

**National  
Maternity and  
Neonatal  
Investigation**

# **Previous Recommendations**

**June 2026**

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	This study highlights the need for continued training, supervision and improved systems to combat mistakes in interpretation of ultrasound scans to detect fetal abnormalities (which result in legal claims for “wrongful birth”.)	2018	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers’ Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Neither pregnancy, caesarean section birth or the immediate postpartum state are absolute contraindications to thrombolysis [Saving Lives, Improving Mothers’ Care 2014]	2019	Trust; Trust	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	All women with risk factors for gestational diabetes should be identified and offered glucose tolerance testing in line with current national guidance. Testing should be performed at the appropriate time, with documentation of results and correct clinical management of abnormal results.	2015	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers’ Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22</b>	Ensure the digital maternity record includes details of language needs including the use of formal interpreter services, to ensure that these are taken into consideration at all interactions, including in emergency situations	2024	Professional Record Standards Body and equivalents in the devolved nations; Professional Record Standards Body and equivalents in the devolved nations	ICB; Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term,</b>	All parents of a stillborn baby should be offered a postmortem. Documentation of this offer and the provision of the written	2015	Trust; Trust	Trust	clinical

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<b>singleton, normally formed antepartum stillbirth</b>	information for parents should be clearly recorded in the maternal notes.				
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Third Annual Report</b>	Use the PMRT parent engagement materials to support engaging parents and families in the review process, including them being made aware a review is taking place and being given flexible opportunities at different stages to discuss their views, ask questions and express any concerns. Many parents may want to give positive feedback about the care they received.	2021	Trusts and Health Boards, staff caring for bereaved parents, Service Commissioners; Trusts and Health Boards, staff caring for bereaved parents, Service Commissioners	ICB; Trust	operational
<b>National Neonatal Audit Programme (NNAP) Summary report on 2024 data</b>	<p>NHS England and health departments in Devolved Governments should:</p> <p>a. issue clear guidance to neonatal services around the correct reporting of preterm brain injury including PHVD, so that robust data collection can support the achievement of the national ambition for neonatal brain injury.</p> <p>b. develop a mandatory NHS neonatal information standard to ensure that clinical reporting systems are interoperable, ensuring robust data collection to support effective measurement and reporting of all neonatal processes and outcomes.</p>	2024	NHS England and health departments in Devolved Governments; NHS England and health departments in Devolved Governments	DHSC; NHSE; Other Bodies	clinical
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal</b>	Involve an external member as part of the PMRT review team.	2019	Trust, Local Maternity Systems; Trust, Local Maternity Systems	Trust	operational

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<b>Mortality Review Tool First Annual Report</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Be aware that signs of uterine inversion include pain when attempting to deliver the placenta, a rapid deterioration of maternal condition and a loss of fundal height without delivery of the placenta	2021	Trust; Trust; All Health Professionals	Trust	clinical
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Ensure there is robust and consistent national training available on the child death review statutory process, SIDS, SUDC and available resources. This will contribute to high quality support for families and good quality information collection to improve the evidence base for research on SIDS and safer sleep, and on sudden unexplained death in childhood (SUDC) and association with febrile seizures.	2019	Trust Local Authorities Health Visitors; Trust Local Authorities Health Visitors	Primary Care; LMNS; Trust	strategic
<b>MBRRACE-UK: Perinatal Mortality Surveillance Report for Births in 2021</b>	Review perinatal pathology services as a national priority, and ensure equity of access to all modalities of post-mortem examination	2023	UK Governments, Royal Colleges, Commissioners; UK Governments, Royal Colleges, Commissioners	Colleges; DHSC; ICB; LMNS	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services should ask all women whether they have experienced domestic violence and abuse. Women should be given the opportunity	2015	Trust; Reproductive health teams; children's services; children and adult safeguarding teams; Trust; Reproductive health teams; children's services;	Trust	operational

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	to disclose domestic abuse in an environment in which they feel secure.		children and adult safeguarding teams		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	In the postnatal period health professionals must perform and record a full set of physiological vital signs, pulse, blood pressure, temperature and respiratory rate, in any woman with symptoms or signs of ill health	2021	All Health Professionals; All Health Professionals	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally formed antepartum stillbirth</b>	Following a stillbirth all relevant health professionals should be telephoned as soon as possible to prevent any insensitive or inappropriate communications with parents.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death and MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	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.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE) ; RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Other Bodies	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	Women should be offered a choice of LMWH or oral anticoagulant for postnatal therapy after discussion about the need for regular	2021	Trust; Trust	Trust	clinical

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<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	blood tests for monitoring of warfarin, particularly during the first 10 days of treatment.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Any woman going to theatre electively with suspected placenta praevia accreta should be attended by a consultant obstetrician and anaesthetist. If the delivery is unexpected, out-of-hours consultant obstetric and anaesthetic staff should be alerted and attend as soon as possible.	2018	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	It is essential that all Trusts and Health Boards provide data which is complete, accurate and reported in a timely manner in order that the most accurate comparative mortality estimates can be calculated and used for quality assurance. In particular, this should be achieved by: a. improving the provision of maternal data for both stillbirths and neonatal deaths; b. ensuring that all relevant deaths are reported to MBRRACE-UK, including those where the baby was discharged home or to a hospice for palliative care; c. ensuring complete and accurate notification of statutory data required for all births under their care to routine sources, including all home births.	2016	Local teams: MSC; HoM and CD; local commissioner; LMNS; Local teams: MSC; HoM and CD; local commissioner; LMNS	LMNS; Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Establish pathways to facilitate rapid specialist stroke care for women with stroke diagnosed in inpatient maternity settings	2021	Service Planners; Commissioners, Hospitals; Trusts; Health Boards; Service Planners;	ICB; Trust	clinical

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<b>into Maternal Deaths and Morbidity 2016-18</b>			Commissioners, Hospitals; Trusts; Health Boards.		
<b>Five years of cerebral palsy claims</b>	Trust boards, alongside their obstetric and midwifery leads, must ensure that all staff undergo annual, locally led, multi-professional training, which includes simulation training for breech birth. This training should focus on integrating clinical skills with enhancing leadership, teamwork, awareness of human factors and communication. Staff should not provide unsupervised care on delivery suite until the competencies have been achieved.	2017	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Women with epilepsy should be informed that the introduction of a few safety precautions may significantly reduce the risk of accidents and minimise anxiety	2021	Trusts; Trusts	Trust	operational
<b>PMRT Learning from Standardised Reviews When babies Die. Second Annual Report (2020)</b>	Improve the engagement of parents in reviews by standardising and resourcing local processes to ensure all bereaved parents are told a review will take place and have ample opportunities at different stages to discuss their views, ask questions and express any concerns as well as positive feedback they have about the care they received	2020	Trusts; Trusts	Trust	strategic

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Ensure that guidance on the management of diabetic ketoacidosis in pregnancy is included in all guidelines used outside of the maternity setting	2022	Joint British Diabetes Societies for Inpatient Care; Joint British Diabetes Societies for Inpatient Care	Other Bodies	clinical
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	NHS maternity service providers, commissioners, policymakers and regulators should not use the rate of maternal intensive care admissions identified through linkage with ICNARC or SIGSAG data as an outcome indicator of maternity care to compare hospitals, trusts or boards.	2015	Provider trusts ICB's LMNS's; Provider trusts ICB's LMNS's	Trust	strategic
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Clinicians should be aware of this increased risk, and have a lower threshold to review, admit and consider multidisciplinary escalation of symptoms in women of BAME background (RCOG Coronavirus and pregnancy guideline 2020).	2020	All Health Professionals; All Health Professionals	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Repeated presentation in pregnancy or postnatally with pain and/or pain requiring opiates should be considered a 'red flag' and warrants a thorough assessment of the woman to establish the cause	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	The route of escalation to critical care services should be clearly defined, and include	2019	Trust; Trust	Trust	operational

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<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	multidisciplinary discussion [Care of the critically ill woman in childbirth 2018]				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	(Improving care of women with malignancy) Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause.	2018	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Commissioning organisations should review both their crude and stabilised mortality rates alongside their high risk population characteristics (e.g. deprivation and ethnicity) to facilitate the development of public health initiatives and to target focused interventions, such as the continued rollout of continuity of carer as recommended by Better Births, with a particular focus on women in high-risk ethnic groups and those living in areas of high deprivation.	2019	CCG's; CCG's	ICB	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	It is the responsibility of mental health services to ensure that a late pregnancy and early postnatal care plan is completed, jointly with the woman, usually at 28-32 weeks of pregnancy. Where the plan includes decisions about medication management, it should be completed, or overseen, by a psychiatrist.	2017	Perinatal Mental Health Teams; Trust; Perinatal Mental Health Teams; Trust	LMNS	operational

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<b>MBRRACE-UK: State of the Nation Themed Report, Lessons Learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-2021.</b>	Develop training resources concerning shared decision making and counselling regarding medication use in pregnancy and breastfeeding, including specific information on the benefits and risks of different medications and non-adherence.	2023	RCOG, RCM, RCP, RCGP MHPRA (Medicines and Healthcare Products Regulatory Agency); RCOG, RCM, RCP, RCGP, MHPRA (Medicines and Healthcare Products Regulatory Agency)	Colleges	strategic
<b>MBRRACE-UK: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death</b>	Develop provision for multiple routes of access to maternity care. These routes should include the ability for a health or social care professional, in any setting, to make a direct referral to maternity services on behalf of a woman with her consent.	2024	Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland).; Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland).	Primary Care; ICB	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Further work is needed to understand the potential for increased use of midwife-led settings. This includes gaining a better understanding of the proportion of women considered suitable to use these settings and the criteria applied by different services through local review by providers and commissioners, inclusion of relevant questions	2017	NHS Trusts/Researchers; NHS Trusts/Researchers	Trust	strategic

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	in national surveys of women, and further research.				
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Junior doctors and midwives must be supported in the development of their decision-making processes, and be confident enough to ask for assistance where necessary.	2018	Trust; Trust	Trust	operational
<b>Five years of cerebral palsy claims</b>	Women and their families offer invaluable insight into the care they received. To ensure this is included in all serious incident (SI) investigations, commissioners should take responsibility by ensuring SIs are not 'closed' unless the woman and her family have been actively involved throughout the investigation process.	2017	CCG's; CCG's	ICB	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure all maternity units have access to an epilepsy team	2021	Trusts; LMNS; Service Planners; Commissioners; Hospitals; Trusts; Health Boards; Trusts; LMNS; Service Planners; Commissioners; Hospitals; Trusts; Health Boards	ICB; LMNS; Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or</b>	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.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National	Colleges; Other Bodies	strategic

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<b>neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>			Institute for Health and Care Excellence (NICE)		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Women with a high BMI should be given information about the symptoms of VTE	2018	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	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.	2022	ACTION: National and Regional Policy Makers, Integrated Care Boards / Health Boards, Regional Commissioners, Trusts and Health Boards; ACTION: National and Regional Policy Makers, Integrated Care Boards / Health Boards, Regional Commissioners, Trusts and Health Boards	Trust	clinical

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<b>MBRRACE-UK: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death</b>	Ensure that the number of women who require language support, and the support provided at each visit, is recorded systematically. This includes documenting the use of professional interpreting services at clinical care interactions and when supporting women through the navigation of care pathways, as well as recording when these services are not available. The resulting data should be used to implement quality improvement measures, and be assessed against existing NICE guidance.	2024	Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.; Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.	ICB	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Advice on appropriate contraception and postponement of pregnancy should be given to women under investigation for suspected breast cancer.	2019	Primary Care; Primary Care	Primary Care	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	In order to achieve the various UK Governments' ambitions renewed efforts need to be focused on reducing stillbirths and continuing the slow but steady decline in neonatal mortality rates observed since 2013.	2018	Trust; LMNS; Trust; LMNS	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Pregnancy should not alter the investigation and treatment of a woman presenting with a stroke.	2017	Trust; Trust	Trust	clinical

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<b>National Neonatal Audit Programme (NNAP) Summary report on 2021 data</b>	Ensure that shared learning from locally delivered, externally supported, multidisciplinary reviews of deaths (including data from the local use of the Perinatal Mortality Review Tool) informs network governance and unit level clinical practice.	2021	LMNS Trust; LMNS Trust	LMNS; Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	Close monitoring of mortality rates is required to ensure that the decline in rates of stillbirth is continued in order to meet Government ambitions.	2017	Nationally led and captured through ONS. At local level - Board level champion; MBRRACE-UK; LMS; National ambition; Nationally led and captured through ONS. At local level - Board level champion; MBRRACE-UK; LMS; National ambition	NHSE	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Advise women at high risk of pre-eclampsia, or with more than one moderate risk factor for pre-eclampsia, to take 75-150 mg of aspirin daily from 12 weeks until the birth of the baby [NICE NG133].	2019	Trust: Trust	Trust	clinical

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<b>National Neonatal Audit Programme (NNAP) Summary report on 2024 data</b>	Neonatal networks and local maternity and neonatal systems should work with the perinatal teams in their constituent neonatal units to: a. ensure that staff receive appropriate and consistent training to confidently ask families about their ethnicity and that of their baby, and to accurately record demographic information, b. use the NNAP dashboard to review how well NNAP process measures are delivered locally, and whether this differs by ethnicity c. where differences exist, seek to understand the underlying causes, and d. with families, co-design quality improvement programme that directly address those causes.	2024	Neonatal networks and local maternity and neonatal systems; Neonatal networks and local maternity and neonatal systems	ICB; LMNS; NHSE; Trust	strategic
<b>MBRRACE-UK: State of the National Themed Report, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth.</b>	Update guidance to make certain that category 4 caesarean section lists are managed separately from more urgent sections to ensure these operations are not delayed to late in the day.	2023	NICE	Other Bodies	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Non-specialist pathologists who routinely report placental histology should engage in relevant training and CPD activities to improve the quality of their interpretation and reporting.	2021	Trusts	Trust	clinical

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<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Maternity services, and where applicable commissioners, should work towards electronic recording of all maternity care contacts to monitor progress in the ability to provide continuity of carer and to evaluate which care models are associated with the highest levels of continuity of carer.	2017	Commissioners, NHS Trust/Boards, Local level IT support & National Bodies; Commissioners, NHS Trust/Boards, Local level IT support & National Bodies	ICB; Trust	strategic
<b>MBRRACE-UK: Perinatal Mortality Surveillance Report for Births in 2021</b>	Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.	2023	UK Governments, Royal Colleges, Commissioners ; UK Governments, Royal Colleges, Commissioners	Colleges; DHSC; ICB; LMNS	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Develop guidance to indicate the need for definitive radiological diagnosis in women who have an inconclusive VQ scan	2021	Royal Colleges of Physicians, Radiologists, Obstetricians and Gynaecologists; Royal Colleges of Physicians, Radiologists, Obstetricians and Gynaecologists	Colleges	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Services should ensure that local information about the rates of care processes and outcomes in labour is made available to women using their services.	2017	NHS Trusts and Maternity Voices partnerships; NHS Trusts and Maternity Voices partnerships	Trust	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review and act upon comprehensive maternity patient experience data. Trusts to meet national mean (2019/20) of	2021	Trusts; Trusts	Trust	operational

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	patient experience response rate, then pursue top decile of performance				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure antenatal care for all women pregnant with twins is provided by a core, multidisciplinary team of specialists within a dedicated multiple pregnancy clinic.	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lowered thresholds and direct access for maternity and primary care professionals.	2018	Primary Care, CCG; Primary Care, CCG	Primary Care; ICB	operational
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	The NHS should monitor the overall national maternal high dependency and intensive care admission rate using routinely collected linked data sets, where possible supplemented by insight from national reviews as established through the UK Obstetric Surveillance System	2015	NHS Digital; NHS Digital	Other Bodies	operational
<b>NHS Resolution Early Notification Scheme report</b>	Increase awareness and research to understand the prevalence, cause and management of impacted fetal head and difficult delivery of the fetal head at caesarean section. Standardise taxonomies for impacted fetal head and difficult delivery of the fetal head at caesarean section to improve generalisability of research.	2022	Royal Colleges; Royal Colleges	Colleges	operational

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<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure prompt senior obstetric review for all women with a multiple pregnancy (particularly those with threatened preterm labour at the extremes of prematurity) upon attendance at maternity services. Produce a clear plan made regarding monitoring in labour, mode of delivery and when referral is required. When necessary, there should be prompt senior neonatal involvement	2021	Trusts; Trusts	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	Improve the availability and quality of information about possible interventions during labour and birth, by offering individualised evidence-based information in a language and format which is accessible and tailored to each woman or birthing person's circumstances. Consider using the IDECIDE decision-making and consent tool (when available).	2022	Trust Management of the Small-for-Gestational-Age Fetus, 11 Royal College of Midwives (2019) Midwifery Care for Induction of Labour <sup>12</sup> ; Trust Management of the Small-for-Gestational-Age Fetus, 11 Royal College of Midwives (2019) Midwifery Care for Induction of Labour <sup>12</sup>	Colleges; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Be aware of how to contact the regional maternal medicine lead for urgent advice to ensure multidisciplinary senior review of women who are unwell	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Women can be reassured that they can breastfeed from the unaffected breast. There should be a time interval of 14 days or more from the last chemotherapy session to start of breastfeeding to allow drug clearance from breast milk. If chemotherapy is restarted, breastfeeding must cease. A short period of lactation may be psychologically beneficial after a stressful pregnancy and be beneficial to the baby [RCOG Green-top guideline 12].	2019	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Services should ensure they have systems in place for data entry and hold regular training and data quality assurance exercises.	2017	Local Digital Midwife Role; Local Digital Midwife Role	Trust	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Initiate a research programme to inform the development of effective interventions to address health inequalities and reduce stillbirth and neonatal mortality rates.	2019	Research Organisations; Policy Makers, UK Public Health Services, Research Funders.; Research Organisations; Policy Makers, UK Public Health Services, Research Funders.	NHSE	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Enhance current programmes in order to accelerate the reduction of stillbirths and neonatal deaths to meet national targets, with an emphasis on reducing rates of preterm birth, particularly the most extreme preterm group.	2022	Policy Makers, UK Public Health Services; NHS England Improvement; Policy Makers, UK Public Health Services; NHS England Improvement	NHSE; Trust	clinical

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<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Enhance current programmes in order to accelerate the reduction of stillbirths and neonatal deaths to meet national targets, with an emphasis on reducing rates of preterm birth, particularly the most extreme preterm group.	2019	NHS England Improvement; NHS England Improvement	NHSE; Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	In order to facilitate the close working between MBRRACE-UK and the Perinatal Mortality Review Tool (PMRT), within Trusts and Health Boards all stillbirths and neonatal deaths should be notified to MBRRACE-UK via the joint web-based system as soon as possible following the death.	2018	Trust; LMNS; Trust; LMNS	LMNS; Trust	strategic
<b>Each Baby Counts, 2015 Full Report</b>	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.	2015	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Commissioners should support services to collect information on planned and actual place of birth, distinguishing between obstetric units, alongside midwifery units, freestanding midwifery units and home, and to collect information on transfers in utero, and during labour and the postnatal period.	2017	Commissioners, Local Digital Midwife Role, MTP Workstream 6. NHS Digital; Commissioners, Local Digital Midwife Role, MTP Workstream 6. NHS Digital	ICB	strategic
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland</b>	Ensure that assessment of adherence to administration forms part of the antenatal or postnatal assessment of women prescribed low molecular weight heparin	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Women with epilepsy taking antiepileptic drugs who become unexpectedly pregnant should be able to discuss therapy with an epilepsy specialist on an urgent basis. It is never recommended to stop or change antiepileptic drugs abruptly without an informed discussion	2021	Trusts	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should ensure that their local group B streptococcus guidance is in line with the RCOG guidance on the prevention of early onset neonatal GBS disease (RCOG, 2017) with particular reference to the immediate administration of antibiotics and provision of printed information for mothers.	2020	Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Ensure there are clear and explicit pathways into specialist perinatal mental health care, which take into account all other aspects of perinatal mental health provision, including specialist roles within midwifery and obstetric services, in order to avoid any confusion over roles and responsibilities	2021	Service Planners/Commissioners, Hospitals/Trusts/Health Boards]; Service Planners/Commissioners, Hospitals/Trusts/Health Boards]	ICB; LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	There is a five-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared to white women. Action is needed to address these disparities	2018	NHSE	NHSE	operational

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Collate recommendations from relevant guidelines into a single definitive source of guidance on the care for older women in pregnancy, including both women planning assisted reproduction and those who conceive spontaneously	2021	Royal Colleges of Obstetricians and Gynaecologists, Physicians; Royal Colleges of Obstetricians and Gynaecologists, Physicians	Colleges	operational
<b>Each Baby Counts, 2015 Full Report</b>	We ask all trusts and health boards for their continued commitment to Each Baby Counts, which is vital for the programme's continuing success and impact.	2015	Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant.	2018	Trust, Primary Care;	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22</b>	Update end-of-life care guidance to include recommendations for the appropriate service delivery to pregnant or recently pregnant women including the need to recognise decline, facilitate time spent with their baby and hold conversations around provision of consent for advanced resuscitation	2024	National Institute for Health and Care Excellence; National Institute for Health and Care Excellence	Other Bodies	clinical
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	In addition to audit, training programmes should be in place to ensure regular updates are available for all staff performing fetal ultrasound. This should include review of	2018	Trust	Trust	clinical

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	complex cases, to familiarise staff with common problems as well as rarer cases.				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure the pathologist is provided with a complete clinical history when requesting post-mortem or placental examination. In cases of twin pregnancy, this should be clearly indicated on the request, including chorionicity and details of the other twin should the examination be requested separately or if there is a surviving sibling.	2021	Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	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.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE); NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency ; NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency	Colleges; Other Bodies; DHSC; NHSE	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	A post-mortem examination should be offered in all cases of stillbirth and neonatal death in order to identify the cause of death where possible, to exclude potential contributory	2016	Board level champion; MBRRACE-UK Lead reporters; LMNS, safety commissioners; Board	LMNS; Trust	clinical

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	factors, and to improve the future pregnancy counselling of parents. For stillbirths, regardless of whether consent is provided for post-mortem examination, the placenta should always be submitted for histological examination, preferably by a specialist pathologist.		level champion; MBRRACE-UK Lead reporters; LMNS, safety commissioners		
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally formed antepartum stillbirth</b>	The presence of reduced fetal movements with additional risk factors, or recurrence of reduced fetal movements in an otherwise low risk woman, should prompt referral for an ultrasound scan and senior obstetric review.	2015	Trust	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should use a neonatal warning chart which incorporates more detail in relation to the baby's behaviour and feeding.	2020	Trust	Trust	clinical
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHS England and NHS Improvement leads the development of minimum operating standards for pre assessment maternity telephone triage services to support safe and consistent telephone triage to ensure reliable identification of risks.	2020	NHSE	NHSE	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential</b>	Perinatal mental health clinical networks should be established to develop local services and clear pathways of care to prevent care being fragmented and uncoordinated.	2015	Perinatal mental health team; LMS; CN's; Perinatal mental health team; LMS; CN's	LMNS	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Networks should always include specialist addictions services.				
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Ensure safer sleep advice is personalised to the individual circumstances of each family, and that support addresses both the environmental and psychological barriers to following advice, to reduce the risks of sudden unexpected, unexplained death in infancy. Professionals discussing safer sleep advice should be aware of the high number of deaths in which unplanned co-sleeping took place in a hazardous environment so they can ensure that every family gets advice for such situations.	2019	Commissioners and Providers of Postnatal Care, Health Visiting Services, Antenatal Services, Neonatal Hospital and Community Staff, Family Nurse Partnerships, GPs and family support workers Trust; Commissioners and Providers of Postnatal Care, Health Visiting Services, Antenatal Services, Neonatal Hospital and Community Staff, Family Nurse Partnerships, GPs and family support workers; Trust	Primary Care; ICB; LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination.	2018	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	All clinicians involved in maternity and neonatal care should take ownership of the completeness and accuracy of the electronic recording of the care they provide. This includes influencing local purchasing decisions to ensure that software systems are appropriate for use and compliant with data standards.	2017	Clinicians/Local level IT support; Clinicians/Local level IT support	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Data gathering on maternal critical illness (including when it is managed in obstetric areas) should be re-examined and strengthened by new definitions in order to capture lessons about good care and near miss events [NMPA 2019].	2019	Royal Colleges, NHSE	Colleges; NHSE	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	The emphasis should be on making a diagnosis, not simply excluding a diagnosis	2021	Trusts	Trust	clinical
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to ensure mothers are advised of the risks and offered all available options when a baby is suspected of being LGA.	2021	Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	In order that Trusts and Health Boards can comply with the recommendations arising from the Morecambe Bay Investigation, they should fully engage with the MBRRACE-UK	2015	MSC's, HoM's and CD; LMNS; MSC's, HoM's and CD; LMNS	Trust	strategic

