Saving babies lives and tackling inequalities – Learning from past reviews and reports

Sands & Tommy's Policy Unit

Working together to save babies' lives

Sands & Tommy's Joint Policy Unit Policy Briefing

Key messages

- Reports and reviews into the safety of maternity and neonatal services consistently identify similar themes.
- We have analysed recommendations from previous reviews/reports to identify those recurring themes.
- Our national policy approach must focus on making progress in these areas.
- While there is a wide range of activity underway, there remains a long way to go to ensure lessons from previous reviews/reports are leading to improvements in the safety and equity of services.
- We need to get much better at understanding the impact that policy initiatives are having in these key areas, through greater focus on evaluation.

Background

There is widespread recognition that reports and reviews into the safety of maternity and neonatal services across the UK consistently identify similar themes, and that these themes keep recurring despite steps to implement recommendations from past reports. The report into East Kent maternity services made clear that the failings identified were not one-off or isolated incidents. The 2022-23 CQC state of care report stated that half (49%) of maternity services were given an overall rating of 'inadequate' or 'requires improvement'. It is vital that lessons are learned from these reports and reviews at a national level and that they inform our policy approaches to improving maternity and neonatal services.

This policy paper identifies key recurring themes from previous reviews and reports into maternity and neonatal services – focussing on those areas most relevant to the Joint Policy Unit's core aims of saving babies' lives and reducing inequalities in loss.

This paper is intended to support a wider programme of work – from the Sands and Tommy's Joint Policy Unit – focussed on identifying and supporting the key policy changes needed to ensure a safe maternity and neonatal system.

Identifying key themes from previous reports/reviews

We analysed recommendations from reviews into individual services, as well as national reports and strategies that made recommendations relevant to improving the safety of maternity and neonatal services, between 2015-2023 (see Table 1).

For each of these reports we identified those recommendations relevant to saving babies' lives and tackling inequalities. A full list of recommendations identified in each report is available in Appendix A. Recommendations from these reports were then grouped into key themes – summarised in Table 2.

Table 1. List of reports/reviews

Individual services	National reports	National strategies/reviews
Reading the Signals: Maternity and Neonatal services in East Kent (2022)	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women who have experienced stillbirth or neonatal death (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women who have experienced stillbirth or neonatal death (2023) MBRRACE-UK Perinatal Confidential Enquiry (2017)	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023) Healthcare Inspectorate Wales – National Review of Maternity Services Phase One (2020)
Ockenden Report - Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (2022)	Spotlight on Nursing and Midwifery (2023)	Saving Babies' Lives Care Bundle v3 (2023) Saving Babies' Lives Care Bundle v2 (2019)
Review of Maternity Services at Cwm Taf (2019)	HSIB maternity investigation programme year in review 2022/23 HSIB summary of maternity themes (2020)	Health and Social Care Committee: The Safety of Maternity Services in England (2021)
The Report of the Morecambe Bay Investigation (2015)	National Perinatal Mortality Review Tool (PMRT) Fifth Annual Report (2023) PMRT Fourth Annual Report (2022) PMRT Third Annual Report (2021)	Recommendations of the Neonatal Critical Care Transformation Review (2019)
Report of the RQIA Review of Intrapartum Care – Northern Health and Social Care Trust, Northern Ireland	CQC – Safety, equity and engagement in maternity services (2022) CQC – Getting safer faster (2020)	The Best Start Scotland: A Five-Year Forward Plan (2016)
HIS Review of Ayrshire Maternity Unit – NHS Ayrshire and Arran	MBRRACE-UK Perinatal Mortality Surveillance Report 2021 (2023)	Better Births: A Five-Year Forward View for Maternity Care (2016)
	National Maternity and Perinatal Audit Organisational Report (2019)	

	Each Baby Counts Full Report (2015)	

Table 2. Summary of key themes

Theme	Description
Staffing levels and training	Staffing levels need to be sufficient to ensure safe care. Workforce plans must be owned by the board with clear mitigation/escalation policies in place when staffing is unsafe. Staff must be suitably qualified with senior staff present on labour wards. All staff must have access to the training that is required for them to carry their roles safely and effectively. To support teamworking, training should be multi-professional and support working together with a shared purpose. It should also include a focus on situational awareness and human factors.
Culture of safety within organisations	Staff must be able to escalate concerns about clinical care whenever necessary, with clear protocols in place to support this. Staff must be able to report safety concerns without fear of reprisal or repercussions. Organisations must review their approach to reputation management and ensure an open learning culture from board to ward level.
Organisational leadership	Safe care must be a shared goal throughout organisations. Boards must take effective ownership of the safety of maternity services with strong oversight of quality and performance of services. Clear arrangements should be in place for sharing patient experience at board level.
Personalisation of care and choice	All women and birthing people should be able to make informed decisions about their care. This includes decisions about mode and place of birth – based on full, impartial information about the safety risks associated with all birth options.
Reducing inequities	Initiatives need to be focussed on improving care for those at increased risk of worse outcomes to reduce rates of miscarriage, stillbirth, neonatal death and preterm birth. This includes accurately recording ethnicity data and using it to respond to risk factors. It also involves working with women and birthing people from minoritized ethnic backgrounds, and other disadvantaged communities, to tailor care and improve outcomes.
Data collection and use	Data collection must help identify variation in outcomes between maternity units, and among different patient groups (for example among women from Black and minority ethnic groups). Steps must be taken to understand the causes of variation and to inform improvements. Better data collection needs to be supported by improving access to digital maternity records.
Learning from reviews and investigations	There should be a standardised, consistent approach to reviews and investigations of serious incidents, with adequate resourcing and families involved in a compassionate manner. Systems must be in place to support the sharing of learning locally, regionally and nationally – with clear actions implemented to address concerns raised.
Engaging with service users	Services must actively engage with, learn from and listen to the needs of women and birthing people. This includes ensuring they are involved in reviews and investigations and consulted on the design and delivery of services.
Delivering care in line with nationally-agreed standards	Reports have consistently highlighted the need to provide timely and responsive care in line with national guidelines. Specific areas that have consistently been identified as requiring improvements are highlighted in Appendix A.

