Royal College of Obstetricians & Gynaecologists

RCOG Maternity Service Standards Framework

December 2025

Foreword

Professor Ranee Thakar

RCOG President

On behalf of the Royal College of Obstetricians and Gynaecologists (RCOG) it is my privilege to introduce our new Maternity Service Standards Framework, designed to support commissioners and service providers to raise the bar of maternity care.

The maternity system is operating in a period of profound challenge and change. Services are increasingly caring for with women whose pregnancies are more complex than ever before: higher maternal age, multiple long-term conditions, obesity, assisted conception and intersecting social vulnerabilities all mean that maternity units must provide ever more skilled and focused care. Equally, staffing pressures remain ever-present and difficult working conditions not only threaten workforce wellbeing and retention, but the delivery of personalised, safe and compassionate care.

The consequences are deeply felt. In 2024, the Care Quality Commission (CQC) found nearly half of maternity services were rated as “requires improvement” or “inadequate” for safety. When services are under-resourced or inconsistent, we see women, babies and families impacted by avoidable harm and staff feel the weight of providing less than they aspire to.

In producing the Maternity Service Standards Framework, the RCOG aims to help shape services that are consistently safe, equitable, compassionate and responsive. This Framework also places equity front and centre, recognising that women and babies from

Black and Asian backgrounds continue to face significantly poorer maternity outcomes than white women.

The high-level service standards set out in this document are designed to guide local commissioning and provision in a consistent way. It is not intended to be overly prescriptive but to establish clear expectations around safety, equity, responsiveness and effectiveness. We invite services to reflect on their local population, variation in outcomes, workforce pressures and the importance of culture, where women's voices matter and teams feel empowered.

The complexity of modern maternity care demands a workforce equipped with up-to-date skills, supported emotionally and professionally, and systems that learn and adapt. Standards are only as strong as the resources, staffing, training and leadership that underpin them. I therefore urge the UK government, policy makers, commissioners and providers to make the necessary investment to deliver rapid, sustainable improvements across the maternity system.

Achieving the standards set out here cannot be achieved by one team, one profession or one part of the system in isolation. It demands committed leadership, robust commissioning, engaged service providers, invested staff, informed families and transparent accountability. The RCOG remains committed to playing our role, in partnership, to achieve their implementation.

The journey to childbirth is one of immense hope and reward, for women, families, and the dedicated professionals who support them. As President of the RCOG, I believe this Framework can drive real improvements and I commend it to you and encourage all who commission, plan, deliver or support maternity services to adopt it.

I offer my thanks to the RCOG Officer team for their leadership in producing this Framework and to the many colleagues across the maternity system for their contributions.

Ranee Thakar
President, Royal College of Obstetricians and Gynaecologists

Geeta Kumar

RCOG Vice President, Clinical Quality

It has been both a privilege and a profound responsibility to lead this work. I hope this updated framework will continue to support progress toward safe, equitable and high-quality care for women, people and their families.

I offer my sincere thanks to the RCOG Women's Network, whose lived experience has shaped this work; their insights have been essential in ensuring the framework remains grounded in the perspectives of those most directly affected by maternity services.

I am very grateful to my co-officers for their hard work and the significant contributions they have made, and to our team of developers, reviewers and stakeholders for their thoughtful scrutiny and engagement.

I would like to express my sincere thanks to the RCOG Clinical Quality team for their expertise and support throughout, and to Ranee Thakar, PRCOG, for her dedicated leadership.

Geeta Kumar
Vice President for Clinical Quality, Royal College of Obstetricians and Gynaecologists

The RCOG Women's Network welcomes the Maternity Services Standards Framework and its strong commitment to care that is personalised, compassionate, equitable, and inclusive. It is encouraging to see genuine choice, active listening, and respectful communication embedded as core standards. These principles reflect what matters most to women and birthing people who use maternity services.

"Listening to women and birthing people - and acting on what they tell us - is essential for safe, high-quality care. Too often, concerns are missed, families feel excluded from decisions, and learning is fragmented. These issues have contributed to the challenges we see today. Making sure that women's and birthing people's voices shape both individual care and wider service improvement is critical for rebuilding trust and improving outcomes.

Commissioners and providers each have a vital role in making this happen. Commissioners must ensure these standards are delivered in practice, not just on paper. This means prioritising models of care that offer informed choice, personalised support, and fair access. Commissioners also need to create the conditions for transparency, learning, and meaningful engagement with communities. Providers, in turn, must build cultures where listening is routine, where teams work together, and where women and people are treated as active partners in their care. Lived experience should inform decisions at every level - from board assurance to frontline quality improvement - so progress is real and lasting.

Those of us using maternity services should be recognised as partners, not passive recipients. By embedding our voices at every level and promoting a culture of learning, openness, and accountability, commissioners and providers can ensure maternity care is truly personalised, responsive, and empowering for all."

Disclaimer

The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance as an aid to good clinical practice and clinical decision-making. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. This guidance is not intended to replace clinical diagnostics, procedures or treatment plans made by a clinician or other healthcare professional and RCOG accepts no liability for the use of its guidance in a clinical setting.

Clinicians and other healthcare professionals may consider it appropriate to depart from specific guidance in certain circumstances, such as serious staff shortages, emergencies or unforeseen absences. In such cases, RCOG strongly recommends that any such departure from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken, and that the rationale for such departure is recorded elsewhere and reported, as appropriate.

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Introduction

Service specifications and standards for the provision of maternity care

This is an update in response to the changing landscape of maternity services in the UK, offering providers and commissioners a contemporary framework for the delivery of safe and high-quality maternity care. It builds on the RCOG framework published in 2015.

This maternity service standards framework is based on the principle that quality improvement demands continuous effort. The standards define quality of care within maternity, building on the World Health Organization's definition of quality of care that it '*is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage. As countries commit to achieving Health for All, it is imperative to carefully consider the quality of care and health services. Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be:*

- *Effective – providing evidence-based healthcare services to those who need them;*
- *Safe – avoiding harm to people for whom the care is intended; and*
- *People-centred – providing care that responds to individual preferences, needs and values.*

To realize the benefits of quality health care, health services must be:

- *Timely – reducing waiting times and sometimes harmful delays;*
- *Equitable – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;*
- *Integrated – providing care that makes available the full range of health services throughout the life course;*
- *Efficient – maximizing the benefit of available resources and avoiding waste.'* (World Health Organization, 2025)

Multidisciplinary teams should use the framework and standards to ensure their contributions meet the needs of pregnant women and people, their babies and their families. They are also designed to support maternity staff to work within well-structured teams, with supportive line management and infrastructure, to deliver safe, personal, kind, professional and high-quality maternity care.

Format and content of this report

The first section of the report presents overarching service standards that cover elements of quality, such as communication, service governance, staffing, education, accountability, family-centred care and the care and birth environment.

Subsequent sections present key service standards along the maternity pathway from pre-pregnancy through pregnancy, labour and birth, and the postnatal period.

Each section has key statements about care and lists associated standards; and the evidence for each statement (where available).

A new chapter, 'Chapter 12: Cross-cultural communication', has been added to this document. This chapter sets out standards for culturally sensitive communication and effective interpretation, recognising the vital role these play in ensuring safe and equitable care for all women and birthing people. This is in response to concerns highlighted in recent MBRRACE reports regarding communication barriers as a contributing factor to adverse clinical outcomes.

The standards have been developed recognising that:

- High-quality maternity care requires services that nurture and develop trusting and responsive relationships with women and birthing people, and their families.
- Delivering such quality requires service providers to work in collaboration with all key stakeholders and engage proactively with service users, ensuring that their views are sought when any significant changes to systems are proposed.
- Service providers respond to feedback in a timely manner and foster a culture of learning and supportive work practices that is open and transparent in the response to, and investigation of, any critical incidents.

Continuous quality improvement

All standards set out in this document are designed to be auditable at a local level, supporting the NHS's commitment to continuous quality improvement and assurance, as outlined in the Long-Term Plan. Where appropriate, selected standards may also be subject to national audit or data collection, enabling system-wide benchmarking and informing strategic commissioning decisions. This approach aligns with NHS England's Framework for Quality Assurance and Improvement, ensuring that quality remains a core organising principle across integrated care systems.

Methods

References used to develop the standards are included throughout and provide contextual evidence and information. Where there was limited evidence-based guidance, the standard

was developed through consensus, where no reference is listed against a standard, that indicates a group consensus between the developers.

The statements and standards were updated by the RCOG Officers, through a review of available evidence and pragmatic discussions with colleagues and all relevant stakeholders, including service users.

The literature review strategy can be found at Appendix 1 and further reading in Appendix 2.

1. Overarching statements and standards for services throughout the maternity care pathway

This standard provides the overarching framework for all subsequent standards within this document.

	Statement and Standards	References
1.1	**Care should be personalised, accessible and provided in partnership with birthing people and their families, respecting their diverse health and wellbeing needs, trauma history, preferences and choices; addressing inequalities related to culture, race, disability, sexuality and economic background; and in collaboration with other organisations whose services impact family wellbeing.**	
1.1.1	Commissioners and service providers should ensure that clear pathways are in place for women and people to access care in a timely manner pre-pregnancy, during pregnancy and birth, and post-pregnancy, and that these pathways are responsive to the needs of the local population.	1–9
1.1.2	Maternity services should ensure that robust systems are in place to deliver respectful and equitable maternity care for all, and that marginalised groups do not face discrimination, prejudice or systemic barriers to accessing care appropriate for their needs.	10–16
1.1.3	Maternity services providers should ensure staff have access to race equity and cultural competence training.	17–22
1.1.4	Effective partnership working across communities should include local authorities and the voluntary sector, ensuring pathways of care that provide access to social care agencies.	23
1.1.5	Maternity services should have a governance structure in place to meet the requirements of the relevant children and young person's legislation, including safeguarding policies and collaboration with local networks.	23–25
1.1.6	When planning, developing and improving services, local Maternity and Neonatal Voices Partnerships (and similar committees from devolved nations) should demonstrate diverse and equitable service user involvement, with people with lived	26–28

	experience central to the development, implementation and review.	
1.1.7	Generic pre-pregnancy advice should be offered in all health-related consultations with women and people of reproductive age.	27,29–32
1.1.8	Commissioners and service providers should make appropriate provisions for optimisation of physical and mental health before pregnancy, along with access to comprehensive support services to provide antenatal, intrapartum and postnatal care.	30,31,33,34
1.1.9	Regarding equity, diversity and inclusion (EDI), maternity services should provide inclusive care, with NHS organisations ensuring policies, staff training and resources address the varied linguistic, psychological, sensory, physical and cultural needs of all people receiving care. Key considerations include: • **Language support:** People who do not speak or read English should have timely access to translation and interpretation services to ensure safe and effective communication • **Mental health needs:** Pregnant and postpartum people with mental health conditions and/or previous experience of birth trauma or marginalisation should have access to perinatal mental health teams or psychiatric services when needed • **Autism support:** Reasonable adjustments should be in place to support people with autism and other forms of neurodiversity to minimise anxiety and improve their care experience • **Disability:** People with physical or learning disabilities should have tailored care plans, accessible facilities and support to enable informed decision-making • **Cultural and religious needs:** Respect for dietary preferences, cultural norms, and religious practices should be supported where possible. • **LGBTQ+ inclusion:** Services should be sensitive to the needs of LGBTQ+ individuals, including appropriate language use, inclusive documentation and safeguarding respectful, non-discriminatory care.	33,35–48
1.1.10	Maternity services should encourage and support the involvement of a pregnant person's partner during maternity care, to prepare for parenthood.	3,49,50
1.2	**Staff should be able to communicate effectively with all members of the maternity team, other professionals, and those receiving care, including their**	

	families. Information relevant to care pathways and available options should be readily accessible. People receiving care should be listened to, supported to make informed choices and empowered to participate in decisions and take responsibility for their own care.	
1.2.1	Commissioners and service providers should ensure that processes and systems are in place that support good communication in all elements of care, e.g. through personalised care and support planning. Patient information resources and care plans should be evidence-based and co-designed with service users, covering risks, benefits and alternatives.	23,51–53
1.2.2	Maternity services should have clear formalised referral pathways for obstetricians and midwives with, primary care, health visitors, laboratory services, emergency services, pelvic health, mental health and other health and social care networks.	54–57
1.2.3	Maternity services should have standard protocols on the content and format of written communication, in particular about transfer of care between professionals, ensuring data protection principles are followed.	58
1.2.4	Data collection, reviews, reports and healthcare improvement activities should focus on outcomes that matter to women and birthing people and their families, and providers should ensure that these resources are regularly reviewed and co-created with service users.	59,60
1.2.5	Commissioners and service providers should ensure that a local policy is in place for women and people choosing to have birth outside of guidance.	61–66
1.3	**Care should be provided in a chosen, comfortable, clean and safe setting that promotes the wellbeing of people receiving care, their families and staff; respects the needs, preferences and privacy of all people receiving care; and supports compassionate care.**	
1.3.1	Commissioners and service providers should ensure that consider care environments in maternity services are planned to deliver efficiency, effectiveness and long-term sustainability. when planning care environments. Designs should facilitate comfort and connections and be developed with involvement of, supporting families. to be involved.	67–69
1.3.2	Commissioners and Service Providers should engage with the findings and immediate actions of the Maternity and neonatal infrastructure review and related reports, and ensure that capital investment, maintenance and design decisions reflect the need to improve the hospital estates (e.g. building, facilities, better access,	70,71

	adequate theatre space, storage space, partner accommodation, community-based services etc) to reduce risks and enhance service users' experience.	
1.4	**Healthcare professionals and staff in maternity services have a personal accountability for continuous professional development (CPD) and lifelong learning. Maternity services should establish a positive learning culture, with opportunities to fulfil these responsibilities.**	
1.4.1	Commissioners and service providers should provide a framework for effective, accessible clinical supervision, to include mentoring and preceptorship for midwifery. For medical professionals, equivalent opportunities for clinical supervision, mentoring and professional development should be provided in line with national and local medical education frameworks.	72
1.4.2	Maternity services should ensure that all members of the maternity team have access to opportunities for team building and learning and maintaining skills. This should include regular multidisciplinary team training including simulation, particularly for time-critical obstetric, neonatal and anaesthetic clinical scenarios, which incorporate elements of human factors.	60,73–78
1.4.3	Maternity services should ensure that all members of the multi-professional team responsible for maternity care are allocated time for training and reflective learning, including fetal monitoring, morbidity and mortality reviews, and promoting civility in workplace meetings.	60,72,75,79–84
1.4.4	Commissioners and service providers should embed support for staff wellbeing and access to psychological support services within supervision and team structures.	60,89
1.5	**Maternity services should audit and maintain safe levels of medical, midwifery and support staff; and make continuity of care throughout the maternity care pathway a high priority.**	
1.5.1	Maternity services should provide staff with a safe working environment and culture that enables and supports them to take adequate rest, comfort and meal breaks.	12,74,90–98
1.5.2	Maternity services should ensure an appropriate skill mix of healthcare professionals (medical, midwifery, anaesthetic, neonatal and support workers) to ensure safe delivery of maternity care and meet the needs of all people receiving care.	10,12,69,73–75,99–102
1.5.3	New staff and existing staff rotating into different clinical areas within maternity care environments should have access to appropriate induction.	75,94,103–106