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	data collection so as to ensure the “systematic recording and tracking of perinatal deaths”.				
<b>Saving Lives, Improving Mothers’ Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Referrals to the NHS ECMO service should be made for pregnant women or women post-pregnancy using the same criteria as for other adult patients i.e. if worsening severe respiratory failure despite appropriate conventional ventilatory support, or for women in whom lung protective ventilation cannot be achieved because of the severity of hypoxaemia or hypercapnia, or significant air-leak (e.g., barotrauma or bronchopleural fistula)	2021	Trusts Clinical Commissioning Groups LMS’s; Trusts Clinical Commissioning Groups LMS’s	ICB; LMNS; Trust	clinical
<b>Saving Lives, Improving Mothers’ Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Critical care outreach or an equivalent service should be available to ill women, and provide support and education to healthcare professionals delivering enhanced maternal care [Care of the critically ill woman in childbirth 2018].	2019	Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	National organisations from across England, Wales and Scotland that are responsible for collating and managing maternity datasets should work together to ensure alignment of data specifications used	2019	MTP Workstream 6. NHS digital; MTP Workstream 6. NHS digital	Other Bodies	strategic
<b>Each Baby Counts, 2015 Full Report</b>	All healthcare professionals should support the dissemination of learning and, where it is needed, culture change within their unit.	2015	Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Syncope during exercise can suggest a cardiac origin, and should prompt cardiac evaluation [ESC syncope guideline 2018].	2019	Trust, Ambulance Service, Primary Care; Trust, Ambulance Service, Primary Care	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision	2022	Service Planners, Service Commissioners, Health Professionals.; Service Planners, Service Commissioners, Health Professionals.	ICB; LMNS	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team.	2018	Trust,; Trust,	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Review the quality of the care environment for women and their families. Focus efforts on improving privacy and on measures that help families stay together while the mother and/or baby are admitted, including private bathrooms for all birth rooms and bedrooms for parents of babies admitted to neonatal units.	2019	Commissioners; Trust/Boards/Service Management (maternity & neonatal); Commissioners; Trust/Boards/Service Management (maternity & neonatal)	ICB; LMNS; Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Develop public health initiatives to address issues linked to high risk populations.	2020	NHS England and Improvement; Department of Health; NHS England	DHSC; NHSE	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation and Improvement; Department of Health	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Misoprostol should always be used with extreme caution for women with late intrauterine fetal death, especially in the presence of a uterine scar. In advanced pregnancy especially with a scar dinoprostone may be more appropriate.	2017	Trust; Trust	Trust	operational
<b>NHS Resolution Early Notification Scheme report</b>	Ongoing work to improve the detection of maternal deterioration in labour, understand monitoring practices, use evidence-based guidance and ensure these are implemented in all birth settings. Further research is required to understand the prevalence and cause of significant intrapartum hyponatraemia.	2022	Royal Colleges; Royal Colleges	Colleges	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Commissioners, together with clinicians, services and policymakers should strongly prioritise the provision of resources to support breastfeeding, both in maternity units and in the community, to reduce the variation in the proportion of babies receiving breast milk at their first feed and at discharge from the maternity unit.	2017	Public Health commissioners/NHS Trusts/Heads of service/Clinicians; Public Health commissioners/NHS Trusts/Heads of service/Clinicians	ICB	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	National guidance is needed regarding the principles that should guide decisions to stop resuscitation and/or re-orientate care. Further research is also needed to guide practice in this area.	2017	Royal Colleges; Royal Colleges	Colleges	strategic

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	When assessing a woman who is unwell, consider her clinical condition in addition to her MEOWS score	2017	Trust; Primary Care;Trust; Primary Care	Primary Care; Trust	operational
<b>MBRRACE-UK: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death</b>	Ensure services provide advocacy for women who have been in the UK for less than a year, or do not speak or understand English, to support care navigation. This should incorporate midwifery and obstetric care when indicated.	2024	Home Office, Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.; Home Office, Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.	ICB; Trust; Other Bodies	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Where local data provided have been insufficient to report results, or where results suggest there may be data quality issues for any or all of the following measures: • birth without intervention • smoking in pregnancy • planned and actual place of birth, maternity service providers should work with maternity information system suppliers and those responsible for collating and managing maternity datasets to improve completeness	2019	Local level IT support (Digital Midwife role); Local level IT support (Digital Midwife role)	Trust	operational

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	and accuracy of the data items required for these measures to inform local quality improvement activities.				
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Vulnerable and young women remain disproportionately represented amongst those who have died from ectopic pregnancy. Ensure care is personalised to provide appropriate additional safety measures	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	clinical
<b>PMRT Learning from Standardised Reviews When babies Die. Second Annual Report (2020)</b>	Improve the process of PMRT review by involving sufficient members of multidisciplinary internal staff and an external member as part of the PMRT review team.	2020	Trusts and Health Boards, regional support systems and organisations e.g. Local Maternity Systems in England, Service Commissioners; Trusts and Health Boards, regional support systems and organisations e.g. Local Maternity Systems in England, Service Commissioners	Trust	operational
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report</b>	Ensure evidence and incentive based smoking cessation programmes, such as those utilised by the Maternity Transformation Programme, are offered to people considering pregnancy or who are pregnant. This should include	2019	Integrated Care Systems; Integrated Care Systems	ICB	operational

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<b>Data from April 2019 to March 2021</b>	following NICE guideline NG209 on smoking cessation				
<b>National Neonatal Audit Programme (NNAP) Summary report on 2024 data</b>	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to regularly review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.	2024	Neonatal Networks; Neonatal Networks	ICB; LMNS; NHSE; Trust	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Where either one or both babies have died, as part of the PMRT process pay particular attention to: <ul style="list-style-type: none"> <li>• Sensitive inclusion of parents' views;</li> <li>• Ensuring the tertiary centre is also included in the review process.</li> </ul>	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	A lack of an immediately available critical care bed must not be a reason for refusing admission for patients requiring urgent neurosurgery.	2017	Trust; neurology; Critical care; Trust; neurology; Critical care	Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick mothers. <ul style="list-style-type: none"> <li>• Reduced or altered conscious level is not an early warning sign; it is a red flag to indicate established illness.</li> </ul>	2016	Trust; Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Recurrent bleeding, pain or agitation should be seen as 'red flags' in women with placenta accrete and women should be advised to remain in hospital.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	The choice of endotracheal tube for pregnant women should start at size 7.0mm and proceed to smaller tube selections if needed (size 6.0mm and 5.0mm). It is recommended that all resuscitation carts used in maternity units should include endotracheal tubes no larger than 7.0mm and include smaller sizes such as 6.0mm and 5.0mm.	2017	Trust; Anaesthetists; Trust; Anaesthetists	Trust	clinical
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Evaluate medical and midwifery staffing requirements, taking into account the range of national ambitions, and fund services accordingly.	2019	Commissioners, NHS Trust/Boards/Service Management; Commissioners, NHS Trust/Boards/Service Management	ICB; Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Maternity and neonatal services should collaborate to improve the recording of in-utero transfers.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	clinical

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<b>NMPA State of the Nation - Based on births in NHS maternity services in England, Scotland and Wales during 2023</b>	<p>Digital teams in the Government health departments should work with maternity data controllers and software developers to incorporate processes and systems into the next version update of each dataset that support maternity care providers to optimise data quality. This should include stakeholder engagement to:</p> <ul style="list-style-type: none"> <li>- Minimise data entry burden while supporting trusts/boards to reduce areas of missing or incomplete data.</li> <li>- Standardise data definitions and data fields to support consistency, comparability and interoperability.</li> <li>- Ensure updates to the dataset technical specifications meet the needs of data users including frontline clinicians, analysts, researchers, and policymakers.</li> <li>- Align maternity data standards with SNOMED CT and the Digital Maternity Record Standard (DMRS), to support future interoperability and integration with other clinical systems.</li> </ul>	2023	Government health departments; Government health departments	Colleges; DHSC; NHSE; Other Bodies	strategic
<b>Five years of cerebral palsy claims</b>	Trusts should monitor the effectiveness of their training by linking it to clinical outcomes. Trust boards should encourage units to publish	2017	Trust; Trust	Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	their local indicators, which can then be subject to benchmarking and external scrutiny.				
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Consider use of validated Safer Sleep Assessment Tools to identify families with infants at higher risk of SIDS. This will support Health Visitors, Social Workers, GPs and Adult Mental Health Services to identify vulnerable families and provide enhanced support. This should include seeing where the infant sleeps during home visits and providing person-centred advice for families depending on their individual circumstances.	2019	Local Authorities Trust; Local Authorities Trust	Primary Care; LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Policy makers and service planners should ensure that there are no barriers in place that prevent clinicians seeking directly the advice and/or involvement of experts in other specialties for women with multiple morbidities, particularly on discharge from maternity care.	2015	Trust; Trust	Trust	strategic
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust needs to ensure that the information which is provided to mothers informs them of birth options and associated advantages and risks to support decision making and informed consent during childbirth.	2021	Trust; Trust	Trust	operational
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to ensure that neonatal clinicians are called as an emergency to attend a birth when a shoulder dystocia occurs. Scenario training may improve team working at resuscitations.	2021	Trust; Trust	Trust	clinical

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Aim for completion of all surveillance data within 90 days to enable timely review with the PMRT and effective use of the MBRRACE-UK real-time data monitoring tool. Utilise the real-time data monitoring tool to ensure the data entered is complete and of high quality.	2020	Trusts; Trusts	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population	2020	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.; Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	ICB; Trust	clinical
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Effective multi-disciplinary team working is also essential to the provision of safe care, as is mutual professional respect, so that midwives support doctors and doctors support midwives.	2018	Trust; Trust	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby's stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy.	2015	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care</b>	Ensure that postgraduate medical and surgical curricula include training in the need for contraceptive advice to women of reproductive	2021	: Academy of Medical Royal Colleges; : Academy of Medical Royal Colleges	Colleges	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	age and how to ensure that it is provided and pre-pregnancy planning to women of reproductive age with medical problems such as cancer				
<b>Evaluating hospital and crisis care for perinatal mental health - Based on births between 1 April 2018 and 31 March 2019 in England.</b>	Mental health diagnoses for inpatient care are more comprehensively recorded in the Mental Health Services Data Set (MHSDS), however improvements are required to the recording of diagnoses for those who received community mental health services.	2018	Mental health services providers, NHS England and healthcare data software developers; Mental health services providers, NHS England and healthcare data software developers	Colleges; Primary Care; ICB; NHSE	operational
<b>NMPA State of the Nation - Based on births in NHS maternity services in England, Scotland and Wales during 2023</b>	<p>Digital teams in the Government health departments should review data definitions and descriptions of care processes and outcomes in the Digital Maternity Record Standard (DMRS) (and Scottish and Welsh equivalents), and their application to clinical practice in order to:</p> <ul style="list-style-type: none"> <li>- Objectively measure and record all volumes of blood loss during labour and birth.</li> <li>- Develop meaningful and consistent measures of: <ul style="list-style-type: none"> <li>* skin-to-skin contact following birth in line with the UNICEF definition and to include reasons for non-occurrence.</li> <li>* establishing and supporting breast milk feeding beyond the first feed.</li> </ul> </li> </ul>	2023	Government health departments; Government health departments	Colleges; DHSC; NHSE; Other Bodies	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Disengagement from care should be regarded as a potential indicator of worsening mental state. All professionals involved in the woman's care should be informed of non-attendances and assertive follow-up arranged where there is already concern regarding mental state or prior evidence of risk [Saving Lives, Improving Mothers' Care 2018].	2019	Trust; Perinatal Mental health; Primary Care; HV; Social Care; Trust; Perinatal Mental health; Primary Care; HV; Social Care	Primary Care; Trust	clinical
<b>MBRRACE-UK: State of the Nation Themed Report, Lessons Learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-2021.</b>	Ensure that staff working within maternal medicine networks are equipped with the skills to care for the complex and multiple medical, surgical, mental health and social care needs of the current maternity population.	2023	Trusts - Maternal Medicine networks; Trusts - Maternal Medicine networks	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Any woman with suspected placenta praevia accreta should be reviewed by a consultant obstetrician and consultant anaesthetist in the antenatal period. The different risks and treatment options should have been discussed and a plan agreed. The plan should always be followed especially in the event of an emergency delivery.	2018	Trust; Trust	Trust	clinical

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<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Emphasise the importance of pre-conception health as a routine part of every health professional's interaction with women who have risk factors for congenital anomaly.	2019	UK Public Health Services, Primary Care Providers, Royal Colleges, Trust and Health Board Directors, Clinical Directors, Heads of Midwifery, Health Professionals; NHS England Improvement; Department of Health; UK Public Health Services, Primary Care Providers, Royal Colleges, Trust and Health Board Directors, Clinical Directors, Heads of Midwifery, Health Professionals; NHS England Improvement; Department of Health	Colleges; Primary Care; DHSC; NHSE; Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Ensure cause of death coding is undertaken by a suitably qualified clinician following PMRT review, and MBRRACE UK surveillance data updated accordingly	2022	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.; Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	Use a validated tool, such as FAST (Face Arm Speech Test), outside hospital to screen people with sudden onset of neurological	2021	Trust; Trust	Trust	clinical

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<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	symptoms for a diagnosis of stroke or transient ischaemic attack (TIA)				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	A persistent sinus tachycardia is a 'red flag' and should always be investigated, particularly when there is associated breathlessness.	2019	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Continuing midwifery support, following discharge from hospital, should be offered to and documented for all women after the birth of a stillborn baby.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	All Trusts and Health Boards should endeavour to improve the quality and completeness of data reported to MBRRACE-UK and for routine inpatient, and birth and death registration purposes. Children's hospitals should continue to develop and embed systems that allow for consistent liaison with birth hospitals to facilitate the collection of maternal information	2018	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	A diagnosis of ectopic pregnancy should be considered in any woman of reproductive age presenting to the emergency department with collapse, acute abdominal/pelvic pain or gastrointestinal symptoms, particularly diarrhoea, vomiting and dizziness, regardless of whether or not she is known to be pregnant. A bedside pregnancy test should always be	2019	Trust - Emergency department; Trust - Emergency department	Trust	clinical

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	performed in these women, if necessary catheterising to obtain urine [Saving Lives, Improving Mothers' Care 2016].				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	In pregnant or postpartum women with complex medical problems involving multiple specialities, the responsible consultant obstetrician or physician must show clear leadership and be responsible for coordinating care and liaising with anaesthetists, midwives, other physicians and obstetricians and all other professionals who need to be involved in the care of these women.	2017	Trust; Trust	Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Standardised multidisciplinary review of all stillbirths should be undertaken to include classification of death, grading of care, adequacy and accuracy of documentation and the generation of a local action plan for any improvements required.	2015	Trust; HSIB; Trust; HSIB	Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Develop guidance on single embryo transfer for older women undergoing in vitro fertilisation, particularly in the context of medical co-morbidities	2021	Royal Colleges of Obstetricians and Gynaecologists, Physicians, British Fertility Society]; Royal Colleges of Obstetricians and Gynaecologists, Physicians, British Fertility Society]	Colleges	operational

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<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band.	2019	Trusts; Trusts	Trust	clinical
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review and act upon comprehensive maternity patient experience data. d) Trusts and CCGs to monitor national patient experience data through NPEU8 and CQC reporting and act upon published findings.	2021	Trusts, CCGs; Trusts, CCGs	ICB; Trust	operational
<b>Each Baby Counts 2018 Progress report</b>	There is an urgent need for a PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.	2018	Royal colleges; Royal colleges	Colleges	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	National quality improvement and training programmes should be implemented to improve compliance with national In the antenatal period guidance. <ul style="list-style-type: none"> <li>• monitoring growth in pregnancy;</li> <li>• management of reduced fetal movements;</li> <li>• documentation of discussion and the agreed management plan for labour and birth following previous caesarean section;</li> <li>• care of women with diabetes in a combined clinic;</li> <li>• the offer of carbon monoxide breath testing at booking and referral to smoking cessation services. In labour</li> <li>• intermittent auscultation during the first and second stage of labour;</li> <li>• real time ultrasound scanning should there be difficulty</li> </ul>	2017	Royal colleges; Royal colleges	Colleges	strategic

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	in detecting the fetal heart rate. At resuscitation • All health care professionals who are routinely present at births should undertake regular Neonatal Life Support training. This includes all new starters and ambulance staff. After birth • Trusts and Health Boards should work to improve the bereavement care for parents; • all maternity units should adopt the national tool for perinatal death review (Perinatal Mortality Review Tool) when it is available.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Postpartum safety advice and strategies should be part of the antenatal and postnatal discussions with the mother alongside discussion of breastfeeding, seizure deterioration and anti-epileptic drug intake.	2017	Trust; Trust	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	The obstetric and midwifery management of the labour of women with an intrauterine death should be no different in quality and content to that of women having a live birth, including the use of a partogram to monitor the progress of labour.	2015	NICE; Royal Colleges; Trust; NICE; Royal Colleges; Trust	Colleges; Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Good communication between primary care, mental health and maternity services is critical to good quality care for women with mental ill health, in particular: · At booking there should be a routine enquiry about a current or past history of mental health problems, which	2015	Trust; Trust	Trust	operational

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	should cover the full range of mental health issues and not just depression. · Maternity services should ensure that the GP is made aware of a woman's pregnancy and enquire of the GP about the woman's past mental health history.				
<b>Each Baby Counts 2018 Progress report</b>	Local guidelines: There must be a clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended.	2018	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Face to face treatment may be preferable when the patient has complex clinical needs, you need to examine the patient or [it is] hard to ensure, by remote means, that patients have all the information they want and need about treatment options (GMC guidance on remote consultations)	2021	Trusts; Trusts	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	In multiple pregnancies where a woman is in established labour or having a planned preterm birth, where appropriate, offer antenatal steroids between 22+0 and 35+6 weeks and antenatal MgSO4 between 23+0 and 33+6 weeks.	2021	Trusts; Trusts	Trust	clinical

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Recognise that 'post-pregnancy' counselling is as important as pre-pregnancy counselling for future pregnancies and for joining up obstetric and medical care to optimise a woman's long-term health	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	operational
<b>MBRRACE-UK: State of the Nation Themed Report, Lessons Learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-2021.</b>	Update guidance on ECMO for severe acute respiratory failure in adults to include specific information on referral and admission of pregnant and recently pregnant women with respiratory failure to ECMO services	2023	NICE; NICE	Other Bodies	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Haemorrhage (which might be concealed) should be considered when classic signs of hypovolaemia are present (tachycardia and/or agitation with hypotension often a late sign) even in the absence of revealed bleeding.	2021	Trusts; Trusts	Trust	clinical

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<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Prioritise research on sudden unexpected and unexplained deaths of children over 1 year of age to identify potentially modifiable factors so professionals can work to prevent these deaths.	2019	DHSC; NHS England, National Institute for Health and Care Research (NIHR), Genomics England, Office for Health Improvement and Disparities, Royal College of Paediatrics and Child Health; DHSC; NHS England, National Institute for Health and Care Research (NIHR), Genomics England, Office for Health Improvement and Disparities, Royal College of Paediatrics and Child Health	DHSC	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Regardless of whether the parents give consent for full post mortem examination, the placenta should always be submitted for histological examination by a specialist pathologist.	2015	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	There should be national development of a standardised risk assessment tool for determining a woman's risk status on admission in presumed labour, or prior to induction, and regularly throughout labour.	2017	Royal Colleges; NICE; Royal Colleges; NICE	Colleges	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based</b>	Following implementation of national initiatives such as the Saving Babies' Lives	2019	NMPA, NHS Trusts; NMPA, NHS Trusts	Trust	strategic

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<b>on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	care bundle in England, the NMPA and NHS trusts and boards should monitor for possible increases in induction rates and the impact of this on women, their babies and service providers.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	When there has been a massive haemorrhage and the bleeding is ongoing, or there are clinical concerns, then a massive haemorrhage call should be activated.	2021	Trust; Trust	Trust	clinical
<b>Each Baby Counts, 2015 Full Report</b>	All local reviews must have the involvement of an external panel member.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	Sustainability and Transformation Plans (STPs) in England need to address existing inequalities, particularly in relation to neonatal mortality.	2017	LMS, maternity; safety commissioners; LMS, maternity; safety commissioners	LMNS	clinical

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<b>MBRRACE-UK: State of the Nation Themed Report, Lessons Learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-2021.</b>	Ensure that pregnant and breastfeeding women are not excluded inappropriately from research, including new vaccine and treatment research, and ensure that messaging about benefits and risks of medication and vaccine use is clear and well informed with involvement of key opinion leaders and representatives of communities at risk from an early stage. Prepare a route to enable rapid dissemination of updated advice and data concerning new vaccines and treatments to both women and their clinicians in the future.	2023	DHSC (and equivalents in Scotland, Wales and Ireland) UKHSA (and equivalents in Scotland, Wales and Ireland) NIHR and other funding agencies RCOG, RCM, RCP, RCGP; DHSC (and equivalents in Scotland, Wales and Ireland) UKHSA (and equivalents in Scotland, Wales and Ireland) NIHR and other funding agencies RCOG, RCM, RCP, RCGP	Colleges; DHSC	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should communicate with mothers and their partners in relation to the increased risk of infection including GBS in labour and the neonatal period following pre-labour rupture of membranes.	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	A raised respiratory rate, chest pain, persistent tachycardia and orthopnoea are important signs and symptoms of cardiac disease which should always be fully investigated. The emphasis should be on making a diagnosis, not simply excluding a diagnosis [Saving Lives, Improving Mothers' Care 2016].	2019	Trust; Trust	Trust	clinical

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Women of reproductive age presenting to the Emergency Department collapsed, in whom a pulmonary embolism is suspected, should have a Focused Assessment with Sonography in Trauma (FAST) scan to exclude intra-abdominal bleeding from a ruptured ectopic pregnancy especially in the presence of anaemia [Saving Lives, Improving Mothers' Care 2016].	2019	Trust; Emergency Department; Sonography; Cardiology; Trust; Emergency Department; Sonography; Cardiology	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Women who have had a previous caesarean section who also have either placenta praevia or an anterior placenta underlying the old caesarean section scar at 32 weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations for surgery made	2018	Trust; Trust	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust to ensure that mothers who require IAP are aware of when to attend the maternity unit and what care to expect, so they are empowered to ensure they receive care in line with national guidance	2020	Trust; Trust	Trust	strategic
<b>MBRRACE-UK: State of the National Themed Report, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid</b>	Review guidance on when to use balloon tamponade to control haemorrhage, how to insert the balloon and inflate it. Resources such as postpartum haemorrhage checklists should include when not to use balloon tamponade and when to abandon it and move on to a different haemostatic technique.	2023	NICE, RCOG; NICE, RCOG	Colleges; Other Bodies	strategic

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<b>embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth.</b>					
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Whilst in many units senior supervision was available, the central issue is often recognising when to request such assistance. Again, audit can help identify how a systems approach can be taken to ensure supervision is given as needed.	2018	Trust; Trust	Trust	operational
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Third Annual Report</b>	Improve the quality of recommendations developed as a consequence of reviews by developing actions targeted at system level changes and audit their implementation and impact.	2021	PMRT review teams, governance teams in Trusts, Service Commissioners; PMRT review teams, governance teams in Trusts, Service Commissioners	ICB; Trust	operational
<b>Each Baby Counts 2018 Progress report</b>	All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.	2018	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	The lead specialist obstetrician of the core team should provide each woman with a 16 week antenatal check to assess and explain the general and specific risks of her pregnancy.	2021	Trusts; Trusts	Trust	operational

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<b>MBRRACE-UK: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death</b>	Pilot the provision of an initial assessment appointment for migrant women of childbearing age when they first access health care services. The purpose would be to carry out a holistic assessment of their reproductive healthcare needs, provide information about reproductive health and availability of maternity services, and to understand any concerns they may have about accessing healthcare services.	2024	NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency, research funders.; NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency, research funders.	Primary Care; NHSE; Other Bodies	clinical
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Trusts and boards, and their commissioners where applicable, should collaborate across geographical areas to ensure all women have access to all four birth settings.	2017	Commissioners, NHS Trust/Boards; Commissioners, NHS Trust/Boards	ICB; Trust	strategic
<b>National Neonatal Audit Programme (NNAP) Summary report on 2021 data</b>	NHS England and the Welsh Government should require neonatal networks to work with their constituent neonatal units to ensure they: Identify an infant feeding lead to train and support staff, with protected time within their job plan for this role. Use the following tools and resources to support their maternal breastmilk focussed quality improvement initiatives- Ensure unrestricted access for parents to the neonatal unit and their baby, and as full as possible for the wider family, including a return to pre-Covid visiting policies if not yet achieved. - Ensure that parent presence on the consultant ward round is recorded daily - Seek to learn from neonatal units that are achieving high rates of parent	2021	NHSE; NHSE	NHSE	strategic

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	involvement, making use of available resources including those provided by Bliss - Ask parents for their views and suggestions for how to improve parental partnership in care, including how to increase parent involvement in consultant ward rounds and how to best ensure that parents meet a senior member of the neonatal team within 24 hours of admission				
<b>Each Baby Counts, 2015 Full Report</b>	Doctors, midwives and other healthcare professionals should ensure this report's recommendations for clinical practice are followed at all times.	2015	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	Key management decisions should not be based on CTG interpretation alone. Healthcare professionals must take into account the full picture, including the mother's history, stage and progress in labour, any antenatal risk factors and any other signs the baby may not be coping with labour.	2015	Trust; Trust	Trust	clinical
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	If a mother chooses to use the birth centre in labour and has risk factors which would indicate a recommendation to use the obstetric unit, the Trust should ensure that multidisciplinary input and review is gained during labour so that the plan of care and decision making is not carried out in isolation.	2021	Trust; Trust	Trust	operational

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<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Continue to develop innovative new programmes of research into reducing preterm birth	2019	NHS England Improvement, UK Public Health Services, Research Funders.; NHS England Improvement, UK Public Health Services, Research Funders.	NHSE	clinical
<b>Evaluating hospital and crisis care for perinatal mental health - Based on births between 1 April 2018 and 31 March 2019 in England.</b>	Ensure that women and birthing people who have previously accessed secondary mental health services are given support and information before they become pregnant, or in the perinatal period, which is tailored to their individual circumstances. As described in NHS England's Perinatal Mental Health Care Pathways, this should include referral to a specialist community perinatal mental health team.	2018	Mental health services providers and maternity care providers, NHS England and RCGP, RCPsych and RCOG, and RCM and RCN; Mental health services providers and maternity care providers, NHS England and RCGP, RCPsych and RCOG, and RCM and RCN	Colleges; Primary Care; ICB; NHSE	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Developers of maternity record standards and national data sets should include the facility to collect information about women receiving high dependency and intensive care and the setting in which this care is provided. Maternity information system suppliers should implement this in their systems. The NMPA endorses the recommendations of the Maternity Critical Care Standards Working Group about the collection of such data.	2021	NHS Digital; NHS Digital	Other Bodies	strategic

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	Placental histology should be undertaken for all stillbirths and if possible all anticipated neonatal deaths, preferably by a perinatal pathologist.	2018	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22</b>	Restructure the existing national VTE risk assessment tool based on research evidence to produce an assessment that is easy to use, clear and accurate and that includes factors that may arise in the postnatal period	2024	National Institute for Health and Care Research in consultation with the Royal College of Obstetricians and Gynaecologists; National Institute for Health and Care Research in consultation with the Royal College of Obstetricians and Gynaecologists	Colleges; Other Bodies	strategic
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Critical care support can be initiated in a variety of settings. Delay caused by bed pressures in a critical care unit is not a reason to postpone critical care (Saving Lives, Improving Mothers' Care 2014).	2020	Hospitals/ Trusts/ Health Boards, All Health Professionals; Hospitals/ Trusts/ Health Boards, All Health Professionals	Primary Care; Trust	clinical