Appendix A. List of recommendations from previous reports, grouped into themes

Theme	Report	Recommendation/issue raised
Staffing		
Staffing levels	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Develop a workforce strategy for NHS Wales maternity & neonatal services with adherence to national workforce standards from BAPM, RCOG & RCM to deliver optimal care. Establish safe standards of care for neonatal, midwifery and obstetric workforce (to include recruitment, retention and training). • Ensure the Maternity & Neonatal Network is structured to deliver its defined responsibilities under the NHS Executive Mandate and resourced adequately with Medical and AHP leads including a lead Pharmacist. • NICUs to have direct clinical care provision of 12-hour consultant cover over 7 days. All NICUs to have a Clinical Director/Lead or equivalent post with a minimum of two funded sessions to deliver against recommendations. • Maternity units to facilitate a consultant ward round every 12 hours. All Maternity Units to have a Clinical Director with sessional allocation in line with RCOG recommendations. • Health Boards to undertake annual working patterns survey to explore inefficiencies and use results to review system waste and ensure prudent deployment of all roles e.g. sufficient administrative staff. • All Health Boards must allocate adequate SPA (non-clinical) time for consultants. This allocation should aim to adhere to the accepted standard of 7:3 DCC (Direct Clinical Care): SPA, with additional time allocated for specific extra lead roles undertaken (e.g., governance, data, Perinatal Mortality Review Tool). • All NICUs should have a data manager with consideration of data management input for LNU/SCU units. • Create permanent midwifery posts within Welsh Ambulance Services Trust to: a. Establish an expert link with maternity and neonatal services, b. Provide expert input into development of a national 'Labour Line' telephone service. c. Provide expert input into consideration of a national 'Triage Line' telephone service. d. Provide specialist input into internal WAST training, paramedic undergraduate and post graduate education.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Workforce planning and sustainability (financing a safe workforce): minimum staffing levels should be those agreed nationally, and must include a locally calculated uplift, representative of all absences eg sickness, training. • Safe staffing – All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals. When daily safe staffing levels are not achieved, this should escalate to senior management.
	PMRT Fourth Annual report (2022)	• Staffing levels continue to be one of the main issues in care during labour and birth, including insufficiently senior staff involved in care and lack of one-to-one care in established labour.
	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• Safe staffing levels are a prerequisite for safe care, and a robust and credible tool to establish safe staffing levels for obstetricians is needed. • Increased workforce numbers needed.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Boards to review workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.

	National Maternity and Perinatal Audit Organisational Report (2019)	• Evaluate medical and midwifery staffing requirements, considering the range of national ambitions, and fund services accordingly.
	Review of Maternity Services at Cwm Taf (2019)	• Lack of availability of a consultant obstetrician to support the labour ward. • Fragmented consultant cover for the labour ward with frequent handovers. • Availability of consultants during out of hours cover is unacceptable, with return times of up to 45 minutes. • The midwifery staffing levels are not compliant with the findings of the Birthrate Plus review in 2017. The Health Board needs to monitor this in real time at a senior level, to assess if the established protocols need to be invoked to ensure patient safety.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• Trusts to review no-site consultant obstetrician and anaesthetic cover on labour wards.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• Staffing issues, with particular concerns around the issues of induction of labour and timely transfer to delivery suite.
Staff training, resourcing and teamworking	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Develop training and resources for all maternity and neonatal staff, so they can provide culturally and religiously sensitive care for all mothers and babies. • Ensure that all relevant staff in Trusts and Health Boards have adequately resourced time in their work plans and contracted hours, and are supported to participate in local PMRT multidisciplinary review panels as internal and external members, so that these safety critical meetings are constituted and conducted appropriately and are never cancelled.

	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Develop a national maternity and neonatal workforce training strategy with local training plans. Establish local training plans in each organisation to ensure that every member of the maternity and neonatal workforce has allocated time, capacity and opportunity to meet all nationally and locally defined training needs. • Define national training/competency requirements and standards for each role within the maternity & neonatal workforce. • Development Toolkit for Neonatal Nurse training, including Qualified in Specialty, and Standardised multidisciplinary simulation training package for midwifery, obstetric and neonatal teams to supplement Neonatal Life Support training. • Ensure adequate administrative support is in place to maintain records of all staff training, competencies, and qualifications. These should be held centrally with in the health boards, reportable and reviewed at least annually for all staff. • Ensure that all additional personal and professional training needs are recorded using local appraisal processes. • All Health Boards to establish and sustain mechanisms for maternity and neonatal teams to work together across service boundaries, to: a. Create strong working relationships and strong communication pathways, b. Support changes in service development c. maximise multidisciplinary learning e.g., Sim training, d. Optimise clinical outcomes
	Reading the Signals: Maternity and Neonatal Services in East Kent (2022)	• Relevant bodies (the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health) be charged with reporting on how teamworking can be improved, with particular reference to establishing common purpose, objectives and training from the outset. • Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development. • Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Multidisciplinary training – Staff who work together must train together. Staff to have allocated time in job plans to ensure attendance, which must be monitored. • All trusts to implement a robust preceptorship programme for newly qualified midwives. These midwives must remain in the hospital for a minimum of one year post qualification, to develop essential skills and competencies. • Labour ward coordinator education module for all midwives responsible for coordinating labour ward. They should also receive an orientation package reflecting individual needs. • All trusts to develop core team of senior midwives trained in the provision of high dependency maternity care. • All trusts to develop succession-planning programme to develop future leaders and senior managers. • Establishment of a sustainable training programme for maternal medicine physicians. • Newly appointed Band 7/8 midwives to be allocated an experienced mentor to support their transition into leadership roles. • All trusts must mandate annual human factor training for all staff, including principles of psychological safety, ensuring staff are enabled to escalate concerns. • Regular multidisciplinary skills drills for management of common obstetric emergencies including haemorrhage, hypertension etc • All trusts to ensure all staff are trained and up to date in CTG and emergency skills. Clinicians must not work on labour wards or provide intrapartum care in any location without regular CTG training and emergency skills training.