1.5.4	Maternity services should provide appropriate support/supervision/mentorship for staff returning from extended period of leave (maternity or sickness).	107,108
1.5.5	Commissioners and service providers should establish an organisational culture that actively promotes inclusion, equity, psychological safety and zero tolerance for discrimination among staff.	85,109
1.5.6	Maternity services should provide clearly structured opportunities for leadership development and succession planning within the maternity (medical and midwifery) workforce.	85,110–112
1.6	**Commissioners and service providers should plan and organise maternity care through multidisciplinary collaboration under obstetric, midwifery, anaesthetic, operational and neonatal leadership, ensuring this supports a high-quality clinical governance framework to deliver personalised maternity services.**	
1.6.1	National evidence-based clinical guidance should be implemented with multi-professional and service user input and subject to regular review.	100
1.6.2	Organisations should have a robust system in place for timely dissemination of all relevant new or updated national clinical guidance, ensuring that staff/teams are supported to implement any required changes in practice.	113
1.6.3	Maternity services should hold regular multidisciplinary clinical governance/risk management meetings, with learning and action plans shared widely using a Board Assurance Framework.	60,78,114
1.6.4	There must be a written risk management policy and system for adverse incident reporting and multi-professional review, with audit of compliance and feedback to service providers and users to progress quality improvement.	25,115,116
1.6.5	Commissioners and services providers should provide a process to ensure a thorough review of all safety incidents, including all maternal and perinatal deaths, by a multi-professional group that includes service users and independent peers. Feedback must be provided to the service and to people and their families. This process should include reflective learning and implementation of quality improvement measures, alongside the rapid dissemination of such learning to multidisciplinary teams.	74,75,78,94,117–124
1.6.6	Commissioners and service providers should ensure electronic data recording, reporting and transfer of information regarding activity, performance and outcomes of maternity care, which can be readily accessed by clinical staff.	60,125

1.6.7	Commissioners and service providers should commission care pathways for the development and maintenance of expertise in caring for pregnant women with medical disorders.	33
1.6.8	Maternity services should provide a system for alerting the local neonatal/paediatric team about any issues in pregnancy that may have implications for the unborn baby, facilitating communication between parents and paediatricians antenatally, and developing a postnatal care plan for the baby.	60,126
1.6.9	Clinical governance systems should include monitoring of inequalities in access, experience and outcomes, with local action plans to address disparities across population groups.	41,127–129
1.6.10	The governance framework should include mechanisms to monitor staff wellbeing and ensure safe and confidential whistleblowing processes.	130,131

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2. Pre-pregnancy

	Statement and Standards	References
2.1	**Pre-pregnancy services should identify and manage the health and social needs of women and birthing people before pregnancy, address modifiable risk factors present before conception, and enable people accessing maternity services to make informed decisions about their pregnancy, with the overarching goal of improving long- and short-term health outcomes of women and birthing people, and their children.**	
2.1.1	Maternity services should engage in multi-agency co-productive partnerships that aim to improve the health of women and people of reproductive age.	1–4
2.1.2	Healthcare professionals should consider every consultation with a woman or birthing person of reproductive age (in primary and secondary care) as an opportunity to discuss pre-pregnancy issues and planning for pregnancy.	2,3,5
2.1.3	Healthcare professionals should offer people accessing maternity services general pre-pregnancy advice on subjects such as diet; weight management; smoking and alcohol consumption; drug and other substance misuse; prescription, over the counter and herbal medicines; and cervical screening and immunisation status.	2,3,6–12
2.1.4	Healthcare professionals should offer screening and counselling for women and birthing people who are at increased risk of having a baby with an inherited genetic disorder.	5,13
2.1.5	Providers of pre-pregnancy advice should inform people who are at increased risk of having a baby with neural tube defects or other congenital anomalies to take folic acid 5 mg daily and, once pregnant, to continue this for at least the first 12 weeks of pregnancy; all other people accessing services should be advised to take folic acid 400 mg daily, and once pregnant, to continue this for at least the first 12 weeks of pregnancy.	5
2.1.6	Providers of pre-pregnancy advice should offer advice on vitamin D supplements as per national guidance.	6

2.1.7	Healthcare professionals should regularly discuss pregnancy plans and review medication (in that context) with women and birthing people of reproductive age who are taking prescribed medication.	
2.2	**Maternity services should provide pre-pregnancy counselling for all women and birthing people with complex medical needs.**	
2.2.1	Commissioners and service providers should make available pathways in local organisations and maternal medicine networks/hubs for specialist pre-pregnancy counselling, ensuring that the right advice is given by a healthcare provider with experience in managing their medical disorder in pregnancy.	14,15
2.2.2	Where possible, maternity services should ensure that condition-specific counselling is given in primary care by a healthcare professional with appropriate training and competency, and referral to specific secondary or tertiary care providers should occur if this expertise is not available in primary care, or if the person requests it). The healthcare professional should ideally be part of the multidisciplinary team that will provide care during the pregnancy.	14
2.2.3	Maternal medicine networks/hubs should have agreed referral criteria and pathways for the care of pregnant people with medical conditions. These pathways should include referral for pre-pregnancy advice and assessment and planning, where appropriate, to support the local secondary care team and optimise care.	14,15
2.2.4	Commissioners and service providers should establish links/referral pathways for reproductive medicine services to discuss assisted reproduction in the context of medical illness, if required.	14
2.2.5	Providers of pre-pregnancy advice should summarise the information given and future plans in an easy-to-understand and readily accessible format. Any recommendations or plans made with the woman or person must also be communicated to providers of primary care and specialised medical secondary care.	14
2.2.6	When advising women and people with mental health issues who wish to become pregnant, providers of pre-pregnancy advice should ensure that they discuss the potential effect of pregnancy and childbirth on their mental health, the importance of controlling symptoms before conception, the implications for their pregnancy care relating to any medications they take for their condition and the risks of removing these treatments.	5,16–25

	Referral to secondary care should be considered for women and people with current or past severe mental health conditions, for pre-pregnancy counselling. For those who do not require referral, care should be delivered using clinical judgement and taking into account their past history and preferences. Women and people of reproductive age with a severe mental health condition should be given information at their annual review about how their condition and its treatment might affect them or their baby if they become pregnant.	
2.2.7	Healthcare professionals should discuss pregnancy with women and people of reproductive age who have chronic medical conditions and refer to an appropriate pre-pregnancy specialist.	5
2.2.8	Healthcare professionals should seek specialist advice or consider referral to a healthcare provider with genetics expertise for people accessing maternity services and their partners who have a personal or family history of an inherited genetic disorder/a previous pregnancy affected by an inherited genetic disorder/consanguinity/recurrent pregnancy loss.	5,26–29
2.2.9	Healthcare professionals should offer pre-pregnancy planning advice to people with diabetes who are of reproductive age.	30,31
2.2.10	Healthcare professionals should not prescribe valproate to treat mental health issues in women, girls and people with a uterus who are of reproductive age.	16,32,33

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3. Antenatal care

	Statement and Standards	References
3.1	**Maternity networks should ensure that antenatal care is evidence-based, person-centred and delivered by appropriately trained individuals who facilitate informed decision-making.**	
3.1.1	Commissioners and service providers should ensure that women and birthing people have timely access to antenatal care, ideally before 10 weeks gestation. Services should ensure multiple access routes, including self-referral, community engagement and culturally appropriate outreach, with translation services as needed.	1–5
3.1.2	Maternity services should ensure that women and birthing people who have complex social, medical, maternal or fetal conditions are supported by named lead healthcare professionals.	1,6–10
3.1.3	Commissioners and service providers should organise and resource antenatal care provisions and consultations so that women and birthing people with complex medical and social needs are supported to make informed decisions, by appropriately trained staff with required resources.	1,2,6,8,9,11–14
3.1.4	Maternity services should ensure that all women and birthing people have a clear antenatal care plan, recorded in a contemporaneous care record (preferably digital), and communicated to relevant providers across settings. • Prioritise interoperable, user-friendly records that surface key safety information at the point of care. • Enable information-sharing across primary and secondary care, and between organisations within the maternity network, against an agreed minimum dataset and transfer-of-care standard. • Provide women and birthing people with the ability to view and contribute to their records where feasible, alongside accessible alternatives and assisted-digital support for those who lack devices, connectivity, or digital skills.	2,3,6,9,15
3.1.5	Maternity networks, commissioners and service providers should establish a system of clear referral pathways, so that women and birthing people with pre-existing medical conditions, complex social needs or complications during pregnancy are	1,6,9,16,17

	treated by the appropriate multidisciplinary or specialist teams. For rare and complex conditions, centralisation should be expected at the regional maternal-fetal medicine centres.	
3.1.6	Maternity services should offer screening tests to pregnant people as recommended by the UK National Screening Committee, in a timely manner, supported by clear information to support decision-making. Services should ensure that women and birthing people are supported with clear, balanced and non-directive information to help them understand their options and make an informed decision. Where a screening test is positive, appropriate and timely onward referral processes should be in place.	6,13,14,17–24
3.1.7	Risk assessment for pre-eclampsia and preterm birth should be undertaken at booking and regularly reviewed, aligned with local/regional/national guidance.	6,17
3.1.8	Services should offer personalised, evidence-based advice on nutrition and physical activity to those with a high body mass index (BMI ≥30 kg/m² at their booking appointment. Services should offer designated multidisciplinary antenatal clinics (obstetrics, midwifery, anaesthesia, dietetics) for those with a BMI ≥40 kg/m², and consider offering for those with a BMI of 35–39.9 kg/m² where additional comorbidities (e.g. gestational diabetes, prior complications) are present.	7,18,25–28
3.1.9	Women and birthing people who smoke should be referred to an evidence-based stop smoking service at the booking appointment. Carbon monoxide testing should be offered at booking and during pregnancy, with referral to stop smoking services for those who smoke or have elevated readings.	1,21,29–32
3.1.10	Commissioners and service providers should offer flexibility in the length, timing and frequency of antenatal appointments, to allow discussion of any complex social issues (e.g. domestic abuse), accommodate work and caring responsibilities, and support communication needs (e.g. interpretation).	11,12,33–35
3.1.11	Women and birthing people should be informed about the importance of monitoring fetal movements, and have access to clear, standardised pathways based on the most recent guidance.	21,29,36
3.1.12	Service providers should ensure timely access to experienced anaesthetic input for women with complex medical conditions, such	1,6,7,21,25,29,30

	as cardiac disease or high BMI, to support multidisciplinary planning and care.	

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4. Vulnerable women and birthing people

	Statement and Standards	References
4.1	**Commissioners and service providers should ensure high-quality maternity care for all women and birthing people with/at risk of mental health issues.**	
4.1.1	**Commissioners and service providers should implement a regional perinatal mental health strategy, and all providers of care for perinatal mental health issues must participate.**	
4.1.1.1	Commissioners and service providers should establish perinatal mental health clinical networks that develop local services, including specialist addiction services, and provide clear pathways of care. Commissioners and service providers should ensure that a perinatal mental health integrated care pathway is in place which covers all levels of service provision and severities of disorder.	1–13
4.1.1.2	Services should ensure that healthcare professionals discuss mental health routinely at every contact. Peer support groups and signposting to local charities and online communities should be offered.	1,11,14
4.1.1.3	Maternity services should work closely with specialised perinatal mental health services to develop local care pathways that ensure a seamless clinical service for people experiencing mental health issues during and after pregnancy.	4,6,14–17
4.1.1.4	Maternity services should ensure that NICE-compliant psychological therapies are available during and after pregnancy for all women and birthing people with mental health issues.	14
4.1.2	**At a local level, providers of maternity care should have a strategy for identifying women and birthing people at risk of mental health issues during and after pregnancy, to assist them in accessing tailored care specific to their needs and those of their baby.**	
4.1.2.1	Maternity services should have policies and protocols for identifying and supporting women and pregnant people at high risk of developing a serious mental illness during pregnancy or after birth.	18,19
4.1.2.2	Commissioners and service providers should ensure that national published guidelines and accepted clinical standards related to perinatal mental health are being followed.	15–17,20

4.1.2.3	When more than one mental health team is involved, there should be a clearly identified individual lead coordinator.	15,21
4.1.2.4	Local perinatal mental health services should be led by a named specialist or general consultant/specialist* psychiatrist.	15
4.1.2.5	A named obstetrician should be identified to lead service and training development along with the named perinatal psychiatrist and midwifery lead.	15
4.1.2.6	Contact details for the specialised perinatal mental health service or, in its absence, a consultant psychiatrist with special interest in psychiatric disorders of pregnancy, should be clearly signposted in each maternity unit.	15
4.1.2.7	Service providers should establish regular basic and refresher training in identification of women and birthing people with current, and/or past history of, mental health issues during and after pregnancy, and when to refer to mental health and primary care services. Training should be provided locally in collaboration with specialised perinatal mental health services.	15
4.1.2.8	Commissioners and service providers should establish locally agreed arrangements between maternity, specialised perinatal mental health services (or, in their absence, general psychiatric services) and primary care, on appropriate administration of antidepressant medication in pregnancy. This may include written guidance to indicate risks associated with specific drugs during and after pregnancy, availability of telephone advice or, where indicated, assessment by specialised perinatal mental health services.	14,15
4.1.2.9	Guidance on care for pregnant people with complex social factors should include a role for networked maternal medical care and postnatal follow-up tailored to individual needs and specifically target vulnerable women and birthing people with medical and mental health comorbidities as well as other social factors.	15,22
4.1.3	**Care providers should ensure that healthcare professionals share relevant information that may affect the care a woman or pregnant person receives during pregnancy, or which may alter their outcomes.**	
4.1.3.1	Lines of communication should ensure that: • Primary care providers inform maternity services of any past psychiatric history. • Maternity services inform the primary care providers of the pregnancy and enquire about past psychiatric history. • Mental health services are informed when people known to them are pregnant. • Mental health services inform maternity services of any risk a pregnant person faces. Those identified as at risk of a recurrence of severe mental illness should have a written plan of agreed multidisciplinary interventions and actions to be taken.	15,18,20

4.1.3.2	All communication between maternity and mental health services should include primary (community midwives, GPs and health visitors) and social care, including when women and pregnant people decline referral to specialised mental health services.	15
4.1.3.3	Health and social care professionals should escalate through safeguarding policies if a woman or pregnant person is thought to be at risk to themselves or their unborn baby.	15,23
4.1.3.4	Care provision for perinatal mental health issues should be through integrated multi-stakeholder teams, including child safeguarding teams, ideally reflecting the needs of the population.	15
4.1.3.5	Service providers should ensure additional training for liaison, crisis and home treatment teams on the distinctive features of emergency and out-of-hours care for pregnant and postnatal women and birthing people.	2
4.1.3.6	Maternity services should identify and share tailored parent education options for pregnant people and their families, relevant to their specific needs. Education should be provided in a range of accessible formats and settings (including digital, community-based and group sessions) to meet diverse learning needs and overcome language, literacy and cultural barriers. Parent education should cover the physical, emotional and social aspects of pregnancy, labour and the postnatal period. It should include information about: • **Labour and birth options**, including modes of delivery, pain relief choices, and management of complications. • **Consent and shared decision-making**, ensuring that pregnant people understand potential interventions (such as induction, assisted birth and caesarean birth) well before labour, allowing informed preferences to be discussed antenatally. • **Recognising early labour and when to seek help**, to promote timely attendance and reduce unplanned emergency presentations. • **Infant feeding, postnatal recovery and emotional wellbeing**, including recognition of perinatal mental health challenges. • **Partner and family involvement**, to promote supportive environments and shared understanding of care plans.	4,6,24–29
4.1.4	**Each managed perinatal mental health network should have designated specialist inpatient services.**	