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<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure that communication with partners and families, including via an interpreting service if necessary, and facilitating visits between women and their partners is a priority when women are critically ill.	2021	Trust; Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; Royal Colleges of Physicians; COVID-19 Guideline Development Groups; Trust; Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; Royal Colleges of Physicians; COVID-19 Guideline Development Groups	Colleges; Primary Care; Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally formed antepartum stillbirth</b>	There is a need for the development of national evidence-based guidelines for the induction of labour following diagnosis of intrauterine death. This should include the care of women with a previous history of caesarean section.	2015	NICE; Royal colleges; NICE; Royal colleges	Colleges	clinical
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and</b>	Maternity service providers who offer specialist fetal procedures, such as intrauterine fetal laser therapy, should work with their coding departments to ensure that the fetal complications and procedures are	2015	Trust; NHS Digital; Trust; NHS Digital	Trust	clinical

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<b>31 March 2017 in England, Wales and Scotland</b>	properly coded into HES, SMR and PEDW by the end of the 2020/21 reporting year				
<b>MBRRACE-UK: State of the National Themed Report, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth.</b>	Review and revise the service specification for centres providing specialist services for managing abnormally invasive placentation to ensure that all specialist units can provide appropriate equipment, facilities and appropriately skilled personnel in an emergency situation occurring at any time of day or night.	2023	NICE; MBRRACE-UK	DHSC; NHSE; Other Bodies	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure a review of individual plans of care is conducted by senior staff at least daily.	2021	Trusts; Trusts	Trust	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision.	2019	Service Planners, Service Commissioners, Health Professionals.; Service Planners, Service Commissioners, Health Professionals.	ICB; LMNS; Trust	operational

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<b>National Neonatal Audit Programme (NNAP) Summary report on 2021 data</b>	<p>All neonatal networks and their constituent neonatal units should, following a review of local mortality results, and relevant national and regional reviews (such as the Getting It Right First Time (GIRFT) neonatal report, the Neonatal Critical Care Review action plan in England, and Independent Maternity Oversight Panel reviews in Wales) take action to:</p> <ul style="list-style-type: none"> <li>• Consider a quality improvement approach to the delivery of evidencebased strategies in the following areas to reduce mortality: timely antenatal steroids, deferred cord clamping, avoidance of hypothermia and management of respiratory disease. Such quality improvement activity should pay due regard to relevant guidance and resources, such as the NICE guidance for specialist respiratory care and the BAPM and NNAP quality improvement toolkits.</li> <li>• Ensure that shared learning from locally delivered, externally supported, multidisciplinary reviews of deaths (including data from the local use of the Perinatal Mortality Review Tool) informs network governance and unit level clinical practice.</li> </ul>	2021	LNMS Trust; LNMS Trust	LMNS; Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	National bodies should develop initiatives to assist clinicians to effectively predict, prevent and recognise severe obstetric haemorrhage.	2017	National Organisations, Professional bodies (RCOG/RCM), policymakers; National Organisations, Professional bodies	Colleges	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation (RCOG/RCM), policymakers	Audience	Type
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Access services such as Psychiatric Liaison, Crisis and Street Triage Teams should alert specialist Perinatal Mental Health Teams to any referrals of self-harm in pregnant or postpartum women that they have received to allow triage regarding the need for specialist follow-up	2022	All Health care professionals; All Health care professionals	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-2023</b>	Update guidelines on the care of women with complex social factors to include clear guidance for a standardised assessment and documentation of social risk factors at booking appointments and at least once more later in pregnancy. In the absence of sufficient evidence to update guidance, commission research to explore the unique care needs of vulnerable populations.	2025	National Institute for Health and Care Excellence (NICE) and National Institute for Health and Care Research (NIHR); National Institute for Health and Care Excellence (NICE) and National Institute for Health and Care Research (NIHR)	Colleges; Primary Care; NHSE; Trust; Other Bodies	operational
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to review and update its place of birth risk assessment tool so that a holistic approach is taken ensuring that ongoing risk assessment is thorough.	2021	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	ECG and measurement of troponin levels are recommended when a pregnant woman has chest pain. Echocardiography is recommended in any pregnant patient with unexplained or	2019	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>into Maternal Deaths and Morbidity 2015–17</b>	new cardiovascular signs or symptoms [ESC cardiovascular diseases in pregnancy guideline 2018].				
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust must ensure that the group B streptococcus and prevention of early-onset neonatal GBS disease guideline is disseminated to staff.	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure maternity units have protocols to support decision-making in the provision of neuraxial analgesia and anaesthesia to women who may be at risk of having abnormal coagulation	2021	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	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	2022	Policy Makers, UK Public Health Services.; Policy Makers, UK Public Health Services.	DHSC; NHSE	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	All organisations, irrespective of their extended perinatal mortality rate, should investigate individual stillbirths and neonatal deaths using a standardised process and independent, multidisciplinary peer review as recommended in the Report of the Morecambe Bay Investigation. The information within the MBRRACE-UK Perinatal Surveillance Reports	2016	PMRT now in place. MBRRACE lead reporters, MSC, CN and LMNS, HSIB; PMRT now in place. MBRRACE lead reporters, MSC, CN and LMNS, HSIB	LMNS; Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	(including the reports for individual Trusts and Health Boards) and recommendations from MBRRACE-UK Confidential Enquiries can facilitate this process.				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trusts and Health Boards should review their policies to ensure that the parents of ALL babies who die are provided with unbiased counselling for post-mortem to enable them to make an informed decision	2019	Trust; Trust	Trust	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	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	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Other Bodies	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure appropriately-trained senior staff lead parental counselling and subsequent interventions.	2021	Trusts; Trusts	Trust	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population	2019	Trust and Health Board Directors, Clinical commissioning group. LMS; Trust and Health	ICB; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			Board Directors, Clinical commissioning group. LMS		
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	Develop training and resources for all maternity and neonatal staff, so they can provide culturally and religiously sensitive care for all mothers and babies.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Other Bodies	strategic
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Ensure the appropriate national Maternity Early Warning Score is used to monitor a pregnant woman wherever in the hospital she receives care	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards]; Service Planners/Commissioners, Hospitals/Trusts/Health Boards]	ICB; LMNS; Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	All maternity services should review their clinical practices to ensure an accurate diagnosis and effective prevention and management of: • postpartum haemorrhage • obstetric anal sphincter injury to minimise variations in care.	2019	NHS trusts boards/ Directorate management, Clinicians; NHS trusts boards/ Directorate management, Clinicians	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	There is clear evidence that doctors and midwives find existing risk scoring systems difficult to apply consistently in practice. There is a need for development of a tool to make the current risk assessment system simpler and more reproducible	2021	NHSE and equivalents in the devolved nations and Ireland; NHSE and equivalents in the devolved nations and Ireland	NHSE	operational
<b>NHS Resolution Early Notification Scheme report</b>	An independent package of support should be offered to all NHS staff to manage the distress that can be associated with providing acute health services and in particular those involved in incidents involving possible avoidable harm. Support should address mental health, wellbeing and post-incident care with access to referral for psychological assessment and intervention where required. This should be confidential and independent of appraisal or revalidation processes.	2022	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including long-acting reversible contraception, to women before they are discharged from the service	2021	All Health Professionals, Service Managers; All Health Professionals, Service Managers	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Use the MBRRACE-UK guidance for the assessment of signs of life in births before 24+0 weeks' gestational age.	2022	Trust; Trust	Trust	operational

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<b>Each Baby Counts, 2015 Full Report</b>	When managing a complex or unusual situation involving the transfer of care or multiple specialties, conduct a 'safety huddle' – a structured briefing for the leaders of key clinical teams. This will ensure everyone understands their roles and responsibilities and shares key clinical information relevant to patient safety.	2015	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	National organisations responsible for collating and managing maternity datasets should review current specifications and consider whether these are fit for purpose or need revising in light of evolving national priorities, including more information on antenatal and postnatal care for women and on outcomes for babies.	2017	National Organisations, Professional bodies (RCOG/RCM); National Organisations, Professional bodies (RCOG/RCM)	Colleges	strategic
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to ensure that a birth plan is developed as early as possible and that this includes place of birth, mode and timing of birth and staff who need to be present, as well as any specific care requirements. This plan is to be made available to the maternity team and to the family.	2021	Trust; Trust	Trust	operational
<b>MBRRACE-UK: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death</b>	Support research to understand women's and healthcare professionals' views on the barriers and facilitators to accessing and navigating maternity and neonatal care for women who have been in the UK for less than a year, or do not speak or understand English and require	2024	National Institute for Health and Care Research, research funders.; National Institute for Health and Care Research, research funders.	Other Bodies	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	professional interpreting services. Use the findings to co-design services.				
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	National professional bodies specialising in maternity and intensive care, including the RCOG, the RCM, the Obstetric Anaesthetists' Association (OAA) and the Intensive Care Society (ICS), should jointly agree definitions of maternal 'high dependency' care to facilitate data collection.	2015	RCOG RCM ICS OAA; RCOG RCM ICS OAA	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Consider skills and drills training on the management of diabetic ketoacidosis in pregnancy to ensure that obstetricians and midwives are aware of the symptoms and signs of diabetic ketoacidosis	2022	Hospitals/Trusts/Health Boards; Hospitals/Trusts/Health Boards	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Extreme preterm admissions form an increasing part of neonatal unit populations. Neonatal clinicians should : Consider re-orientation of care for babies deteriorating despite maximum intensive care and discuss the best interests of the baby with the parents.	2021	Trusts;; Trusts;	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Ensure that there is a multi-agency targeted approach affecting people living in areas of high socio-economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway	2022	Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.; Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.	DHSC; ICB; LMNS	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Ensure that pregnant and postpartum women are considered for antiviral or other specific therapies for COVID19 as part of routine care, early access or compassionate use programmes. Pregnant and postpartum women should not be excluded from clinical trials unless there is a clear contraindication.	2020	Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/ Royal Colleges of Physicians COVID-19 Guideline Development Groups; Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/ Royal Colleges of Physicians	Colleges	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			COVID-19 Guideline Development Groups		
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	The NMPA, in collaboration with ICNARC and SIGSAG, NHS Digital, ISD Scotland and NHS Wales Informatics Service (NWIS), should undertake further work to understand methods and sources of information for identifying critically unwell women in routinely collected maternity data sets.	2015	NHS Digital; NHS Digital	Other Bodies	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	There is clear evidence that doctors and midwives find existing scoring systems for thromboembolic risk difficult to apply in practice. There is a need for development of a tool to make the current risk assessment system simpler and more reproducible.	2018	Royal colleges; Royal colleges	Colleges	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Neonatal Audit Programme (NNAP) Summary report on 2024 data</b>	<p>Neonatal networks should:</p> <p>a. Review their mortality data and, where rates are higher than expected, develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality, with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices.</p> <p>b. With their constituent units, undertake reviews of deaths in accordance with the BAPM Framework for Practice: Neonatal Mortality Governance (expected to be published in the second part of 2025) and engage with other statutory death review processes. Shared learning from these reviews should inform network governance and unit level clinical practice.</p>	2024	Neonatal networks; Neonatal networks	Primary Care; ICB; LMNS; NHSE; Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	Review all cases of postnatal maternal readmission to understand common indications, and identify changes in practice that may decrease the chance of readmission, especially among those having a caesarean birth	2022	Trust, NHS England and NHS Improvement (2020) Better Births Four Years On, NHS England (2019) The NHS Long Term Plan, NHS England (2019) Saving Babies' Lives Version Two, Welsh Government (2019) Maternity Care in Wales: A Five Year Vision for the Future (2019–2024), NHS England (2016) Saving Babies' Lives: A Care Bundle for Reducing Stillbirth	NHSE; Trust	operational
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Update guidance to reflect that safeguarding actions, including removal to a place of safety if necessary, should be followed in the context of public health measures such as lockdown.	2020	ICB; LMNS; Primary Care; Local Authority; ICB; LMNS; Primary Care; Local Authority;	ICB	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Continue to improve access to electronic maternity records, both for women and for all healthcare professionals involved in their maternity care.	2019	Commissioners, NHS Trust/Boards/Service Management/Maternity Information Systems and local level IT support; Commissioners, NHS Trust/Boards/Service Management/Maternity Information Systems and local level IT support	ICB; Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally formed antepartum stillbirth</b>	The standardised approach to perinatal death review developed by the Sands/Department of Health Perinatal Mortality Review Task and Finish Group should be implemented.	2015	DHSC; DHSC	DHSC	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	All Trusts and Health Boards should work closely with MBRRACE-UK to improve their coding of the cause of death, based on the Cause Of Death & Associated Conditions (CODAC) classification system, in order to facilitate the appropriate targeting of interventions to reduce specific types of death.	2016	MBRRACE-UK lead reporters: MSC; HoM and CD; MBRRACE-UK lead reporters: MSC; HoM and CD	Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band	2020	Trusts; Trusts	Trust	clinical
<b>HSIB Severe brain injury, early neonatal death and intrapartum</b>	The Trust to ensure all risks to both mothers and babies are discussed for those identified	2021	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>stillbirth associated with larger babies and shoulder dystocia</b>	to be at increased risk of shoulder dystocia. This discussion should be in line with the Montgomery ruling.				
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should implement a mechanism to appropriately assess and communicate risk, prior to the early discharge of a baby. This would support identification of emerging signs of concern, including reluctance to breast feed (NICE, 2012).	2020	Trust; Trust	Trust	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Improve recording of data about key aspects of maternity care, including outcome data for mothers and babies. For example, spontaneous birth, caesarean section, assisted birth. b) Local Maternity Systems (LMS) to actively monitor 12 month rolling average rate of serious incidents and referrals to HSIB in each hospital	2021	LMS; LMS	LMNS	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	In women over 20 weeks of gestation, if there is no response to correctly performed cardiopulmonary resuscitation within 4 minutes of maternal collapse or if resuscitation is continued beyond this, then perimortem caesarean section should be undertaken to assist maternal resuscitation. Ideally, this should be achieved within 5 minutes of the collapse	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	The key actions for diagnosis and management of sepsis are: · Timely recognition · Fast administration of	2021	Trust; All Health Professionals; Primary Care; Trust; All Health	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	intravenous antibiotics · Quick involvement of experts - senior review is essential		Professionals; Primary Care		
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and 31 March 2017 in England, Wales and Scotland</b>	Maternity service providers and national organisations responsible for collating and managing maternity datasets should work to include a compulsory field on planned mode of birth, to enable distinction between those women who have an urgent caesarean birth following labour onset for new clinical reasons and those who have planned caesarean birth. This should be implemented in the next version of the national data specification.	2015	Trust; NHS Digital; Trust; NHS Digital	Trust	strategic
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Consideration should be given to the recommendation of at least one member of staff having specialist knowledge and training in bereavement care to ensure that bereaved parents are supported in an appropriate and sensitive manner.	2015	Trust; Trust	Trust	operational
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	The ongoing training of maternity staff, through dedicated programmes which are flexible enough to ensure attendance/completion, is vital	2018	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Ensure participation in a perinatal mental health network where this is not already the case, in order to optimise access to and effectiveness of the increased local provision of perinatal mental health support services.	2019	Commissioners, NHS Trust/Boards/Service Management; Commissioners, NHS Trust/Boards/Service Management	ICB; Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Develop focused 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	2019	Policy Makers, UK Public Health Services, NHS England Improvement, Department of Health; Policy Makers, UK Public Health Services, NHS England Improvement, Department of Health	DHSC; NHSE	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	The following are 'red flag' signs for severe maternal mental illness and require urgent senior psychiatric assessment: <ul style="list-style-type: none"> <li>Recent significant change in mental state or emergence of new symptoms,</li> <li>New thoughts or acts of violent self-harm.</li> <li>New and persistent expressions of incompetency as a mother or estrangement from the infant.</li> </ul>	2015	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	There is variation in the reported number of antenatal and postnatal beds per rostered midwife, which ranges from 2 to 16 (median 7). Midwifery ward staffing requirements should be examined and standards for antenatal and postnatal ward staffing should be developed after further exploration of associations between staffing and outcomes.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	Placental histology should be undertaken (if possible) for all stillbirths, preferably by a perinatal pathologist.	2017	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Information should be clearly displayed in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse. This should include information about relevant local and national helplines. These details should be provided in booking information and hand-held maternity notes.	2015	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Assess women with persistent and severe insomnia carefully for signs of underlying mental illness	2022	All Health care professionals; All Health care professionals	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Ensure local incident review teams are multidisciplinary in composition and that investigations are carried out across organisational structures where indicated	2021	Hospitals/Trusts/Health Boards; Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	Review the appropriateness of routine perinatal and postnatal data to obtain a meaningful measure of care, such as duration of skin-to-skin, who with and reasons for non-occurrence	2022	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Electrical cardioversion is safe in all phases of pregnancy. Immediate electrical cardioversion is recommended for any woman with a tachycardia with haemodynamic instability and for pre-excited atrial fibrillation [ESC cardiovascular diseases in pregnancy guideline 2018].	2019	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	Women with medical disorders in pregnancy should have access to a coordinated multidisciplinary obstetric and medical clinic, thereby avoiding the need to attend multiple appointments and poor communication between senior specialists responsible for their care.	2014	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	Multi-agency evidence based operational guidance is urgently required to standardise and improve the care of pregnant women with epilepsy.	2014	Royal colleges; Royal colleges	Colleges	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Growth should be monitored from 24 weeks by measurement of the symphysis fundal height and plotting the measure on a growth chart. Abnormal findings should be acted upon.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	Those Trusts and Health Boards providing the most complex care to particularly high-risk mothers and babies should ensure that the data provided to MBRRACE-UK is of the	2017	PMRT, HSIB (some cases); MBRRACE-UK lead reporters, MS champions, M&NHSC; PMRT, HSIB	LMNS; NHSE	strategic

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	highest quality. This will permit more appropriate sub-analyses and comparisons.		(some cases); MBRRACE-UK lead reporters, MS champions, M&NHSC		
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist	2022	Trusts; ICB; LMNS; Trusts; ICB; LMNS	ICB; Trust	clinical
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-2023</b>	Set up an urgent referral pathway in early pregnancy for women with high-risk medical conditions or complex social circumstances to ensure they receive early triage for senior or specialist consultation.	2025	Maternal Medicine Networks in England and Health Boards in devolved nations; Maternal Medicine Networks in England and Health Boards in devolved nations	Primary Care; ICB; LMNS; Trust; Other Bodies	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review antenatal care ensuring schedules as outlined in NICE guidance are followed. Follow the Saving Babies' Lives Care Bundle2 as outlined in the NHS Long Term Plan c) Trusts, CCGs and NHS England and NHS Improvement to work with royal colleges and professional bodies to address care inequalities, such as racial and geographical inequalities, and complex social factors, and develop strategies to engage the at-risk groups identified in their region	2021	Trusts, CCGs, NHS England and NHS Improvement, RCOG and other relevant colleges and professional bodies; Trusts, CCGs, NHS England and NHS Improvement, RCOG and other relevant colleges and professional bodies	Colleges; ICB; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	The limitations of remote consultation methods should be recognised, including being aware that some women will not have sufficient internet access on their mobile devices or other computer hardware, there are challenges for women from socially vulnerable groups, women for whom English is not their first language or women who are hearing impaired, and that women may have unvoiced concerns regarding their care if they have less contact in person (RCOG/RCM Coronavirus guidance version13)	2021	Trusts; Trusts	Trust	operational
<b>HSIB The diagnosis of ectopic pregnancy</b>	It is recommended that the Care Quality Commission Services Framework for Gynaecology and Termination Services includes an assessment of early pregnancy services, using as a reference the National Institute for Health and Care Excellence Guideline 126, Ectopic pregnancy and miscarriage: diagnosis and initial management.	2021	CQC; CQC	Other Bodies	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Concerns identified in this confidential enquiry about staffing and capacity issues in maternity services, particularly around the issues of induction of labour and timely transfer to delivery suite, need to be addressed.	2017	Trust; Trust	Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Ensure that there is a multi-agency targeted approach affecting women living in areas of high socio- economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway.	2020	Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.; Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.	DHSC; ICB; LMNS	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Ensure all pregnant or post-partum women with COVID-19 receive multidisciplinary team care and obstetric leadership with daily review. This is essential in order to ensure timely recognition of deterioration, early assessment of the need for iatrogenic birth to help respiratory function and identification of postnatal complications.	2020	Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/Royal Colleges of Physicians COVID-19 Guid; trust;primay care; Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/Royal Colleges of Physicians	Colleges; Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			COVID-19 Guid; trust;primay care		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Peri-mortem caesarean section (PMCS) is a vital component of advanced life support in resuscitation of a woman who is pregnant. Guidance relating to PMCS needs to be reviewed and strengthened [Saving Lives, Improving Mothers' Care 2014].	2019	Trust;; Trust;	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Coagulation factors should be administered promptly after multidisciplinary discussion in accordance with the principles in RCOG Green-top Guideline 52	2021	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Pregnant or postpartum women recovering from anaesthesia require the same standard of postoperative monitoring, including documentation, as non-obstetric patients	2021	Trust; Trust	Trust	operational

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<b>MBRRACE-UK: Perinatal Mortality Surveillance Report for Births in 2021</b>	Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes	2023	Royal Colleges, Commissioners ; Royal Colleges, Commissioners	Colleges; ICB; LMNS	clinical
<b>NHSR The evolution of the Early Notification Scheme</b>	NHS Resolution to support the work of royal colleges and wider stakeholders to improve antenatal counselling before trial of vaginal birth after caesarean	2022	NHSR/ Colleges; NHSR/ Colleges	Colleges	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Midwives and obstetricians should emphasise the importance of fetal movements to women at each antenatal contact as a method of fetal surveillance, and document the detail of this conversation.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	There should be a national discussion about the content of fetal monitoring training (both intermittent auscultation and continuous electronic fetal monitoring) and agreement over the content, duration and frequency of training as well as whether competency should be formally assessed for healthcare professionals caring for women in labour.	2017	Royal Colleges; NICE; Royal Colleges; NICE	Colleges	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	A national forum should be established by NHS England, the Scottish government, NHS Wales, and the Northern Ireland Department of Health, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in relevant specialties, to agree an appropriate benchmark against which stillbirth and neonatal mortality rates should	2018	HQIP; DHSC; HQIP; DHSC	DHSC	clinical

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	be monitored across the UK. This process should be facilitated by HQIP.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Offer influenza vaccine to pregnant women at any stage of pregnancy (first, second or third trimesters)	2021	All Health Professionals; All Health Professionals	Trust	operational
<b>Each Baby Counts 2018 Progress report</b>	All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes	2018	Trust; Trust	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Software providers of maternity information systems should continue to develop solutions to allow users to review data quality. They should design systems that support users to enter accurate and complete data which are easily retrieved for care provision and reporting.	2017	System Suppliers; System Suppliers	Other Bodies	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Several key NMPA data items are not currently routinely captured by all services, including blood loss, labour onset, fetal presentation, and the use of anaesthesia and analgesia in labour. Maternity services should aim to enter complete data for all key data items and ensure that standard coding definitions are followed to improve consistency.	2017	Local level IT support (Digital midwives), MTP Workstream 6. NHS Digital; Local level IT support (Digital midwives), MTP Workstream 6. NHS Digital	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure that women on prophylactic and treatment dose anticoagulation have a structured management plan to guide practitioners during the antenatal, intrapartum and postpartum period	2021	All Health Professionals; All Health Professionals	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	Trusts and Health Boards should ensure that systems are in place to implement appropriate national guidance related to monitoring fetal growth.	2017	Local teams: Maternity safety Champions; HoM and CD to drive; MatNeoSiP; SBLCB team and CNST scheme; Local teams: Maternity safety Champions; HoM and CD to drive; MatNeoSiP; SBLCB team and CNST scheme	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Wheeze can be due to pulmonary oedema. Consider wheeze which does not respond to standard asthma management and exertional syncope as red flag symptoms of cardiovascular disease in addition to orthopnoea and chest pain	2022	Trust;Primary Care; Trust;Primary Care	Primary Care; Trust	operational

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<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	All women and birthing people should be routinely counselled and offered an episiotomy prior to experiencing a forceps-assisted birth, to reduce the chance of an OASI.	2022	Trust Royal College of Obstetricians and Gynaecologists (2018) OASI Care Bundle, 13 Royal College of Obstetricians and Gynaecologists (2020) Assisted Vaginal Birth <sup>14</sup> ; Trust Royal College of Obstetricians and Gynaecologists (2018) OASI Care Bundle, 13 Royal College of Obstetricians and Gynaecologists (2020) Assisted Vaginal Birth <sup>14</sup>	Colleges; Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Clear communication of findings is important and attempts must be made in each hospital to ensure that the clinical and pathological findings can be discussed with parents in an open, honest and constructive way to enable them to gain the best understanding of events leading to stillbirth and any impact on future pregnancy plans.	2015	Trust; Trust	Trust	operational
<b>HSIB Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic</b>	It may be beneficial if further work is done to understand the increased risk of maternal death for women from Black, Asian and minority ethnic backgrounds and those with higher socio-economic deprivation.	2021	NHSE; NHSE	NHSE	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	At diagnosis, the impact of the cancer and its treatment on future fertility should be discussed between the woman diagnosed with cancer and her cancer team [NICE CG156].	2019	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Commissioners should facilitate the dissemination of these results to GPs and local authorities.	2017	Public health commissioners; Public health commissioners	ICB	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Thrombolysis or surgical embolectomy should be considered for pregnant women with high-risk PE	2021	Trust; Trust	Trust	clinical
<b>HSIB The diagnosis of ectopic pregnancy</b>	The National Institute for Health and Care Excellence should review and revise the clinical knowledge summary for 'urinary tract infection (lower) – women' to include ectopic pregnancy as a category under 'alternative or serious diagnoses	2021	NICE; NICE	Other Bodies	clinical
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Encourage women's involvement in audit, guideline development and labour ward forums (where these exist).	2019	NHS Trusts, Maternity voices partnerships, Clinical audit organisations (NMPA); NHS Trusts, Maternity voices partnerships,	Trust	operational