	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• A set of stretching safety training targets should be established by the Maternity Transformation Programme board. • Training and ring-fenced funding for training is needed. • Establish safety training targets.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency. • Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care. • Ensure that staff have timely access to the training that is required for them to carry out their roles effectively. • Consider an all Wales approach to appraisals to ensure a consistent approach. • Consider a review of the preceptorship. programme to improve the experience for newly qualified staff.
	CQC – Getting Safer Faster (2020)	• Individual staff competencies, teamworking and multi-professional training - When urgent action is required to respond to an emergency, it is critical that teams can work together well, and have the knowledge and skills to manage fast moving situations effectively. This can only happen if the whole team is prepared and regularly trained to recognise and manage different types of emergencies.
	Review of Maternity Services at Cwm Taf (2019)	• Inadequate support provided for trainee and middle grade doctors within the obstetric service and particularly on the labour ward. • The service has a high usage of locum staff at all grades and specialties; no effective induction programme for these staff. • The high-risk obstetric antenatal clinic must be attended and led by a consultant obstetrician with the relevant skills.
	HIS Review of Ayrshire Maternity Unit (2017)	• Ensure that the training and development needs of staff are identified and met in a timely manner. This should include: producing a training needs analysis, ensuring access to training programmes, and monitoring attendance at training. • NHS Scotland should develop and agree a list of mandatory skills and competencies for maternity services to support ongoing training programmes in NHS boards. This process should include how NHS boards can be supported to implement and monitor their training programmes.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• Multidisciplinary training in situational awareness and human factors should be undertaken by all staff. • Need for national discussion about the content of fetal monitoring training.
	The Best Start Scotland (2016)	• It is essential that all staff in remote and rural areas can access high quality education, training and support and rotation to larger units for skills maintenance.
	Better Births National Maternity Review (2016)	• Those who work together should train together (including midwives and obstetricians) to understand and respect each other's skills and perspectives. • Multi-professional training should be a standard part of continuous professional development. • Multi-professional peer review of services should be available to support and spread learning
	Each Baby Counts (key recommendations for care) (2015)	• Staff tasked with CTG interpretation must have documented evidence of annual training. • All members of the clinical team working on the delivery suite need to understand the key principles of maintaining situational awareness to ensure the safe management of complex clinical situations.

	The Report of the Morecambe Bay Investigation (2015)	• National standards to set out professional duties and expectations of clinical leads/responsibilities for clinical quality of other managers.
Support and staff wellbeing	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• NHS Wales to ensure provision of psychological support, within each maternity and neonatal unit for all staff. All maternity and neonatal units should implement an annual validated psychological safety survey e.g., SCORE, SAFE, with results shared and discussed at local team, unit, Health Board and national levels. • Inform future workforce strategies and workforce planning by maximising standardised exit interview uptake, reporting and taking action to address themes both locally and at national level. • All maternity & neonatal services to embed Psychological Safety and the principles of a Just Culture embedded as cultural norms. • All maternity and neonatal units should appoint a Freedom to Speak Up Champion.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• There must be mechanisms in place to support emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Consider implementation of positive initiatives to recognise good work by staff within midwifery and medical teams.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• The Northern Ireland Maternity System review should ensure that the system is meeting the needs of health professionals working within maternity services.
	Each Baby Counts (key recommendations for care) (2015)	• Clinical staff should be empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective, when they feel stressed or tired.
Culture of safety within organisations		
Accountability and escalation	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• National guidance that is not followed should be reported by each health board to the NHS Executive Maternity and Neonatal Network. • All maternity and neonatal units to have robust governance team structure, with accountability and line management to the Director of Midwifery and Clinical Directors.
	Spotlight on Nursing and Midwifery Report – NMC (2023)	• Recurring examples of poor communication between colleagues and difficulties with inter-professional working. Where concerns were escalated, they were not always acted upon appropriately or escalated to the appropriate level (eg by obstetricians-in-training to consultants).
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Staff must be able to escalate concerns if necessary.

	HSIB Summary of Maternity Themes (2020)	• Clinicians calling for support from a more experienced colleague is a regular occurrence during a mother's admission and labour. HSIB investigations observed maternity units where there are rigid processes for escalation; requests for support move stepwise through a hierarchy of seniority, instead of empowering the clinician to seek the medical support directly. In some cases, this led to a delay in accessing the appropriate expertise • Quality of handover of care continues to be a finding in a number of HSIB national and maternity investigations.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Consider the implementation of a live PSAG (Patient Status at a Glance) visual display feed, to enhance patient handover.
	Review of Maternity Services at Cwm Taf (2019)	• Lack of awareness and accessibility to guidelines, protocols, triggers and escalations. (e.g. no guidance for pre-eclampsia).
	Better Births National Maternity Review (2016)	• Rapid referral protocols to be put in place between professionals across organisations.
Developing a safe and open learning culture	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• NHS Wales to implement annual assurance safety metrics which are aligned with safety actions elsewhere in the UK, including consideration of incentivisation. • Ensure that perinatal quality improvement is embedded and sustained as a cultural and behavioural norm throughout NHS Wales. Supporting implementation of local improvement activities in each unit and Health Board, and national improvement activities such as perinatal optimisation PeriPrem Cymru and MatNeoSSP Improvement Collaborative.
	Reading the Signals: Maternity and Neonatal Services in East Kent (2022)	• Organisational behaviour: Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
	Health & Social Care Committee Safety of Maternity Services in England Report (2021)	• To use a threshold of 'avoidability' rather than 'negligence' to award compensation (to help shift culture away from blame to one of learning). • For professional regulators to review changes required to allow staff to open up more about mistakes that are made.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Encourage staff to speak up and report incidents without fear of reprisal or repercussion.
	Review of Maternity Services at Cwm Taf (2019)	• The culture within the service is still perceived as punitive. Staff require support from senior management at this difficult time.
	Better Births National Maternity Review (2016)	• Boards should promote a culture of learning and continuous improvement to maximise quality care.

