Healthcare Improvement Scotland

Maternity care

Standards

March 2026

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socioeconomic status or any other status. Suggested aspects to consider and recommended practice throughout these standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing health and social care services will experience the intended benefits of these standards in a fair and equitable way. A copy of the EQIA is available on request.

Healthcare Improvement Scotland is committed to ensuring that our standards are up-to-date, fit for purpose and informed by high-quality evidence and best practice. We consistently assess the validity of our standards, working with partners across health and social care, the third sector and those with lived and living experience. We encourage you to contact the standards and indicators team at his.standardsandindicators@nhs.scot.

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Contents

Introduction

Women/birthing people and their babies should experience safe, effective and high-quality maternity and newborn care, wherever they live and whatever their circumstances. The terms **woman and women** are used within these standards to include women, girls, trans men, non-binary and intersex people, who are pregnant or have recently been pregnant.

Maternity care in Scotland is provided by NHS boards and delivered by healthcare professionals working within integrated multidisciplinary and interdisciplinary teams. For the purposes of these standards, the term **multidisciplinary** is used as an overarching descriptor for both multidisciplinary and interdisciplinary practice, reflecting collaborative, coordinated, and integrated professional working across health disciplines.

The Scottish Government is committed to ensuring high-quality maternity services that reflect current best evidence and practice, demonstrate dynamic learning systems and meet the needs of women, their babies and their wider families. This commitment is outlined in key policies, including The Best Start, the Women's health plan and the Population Health Framework. These policies outline the importance of maternity care as a significant public health intervention. Maternity services should provide the right care for every woman and her baby, offer continuity of carer and support every child to have the best start in life.

The Best Start emphasises the importance of offering women and their babies a family-centred, safe and compassionate approach to care that recognises their unique circumstances and preferences. To support a family-centred approach, fathers, co-parents, partners and other family members should be actively encouraged and supported to be involved, where appropriate. The term care partner is used within these standards to include anyone that the woman wishes to accompany her to appointments or be involved in any aspect of her care, including birth. The woman's care partner might be the biological father or parent of the baby, a co-parent, partner, family member or friend. In these standards, the term **baby** is used inclusively to refer to babies from both single and multiple pregnancies.

It is essential that women are informed about their choices and the support available to them and their babies before, during and after birth. Maternity care should be underpinned by evidence and best practice. Women should be at the heart of decision making, receive tailored information and experience high-quality communication. This will enable care to be provided in partnership and support women to achieve the best outcomes and future health for themselves and their babies.

Recent UK reports and audits have highlighted variation in the quality and consistency of maternity care.[1-4] Evidence indicates the need to improve health outcomes for women from underserved groups.[5, 6] Complications in pregnancy and mortality rates are higher for Black and Asian women and their babies.[7] Women from mixed heritage and gypsy traveller backgrounds also experience less positive maternity outcomes, often due to barriers in accessing antenatal care services.[7, 8] Missed or late appointments are both a consequence

and a driver of health inequalities, with women from socially disadvantaged and ethnic minority backgrounds disproportionately affected.[9, 10]

The Scottish Government commissioned Healthcare Improvement Scotland to develop standards to support a holistic approach to improving and sustaining quality maternity care across Scotland. The standards aim to ensure all women and their babies who access maternity services, receive consistent, person-centred, compassionate, high-quality care and support, regardless of their individual circumstance or needs.

Scope of the standards

The standards apply to:

- all women receiving maternity care in Scotland throughout their pregnancy and extending up to six weeks (42 days) after the birth of their baby
- all babies receiving newborn care, until their care is transferred to the universal health visiting or family nurse partnership service (usually at ten days old). To note, the standards do not include babies receiving specialist neonatal care
- care partners of women receiving maternity services, where appropriate.

The standards aim to support current and future provision of maternity services. They also promote improvement in the delivery and coordination of maternity care and support for all women and their babies.

The standards cover maternity care delivered in all settings, including midwifery units, community or home settings, hospitals, primary care and prisons.

These standards apply to all NHS Scotland staff involved in the multidisciplinary delivery of maternity services. In Scotland, midwives are usually the main coordinators and providers of maternity care, and all pregnant women are offered midwifery care when they first book for antenatal care. Women with complex care needs may be referred to an obstetrician (specialist doctor in maternity care or medicine) to lead their care.