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			Clinical audit organisations (NMPA)		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Offer pharmacological treatment to women if blood pressure remains above 140/90 mmHg. Aim for a target blood pressure of 135/85 mmHg or less once on hypertensive treatment [NICE NG133].	2019	Trust; Trust	Trust	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	For women with severe complications of COVID-19, the appropriate dosing regimen of LMWH should be discussed in a multidisciplinary team (MDT) that includes a senior obstetrician or clinicians with expertise in managing COVID-19 and VTE in pregnancy (RCOG Coronavirus and pregnancy guideline 2020).	2020	Hospitals, Trusts, Health Boards, all Health Professionals; Hospitals, Trusts, Health Boards, all Health Professionals	Primary Care; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	If psychotropic medication has been discontinued in advance of, or during, pregnancy, ensure women have an early postnatal review to determine whether they should recommence medication	2021	All[@[Tags (Required, seperated with; )]]als; All[@[Tags (Required, seperated with; )]]als	Primary Care; Trust	operational

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	A renewed focus on neonatal deaths is required in order to achieve a significant reduction in neonatal mortality rates from the position seen over the past three years.	2017	NHSE via SBLCB and new preterm initiative, brain injury definition; part of 'Halve It 'campaign; NHSE mortality work; NHSE via SBLCB and new preterm initiative, brain injury definition; part of 'Halve It 'campaign; NHSE mortality work	NHSE	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust to ensure all mothers using their maternity service are aware of and are provided with patient information on group B streptococcus. This should be undertaken at an appropriate time during their pregnancy, typically between 28 and 34 weeks, to avoid information overload	2020	Trust; Trust	Trust	operational
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Women of BAME background, [or with other risk factors such as hypertension, diabetes or raised BMI], should be advised that they may be at higher risk of complications of COVID-19; we advise they seek advice without delay if they are concerned about their health (RCOG Coronavirus and pregnancy guideline 2020).	2020	Hospitals/Trusts/Health Boards, All Health Professionals; Hospitals/Trusts/Health Boards, All Health Professionals	Primary Care; Trust	clinical

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<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Ensure agencies responsible for conducting the statutory Joint Agency Response are compliant with national guidance including the joint attendance of police and healthcare professionals to facilitate appropriate support of families and achieve good quality data collection.	2019	National Police Chiefs Council, Commissioners of Joint Agency Response processes, Department of Health and Social Care and other; National Police Chiefs Council, Commissioners of Joint Agency Response processes, Department of Health and Social Care and other	DHSC; Other Bodies	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	Access to antenatal care remains an issue amongst women who died and ensuring access to appropriate care for all groups must remain part of service planning. More than two thirds of women who died did not receive the nationally recommended level of antenatal care; a quarter did not receive a minimum level of antenatal care.	2014	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14</b>	Key investigations must not be delayed because of pregnancy. A) Severe respiratory failure in pregnant women and new mothers should trigger early referral to an ECMO centre. B) Obstetricians and obstetric anaesthetists must remain closely involved in the clinical management of women with obstetric specific conditions such as pre-eclampsia. These conditions are rarely seen on the general	2016	Trust; Trust	Trust	clinical

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	critical care unit but are common problems on the labour ward.				
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	What is required is an engagement with the risk management process at all levels, from staff working in maternity units through to trust boards, which ensures that there is identification and analysis of the risks within their organisation and furthermore that adequate resources and systems are in place to control the risk and learn from incidents which may or may not have resulted in harm. Regular review of claims, complaints and incident reports will allow organisations to look for any patterns of error which would not be apparent on analysing a single case.	2018	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure risk assessment and counselling in relation to extremely preterm prelabour rupture of membranes includes consideration that there is a risk of maternal mortality and serious morbidity with impact on future pregnancies.	2021	Trust; Trust	Trust	clinical

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<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Ensure that referral with mental health concerns on more than one occasion is considered a 'red flag' which should prompt clinical review, irrespective of usual access thresholds or practice.	2020	Royal College of Obstetricians and Gynaecologists /Royal College of Midwives/Obstetric Anaesthetists Association/ Royal College of Psychiatrists COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards; Royal College of Obstetricians and Gynaecologists /Royal College of Midwives/Obstetric Anaesthetists Association/ Royal College of Psychiatrists COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Establish a mechanism to disseminate the learning from this report, not only to maternity staff, but more widely to GPs, emergency	2021	Academy of Medical Royal Colleges; Academy of Medical Royal Colleges	Colleges; Trust	operational

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<b>into Maternal Deaths and Morbidity 2016-18</b>	department practitioners, physicians and surgeons				
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and 31 March 2017 in England, Wales and Scotland</b>	Maternity service providers and national organisations responsible for collating and managing maternity datasets should make chorionicity and amnionicity a compulsory data item in maternity information systems and national datasets for women with multiple pregnancy. This should be implemented in the next version of the national data specification.	2018	Trust; NHS Digital; Trust; NHS Digital	Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	All organisations responsible for maternity services should report to MBRRACE-UK all births between 22+0 and 23+6 weeks gestational age who do not survive the neonatal period.	2015	MBRRACE lead reporters, MSC, CN and LMS; MBRRACE lead reporters, MSC, CN and LMS	LMNS	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Early pregnancy assessment services should ensure processes are in place to review and act upon the results of investigations promptly	2019	Trusts;; Trusts;	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Continued focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths. Assessors judged that 44% of women who died had good care. However, improvements in care which may have made a difference to the outcome were identified for 29% of women who died	2019	NHSE; NHSE	NHSE	clinical

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<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	National guidance should be developed for care during the latent phase of labour once a mother accesses maternity services and this should take account of her risk status. This should include frequency, nature (intermittent auscultation or cardiotocography), and interpretation of fetal heart rate assessment.	2017	NICE; Royal Colleges; NICE; Royal Colleges	Colleges	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Haemorrhage should be considered when classic signs of hypovolaemia are present (tachycardia and/or agitation and the late sign of hypotension) even in the absence of revealed bleeding.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	Women with pre-existing medical conditions should have pre-pregnancy counselling by doctors with experience of managing their disorder in pregnancy.	2014	Primary Care; Trust; Primary Care; Trust	Primary Care	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Be aware of the added risk of fetal compromise when a woman's pregnancy is complicated by both hypertension and diabetes. It is not only babies predicted to be small for gestational age who may be a	2022	All Health care professionals /Professional education programmes]; All Health care professionals /Professional education programmes]	Primary Care; Trust	clinical

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<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Clinicians should make every possible effort for all babies to have skin to skin contact with their mothers within one hour of birth, where the condition of mother and baby allows. For babies who are to be admitted to a neonatal unit, all efforts should be made to offer skin to skin contact prior to transfer of the baby where the baby's clinical condition allows.	2017	Clinicians; Clinicians	Trust	clinical
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Develop public health initiatives to address issues linked to high risk populations.	2019	NHS England and Improvement; Department of Health; NHS England and Improvement; Department of Health	DHSC; NHSE	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Develop a local process for regularly reviewing the training and expertise of sonographers and the quality of scanning of twin pregnancies	2021	Trusts; Trusts	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	Commissioning organisations should review both their crude and their stabilised & adjusted mortality rates to facilitate the identification of high risk populations and to target interventions for known inequalities.	2018	LMS; LMS	LMNS	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	National bodies should continue their work to develop and implement package interventions for prevention and management of third and fourth degree tears and postpartum haemorrhage	2019	RCOG/RCM; RCOG/RCM	Colleges	clinical

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Consideration should be given to 'declaring sepsis', analogous to activation of the major obstetric haemorrhage protocol, to ensure the relevant members of the multidisciplinary team are informed, aware and act	2017	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.	2020	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure that a consultant reviews and prioritises women prescribed prophylactic and treatment dose anticoagulation waiting for induction of labour in order to reduce the time these women are not receiving low molecular weight heparin.	2021	Trust; Trust	Trust	clinical
<b>HSIB Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic</b>	It may be beneficial if written safety netting advice is developed for pregnant and postpartum women about COVID-19 and other common conditions, incorporating the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) recommendations.	2021	RCOG, RCM; RCOG, RCM	Colleges	clinical

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	A national forum should be established by NHS England, NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in relevant specialties, to agree the appropriate approach to reporting the influence on overall mortality rates of neonatal deaths and late fetal losses amongst babies born before 24 weeks gestational age and of deaths due to congenital anomalies.	2017	DHSC; DHSC	DHSC	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure that all clinical staff working within a maternity triage or emergency assessment area are equipped with knowledge of the pathophysiology and warning signs of extreme preterm birth and of twin-to-twin transfusion syndrome	2021	Trusts; Trusts	Trust	clinical
<b>Linking the national maternity and perinatal audit data set to the National Neonatal Research Database for 2015/16 2019</b>	Organisations supplying neonatal data extracts should provide complete data extracts, as requested, to allow for accurate analysis of these extracts by requesting organisations.	2015	Provider trusts ICB's LMNS's; Provider trusts ICB's LMNS's	LMNS; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause. Pain severe enough to prevent a woman caring for her baby represents a similar 'red flag' [Saving Lives, Improving Mothers' Care 2018].	2019	Trust; Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Lack of co-location of obstetric and cardiac services jeopardises interdisciplinary working and communication. Measures such as joint obstetric cardiac clinics, multidisciplinary care plans, copying letters to the woman and all clinicians involved in her care, as well as staff from all specialties writing in the woman's hand held notes may mitigate against the inherent risk of inadequate communication between specialists.	2016	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Clinicians should record maternal smoking status, both at booking and at the end of pregnancy.	2017	Clinicians; Clinicians	Trust	operational
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and 31 March 2017 in England, Wales and Scotland</b>	Maternity service providers should consider the local reasons for inaccuracies in the recording of 'number of infants' at birth and work to correct these by the end of the 2020/21 reporting year. This might require auditing local data, mandating the 'number of infants' data item and checking data download reports for national datasets to ensure that 'birth order' has not been mislabelled as 'number of infants'.	2015	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Pregnant women with epilepsy should have access to regular planned antenatal care with a designated epilepsy care team	2021	Trusts; Trusts	Trust	operational

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<b>into Maternal Deaths and Morbidity 2016-18</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Women with multiple and complex problems may require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues.	2017	Trust; Trust	Trust	operational
<b>NHS Resolution Early Notification Scheme report</b>	All families whose baby meets the EN criteria and requires treatment and separation from them for a potentially severe brain injury are offered a full, open conversation about their care. This should include an apology in accordance with the principles of candour, options for their involvement and description of the national agencies involved in investigating their care.	2022	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Twin pregnancy is a risk factor for pre-eclampsia. The presence of other risk factors should therefore be carefully identified and documented to ensure prophylactic treatment is offered where indicated.	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	All women should undergo a documented assessment of risk factors for venous thromboembolism in early pregnancy or pre-pregnancy. Risk assessment should be repeated if the woman is admitted to hospital for any reason or develops other intercurrent	2018	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	problems. Risk assessment should be repeated again intrapartum or immediately postpartum.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Offer antihypertensive treatment to pregnant women who have chronic hypertension and who are not already on treatment if they have: <ul style="list-style-type: none"> <li>• sustained systolic blood pressure of 140 mmHg or higher</li> <li>• or sustained diastolic blood pressure of 90 mmHg or higher</li> </ul>	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Clear guidance on contraceptive choices for women with cardiac disease is available and should be consulted (UK Medical Eligibility Criteria for Contraceptive Use 2016).	2019	Trust, primary care; Trust, primary care	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-2023</b>	Ensure specialist perinatal mental health teams undertake a leadership role for the care of pregnant or recently pregnant women with mental health conditions even if women are not accepted for care under their services. This should include a risk assessment, provision of advice and guidance, oversight for joint care planning and support to ensure rapid onward referral into other appropriate mental health services.	2025	Integrated Care Boards and Health Boards; Integrated Care Boards and Health Boards	Primary Care; Regulators; ICB; LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland</b>	Ensure symptoms of possible cancer are followed up postnatally	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	operational

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<b>Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>					
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Use the newly-developed MBRRACE-UK interactive maps and tables to compare stabilised and adjusted stillbirth, neonatal mortality and extended perinatal mortality rates between organisations.	2019	Clinical Commissioners, Trusts; Clinical Commissioners, Trusts	ICB; Trust	clinical
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Provide adequate resourcing of PMRT review teams	2019	Trust, Service Commissioners; Trust, Service Commissioners	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Maternity and neonatal service providers with higher than expected levels of mechanical ventilation between 37+0 and 42+6 weeks should work together to explore reasons behind the variation and implement any changes to clinical practice identified.	2019	NHS trusts boards/ Directorate management, Clinicians; NHS trusts boards/ Directorate management, Clinicians	Trust	clinical
<b>Each Baby Counts 2018 Progress report</b>	Escalating high activity: There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own specialty but also on behalf of another specialty. The	2018	Trust; Trust	Trust	strategic

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	consultant obstetrician should always be informed when labour ward activity is high.				
<b>Each Baby Counts, 2015 Full Report</b>	All local reviews of Each Baby Counts babies should contain sufficient information to determine the quality of the care provided.	2015	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff. Healthcare professionals should help support these women's uptake of antenatal care services by: <ul style="list-style-type: none"> <li>• using a variety of means to communicate with women</li> <li>• telling women about antenatal care services and how to use them</li> <li>• undertaking training in the specific needs of women in these groups.</li> </ul>	2021	Trusts; Trusts	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	When planning services, commissioners together with policymakers and providers should take into account local demographics, including the increasing age and BMI of women giving birth.	2017	Public Health commissioners/NHS Trusts/Heads of service; Public Health commissioners/NHS Trusts/Heads of service	ICB	strategic

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<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Due to differing local circumstances maternity services should develop local guidance that clarifies the actions that should be undertaken when serious problems arise in a home birth, either planned or unplanned.	2017	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Neuroimaging should be performed urgently in any woman with hypertension or pre-eclampsia who has focal neurology or who has not recovered from a seizure.	2016	Trust; Neurology;; Trust; Neurology;	Trust	clinical
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review antenatal care ensuring schedules as outlined in NICE guidance are followed. Follow the Saving Babies' Lives Care Bundle <sup>2</sup> as outlined in the NHS Long Term Plan a) For uncomplicated pregnancies, trusts to follow NICE guidance CG62 Antenatal care for uncomplicated pregnancies, as a minimum	2021	Trusts, CCGs, ICSs; Trusts, CCGs, ICSs	ICB; Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Research into how best to assess the baby's wellbeing during labour should be prioritised.	2017	Royal Colleges; Royal Colleges	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	There is an urgent need to establish pathways for release of mental health records with the Chief Medical Officers and Departments of	2018	DHSC; DHSC	DHSC	clinical

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<b>into Maternal Deaths and Morbidity 2014–16</b>	Health of Ireland and the four UK nations to MBRRACE-UK.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	For [women] who are admitted to the emergency department with a suspected stroke or TIA, establish the diagnosis rapidly using a validated tool, such as ROSIER (Recognition of Stroke in the Emergency Room)	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Ensure maternal medicine networks and their equivalents in the devolved nations and Republic of Ireland can provide appropriate expertise and supervision for all women including those in rural/remote areas	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	strategic
<b>NHS Resolution Early Notification Scheme report</b>	There is an urgent need for a standard approach to fetal monitoring based on the NICE guidance. Computerised CTGs should be used for antenatal assessment. Effective improvement strategies for fetal monitoring require in-depth understanding of the technical and social mechanisms underpinning the process and there should be more research in this area.	2022	Royal Colleges; Royal Colleges	Colleges	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths</b>	Two thirds of women died from indirect causes and almost three quarters of all women who died had coexisting medical complications. High level actions are needed to ensure that physicians are appropriately trained in, and	2014	Trust; LMNS; Trust; LMNS	LMNS; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>and Morbidity 2009-2012 December</b>	engaged with, the care of pregnant women, and that services are designed for women with medical conditions which provide appropriate and evidence-based care across the entire pathway, including pre-pregnancy, during pregnancy and delivery, and postpartum.				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Adopt the BAPM Clinical Framework for the Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation; in particular: <ul style="list-style-type: none"> <li>• Management of labour, birth and the decision on active resuscitation or palliative care should be made with the parents at the centre of the decision-making and informed and supported in partnership with a multidisciplinary team including obstetric and neonatal professionals.</li> <li>• Conversations with parents must be clearly documented and agreed management plans carefully and clearly communicated between professionals and staff shifts.</li> <li>• The decisions on management should be regularly reviewed before and after birth in conjunction with the parents and the plans reconsidered if the risk for the baby/babies changes or if parental wishes change.</li> </ul>	2021	Trusts; Trusts	Trust	strategic

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<b>National Neonatal Audit Programme (NNAP) Summary report on 2021 data</b>	All neonatal and perinatal networks (including Local Maternity Systems (LMS) and Local Maternity and Neonatal Systems (LMNS) in England) should undertake exception reporting for all cases where a baby of less than 27 weeks' gestation (less than 28 weeks' for multiple births) is not born at a maternity service on the same site as a NICU, and should adopt evidence-based practices, using the following guidance and methodologies to support improvement: • Maternity and Neonatal Safety Improvement Programme • BAPM and NNAP Antenatal Optimisation Toolkit • Healthcare Improvement Scotland, Maternity and Children Quality Improvement Collaborative (MCQIC) Preterm Perinatal Wellbeing Package • BAPM Building Successful Perinatal Teams Resource (publication due late 2022).	2021	LMNS Trust; LMNS Trust	LMNS; Trust	strategic
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-2023</b>	Develop guidance for information sharing within maternity services and across health services and other agencies in the event of safeguarding concerns. Ensure that codes for flagging domestic abuse are applied in women's records and are known to all those caring for her.	2025	National Institute for Health and Care Excellence (NICE); National Institute for Health and Care Excellence (NICE)	Colleges; Primary Care; Trust; Other Bodies	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and</b>	Treat pregnant and postpartum women the same as non-pregnant women unless there is a clear reason not to (Multiple MBRRACE-UK reports)	2021	Trusts; Trusts	Trust	operational

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<b>associated maternal deaths in the UK - June 2020-March 2021</b>					
<b>Each Baby Counts, 2015 Full Report</b>	Trusts and health boards should support their staff to implement the recommendations set out in this report, ensuring staff tasked with CTG interpretation receive annual training, promoting the development of non-clinical skills such as situational awareness and providing multidisciplinary training to support good team-working.	2015	Trust; Trust	Trust	strategic
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	A clear, concise and evidence-based clinicopathological correlation should be included in every post mortem and placental histology report.	2015	Trust; Trust	Trust	clinical
<b>HSIB Detection of retained vaginal swabs and tampons following childbirth</b>	It is recommended that NHS England/Improvement carries out its intention to commission and publish an independent evaluation of its alternative design for swabs and tampons. The evaluation should also consider other solutions or technologies and include usability, cost/benefit analysis and the impact on reducing harm.	2021	NHSE; NHSE	NHSE	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Increase focus on reducing the rate of obstetric anal sphincter injury (OASI) so that all trusts achieve OASI levels similar to those at the top decile of trusts. b) All trusts to audit the effectiveness of the implemented/established OASI care bundle.	2021	Trusts; Trusts	Trust	clinical

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<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Use the local summary reports and this national report as the basis to prioritise resources towards the aspects of care identified as having issues	2019	Trusts; Trusts	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	All units are required to have escalation policies for periods of high activity. These policies should include a plan to obtain more and senior obstetric and anaesthetic assistance as well as considering midwifery staffing and diverting activity. Local review reports submitted to MBRRACE-UK should include a full assessment of staffing-workload balance issues if these were felt to be a contributory factor.	2017	Trust; LMS; Trust; LMS	LMNS; Trust	operational
<b>Each Baby Counts 2018 Progress report</b>	All Each Baby Counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).	2018	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Focused, point of care ultrasound investigations can help guide decision making in the management of maternal collapse. A limited cardiac echo study as well as a FAST scan can provide vital clues to differentiate key diagnoses and is the gold standard of care for a woman with severe cardiovascular instability or compromise.	2019	Trust; Trust	Trust	clinical

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<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Multi-agency local reviews of all women who die from a mental health-related cause at any stage during pregnancy and the first postnatal year should be carried out and should involve all the services that cared for the woman. Similar reviews should be considered for women with complex or multiple morbidities.	2015	Perinatal mental health team; Perinatal mental health team	LMNS	operational
<b>PMRT Learning from Standardised Reviews When babies Die. Second Annual Report (2020)</b>	Use the local PMRT summary reports and this national report as the basis to prioritise resources towards key aspects of care identified as requiring action.	2020	Trusts; Trusts	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Results for individual measures should not be interpreted in isolation. Rather, services should examine all measures together, attempting to understand possible relationships between them, and use this analysis to improve services as a whole, not just to one particular target. Measures in this report should also be considered together with perinatal mortality results from MBRRACE and measures of neonatal care from the National Neonatal Audit Programme (NNAP).	2017	NHS Trusts/Boards; NHS Trusts/Boards	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry</b>	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	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Other Bodies	operational

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<b>A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>					
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Consider all aspects of communication throughout the care pathway as part of any perinatal death review.	2021	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	For women with cancer, advice on postponement of pregnancy should be individualised and based on treatment needs and prognosis over time. Most women with breast cancer should wait at least two years after treatment, which is when the risk of breast cancer recurrence is highest.	2018	Primary Care, Trust; Primary Care, Trust	Primary Care; Trust	clinical
<b>Each Baby Counts, 2015 Full Report</b>	Staff tasked with CTG interpretation must have documented evidence of annual training.	2015	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	There should be adequate provision of appropriate critical care support for the management of a pregnant woman who becomes unwell. Plans should be in place for provision of critical care on delivery units or maternity care on critical care units, depending on most appropriate setting for a pregnant or postpartum woman to receive care.	2014	Trust; LMNS; Trust; LMNS	LMNS; Trust	operational
<b>National Neonatal Audit Programme (NNAP) Summary report on 2021 data</b>	Consider a quality improvement approach to the delivery of evidence based strategies in the following areas to reduce mortality: timely antenatal steroids, deferred cord clamping,	2021	Trust; Trust	Trust	strategic

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	avoidance of hypothermia and management of respiratory disease. Such quality improvement activity should pay due regard to relevant guidance and resources, such as the NICE guidance for specialist respiratory care and the BAPM and NNAP quality improvement toolkits.				
<b>PMRT Learning from Standardised Reviews When babies Die. Second Annual Report (2020)</b>	Improve the quality of service improvements as a consequence of reviews by developing 'strong' actions targeted at system level changes and audit their implementation and impact.	2020	Trusts; Trusts	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	All reviews of live born Each Baby Counts babies must involve neonatologists/neonatal nurses.	2015	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trusts and Health Boards should aim to notify all deaths via the MBRRACE-UK system within 30 days of the death occurring. Mechanisms for timely notification should be incorporated into local processes, and must have adequate staff, time allocation and resources. Trusts and Health Boards should aim for completion of all surveillance data within 90 days in order to facilitate data sharing with the PMRT and aid discussions with parents at follow-up appointments	2019	Trust; Trust	Trust	strategic

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<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Ensure that there is a multi-agency targeted approach affecting women living in areas of high socio- economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway.	2019	Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.; Department of Health; NHS England and Improvement; Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.	DHSC; ICB; LMNS	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Genetic counselling should state for women known to be carriers of any inherited condition, whether the associated genetic mutation is known or unknown, and whether they need a cardiovascular risk assessment in pregnancy. Anyone with a family history or genetic confirmation of aortopathy or channelopathy should be referred for cardiac assessment before pregnancy.	2019	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	2019	Trusts; ICB; LMNS; Trusts; ICB; LMNS	ICB; Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based</b>	Audit departments should facilitate dissemination of these findings among all	2017	NHS Trusts/MVP's; NHS Trusts/MVP's	Trust	strategic

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<b>on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	relevant staff and services and commissioners should share and discuss the findings as part of their Maternity Voices Partnerships (formerly Maternity Services Liaison Committees).				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are monitoring their impact on reducing preterm birth	2020	Service Commissioners; Trust; LMNS; Clinical Commissioners;; Service Commissioners; Trust; LMNS; Clinical Commissioners;	ICB; LMNS; Trust	clinical
<b>Each Baby Counts, 2015 Full Report</b>	Healthcare professionals involved in local reviews should ensure good practice is followed, based on this report's recommendations for the conduct of future reviews.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK: State of the National Themed Report, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth.</b>	Clarify that review of the care of women who return to theatre may provide important safety learning but should not be perceived as a performance metric after caesarean birth, as re-operation may be the appropriate response to control internal haemorrhage.	2023	MBRRACE-UK; MBRRACE-UK	NHSE; Other Bodies	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care</b>	Develop guidance for the use of Brain Natriuretic Peptide measurement in pregnancy	2022	Royal Colleges of Obstetricians and Gynaecologists,	Colleges	operational

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<b>from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>			Physicians; Royal Colleges of Obstetricians and Gynaecologists, Physicians		
<b>Each Baby Counts 2018 Progress report</b>	Migration of boundaries: Teams should protect against migration of boundaries by ensuring that real practice reflects practice as described in guidelines. Audit identifies where migrations from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these migrations can be corrected.	2018	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	Decision making is more difficult when staff feel stressed and/ or tired. A different perspective improves the chances of making a safe decision. Clinical staff should be empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective (either in person or over the phone).	2015	Trust; Trust	Trust	operational
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and 31 March 2017 in England, Wales and Scotland</b>	Maternity service providers and national organisations responsible for collating and managing maternity datasets should request/record data on the number of fetuses in the first trimester of pregnancy, in addition to number at birth, for women with multiple pregnancy, and should plan to be compliant with this for the next version of the national data specification.	2015	Trust; Trust	Trust	strategic

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<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Counsel parents prior to the birth of Twin 1, regarding the possible option of delayed birth of Twin 2 including the maternal risks as well as the risk of Twin 2 still being born at the extremes of prematurity	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Midwives and others carrying out postnatal checks in the community should have a thermometer to enable them to check the temperature of women who are unwell.	2021	Trust; Community midwives; Trust; Community midwives	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	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.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Primary Care	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Adopt the standards of National Bereavement Care Pathway for pregnancy and baby loss regarding care of these parents. Particular attention should be given to: <ul style="list-style-type: none"> <li>• Involvement of the bereavement team, where one exists;</li> <li>• Sensitive and caring consideration being given to the parents' wishes regarding seeing and</li> </ul>	2021	Trusts; Trusts	Trust	clinical