	The Report of the Morecambe Bay Investigation (2015)	• Duty to report openly the findings of any external investigation
	Each Baby Counts (key recommendations for care) (2015)	• When managing a complex or unusual situation involving the transfer of care or multiple specialities, conduct a 'safety huddle' - a structured briefing for the leaders of key clinical teams.
Organisational leadership		
Leadership and governance	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023	• All Health Boards to appoint a Director of Midwifery to manage the strategic delivery of maternity services locally. • Implement quarterly standardised leadership walk-arounds. • All Health Boards to appoint and resource Obstetric and Neonatal Consultant Safety Leaders and a neonatal senior nurse to sit at a senior level. • Ensure staff in recognised leadership roles have access to leadership training which includes content on culture and the principles of high performing teams and that resourcing for higher/additional qualifications is supported. • Ensure structures and ways of working, including co-location, which enable midwifery, obstetric and neonatal leads to regularly meet, share, and learn together.
	Reading the Signals: Maternity and Neonatal Services in East Kent (2022)	• Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance. • NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Clinical governance – leadership – Trust boards must have oversight of the quality and performance of their maternity services. They should work together with maternity departments to develop regular process and exception reports, assurance reviews and regularly review the progress of any improvement and transformation plans. • Clinical governance – incident investigation and complaints – Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner. • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. • All maternity services to ensure there are midwifery and obstetric co-leads for developing guidelines. They must also ensure midwifery and obstetric co-leads are available for audits.
	CQC – Safety, Equity, and Engagement in Maternity Services (2022)	• Leadership: In line with essential action 2 of the Ockenden review, Boards must take effective ownership of the safety of maternity services.
	CQC – Getting Safer Faster (2020)	• Governance, leadership and risk management - Board and leadership teams are key in making sure that maternity services have staff with the required knowledge and skills, and who work effectively as multidisciplinary teams, so that they are able to recognise and act on any changes that move a pregnancy from low-risk to high-risk.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Take steps to ensure that learning from women's experiences can be improved/ strengthening arrangements for sharing patient stories at board and quality and safety committees.

	Review of Maternity Services at Cwm Taf (2019)	• The lack of a functioning governance system does not support safe practice.
	Better Births National Maternity Review (2016)	• Provider boards should have a board level champion for maternity services (to routinely monitor information about quality, including safety, and take necessary action.
	Each Baby Counts (key recommendations for care) (2015)	• A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks – the 'helicopter view'.
Personalisation of care and informed choices		
Decision-making about mode and place of birth	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Health Boards to implement All Wales Midwifery-Led Care Guideline (6th Edition) guidance to ensure all women have the choice to birth in a Midwifery Led setting.
	HSIB Maternity Investigation Programme Year in Review 2022/23 (2023)	• Staff should be enabled to proactively monitor and adjust the place of labour care and birth for pregnant women based on the individual's specific care needs during the course of their pregnancy and labour.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary
	PMRT Third Annual Report (2021)	• Mode of birth decisions (type, timing and management) and inappropriate location of birth were key issues identified.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• Maternity services should develop local guidance that clarifies the actions that should be undertaken when serious problems arise in a home birth.
	Better Births National Maternity Review (2016)	• Women should be able to choose the provider of their antenatal, intrapartum and postnatal care. • Women should be able to make decisions about the support they need during birth and where they want to give birth (after full discussion of benefits and risks).
	The Best Start Scotland (2016)	• All women should have an appropriate level of choice for place of birth including home birth, birth in a midwifery unit and hospital birth.
	The Report of the Morecambe Bay Investigation (2015)	• There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated.

Personalisation of care and informed choices	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Ensure maternity services deliver personalised care, which should include identifying and addressing the barriers to accessing specific aspects of care for each individual. • Further develop and improve user guides for perinatal services, to empower women and families to make informed decisions about their care and that of their babies.
	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Agree and implement standardised decision-making aids to support women and families in making informed choices.
	CQC – Safety, Equity, and Engagement in Maternity Services (2022)	• In line with the Cumberlege review 'First do no harm', maternity services must ensure that all women and their families have information and support that allows them to make choices about their care. This includes listening to individual women and fully explaining choices, in an accessible way throughout the pregnancy journey.
	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• Need to stamp out damaging ideological focus on "normality at any costs". • Women must be fully and impartially informed about the safety risks associated with all birthing options.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Ensure that women are aware of how they can request information or support in their language of choice. • Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• The Maternity Strategy Implementation Group in collaboration with trusts to provide greater clarity around the role of the GPs in relation to informed choice for women and their referrals to midwifery-led units.
	Better Births National Maternity Review (2016)	• Every woman should develop a personalised care plan – which is up-to-date and sets out decisions reflecting her wider health needs. • Unbiased information should be made available to all women to help them make decisions for their care plan.
	The Best Start Scotland (2016)	• All women should be supported with advice and services to promote lifestyle changes during their pregnancy to improve their own and their baby's health.
Continuity of carer	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Establish an agreed method of understanding the continuity of care that women in Wales currently receive. Use that method to collect baseline continuity of carer data and establish improvement plans where required. • Health Boards to review community midwifery service provision to ensure that women see no more than 2 midwives antenatally and postnatally, and their named midwife for postnatal discharge.
	Ockenden Report – Review of Maternity Services at the	• All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer unless they can demonstrate staffing meets safe minimum requirements on all shifts.