4.1.4.1	Women and birthing people who require admission to a psychiatric hospital following birth should be admitted to a specialist psychiatric mother and baby unit, and this unit should fulfil the national standards.	15–17
4.1.5	**Service providers should ensure that a perinatal mental health service that only offers advice or signposting, while the care of the woman or pregnant person is undertaken by a general adult team, is not involved in safeguarding of the pregnant person's condition.**	
4.1.5.1	Community perinatal mental health services should be adequately resourced so that they can provide both senior specialist clinical opinion and undertake the care of women and people with serious perinatal illness until its resolution.	2
4.1.6	**Investigations into deaths from psychiatric causes at any stage during pregnancy and the first year after pregnancy should be multi-agency and involve all services that cared for the woman or birthing person.**	
4.1.6.1	Mental health services should produce a multidisciplinary report on maternal deaths from psychiatric causes and share it widely among mental health staff, to highlight messages directly relevant to improving care for pregnant and postpartum people with mental health issues.	2
4.2	**Commissioners and service providers should ensure high-quality maternity care for all women and birthing people who misuse substances or alcohol.**	
4.2.1	**Women and birthing people who misuse alcohol and/or substances should receive multidisciplinary care from a number of agencies, who should communicate freely and conscientiously.**	
4.2.1.1	All women and birthing people with significant substance and/or alcohol misuse issues should receive their care from a multi-agency team, to include a specialist midwife and/or obstetrician, social workers, health visitors and perinatal mental health team.	6,30–33
4.2.1.2	A coordinated care plan, with contributions from all agencies involved, should be available in a single document through which the woman or birthing person's progress can be tracked, and plans noted for the care of the baby.	34
4.2.1.3	Health and social care professionals must escalate through safeguarding policies if someone is thought to be at risk to themselves or their unborn baby because of alcohol and/or substance misuse.	31
4.2.2	**Access to appropriate health and social care should be facilitated for women and people who misuse alcohol and/or substances during pregnancy.**	
4.2.2.1	Commissioners and service providers of local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example, co-locating services.	34

4.2.2.2	Maternity services should fast-track pregnant women and birthing people who misuse alcohol and/or substances into addiction treatment, to promote early engagement and achieve progress at the earliest possible stage.	35
4.2.2.3	Pregnant and postpartum women who misuse alcohol and/or substances often have complex social and mental health issues, and these women should have easy access to assertive outreach care from specialist addiction and mental health services.	2
4.2.2.4	Maternity services should offer women and birthing people who misuse alcohol and/or substances contact details for a named healthcare professional with specialised knowledge and experience.	34
4.2.2.5	Service providers should ensure that women and birthing people who misuse alcohol and/or substances have access to specialist breastfeeding advice.	
4.3	**Commissioners and service providers should ensure high-quality maternity care for all pregnant women and people subject to, or at risk of, domestic abuse.**	
4.3.1	**A multi-agency partnership should support pregnant women and people subject to, or at risk of, domestic abuse.**	
4.3.1.1	Local authorities, health services (including maternity services) and their strategic partners (including the voluntary and community sectors) should ensure senior officers participate in a local strategic partnership to prevent domestic abuse, along with representatives of frontline practitioners and service users or their representatives.	34,36–38
4.3.1.2	Service providers should establish a local guideline, developed jointly with social care providers, the police and third-sector agencies that is written by a healthcare professional with expertise in the care of pregnant women and birthing people experiencing domestic abuse, with clear referral pathways.	34
4.3.1.3	Maternity services should ensure that all healthcare professionals caring for pregnant women and birthing people are aware of the care pathway once domestic abuse is disclosed, and when/how to escalate to senior staff.	34
4.3.2	**Information and access to support services should be readily available to women and birthing people who are subject to, or at risk of, domestic abuse.**	
4.3.2.1	Maternity services should clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic abuse and modern slavery. These details should be provided in booking information and handheld/electronic maternity records.	1,14,34,39
4.3.2.2	Maternity services should make an up-to-date list (including addresses and telephone numbers) of sources of support, such as social services, the police, support groups and women's refuges, easily accessible to birthing people and their carers.	34
4.3.3	**Disclosure of domestic abuse should be encouraged and facilitated.**	

4.3.3.1	Service providers should ensure that frontline staff are trained to recognise the indicators of domestic abuse and modern slavery, and that they are able to routinely ask relevant questions to service users about past or present experience of domestic abuse.	2,37,40–42
4.3.3.2	Commissioners and service providers should implement systems to recognise and provide support for staff who may be subject to, or have been previous victims of, domestic abuse, and may require extra support to provide this support for others.	
4.3.3.3	Commissioners and service providers should have facilities and strategies in place to ensure that the enquiry can be made in private, on a one-to-one basis, in a kind and sensitive manner, in an environment where the person feels safe.	2,37
4.3.4	**Service providers should have processes in place to ensure that all agencies involved in the care of pregnant women and birthing people learn from serious untoward events resulting from domestic abuse.**	
4.3.4.1	The care of any woman or birthing person murdered during or up to one year after pregnancy should be subject to a multi-agency Domestic Homicide Review or equivalent.	43,44
4.4	**Commissioners and service providers should ensure high-quality maternity care for vulnerable populations.**	
4.4.1	**Commissioners and service providers should provide care that is inclusive, flexible and suitable for their specific needs for all pregnant teenagers.**	
4.4.1.1	Commissioners and service providers should ensure that specialist antenatal services for teenage mothers are mostly community-based, using a flexible model of care tailored to the needs of the local population. There should be identified and specific midwifery support to guide and oversee the provision of this service.	34,45–47
4.4.1.2	Maternity services should provide pregnant young people aged under 20 with access to a named midwife, who is responsible for and provides the majority of antenatal care.	34
4.4.1.3	Service providers should provide training for healthcare professionals about their safeguarding responsibilities for both the young person and their unborn baby, and should refer to the most recent GMC guidance on consent for examination or treatment.	25,34
4.4.1.4	Maternity services should provide pregnant teenagers with access to information suitable for their age – including information about care services, postnatal contraception, antenatal peer group education and benefits – in a variety of formats.	25,27,34,48,49,79
4.4.2	**Commissioners and service providers should provide care that is inclusive, flexible and suitable for their specific needs for pregnant women and birthing people.**	
4.4.2.1	Local maternity services should ensure that they are inclusive for women and birthing people with intellectual and physical disabilities,	50,51

	and those who are neurodiverse, taking into account their communication, equipment and support needs.	
4.4.2.2	Healthcare professionals should provide learning passports to disabled pregnant women and birthing people, so that they and their families can input their needs and communication preferences as easily as possible.	
4.4.2.3	Commissioners and service providers should ensure that maternity services are inclusive and responsive to the needs of LGBTQ+ people, including trans and non-binary parents, same-sex couples and those with diverse family structures. Care should be individualised, respectful of identity, and provided in a safe, non-judgemental environment. Services should ensure staff receive training on inclusive language, communication, and the specific health and psychosocial needs of LGBTQ+ individuals. Maternity documentation, patient information, and digital systems should be reviewed to ensure they use inclusive terminology and enable people to self-identify appropriately.	52–55
4.4.3	**Commissioners and service providers should provide care that is inclusive, flexible and suitable for their specific needs for pregnant women and people in contact with the health and justice system.**	
4.4.3.1	Commissioners and service providers should make arrangements to link healthcare services for pregnant people and newborns in local women's prisons and asylum seeker accommodation.	34,56–60
4.4.4	**Commissioners and service providers should provide care that is inclusive, flexible and suitable for their specific needs for pregnant women and people who have refugee, Asylum Seeking and Undocumented Migrant Women status.**	
4.4.4.1	Commissioners and service providers should make arrangements to link healthcare services for pregnant people and newborns who have refugee, Asylum Seeking and Undocumented Migrant Women status	39,61–67
4.5	**Commissioners and service providers should ensure high-quality maternity care for those at risk of, and survivors of, female genital mutilation (FGM).**	
4.5.1	**Survivors of FGM should have ready access to high-quality, multi-agency care.**	
4.5.1.1	Service providers should ensure multiple and clear routes of referral into FGM services, including self-referral.	68–77
4.5.1.2	In low prevalence areas, networks should establish 'Hub and Spoke' models of service provision to ensure that care is provided by professionals with the appropriate expertise.	69
4.5.1.3	Maternity services should provide access to antenatal de-infibulation for all pregnant women and birthing people with type 3 FGM.	69
4.5.1.4	FGM services should have comprehensive links with other specialist services, such as psychology and urogynaecology.	68,69

4.5.2	**FGM services should provide women and girls with high-quality healthcare, consider the need for safeguarding any women and girls in the family unit, and initiate a suitable multi-agency response that includes the police and social services.**	
4.5.2.1	Commissioners and service providers should ensure that all acute organisations have a designated obstetrician and midwife responsible for the care of women with FGM.	78
4.5.2.2	All services should be designated following consultation with service users and local community groups. Where possible, ongoing involvement should be built into the service assurance model to ensure it remains fit for purpose.	69
4.5.2.3	FGM services should be designed to meet both the physical and mental health needs of a woman with FGM.	68
4.5.2.4	FGM services should perform a safeguarding assessment of the woman or girl, and the children of the patient, and consideration should be given to other children within the family unit.	68,70,71,73
4.5.2.5	Written/digital information in an accessible format and language should be available to all women attending the clinic. This should contain information about the clinic and staff, as well as basic information about the health risks and legal status of FGM.	70,71
4.5.2.6	Services should make contact details for their local safeguarding lead available in the clinic.	71
4.5.2.7	Services should offer contact details of any local community groups, as well as national groups such as FORWARD and Daughters of Eve, to encourage peer support.	68
4.5.3	**Education of healthcare workers about FGM is mandatory, and learning should be facilitated by review and audit of local services.**	
4.5.3.1	FGM services should complete the mandatory Department of Health and Social Care FGM Enhanced Dataset return.	70
4.5.3.2	FGM services should record and audit FGM referrals and de-infibulation procedures.	70
4.5.3.3	Service providers should ensure healthcare professionals providing maternity care have undertaken mandatory training on FGM and its management, including de-infibulation.	68,78

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

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5. Medical complexity

	Statement and Standards	References
5.1	**Commissioners and service providers should ensure access to specialised care for all women and birthing people with complex medical needs.**	
5.1.1	All people using maternity services should be given a comprehensive formal risk assessment at their first antenatal contact, and then further risk review at subsequent visits, to include the need for specialist medical input to care, continued access to appropriately trained professionals and ongoing review of the intended place of birth, based on the developing clinical picture. Maternity services should provide access to pre-pregnancy counselling for women with medical disorders.	1–3
5.1.2	Maternity services should aim that all women and birthing people with a pre-pregnancy, unmasked or *de novo* medical diagnosis are reviewed by an experienced physician (obstetric or specialty) before 20 weeks gestation if they: • were attending a physician pre-pregnancy, • received pre-pregnancy counselling from a physician before pregnancy, • were recently discharged from a general medicine service, • have an unplanned pregnancy, or have noticed any change in their medical problem since becoming pregnant.	3,4
5.1.3	Maternity services should develop pathways for timely reviews to identify women and people who are pregnant and known to be diabetic, as they need to be seen more urgently. Services should have guidelines and capacity to facilitate rapid review.	3,5–7
5.1.4	Maternal medicine networks should establish agreed evidence based care pathways to ensure that women and pregnant people with medical disorders receive optimal care and timely specialist advice. Care should be tailored to individual risk factors, and provided in the most appropriate centre, within the nearest maternal medicine network.	3,4
5.1.5	Maternity services should involve specialists with appropriate training and experience in the decision-making for the care of pregnant	4

	women and birthing people with medical problems who require inpatient care.	
5.1.6	Commissioners and services providers should establish clear and timely pathways for people who want to end their pregnancy if the decision is made on maternal health grounds.	
5.2	**Commissioners and service providers should utilise multidisciplinary working to ensure that women and birthing people with complex medical needs have access to the expertise, specialised care and support appropriate for their needs.**	
5.2.1	Commissioners and service providers should ensure the development and maintenance of local and regional expertise in caring for pregnant women and birthing people with medical disorders.	[4]
5.2.2	Oversight of care of women with suspected or confirmed medical disorders, particularly when complex or severe, should be provided by a multidisciplinary team as part of a maternal medicine network.	[3,8]
5.2.3	Regional maternal medicine centres (as described in national service specifications) are responsible for providing clinical leadership in regional maternal medicine services and centralised care for women with complex medical disorders where necessary. The service should include specialist midwifery support, obstetricians with appropriate training and experience, access to an obstetric physician, subspecialty physicians and other specialists (e.g. (obstetric) anaesthetists), as appropriate. Women and people with complex medical needs should be involved in co-developing these services, along with their partners and families and/or carers.	[3]
5.2.4	Commissioners and service providers should ensure that specialised maternal medicine services, are compliant with standards and referral pathways discussed and agreed at a network level.	
5.2.5	An obstetrician with a special interest in maternal medicine will normally have completed the Maternal Medicine Special Interest Training Module (SITM) or equivalent. They should have dedicated sessions in their job plan for maternal medicine clinic and should show ongoing professional development in this field with regular attendance at network multidisciplinary and educational meetings..	
5.2.6	Maternity services for women and birthing people with medical disorders should be multi-professional and multidisciplinary, with clinic structures designed to minimise the number of separate	[4]

	appointments needed and maximise communication and learning between specialties and professional groups.	
5.2.7	Care of women and people with medical disorders during pregnancy should follow national guidance and be subject to regular audit. Guidance may be adapted in local organisations or regions to take into account the specific needs of local populations, and issues related to demographics or service infrastructure and configuration.	
5.2.8	Maternity services should ensure that pregnant women and birthing people have access to a maternal medicine midwife with appropriate expertise, who can provide personalised support, advocacy, and continuity of care.	9
5.2.9	Maternity services should comply with regional and national audit requirements for maternal medicine services.	3,10
5.3	**Commissioners and service providers should ensure high-quality postnatal care for women and birthing people with complex medical issues.**	
5.3.1	Women and people who develop medical complications during pregnancy, or who have ongoing medical disorders, should be reviewed by an obstetric consultant/specialist* and, where appropriate, the maternal medicine specialist (or after discussion with the maternal medicine specialist before discharge), with a clear plan for the postnatal period. This review should include input from all relevant colleagues, including referral and discussion with the maternal medicine network where appropriate.	11
5.3.2	Maternity services should ensure targeted follow-up for women and birthing people with complex medical needs, verifying that expected recovery has occurred and any ongoing care needs are being met.	3,12,13
5.3.3	A senior obstetrician (ST6 level or above, or equivalent senior SAS doctor) should provide a comprehensive summary of the maternity care episode, including follow-up arrangements, to the primary care provider who should be responsible for coordinating care after discharge from the maternity service. This information should include information about illness prevention/health promotion.	11
5.3.4	Following a pregnancy, whatever the outcome, women and birthing people with complex medical disorders should be given appropriate advice regarding future pregnancy. This should include the potential risks and complications of future pregnancy, and how this can be modified by appropriate care planning including contraception and provision. This should be provided by practitioners with suitable experience in maternal medicine and the relevant medical specialty.	14
5.4	**Commissioners and service providers have a responsibility to ensure opportunities for services to learn from maternal deaths.**	
5.4.1	Investigations into maternal deaths where a woman or birthing person had a pre-existing medical issue at any stage during their pregnancy, or up to one year after pregnancy, should involve a	11,15,16

	summary of learning and action plans from After Action Reviews, Patient Safety Incident Investigations or other investigations undertaken as part of PSIRF, MBRRACE/PMRT.	
5.4.2	Along with referral to MBRRACE-UK and the Maternity and Newborn Safety Investigations (MNSI) programme, all maternal death investigations should involve the maternal medicine network, as co-existing medical condition/s will often be a contributing factor, typically undiagnosed before pregnancy.	[3]
5.5	**Maternity services should provide high-quality, collaborative and multidisciplinary care for women and birthing people with existing medical conditions who present with obstetric complications during intrapartum care.**	
5.5.1	Maternity services should involve pregnant women and birthing people who have existing medical conditions or obstetric complications in developing and reviewing their individualised intrapartum care plan.	[17,18]
5.5.2	Pregnant women birthing people with existing medical conditions should be cared for by a multidisciplinary team with expertise in managing the medical condition in pregnancy, led by a named healthcare professional.	
5.5.3	Pregnant women and birthing people with heart disease should have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.	
5.5.4	Pregnant women and birthing people in labour with suspected sepsis should have an immediate assessment by a senior clinical decision maker, and antibiotics given within 1 hour of recognition.	[19]
5.5.5	Pregnant women and birthing people who present in labour with no antenatal care should have an obstetric assessment and medical examination, as well as assessment of their medical, psychological and social history.	