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	holding the baby/babies and making memories, particularly if one twin survives; • Development and use of a bereavement checklist bespoke to multiple pregnancy; • Discussion of consenting to post-mortem examination as appropriate; • Joint working between the maternity and neonatal teams; • Continuity of care from the specialist multiples team (obstetrician and midwives) for postnatal and follow-up support.				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trusts and Health Boards should use the MBRRACE-UK real time data monitoring tool to monitor the completeness of their data. Particular emphasis should be placed on carbon monoxide monitoring and other data items feeding into national initiatives such as the Saving Babies' Lives Care Bundle .	2019	Trust; LMNS; Trust; LMNS	Trust	strategic
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Ensure the continuation of targeted initiatives with health education organisations not only aimed at reducing teenage pregnancy but also providing pre-conception advice	2019	Department of Health and Health Education Services, Primary Care Providers, Health Professionals.; Department of Health and Health Education Services, Primary Care Providers, Health Professionals.	Primary Care; DHSC	clinical
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	Developers of maternity record standards and national data sets should include the facility to collect information about women receiving high dependency and intensive care and the setting in which this care is provided. Maternity	2015	NHS Digital; NHS Digital	Other Bodies	strategic

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	information system suppliers should implement this in their systems. The NMPA endorses the recommendations of the Maternity Critical Care Standards Working Group about the collection of such data.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	In sudden onset severe maternal shock e.g. anaphylaxis, the presence of a pulse may be an unreliable indicator of adequate cardiac output. In the absence of a recordable blood pressure or other indicator of cardiac output, the early initiation of external cardiac compressions may be lifesaving.	2017	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	All organisations responsible for maternity services should have systematic processes in place in order to ensure that all babies born between 22+0 and 23+6 weeks gestational age who are not alive at delivery or who do not survive the neonatal period are reported to MBRRACE-UK. This will ensure international consistency of extended perinatal mortality rates which are not possible from current routine registration sources.	2016	MBRRACE lead reporters, MSC, CN and LMS; MBRRACE lead reporters, MSC, CN and LMS	LMNS	clinical
<b>Five years of cerebral palsy claims</b>	In line with the Kirkup and Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby Counts reports, all cases of potential severe brain injury, intrapartum stillbirth and early neonatal death should be subject to an external or independent peer review. However, the most appropriate model requires further national clarification.	2017	Royal Colleges; Royal Colleges	Colleges	clinical

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<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Provide specific advice to pregnant and post-partum women with COVID-19 infection about the risk of deterioration and when to seek urgent medical attention or go to the hospital. This should be communicated via an interpreter if necessary	2021	Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; COVID-19 Guideline Development Group; Primary Care; Trusts; Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; COVID-19 Guideline Development Group; Primary Care; Trusts	Colleges; Primary Care; Trust	operational
<b>National Neonatal Audit Programme (NNAP) Summary report on 2024 data</b>	Neonatal networks and local maternity and neonatal systems should ask their constituent units with below average rates of breastmilk feeding by day 2 to:  a. investigate reasons for variation in uptake locally, and b. with families, co-design targeted, quality improvement programmes.	2024	Neonatal networks and local maternity and neonatal systems; Neonatal networks and local maternity and neonatal systems	ICB; LMNS; NHSE; Trust	strategic
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Use the MBRRACE-UK guidance for the assessment of signs of life in births before 24+0 weeks gestational age	2019	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	Liaison, crisis and home treatment staff should have specific training, at induction and continuing professional development, in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out-of-hours care for pregnant and postnatal women. Formal links should be made with local specialist perinatal mental health services to facilitate training.	2018	Primary Care, CCG; Primary Care, CCG	Primary Care; ICB	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	All women should undergo a documented assessment of risk factors for venous thromboembolism in early pregnancy or pre-pregnancy. This should be repeated intrapartum or immediately postpartum and if the woman is admitted to hospital or develops other inter-current problems.	2015	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Ensure that the national Patient Group Direction allowing prescription of aspirin for pregnant women at risk of pre-eclampsia by midwives and pharmacists is widely implemented	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Units should implement a policy to ensure that all parents of a stillborn baby are offered a post mortem. Placental histology should be undertaken in all cases.	2015	Trust; Trust	Trust	strategic

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<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review antenatal care ensuring schedules as outlined in NICE guidance are followed. Follow the Saving Babies' Lives Care Bundle2 as outlined in the NHS Long Term Plan b) Trusts to follow NICE guidance NG121, Intrapartum care for women with existing medical conditions or obstetric complications and their babies, as applicable	2021	Trusts; Trusts	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	It is essential that all Trusts and Health Boards provide data which are complete, accurate and reported in a timely manner in order that the most accurate comparative mortality estimates can be calculated and used for quality assurance. In particular by: a) Improving the provision of maternal data for neonatal deaths; b) Working closely with MBRRACE-UK to improve the classification of cause of death.	2015	Board level champions; MBRRACE Lead reporters; ODN's; PMRT; HSIB (some cases). Supported by MatNeoSiP; Board level champions; MBRRACE Lead reporters; ODN's; PMRT; HSIB (some cases). Supported by MatNeoSiP	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Allocation of sufficient staff and financial resource is required to ensure high quality electronic maternity data. Funding for maternity services should include provision for sufficient staff time to enter data and check quality, and to maintain adequate hardware and software.	2017	Public Health commissioners/NHS Trusts/Heads of service; Public Health commissioners/NHS Trusts/Heads of service	ICB	strategic
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Clearly define the rapid access pathways for prescribing thromboprophylaxis to ensure that women known to be at risk are able to access	2024	Integrated Care Boards and Health Boards; Integrated Care Boards and Health Boards	ICB	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>into Maternal Deaths and Morbidity 2020-22</b>	thromboprophylaxis when they need it, particularly in the first trimester				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	Trusts and Health Boards should ensure that the data provided to MBRRACE-UK is of the highest quality. This is of particular importance for those providing the most complex care to particularly high risk mothers and babies as this will permit more appropriate sub-analyses and comparisons.	2018	Local teams: Maternity safety champion HoM and CD; local commissioner; LMNS; Local teams: Maternity safety champion HoM and CD; local commissioner; LMNS	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Commissioners, in collaboration with public health departments and services, should examine the rates of women who stop smoking during pregnancy and consider initiatives to increase this.	2017	Public health commissioners; Public health commissioners	ICB	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band.	2020	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	In general, for women with breast cancer, early delivery to avoid delays in chemotherapy should not be recommended. For women diagnosed with breast cancer in the third trimester, the risk-benefit is likely to favour both mother and baby if a woman can receive at least two cycles of chemotherapy prior to a term (39-40 week) birth.	2019	Trust; Trust	Trust	clinical

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Commissioning bodies should ensure that providers of specialist Perinatal Mental Health Teams have sufficient resource to advise, and in complex or high-risk cases, be involved, in mental health assessments when in normal working hours	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	strategic
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	The availability of more experienced senior medical staff to assist in difficult decisions may help to develop a system whereby error on the part of less experienced staff dealing with difficult situations can be identified before any harm occurs to the patient.	2018	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Maternity services, primary care and public health services should work together, with involvement of local service users, to ensure that there is appropriate provision to support weight management prior to, during and after pregnancy.	2019	Public health commissioners; Public health commissioners	Other Bodies	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange.	2018	Trust; Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	A diagnosis of ectopic pregnancy should be considered in any woman of reproductive age presenting to the emergency department with collapse, acute abdominal/pelvic pain or gastrointestinal symptoms, including diarrhoea, vomiting and dizziness, regardless of whether or not she is known to be pregnant. · A bedside pregnancy test should be performed in these women. · A woman with a suspected ectopic pregnancy and deteriorating symptoms, should be seen by a senior gynaecologist as a matter of urgency.	2016	Trust;; Trust;	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	All pregnant and postnatal women presenting to the Emergency Department with medical problems should be discussed with a member of the maternity medical team. This should ensure appropriate investigations and treatments for pulmonary embolism are not withheld and prophylaxis is prescribed where appropriate.	2015	Trust; Trust	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Effective interpreting services should be available to all women unable to communicate in English.	2015	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	Each Baby Counts should be supported to fulfil its maximum potential as part of the continuing commitment to maternity safety.	2015	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal</b>	If women have a blood pressure over 140mmHg systolic or 90mmHg diastolic on	2016	Trust; Trust	Trust	clinical

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<b>deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	two occasions in labour or immediately after birth they should be considered for transfer to a consultant unit.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer if they are aged 30 and over and have an unexplained breast lump with or without pain. Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer in women: with skin changes that suggest breast cancer or aged 30 and over with an unexplained lump in the axilla [RCOG Green-top guideline 12].	2019	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same timescale as for a non-pregnant woman, but with caution when there is evidence of specific risks to the fetus. In such instances, a discussion of potential risks and benefits with the woman should be used to determine the most appropriate pathway of investigation.	2018	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Review of the RCOG 'Responsibility of Consultant on Call' guidance is needed to ensure that deviation from the usual clinical pathway, with unexpected or unexplained symptoms, triggers consultant review	2019	Royal Colleges; Royal Colleges	Colleges	operational

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<b>into Maternal Deaths and Morbidity 2015–17</b>					
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	A co-ordinated approach should be adopted for care following all intrapartum related deaths with good communication between maternity and neonatal care providers as relevant to ensure seamless care for parents. This should include: <ul style="list-style-type: none"> <li>o the development and implementation of a bereavement checklist for all intrapartum related deaths irrespective of the place of death;</li> <li>o follow-up with input from all relevant professional groups who have been involved in the care.</li> </ul>	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Following resuscitation from an arrest with a likely cardiac cause, coronary angiography ± percutaneous coronary intervention is the appropriate initial diagnostic investigation (UK Resuscitation Council guidelines 2015].	2019	Trust; Trust	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	In a climate where resources are limited, maternity units should protect the funding directed towards bereavement care to ensure the quality of the support provided is not compromised for this vulnerable group of women and their families.	2015	Trust; Trust	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity</b>	Services should examine their own findings and data quality and compare these to internal audits where available, both to evaluate their data quality and to consider how they compare	2017	NHS Trusts/Boards/Heads of service; NHS Trusts/Boards/Heads of service	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
services between 1 April 2015 and 31 March 2016	with national rates, and to determine action plans for quality improvement.				
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	The full range of clinical and investigatory services required to assess women with early pregnancy emergencies should be available throughout the whole week.	2016	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Multidisciplinary training in situational awareness and human factors should be undertaken by all staff who care for women in labour.	2017	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum	2018	Primary Care, Trust; Primary Care, Trust	Primary Care; Trust	clinical
<b>Each Baby Counts 2018 Progress report</b>	Neonatal input: Assess your local processes for involving neonatal team members in the review of Each Baby Counts babies to see whether this needs to be improved to ensure a collaborative multidisciplinary approach. This could include identifying an Each Baby Counts neonatal lead for each unit.	2018	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision	2019	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	Amend data fields to: <ul style="list-style-type: none"> <li>• collect the availability and timeliness of epidural anaesthesia</li> <li>• separate the recording of intrapartum analgesia by type for both England and Wales</li> <li>• collect analgesia and anaesthesia into two separate fields and enhance anaesthesia coding granularity to capture epidural, spinal or general anaesthesia separately in Wales.</li> </ul>	2022	Trust National Institute for Health and Care Excellence (2017) Intrapartum Care for Healthy Women and Babies, <sup>6</sup> Association of Anaesthetists of Great Britain & Ireland and Obstetric Anaesthetists' Association (2013) OAA / AAGBI Guidelines for Obstetric Anaesthetic Services 2013 <sup>16</sup> ; Trust National Institute for Health and Care Excellence (2017) Intrapartum Care for Healthy Women and Babies, <sup>6</sup> Association of Anaesthetists of Great Britain & Ireland and Obstetric Anaesthetists'	Trust; Other Bodies	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			Association (2013) OAA / AAGBI Guidelines for Obstetric Anaesthetic Services 201316		
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Where birth is anticipated between 22+0 and 26+6 weeks gestational age ensure prompt discussions between the parents, obstetric and neonatal teams to guide whether active resuscitation or palliative care should be undertaken. Care of the woman and her baby/babies should reflect the wishes and values of the woman and those of her partner, informed and supported by consultation and in partnership with obstetric and neonatal professionals	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	From 20 weeks of gestation onwards, the pressure of the gravid uterus must be relieved from the inferior vena cava and aorta during maternal resuscitation	2019	Trust; Trust	Trust	clinical

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<b>into Maternal Deaths and Morbidity 2015–17</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy	2019	NICE; Royal Colleges; NICE; Royal Colleges	Colleges	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Regard nocturnal seizures as a 'red flag' indicating women with epilepsy need urgent referral to an epilepsy service or obstetric physician	2021	All Health Professionals; All Health Professionals	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Use the scenarios identified from review of the care of women who died for 'skills and drills' training	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Be aware that pulmonary embolism can occur in women receiving thromboprophylaxis. Follow RCOG guidelines for investigation and treatment of venous thromboembolism if women receiving thromboprophylaxis develop symptoms and signs suggestive of PE	2021	Trust; Trust	Trust	clinical
<b>Five years of cerebral palsy claims</b>	Adverse events within maternity can have serious negative effects on staff, who are often provided with inadequate support. Trusts'	2017	Trust; Trust	Trust	strategic

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	obstetric and midwifery leads, with support from their board level maternity champion, must ensure that improving emotional support for staff throughout an investigation, irrespective of whether it becomes a compensation claim, is a priority.				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Consider reduced fetal movements in a twin pregnancy as a 'red-flag warning sign' of TTTS, in addition to rapid maternal abdominal distension, abdominal pain, and acute dyspnoea	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Women should receive continuity of mental health care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care.	2018	Primary Care, CCG; Primary Care, CCG	Primary Care; ICB	operational
<b>Each Baby Counts 2018 Progress report</b>	Workload: The labour ward coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal period.	2018	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	Trusts and health boards should ensure the necessary protocols are in place to ensure all local reviews are of high quality, incorporating the key points highlighted in this report.	2015	Trust; Trust	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity</b>	When procuring maternity IT systems, maternity services should take into account the need for ongoing support from system	2017	NHS Digital; Digital Midwife; NHS Digital; Digital Midwife	Trust	operational

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<b>services between 1 April 2015 and 31 March 2016</b>	suppliers for operational use and meeting national data submission requirements.				
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Pathologists undertaking maternal autopsies where the clinical pathology points to cardiac disease should follow the protocols in the Royal College of Pathologists' autopsy guidelines.	2016	Trust; Pathologists;; Trust; Pathologists;	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Resort to hysterectomy sooner rather than later (especially in cases of placenta accreta or uterine rupture)	2021	Trust; Trust	Trust	clinical
<b>Linking the national maternity and perinatal audit data set to the National Neonatal Research Database for 2015/16 2019</b>	Requests for extracts should be as specific and detailed as possible to ensure clarity about what is required from organisations providing data extracts.	2015	Provider trusts ICB's LMNS's; Provider trusts ICB's LMNS's	LMNS; Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	Units should ensure that a post-mortem examination is offered in all cases of stillbirth and neonatal death In order to improve future pregnancy counselling of parents.	2015	Trusts; LMNS, ICB; Trusts; LMNS, ICB	LMNS; Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Consider delaying the birth of Twin 2 following the spontaneous preterm birth of Twin 1 at less than 24 weeks, if there are no	2021	Trusts; Trusts	Trust	clinical

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	contraindications such as infection, fetal compromise or bleeding.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues	2018	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Staff should be aware that agitation and restlessness may be a sign of an underlying problem in women with hypertension.	2016	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Statutory health organisations should consider routine monitoring of the proportion of women and babies who are unnecessarily separated when the mother is admitted to psychiatric care.	2017	Perinatal mental health teams; Perinatal mental health teams	LMNS	operational

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<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Provide specific advice to pregnant and post-partum women with COVID-19 infection about the risk of deterioration and when to seek urgent medical attention or go to the hospital. This should be communicated via an interpreter if necessary.	2020	Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; COVID-19 Guideline Development Group; Primary Care; Trusts; Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; Obstetric Anaesthetists Association; COVID-19 Guideline Development Group; Primary Care; Trusts	Colleges; Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Mental Health Services should publicise the findings of this report and its procedures widely among mental health staff in order to highlight the messages directly relevant to improving care for pregnant and postpartum women with mental health problems.	2015	Perinatal mental health team; Perinatal mental health team	LMNS	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	New onset of cardiorespiratory symptoms and/or absence of valve clicks in women with prosthetic heart valves should prompt careful echocardiography and early review by a senior cardiologist to exclude the possibility of valve thrombosis.	2016	Trust; Cardiologists;; Trust; Cardiologists;	Trust	clinical

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<b>into Maternal Deaths and Morbidity 2009–14</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Critical care support can be initiated in a variety of settings. Critical care outreach nurses can work in partnership with midwives to provide care before transfer to the critical care unit. Delay caused by bed pressures in a critical care unit is not a reason to postpone critical care	2021	All Health Professionals, Service Managers; All Health Professionals, Service Managers	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	All staff should participate in the review of care for the Confidential Enquiry. Individual clinician's perspectives on the care they have provided to women who die or have severe morbidity is invaluable to identify fully the lessons to be learned.	2014	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Maternity and neonatal service providers should together review their rates of late preterm and term admissions to neonatal units and consider whether any of their admissions may be avoidable. The NMPA endorses the recommendations made by the ATAIN programme to address avoidable term admissions.	2019	NHS trusts boards/ Directorate management, Clinicians; NHS trusts boards/ Directorate management, Clinicians	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	Babies who are considered suitable for discharge early should have a risk assessment completed that incorporates feeding establishment (NICE, 2012).	2020	Trust; Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Since women attend maternity services during pregnancy, funding streams should facilitate the offer and delivery of influenza immunisation in maternity services as part of antenatal care, rather than in primary care	2017	Trust, CCG; Trust, CCG	ICB; Trust	strategic
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Be aware that women using oral anticoagulation with warfarin may be more safely managed without transition to low molecular weight heparin treatment when having an early termination of pregnancy	2022	All Health care professionals /Professional education programmes]; All Health care professionals /Professional education programmes]	Primary Care; Trust	clinical
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Improve the engagement of parents in reviews making sure they have ample opportunities at different stages after their bereavement to discuss their views, ask questions and express any concerns they have about the care they received	2019	Trust;; Trust;	Trust	operational
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to ensure that staff are supported to follow the escalation process to alert the neonatal team to attend so that skilled staff are present at a baby's resuscitation.	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Pregnant and postnatal women who are substance misusers often have complex social and mental health issues and these women need access to assertive outreach care from specialist addictions and specialist mental health services.	2015	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Counsel women with asthma regarding the importance and safety of continuing their asthma medications during pregnancy to ensure good asthma control	2021	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Where the rate for a service differs substantially from the overall rates, the service should identify reasons for this. This includes rates that appear to be 'positive' outliers as this may be due to under-diagnosis or data quality issues. Where true positive outliers are identified, services should consider ways of sharing best practice with their peers and with the NMPA so that these can be shared with other services.	2017	NHS Trusts/Boards/Heads of service; NHS Trusts/Boards/Heads of service	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Where a woman with severe postnatal illness has previously responded well to treatment then there should be an expectation of a good recovery from subsequent postpartum episodes. Ensure that it is recognised that discharge from inpatient care before recovery is achieved is likely to be associated with continued risk	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	All organisations identified as having a stabilised & adjusted extended perinatal mortality rate that falls in the red or amber band should conduct a local review. This should include data checking for case	2016	Board level champion; MBRRACE-UK Lead reporters; LMNS, safety commissioners; Board level champion;	LMNS; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	validation and data quality followed by a full review of the care provision for all stillbirths and neonatal deaths in order to identify any local factors which might be responsible for their reported high stabilised & adjusted mortality rate. The review should also establish whether there are lessons to be learned to improve the quality of care provision within their organisation.		MBRRACE-UK Lead reporters; LMNS, safety commissioners		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Neurological examination including assessment for neck stiffness and fundoscopy is mandatory for all women with new onset headaches or headache with atypical features, particularly focal symptoms.	2017	Trust; Primary Care; GP's; Trust; Primary Care; GP's	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Early involvement of senior clinicians from the obstetric and cardiology multidisciplinary team is important, wherever a pregnant or postpartum woman presents with suspected cardiac disease, but particularly if she presents to the Emergency Department. · A raised respiratory rate, chest pain, persistent tachycardia and orthopnoea are important signs and symptoms which should always be fully investigated. The emphasis should be on making a diagnosis, not simply excluding a diagnosis. · A normal ECG and/or a negative Troponin does not exclude the diagnosis of an acute coronary syndrome.	2016	Trust; Trust	Trust	clinical

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<b>NHSR The evolution of the Early Notification Scheme</b>	NHS Resolution to support the work of royal colleges and wider stakeholders to improve awareness in relation to response to harm for families and staff	2022	NHSR/colleges; NHSR/colleges	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	In women with gestational hypertension who have given birth: • continue antihypertensive treatment if [it was] required, • advise women that the duration of their postnatal antihypertensive treatment will usually be similar to the duration of their antenatal treatment (but may be longer), • reduce antihypertensive treatment if their blood pressure falls below 130/80 mmHg [NICE NG133].	2019	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	In major PPH (blood loss greater than 1000 ml) and ongoing haemorrhage or clinical shock monitor temperature every 15 minutes.	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	"Think Sepsis" at an early stage when presented with an unwell pregnant or recently pregnant woman, take the appropriate observations and act on them	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care</b>	Do not delay Consultant appointments and evidence-based effective preventive interventions such as aspirin pending the	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	clinical

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<b>from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	results of investigations such as prenatal diagnosis				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	In women with gestational hypertension who have given birth, measure blood pressure: <ul style="list-style-type: none"> <li>• daily for the first 2 days after birth,</li> <li>• at least once between day 3 and day 5 after birth,</li> <li>• as clinically indicated if antihypertensive treatment is changed after birth [NICE NG133].</li> </ul>	2019	Trust; Trust	Trust	clinical
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review and act upon comprehensive maternity patient experience data. b) Trusts to promote greater use of the Friends and Family Test.	2021	Trusts; Trusts	Trust	operational
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Organisations must therefore ensure not only that their guidelines and protocols are up-to-date and accessible when needed, but also that staff are familiar with the detail of the protocol or guideline and the need to follow it as appropriate.	2018	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Involve the critical care team in antenatal multidisciplinary team planning for women with serious morbidity who are anticipated to require admission to intensive care after giving birth	2022	All Health care professionals /Professional education programmes]; All Health care professionals /Professional education programmes]	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning</b>	Ensure early senior involvement of the maternal medicine team for any pregnant or	2021	Trusts; Trusts	Trust	operational

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<b>from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	postpartum woman admitted with COVID-19, whatever her gestation and wherever in the hospital she receives care				
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Medical staffing requirements should be evaluated and standards for obstetric staffing should be developed with reference to case mix and levels of specialist service provision.	2017	NHS Trusts/Boards/Service management/Professional bodies (RCOG/RCM); NHS Trusts/Boards/Service management/Professional bodies (RCOG/RCM)	Colleges; Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Women should have a venous thromboembolism (VTE) risk assessment performed during their pregnancy in line with RCOG Green-top Guideline No. 37a. Infection with SARS-CoV-2 should be considered a transient risk factor and trigger reassessment (RCOG/RCM Coronavirus guidance version 13)	2021	Trusts; Trusts	Trust	clinical
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	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 (software, hardware and connectivity, and staff time).	2019	Commissioners, NHS Trust/Boards/Service Management/Maternity Information Systems and local level IT support; Commissioners, NHS Trust/Boards/Service Management/Maternity Information Systems and local level IT support	ICB; LMNS; Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform</b>	Consultant to consultant referral is appropriate when specialist advice is needed.	2014	Trust; Trust	Trust	operational

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<b>future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>					
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Improve recording of data about key aspects of maternity care, including outcome data for mothers and babies. For example, spontaneous birth, caesarean section, assisted birth. a) Trusts to improve data capture, such as local audit, that can then be used to inform and optimise : I. Rates of caesarean section and maximise use of Robson classification. ii. Mode of birth in line with evidence-based best practice. iii. Rates of babies born at term who are small for gestational age, as defined in Saving Babies' Lives Care Bundle volume 2. iv. Rate of induction, including clinical reasoning	2021	Trusts; Trusts	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Confirm the accurate gestational age of a pregnancy when a woman presents with threatened or established extreme preterm labour to enable the correct risk assessment for potential neonatal survival and therefore direct the optimal multidisciplinary care bundle.	2021	Trusts; Trusts	Trust	clinical
<b>Each Baby Counts, 2015 Full Report</b>	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	2015	Trust; Trust	Trust	operational

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	monitoring method. The development of IT tools that bring together data from across a trust's systems to support accurate, easily accessible risk assessment should be prioritised.				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	In a twin pregnancy when established labour has been diagnosed, initiate and complete a partogram throughout all stages of labour	2021	Trusts; Trusts	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust to ensure information gathered during telephone triage is collected in a structured manner to ensure all relevant information is captured and recorded accurately. The Trust to ensure that when assessment of a mother in labour over the phone is being carried out that the staff speak directly to the mother (or to a family member in the same room as the mother) if possible.	2020	Trust; Trust	Trust	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	All members of staff who could potentially interact with bereaved parents should have access to basic bereavement skills training.	2015	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Pregnancy should not be viewed as a contraindication to surgery in the presence of malignancy or progressive symptoms or conditions at high risk of progression or exacerbation in pregnancy.	2017	Trust; Cancer services;; Trust; Cancer services;	Trust	operational