The standards also apply to other healthcare staff within the integrated multidisciplinary maternity care team, including primary care and allied health professionals. The standards cover locum staff, contracted staff and those covered by reciprocal work arrangements, students and junior staff in training (including resident doctors).

The standards should be read as a collective rather than a linear document. For example, the criteria in Standards 6-11 should be provided in line with the principles set out in Standards 1-5.

Clinical governance standards

As part of a wider approach to improving healthcare across Scotland, Healthcare Improvement Scotland has worked collaboratively with stakeholders to develop clinical governance standards. The clinical governance standards apply to all clinical services planned, commissioned or delivered within the health and social care system in Scotland. They provide detailed criteria on:

- leadership and staffing
- quality management and continuous improvement
- clinical effectiveness
- clinical safety and risk management
- education and training
- service user and patient involvement
- data and information.

These maternity care standards should be implemented alongside the clinical governance standards.

Terminology

Wherever possible, we have used generic terminology that can be applied across all maternity care settings. All terminology is described in the glossary.

The term **national maternity pathway** refers to the Maternity pathway and schedule of care: clinical guidance and schedule.

The term **relevant guidance** refers to clinical guidance, pathways, protocols or standards, which should be read alongside these standards. Links to relevant guidance are included in Appendix 5.

Standards summary

Standard 1: Principles of care

NHS boards ensure all women and babies have equitable, high-quality, safe and compassionate maternity care which respects their rights, preferences and choices.

Standard 2: Reducing inequalities

NHS boards actively work to reduce health inequalities and improve outcomes for women and their babies.

Standard 3: Leadership and culture

Maternity services have effective leadership, robust clinical governance and a culture of openness and learning.

Standard 4: Service planning and facilities

NHS boards ensure services and facilities deliver safe, high-quality maternity care.

Standard 5: High-performing and functioning teams

Maternity care is delivered by high-performing and functioning multidisciplinary teams.

Standard 6: Antenatal care

NHS boards ensure timely, safe and effective antenatal care.

Standard 7: Intrapartum care

NHS boards ensure timely, safe and effective intrapartum care.

Standard 8: Postnatal and newborn care

NHS boards ensure timely, safe and effective postnatal and newborn care.

Standard 9: Unscheduled, emergency and critical care

NHS boards ensure women and babies receive unscheduled, emergency and critical care that is timely, safe and effective.

Standard 10: Mental health and wellbeing

NHS boards ensure women and their babies can access mental health and wellbeing support that is timely, equitable, consistent and trauma informed.

Standard 11: Loss and bereavement

Women who experience pregnancy or baby loss have compassionate, person-centred, trauma-informed care and support.

Standard 1: Principles of care

Standard statement

NHS boards ensure all women and babies have equitable, high-quality, safe and compassionate maternity care which respects their rights, preferences and choices.

Rationale

NHS boards should ensure that all women/birthing people have timely and equitable access to high-quality and safe maternity care. This is achieved through embedding a human rights approach and applying family-centred, person-centred and trauma-informed principles in line with national policy and guidance. Keeping women and their babies together is a core part of this care.

Maternity care should be responsive to each woman's individual needs. Women are empowered and trust is strengthened when care is relationship-based, respectful, kind and compassionate.[11] Positive experiences and maternity outcomes are associated with being listened to, fully informed and having choice and control over decisions about their maternity care. Parental choice for newborn care should be respected, however, the baby's clinical needs and best interests take precedence in line with Getting It Right for Every Child (GIRFEC) and United Nations Convention on the Rights of the Child.

NHS boards should ensure that all women have continuity of carer from a primary midwife.[12] Where obstetric care is required, women should have a named primary consultant obstetrician and a consistent obstetric team. Clinical care is covered in Standards 6-11.

Throughout maternity care, women should receive clear, evidence-based information and support aligned with the national maternity pathway. NHS boards should understand and respond to each woman's individual information and communication needs. NHS boards should ensure communication needs (including those related to disability, sensory loss and digital exclusion) are addressed. Access or signposting to appropriate translation, interpretation or advocacy services should be available in line with NHS Scotland policy.

Women should have regular opportunities to ask questions to plan and make informed decisions about their own care and that of their baby. Discussions should involve the woman's care partner, where appropriate. Women should be offered information and access to services that promote positive lifestyle changes during pregnancy to support their own health and the health of their baby.