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

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6. Inpatient care

	Statement and Standards	References
6.1	**Women and birthing people who are inpatients should experience coordinated care underpinned by clear and accurate information exchange between relevant health and social care professionals.**	
6.1.1	Service providers should ensure that a validated tool such as SBAR (Situation, Background, Assessment, Recommendation) is consistently used to support clear and safe communication between relevant healthcare staff.	1
6.1.2	Maternity services should ensure that the review of both antenatal, inpatient and maternity triage acuity are included in the consultant/specialist* led ward rounds twice daily (over 24 hours), seven days a week, in collaboration with the labour ward midwifery coordinator.	2–4
6.1.3	Staff providing maternity care should receive multidisciplinary training appropriate for their expected clinical and mandatory competencies, including cardiopulmonary resuscitation. Those trained and delivering high-dependency care should have their competencies regularly assessed to ensure skills are maintained.	5–7
6.1.4	Services should use the National Maternity-specific Early Warning Scoring system for all pregnant women and birthing people, from conception to four weeks postnatally, regardless of their reason for admission or care setting.	
6.1.5	Commissioners and service providers should establish clear local guidelines for referral to critical care (level 2 and 3) units.	8
6.1.6	High-dependency/enhanced maternal care should be available on or near the labour ward, with appropriately trained staff. here should be clear escalation protocols for recognition, referral and transfer to critical care.	8–10
6.1.7	Maternity services should ensure that review of women and people receiving enhanced maternal care (EMC) is included in the consultant/specialist* led ward rounds twice daily (over 24 hours),	8,11

	seven days a week, ideally in a multidisciplinary team including a senior midwife and obstetric anaesthetist.	
6.1.8	Commissioners and NHS providers should consider implementing an enhanced recovery pathway after caesarean birth.	12–17

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7. Planned birth

	Statement and Standards	References
7.1	**Commissioners and service providers should provide high-quality maternity care for planned birth before spontaneous onset/induction of labour, through informed decision-making, multidisciplinary planning and timely access to care that aims to improve the birth experience for all women and birthing people.**	
7.1.1	**Decisions made regarding induction of labour should be made in partnership with the woman.**	
7.1.1.1	Discussions and decisions regarding induction of labour should be made with a healthcare professional capable of an individualised approach, taking into account maternal and newborn risks, the clinical setting, the woman or birthing person's preferences and available alternatives to induction. Maternity services should ensure that all induced births are based on clinical indications, using agreed-upon local guidance protocols that align with national NICE guidance.	1–5
7.1.1.2	A personalised maternity care pathway must be developed collaboratively with the birthing person and the multidisciplinary healthcare team. This team-based approach ensures safe, holistic and responsive care.	6,7
7.1.1.3	Appropriate decision aids should be provided to women and birthing people who are offered induction of labour, clearly explaining what the procedure involves. Maternity services should offer women and birthing people individualised counselling using written, video or online resources with discussions clearly documented Fully informed consent should include the benefits and risks of induction including the risks of unsuccessful induction, alternatives to induction and reflect the woman or birthing person's individual preferences. Services must provide co-designed decision aids, developed and reviewed with service user groups to ensure clarity and relevance. Materials must:	3–5,8,9

	• cover benefits, risks, uncertainties, and alternatives (including no induction where appropriate). • be available in multiple languages and accessible formats that are sensitive to physical, psychological and cultural needs • include safety-netting ('when to call') and local contact routes.	
7.1.2	**Women and birthing people being offered induction of labour should be able to access urgent obstetric and neonatal care.**	
7.1.2.1	Service providers offering induction of labour should follow evidence-based national guidelines and provide guidance for women and birthing people being induced in particular circumstances, for example, previous caesarean birth. Methods of induction (e.g. balloon catheter, prostaglandins) should be documented and tailored to the clinical context. Maternity services must ensure that there is appropriate midwifery, obstetric and anaesthetist staffing to ensure safe delivery of care before proceeding with induction, and to escalate in the event of deterioration.	4,5,10
7.1.2.2	Services providing induction of labour should offer a full range of pain relief options for labour.	4,5
7.1.3	**The service should be continuously reviewed, including implementation of a maternity dashboard.**	
7.1.3.1	Services should monitor indications for induction of labour, to identify temporal trends or issues that may need to be addressed.	11
7.1.3.2	Information on the induction of labour should be captured through the maternity dashboard and include gestations, delays with induction of labour and outcomes by ethnicity and parity to facilitate monitoring of equity.	12
7.1.3.3	Where feasible, services should offer women and birthing people a choice of inpatient or outpatient induction of labour, supported by clear safety protocols and escalation pathways.	13,14
7.1.3.4	Services should ensure that learning from near misses and poor outcomes following induction of labour is recorded and reviewed in multidisciplinary team forums.	15,16
7.2	**Commissioners and service providers should provide high-quality maternity care for planned caesarean birth, through informed decision-making, multidisciplinary planning and timely access to care that aims to improve the birth experience for all women and birthing people.**	

7.2.1	**Service providers should facilitate pre-operative decision-making and assessment for all women and birthing people.**	
7.2.1.1	Service providers must ensure that every woman and birthing person has the opportunity to discuss options for birth and the pros and cons of different modes of birth, with an appropriately trained healthcare professional. This discussion should explore the birthing person's preferences, assess clinical risks and benefits, and consider alternative options that may include mental health support. Culturally sensitive decision aids including information in accessible formats should be made available.	17,18
7.2.1.2	Decisions for planned caesarean birth should be made or agreed upon by a senior obstetrician (consultant/specialist* doctor or ST6/above or advanced trainee or a senior SAS doctor) with relevant competencies.	
7.2.1.3	A point of contact in the hospital should be identified, and their contact details provided to women and birthing people having a planned caesarean birth, to address any queries or concerns about the procedure prior to the surgery.	
7.2.1.4	Women and birthing people booked for planned caesarean birth should have pre-anaesthetic assessment and counselling by suitably qualified healthcare professionals. Women or birthing people with significant medical or surgical comorbidities should be reviewed by a senior anaesthetist before their planned birth.	10,14,19–21
7.2.1.5	Service providers should discuss and offer the option of external cephalic version for women and birthing people with a persistent breech presentation from 36 weeks of gestation.	17,18,22,23
7.2.1.6	Pregnant women and birthing people having a planned caesarean who are at a higher risk of major obstetric haemorrhage, should have the surgery carried out in a maternity unit with on-site blood transfusion services.	17,18,24,25

	For women who decline blood products, service providers should have clear protocols in place that include an antenatal discussion of the implications and the use of intraoperative cell salvage.	
7.2.1.7	Maternity service providers should have a locally agreed protocol/guidance for management of morbidly adherent placenta, including antenatal diagnosis, access to appropriate and timely imaging, multidisciplinary planning and networked care with tertiary centre as required.	17,18,24,25
7.2.2	**Women and birthing people should have access to a safe, welcoming environment for planned caesarean birth that meets their medical needs.**	
7.2.2.1	Women and birthing people should usually be admitted on the day of their planned caesarean birth and supported in a welcoming environment, that provides space for accompanying relative(s) to wait with them, and privacy during pre-operative assessment and preparation for theatre.	
7.2.2.2	There should be an identified midwife to prepare the woman or birthing person for theatre and address any concerns..	
7.2.2.3	There should be an opportunity for both the anaesthetic and obstetric teams to meet the woman or birthing person in advance of completing the World Health Organization surgical safety checklist, to allow review of health records, the addressing of any concerns and to confirm fully informed consent..	
7.2.2.4	The operation theatre and equipment availability should conform to the guidelines set out by the Obstetric Anaesthetists' Association.	21
7.2.2.5	Service providers must ensure availability of intra operative cell salvage for women at high risk of major haemorrhage.	26
7.2.3	**Services should ensure availability of appropriately skilled staff and access to additional support when required for caesarean births.**	
7.2.3.1	Service providers must ensure that surgery for planned caesarean birth is performed by an appropriately trained obstetrician.	27
7.2.3.2	Services must ensure that immediate access to help and support from a senior obstetrician is available when planned caesarean birth is performed by an ST3 or below trainee/or early career specialty or LE (locally employed) doctor.	
7.2.3.3	Providers must ensure adequate medical, midwifery, anaesthetic and other relevant staff are available for planned caesarean births.	28

7.2.3.4	Scheduled obstetric anaesthetic activities (e.g. planned caesarean birth clinics) should have identified anaesthetic support.	21
7.2.3.5	There must be separate provision of staffing and resources to enable planned work to run independently of emergency work to prevent delays to both emergency and elective procedures, and timely provision of analgesia in labour.	21
7.2.3.6	An appropriately trained practitioner skilled in the resuscitation of the newborn should be present at any caesarean performed under general anaesthesia or where there is evidence of fetal compromise.	17,18,29
7.2.4	**Commissioners and service providers should provide all women and birthing people with high-quality, comprehensive post-operative care.**	
7.2.4.1	A local guideline should be in place, and adhered to, with respect to routine observations required following planned elective caesarean births.	17
7.2.4.2	High dependency care should be accessible for women and birthing people unexpectedly requiring more intensive care following caesarean birth, with transfer protocols in place if this necessitates movement to an alternative site or hospital.	17
7.2.4.3	Commissioners and service providers should promote and facilitate implementation of Enhanced recovery pathways for planned caesarean births.	
7.2.4.4	Women and birthing people who have had a caesarean birth, should have the opportunity to discuss the reasons for the caesarean with healthcare professionals, and receive verbal and written information on birth options for any future pregnancies. This information may also be provided at a later date, if preferred.	17
7.2.4.5	All women should have a risk assessment for venous thromboembolism performed with appropriate provision of low molecular weight heparin where needed, before discharge.	30
7.2.4.6	Women and birthing people should be offered contraception counselling antenatally and before discharge following a planned caesarean. Services should discuss and offer immediate postnatal contraception (e.g. intra-uterine contraceptive device insertion, injectables) if desired.	10,31–33
7.2.5	**Commissioners and service providers should continuously review the service to ensure they meet the needs of women and birthing people.**	

7.2.5.1	Commissioners should ensure provision of sufficient number of dedicated operating sessions for planned caesarean births, reflecting local population needs and that these sessions are appropriately staffed and resourced.	
7.2.5.2	Providers should continuously collect and analyse the data on planned caesarean rates, indications, the proportion performed before 39^{+0} weeks gestation, and the number of planned caesarean births delayed from the original planned date. Such information should be reviewed regularly, and trends noted and acted upon as necessary.	

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8. Intrapartum care

	Statement and Standards	References
8.1	**Maternity services should ensure that a choice of birth settings are available for women and birthing people, and that people in labour have the information and opportunity to participate fully in the decision-making process.**	
8.1.1	Commissioners and service providers should ensure that all birth settings (Home, Freestanding Midwifery Unit, Alongside Midwifery Unit and Obstetric Unit) are available and accessible to low-risk women and birthing people.	1,2
8.1.2	Maternity services should ensure that women and birthing people participate equally in all decision-making processes and can make informed choices about their care, taking into account assessment of personalised clinical risk. Women and birthing people should be informed in advance about the possibility of needing to transfer care during their pathway. They should be provided with information on their transfer time to the hospital obstetric unit when choosing an out-of-hospital birth. Such information should be jointly developed and agreed between maternity services and the local ambulance services.	1,3
8.1.3	Women and birthing people should have access to information in formats appropriate to their needs about different types of analgesia and anaesthesia available for pain relief in labour, including their benefits/risks.	4,5
8.1.4	Commissioners and service providers should ensure there is easy access to at least one fully equipped and appropriately staffed obstetric theatre in the labour ward at all times for women in labour. It is recognised that emergency activity may affect immediate access to such a theatre, but elective activity should be planned and organised to avoid compromising access for emergency use. Units should have a contingency plan if the maternity theatre is busy and there is another obstetric emergency requiring theatre at the same time.	4–6

8.1.5	Commissioners and service providers should ensure that estate facilities in all birth settings are of an appropriate standard and take into account the needs and views of women and birthing people.	7–9
8.1.6	Neonatal operational delivery networks, or equivalent, should define the levels of neonatal care that can be provided within each provider of maternity care, and ensure transfer and repatriation protocols are in place.	7,10,11
8.1.7	Maternity services should provide women and birthing people with information regarding the availability of neonatal and/or paediatric expertise available in various birth settings to help inform their decision-making regarding place of birth.	10
8.1.8	Commissioners and service providers should ensure that environmental temperatures and practices are optimised in all birthing facilities (e.g. operating theatres) to ensure normal temperatures of newborns.	
8.1.9	Maternity care providers should have policies for perinatal optimisation measures to ensure appropriate care of birthing people in preterm labour and their babies.	12–14
8.2	**Commissioners and service providers should have systems in place to ensure the safe and timely transfer of care between settings.**	
8.2.1	Commissioners and service providers should ensure that there are robust protocols in place for transfer of care between settings, including when crossing provider boundaries, if the nearest obstetric or neonatal unit is closed to admissions or the local midwifery unit is full.	1,15,16
8.2.2	Commissioners and service providers should establish local service-level agreements with the ambulance service for attendance at emergencies, or when transfer is required.	7,15,17
8.2.3	Service providers should have clear local guidance for peripartum transfer, including transfer to high-dependency or intensive care units, and provide safe and effective access to these units for all antenatal and postpartum women and people.	7,17
8.2.4	Commissioners and service providers should collect and monitor data on transfers and issues relating to service capacity and staffing, in particular delays of 24 hours or more in induction of labour or planned caesarean birth.	