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<b>MBRRACE-UK: Perinatal Mortality Surveillance Report for Births in 2021</b>	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.	2023	UK Governments, Royal Colleges, Commissioners ; UK Governments, Royal Colleges, Commissioners	Colleges; Regulators; ICB; LMNS	clinical
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	All high dependency and intensive care units should submit data to national data sets, such as the ICNARC and SIGSAG data sets, in order to enable the monitoring of maternal admissions.	2015	Provider trust; Provider trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure at least one senior clinician takes a 'helicopter view' of the management of a woman with major obstetric haemorrhage to coordinate all aspects of care	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	All women with any symptoms or signs of ill health, including those who are postnatal, should have a full set of basic observations taken (temperature, pulse rate, respiratory rate and blood pressure), and the results documented and acted upon. Normality cannot be presumed without measurement.	2014	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales</b>	Conduct reviews of data completeness, data capture software and practices including mandatory field requirements. Utilise user feedback to identify patterns in missing data and opportunities to support healthcare	2022	vNHS Digital (2021) DCB3066 Digital Maternity Record Standard15 Trust; vNHS Digital (2021)	Trust; Other Bodies	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>between 1 April 2018 and 31 March 2019</b>	professionals to provide complete data without compromising clinical care.		DCB3066 Digital Maternity Record Standard15 Trust		
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22</b>	Revise and implement guidance for cancer diagnosis and management in pregnant women to include clear recommendations on the use and safety of diagnostic imaging modalities in pregnant women with a history of or with newly diagnosed cancer	2024	Royal College of Obstetricians and Gynaecologists in partnership with other royal colleges and professional societies; Royal College of Obstetricians and Gynaecologists in partnership with other royal colleges and professional societies	Colleges; Primary Care	clinical
<b>Each Baby Counts 2018 Progress report</b>	A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre before the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.	2018	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Clinicians involved in maternity care should, in multidisciplinary teams, familiarise themselves with the findings for their own service and how these compare to national averages in order to determine the focus of quality improvement activity required.	2017	Clinicians; Clinicians	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Guidance is needed on maternal medical assessment and screening prior to assisted reproduction, particularly for older women who are at higher risk of co-morbidities such as cardiac disease and cancer	2019	Royal Colleges. NICE; Royal Colleges. NICE	Colleges	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Aortocaval compression should be suspected in any supine pregnant woman who develops severe hypotension after induction of anaesthesia; even if some lateral tilt has been applied. If there is a delay in delivery, putting the woman into the left lateral position may be the only option if other manoeuvres fail or if the woman has refractory severe hypotension.	2017	Trust; Anaesthetists; Trust; Anaesthetists	Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Update guidance to reflect that safeguarding actions, including removal to a place of safety if necessary, should be followed in the context of public health measures such as lockdown.	2021	ICB; LMNS; Primary Care; Local Authority;; ICB; LMNS; Primary Care; Local Authority;	ICB	operational
<b>Each Baby Counts, 2015 Full Report</b>	The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.	2015	Trust; Trust	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust must ensure that there is a robust system for ensuring all maternal investigations are reviewed in a timely way to allow appropriate actions to be taken.	2020	Trust; Trust	Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure that women on prophylactic and treatment dose anticoagulation have a structured management plan to guide practitioners during the antenatal, intrapartum and postpartum period.	2021	Trust; Trust	Trust	clinical
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHS England and NHS Improvement develop a framework to support Trusts to anticipate operational risk in maternity services when delivering neonatal resuscitation	2020	NHSE; NHSE	NHSE	strategic
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHSX develops specifications for electronic patient record (EPR) systems that require adherence to national interconnectivity standards for the exchange of core maternity healthcare information. The specifications should include functionality to enable both women and pregnant people and professionals to add to the record, and also support alerting functionality.	2020	NHS Digital; NHS Digital	Other Bodies	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Recommendations from the NMPA report on 2015/16 data remain relevant, particularly those related to data quality and to the wide variation in rates of smoking cessation, breastfeeding and skin-to-skin contact. All users of this report should review and assess their performance locally against data in this	2019	Heads of service/departments at NHS trusts (head of Obstetrics/Midwifery); Heads of service/departments at NHS trusts (head of Obstetrics/Midwifery)	Trust	clinical

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	report and consider improvement action required in response				
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Develop guidance on ketone testing in pregnancy and the subsequent response to an abnormal test	2022	Royal Colleges of Obstetricians and Gynaecologists, Midwives, Physicians, General Practitioners; Royal Colleges of Obstetricians and Gynaecologists, Midwives, Physicians, General Practitioners	Colleges	operational
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should identify a system whereby mothers found to be GBS positive have antibiotics prescribed and administered within one hour of the onset of active labour, or within one hour of admission if the mother is already in active labour	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure that women on prophylactic and treatment dose anticoagulation have a structured management plan to guide practitioners during the antenatal, intrapartum and postpartum period. Identify clear lines of responsibility to facilitate prescribing of thromboprophylaxis when indicated in the plan	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	In women with epilepsy with active seizures, advising on care to minimise the period of time they go unobserved should be considered. Individuals with unwitnessed seizures are at	2021	Trusts; Trusts	Trust	clinical

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<b>into Maternal Deaths and Morbidity 2016-18</b>	high risk of Sudden Unexpected death in Epilepsy (SUDEP), with nocturnal seizures being an independent risk factor				
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	To reduce unnecessary admissions to neonatal units and keep mothers and babies together where possible, all sites with a neonatal unit should provide transitional care.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	When reorganising services, maternity units should be particularly cognisant of evidence that BAME individuals are at particular risk of developing severe and life threatening COVID-19 disease (RCOG Coronavirus and pregnancy guideline 2020).	2020	Hospitals/Trusts/Health Boards, All Health Professionals; Hospitals/Trusts/Health Boards, All Health Professionals	Primary Care; Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.	2018	Trust; LMS; Trust; LMS	LMNS, Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Development of an appropriate evidence-based early warning scoring system for pregnant and postpartum women should be a priority	2019	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Extreme preterm admissions form an increasing part of neonatal unit populations. Neonatal clinicians should: Involve parents in	2021	Trusts; Trusts	Trust	clinical

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	joint decision-making around the care of their baby and respect their autonomy.				
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22</b>	Review ambulance service algorithms for risk categorisation to ensure that 999 calls regarding women who are pregnant, recently pregnant or have the potential to be pregnant are appropriately managed, which may include early navigation and assessment. Ensure that repeated calls and calls made by minors are escalated to enable a rapid response by appropriately trained paramedics	2024	NHS England and ambulance service commissioners in the devolved nations; NHS England and ambulance service commissioners in the devolved nations	ICB; NHSE; Trust	clinical
<b>HSIB The diagnosis of ectopic pregnancy</b>	The Royal College of Obstetricians and Gynaecologists should provide guidance on the information that should be provided during referral to early pregnancy units to standardise and improve the flow of information required to identify those most at risk from ectopic pregnancy and any consequent deterioration.	2021	RCOG; RCOG	Colleges	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	The key actions for diagnosis and management of sepsis are: · Timely recognition · Fast administration of intravenous antibiotics · Quick involvement of experts - senior review is essential	2014	Trust; All Health Professionals; Primary Care; Trust; All Health Professionals; Primary Care	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Women should be advised that neither heparin (unfractionated or LMWH) nor warfarin is contraindicated in breastfeeding	2021	Trust; Trust	Trust	clinical

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<b>into Maternal Deaths and Morbidity 2016-18</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language	2021	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	An urgent multidisciplinary team meeting should be arranged for any unwell [pregnant or postpartum] woman with suspected or confirmed COVID-19 (RCOG/RCM Coronavirus guidance version 13)	2021	Trusts; Trusts	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Follow national guidance regarding offering a follow-up appointment to all women. Particular attention should be paid to: <ul style="list-style-type: none"> <li>• Joint obstetric and neonatal review where it is appropriate;</li> <li>• Ensuring that the letter sent to parents is personalised and caring, and includes advice regarding any future pregnancies.</li> </ul>	2021	Trust; Trust	Trust	strategic
<b>MBRRACE-UK: State of the National Themed Report, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic</b>	Update guidance on the use of coagulation tests in the context of obstetric haemorrhage including the timelines for availability and how to interpret these, noting that women should not be inappropriately denied clotting products based on a single measure of coagulation in the face of ongoing haemorrhage.	2023	NICE RCOG RCP OAA ; NICE RCOG RCP OAA	Colleges; Other Bodies	clinical

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causes 2019-21 and morbidity following repeat caesarean birth.					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Midwives and others carrying out postnatal checks in the community should have a thermometer to enable them to check the temperature of women who are unwell.	2017	Trust; Community midwives; Trust; Community midwives	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse. This is even more important with increasing use of electronic records to ensure all agencies involved in a woman's care are aware of her risk of domestic abuse. This would be further facilitated by support for the intra-operability of systems to support information sharing through electronic records.	2018	Trust, primary care, NHSX; Trust, primary care, NHSX	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland</b>	Allow sufficient opportunity in electronic records systems for free text comment rather than relying solely on 'tick boxes'. Where a woman has a history of mental health	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service	ICB; LMNS; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	difficulties, make a brief (as a minimum) comment on mental health		Planners/Commissioners, Hospitals/Trusts/Health Boards		
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure protocols for assessment of pregnant women with respiratory symptoms include the consideration of SARS-CoV-2 and the different pattern of symptoms in pregnant compared to non-pregnant women. Be aware that the degree of respiratory symptoms may mask the severity of underlying lung pathology and that progression to respiratory failure in COVID-19 can occur rapidly	2021	RCOG/RCM/Obstetric Anaesthetists Association/RCP/RCGP/C OVID-19 Trusts; RCOG/RCM/Obstetric Anaesthetists Association/RCP/RCGP/C OVID-19 Trusts	Colleges	clinical
<b>HSIB - Investigation report: Delays to intrapartum intervention once fetal compromise is suspected</b>	It is recommended that the Care Quality Commission, in collaboration with relevant stakeholders, includes assessment of relational aspects such as multidisciplinary teamwork and psychological safety in its regulation of maternity units.	2020	CQC & relevant stakeholders; CQC & relevant stakeholders	ICB	operational
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	It is recommended that the Royal College of Obstetricians and Gynaecologists (RCOG) takes into consideration the findings of this HSIB review when updating the RCOG Green Top shoulder dystocia guideline (No.42).	2021	RCOG; RCOG	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into</b>	Be aware of the common risk factors for heart disease and venous thromboembolism, such as extreme obesity, and consider on an individual basis whether women should be made aware of the symptoms and signs of	2022	All Health care professionals /Professional education programmes]; All Health care professionals	Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Maternal Deaths and Morbidity 2018-20</b>	heart disease as well as those of venous thromboembolism		/Professional education programmes]		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy	2018	NICE; Royal Collages; NICE; Royal Collages	Colleges	strategic
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The information about group B streptococcus (GBS) and the prevention of early-onset neonatal GBS disease provided for mothers, both written and verbal, must make it clear what events require a mother to attend/reattend the maternity unit	2020	RCOG; RCOG	Colleges	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	The deaths of all women should undergo multidisciplinary review at a local level.	2014	Trust; Trust	Trust	operational
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHS England and NHS Improvement develop minimum operating standards for interpretation services in maternity care which will include a communication risk assessment	2020	NHSE; NHSE	NHSE	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Commissioners should hold providers to account on data quality performance.	2017	Commissioners; Commissioners	ICB	strategic
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Social workers should explain [to ensure face to face contact] why it is essential that they have access to the home, or that they see and speak to the children, to ensure they are safe and well. Visits should be face-to-face where possible and should be sufficient to meet the intended purpose of the visit whether that is safeguarding or promotion of the child's welfare (Coronavirus (COVID-19): guidance for children's social care service)	2021	All Social Care Professionals; All Social Care Professionals	Primary Care; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	When a woman collapses out of hospital good communication should ensure senior review at admission and multidisciplinary involvement to determine the diagnosis promptly and enable rapid appropriate treatment.	2019	Trust; Trust	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	In order that data are of the highest quality, Trusts and Health Boards must collaborate with each other in the provision of information to MBRRACE-UK about mothers and babies who change provider units during pregnancy and after delivery.	2015	Board level champion; MBRRACE-UK Lead reporters; LMNS; Board level champion; MBRRACE-UK Lead reporters; LMNS	LMNS; Trust	strategic

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure each regional maternal medicine network has a pathway to enable women to access their designated epilepsy care team within a maximum of two weeks	2021	Maternal Medicine Networks and equivalent structures in Ireland and the devolved nations; Maternal Medicine Networks and equivalent structures in Ireland and the devolved nations	Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	More research is required to identify the extent to which deaths before 32 weeks gestational age are avoidable and to try to develop practices and policies which could reduce potential variation in management across the UK.	2017	LMNS; Trust; LMNS; Trust	LMNS; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure care for pregnant and postpartum women with COVID-19 follows RCOG/RCM guidance	2021	Trusts; Trusts	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	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.	2019	Commissioners, NHS Trust/Boards/Service Management (maternity & neonatal); Commissioners, NHS Trust/Boards/Service Management (maternity & neonatal)	ICB; Trust	clinical
<b>HSIB Severe brain injury, early neonatal death and intrapartum</b>	The Trust to continue to provide local multi-professional training in emergency drills as recommended by NHS Resolution	2021	Trust; Trust	Trust	operational

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<b>stillbirth associated with larger babies and shoulder dystocia</b>					
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Services should conduct an internal audit of their elective deliveries prior to 39 weeks without recorded clinical indication. This should aim to identify whether improvements in clinical practice or documentation, or both, are required to ensure that elective delivery before 39 weeks only occurs with appropriately documented clinical indication.	2017	NHS Trusts/Boards/Heads of service; NHS Trusts/Boards/Heads of service	Trust	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Treat cancer the same in pregnancy as in non-pregnant women. Treating cancer does not usually require early delivery.	2015	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-2023</b>	Discharge summaries for primary care should clearly indicate in an initial summary box the key conditions that require ongoing support or management and a clear plan for postnatal care. Detailed information about medical, mental health and social complexities and ongoing medications, monitoring requirements or safeguarding concerns must be included to facilitate a clear plan for postnatal care.	2025	Integrated Care Boards and Health Boards; Integrated Care Boards and Health Boards	Primary Care; ICB; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Local investigations and reviews of maternal death should not be confined to a timeline of events and a clinical narrative. The strength or	2019	Trust; Trust	Trust	operational

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<b>into Maternal Deaths and Morbidity 2015–17</b>	weakness of multi-disciplinary team working should merit specific comment				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth.	2018	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Women with epilepsy should be provided, before conception, with verbal and written information on prenatal screening and its implications, the risks of self-discontinuation of anti-epileptic drugs and the effects of seizures and anti-epileptics on the fetus and on the pregnancy, breastfeeding and contraception.	2017	Primary Care; GP's; HV; Primary Care; GP's; HV	Primary Care	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	A checklist should be developed to ensure that the recommended maternal tests are undertaken following a stillbirth prior to discharge from hospital.	2015	Trust; Trust	Trust	operational
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to ensure all mothers with an identified increased risk of shoulder dystocia receive counselling regarding the risks and benefits associated with a vaginal birth and alternative options for care. Details of this discussion should be documented in the mother's healthcare records	2021	Trust; Trust	Trust	operational

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band	2022	Trusts; Trusts	Trust	clinical
<b>HSIB Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic</b>	It may be beneficial if the NHS England and NHS Improvement communications toolkit for local maternity teams to improve communications with women from Black, Asian and minority ethnic backgrounds is implemented in all healthcare services for pregnant women.	2021	NHSE; NHSE	NHSE	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Consider previous history, pattern of symptom development and ongoing stressors when assessing immediate risk and management of women with mental health symptoms. Plans should address immediate, short-term and long-term risk	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Provide specialist multidisciplinary care for pregnant women who have had bariatric surgery by a team who have expertise in bariatric disorders	2021	Service Planners, Commissioners; Trusts; Service Planners, Commissioners; Trusts	ICB; Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	For women with gestational hypertension who did not take antihypertensive treatment and have given birth, start antihypertensive treatment if their blood pressure is 150/100 mmHg or higher. ACTION: All Health Professionals. In women with chronic hypertension who have given birth: <ul style="list-style-type: none"> <li>• aim to keep blood pressure lower than 140/90 mmHg</li> <li>• continue antihypertensive treatment, if required</li> </ul>	2021	Trust; Trust	Trust	clinical
<b>NMPA State of the Nation - Based on births in NHS maternity services in England, Scotland and Wales during 2023</b>	Government health departments should incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used to: Anticipate and respond with appropriate allocation of resources, such as workforce, bed/cot and obstetric theatre capacity, and finances, to optimise the options women and birthing people have for when and where they choose to give birth.	2023	Government health departments; Government health departments	DHSC; ICB; LMNS; NHSE; Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	National bodies such as NHS England, the Scottish Government, the Welsh Government, the RCOG and the RCM should work together to review the need for guidance and standards to reduce variation in key aspects of maternity care, including induction of labour and modes of birth	2019	National & Professional Bodies.; National & Professional Bodies.	NHSE	operational

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<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Maternity units should develop triage tools to assess the severity of illness for women who telephone with suspected or confirmed COVID-19. This should include an assessment of symptoms, clinical and social risk factors and escalation pathways. This should include 'safety netting advice' about the risks of deterioration and when to seek urgent medical attention	2021	Trusts;; Trusts;	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	In cases where delayed birth of Twin 2 is an option, manage the pregnancy as high risk in a tertiary centre, with close monitoring for signs of infection, clotting abnormalities and fetal growth.	2021	Trusts; LMS's; Trusts; LMS's	LMNS; Trust	clinical
<b>NMPA State of the Nation - Based on births in NHS maternity services in England, Scotland and Wales during 2023</b>	Government health departments should work with stakeholders to develop national and local level initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate.	2023	Government health departments; Government health departments	Colleges; Primary Care; DHSC; Regulators; ICB; LMNS; NHSE; Trust; Other Bodies	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Placental histology should be undertaken for all stillbirths and if possible all anticipated neonatal deaths, preferably by a perinatal pathologist.	2019	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	There is a need for consideration of how competence in abdominal hysterectomy can be achieved for obstetricians in training, and	2017	Trusts; Obstetricians; Theatre staff; Trusts;	Trust	clinical

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<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	how these skills can be maintained at consultant level, e.g. through simulation training.		Obstetricians; Theatre staff		
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Emphasise the importance of pre-conception health as a routine part of every health professional's interaction with people who have risk factors for congenital anomaly	2022	UK Public Health Services, Primary Care Providers, Royal Colleges, Trust and Health Board Directors, Clinical Directors, Heads of Midwifery, Health Professionals; NHS England Improvement; Department of Health; UK Public Health Services, Primary Care Providers, Royal Colleges, Trust and Health Board Directors, Clinical Directors, Heads of Midwifery, Health Professionals; NHS England Improvement; Department of Health	Colleges; Primary Care; DHSC; NHSE; Trust	operational
<b>Five years of cerebral palsy claims</b>	The quality of SI investigations has repeatedly been found to be poor with very little or no training for investigators across the NHS. A working party, involving, and possibly led by the Healthcare Safety Investigation Branch (HSIB) should discuss creating a national standardised and accredited training programme for all staff conducting SI investigations. This should focus on improving	2017	HSIB; HSIB	Other Bodies	strategic

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	competency of investigators and reduce variation in how investigations are conducted.				
<b>PMRT Learning from Standardised Reviews When babies Die. Second Annual Report (2020)</b>	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support.	2020	Trusts and Health Boards, Service Commissioners; Trusts and Health Boards, Service Commissioners	Trust	strategic
<b>MBRRACE-UK: Perinatal Mortality Surveillance Report for deaths of babies born in 2022</b>	Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care.	2024	Commissioners; Commissioners	ICB; Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	In cases of massive obstetric haemorrhage women must be adequately resuscitated and bleeding stopped prior to extubation following general anaesthesia. Evidence of adequate resuscitation should be sought prior to extubation.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Ensure specialist services have the capacity to assess and manage all women who require secondary care mental health services, and be able to adjust for the altered (generally lowered) thresholds for assessment in the perinatal period	2021	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	strategic

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Be alert to factors, such as cultural stigma or fear of child removal, which may influence the willingness of a woman or her family to disclose symptoms of mental illness, thoughts of self-harm or substance misuse	2022	All Health care professionals /Professional education programmes]; All Health care professionals /Professional education programmes]	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Recognise the importance of a trauma history in the assessment of risk. Involve specialist Perinatal Mental Health Teams where there is a history of significant involvement with secondary mental health services or significant risk, particularly if it is a first pregnancy	2022	Service Planners/Commissioners, Hospitals/Trusts/Health Boards; Service Planners/Commissioners, Hospitals/Trusts/Health Boards	ICB; LMNS; Trust	operational
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Signs of decompensation include an increase in oxygen requirements or FiO <sub>2</sub> > 40%, a respiratory rate >30/ min, reduction in urine output, or drowsiness, even if oxygen saturations are normal. Escalate urgently if any signs of decompensation develop (RCOG Coronavirus and pregnancy guideline).	2020	Hospitals, Trusts, Health Boards, All Health Professionals; Hospitals, Trusts, Health Boards, All Health Professionals	Primary Care; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Where sepsis is present the source should actively be sought with appropriate imaging and consideration given to whether surgical or radiological-guided drainage is required [RCOG Green-top guideline 64b].	2019	Trust; Trust	Trust	clinical

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<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	National bodies should look to develop self-reported outcome and experience measures for women using maternity services to complement the set of NMPA measures.	2017	National Organisations, Professional bodies (RCOG/RCM); National Organisations, Professional bodies (RCOG/RCM)	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	All women who die from sudden cardiac arrest and who have a morphologically normal heart should have molecular studies at post-mortem with the potential for family screening.	2016	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure early senior involvement in the care of women with extremely preterm prelabour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy	2021	Trust; Trust	Trust	clinical
<b>Each Baby Counts, 2015 Full Report</b>	As an urgent priority, maternity units need to be adequately resourced. Without this, trusts, health boards and healthcare professionals will struggle to implement the recommendations from the Each Baby Counts team.	2015	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care</b>	Ensure perinatal mental health services do not exclude patients on the basis of diagnosis,	2021	Service Planners/Commissioners, Hospitals/Trusts/Health	ICB; LMNS; Trust	clinical

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<b>from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	where they would ordinarily be seen by general adult mental health teams		Boards]; Service Planners/Commissioners, Hospitals/Trusts/Health Boards]		
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	In order to achieve the various UK Governments' ambitions renewed efforts need to be focused on implementing existing national initiatives to reduce stillbirths and continue the slow but steady decline in neonatal mortality rates observed since 2013. Particular emphasis should be placed on reducing preterm birth.	2019	Trust; LMNS; Trust; LMNS	Trust	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Senior decision-making doctors need to assess the woman, and after multi-disciplinary team discussion with senior colleagues in other units, decide on the best place for her ongoing care; decisions must include the means and timing of inter- or intra-hospital transfer to ensure that the transfer is carried out safely and to a high standard (Saving Lives, Improving Mothers' Care 2015). [ACTION: Hospitals/Trusts/Health Boards, All Health Professionals]	2020	Hospitals/Trusts/ Health Boards, All Health Professional; Hospitals/Trusts/ Health Boards, All Health Professional	Primary Care; Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015</b>	There is a continuing need for Trusts and Health Boards with a stabilised & adjusted extended perinatal mortality rate that falls in the red or amber band to conduct a local review in order to develop an action plan to improve the quality of their care provision.	2017	Trust Maternity Safey Champions; Trust Maternity Safey Champions	Trust	strategic

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<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Services should engage with national initiatives aimed at identifying babies that are small for gestational age (the Saving Babies' Lives care bundle in England and the Scottish Patient Safety Collaborative) in order to enable appropriate care for mothers carrying small for gestational age babies.	2017	NHS Trusts/Boards/Heads of service; NHS Trusts/Boards/Heads of service	Trust	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should introduce a system to improve communication within the multidisciplinary team to ensure that clinical plans are communicated to the member of staff who needs to carry out the recommended plan.	2020	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Document discussions with parents regarding placental examination.	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	When using medicines to treat hypertension in pregnancy, aim for a target blood pressure of 135/85 mmHg	2021	Trust; Trust	Trust	clinical
<b>Maternity admissions to intensive care in England, Wales and Scotland in 2015/16 2019</b>	Maternity service providers should investigate and monitor maternal admissions to high dependency and intensive care units locally and across their regional networks. Admission counts based on routinely collected data could	2015	Trust ICB; LMNS;; Trust ICB; LMNS;	Trust	strategic

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	be supplemented with case reviews to improve insight into who gets admitted and why.				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Produce guidance on which bedside tests should be used for assessment of coagulation and the required training to perform and interpret those tests	2021	Royal Colleges of Anaesthetists, Obstetricians and Gynaecologists, Physicians; Royal Colleges of Anaesthetists, Obstetricians and Gynaecologists, Physicians	Colleges	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Involve parents in joint decision-making around resuscitation and stabilisation using both local and national outcome data to assist families to make an informed decision.	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	One in eleven women died from influenza. Increasing immunisation rates in pregnancy against seasonal influenza must remain a public health priority.	2014	OHID; OHID	Other Bodies	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	System configurations currently support at best the entry of electronic information at booking and at birth, leading to a paucity of information about changes during pregnancy and postnatal care. This has significant implications for measurement of outcomes	2017	System Suppliers; System Suppliers	Other Bodies	strategic

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	and care of interest to women, clinicians, commissioners and policymakers. System suppliers should therefore develop and implement solutions to support the collection of information during and after pregnancy, such as electronic hand held records.				
<b>MBRRACE-UK: State of the Nation Themed Report, Lessons Learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-2021.</b>	Ensure that guidance on care for pregnant women with complex social factors is updated to include a role for networked maternal medical care and postnatal follow-up to ensure that it is tailored to women's individual needs and that resources in particular target vulnerable women with medical and mental health co-morbidities and social complexity"	2023	NICE ; NICE	Other Bodies	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	Public health initiatives should continue to be developed to reduce the impact of known risk factors for stillbirth and neonatal death; for example, smoking and obesity.	2018	DHSC; NHSEI Prevention team; DHSC; NHSEI Prevention team	DHSC	clinical
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should ensure a system is in place to review and assess new national guidance ... The Trust should ensure that its ... GBS policy is updated as a matter of urgency. As part of this the Trust should ... offer immediate induction of labour to women with term pre-labour rupture of membranes	2020	Trust; Trust	Trust	strategic