Where care is declined or a second opinion is sought, the woman's choices should be respected and staff should be enabled to support her decision.[3] Consent and information sharing should follow national legislation and guidance. Where there are any safeguarding issues or other protection concerns, staff should follow child protection and adult protection

guidance. Integrated and personalised care plans should be co-designed with women, shared appropriately and regularly reviewed to reflect changing circumstances.

Meaningful engagement with women (and, where appropriate, their care partners) ensures maternity care is informed by lived experience, inclusive of diverse voices and responsive to changing population needs. This is achieved through a structured, evidence-based co-design approach that is continually evaluated to ensure services meet women's needs. The impact of inequalities, barriers and discrimination can be further reduced through effective planning, delivery of services in locality areas and targeted public health messaging and interventions. See Standard 2 on addressing inequalities in maternity care.

Criteria

1.1 NHS boards ensure women and their babies have timely and equitable access to safe and high-quality maternity care that is:

- rights based
- aligned with family-centred, person-centred and trauma-informed care principles
- informed by evidence-based practice.

This applies to all women and their babies wherever and whenever they receive maternity care.

1.2 Women have positive experiences of maternity care because they are:

- fully informed and listened to
- welcomed and feel safe
- recognised as experts in their own needs and preferences
- respected in the decisions they make about their own care and their baby's care
- supported to uphold their rights and the rights of their baby
- given meaningful opportunities to build trust with staff.

1.3 Women and their babies should not be separated unless there are evidence-based clinical, legal or safeguarding reasons that are fully discussed, documented and appropriately shared.

1.4 From birth, babies are recognised as individuals with their own legal rights and their wellbeing is central to all decisions about their care and treatment.

Women are supported to act in the baby's best interests, make decisions on their behalf and provide the nurturing environment needed for healthy development.

1.5 NHS boards ensure women have continuity of carer by providing access to:

- a primary midwife
- a consultant obstetrician or obstetric team, when required
- specialist support from appropriate professionals, when required.

1.6 Women are enabled to make informed decisions about their maternity care, including treatment and/or interventions, as they are supported to:

- understand the benefits and risks for any aspect of their care, including the option to decline care
- understand, and to provide, informed consent
- access data and reports of local maternity outcomes and services
- raise questions or concerns at a time and pace that is right for them
- discuss their care and options with appropriate healthcare professionals (including, but not limited to obstetric, midwifery and neonatal staff)
- understand their right to seek a second opinion or request an alternative staff member.

1.7 NHS boards ensure women have the information and support they need to make decisions about their own and their baby's care throughout the antenatal, intrapartum and postnatal periods. This includes:

- that helps them to develop the knowledge, skills and confidence to manage their own maternity care and wellbeing
- on who to contact for concerns, advice or appointments
- support to recognise and communicate any changes in their or their baby's health or circumstance to their maternity team
- access to services, technology and equipment to enable independence and support maternity care at home or in the community
- opportunities to have empathetic, informed discussions with appropriate staff to support decision making prior to referrals being made
- signposting to relevant local or national maternity services and support.

1.8 Women have timely access to tailored high-quality information, advice and support that is:

- accessible and responsive to their communication needs, including when additional support is required
- based on current practice and evidence and non commercial
- appropriate to the woman's stage of the maternity pathway.

1.9 For every woman, a single, integrated and co-designed maternity care plan is in place that:

- covers all care and support for the woman and her baby
- is regularly reviewed and updated
- documents any changes or delays in care
- reflects the woman's physical, psychological, social, cultural and spiritual needs and preferences
- includes relevant clinical information, such as medical history, assessments, ultrasound scans and test results
- records decisions, including where care is sought outside of guidance.

1.10 Women who seek care that is outside of guidance or evidence-based practice:

- have their decisions respected in line with principles of person-centred and informed choice
- are supported to access their preferred care
- have their experiences and outcomes monitored and reviewed to ensure that they continue to receive the best possible care.

1.11 NHS boards ensure that when women (and, where appropriate, their care partners) raise concerns, they:

- receive a timely response
- are listened to, taken seriously and treated with dignity and respect.

This includes when concerns are raised through use of bedside call buttons and when community midwifery or assessment services, or any other part of the service, are contacted by telephone.