8.3	**Maternity services should have a structure that ensures clinical leadership and accountability in birth settings.**	
8.3.1	Maternity services should have a maternity matron and labour ward manager/lead midwife in every maternity unit, who are responsible for resource management and ensuring service quality.	7
8.3.2	Maternity services should have a rota of experienced senior midwives as labour ward shift coordinators for each labour ward, supernumerary to the staffing numbers required for one-to-one care.	7,18,19
8.3.3	Each obstetric unit should identify a lead consultant obstetrician as the labour ward lead who along with the multidisciplinary team is responsible for the organisation, standard setting and audit/quality improvement activities. There should be formal recognition of this responsibility in their job plan.	7,20
8.3.4	Each obstetric unit should have a nominated lead consultant anaesthetist for obstetric anaesthesia services There should be formal recognition of this responsibility in their job plan.	5
8.3.5	Each unit should have clearly identified Professional Midwifery Advocates (PMAs)/equivalent role, with time allocated within their job plan to fulfil this role. Organisations should aim to achieve a PMA to midwife ratio of 1 in -20 or better.	5,21
8.4	**Commissioners and service providers should establish good clinical governance structures within the services providing intrapartum care.**	
8.4.1	Service providers should ensure that there is a nominated Obstetrics governance lead, working in collaboration with the clinical director/lead and midwifery, anaesthetic and neonatal teams, to provide effective oversight of risk management within maternity services. Adequate, protected time should be allocated within their job plan to enable them to fulfil this role.	1,2
8.4.2	A labour ward forum, or equivalent, should meet regularly (frequency guided by labour ward activity but at least every three months) and be chaired by the intrapartum leads for midwifery and obstetrics. There should be regular representation from neonatal/paediatric services, anaesthetics, theatre teams and service user representatives.	7
8.4.3	Comprehensive evidence-based guidelines, protocols and standards for intrapartum care based on national guidance should be agreed by the local labour ward forum or equivalent, ratified via locally/regionally agreed governance pathways and reviewed at least every three years.	7

8.4.4	Service providers should ensure that the standard of record-keeping meets local governance standards and storage of data is clear, rigorous and precise.	7,22–24
8.4.5	Service providers should ensure that all members of the maternity team utilise computerised documentation systems at a level appropriate to their role, which uses recognised and acceptable programmes. New starters should have formal induction with training on relevant computerised systems.	
8.4.6	Past guidelines and protocols should be dated and archived in case they are needed for reference at a later date.	7
8.4.7	There should be a board-level Non-Executive Director (NED) Maternity Safety Champion role, to provide independent oversight and challenge to maternity services.	19
8.5	**Maternity services should ensure a process of learning and improvement via audit and quality improvement projects to review intrapartum care provision and outcomes.**	
8.5.1	Maternity services should maintain a multidisciplinary maternity risk management group, to meet at least every month, with defined clinical leadership.	
8.5.2	Maternity services should have a written risk management policy, including trigger incidents for risk and adverse incident reporting	7,25,26
8.5.3	Service providers should ensure evidenced multi-professional input into reviews of adverse incidents, in keeping with PSIRF methodology.	7,27,28
8.5.4	There should be continuous audit of maternity service user feedback. This should incorporate Friends and Family Test results as well as quantitative and qualitative analysis of complaints, concerns and compliments.	29,30
8.5.5	All birth settings should audit birth outcomes including types of birth and any complications, as outlined in the maternity dashboard. This should be reviewed on at least a quarterly basis. Any changes or trends should be evaluated, with timely robust action plans instigated to address instances where adverse outcomes appear to be higher than expected..	
8.5.6	Maternity services should maintain a risk register and issue log at unit level, along with a clear process for escalation and the sharing of	

	lessons learnt. The risk register should be regularly reviewed by the risk management group on at least a quarterly basis.	
8.6	**Commissioners and services providers should ensure that the level, expertise and availability of staff are sufficient to provide high-quality intrapartum care for all women and birthing people.**	
8.6.1	Commissioners and service providers should calculate and implement midwifery staffing levels, according to the birth setting and case-mix categories, to provide the midwife-to-woman standard ratio in labour (1.0–1.4 WTE midwives per woman).	7,31,32
8.6.2	Maternity services should provide women and birthing people in established labour with one-to-one care from a midwife.	1
8.6.3	Outside the required hours of consultant/specialist* presence on labour ward, a consultant obstetrician should be available for emergency attendance within 30 minutes.	7,33,34
8.6.4	The anaesthetic and theatre team's response time should be such that an unplanned caesarean birth can be started within a time appropriate to the clinical condition and urgency.	7,35
8.6.5	Maternity services should ensure there must be a minimum of twice daily consultant/specialist*-led labour ward rounds in each 24-hour period. These must be timed to inform the management of the day-time activity and also the evening and overnight clinical planning and care. The ward round should be multidisciplinary and in collaboration with the labour ward midwifery coordinator. In addition, the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	3,7,33,36
8.6.6	Complicated births in obstetric units should be attended by a consultant obstetrician. Units should ensure compliance with the national guidelines in this respect..	1,33,37
8.6.7	Commissioners and service providers should ensure that resident doctors (obstetricians, anaesthetists and paediatricians) of appropriate competencies, as determined by the College curricula and the type of maternity unit, are immediately available on the labour ward.	4,10
8.6.8	Resident doctors' shift patterns should incorporate dedicated time for a formal verbal and written handover from one team to another.	7,38

8.6.9	Service providers should ensure that a duty anaesthetist, with trained anaesthetic support, is immediately available for emergency work on the delivery suite 24 hours a day, and that there is a clear line of communication for the duty anaesthetist and all maternity staff to the duty anaesthetist's supervisor and the on call consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of non-obstetric patients to attend immediately to obstetric patients.	5
8.6.10	Anaesthetic team staffing levels should ensure that the duty anaesthetist for labour ward is not primarily responsible for planned obstetric work or solely responsible for the intensive care unit or cardiac arrests. Any planned caesarean lists should have dedicated obstetric, anaesthesia, theatre and midwifery staff.	5,7,39
8.6.11	Commissioners and service providers should ensure that units providing neonatal care are appraised against and meet national (BAPM) staffing standards.	10
8.6.12	Service providers should ensure that a trained healthcare professional (midwife, neonatal nurse, advanced neonatal nurse practitioner , paediatrician) competent in neonatal basic life support is immediately available for all births, in any setting.	10
8.6.13	In a hospital setting, there must be immediate, on-site availability of healthcare professionals with advanced neonatal life support skills.	7
8.6.14	Service providers should ensure that obstetric units have 24-hour availability of a senior paediatric nurse or medical practitioner who is trained and assessed as competent in neonatal advanced life support, and able to attend within 10 minutes.	7
8.6.15	Service providers should ensure that obstetric units have 24-hour availability of a consultant paediatrician or neonatologist (or equivalent SAS grade) trained and assessed as competent in neonatal advanced life support and is able to attend within 30 minutes.	7
8.6.16	Commissioners and service providers should establish standardised operational policies for when more experienced paediatric support should be requested by resident doctors and nurse practitioners attending births.	7
8.6.17	Maternity services should ensure the availability of a suitably trained senior member of staff from either nursing, midwifery or operating	7

	departments, who has responsibility for the safe running of obstetric theatres, in collaboration with the delivery suite co-ordinator, 24 hours a day.	
8.6.18	Services should recognise that skilled anaesthetic assistance and post-anaesthetic recovery care are of particular importance for women and birthing people in labour. Recovery room (post-anaesthetic care) staff should be appropriately trained and updated in all relevant aspects of postoperative care for obstetric patients.	4,40–42
8.6.19	Commissioners and service providers should ensure that maternity care assistants have received accredited training for the appropriate competencies expected of them.	7,43
8.6.20	Maternity services should ensure that labour wards have appropriate administrative support, available for maternity services both in- and out-of-hours	7
8.7	**Maternity services should have clear communication across the multidisciplinary maternity team, to provide continuous high-quality intrapartum care.**	
8.7.1	Maternity services should ensure a clear line of communication from the duty obstetrician, coordinating midwife and duty anaesthetist to the supervising consultant at all times. Consultant support and on-call availability are essential 24 hours per day, 7 days a week.	5,7,33
8.7.2	Maternity services should ensure a clear line of communication between the midwifery team leader (usually the labour ward coordinator) and theatre team leader once a decision is made to undertake an emergency caesarean birth..	5
8.7.3	Service providers should have clear guidelines available for whom to call if two or more emergencies occur simultaneously.	
8.7.4	Maternity services should conduct regular review of inpatient service provision, through multidisciplinary meetings, to include appropriate representation from the labour ward, neonatal care, antenatal and postnatal inpatient care. These meetings should be scheduled at least once per quarter.	
8.7.5	Commissioners and services providers should have an identified standard operative procedure (SOP) for supporting Complex Obstetric surgery, both planned and emergency procedures. Services should ensure that clinicians with appropriate level of skill and experience for the required surgical procedure are identified to provide support. This may include obstetricians, gynaecologists and other surgical and interventional specialties (e.g. Radiology, anaesthesia, intensive care).	33

8.7.6	Maternity services should have a weekly multidisciplinary capacity meeting and daily tactical huddles to ensure the correct planning and provision of planned activity (caesarean birth/induction of labour)/daily team review of staffing and activity. These should not detract from or be considered a substitute for continuous review and situational awareness of activity and clinical safety.	36
8.8	**Commissioners and service providers should provide all staff with the training and time necessary to learn and maintain the knowledge and skills needed to provide high-quality intrapartum care.**	
8.8.1	Service providers should ensure provision of protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.	1,3,5,7,12,19
8.8.2	Commissioners and service providers should ensure annual training in monitoring of fetal and maternal wellbeing and cardiotocography/fetal heart rate interpretation for midwives and obstetricians providing intrapartum care.	44
8.8.3	Birthing services should ensure training and practice to mitigate risk of obstetric anal sphincter injury, pelvic floor dysfunction and bladder injury during childbirth, with clear information provision and support to the woman or birthing person.	19,45,46

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

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9. Postnatal care

	Statement and Standards	References
9.1	**Commissioners and service providers should focus on improving population health and access to high-quality care while reducing inequalities and enabling collaborative working between wider system partners to deliver joined-up postnatal care for women and their babies.**	
9.1.1	Service providers should provide data on postnatal systems, processes and outcomes through a robust postnatal dataset.	1–3
9.1.2	Service providers should ensure that a lead professional, normally the named midwife, is identified who will be responsible for reassessing individual needs and coordinating the postnatal care of all babies and women or birthing people, whether in the community or a clinical unit.	4
9.1.3	Commissioners should ensure that women and birthing people are offered an opportunity to talk about their birth experiences and ask questions about the care they received during labour. Service providers should offer a review of the woman or birthing person's psychological and emotional wellbeing using validated tools, physical health and social needs, conducted by the coordinating healthcare professional, at each postnatal contact and the end of the postnatal period (6–8 weeks).	5–8
9.1.4	Physical examination and screening of the newborn should be arranged according to national postnatal care guidelines.	5,9,10
9.1.5	Services should adopt the Newborn Early Warning Trigger and Track (NEWTT2) system, or an equivalent evidence-based early warning tool, to support the timely identification and management of neonatal deterioration.	11–13
9.1.6	Commissioners and service providers should establish systems that provide an individualised postnatal care plan that is reviewed and documented at each postnatal contact. This care plan should be developed with the woman or birthing person, ideally commenced in the antenatal period and completed as soon as possible after birth. Before transfer from maternity unit to community care, this postnatal care plan, including contact details if any concerns arise, must be clearly communicated.	5,14,15

9.1.7	Postnatal follow-up appointments should be arranged with the appropriate services before the women or birthing person is discharged from hospital. Services should have clear lines of escalation and communication between multidisciplinary teams if a woman or birthing person misses an appointment.	16
9.1.8	Maternity services should ensure that women or birthing people with complex medical problems who may require additional care following birth, have a senior clinical multidisciplinary review before discharge, with a clear plan developed for the postnatal period.	16
9.1.9	Where a woman or birthing person remains in hospital following birth, their postnatal care plan should be reviewed on a daily basis until their discharge and then reviewed at each subsequent contact.	
9.1.10	Postnatal care providers must develop and implement comprehensive local clinical guidelines, aligned with national standards, to ensure consistent, high-quality care. These guidelines must include specific provisions for women and birthing people whose babies require neonatal care, as well as those who are bereaved or separated from their baby.	4
9.1.11	A tailored plan to meet individual needs for those with raised BMI should be developed, incorporating recommended management options for overweight and obesity.	17
9.1.12	Healthcare professionals should communicate a plan for ongoing antihypertensive management to GPs of people who had hypertension in pregnancy when they are transferred to community care after the birth.	18,19
9.1.13	Maternity services should be commissioned to offer postpartum contraception to all women and birthing people. Maternity staff should receive appropriate training to support this service provision.	17,20
9.1.14	Postnatal readmissions should be reviewed by a senior obstetrician as soon as possible, and at latest within 14 hours of admission.	9,21–23
9.1.15	Service providers should set defined standards for accommodation on postnatal wards, to provide high quality care that meets patients' clinical needs, safeguards them from the risk of harm and ensures their privacy and dignity. Providers of neonatal and transitional care should ensure there is adequate accommodation provision for parents.	22–25

9.2	**Maternity services should ensure smooth transition between midwifery, obstetric and neonatal care, and ongoing care in the community from their community midwives, GP and health visitor.**	
9.2.1	Maternity services must ensure that women and people and families are involved in their care plans, experience smooth, safe and person-centred transitions between midwifery, obstetric, neonatal, general practice, health-visiting and community mental health (perinatal) services. Care should be coordinated through shared plans, effective communication and integrated records, reducing duplication and gaps.	1,2,4,26,27
9.2.2	When giving information about postnatal care, service providers must use clear language, in an accessible format and tailor the timing, content and delivery of information to the woman and birthing person's needs and preferences.	5,28
9.2.3	Where a woman and birthing person suffers a pregnancy or birth-related trauma, there should be a multi-professional de-brief and handover between labour and postnatal care, and the personalised care plan should be updated in discussion with them to ensure that their physical, psychological and emotional needs are met. Ensure documentation that captures all details of ongoing care plan is shared with relevant community professionals, including GPs.	4,6,29
9.2.4	Commissioners should support provision of postnatal clinics for those who have experienced complexities (e.g. medical or surgical problems, birth complications like OASI, massive obstetric haemorrhage, baby requiring admission to NICU, birth trauma), and such clinics should be supported by multidisciplinary professionals which may include obstetricians, midwives and other allied health specialists, e.g. pelvic floor physiotherapists.	30,31
9.3	**Service providers should ensure the safeguarding of women and birthing people during their birthing experience.**	
9.3.1	Women and birthing people should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour.	32–37
9.4	**Women and birthing people should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being, and to recognise and respond to problems.**	