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<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	All units should implement national guidance regarding: <ul style="list-style-type: none"> <li>o Screening and identification of women who should be offered a glucose tolerance test to detect gestational diabetes.</li> <li>o Routine measurement of growth by symphysis fundal height measurement and recording at each antenatal appointment from 24 weeks gestational age.</li> <li>o The management of reduced fetal movements and identification of additional risk factors.</li> <li>o Standardised multidisciplinary review of ALL term stillbirths.</li> </ul>	2015	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	The new maternal medicine networks which are being developed in England and similar structures in the devolved nations should define pathways of referral for women with multiple and complex problems	2019	NHSE/I, LMS; NHSE/I, LMS	NHSE	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision.	2020	Clinical Commissioning Groups; Trusts; Service Planners, Service Commissioners, Health Professionals.; Clinical Commissioning Groups; Trusts; Service Planners, Service Commissioners, Health Professionals.	ICB; LMNS; Trust	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	For women with cancer, advice on postponement of pregnancy should be individualised and based on treatment needs and prognosis over time. The risk of breast cancer recurrence is highest within the first two years after treatment. Most women with breast cancer should therefore wait at least two years after treatment	2019	Trust; Trust	Trust	clinical
<b>HSIB Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia</b>	The Trust to develop joint skills and drills training for obstetric and neonatal emergencies that involves all teams across the perinatal service.	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	When critical care staff have any involvement in a maternal death, it is imperative that they are included in case reviews, root cause analysis and serious incident investigations.	2016	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	The birth of the baby should be timed after discussion with the woman and the multidisciplinary team. Most women can go to full term of pregnancy and have a normal or induced birth [RCOG Green-top guideline 12].	2019	Trust; Trust	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2019 Relevant key findings</b>	Review reasons for any short-term, long-term and permanent closures of FMUs. Evaluate how effectively the viability of these units is	2019	Commissioners, Trust; Commissioners, Trust	ICB; LMNS; Trust	strategic

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	assessed in terms of demand and resources, both in local and regional context. Evaluate the impact of these closures on the women affected.				
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHS England and NHS Improvement leads work to collate and act on the evidence on the risks and benefits associated with the use of remote consultations at critical points in the maternity care pathway.	2020	NHSE; NHSE	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trusts and Health Boards with a stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate that falls into the red or amber band should carry out an initial investigation of their data quality and possible contributing local factors. Organisations should review their performance against national outcome measures with a view to understanding where improvement may be required.	2019	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy.	2015	NICE; Royal Collages; NICE; Royal Collages	Colleges	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Third Annual Report</b>	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support and ensure the involvement of independent external members in the team.	2021	Trusts and Health Boards, regional/network support systems and organisations, Service Commissioners; Trusts and Health Boards, regional/network support systems and organisations, Service Commissioners	ICB; Trust	strategic
<b>NHS Maternity Care for women with multiple births and their babies A study on feasibility of assessing care using data from births between 1 April 2015 and 31 March 2017 in England, Wales and Scotland</b>	Maternity service providers should put local systems in place by the end of the 2020/21 reporting year to ensure that the NHS number for every Newborn baby is stored in the maternity information system and linked to the mother's number. Particular care must be taken to ensure that the baby's NHS number is not linked to the baby record of the other twin.	2015	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal</b>	Initiate a research programme to inform the development of effective interventions to	2022	Policy Makers, UK Public Health Services, Research Funders.; Policy Makers,	NHSE	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Deaths for Births from January to December 2020</b>	address health inequalities and reduce stillbirth and neonatal mortality rates.		UK Public Health Services, Research Funders.		
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death</b>	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.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Primary Care	operational
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Parents' perspectives of their care should be included in the review of their stillborn baby and the results of the review shared with them.	2015	Trust; HSIB; Trust; HSIB	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Prompt action and good communication within and between teams are crucial when dealing with sudden unexpected catastrophes, especially when the diagnosis is not immediately clear.	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Do not perform controlled cord traction if there are no signs of placental separation (blood loss and lengthening of the cord) and take steps to manage the placenta as retained	2021	Trust;; Trust;	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>into Maternal Deaths and Morbidity 2016-18</b>					
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Services should examine the reasons for the variation in the number of postnatal contacts and national standards should be developed.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	strategic
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	Reluctance to feed as a potential sign of sepsis must be included in infant feeding training for all staff caring for postnatal women, and infant feeding education delivered to women	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Women of reproductive age presenting to the Emergency Department collapsed, in whom a pulmonary embolism is part of the differential diagnosis, should have a Focused Assessment with Sonography in Trauma (FAST) scan to exclude intra-abdominal bleeding from a ruptured ectopic pregnancy before thrombolysis is given. This should be done especially in the presence of anaemia.	2016	Trust; ED; Sonography;; Trust; ED; Sonography;	Trust	clinical
<b>NHSR The evolution of the Early Notification Scheme</b>	NHS Resolution to support the working relationships with NHS providers and wider stakeholders, encouraging a joined-up approach between trust legal services and maternity & risk teams	2022	NHSR/Trust; NHSR/Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	Ensure that the response to obstetric haemorrhage is tailored to the proportionate	2021	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	blood loss as a percentage of circulating blood volume based on a woman's body weight				
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14</b>	Similarly when aortic dissection occurs in a young person, the underlying diagnosis should be assumed to be an inherited aortopathy, with a need for family screening until proven otherwise. Future sudden deaths amongst relatives may then be prevented.	2016	Primary Care; GP;; Primary Care; GP;	Primary Care	clinical
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Only 63% of sites have a private bathroom for every birth room, which should be improved to preserve privacy and dignity for women in labour.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure all pregnant or post-partum women with COVID-19 receive multidisciplinary team care and obstetric leadership with daily review. This is essential in order to ensure timely recognition of deterioration, early assessment of the need for iatrogenic birth to help respiratory function and identification of postnatal complications	2021	Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/Royal Colleges of Physicians COVID-19 Guid; trust;primay care; Royal College of Obstetricians and Gynaecologists/Royal College of Midwives /Obstetric Anaesthetists Association/Royal	Colleges; Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			Colleges of Physicians COVID-19 Guid; trust;primay care		
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Conduct research into new interventions that may be required to address issues with care identified in the PMRT report.	2019	Research funding organisations and researchers; Research funding organisations and researchers	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Establish triage processes to ensure that women with mental health concerns can be appropriately assessed, including face-to-face if necessary, and access specialist perinatal mental health services in the context of changes to the normal processes of care due to COVID-19. Perinatal mental health services are essential and face to face contact will be necessary in some circumstances. There is a clear role for involvement of the lead mental health obstetrician or midwife in triage and clinical review.	2021	Royal College of Obstetricians and Gynaecologists;Royal College of Midwives;Obstetric Anaesthetists Association;Royal College of Psychiatrists; COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards; Trusts; Primary Care; Royal College of Obstetricians and Gynaecologists;Royal College of Midwives;Obstetric Anaesthetists Association;Royal College of Psychiatrists; COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards; Trusts; Primary Care	Colleges; Primary Care; Trust	clinical
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for</b>	Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are	2019	LMS's Clinical Commissioners; Trusts;	ICB; LMNS; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Births from January to December 2019</b>	monitoring their impact on reducing preterm birth.		LMS's Clinical Commissioners; Trusts		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Women with any past history of psychotic disorder, even where not diagnosed as postpartum psychosis or bipolar disorder, should be regarded as at elevated risk in future postpartum periods and should be referred to mental health services in pregnancy to receive an individualised assessment of risk.	2017	Perinatal mental health service; Trust; GP; Perinatal mental health service; Trust; GP	Primary Care	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	All pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered, particularly, but not only hereditary non-polyposis colorectal cancer, with appropriate investigations, including tumour testing, performed and family testing offered as appropriate.	2018	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	If women need thromboprophylaxis as soon as they become pregnant there should be clear pathways for them to access prescriptions and support to ensure compliance.	2018	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	clinical
<b>NHS Resolution Early Notification Scheme report</b>	Awareness of the importance of high quality resuscitation and immediate neonatal care on outcomes for Newborn infants. This requires collaboration of the whole multiprofessional team in setting maternity safety agendas, guidance, investigations and local protocols	2022	Trust; Trust	Trust	clinical

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	recognising that neonatal and allied specialties such as anaesthetics are intricately linked with safe maternity care.				
<b>HSIB The diagnosis of ectopic pregnancy</b>	The Royal College of Emergency Medicine should provide standardised discharge information for clinicians to offer to women following discharge from the emergency department with a problem in early pregnancy and while awaiting further assessment by early pregnancy services.	2021	RCEM; RCEM	Colleges	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	While pyrexia may suggest COVID-19, clinicians should not assume that all pyrexia is due to COVID-19. The possibility of bacterial infection should be considered and a full sepsis screen performed in line with the UK Sepsis Trust Sepsis Screening and Action Tool and intravenous (IV) antibiotics administered when appropriate (RCOG/RCM Coronavirus guidance version 13)	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14</b>	Pregnancy can make the differential diagnoses of critical illness more complex. There must be a balance between appropriate clinical suspicion and a conclusive diagnosis; not all hypertension is pre-eclampsia and shortness of breath is not always a pulmonary embolism.	2016	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Clinicians should be aware that young, fit women can compensate for deterioration in respiratory function and are able to maintain normal oxygen saturations until sudden decompensation (RCOG/RCM Coronavirus guidance version 13)	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Obstetric teams should take urgent action when pregnant women with a current or past diagnosis of epilepsy have discontinued anti-epileptic drugs without specialist advice. Urgent attempts should be made by all clinicians involved in care to offer the woman immediate access to an appropriately trained professional (e.g. neurologist/epilepsy specialist nurse or midwife) to review her medication and prescribe anti-epileptic drugs if appropriate.	2017	Trust; Trust	Trust	clinical
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Prioritise measures to reduce poverty and deprivation with a particular emphasis on families with children in line with the recommendations in the Health Equity in England: The Marmot Review 10 Years On report	2019	DHSC; Department for Levelling Up; Housing and Communities; DHSC; Department for Levelling Up; Housing and Communities	DHSC	operational
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	There is a need to ensure that protocols are in place in every unit, that they are effectively implemented and updated, and that staff are aware of how they should be used.	2018	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Organisational report 2019</b> Relevant key findings	Improve access to smoking cessation and weight management support services before, during and after pregnancy.	2019	Commissioners, Public Health local authorities, NHS Trust/Boards/Service Management; Commissioners, Public Health local authorities, NHS Trust/Boards/Service Management	ICB; Other Bodies	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	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.	2019	Primary Care Providers, Trust .; Primary Care Providers, Trust .	Primary Care	clinical
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Employers should ensure pregnant women are able to adhere to any active national guidance on social distancing and/or advice for pregnant women considered to be clinically extremely vulnerable. Employers should consider both how to redeploy staff who are 28 weeks pregnant and beyond or with underlying health conditions that place them at a greater risk of severe illness from coronavirus and how to maximise the potential for homeworking, wherever possible. Where adjustments to the work environment and role are not possible and alternative work cannot be found, [pregnant women] should be suspended on paid leave. (Department of Health and Social Care guidance Coronavirus: Advice for Pregnant Employees)	2021	All Employers; All Employers	Primary Care; Trust	strategic

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	Develop strategies to ensure harmonisation between national maternity datasets, in particular that data are collected to: <ul style="list-style-type: none"> <li>record pre-existing conditions in the Welsh Initial Appointment dataset</li> <li>include a 'number of infants' variable in the English MSDS v2.0</li> <li>prevent the under-reporting of all diagnoses within HES and PEDW</li> </ul>	2022	NHSE (digital); NHSE (digital)	Other Bodies	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	One member of the team should be assigned the task of recording events, fluids, drugs, blood and components transfused, and vital signs.	2021	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	In sudden onset severe maternal shock e.g. anaphylaxis, the presence of a pulse may be an unreliable indicator of adequate cardiac output. In the absence of a recordable blood pressure or other indicator of cardiac output, the early initiation of external cardiac compressions may be life- saving	2021	Trust; Trust	Trust	clinical
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Improve the quality of the actions planned to ensure that the majority of actions are 'strong' and result in system level changes	2019	Trusts; Trusts	Trust	operational
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Service planning would be supported by the development of a categorisation system for maternity units based on service provision, unit	2017	Commissioners, NHS Trust/Boards;	ICB; Trust	clinical

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	size and the characteristics of the women who use the service, along similar lines as that for neonatal services.		Commissioners, NHS Trust/Boards		
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure protocols for assessment and monitoring of pregnant women with COVID-19 in the community take account of known risk factors for severe disease in pregnancy	2021	General Practices, NHS 111, Community-based Antenatal Services Trust Assessment units; General Practices, NHS 111, Community-based Antenatal Services Trust Assessment units	Primary Care; Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	The NMPA, MBRRACE-UK and other national organisations responsible for collating and managing maternity datasets should continue to monitor for evidence of improvements in: <ul style="list-style-type: none"> <li>• the rate of detection of small-for-gestational-age babies</li> <li>• stillbirth rates.</li> </ul>	2019	NMPA, MBRRACE-UK; NMPA, MBRRACE-UK	Other Bodies	operational
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Review and act upon comprehensive maternity patient experience data. <ul style="list-style-type: none"> <li>a) All CCGs to have a Maternity Voices Partnership (MVP) and to actively seek to capture patient views from the whole of the local population, exploring relevant methods to expand participation in patient surveys and increase response rates from under-represented groups.</li> </ul>	2021	CCGs, MPVs; CCGs, MPVs	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK</b>	All organisations which have been identified as having a stabilised & adjusted stillbirth, neonatal or extended perinatal mortality rate	2015	Trust; Maternity Safety Champions; Trust;	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Perinatal Deaths for births from January to December 2013</b>	that fall in the red band should conduct a local review in order to check their data and to identify factors which might be responsible for their reported high stabilised & adjusted mortality rate.		Maternity Safety Champions		
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	New expressions or acts of violent self-harm, or new and persistent expressions of incompetency as a mother or estrangement from the infant are 'red flag' symptoms and should always be regarded seriously.	2018	Trust, Primary Care; Trust, Primary Care	Primary Care; Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	All eligible babies should be reported to Each Baby Counts within 5 working days	2015	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2014</b>	NHS England, NHS Scotland, NHS Wales, Health and Social Care in Northern Ireland, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in the relevant specialties (where in existence), should establish targets that reflect each country's aspirations for rates of stillbirths, neonatal deaths, and extended perinatal deaths against which services can be assessed in future.	2016	NHSE/DH/RCOG/RCM/NHSI/HEE/PHE etc; NHSE/DH/RCOG/RCM/NHSI/HEE/PHE etc	NHSE; Other Bodies	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Women with risk factors for pre-eclampsia and those who develop hypertension or proteinuria in pregnancy should have a plan for an appropriate schedule of checks (with more visits than those for low risk pregnant women). · New onset hypertension or proteinuria	2016	Trust; Trust	Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>into Maternal Deaths and Morbidity 2009–14</b>	needs prompt referral with clear communication between health professionals. · Monitor blood pressure and urinalysis at each antenatal attendance in both primary and secondary care and make sure results from tests are followed-up. · Keep blood pressure in all women to below 150/100, with urgent treatment to achieve this in women with severe hypertension.				
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust should consider the use of Newborn early warning score (NEWS) charts for all babies in order to record observations to support the communication of observations and the recognition of babies at risk of deterioration.	2020	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	Women should be advised, within 24 hours of giving birth, of the symptoms and signs of conditions, including sepsis, that may threaten their lives and require them to access emergency treatment.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure clear protocols are in place with ambulance services to ensure rapid transfer when there is obstetric haemorrhage outside a consultant unit	2021	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2022 Based</b>	Further information is required to better understand the underlying causes and patterns	2022	LMNS Trust; LMNS Trust	LMNS; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019</b>	of variation in measures. Use local audit of measures to investigate differences in practice that may contribute to observed variation in rates.				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for births from January to December 2013</b>	Organisations whose stabilised & adjusted stillbirth, neonatal or extended perinatal mortality rate fall within the amber band should similarly consider carrying out a local review.	2015	Trust; Maternity Safety Champions; Trust; Maternity Safety Champions	Trust	clinical
<b>Each Baby Counts 2018 Progress report</b>	Cross-site communication: Women receiving care from multiple units must have an individualised management plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic.	2018	Trust; Trust	Trust	operational
<b>Each Baby Counts, 2015 Full Report</b>	If therapeutic hypothermia is being considered, continuous monitoring of core temperature must be undertaken. Early efforts to passively cool the baby should also be considered (turn off the heater, take off the hat).	2015	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16</b>	Healthcare professionals need to be alert to the symptoms or signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure.	2018	Trust, primary care; Trust, primary care	Primary Care; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Undertake regular training and simulation sessions to maintain team skills in acute resuscitation.	2021	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Postnatal review for women who develop VTE during pregnancy or the puerperium should, whenever possible, be at an obstetric medicine clinic or a joint obstetric haematology clinic	2021	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Arrange urgent assessment [of pregnant women with UTI] in secondary care if there are any features of serious systemic illness such as sepsis or pyelonephritis (NICE Clinical Knowledge Summary Urinary tract infection (lower) - women)	2021	All Health Professionals; All Health Professionals	Primary Care; Trust	clinical

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	Establish triage processes to ensure that women with mental health concerns can be appropriately assessed, including face-to-face if necessary, and access specialist perinatal mental health services in the context of changes to the normal processes of care due to COVID-19. Perinatal mental health services are essential and face to face contact will be necessary in some circumstances. There is a clear role for involvement of the lead mental health obstetrician or midwife in triage and clinical review	2020	Royal College of Obstetricians and Gynaecologists;Royal College of Midwives;Obstetric Anaesthetists Association;Royal College of Psychiatrists; COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards; Trusts; Primary Care; Royal College of Obstetricians and Gynaecologists;Royal College of Midwives;Obstetric Anaesthetists Association;Royal College of Psychiatrists; COVID-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; Health Boards; Trusts; Primary Care	Colleges; Primary Care; Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and</b>	Women admitted with sickle cell crisis should be looked after by the multidisciplinary team,	2021	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	involving obstetricians, midwives, haematologists and anaesthetists				
<b>Maternity and Gynaecology GIRFT programme national speciality report published September 2021</b>	Increase focus on reducing the rate of obstetric anal sphincter injury (OASI) so that all trusts achieve OASI levels similar to those at the top decile of trusts. a) All trusts to implement an OASI care bundle and improve the safety of episiotomy when indicated.	2021	Trusts; Trusts	Trust	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Practice and assess communication skills. Consider this as important as any other clinical skill.	2021	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Local guidance should be developed to cover the particular circumstance of resuscitation of a baby born in extremis and out of hours in their service. This guidance should be practical and include issues around the use of volume expanders and the use of neonatal intubation.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</b>	Liaison, crisis and home treatment mental health teams require additional support and education in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out-of-hours care for pregnant and postnatal women.	2015	Perinatal mental health team; Perinatal mental health team	LMNS	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	A summary of their follow-up appointment written in plain English should be sent to the parents and also to their GP.	2015	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Evaluating hospital and crisis care for perinatal mental health - Based on births between 1 April 2018 and 31 March 2019 in England.</b>	<p>More complete recording of hospital bed type is required to understand the patterns of bed usage by bed type.</p> <p>Future research should include the distance from home to an available bed and the experiences of those receiving care, including the effects of relocation and the impact on the individual and their family.</p>	2018	<p>Researchers and research funding bodies, NHS England and the Perinatal Mental Health Clinical Reference Group;</p> <p>Researchers and research funding bodies, NHS England and the Perinatal Mental Health Clinical Reference Group</p>	NHSE; Other Bodies	operational
<b>Linking the national maternity and perinatal audit data set to the National Neonatal Research Database for 2015/16 2019</b>	Organisations that request data extracts from third parties such as NDAU should request written documentation or code, including details of any assumptions made, to explain how the extract was generated. This will ensure transparency and reproducibility of the data extract	2015	Provider trusts ICB's LMNS's; Provider trusts ICB's LMNS's	LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Women should be advised to continue their routine antenatal care, although it may be modified, unless they meet self-isolation criteria for individuals or households (including social bubbles) with suspected or confirmed COVID-19 (RCOG/RCM Coronavirus guidance version 13)	2021	Trusts; Trusts	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly	2021	All Health Professionals; All Health Professionals	Trust	operational

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<b>into Maternal Deaths and Morbidity 2016-18</b>					
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Third Annual Report</b>	Use the local PMRT summary reports and this national report as the basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action.	2021	Trusts, Service Commissioners.; Trusts, Service Commissioners.	ICB; Trust	strategic
<b>Linking the national maternity and perinatal audit data set to the National Neonatal Research Database for 2015/16 2019</b>	Organisations should provide details of the extraction process and an explanation of any assumptions made or validation checks performed. Any instances of dropped records due to a priori assumptions should be fully explained in writing and ideally discussed with the recipients beforehand	2015	Provider trusts ICB's LMNS's; Provider trusts ICB's LMNS's	LMNS; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Pregnant or recently pregnant women should have access at all times to a healthcare professional who has enhanced maternal care competencies [Care of the critically ill woman in childbirth 2018].	2019	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Develop clear standards of care for joint maternity and neurology services, which allow for • Early referral in pregnancy, particularly if pregnancy is unplanned, to optimise anti-epileptic drug regimens • Rapid referral for neurology review if women have worsening epilepsy symptoms • Pathways for immediate advice for junior staff out of hours • Postnatal	2021	NHSE and equivalents in the devolved nations and Ireland; NHSE and equivalents in the devolved nations and Ireland	NHSE	operational

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	review to ensure anti-epileptic drug doses are appropriately adjusted				
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	2020	Trusts; ICB; LMNS; Trusts; ICB; LMNS	ICB; Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Maternity service providers and local service users should work together to understand the barriers to birth without intervention in their service by reviewing: <ul style="list-style-type: none"> <li>• rates of birth without intervention (where local data provided have been adequate to report against this measure)</li> <li>• rates of individual interventions</li> <li>• place of birth.</li> </ul>	2018	NHS trust boards and maternity voices partnerships; NHS trust boards and maternity voices partnerships	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	When assessing a woman who is unwell consider her condition in addition to her MEOWS score	2021	Trust;Primary Care; Trust;Primary Care	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Develop a mechanism to ensure all VTE risk assessment tools used for pregnant and postpartum women are consistent with national guidance	2021	NHSE/I and equivalents in the devolved nations and Ireland]; NHSE/I and equivalents in the devolved nations and Ireland]	NHSE	strategic

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20</b>	Ensure that women's electronic records can be easily accessed and shared when they receive care in different settings	2022	National Digital Policy Teams, Service Planners, Commissioners, HospitalsTrusts, Health Boards; National Digital Policy Teams, Service Planners, Commissioners, HospitalsTrusts, Health Boards	ICB; LMNS; Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Develop focused initiatives to reduce stillbirths and neonatal deaths among those at the highest risk, informed by the multidimensional effects of ethnicity, deprivation and age	2022	Policy Makers, UK Public Health Services, NHS England Improvement, Department of Health; Policy Makers, UK Public Health Services, NHS England Improvement, Department of Health	DHSC; NHSE	clinical
<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland</b>	While relatives provide invaluable support to the woman, complementing the care provided by universal and specialist services, they should not be given responsibilities beyond	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	operational

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<b>Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	their capabilities or be expected to act as a substitute for an effective mental health response				
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	Commissioners (where applicable) and providers, with the support from their governments, need to address electronic information sharing to enable safe and effective care and give women access to their electronic maternity record.	2017	Commissioners, NHS Trust/Boards, Local level IT support & National Bodies; Commissioners, NHS Trust/Boards, Local level IT support & National Bodies	ICB; Trust	strategic
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Audit adherence to the national guidance for scan frequency, the quality of scans, and training, in order to improve the quality of scanning and documentation of scans provided by the multidisciplinary team at all levels (sonographers, obstetricians and fetal medicine specialists). Particular attention should be paid to: <ul style="list-style-type: none"> <li>• Consistent labelling of the twins;</li> <li>• Plotting measurements on a growth chart;</li> <li>• Calculating weight discordance (where appropriate);</li> <li>• Recognition of the complications of twin pregnancy and referral to fetal medicine specialist in line with national guidance;</li> <li>• Ensuring the availability of adequately trained sonographers to monitor twin pregnancies</li> </ul>	2021	Trusts; Trusts	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Women with pre-existing medical conditions should have pre-pregnancy counselling by doctors with experience of managing their disorder in pregnancy.	2021	Primary Care; Trust; Primary Care; Trust	Primary Care; Trust	operational

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<b>into Maternal Deaths and Morbidity 2016-18</b>					
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Where birth is at <27 weeks gestational age, every attempt should be made to deliver the babies in a centre with a tertiary level neonatal unit	2021	Trusts; Commissioners; LMNS's; Trusts; Commissioners; LMNS's	ICB; LMNS; Trust	clinical
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	Professional bodies and policymakers should establish tools for investigating and reducing unwarranted variation.	2017	National Organisations, Professional bodies (RCOG/RCM), policymakers; National Organisations, Professional bodies (RCOG/RCM), policymakers	Colleges	strategic
<b>Each Baby Counts, 2015 Full Report</b>	NICE guidance on when to switch from intermittent auscultation to continuous cardiotocography (CTG) monitoring should be followed. This requires regular reassessment of risk during labour.	2015	RCOG; RCOG	Colleges	clinical
<b>MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death AND MBRRACE-UK Perinatal Confidential Enquiry A comparison of the care of Asian and White women who</b>	Ensure maternity services deliver personalised care, which should include identifying and addressing the barriers to accessing specific aspects of care for each individual.	2023	RCOG, BAPM, National Institute for Health and Care Excellence (NICE); RCOG, BAPM, National Institute for Health and Care Excellence (NICE)	Colleges; Other Bodies	operational

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<b>have experienced a stillbirth or neonatal death</b>					
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Audits should be conducted not only to assess whether thromboembolism risk assessment was performed, but also whether the calculated risk score was correct	2021	Trust; Trust	Trust	clinical
<b>Five years of cerebral palsy claims</b>	Cardiotocograph (CTG) interpretation should not occur in isolation. It should always occur as part of a holistic assessment of fetal and maternal wellbeing. CTG training should incorporate risk stratification, timely escalation of concerns and the detection and treatment of the deteriorating mother and baby.	2017	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Young women are vulnerable to pressure sores and care should be taken of pressure points in the obstetric population as well as other populations	2018	Trust; Trust	Trust	operational
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that the Department of Health and Social Care commission a review to improve the reliability of existing assessment tools for fetal growth and fetal heart rate to minimise the risk for babies.	2020	DHSC; DHSC	DHSC	operational