1.12 Staff ensure women's decisions about their and their baby's care are documented and shared appropriately.

1.13 NHS boards ensure that women are supported to access relevant public health interventions, including referrals, where appropriate, to:

- address concerns relating to social and economic factors such as gender-based violence, income maximisation and housing (tenancy and homelessness)
- address addiction and reduce exposure to health-harming products (including tobacco, alcohol and other addictive substances) and health-harming behaviours
- support physical health and wellbeing, including healthy eating, maintaining a healthy weight and becoming more physically active
- support mental health and wellbeing (see Standard 10)
- support positive sexual health
- attend cervical screening
- understand long-term health implications of pregnancy and birth.

This support is available throughout the antenatal and postnatal periods.

1.14 NHS boards ensure women (and, where appropriate, their care partners) have opportunities to participate in the planning, design or evaluation of maternity care services. Engagement should be:

- proportionate
- inclusive
- meaningful
- responsive to the needs of different communities, including cultural, language and additional support needs
- informed by validated engagement approaches and frameworks
- appropriately and adequately supported.

1.15 Where appropriate, care partners:

- Receive, or are signposted to, tailored information and support
- can attend appointments and the birth
- are welcomed and recognised as an important part of the woman's support network.

What does the standard mean for women and their babies?

- Your care will be based on your, and your baby's, individual needs and circumstances.
- You will feel welcomed and safe, and your privacy and dignity will be respected at all times.
- You will be listened to, kept fully informed and taken seriously if you have questions or concerns.
- You and your baby will stay together as much as possible.
- You and your baby's rights to safe healthcare will be upheld.
- You will have a primary midwife who will support you throughout your maternity care. Your midwife will work with a team to make sure you get the care and support you need.
- If you need one, you will have a named obstetrician who is responsible for your care.
- You have the right to choose what is best for you and staff will respect your choices.
- You have the right to accept or decline the maternity care you are offered.
- You will be supported to act in your baby's best interests and to make decisions on their behalf.
- You will be asked for your consent before all examinations or interventions.
- Information will be given in a way that works for you — at the right time, in the right format, and in a language you understand.
- You can involve your chosen care partner as much as you wish.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace settings:

- are empathetic, respectful and compassionate
- provide continuity of maternity care that is safe, effective, evidence based, person centred and trauma informed
- support women in informed decision making and the self management of their care, and provide opportunities for discussion and questions
- support women to understand and uphold their rights and the rights of their baby
- share, or signpost women to, relevant tailored information and support.

What does the standard mean for the NHS board?

NHS boards:

- have systems and processes in place to provide equitable, high-quality and evidence-based maternity care in line with the national maternity pathway and related guidance
- demonstrate maternity care is underpinned by a human rights approach and support women to uphold their own, and their newborn's, rights
- deliver maternity care that is family-centred, person centred and trauma informed
- demonstrate compliance with information accessibility requirements, information governance, confidentiality and consent policies and legislation
- ensure women have continuity of carer, including a primary midwife
- demonstrate a public health approach to maternity care with referrals and pathways to appropriate interventions, when required
- have mechanisms to record and act upon feedback from women and, where appropriate, their care partners.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
1.1	Board-level statements and strategies that show a clear organisational commitment to rights-based maternity care.
1.2	Documented responses to feedback from women, including feedback from patient experience surveys, complaints and Care Opinion.
1.3	Audit of any decisions to separate women from their babies.
1.4	Use of tools and frameworks (for example, BRAN) to support women to make informed decisions about their baby's care.
1.5	Review of case records to evidence continuity of carer, including primary midwife.
1.6	Requests for second opinion or alternative staff member, with actions recorded.
1.7	Evidence of supporting women to identify and monitor their health and wellbeing needs.
1.8	Evidence of information provided in alternative formats and languages.
1.9	Evidence of co-designed service plans.
1.10	Evaluation of maternity outcomes for women seeking care that is outside of guidance.

1.11	Review of the timeliness of call handling and call-back processes in labour wards, community midwifery and maternity assessment services.
1.12	Documentation demonstrating supported decision making.
1.13	Audit of referrals to public health interventions and services, including tobacco dependency and smoking cessation services.
1.14	Tools to support women to participate meaningfully in shaping service design. For example, the Quality Framework for Community Engagement and Participation.
1.15	Policies and activities to support care partners to be involved in women's maternity care.