9.4.1	Women and birthing person should be given personalised postnatal care plan for their ongoing care in written or digital format at the time of discharge from maternity services to community care.	33
9.4.2	At each postnatal contact, parents should be offered information and advice to enable them to: • Assess their baby's general condition. • Identify signs and symptoms of common health problems seen in babies. • Contact a healthcare professional or emergency service if required.	33
9.4.3	Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth, women and birthing people should be provided with information about: • the postnatal period and what to expect • the importance of pelvic floor exercises • what support is available (statutory and voluntary services).	33
9.4.4	Women and birthing people should be provided with contact details to readily access advice and reassurance. This should include signposting them to local groups and community support structures and information on the duration up to when maternity services can be contacted after the end of the pregnancy and the use of NHS emergency services after that.	33
9.4.5	Service providers should develop updated guidance for information sharing within maternity services and across health services and other agencies in the event of safeguarding concerns. Guidance should include the role of networked maternal medicine care and postnatal follow-up to meet individual needs, particularly for vulnerable women and birthing people with medical and mental health concerns and social complexity.	38–40
9.5	**Commissioners and service providers should ensure high-quality maternity care for all women and birthing people with/at risk of postnatal complications.**	
9.5.1	Maternity services should monitor and report postnatal readmission rates for women and birthing people and their babies.	41
9.5.2	All women and birthing people should be assessed immediately after giving birth by a suitably qualified member of the birth team (doctor	42

	or a midwife), and again before transfer to community care and/or within 24 hours of giving birth, by a midwife.	
9.5.3	Local maternity systems need to be organised to support the diverse multidisciplinary professionals to identify and respond to postnatal complications, which may include ongoing hypertension, thromboembolism, endometritis, mastitis, developing sepsis of mother/birthing person and baby and postnatal mental health concerns.	16,19,43,44
9.5.4	Services should ensure use of a validated pain scale to monitor perineal pain and refer early for assessment in specialist perineal clinic services where indicated.	5
9.5.5	Women and birthing people with potentially life-threatening conditions should be cared for by healthcare professionals with expertise in this area. They should be cared for by a multidisciplinary team including obstetrics, midwifery, anaesthetics and healthcare professionals with specific expertise, including intensivists if needed. Place of care should be decided based on the multidisciplinary team, but, if cared for outside of maternity, there should be regular input from the maternity team.	16
9.5.6	Targeted follow-up should take place for women and birthing people with complex medical needs, to ensure that the expected recovery has occurred and that the need for any ongoing care is being met. A single individual/team should take a leadership role, and the care should incorporate other specialists like obstetric physicians and the use of maternal medicine networks or similar.	16,45
9.5.7	Policy makers, strategic commissioners and service planners should ensure timely involvement of specialist services, and/or involvement of experts in other specialities for women and birthing people with multiple morbidities, on discharge from maternity care.	16
9.5.8	Policy makers, strategic commissioners and service planners should ensure that women or birthing people receiving inpatient care following a complicated birth, should be reviewed daily by the obstetric team until discharge.	
9.5.9	Women and birthing people should be provided with emergency contact details, including phone numbers and other ways of	5

	communication, enabling them to readily access maternity team review. This should include information on when to access services.	
9.5.10	Women and birthing people with postpartum complications should have ready access to critical care facilities if needed.	46–48
9.5.11	Service providers should ensure that women and birthing people who experience obstetric anal sphincter injury are followed up as per local and national guidelines.	49
9.5.12	Services should ensure that women and birthing people who have sustained perineal trauma and/or obstetric anal sphincter injury have access to appropriate and timely investigations and follow-up along with support. All women, in the antenatal period, should be given evidence-based information and advice about pelvic floor muscle exercises, ideally through a structured programme.	30,31,50
9.6	**All women and birthing people should receive comprehensive, non-judgemental advice and support regarding infant feeding**.	
9.6.1	All maternity and neonatal care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard. Services should support the woman or birthing person's informed decision with regards to infant feeding, considering that babies may be partially formula fed alongside breastfeeding or expressed breast milk.	5,51,52
9.6.2	All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to staff and parents. This should include support for, and meet the needs of, those who are considering or need to formula feed, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.	5,51
9.6.3	Each provider should identify a lead healthcare professional responsible for implementing the policy on planning and supporting babies' feeding and relationship building.	5
9.6.4	Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to parent's infant feeding choices in all non-maternity services.	5

9.6.5	Women and birthing people should be provided with readily accessible information (including helpline numbers) and support in their chosen method of feeding, including access to peer support groups and voluntary organisations.	5
9.6.6	Women and birthing people who are taking medicines should be able to receive specialist advice, based on best available evidence, in relation to breastfeeding. Support should be available for those who cannot or choose not to breastfeed. This may include an offer of lactation suppression for those who cannot breastfeed for medical reasons or in the event of death of a baby.	42,53,54
9.6.7	Infant feeding support should be made available regardless of the location of care.	5
9.6.8	Services must follow recommendations of NHS race and health observatory guidance for assessing a baby's condition after birth for Black, Asian, and minority ethnic newborns.	55,56
9.7	**Every mother and birthing person should receive continuing assessment and support throughout the postnatal period, to give them the best possible start with their new baby and for the change in their life and responsibilities.**	
9.7.1	Group-based parent-training programmes co-designed with parents to promote emotional attachment and improve parenting skills should be available to parents who wish to access them.	5,14
9.7.2	Healthcare providers should offer fathers and partners information and support in adjusting to their new role and responsibilities within the family unit.	5,57–59
9.7.3	At each postnatal contact, women and birthing people should be asked about their emotional wellbeing, family and social support and their usual coping strategies for dealing with day-to-day matters. Discussion should include symptoms and signs of postnatal physical, mental health and social concerns.	5
9.8	**Commissioners and service providers should ensure that staff are competent and skilled to deliver supportive postnatal care for all women and birthing people, including those who are vulnerable or those with physical/mental health needs.**	
9.8.1	Relevant healthcare professionals should have demonstrated competency and sufficient ongoing clinical experience in undertaking maternal and newborn physical examinations and recognising abnormalities.	5

9.8.2	All health professionals should be competent in recognising the risks, signs and symptoms of child abuse and who to contact for advice and management.	
9.8.3	All health professionals providing maternal and neonatal care should be competent in recognising the risks, signs and symptoms of domestic abuse and who to contact for advice and management.	35
9.8.4	All professionals involved in the care of women and birthing people immediately following childbirth should be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer for support according to their needs.	35
9.8.5	Commissioners and service providers responsible for the organisation of local postnatal services should recognise that postnatal care is deeply influenced by cultural beliefs and practices, varying significantly across different communities. Understanding these diverse perspectives is crucial for providing culturally sensitive and effective care to new mothers and parents. Service providers should support training in race equity and cultural competence.	60

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10. Fetal medicine

	Statement and Standards	References
10.1	**All women and pregnant people whose fetus (or fetuses) with a suspected or confirmed anomaly should have timely access to patient-focused, high-quality, evidence-based care.**	
10.1.1	After identifying a confirmed or suspected fetal anomaly, maternity services should provide women and pregnant people with immediate basic information from the sonographer, a specialist midwife or an obstetrician with appropriate competencies.	1,2
10.1.2	Maternity services should ensure that women and pregnant people with a suspected or confirmed fetal anomaly are seen by an obstetrician with a special interest in fetal medicine (ATSM, SITM or equivalent) or a fetal medicine (sub) specialist within 3–5 working days, depending on the anomaly and its severity.	3–5
10.1.3	Commissioners and service providers should establish clear referral pathways and develop local clinical guidelines to support the provision of safe, appropriate care These guidelines should balance the need for access to highly specialised fetal medicine services with the benefits of providing care close to home, where appropriate. They should also include provisions for remote monitoring, teleconsultation and the secure sharing of ultrasound images to support timely decision-making and continuity of care.	
10.1.4	Fetal medicine services should work in partnership with the referring/base multidisciplinary team to maintain effective communication of information and ensure optimum standards of care.	1,6
10.1.5	All cases of suspected fetal cardiac anomaly should be seen by a fetal cardiology specialist within 5 working days of referral by a fetal medicine (sub) specialist, and preferably within two working days if possible.	7
10.1.6	If the required expertise is not available through the provider network, or if the problem is too complex, then maternity services should ensure the woman or pregnant person receives a timely	6

	referral to a specialist/tertiary fetal medicine centre with the required skills and resources.	
10.1.7	Service providers should have clear referral pathways that include perinatal palliative care for women and pregnant people continuing a pregnancy affected by a known, life-limiting fetal anomaly and babies with life-limiting conditions. These services should include advanced antenatal care planning, birth care coordination, symptom management and bereavement support.	8–11
10.1.8	Fetal medicine services should provide women and pregnant people who have a diagnosed fetal anomaly with a named point of contact, such as a specialist midwife/healthcare professional, and a direct telephone number for ongoing support and queries. They should also be signposted to appropriate support organisations, such as Antenatal Results and Choices (ARC).	3,12
10.1.9	Fetal medicine services should ensure access to fetal magnetic resonance imaging (MRI) where clinically indicated, with interpretation by appropriately trained and experienced radiologists.	3,12
10.1.10	Commissioners and service providers should establish clear pathways for women and pregnant people with a prior affected pregnancy or a known/presumed genetic condition. Pathways should include timely referral to clinical genetics for pre-pregnancy counselling and discussion of available options followed by early pregnancy surveillance in fetal medicine centres.	3,4,12
10.1.11	Tertiary fetal medicine centres should have access to facilities for fetal MRI and genomic and virology testing. Maternity networks/fetal medicine services must maintain clear, documented referral pathways to ensure equitable access for all women and pregnant people regardless of booking site, including: • eligibility criteria and referral forms. • pre-test counselling and consent processes. • sample collection, packaging, and courier logistics. • named contacts and agreed turnaround times. • funding/commissioning arrangements; and • feedback of results to the referring team and the family, with safety-netting. To ensure equity and inclusion, networks should monitor referrals, successful sample submissions and time-to-result by site and key	13,14

	demographics, and implement actions where variation suggests inequity in access or outcomes.	
10.1.12	Fetal medicine services should provide postnatal follow-up to support the physical and emotional needs of women and pregnant people following complex pregnancy outcomes	
10.2	**Providers of fetal medicine services should be suitably qualified and have sufficient relevant clinical exposure to maintain and develop competencies.**	
10.2.1	Any person undertaking an ultrasound scan, for the purpose of screening and diagnosis of a fetal condition, should be suitably qualified and maintain competencies via regular professional development, audit and quality assurance participation.	3
10.2.2	Subspecialist consultants in maternal and fetal medicine (MFM) should have completed the RCOG-accredited subspecialty training, have a job plan containing at least two subspecialty service sessions per week and demonstrate ongoing professional development in this field, with regular attendance at network multidisciplinary and educational meetings	6,15
10.2.3	Consultants/specialists* with a special interest in fetal medicine should have completed the ATSM/SITM/equivalent training and should demonstrate ongoing professional development in this field, with regular attendance at network multidisciplinary and educational meetings. They should have at least one session each week dedicated to this special interest.	6,15
10.2.4	Fetal medicine units should conduct regular audits of congenital anomaly detection rates, timeliness of referrals and access to multidisciplinary specialist care. Participation in the National Congenital Anomaly and Rare Disease Registration Service (NCARDRS) and adherence to FASP national assurance processes is recommended.	6,16–18
10.2.5	Fetal medicine centres performing invasive procedures should monitor annual audits of the number of procedures and related outcomes.	6,19,20
10.2.6	Fetal medicine services must define the training, competencies and scope of practice for fetal medicine specialist midwives (FMSMs) and other multidisciplinary members. Information-giving and counselling about screening tests must comply with national screening programme standards and be delivered only by practitioners who meet programme-specific competency and update requirements	8,9,21,22

	(e.g. FASP training, supervision and audit). FMSMs may provide counselling where they hold the requisite competencies and work within agreed clinical governance; diagnostic consent remains the responsibility of the practitioner who is clinically accountable for the test/procedure.	
10.2.7	Each fetal medicine unit should employ a designated fetal medicine midwife, who will support the families through the provision of continuity of care and ensure timely follow-up.	6
10.3	**A fetal medicine service should be multidisciplinary and holistic in its approach to the care of women and pregnant people who have suspected or confirmed fetal anomalies, or a relevant history in a previous pregnancy.**	
10.3.1	Specialist fetal medicine centres should be staffed by at least two subspecialist consultants (i.e. those who have completed maternal and fetal medicine subspecialty training) who can provide prenatal diagnosis and fetal therapy services in collaboration (and co-located) with other specialist services and include specialist midwifery support.	6
10.3.2	Specialist fetal medicine services should work closely with neonatology, paediatric subspecialties (surgery, cardiology, neurology/neurosurgery, nephrologists/urologists, radiology), clinical genetics and molecular/cytogenetics. It is anticipated that most/all of these services will be co-located. Where an additional multidisciplinary service is required for the purpose of antenatal counselling related to a specific anomaly, and is not available within the network, this should be externally referred.	6
10.3.3	Fetal medicine services should ensure that care for women with suspected or confirmed fetal anomalies is provided by a multidisciplinary team, coordinated by a consultant obstetrician with a special interest in fetal medicine, or a subspecialist in maternal and fetal medicine. Regular team meetings should be in place to discuss all new referrals.	6
10.3.4	Smaller fetal medicine units (staffed by obstetricians with a special interest in fetal medicine) may provide elements of specialised care. These specialised services should be compliant with standards that have been discussed and agreed at a network level and should have a named consultant with expertise in fetal medicine.	6
10.3.5	Commissioners and service providers should ensure that fetal medicine services provide comprehensive counselling to support reproductive choices of women and birthing people. This includes	

	timely and equitable access to medical and surgical termination of pregnancy services and late feticide where legally required. Fetal medicine services should provide ongoing emotional and clinical support to women and pregnant people who choose to continue a pregnancy following the diagnosis of a congenital anomaly. Care should be coordinated by the multidisciplinary team, which should include a specialist midwife.	
10.3.6	Where fetal therapy is recommended in line with clinical guidance (e.g. fetoscopic laser ablation), women and pregnant people should be referred to an appropriately accredited level unit and reviewed within 48–72 hours.	20
10.3.7	Women and pregnant people with complex or higher-order multiple pregnancies (triplets or more) should have a tertiary-level fetal medicine consultant involved in their care.	23–25

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

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11. Perinatal loss

Care providers should be sensitive to the fact that some parents may prefer the term 'perinatal bereavement' instead of 'loss'.

This document primarily focuses on standards of care for pregnancy losses after the first trimester. Early pregnancy loss standards will be addressed in the updated gynaecology standards document.