	Shrewsbury and Telford NHS Trust (2022)	
	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• We support the principles of the continuity of carer model but conclude that further work is required to ensure it can be implemented in a sustainable manner. The model alone is unlikely to resolve the deep seated and long-standing inequalities persisting in outcomes.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Health Boards to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care
	Better Births National Maternity Review (2016)	• Every woman should have a midwife based in the community who knows the woman and family, and can provide continuity throughout pregnancy, birth and postnatally. • Each team of midwives should have an identified obstetrician who can advise on issues. • The woman's midwife should liaise closely with obstetric, neonatal and other services ensuring she gets the care she needs.
	The Best Start Scotland (2016)	• All women to have continuity of midwifery carer from a primary midwife. • Midwifery and obstetric teams to be aligned with a caseload of women and be co-located for the provision of community and hospital-based services. • The existing midwifery and obstetric workforce to be reconfigured to work in a way to support continuity of carer, with early adopter NHS boards to be identified to lead the change in practice.
Reducing health inequalities		
Reducing inequities in outcomes	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Develop a UK-wide specification for identifying and recording the number and nature of social risk factors, updated throughout the perinatal care pathway, in order to offer appropriate enhanced support and referral.
	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• All health boards to ensure: a) rapid access to advice if women from an ethnic minority background are concerned about their health, and b) that all staff have a lower threshold to review, admit and consider multidisciplinary escalation in women from an ethnic minority background. • Where possible transcutaneous bilirubinometers to be used in the community alongside awareness of challenges for diagnosis of jaundice in ethnic minority babies. Explore introduction of home phototherapy.
	MBRRACE-UK Perinatal Mortality Surveillance (2023)	• Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.
	CQC – Safety, Equity, and Engagement in	• Services and systems should use ethnicity data they collect to review safety outcomes for women from Black and minority ethnic groups, and take action in response to risk factors. This includes working with Black and minority ethnic women to personalise care and reduce inequality of outcomes.

	Maternity Services (2022)	
	MBRRACE-UK Perinatal Mortality Surveillance (2022)	• Commission a review of evidence in order to enhance perinatal services for disadvantaged populations to reduce inequitable outcomes. • Develop UK-wide harmonised indicators to identify high risk groups, including ethnicity and deprivation measures, to facilitate direct population comparisons.
	MBRRACE-UK Perinatal Mortality Surveillance (2021)	• Develop focussed initiatives to reduce stillbirths and neonatal deaths among groups of mothers at the highest risk, informed by the multidimensional effects of ethnicity, deprivation and mother's age.
	Better Births National Maternity Review (2016)	• Commissioners need to take clear responsibility for improving outcomes and reducing health inequalities, by commissioning against clear outcome measures.
Improving accessibility	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Provide maternity staff with guidance and training to ensure accurate identification and recording of language needs in order to support personalised care. This should include guidance about when it is appropriate to use healthcare professionals as interpreters. • Provide national support to help identify and overcome the barriers to local, equitable provision of interpretation services at all stages of perinatal care. This should include the resources to provide written information and individual parent follow-up letters in languages other than English.
	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• All Health Boards to invest in portable visual interpreting systems. These should be accessible 24 hours a day so that they can be used in clinic, theatres, and neonatal units. • Ensure that standardised clinical advice is made available to women and their families through: using Plain English principles, being available via the most accessible channels and easily available at times of critical need, and translated into multiple languages (including Welsh). • All women with limited English language skills should be provided with a co-produced, maternity access card to advise them on how/where to attend an obstetric unit in case of a concern.
Data collection and usage		
Data collection	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Develop national guidance and training for all health professionals to ensure accurate recording of women's and their partner's self-reported ethnicity, nationality and citizenship status, to support personalised care.

	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Ethnicity must be accurately recorded at booking and data used to monitor outcomes for women of different ethnic origins. • Gather place of birth data to a) benchmark data with 2011 Birthplace Study results, and b) analyse findings to identify variation/risks and use data to inform quality improvement activity and implementation of sustainable practice changes.
	Reading the Signals: Maternity and Neonatal Services in East Kent (2022)	• The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.
	MBRRACE-UK Perinatal Mortality Surveillance (2022)	• Ensure cause of death coding is undertaken by a suitably qualified clinician following PMRT review, and MBRRACE UK surveillance data updated accordingly.
	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• DHSC to ensure that insights collected by all bodies are collated in a coordinated manner and shared across organisations in a timely manner. They must assess current data gaps and develop a plan to address these. • Focus should be given to using data to understand the causes of and reduce the variation between maternity units.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved. • To ensure that the implementation of an electronic record is achieved as soon as possible. • Ensure the timely implementation of a single maternity dashboard across Wales.
	National Maternity and Perinatal Audit Organisational Report (2019)	• Improve access to electronic maternity records, both for women and for all healthcare professionals involved in their maternity care. • Provide adequate resource to record all care contacts electronically in order to ensure effective monitoring of the level of continuity of carer that women experience.
	Better Births National Maternity Review (2016)	• Teams should routinely collect data on quality and outcomes, measure their own performance and compare with others to improve. • Use of an electronic maternity record should be rolled out nationally. Providers should ensure the woman shares and can input her information. • Data collection should be refocused on the most useful information. A nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services.
	The Best Start Scotland (2016)	• A national datahub, integrated with Information Services Division, part of NHS National Services Scotland, should be developed to coordinate the collection and verification of all Scottish-related neonatal and maternity data. • A Scottish electronic women's maternity record should be developed.
	The Report of the Morecambe Bay Investigation (2015)	• More systematic recording of perinatal deaths and independent scrutiny.
Data usage	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• NHS Wales to agree the content and output of a national standardised data dashboard which enables benchmarking against the NHS England Maternity Services and National Maternity and Perinatal Audit data sets. • Health Boards to collaborate and develop local dashboards, to include the standardised perinatal quality surveillance dashboard (see example in report appendix) to enable real-time activity/outcome measurement and monitoring to support local improvements.
	MBRRACE-UK Perinatal Mortality Surveillance (2022)	• Continue to evaluate and implement the national initiatives to reduce stillbirth and neonatal deaths and monitor their impact on reducing preterm birth, particularly the most extreme preterm group.

