adopt the Six Principles of Inclusive Communication[18], ensuring that all information is made available in formats such as community languages, BSL, Braille, Moon, Easy Read, clear and large print, and paper versions. In line with out More than Words: Communication for All campaign, inclusive communication should be seen as a core component of quality care, not an optional extra. Accessible communication and information is essential, as without, women cannot fully understand, exercise, or act upon their right to health.

Healthcare Improvement Scotland should also involve accessibility and language experts early in the process to ensure that materials are understandable and usable for all going forward, including the finalised Maternity Care Standards.

Recognition of ongoing impact of COVID-19 related trauma

The Standards would benefit from explicit recognition of the long term psychological impact of pregnancy, birth and loss during the COVID-19 pandemic. Evidence from our joint research demonstrates that many women and birthing people experienced isolation, loss of autonomy, and distress as a result of restriction on partner involvement, reduced in-person care, and fragmented communication. For some, these experiences were deeply traumatic and continue to shape decisions about future pregnancy, birth and family planning.

Integrating explicit acknowledgement of COVID-era trauma within the Standards – particularly under Standards 1, 6 and 7 – would help ensure that maternity services remain sensitive to the enduring needs of those affected. Doing so would also support learning from this period to strengthen preparedness for any future disruption to maternity care.

Stronger integration of lived experience feedback loops

The ALLIANCE strongly advocates for stronger lived experience feedback loops integrated into maternity services. Effective maternity care relies not only on the expertise of professionals but also meaningful partnership with women, families and the third sector. Standards 2 and 3 rightly acknowledge this but to make it meaningful and productive, we recommend building in structured, ongoing mechanisms for service user feedback and co-production.

While Standard 2.7 highlights the importance of ‘listening’ to people’s experiences, this should be expanded to include clear mechanisms for continuous feedback and, where appropriate, co-production. Service users

should not only be heard but should actively shape decisions, culture and improvement initiatives. Leadership structures should establish routine, systemic pathways for engagement with service suers, creating a continuous feedback loop that ensures lived experience consistently informs practice and organisation culture.

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector membership organisation for the health and social care sector. We bring together over 3,500 people and organisations dedicated to achieving our vision of a Scotland where everyone has a strong voice and enjoys the right to live well, with dignity and respect. Our members are essential in creating a society in which we all can thrive, and we believe that by working together, our voice is stronger.

We work to improve the wellbeing of people and communities across Scotland by supporting change in health, social care and other public services so they better meet the needs of everyone in Scotland. We do this by bringing together the expertise of people with lived experience, the third sector, and organisations across health and social care to shape better services and support positive change.

The ALLIANCE has three core aims.

We seek to:

- **Empower people with lived experience**: we ensure disabled people, people with long term conditions, and unpaid carers are heard and that their needs remain at the heart of the services and communities.
- **Support positive change**: we work within communities to promote co-production, self management, human rights, and independent living.
- **Champion the third sector**: we work with, support and encourage co-operation between the third sector and health and social care organisations.

The ALLIANCE is committed to upholding human rights. We embed lived experience in our work and aim to ensure people are meaningfully involved at every level of decision-making.

Working together creates positive, long-lasting impact. We work in partnership with the Scottish Government, NHS Boards, universities, and other key organisations within health, social care, housing, and digital technology to manage funding and develop successful projects. Together, our voice is stronger, and we can create meaningful change.

Contact

Lowri Butler, Policy and Research Officer
E: lowri.butler@alliance-scotland.org.uk

Rob Gowans, Policy and Public Affairs Manager
E: rob.gowans@alliance-scotland.org.uk

T: 0141 404 0231
W: http://www.alliance-scotland.org.uk/

[1] Healthcare Improvement Scotland, “Maternity Care Standards”, (September 2025), available at: https://www.healthcareimprovementscotland.scot/publications/maternity-care-standards/

[2] Scottish Parliament, “Meeting of Parliament – Wednesday 29 October 2025”, (October 2025, available at: https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=16643

[3] The ALLIANCE, “More than Words: Communication for All” (n.d), available at: https://www.alliance-scotland.org.uk/more-than-words-communication-for-all/

[4] Participant Account, Engender and the ALLIANCE, “Trauma, abandonment and isolation”: Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[5] Engender, OUR BODIES, OUR RIGHTS: Identifying and removing barriers to disabled women’s reproductive rights in Scotland (November, 2018), available at https://www.engender.org.uk/files/our-bodies,-our-rights-identifying-and-removing-barriers-to-disabled-womens-reproductive-rights-in-scoltand.pdf

[6] The ALLIANCE, “More than Words: Communication for All” (n.d), available at: https://www.alliance-scotland.org.uk/more-than-words-communication-for-all/

[7] The ALLIANCE, “New tools to help improve rights-based policy and practice” (September, 2025), available at https://www.alliance-scotland.org.uk/blog/news/new-reports-and-tools-to-help-improve-rights-based-policy-and-practice/

[8] The ALLIANCE, ”Health and Social Care Academy” (n.d), available at: https://www.alliance-scotland.org.uk/health-and-social-care-integration/health-and-social-care-academy/

[9] The ALLIANCE, “Five Ambitions for the future of Health and Care” (n.d). available at https://www.alliance-scotland.org.uk/health-and-social-care-integration/health-and-social-care-academy/five-ambitions-for-the-future-of-health-and-care/

[10] The ALLIANCE, Investigating knowledge and understanding of the right to health (December 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/12/Right_to_Health_report_PDF.pdf

[11] Participant Account, Engender and the ALLIANCE, “Trauma, abandonment and isolation”: Experiences of pregnancy and maternity services in Scotland during COVID-

19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[12] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[13] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[14] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[15] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[16] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[17] Participant Account, Engender and the ALLIANCE, "Trauma, abandonment and isolation": Experiences of pregnancy and maternity services in Scotland during COVID-19 (September 2023), available at https://www.alliance-scotland.org.uk/wp-content/uploads/2023/09/EngenderALLIANCE-report1.pdf

[18] Inclusive Communication, 'Six Principles of Inclusive Communication'. Available at: https://inclusivecommunication.scot/the-six-principles-of-inclusive-communication