Recommendations

For NHS trusts

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

For NHS trusts and integrated care boards (ICBs)

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

For NHS England

We recommend NHS England:

- Develops guidance and definitions of a patient safety event, where something unexpected or unintended happens in maternity services, ensuring reporting in line with Learn from Patient Safety Events (LFPSE), to tackle the issue of inconsistency in interpretation.
- Oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."
- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.
- Ensures trusts are proactively managing succession planning in midwifery services and, In line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.

For the Department of Health and Social Care (DHSC)

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

For the Royal College of Obstetricians and Gynaecologists

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

For the Nursing and Midwifery Council

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.