		• Improve the availability and accessibility of initiatives and policies to reduce stillbirth and neonatal mortality across the UK for health professionals, policy makers, academics, health service researchers and the public. Provide regular updates on progress towards publicised ambitions and targets.
Learning from reviews and investigations		
Learning from reviews and investigations	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Develop and implement NHS Wales Maternity and Neonatal Trigger Tools to guide standardisation of event/incident reporting. Appoint national Maternity and Neonatal Safety Leads to support national learning and ensure implementation of learning from incidents. • NHS Wales to develop and implement a standardised maternity & neonatal adverse event review process. • All incident investigators to be fully trained and competent to undertake their roles, to include consideration of training in Systems Engineering Initiative for Patient Safety (SEIPS) and Patient Safety Investigation Response Framework (PSIRF). • All Health Boards to ensure recorded justification and decision making to support any local deviation from nationally agreed protocols/guidance/ best practice. • NHS Wales to develop or commission a system for external independent review for all cases of: maternal death, term intrapartum stillbirth, early neonatal death (37 weeks) and hypoxic ischaemic encephalopathy (HIE). • Ensure all instances where babies were not born in the right place (e.g., <32 weeks) are subject to robust local and national review.
	MBRRACE-UK Perinatal Mortality Surveillance (2023)	• Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation. • Review perinatal pathology services as a national priority, and ensure equity of access to all modalities of post-mortem examination.
	Reading the Signals: Maternity and Neonatal Services in East Kent (2022)	• The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Language used in investigation reports must be easy to understand for families eg all medical terms to be explained in lay terms. • Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. • Actions arising from a serious incident investigation which involve a change in practice must be audited. This change must be seen within six months after the incident occurred. • All trusts to ensure that complaints which meet the serious investigation threshold to be investigated as such.
	Health & Social Care Committee Safety of Maternity Services in England report (2021)	• Involving families in a compassionate manner in reviews and investigations. • Maintain independent, standardised method of investigating the most serious incidents. • Improve the timeliness of investigations and the relationship between HSIB and trusts to ensure local ownership of recommendations made. • Improve local and regional sharing of key learnings. • That HSIB shares the learning from its maternity reports in a more systematic and accessible manner.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• Adequate resource and training should be given to enable all intrapartum deaths to be systematically reviewed to facilitate organisational learning.

	Better Births National Maternity Review (2016)	• There should be a national standardised investigation process when things go wrong, to understand what went wrong, why and how things can be improved.
	The Report of the Morecambe Bay Investigation (2015)	• Standards for incident reporting and investigation in maternity services. • Involvement of patients and relatives in the investigation of serious incidents. • Review of the NHS complaints system to strengthen local resolution and improve timeliness. • A framework for external reviews and professional responsibilities in undertaking them. • A system to collate learning from reviews.
Engaging with service users		
Listening to and engaging with service users	MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Asian and White women (2023) MBRRACE-UK Perinatal Confidential Enquiry: Comparison of care between Black and White women (2023)	• Further develop existing PMRT guidance to ensure that all women's and parents' voices are actively sought, and their questions are addressed, as part of the local review carried out using the national Perinatal Mortality Review Tool.
	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• All Health Boards to co-produce communications tailored for ethnic minority women in their communities. • Each Health Board should engage with their local Maternity Voices Partnership volunteers to create points of contact in harder to reach communities, and establish paid Chair & Deputy Chair Maternity Voices Partnership positions to embed co-production of services. • Establish an All Wales Maternity and Neonatal Service User Framework Group to ensure the voices of women and families are central to national coproduction of services. • Agree and embed a standardised Maternity and Neonatal Feedback mechanism into NHS Wales services, including transitional care. Ensure inclusion of feedback question/s about parental opinion on safety of care experienced. Ensure simplicity of process, communication materials to promote to families and information/training for staff. Make results available to parents, families, staff and senior leaders.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• All maternity services must ensure service users are involved (ideally via their MVP) in developing complaints response processes that are caring and transparent.
	CQC – Safety, Equity, and Engagement in Maternity Services (2022)	• Local maternity systems need to improve how they engage with, learn from and listen to the needs of women, particularly women from Black and minority ethnic groups. They also need to make sure that targeted engagement work is appropriately resourced.
	HSIB Summary of Maternity Themes (2020)	• Investigations found a disproportionate number of misunderstandings and miscommunications between staff and parents from Black, Asian, minority and ethnic communities. In some cases where parents were of non-English speaking background these misunderstandings may have been due to language barrier. Investigations found that although translation services are available, they may not be available or utilised by staff at the relevant time.

