

Key messages

from the report 2026

Proactive, not reactive, maternity care

Readiness

Plan ahead for
changing needs



Pregnancy counselling and consistent advice

Ensure women with physical and mental health conditions receive pre-pregnancy counselling and that postnatal contraception is available in maternity services for future pregnancy planning

Response

Act early to avoid
delays in management

Rapid access to antibiotics and medications



Implement processes to allow for rapid access to antibiotics in hospital-based settings or prescription of urgently needed medications at the point of care



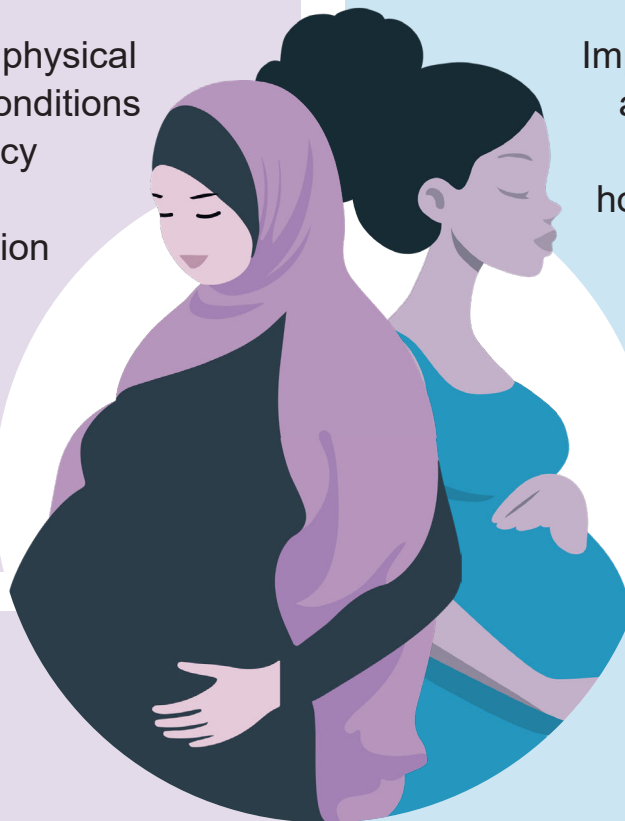
Service provision and clinical demand

Review staffing models and theatre capacity to keep up with changing maternity characteristics, including increased rates of caesarean birth



Maternal observations and escalation of care

Assess and record women's vital signs using maternity early warning scores (MEWS) to recognise deterioration and escalate care if needed

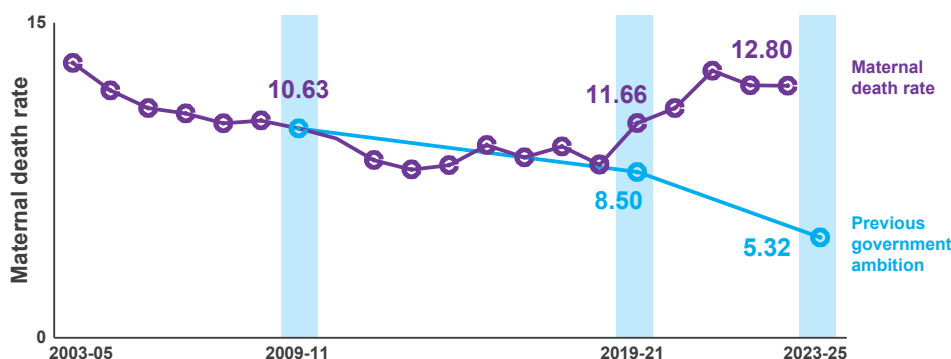


Key messages

from the surveillance report 2026



In 2022-24, **252 women died** during pregnancy or up to six weeks after pregnancy in the UK, a maternal death rate of **12.80 women per 100,000** women giving birth



This rate is 20% higher than the maternal death rate in 2009-11, when the previous government set an **ambition to halve the number of maternal deaths** in England by 2025

Inequalities in maternal mortality

Ethnic group

White women

12/100,000



Asian women

15/100,000



1.3x

Black women

32/100,000



2.7x

Deprivation

Least deprived

9/100,000



Most deprived

18/100,000



1.9x

Leading causes of maternal deaths

1



Blood clots
(42 women)

2



Heart disease
(39 women)

3



Mental health conditions
(35 women)

4



Epilepsy and stroke
(30 women)

5



Infection (excl. COVID-19)*
(26 women)

6



Other physical conditions*
(26 women)

*Responsible for the same number of maternal deaths in 2022-24