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<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016</b>	All parents of babies who die should be provided with unbiased counselling for post-mortem to enable them to make an informed decision.	2018	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Ensure that the adoption of electronic health care records does not impair clear communication between healthcare professionals and between healthcare professionals and service users.	2021	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	Prompt review by an obstetrician (experienced in the management of multiple pregnancies) for all women with a multiple pregnancy attending maternity triage units with unscheduled pregnancy-related concerns is essential.	2021	Trusts; Trusts	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trust and Health Boards should use Perinatal Mortality Review Tool multidisciplinary meetings to improve the quality of cause of death coding	2019	Trust; Trust	Trust	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity services between 1 April 2015 and 31 March 2016</b>	National organisations responsible for collating and managing maternity datasets should continue efforts to report data quality concerns back to services which repeatedly submit poor quality data and provide support to help them improve their data collection systems. Both information professionals and clinical teams should be informed and encouraged to work together to find solutions to local challenges.	2017	National Organisations, Professional bodies (RCOG/RCM); National Organisations, Professional bodies (RCOG/RCM)	Colleges	operational

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<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	Maternity and neonatal service providers with higher than expected rates of encephalopathy between 35+0 and 42+6 weeks should work together to explore reasons behind the variation and implement any identified actions and changes to clinical practice	2019	NHS trusts boards/ Directorate management, Clinicians; NHS trusts boards/ Directorate management, Clinicians	Trust	clinical
<b>MBRRACE-UK 2015 Perinatal Confidential Enquiry - Term, singleton, normally-formed antepartum stillbirth</b>	Evidence-based guidance regarding lactation suppression should be developed.	2015	NICE; Royal Colleges; NICE; Royal Colleges	Colleges	operational
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	National guidance should consider the approach to the resuscitation of a baby with prolonged bradycardia following delivery after lung aeration is confirmed.	2017	Royal Colleges; Royal Colleges	Colleges	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15</b>	High level actions are needed to ensure that it is seen as the responsibility of all health professionals to facilitate opportunistic pre- and post-pregnancy counselling and appropriate framing of the advice when women with pre-existing conditions attend any appointment, and that resources for pre- and post-pregnancy counselling are provided, together with open access to specialist contraceptive services.	2017	Royal Colleges; Primary Care; GP's Trust; HV; Sexual reproductive health clinics;; Royal Colleges; Primary Care; GP's Trust; HV; Sexual reproductive health clinics;	Colleges; Primary Care	strategic
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity</b>	Maternity service providers and national organisations responsible for collating and managing maternity datasets should use the NMPA data items described in the NMPA	2019	MTP Workstream 6. NHS digital; MTP Workstream 6. NHS digital	Other Bodies	strategic

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<b>services between 1 April 2016 and 31 March 2017</b>	Measures Technical Specification as a guide to focus improvements to data quality				
<b>National Maternity and Perinatal Audit Clinical Report 2019 Based on births in NHS maternity services between 1 April 2016 and 31 March 2017</b>	National projects working in the area of neonatal brain injury (NNAP, NMPA, Each Baby Counts) should work together to develop an agreed, jointly used, measurable definition for neonatal encephalopathy as a component of neonatal brain injury to ensure consistent measurement	2019	British Association of Perinatal Medicine (BAPM), NMPA, NNAP, EBC, HSIB; British Association of Perinatal Medicine (BAPM), NMPA, NNAP, EBC, HSIB	Other Bodies	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Pregnant women with complex needs or a complex medical history should have timely antenatal multi-disciplinary planning, and an experienced obstetric anaesthetist should contribute to the planning	2021	Trust; Trust	Trust	operational
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Units must ensure that equipment is up-to-date, regularly serviced, and staff are fully trained in the use of the equipment. An RCOG Working Party has previously recommended that ultrasound examinations for fetal anomaly detection should be carried out on equipment no older than five years.	2018	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	95% of trusts and boards conduct multiprofessional team training for emergency situations involving mothers and babies. However, only 56% provide multiprofessional training in communication and 17% in facilitating normal birth. This provision should be expanded.	2017	NHS Trusts/Boards/Service management; NHS Trusts/Boards/Service management	Trust	strategic

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<b>Saving Lives, Improving Mothers' Care Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19</b>	Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy	2021	All Health care professionals; All Health care professionals	Primary Care; Trust	operational
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	Information technology and initiatives such as e-learning can assist in the dissemination and updating of protocols and guidelines.	2018	Trust; Trust	Trust	clinical
<b>National Maternity and Perinatal Audit Organisational report 2017 Relevant key findings</b>	All trusts and boards, and commissioners where applicable, should participate in networks to share best practice, plan services and develop agreed referral routes for women and babies needing specialised care. This will allow consideration of the regional distribution of services across all unit types and referral pathways, and integrated planning of maternity and neonatal services.	2017	Commissioners, NHS Trust/Boards; Commissioners, NHS Trust/Boards	ICB; Trust	strategic
<b>Evaluating hospital and crisis care for perinatal mental health - Based on births between 1 April 2018 and 31 March 2019 in England.</b>	In order to better understand the care pathway for inpatient psychiatric care, we suggest that start and end dates are recorded for all inpatient admissions. Details of the ward or bed type should be recorded for each episode of care.	2018	Mental health service providers, NHS England and healthcare data software developers; Mental health service providers, NHS England and healthcare data software developers	Primary Care; ICB; NHSE	operational

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<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17</b>	Guidance is needed to ensure timely staging investigations are conducted in women with breast cancer in pregnancy to guide appropriate future care	2019	Trust; Trust	Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Where there is concern about a woman's condition during recovery after surgery the anaesthetist has a responsibility to make a full assessment, diagnosis and a plan of care which may include escalation measures and seeking senior advice. The anaesthetist has a responsibility to ensure the plan of care has been implemented and to reassess the woman's condition	2021	Anaesthetists; Anaesthetists	Trust	clinical
<b>NHS Resolution Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data</b>	With increasing access to electronic image storage, it would be helpful if images of all fetal parts examined were stored, normal and abnormal. The National Screening Committee in its 2010 standards recognises this need and clearly defines which fetal parts should be examined and states that all required images should be captured, stored and archived for the purposes of a complete medical record and to fulfil medico legal requirement.	2018	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries</b>	Any facility performing laparoscopic surgery in pregnancy should have blood immediately available, staff should be able to perform measures to control haemorrhage prior to	2019	Trust; Trust	Trust	strategic

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<b>into Maternal Deaths and Morbidity 2015–17</b>	definitive treatment and an escalation protocol for rapid assistance should be in place				
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16</b>	Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour.	2018	Trust; Trust	Trust	operational
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2020</b>	Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised & adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.	2022	Trusts; Trusts	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	In women with severe hypertension (blood pressure of 160/110 mmHg or more) offer pharmacological treatment to all women and measure blood pressure every 15-30 minutes until BP is less than 160/110 [NICE NG133].	2019	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK - June 2020-March 2021</b>	Ensure that referral with mental health concerns on more than one occasion is considered a 'red flag' which should prompt clinical review, irrespective of usual access thresholds or practice	2021	primary care/trust; primary care/trust	Primary Care; Trust	operational

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<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust to ensure, where there are identified risk factors for early onset neonatal GBS, there is early administration of IAP.	2020	Trust; Trust	Trust	clinical
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17</b>	Women with multiple organ dysfunction need consultant involvement and there should be early consideration regarding the optimal setting for their care and whether transfer to a local or specialist critical care unit is warranted.	2019	Trust; Trust	Trust	operational
<b>Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2019</b>	Notify all deaths via the MBRRACE-UK system within 2 working days of the death occurring. Incorporate mechanisms for timely notification into local processes.	2019	Trusts; Trusts	Trust	operational
<b>Sudden and Unexpected Deaths in Infancy and Childhood National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2021</b>	Ensure that health visitors and midwives in the CORE20PLUS5 areas have enhanced staff numbers to allow for support and training to deliver individualised safe sleeping advice. This will utilise the NHS England Core20PLUS5 approach to reducing health inequalities and current multi-disciplinary training.	2019	Maternity Transformation Partnership, Local Authorities, Commissioners of Maternity Services, Commissioners of Health Visiting Services, NHS England Trust Local Authorities; Maternity Transformation Partnership, Local Authorities, Commissioners of Maternity Services,	Primary Care; LMNS; Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
			Commissioners of Health Visiting Services, NHS England Trust Local Authorities		
<b>HSIB NLR: Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection</b>	The Trust must ensure that any written information about group B streptococcus and the prevention of early-onset neonatal GBS disease is available in a range of fully accessible formats including languages spoken within the local area.	2020	Trust; Trust	Trust	clinical
<b>Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020</b>	All pregnant women admitted with confirmed or suspected COVID-19 should receive prophylactic LMWH, unless birth is expected within 12 hours (RCOG Coronavirus and pregnancy guideline 2020).	2020	Hospitals/ Trusts/Health Boards, All Health Professionals; Hospitals/ Trusts/Health Boards, All Health Professionals	Primary Care; Trust	operational
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Ensure a thorough history is obtained from women with a pre-existing medical disorder to ascertain its severity	2021	All Health Professionals; All Health Professionals	Trust	operational
<b>National Maternity and Perinatal Audit Clinical Report 2017 Based on births in NHS maternity</b>	Maternity services, commissioners, GPs and local authorities should work together to support women to achieve and maintain a	2017	Public health commissioners, Clinicians;	Trust	strategic

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<b>services between 1 April 2015 and 31 March 2016</b>	healthy weight before, during and after pregnancy.		Public health commissioners, Clinicians		
<b>MBRRACE-UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death</b>	Adequate resource and training should be given to enable all intrapartum deaths to be systematically reviewed to facilitate organisational learning: a) using a standardised tool / methodology and following the relevant national Serious Incident Frameworks, including review of the contributory factors; b) by an appropriate multidisciplinary panel including obstetricians, midwives and pathologists and, as appropriate, a neonatologist and anaesthetist. c) Opportunity for the parents' perspectives of their care to be included in the review. Consideration should be given to including an independent external assessor on the panel.	2017	Trust; Trust	Trust	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 December</b>	Junior staff should not hesitate to seek senior advice.	2014	Trust; Trust	Trust	operational
<b>NMPA State of the Nation - Based on births in NHS maternity services in England, Scotland and Wales during 2023</b>	Maternity care commissioners and maternity networks (e.g. English local maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network) should use the evidence of variation in care processes and	2023	Maternity care commissioners and maternity networks; Maternity care commissioners and maternity networks	Primary Care; ICB; LMNS; NHSE; Trust	strategic

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	outcomes identified in this report, and the results for their local populations, when working with their constituent units to identify opportunities for improvements in service provision and clinical practice.				
<b>MBRRACE-UK Perinatal Confidential Enquiry of Stillbirths and Neonatal Deaths in Twin Pregnancies report 2020</b>	The priority risks and potential symptoms and signs of preterm labour, and the 'red flag' warning signs of TTTS if her pregnancy is monochorionic, should be explained to the woman at the 16 week antenatal visit, with advice to immediately self-refer for assessment if she experiences any of these symptoms.	2021	Trusts; Trusts	Trust	clinical
<b>MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2017</b>	Trusts and Health Boards should work to implement fully the National Bereavement Care Pathway to ensure that all parents are offered high quality, individualised bereavement care after the loss of their baby	2019	Trust; LMNS; Trust; LMNS	LMNS; Trust	strategic
<b>MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018</b>	Notify all deaths via the MBRRACE-UK system within 7 working days of the death occurring, but with an aim to notify within 2 working days. Incorporate mechanisms for timely notification into local processes.	2020	Trusts; Trusts	Trust	operational
<b>PMRT - Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool First Annual Report</b>	Improve the recording of the staff involved in PMRT reviews	2019	Trust; Trust	Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that NHS England and NHS Improvement leads work to develop a process to ensure consistency and clarity across national maternity clinical guidance	2020	NHSE; NHSE	NHSE	operational
<b>HSIB Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020</b>	HSIB recommends that future iterations of the Royal College of Obstetricians and Gynaecologists' guidance clarify the management of a reported change in fetal movements during the third trimester of pregnancy with due regard to national policy	2020	RCOG; RCOG	Colleges	strategic
<b>Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18</b>	Develop guidance to ensure SUDEP awareness, risk assessment and risk minimisation is standard care for women with epilepsy before, during and after pregnancy and ensure this is embedded in pathways of care	2021	Royal Colleges of Obstetricians and Gynaecologists, Physicians; Royal Colleges of Obstetricians and Gynaecologists, Physicians	Colleges	operational
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	We agree with the select committee that the budget for maternity services be increased by £200 to 350 million a year with immediate effect.	2022		DHSC	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	DHSC must work with the RCOG and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to ensure a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their	2022		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	annual financial and quality accounts.ble trusts to deliver safe obstetric staffing over the years to come.				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual financial and quality accounts. We endorse the Health Select Committee recommendation that the Maternity Transformation Programme board should establish what proportion of maternity budgets should be ring-fenced for training, but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board,	2022		NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	training targets should be enforced by NHSEI's Maternity Transformation Programme, the RCM, the RCOG and the CQC through a regular collaborative inspection programme.	2022		NHSE, Royal Colleges, CQC	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	families must be involved in the investigative process, and that lessons must be learned and implemented in a timely way to prevent further tragedies	2022		Trusts, other	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife.	2022		Trusts, NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	2022		DHSC, NHSE, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQMs), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM position statement for this.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience, and provide a	2022		Trusts, LMNS	investigation-based

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	structured period of transition from student to accountable midwife.				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure all midwives responsible for co-ordinating a labour ward attend a fully funded and nationally recognised labour ward co-ordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety to tackle behaviours in the workforce.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts to ensure newly appointed labour ward coordinators receive an orientation package that reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop a core team of senior midwives who are trained in the provision of high-dependency maternity care. The core team should be large enough to ensure there is at least one high-dependency unit-trained midwife on each shift 24/7.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by	2022		a Trust	investigation-based

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	specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	The review team acknowledges the progress around the creation of maternal medicine networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established to ensure the appropriate workforce long term.	2022		DHSC, NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	When agreed staffing levels across maternity services are not achieved on a day-to-day basis, this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, patient safety champion and local maternity system (LMS).	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	In trusts with no separate consultant rotas for obstetrics and gynaecology, there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	2022		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure the labour ward co-ordinator role is recognised as a specialist job role with an accompanying job description and person specification.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must review and suspend if necessary the existing provision and further roll-out of midwifery continuity of carer model(MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	2022		Other Bodies	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	2022		a Trust	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Newly appointed Band 7 or 8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop strategies to maintain bidirectional robust pathways between midwifery staff in the community setting and those based in the hospital setting to ensure high-quality care and communication.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	If not resident, there must be clear guidelines for when a consultant obstetrician should attend.	2022		Trusts LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence, trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	2022		a Trust	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on call should be informed of activity within the unit.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	In all maternity services, the director of midwifery and clinical director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trust boards must work together with maternity departments to develop regular progress and exception reports and assurance reviews, and regularly review the progress of any maternity improvement and transformation plans.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All maternity service senior leadership teams must use appreciative inquiry to complete the national maternity self-assessment tool if not previously done. A comprehensive report of their self-assessment, including governance structures and any remedial plans, must be shared with their trust board.	2022		a Trust	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Every trust must ensure they have a patient safety specialist who is specifically dedicated to maternity services.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	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.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda, and have links with audit and research.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families – for example, ensuring any medical terms are explained in lay terms.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	2022		Trusts, LMNS	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred.	2022		Trusts, LMNS, NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure that complaints that meet the serious incident threshold must be investigated as such.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Complaints themes and trends must be monitored by the maternity governance team.	2022		trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	In the case of a maternal death, a joint review panel or investigation of all services involved in the care must include representation from all applicable hospitals or clinical settings. NHSEI must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.  This joint review panel or investigation must:	2022		Trusts, LMNS, NHSE, royal colleges, other	investigation-based

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	<p>have an independent chair  be aligned with local and regional staff  seek external clinical expert opinion where required  Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.</p>				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Clinicians must not work on a labour ward without appropriate regular CTG training and emergency skills training.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must mandate annual human factor training for all staff working in a maternity setting. This should include the principles of psychological safety and upholding civility in	2022		a Trust	investigation-based

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	the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies, including haemorrhage, hypertension and cardiac arrest, and the deteriorating patient.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be mechanisms in place to support the 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.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must provide services for women with multiple pregnancy in line with national guidance.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.	2022		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and specialist midwifery staffing.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	These recommendations are supported by the NICE guideline (NG137) on twin and triplet pregnancy (2019).	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	NICE guideline (NG3) on diabetes in pregnancy (2020) should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	2022		Trusts	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate, and discuss risks and benefits to treatment. Women must be commenced on aspirin 75 to 150mg daily from 12 weeks gestation in accordance with the NICE guideline (NG133) on hypertension in pregnancy (2019).	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must implement NHS Saving Babies Lives Version Two (2019).	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival, and are aware of the risks of possible associated disability.	2022		Trusts	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be a continuous audit process to review all in-utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and, when delivery subsequently occurs, in the local unit.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Centralised CTG-monitoring systems should be mandatory in obstetric units.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen that might change recommendations about place of birth. These must be shared with women to enable an informed decision regarding place of birth to be made.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Midwifery-led units must:  complete yearly operational risk assessments undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	It is mandatory that all women who choose birth outside a hospital setting are provided with accurate and up-to-date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information by working	2022		a Trust	investigation-based

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	together and in agreement with the local ambulance trust.				
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Maternity units must have pathways for induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Centralised CTG-monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	2022		NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience, and reduce the risk of long-term psychological consequences.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in the General Medical Council's Good medical practice.	2022		Trusts	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core data sets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Postnatal wards must be adequately staffed at all times.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop a system to ensure consultant review of all postnatal readmissions and unwell postnatal women, including those requiring care on a non-maternity ward.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward, both day and night, for both mothers and babies.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	2022		a Trust	investigation-based

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<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement, and in the purpose and procedures of post-mortem examinations.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcomes.	2022		a Trust	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Compassionate, individualised and high-quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	2022		Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care, including the designation of each unit and on the level of neonatal care that is provided.	2022		Trust, NHSE	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly), and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the LMS or LMNS on a quarterly basis.	2022		Trusts, LMNS	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	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. For example, senior medical, advanced neonatal nurse practitioner and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	2022		NODNs, Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	2022		NODNs, Trusts, LMNS	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Neonatal providers must ensure that processes are defined that enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example, out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	2022		Trusts	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Neonatal practitioners must ensure that, once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cm H2O in term babies, or above 25cm H2O in preterm babies may be required. The Resuscitation Council UK's Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	2022		Trusts, other	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle-grade doctors or advanced neonatal nurse practitioners) and nurses are available in every type of neonatal unit (NICU, local neonatal unit and special care baby unit) to deliver safe care 24/7 in line with national service specifications.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Maternity care providers must actively engage with the local community and those with lived experience to deliver services that are informed by what women and their families say they need from their care.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	2022		Trusts	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	2022		Trusts	investigation-based
<b>The Independent Review of Shresbury and Telford, Donna Ockenden</b>	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	2022		Trusts	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council	2015		Other Bodies	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	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. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS	2015		NHSE, DHSC or department health	investigation-based

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	England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England	2015		NHSE, DHSC or department health	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of	2015		royal colleges, other	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health	2015		NHSE, DHSC or department health	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive	2015		NHSE, DHSC or department health	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	personal feedback on the results. Action: the Care Quality Commission, NHS England				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse	2015		Other Bodies	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and nonexecutives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts	2015		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the	2015		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	Care Quality Commission, the Parliamentary and Health Service Ombudsman				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (Midwifery regulation in the United Kingdom) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council	2015		a Trust	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<p><b>Morecambe Bay Investigation, Dr Bill Kirkup</b></p>	<p>We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health</p>	<p>2015</p>		<p>a Trust</p>	<p>investigation-based</p>
<p><b>Morecambe Bay Investigation, Dr Bill Kirkup</b></p>	<p>The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and</p>	<p>2015</p>		<p>regulators, other</p>	<p>investigation-based</p>

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health	2015		NHSE, DHSC or department health	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including	2015		a Trust	investigation-based

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	safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health	2015		NHSE, DHSC or department health	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans	2015		a Trust	investigation-based

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	brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England				
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health	2015		a Trust	investigation-based

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<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health	2015		NHSE, DHSC or department health	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor	2015		a Trust	investigation-based

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<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, High Quality Care for All, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health	2015		a Trust	investigation-based
<b>Morecambe Bay Investigation, Dr Bill Kirkup</b>	there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. Action: the Department of Health	2015		NHSE, DHSC or department health	investigation-based
<b>The Independent Investigation into East Kent, Dr Bill Kirkup</b>	The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal	2022		NHSE	investigation-based

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	outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.				
<b>The Independent Investigation into East Kent, Dr Bill Kirkup</b>	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. 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	2022		royal colleges, other	investigation-based
<b>The Independent Investigation into East Kent, Dr Bill Kirkup</b>	Relevant bodies, including 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 in maternity and neonatal care 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	2022		NHSE, Royal Colleges	investigation-based

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
	and training of junior doctors to improve support, teamworking and development				
<b>The Independent Investigation into East Kent, Dr Bill Kirkup</b>	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. Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards. NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership	2022		DHSC, NHSE	investigation-based
<b>Neonatal Critical Care Service Specification, NHS England</b>	Providers should ensure that medical, nursing, Allied Health Professional (AHP) and psychological professional staff with specialist skills, and numbers in accordance with those specified or referenced below, are in place to deliver the level of care required for that NNU.	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	NNUs should engage with ODN workforce strategies. Ongoing development and modernisation of the workforce should be reviewed annually to ensure skills meet future service requirements.	2024		a Trust	strategic

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<b>Neonatal Critical Care Service Specification, NHS England</b>	NNUs, ODNs and LMNSs should work with commissioners to produce annually updated workforce plans, with workforce transformation considered for gaps or anticipated gaps in nursing, medical, AHP, psychological and pharmacy staffing.	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	Each NNU must implement or work towards an agreed plan with commissioners for nurse staffing levels based on the following staff to baby ratios for direct patient care, as described in the Toolkit for High Quality Neonatal Services (2009) and recommended by the British Association of Perinatal Medicine (BAPM) and the Neonatal Nurses Association (NNA)	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	Each NNU should ensure that non-direct patient-facing roles (i.e. additional to the above direct patient care ratios) including provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator and discharge planning / outreach co-ordinator, patient safety and governance nursing lead and other roles outlined in the Toolkit for High Quality Neonatal Services (2009)	2024		a Trust	clinical
<b>Neonatal Critical Care Service Specification, NHS England</b>	Provider NNUs and ODN Education and Workforce Lead Nurses should produce an annually updated gap analysis of nurse staffing.	2024		a Trust	strategic

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<b>Neonatal Critical Care Service Specification, NHS England</b>	ODN Education and Workforce Lead Nurses should monitor nurse staffing and vacancy levels against clinical outcomes using quality dashboard models in liaison with commissioners, thereby providing an audit of mitigation strategies	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	ODN Education and Workforce Lead Nurses should support NNUs to develop non-registered workforce roles to support families and carers of babies receiving special and transitional care.	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	NICU providers should ensure that medical staff numbers are consistent with those recommended in Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021): A BAPM Framework for Practice.	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	LNU and SCU providers should ensure that medical staffing numbers are consistent with those recommended in Optimal Arrangements for Local Neonatal Units and Special Care Units in the UK (2018): A BAPM Framework for Practice	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	Each NNU should ensure adequate time in consultant job plans for a named clinical lead, a named education/training lead, each consultant providing educational supervision and for Perinatal Mortality Review Tool (PMRT) and Child Death Overview Panel (CDOP) reviews	2024		a Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Neonatal Critical Care Service Specification, NHS England</b>	NNUs and ODNs should also ensure that parents, carers and staff have access to psychological support.	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	A neonatal pharmacist is an essential member of the NNU parenteral nutrition team	2024		a Trust	clinical
<b>Neonatal Critical Care Service Specification, NHS England</b>	NICUs should have a minimum of five day access to an aseptic and centralised intravenous additive service where this is needed to provide bespoke parenteral nutrition and for provision of high risk intravenous medications	2024		a Trust	clinical
<b>Neonatal Critical Care Service Specification, NHS England</b>	Each NNU should ensure that a minimum of 70% (special care) and 80% (high dependency and intensive care) of the nursing and midwifery establishment hold NMC registration	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	Each NNU should ensure that a minimum of 70% of registered neonatal nursing establishment hold a post registration qualification in specialised neonatal care (QIS).	2024		a Trust	clinical
<b>Neonatal Critical Care Service Specification, NHS England</b>	All staff should receive training in the provision of developmentally sensitive care, delivered by a multi-disciplinary team.	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	Parents / carers must have 24-hour access to their baby, including during medical and nursing rounds, and during handover.	2024		a Trust	operational

Publication	Recommendation	Year Published	System Lead Lead Organisation	Audience	Type
<b>Neonatal Critical Care Service Specification, NHS England</b>	Facilities and resources must be available to enable parents / carers to be resident with their baby for as long as they want and are able to be. This includes sufficient accommodation on or close to the neonatal unit for all families, support with travel and subsistence costs (free parking, support with public transport and meal costs), private and comfortable breastfeeding/expressing facilities, an area for making drinks and preparing simple meals, a private room for confidential conversations and any other relevant facilities to support family-centred care and parent / carer involvement in delivering care to their baby.	2024		a Trust	strategic
<b>Neonatal Critical Care Service Specification, NHS England</b>	Providers should have a named lead who is responsible for receiving and responding to concerns from parents / carers	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	Following discharge, the baby and family should be contacted by a health visitor or other designated community professional in primary care within one week.	2024		a Trust	operational
<b>Neonatal Critical Care Service Specification, NHS England</b>	The ODN and the Regional Specialised Commissioning team should receive a report detailing the reason for delayed discharge home or transfer to paediatrics services for all babies remaining on an NNU beyond 44 weeks corrected gestational age.	2024		a Trust	strategic

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<b>Neonatal Critical Care Service Specification, NHS England</b>	Babies born preterm who are eligible for enhanced neurodevelopmental surveillance should have at least 2 follow-up appointments in the first year and an assessment at 2 years age corrected for prematurity that focus on development. The results of the 2-year corrected gestational age assessment should be entered into the baby's electronic records	2024		a Trust	clinical

# **National Maternity and Neonatal Investigation**