	CQC – Getting Safer Faster (2020)	• Active engagement with women using maternity services: Seeking ways to listen to and learn from the experiences of women who have used maternity services is vital to improving and developing services.
	National Maternity and Perinatal Audit Organisational Report (2019)	• Encourage women's involvement in audit, guideline development and labour ward forums.
	The Best Start Scotland (2016)	• Maternity and neonatal care should be co-designed with women and families from the outset, with information and evidence provided to allow her to make informed decisions.
Delivering care in line with best practice		
Recognition of risk	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Consideration should be given to NHS Wales procurement of digital tools to assist in accurate risk assessment for adverse pregnancy outcome in early pregnancy. • Develop an All-Wales Maternity Early Warning Score (MEWS) Chart and implement in every healthcare setting in Wales where a pregnant woman could receive care.
	HSIB Maternity Investigation Programme Year in Review 2022/23 (2023)	• Telephone triage services should support 24-hour access to a systematic structured matrisk assessment of pregnant women's needs. • Telephone triage services should be operated by appropriately trained and competent staff who are skilled in the specific needs required for effective telephone triage. • Face-to-face triage in maternity units should use a structured approach to prioritise pregnant women in order of clinical need. • Each pregnant woman should be helped to understand their individualised risk associated with a vaginal or caesarean birth after a previous caesarean birth, based on their specific risk factors and care needs.
	PMRT Fourth Annual Report (2022)	• Issues of care identified with lack of maternal risk assessment at the start of and during the course of labour, or inadequate management based on the risk.
	HSIB Summary of Maternity Themes (2020)	• HSIB investigations have found that many mothers, as their pregnancy progressed, experienced events or changes in circumstances which increased their level of risk, but which were not recognised or factored into decision making about their care. • Investigations frequently found that maternity staff were inclined to seek reassurance that symptoms were not a concern.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• Development of a standardised risk assessment tool for determining a woman's risk status on admission.
Fetal growth surveillance	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• NHS Wales to undertake a review of the effectiveness of GAP/GROW compared to alternative models for detecting small for gestational age babies.

	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• There should be robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height measurements and audit of the documentation of it, at least annually.
	PMRT Third Annual Report (2021)	• Issues of care identified with screening for fetal growth restriction
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• There should be a review by the Maternity Strategy Implementation Group regarding the role of the GP in provision of antenatal care, specifically in the use of customised growth charts.
Reduced fetal movements	PMRT Fourth Annual Report (2022)	• Issues of care identified with management of reduced fetal movements
Fetal monitoring during labour	Spotlight on Nursing and Midwifery Report – NMC (2023)	• Issues relating to CTGs being incorrectly classified, and delays in acting upon abnormal CTG readings, have also been identified as factors leading to major failings of care in maternity services.
	HSIB Maternity Investigation Programme Year in Review 2022/23 (2023)	• Pregnant women whose labour has been induced need clinical oversight and an individualised plan of care for maternal and fetal monitoring.
	PMRT Fourth Annual Report (2022)	• Issues of care identified with fetal monitoring in labour.
	HSIB Summary of Maternity Themes (2020)	• Investigations found a number of examples where there were multiple reassessments of a mother's progress in labour, or the CTG reading. At these reviews, clinicians indicated the need for further assessments, rather than intervention, in the expectation that the labour would progress normally or the CTG would improve and a vaginal birth would be achieved. In some cases, these multiple reviews accrued delays in decision making and prevented timely escalation of a mother's care.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Consider the introduction of live stream CTG monitoring in all units.
	Each Baby Counts (key recommendations for care) (2015)	• Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method. • NICE guidance on when to switch from intermittent monitoring to continuous CTG monitoring should be followed. This requires regular risk assessment during labour. • Key management decisions should not be based on CTG interpretation alone. The full picture including the mother's history, stage and progress in labour must be taken into account.
Intrapartum care	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• All women to undergo a full clinical assessment when presenting in early or established labour, including a review of any risk factors and considering whether any complicating factors have arisen. These must be shared with women to enable informed decisions eg place of birth. • Midwifery-led units must complete yearly operational risk assessments. • All women who choose birth outside of a hospital must be provided accurate and updated written information about transfer times to consultant obstetric unit.

		• Units must have pathways for induction of labour.
	HSIB Summary of Maternity Themes (2020)	• For some mothers, delaying their clinical attendance based on a telephone triage process prevented them from receiving the care and assessment they needed to support safe management during labour and reduce the risk to their baby.
	MBRRACE-UK Perinatal Confidential Inquiry (2017)	• National guidance should be developed for care during the latent phase of labour.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• Maternity Strategy Implementation Group should consider incorporating the Robson classification for caesarean section criteria into the Northern Ireland Maternity System.
Management of complex pregnancy	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• All Health Boards to review existing complement of specialist midwives and ensure there are posts to cover multiple pregnancy, diabetes and preterm birth. • All Health Boards to implement Placental Growth Factor (PLGF) testing for women with suspected pre-eclampsia. • All Health Boards to establish multiple pregnancy clinics with a specialist midwife, obstetrician, and sonographer as core staff.
	PMRT Fourth Annual Report (2022)	• Issues of care identified with delay in diagnosis or inappropriate management of medical, surgical or social problems.
	MBRRACE-UK Perinatal Mortality Surveillance (2022)	• Investigate the characteristics of stillbirths and neonatal deaths in twin pregnancies, particularly with regard to gestation at delivery, in order to understand the reasons for increasing mortality rates.
	The Best Start Scotland (2016)	• Maternal and fetal medicine services for women with the most complex needs should be managed by a core group of experienced consultants at a regional or national level.
Management of preterm birth	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• In suspected preterm labour, all Health Boards to ensure all women have access to the most accurate preterm birth tests when presenting, including: aultrasound machines to perform transvaginal cervical length, and quantitative fetal fibronectin. • In suspected preterm labour, all Health Boards to ensure obstetricians are trained to perform transvaginal cervical length scans.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• The Local Maternity and Neonatal Systems, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. • Senior clinicians must be involved in counselling women at high risk of very preterm birth. • Women to receive expert advice on the most appropriate fetal monitory that should be undertaken, and what mode of delivery should be considered. • Discussions must involve the local and tertiary neonatal teams so parents understand chances of survival and are aware of possible associated disability.
	MBRRACE-UK Perinatal Mortality Surveillance (2021)	• Continue to develop innovative new programmes of research into reducing preterm birth.