	Statement and Standards	References
11.1	**Commissioners and service providers should work collaboratively with local and national organisations, following national guidance, to ensure systems are in place to minimise the risk of perinatal loss.**	
11.1.1	Maternity service providers should adopt strategies laid out in NHS England Saving Babies Lives- latest version or equivalent national standards/guidance.	[1]
11.1.2	The Local Maternity and Neonatal System, commissioners and Trusts/health boards should work collaboratively to ensure systems are in place for the care of women and pregnant people at high risk of preterm birth.	[2,3]
11.1.3	Universal (growth standard) estimated fetal weight charts should not be used without consideration of local population variation and adjusting thresholds to avoid under- or over-detection of small-for-gestational-age fetuses.	[1,4]
11.1.4	Commissioners and service providers should audit the quality and effectiveness of hospital-level perinatal morbidity/mortality reviews and ensure they are in line with current national guidance.	[5–9]
11.1.5	Following a standardised multidisciplinary review of all stillbirths, a local SMART (Specific, Measurable, Achievable, Relevant and Time-bound) action plan should be generated for any improvements required.	[8,10]
11.2	**Maternity services should provide the highest quality care and support to women and birthing people and their families when perinatal loss occurs.** **Care providers should remember that every contact is a chance to make things**	

	better, or worse, for the grieving family. Where possible, bereaved parents (with appropriate training and support) should be involved in the design, delivery and audit of bereavement services and pathways.	
11.2.1	Maternity services should provide compassionate, individualised and high-quality 24-hour bereavement care to all women, birthing people and families who suffer pregnancy loss. Services should ensure that there is a 'bereavement lead' in every healthcare setting where a pregnancy or baby loss may occur.	2,11–16
11.2.2	Service providers should ensure adequate numbers of trained staff are available to discuss postmortem consent, so that families can be counselled about postmortem within 48 hours of birth.	2,12,13
11.2.3	Service providers should develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcomes. A system should be in place to clearly signal to all relevant healthcare professionals and staff that parents have experienced a bereavement, to enable continuity of care and ensure that people are invited for their post-natal check in a sensitive way.	2,12,13
11.2.4	Service providers should ensure implementation of bereavement care pathways and services in line with the national bereavement care pathway.	2,12,13
11.2.5	Service providers should ensure that all healthcare staff who come into contact with bereaved parents/families are provided with, and have immediate access to, training, support and resources to deliver high-quality bereavement care for all types of perinatal loss, including multiple pregnancies or after termination of pregnancy for fetal anomaly.	2,12,13
11.2.6	Maternity services should investigate and manage all late intrauterine deaths and stillbirths in line with national guidance.	17,18
11.2.7	Women and birthing people experiencing perinatal loss should be reviewed by an experienced obstetrician and midwife to provide a parent-led, tailored bereavement care plan. The preferences of bereaved families should be sought, and bereaved parents should be empowered to make informed choices about their care and the care of their babies.	18

11.2.8	During labour, healthcare professionals should provide high-quality, compassionate care in privacy, with adequate analgesics. The baby must be handled with dignity and respect, and parents should be given the opportunity to make memories.	11,17,18
11.2.9	All maternity unit staff should have access to a specially trained bereavement midwife who is responsible for staff training and support, and for monitoring policies and procedures to ensure that bereaved parents receive high-quality care.	17
11.2.10	Culturally appropriate emotional, pastoral and psychological support should be available for all bereaved families. Bereaved parents should be informed about this support (e.g. the hospital chaplaincy team and/or the families' own religious community leaders) and referred for specialist mental health support when needed.	19,20
11.2.11	There should be at least one dedicated bereavement room or suite, away from celebrating families and the sounds of live babies, where a woman whose baby has died can labour and/or be cared for afterwards. Cold cots should be available.	17,21
11.2.12	Maternity services should provide support booklets/information for bereaved parents and guidelines for professionals on every maternity unit.	17,22
11.2.13	Continuing midwifery support, following discharge from hospital, should be offered and documented for all women and birthing people after a perinatal loss.	23
11.2.14	All parents should be offered a follow-up appointment, in an appropriate setting, with a senior obstetrician (consultant/specialist*), to discuss events leading to their perinatal loss, the actual or potential cause, the chance of recurrence and plans for any future pregnancy. Translation services and extra time for this should be made available if necessary for the appointment.	23
11.2.15	Women and birthing people who have experienced perinatal loss (including second trimester miscarriage) should be offered appropriately tailored care in subsequent pregnancies, in line with relevant national and RCOG guidance.	
11.2.16	Service providers should ensure that all staff dealing with perinatal loss are able to access support from suitably trained and	24

	experienced colleagues and occupational health/psychological support services if necessary.	
11.3	**Commissioners and service providers have a responsibility to investigate occurrences of perinatal loss, following national guidance and processes, and with the involvement of parents.**	
11.3.1	All maternity service providers should contribute to national audits and enquiries, including MBRRACE National Reports, the Perinatal Mortality Review Tool (PMRT) Annual Report and MNSI reports.	5–8
11.3.2	Service providers should implement a standardised approach to perinatal death review and investigation using the Perinatal Mortality Review Tool (PMRT).	6,8,23
11.3.3	Parents should be empowered to contribute to the PMRT, including any questions they would like answered included in the terms of reference. Parents should be kept fully informed of review findings, and any learning/changes resulting from the review should be shared with parents in a timely manner.	23,25
11.3.4	Service providers should ensure that maternity services adhere to the criteria for perinatal postmortem investigation of fetal and neonatal deaths as recommended in national guidance.	9,17
11.3.5	All parents should have the opportunity to discuss postmortem examination with a suitable trained healthcare professional. This should be done in a sensitive manner, with due consideration to cultural differences.	17,26
11.3.6	Service providers should ensure that a nationally recommended postmortem consent form is used.	17,26
11.3.7	Maternity services should refer all perinatal losses that meet the relevant criteria to the coroner.	27,28
11.4	**Maternity services should communicate with other services when perinatal loss occurs.**	
11.4.1	Maternity service providers should have written guidance documenting when and how perinatal loss is communicated to primary, local authority (health visiting) and other secondary care providers, with named contact details.	17,20
11.4.2	A summary of the follow-up appointment should be sent to the parents and, with their consent, to the birthing person's GP as soon as possible. This consent should be recorded in their notes.	20,23

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

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12. Interpreting services/cross-cultural communications

	Statement and Standards	References
	Commissioners and service providers should ensure all women and their birthing partners have access to interpreting services in their preferred language for every health service encounter to support their active involvement in care, facilitate understanding of choices and treatment options and enable informed decision-making and consent. AI shows promise in clinical translation, but the complexity of medical consultations requires a balanced approach combining AI and human translation services for quality care.	1–4
12.1	**Women and birthing people should expect that they are provided with access to confidential, respectful and unbiased interpretation services and education information in their chosen language, in a timely manner.**	
12.1.1	**Women's and birthing people's rights and expectations for interpreting services**	
12.1.1.1	Women and birthing people should be offered professional interpreting and translated information, free at the point of use, for all encounters where language barriers could affect safety, consent, understanding or experience.	1,4,5–7
12.1.1.2	Women and birthing people should be offered professional interpreting and translated information, free at the point of use, for all encounters where language barriers could affect safety, consent, understanding or experience.	1,4,5-7
12.1.1.3	Preferred language (including dialect and literacy needs) and interpreter requirements should be recorded at first contact and made visible across all services and settings.	1,2,4,5-7
12.1.1.4	Women and birthing people should be informed at first contact and booking of their right to a professional interpreter and how to request one, including for emergency attendances and community or virtual contacts.	1,2,4,7

12.1.1.5	Women and birthing people should be informed of how to provide feedback or raise concerns about interpreting, including in their own language	1,2,5,6
12.1.1.6	Routine use of family members, friends or children as interpreters is discouraged, except in extreme life threatening emergencies where no professional or approved digital option is immediately available.	1,4,5–7
12.1.1.7	When a woman or birthing person declines a formal interpreter and prefers family interpreting in non-emergency situations, staff should discuss risks of miscommunication, explore alternatives, and clearly document the decision and review plan.	1,4,5–7
12.1.1.8	Women and birthing people should be given clear information about any use and limitation of AI-enabled tools in interpreting and translation, and a straightforward route to request a human interpreter instead.	1,4,5–7
12.1.2	**Cultural sensitivity**	
12.1.2.1	Women and birthing people should be able to expect interpreters and staff to be culturally sensitive and respectful of their beliefs, practices and family structures.	7,8,9
12.1.2.2	Interpreting should support open discussion of sexual and reproductive health, FGM, trauma and mental health in a way that is non-judgemental and confidential.	8
12.1.2.3	In non-emergency settings, women's and birthing people's gender-specific interpreter requirements (e.g. female interpreter) should be respected and treated as a reasonable expectation.	8,9
12.1.2.4	In non-emergency settings, women's and birthing people's gender-specific interpreter requirements (e.g. female interpreter) should be respected and treated as a reasonable expectation.	
12.1.3	**Timely service**	
12.1.3.1	Women and birthing people should be able to expect interpreting services to be available promptly, minimising delays in assessment, decision-making and treatment.	4,10
12.1.3.2	Services should build in additional time for consultations where interpreting is required, for example by offering double-length appointments for complex or high-risk discussions.	4,10

12.1.3.3	Urgent and emergency maternity and neonatal services should have rapid access pathways (e.g. 24/7 telephone/video) to interpreters so that language barriers do not delay critical care.	4,10
12.2	**NHS Commissioners** **Commissioners should ensure that systems are in place for timely, culturally sensitive and unbiased translation and interpretation options for all women and birthing people. These options should be regularly monitored and audited to ensure that women and birthing people have continuous access to high-quality care, even in urgent situations.**	
12.2.1	**Availability and accessibility**	
12.2.1.1	Commissioners should ensure contracts provide 24/7 access to interpreting for maternity and neonatal services, with rapid response for urgent and emergency cases.	1,11,12
12.2.1.2	Service specifications should require gender preference options for interpreters in non-emergency contexts and set out how these preferences will be met.	1,11,12
12.2.1.3	Commissioning arrangements should include contingency provision for rare languages and dialects, including access to regional or national interpreter pools.	1,11,12
12.2.1.4	All commissioned providers should be required to record and share women and birthing people's preferred language of communication, dialect and interpreter requirements in clinical records, enabling continuity across services and sectors.	
12.2.2	**Training and certification**	
12.2.2.1	Commissioning specifications should refer to provider responsibilities for training and certification (as set out in NHS provider standards), including minimum interpreter qualification and registration requirements	
12.2.2.2	Commissioners should support the development and use of a Level 3–6 National Register of Community Interpreters, particularly for high-need maternity languages.	
12.2.3	**Service quality monitoring**	
12.2.3.1	All interpreting and translation contracts should include clear requirements for regular audit of interpreter use, timeliness, continuity and quality, including spot checks of both human and AI-assisted provision.	

12.2.3.2	Commissioners should require EPR-enabled recording and reporting of interpreter ID, language, modality and session data, enabling continuity monitoring.	
12.2.3.3	Commissioners should commission mechanisms for gathering and analysing feedback from both women and birthing people and providers disaggregating by ethnicity and language spoken where possible	
12.2.3.4	Commissioners should require providers to measure and report the impact of interpreting and translation on safety, health outcomes and satisfaction, using agreed KPIs.	
12.2.3.5	Contracts should include escalation processes for addressing quality, performance or safeguarding breaches relating to interpreting and translation.	
12.2.4	**Awareness and promotion**	
12.2.4.1	Commissioning arrangements should include requirements for ongoing public awareness activities that inform women and birthing people of their right to free professional interpreting and how to access it.	
12.2.5	**Governance and accountability**	
12.2.5.1	Commissioners should use NHS England's Improvement Framework for Community Language Translation and Interpreting Services as the baseline for commissioning governance.	
12.2.5.2	Contracts involving AI-enabled interpreting or translation should require compliance with NHS digital governance, data protection and continuous updating protocols.	
12.2.5.3	Commissioning bodies should ensure director-level leadership and board-level accountability for translation and interpreting services across their geographic area.	
12.2.6	**Safety and risk management**	
12.2.6.1	Commissioning specifications should require providers to have clear safeguarding and escalation protocols for situations where interpreters identify risk of harm.	13–15
12.2.6.2	Commissioners should ensure that providers have robust mechanisms for handling complaints, informal concerns and near-miss incidents involving interpreting or translation errors.	13–15

12.2.6.3	Providers should evidence that staff and interpreters receive training in safeguarding escalation and compliance with statutory referral duties.	13–15
12.2.6.4	Providers should be required to implement systems (e.g. SMS notifications) to confirm interpreter bookings to women and birthing people, especially for high-risk or complex appointments.	13–15
12.2.7	**Continuous improvement and co-production**	
12.2.7.1	Commissioning specifications should require providers to involve women and birthing people from diverse communities in the design, evaluation and improvement of interpreting and translation services.	16
12.2.7.2	Commissioners should fund regular focus groups or advisory panels with women, families and community representatives to inform culturally appropriate approaches and monitor impact.	16
12.2.7.3	Contracts should include mechanisms for annual review and joint learning between providers, commissioners and women and birthing people, with clear processes for updating service models and specifications.	16
12.3	**NHS providers** **Service providers should provide a range of timely, culturally sensitive and unbiased translation and interpretation options for all women and birthing people.**	
12.3.1	**Availability and accessibility**	
12.3.1.1	All women and birthing people should have their preferred language of communication (including dialect and literacy needs) documented at booking.	10,17,18
12.3.1.2	Where interpreters are required, this need – including any interpreter gender preference – should be clearly highlighted in documentation and electronic records for all subsequent visits.	10,17,18
12.3.1.3	Interpreter gender preference should be respected in non-emergency contexts; in emergencies, the priority is timely, lifesaving care while minimising distress.	10,17,18
12.3.1.4	Women and birthing people who decline use of a formal interpreter should have their reasons explored and be counselled on the risks, including potential negative and life-threatening consequences.	10,17,18
12.3.1.5	Interpreting services should be readily available 24/7, particularly for urgent and emergency situations.	10,17,18
12.3.1.6	Providers should offer a range of interpreting and translation options, including in-person, written, telephone and video; BSL and	10,17,18

	other non-spoken languages should be provided in parity with spoken languages.	
12.3.1.7	Women, birthing people and communities should be actively involved in co-producing and improving interpreting services.	10,17,18
12.3.1.8	Any use of AI tools for interpreting or translation should operate only within clearly defined Trust policy and risk assessment, supported by AI governance SOPs, human-in the-loop verification and documented use for each language.	10,17,18
12.3.1.9	Providers should explore employing interpreters directly for the main demographic languages, alongside commissioned services.	10,17,18
12.3.1.10	Routine use of bilingual staff as interpreters is discouraged and should be limited to emergency situations; where used, they should be trained in interpretation and familiar with clinical terminology, and hand back to professional interpreters as soon as practicable.	10,17,18
12.3.1.11	Women and birthing people should be informed of the risks of using non-professional interpreters (including family and friends).	10,17,18
12.3.2	**Training and certification**	
12.3.2.1	AI systems used for language support should be regularly updated and validated for accuracy and reliability in medical terminology for each language in which they are deployed.	
12.3.2.2	Centrally/NHS-employed interpreters should receive yearly safeguarding training (adult and child) and periodic revalidation in line with Trust policy.	
12.3.3	**Service quality monitoring**	
12.3.3.1	Providers should implement mechanisms to regularly monitor and evaluate the quality of both human and AI interpreting services, including spot checks and case reviews.	
12.3.3.2	EPR systems should record interpreter ID, language, modality and session data for all interpreted contacts.	
12.3.3.3	Feedback from women, birthing people and health professionals on interpreting services should be routinely collected and used to inform quality improvement.	
12.3.3.4	Use of interpreters and dissemination/use of translated educational tools should be regularly audited to confirm that all who need support are being offered appropriate interpreting and translation.	
12.3.3.5	Board-level accountability should be established (e.g. Chief Nurse and Quality Committee oversight), with interpreting-related risks and findings feeding into the Perinatal Quality and Safety Model and other escalation pathways.	