Neonatal care provision/pathways	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Develop a standardised mechanism for multidisciplinary maternity & neonatal teams to review ATAIN (Avoiding Term Admissions into Neonatal) rates. • Expand Neonatal Outreach services across NHS Wales to enable earlier discharge from neonatal units, transitional care, and postnatal wards. This should: a) Be available 7 days a week, b) Include access to Allied Health Professional Services. F) Include the ability to support short-term nasogastric tube feeding in the community for preterm infants. • All Neonatal Units to achieve Bliss Baby Charter accreditation. Resource and workforce capacity should be explicitly allocated to support achieving and maintaining accreditation • Ensure that all Neonatal Transitional Care standards are embedded by ensuring services are commissioned and sustainably staffed to BAPM standards, including a designated nurse lead (band 7); a ratio of nursing/ nursery staff to babies of 1:4; and all babies to have a named paediatric or neonatal consultant. • Develop and implement an NHS Wales robust definition and process for review of all infections in babies on neonatal units. Health Boards to constantly record and monitor local instances, and report and publish infection rates nationally every 6 months. • Ensure neonatal teams embed national guidance on specialist neonatal respiratory care for babies born preterm. • Undertake a national review of care pathways for babies with bilious vomiting to enable close partnership working between surgical NICU's, transport services and all service providers. • Develop a system of radiology support for neonatal units with no out of hours radiology services in order to reduce delays in access to surgical review and upper GI contrast study.
	MBRRACE-UK Perinatal Mortality Surveillance (2023)	• Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes.
	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• There must be clear pathways of care for neonatal carete provision, agreed by neonatal and maternity care providers, commissioners and networks. Care that is outside this must be monitored by exception reporting (quarterly). • Maternity and neonatal services must continue to work towards at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU. • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. • Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. Where a consultant is not immediately available (eg out of hours), there must be a mechanism that allows real-time dialogue to take place directly between the consultant and resuscitating team. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff and nurses are available in every type of neonatal unit.
	Implementing the Recommendations of the Neonatal Critical Care Transformation Review (2019)	• Neonatal Operational Delivery Networks (ODNs) should undertake a review to determine which units have correct capacity for the kind of neonatal care they provide, and the additional capacity that is required. Where a NICU does not meet the criteria, the ODN and the provider trust should produce a viable plan to meet it within a 5-year timescale. • Transfer during the provision of intensive care may be avoided by ensuring that births occur in the right setting, requiring aligned capacity in maternity and neonatal services. • ODNs and NHS providers should produce a gap analysis of staffing within the ODN. ODNs should also monitor staffing/vacancy levels against outcomes using quality dashboard models in liaison with commissioning teams. • NHS Trusts should ensure that there are sufficient medical staff available at all times during intensive care. In parallel, workforce transformation is recommended including, for example the training of physician assistants to support medical workforce and consideration of the recruitment of trained and competent Advanced Neonatal Nurse Practitioners to fulfil appropriate roles within the service.

		• NHS Trusts should develop an allied health professional (AHP) strategy as part of workforce planning which sets out the level and expertise of pharmacy and AHP required, the level currently available, and how any gaps will be filled.
	National Maternity and Perinatal Audit Organisational Report (2019)	• Provide neonatal transitional care at all sites with a neonatal unit. Ensure that adequately skilled staff are available at all times to provide transitional care.
	The Best Start Scotland (2016)	• Babies with moderate care needs (e.g. late preterm) should, when possible, be cared for in postnatal wards. • A national Framework for Practice should be developed which outlines clear pathway for newborn care • A national level group should be established to develop National Frameworks for Practice Scotland, which are evidenced-based and describe minimum acceptable standards for newborn care.
	Each Baby Counts (key recommendations for care) (2015)	• The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.
Preconception counselling/ information and advice	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Ensure all postnatal women who had a preterm birth under 34 weeks have an appointment with a specialist obstetrician to discuss implications for future pregnancies.
	MBRRACE-UK Perinatal Mortality Surveillance (2021)	• Ensure the continuation of targeted initiatives with health education organisations not only aimed at reducing teenage pregnancy but also providing preconception advice. • Provide pre- and post-conception information for women aged 35 and over, clarifying the risk of stillbirth and neonatal death associated with increased maternal age to empower their decision making throughout the care pathway. • Emphasise the importance of preconception health as a routine part of every health professional's interaction with women who have risk factors for congenital anomaly.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• Maternity Strategy Implementation Group should review the role of primary care in relation to provision of pre-pregnancy counselling to both high and low risk women. • Maternity Strategy Implementation Group should explore ways to make better use of community pharmacy links in relation to providing information and advice on good preconceptual care to women of childbearing age.
Preconception care for people with specific conditions	Ockenden Report – Review of Maternity Services at the Shrewsbury and Telford NHS Trust (2022)	• Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care. Women with pre-existing medical disorders must have access to preconception care with a specialist familiar in managing that disorder.
	Review of a Strategy for Maternity Care in Northern Ireland (2012-18) (2017)	• A pathway for preconceptual care should be developed by the Maternity Strategy Implementation group, to include preconceptual care for women with specific medical conditions such as cardiac disease and autoimmune conditions.
Reducing smoking in pregnancy	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)	• Resource and maintain clear service pathways between maternity services, Public Health Wales and primary care to support women to: a. Achieve and maintain a healthy weight, b. Access smoking cessation support services, before, during and after pregnancy.

	PMRT Third Annual Report (2021)	• Issues of antenatal care identified with lack of smoking assessment and management of exposure to tobacco smoke.
	Healthcare Inspectorate Wales – National Review of Maternity Services (2020)	• Consider the introduction of smoking cessation leads/ work with Public Health Wales to further promote healthier living and lifestyles.
	National Maternity and Perinatal Audit Organisational Report (2019)	• Improve access to smoking cessation and weight management support services before during and after pregnancy.