12.3.4	**Cultural competence and safety**	
12.3.4.1	Healthcare providers should be trained and supported in cultural competence, antiracism and trauma-informed care, so they can work effectively with interpreters and understand the cultural contexts of the women and birthing people they care for.	
12.3.4.2	Guidelines for culturally appropriate care in perinatal and women's health services should be developed, implemented and regularly reviewed.	17,19
12.3.4.3	Practical clinical guidance should be in place to support safe interpreted consultations, including offering double-length appointments; pre-briefing interpreters and checking name, dialect and gender; speaking directly to the woman or birthing person and maintaining eye contact; using short sentences and allowing clarification pauses; debriefing interpreters after complex or traumatic sessions; and recording interpreter details in the notes at every relevant contact.	17,19
12.3.4.4	Providers should monitor for vicarious trauma among interpreters and staff working frequently with interpreted, trauma-related content, and ensure access to appropriate wellbeing and psychological support.	17,19
12.3.5	**Awareness and promotion**	
12.3.5.1	The availability of free interpreting and translation services should be actively promoted to women and birthing people through multiple channels, including leaflets, posters and digital platforms in relevant languages.	4,20–22
12.3.5.2	All staff should be aware of how to access and use interpreting and translation services effectively, including any approved AI-powered tools and other digital communication technologies.	4,20–22
12.3.5.3	Providers should signpost staff to established best-practice resources on working with interpreters (e.g. British Psychological Society, Migrant and Refugee Health Partnership, ASLI, Sands & Tommy's JPU) and embed these within local guidance, training and induction programmes.	4,20–22
12.4	**Language service providers (LSPs)** **LSPs should exhibit high levels of professionalism and confidentiality and meet all information governance requirements for safeguarding personal data. They should ensure that all staff are able to meet these requirements.**	
12.4.1	**Professionalism and safeguarding**	
12.4.1.1	LSPs supplying interpreters to maternity, neonatal and gynaecology services should set and enforce high ethical	11,18,23–25

	standards, including confidentiality, impartiality, non-discrimination and professional boundaries.	
12.4.1.2	LSPs should ensure that all interpreters have access to NHS-equivalent mandatory safeguarding training (adult and child) free of charge, and that such training is completed and evidenced before any contact with women, birthing people or babies.	
12.4.1.3	Spoken language interpreters working in maternity and neonatal settings should hold at least a Level 3 Certificate in Community Interpreting (CCI) in healthcare or an equivalent healthcare-specific interpreting qualification; sign language interpreters should have British Sign Language Level 6 or an honours degree in their second language.	
12.4.1.4	LSPs should provide training in 'interpreting in UK healthcare', including maternity and neonatal care, to all interpreters working in these settings.	
12.4.2	**Information governance and confidentiality**	
12.4.2.1	LSPs should ensure that interpreters comply with NHS information governance requirements and maintain confidentiality in line with UK GDPR and NHS standards (NHS England, 2018).	[1]
12.4.2.2	LSPs should have clear information governance policies covering secure handling of personal data, restrictions on recording or sharing information, and use of approved systems only.	
12.4.2.3	Where LSPs provide or support digital or AI-enabled interpreting tools, they should comply with relevant NHS Digital clinical safety and data-protection standards, including DCB0129/DCB0160.	
12.4.2.4	LSPs should be able to evidence interpreter registration with recognised professional bodies (e.g. NRPSI, ITI, CIOL, NRCPD) where applicable, and to demonstrate that qualification and training standards specified by commissioners are met.	
12.4.3	**Responsibilities**	
12.4.3.1	LSPs should ensure that all interpreters deployed to maternity, neonatal and gynaecology work have at least a Level 3 CCI in healthcare interpreting (or equivalent) and are appropriately matched to clinical risk.	11,24,26
12.4.3.2	LSPs should operate ongoing quality-assurance programmes, including audits, structured feedback and performance monitoring, and act promptly on concerns.	11,24,26
12.4.3.3	LSPs should maintain systems to support continuity of interpreter for women and birthing people with complex or trauma-related needs, while respecting their right to request a change of interpreter at any time.	11,24,26

12.4.4	**Accessibility**	
12.4.4.1	Interpreting providers should be able to provide access to interpreters 24 hours a day, 7 days a week, for maternity, neonatal and gynaecology services.	5,6
12.4.4.2	LSPs should maintain sufficient capacity across telephone, video and face-to-face modalities to meet agreed response times, including for urgent and emergency contacts.	5,6
12.4.5	**Training and hiring**	
12.4.5.1	LSPs should operate robust recruitment and vetting processes, including verification of identity, right to work, enhanced DBS checks, qualifications, safeguarding training and references for all interpreters.	1,18,27,28
12.4.5.2	LSPs should maintain up-to-date rosters showing each interpreter's languages, dialects, qualification level, healthcare experience and any work restrictions.	1,18,27,28
12.4.5.3	LSPs should accept commissioner and provider audit of recruitment and vetting records and address any deficiencies through agreed action plans.	1,18,27,28
12.5	**Interpreters** **High ethical and accuracy standards, a duty of confidentiality and safeguarding responsibilities are mandatory, and this duty extends to interpreters.**	
12.5.1	**Registration and training**	
12.5.1.1	Interpreters should be registered with and regulated by the National Register of Public Service Interpreters (NRPSI) and/or be suitably qualified in at least Level 3 Certificate of Community Interpreting (CCI). The Chartered Institute of Linguists ciol.org.uk runs the Diploma in Public Service, which includes a specialism in health. Those who pass the exam are listed on the National Register of Public Service Interpreters (NRPSI). They make allowances for languages that they don't examine. See nrpsi.org.uk for more details	1,9,25,29–31
12.5.1.2	Where interpreters have not already had their security clearances checked by NRPSI, they should undergo appropriate checks and clearance in line with Disclosure and Barring Service (DBS) guidelines. Commissioners are encouraged to carry out a physical check of those documents with interpreting agencies if the interpreter has not already been vetted by NRPSI.	1,9,25,29–31
12.5.1.3	If not registered with NRPSI and not holding a Level 3 Certificate of Community Interpreting (CCI), then interpreters can be found in	1,9,25,29–31

	the membership of recognised professional institutes such as CIOL or ITI, but their public service interpreting experience should be checked and validated.	
12.5.1.4	As a minimum, spoken-language interpreters should: • Have completed mandatory safeguarding training for both children and adults, in line with NHS organisational standards, with evidence of regular refreshers. • Understand the Mental Capacity Act and be able to interpret accurately and neutrally in capacity assessments while maintaining boundaries – supporting the person to make their own decision rather than steering it. • Domain-specific knowledge is also essential. Interpreters should understand basic obstetric and neonatal concepts (e.g. induction, pre-eclampsia, fetal movements, caesarean section, FGM, stillbirth, neonatal intensive care), the structure of UK maternity services, and the legal framework around consent and safeguarding. Without adequate training, lay interpreters may use everyday expressions that distort meaning (for example, describing induction as 'forcing the baby out') with predictable impact on fear, refusal and mistrust.	1,9,25,29–31
12.5.2	**Confidentiality**	
12.5.2.1	Interpreters should maintain strict confidentiality about all information gained during assignments, sharing it only with the clinical team as necessary for care and safeguarding.	23,32
12.5.2.2	Interpreters should not disclose information to family members, community contacts or on social media, even if they believe 'everyone already knows'.	23,32
12.5.2.3	At the start of consultations, interpreters should explain to women and birthing people that anything said in their role as interpreter will be shared with the healthcare provider and clarify the limits of confidentiality.	23,32
12.5.3	**Impartiality**	
12.5.3.1	Interpreters should remain neutral and unbiased, interpreting accurately without adding, omitting or altering content according to personal beliefs or loyalties.	23,32–34
12.5.3.2	Interpreters should not provide personal opinions, advice or counselling about clinical decisions; they should encourage women and birthing people to direct questions to the healthcare professional.	23,32–34

12.5.3.3	If miscommunication is suspected, interpreters may briefly intervene to seek clarification, making their intervention explicit to both parties and then resuming neutral interpreting.	23,32–34
12.5.4	**Respect**	
12.5.4.1	Interpreters should treat all parties with respect, recognising the inherent dignity of women and birthing people, their families and healthcare providers.	32
12.5.4.2	Interpreters should use respectful language and avoid derogatory, stigmatising or mocking comments or behaviour.	
12.5.4.3	Interpreters should be sensitive to preferred forms of address and identity and adapt their language accordingly.	
12.5.5	**Cultural awareness**	
12.5.5.1	Interpreters should be aware of cultural nuances and avoid cultural biases, ensuring that these do not interfere with the interpreting process.	32,35
12.5.5.2	Interpreters may, when necessary, briefly explain cultural nuances or potential misunderstandings, clearly signalling when they are adding cultural context rather than interpreting verbatim.	32,35
12.5.5.3	Interpreters should alert the healthcare team if they believe a cultural barrier, misunderstanding or prejudice – including their own – poses a risk to the woman or birthing person.	32,35
12.5.5.4	Interpreters should not reinforce harmful cultural norms or minimise practices that breach human rights or UK law (e.g. FGM, domestic abuse).	
12.5.6	**Role boundaries and responsibilities and professional Development**	
12.5.6.1	Interpreters should maintain clear professional role boundaries, introducing themselves and explaining their role at the start of each assignment.	17,32
12.5.6.2	Interpreters should not provide personal opinions or counselling, accept inappropriate gifts or develop dual relationships that compromise impartiality.	17,32
12.5.6.3	All telephone and video interpreting should be conducted in a secure environment where conversations cannot be overheard or interrupted.	17,32
12.5.6.4	Interpreters should understand and fulfil safeguarding responsibilities, promptly escalating concerns about abuse, exploitation or risk of harm via agreed pathways.	17,32

12.5.6.5	Interpreters should engage in ongoing professional development related to maternity, neonatal care, mental health and safeguarding, and should have access to supervision or debriefing to manage the emotional impact of their work.	
12.6	**Innovation and digital integration** **Maternity services should make AI technology available in translation assistance for women and birthing people, and ensure innovation and digital integration of interpreting services.**	
12.6.1	All digital and AI solutions used for translation or interpreting support in maternity, neonatal and gynaecology services should be medically validated for accuracy before deployment in clinical settings.	
12.6.1.1	Digital and AI solutions should be subject to regular evaluation for clinical accuracy, equity of access and alignment with women's and birthing people's preferences.	
12.6.1.2	AI-powered tools may only be used in low-risk, non-clinical or administrative contexts (e.g. reminders, signposting, staff drafts), and never as substitutes for professional interpreters in high-risk clinical communication.	
12.6.1.3	AI and general machine translation should not be used for breaking bad news, discussing serious diagnoses, obtaining consent, conducting safeguarding or mental health assessments, or undertaking capacity assessments; professional interpreters are required in these contexts	
12.6.1.4	Women and birthing people should be clearly informed whenever digital or AI tools are used to communicate with them, and should always have the option to use a human interpreter.	
12.6.1.5	AI-powered tools should adhere to NHS standards on confidentiality and data usage and should not use people's data for secondary purposes (e.g. model training, marketing) without explicit consent.	
12.6.2	**Governance and data protection**	
12.6.2.1	All AI and digital tools used for language support should comply with local and national policies, UK GDPR, the Data Protection Act and NHS information governance requirements.	36–40
12.6.2.2	DPIAs should be completed and kept up to date for all AI and digital tools processing personal data, covering data location, DSPT compliance, encryption, retention, audit logs, opt-out mechanisms and secondary data use.	36–40

12.6.2.3	Vendors supplying AI and digital translation tools should demonstrate compliance or strong alignment with relevant international standards.	36–40
12.6.2.4	AI and digital tools should be regularly audited and monitored for security, functional performance and bias, with prompt remediation or withdrawal where risks are identified.	36–40

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Appendix 1: Search strategy for Maternity Service Standards

Sources

Catalogues/databases and individual websites of relevant organisations

Type/Name	URL	Notes
Databases		
King's Fund Library catalogue	https://koha.kingsfund.org.uk/	See below
Internal RCOG Library catalogues – Adlib		See below
Maternity and Infant Care Database		Royal College of Midwives search pack
Health organisations – general UK &I		
	NHS England	Filter for topic = Maternity; Nursing, midwifery and care
Web search		
equivalent documents from Scotland, Wales, Northern Ireland and Ireland where England only documents retrieved		

Strategies

King's Fund Library catalogue

Keyword search: 05/09/2025

((maternity service) OR (pregnancy) OR (childbirth) OR (maternal mortality) OR (antenatal care) OR (perinatal care) OR (post natal care) OR (pre conceptual care)), (date-of-publication:[2016 TO *])

Keyword search: 12/09/2025

((maternity services) NOT (maternity service)), (date-of-publication:[2016 TO *]) AND (suppress:false)

Keyword search: 13/09/2025

((female genital mutilation) OR (interpreting services) OR (maternity units) OR (midwifery services) OR (midwives) OR (neonatal care) OR (neonatal intensive care units) OR (neonatal mortality) OR (obstetricians) OR (perinatal mortality) OR (pre conceptual care) OR (premature babies) OR (stillbirth) OR (translation services)), (date-of-publication:[2016 TO *]) AND (suppress:false)

Keyword search: 25/09/2025

((domestic violence) OR (domestic abuse)), (date-of-publication:[2016 TO *]) AND (suppress:false)

informed consent, (date-of-publication:[2016 TO *]) AND (suppress:false)

consent, (date-of-publication:[2016 TO *]) AND (suppress:false)

safeguarding, (date-of-publication:[2016 TO *]) AND (suppress:false)

Internal RCOG Library catalogues – Adlib

15/09/2025 – Guidelines:

((((material_type = guidelines or keyword.contents = guidelines) and year_of_publication > 2015) and not keyword.contents = "RCOG publications") and not keyword.contents = coronavirus)

16/09/2025

((((((((((((((((((((((((((((((((keyword.contents = "maternity services" or keyword.contents = "maternity care") or keyword.contents = workforce) or keyword.contents = "maternal health services") or keyword.contents = "health personnel") or keyword.contents = "perinatal care") or keyword.contents = "antenatal care") or keyword.contents = "prenatal care") or keyword.contents = "midwifery") or keyword.contents = "midwives") or keyword.contents contains vulnerable) or keyword.contents contains ethnic) or keyword.contents contains inequalit) or keyword.contents contains disparit) or

keyword.contents contains complain) or keyword.contents contains enquir) or keyword.contents = "Circumcision, female") or keyword.contents contains pregnancy) or keyword.contents = childbirth) or keyword.contents = parturition) or keyword.contents = "postnatal care") or keyword.contents contains interpret) or keyword.contents contains translat) or title contains interpret) or title contains translat) or keyword.contents = "preconception care") or keyword.contents = "maternal mortality") or keyword.contents contains neonat) or keyword.contents contains perinat) or keyword.contents contains prematur) or keyword.contents = stillbirth) or keyword.contents = "fetal death") and year_of_publication >= 2016) and not keyword.contents = "RCOG publications") and not keyword.contents contains coronavirus) and search_year > 2015)

Keyword searches: 25/09/2025

- Domestic violence or violence
- Consent forms or informed consent
- Safeguarding in title

Appendix 2: Further reading

Public Health

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