Standard 2: Reducing inequalities

Standard statement

NHS boards actively work to reduce health inequalities and improve outcomes for women and their babies.

Rationale

Evidence consistently demonstrates the impact of health inequalities on maternity outcomes, including the health of women/birthing people and their babies. These inequalities affect a woman's ability to access and receive equitable maternity care.[5, 7, 8, 13] The main factors that impact health inequalities in Scotland's maternity care include ethnicity and language, migration background, age and family status, mental health and socioeconomic status.[10, 14]

National strategies are in place to address health inequalities in healthcare including maternity services. This includes the Race Equality Immediate Priorities Plan, the Women's health plan and The Best Start framework. NHS boards should identify and implement actions to address inequalities and improve maternity outcomes in their local populations. This may include the use of impact assessments and the gathering, analysing and responding to feedback and data on experiences and outcomes from women, staff and services

Active listening, maintaining open communication and being responsive to the individual needs of women (including language, social and cultural needs) supports meaningful engagement with all underserved groups.[6] This approach helps build trust and supports women to uphold their rights (see Standard 1). Staff should be enabled to deliver responsive and culturally-appropriate services. Staff should also be equipped to recognise how factors such as cultural background and beliefs, socioeconomic status and neurodiversity may impact on people's engagement and experiences.[2, 3]

Women under the age of 18 years have rights protected under the United Nations Convention on the Rights of the Child. Young people should be supported by staff who have the skills and confidence to identify and respond to their individual maternity care needs. Staff should be trained to identify safeguarding concerns, such as exploitation and abuse, and take appropriate action including referral to relevant support or protection services. Continuity of carer enables a relationship-based and person-centred approach to maternity care.[15] The emphasis on participation, supported decision making and upholding rights is important for young people, particularly those made vulnerable by their circumstances, including care experienced young people.

Women affected by gender-based violence are at increased risk of harm during pregnancy, birth and the postnatal period. Trauma-informed and person-centred maternity care helps ensure safety, dignity and choice, while avoiding re-traumatisation. Integrating inequalities policies is essential because social and structural factors, such as poverty, ethnicity,

disability, gender identity, migration status and other protected characteristics can influence both exposure to gender-based violence and access to support. An inequalities-sensitive approach promotes equitable and culturally-responsive care. NHS boards should ensure staff can access specialist expertise and clear referral pathways for child and adult protection, sexual exploitation, and gender-based violence. This enables timely, appropriate intervention and coordinated support, improving outcomes for women and their babies.[2, 3]

Criteria

2.1 NHS boards address health inequalities and provide equitable access to maternity care for all women and their babies by:

- offering responsive and personalised information, support and care, including access to translation and interpreter services, when required
- addressing all forms of prejudice and discrimination, including systemic racism
- working in partnership with women with lived experience and with third-sector agencies and support services.

2.2 Women can be confident that their culture, beliefs and personal preferences will be respected by staff who are nonjudgemental and compassionate.

2.3 NHS boards have systems and processes in place to implement national frameworks, guidance and strategies to tackle prejudice and inequalities across the maternity care pathway.

2.4 NHS boards routinely undertake comprehensive population health needs and impact assessments and use the data to:

- understand their local populations and identify underserved groups
- understand the impact of intersectionality and health inequalities on women's and baby's experiences and outcomes
- improve access to maternity care for all
- inform maternity care service provision
- benchmark progress and improvements.

2.5 NHS boards use local population demographic data to take an evidence-based approach to reducing health inequalities in:

- clinical and health outcomes, including morbidity and mortality
- quality of care.

2.6 NHS boards ensure staff undertake appropriate education and training to deliver maternity care that:

- recognises differences in experiences and outcomes that may be influenced by factors such as cultural background and beliefs or socioeconomic status
- reduces the impact of health inequalities, intersectionality and protected characteristics on women's experiences and outcomes
- addresses and mitigates the risk of bias (including racial bias) or stereotyping in clinical practice and communication
- is respectful, nonjudgemental, compassionate, culturally sensitive and equitable.

2.7 NHS boards deliver maternity care for women under the age of 18 that upholds their rights and meets their individual needs by ensuring**:**

- staff have the skills and confidence to identify and respond to the specific rights and maternity care needs of young people
- appropriate referral pathways are in place for relevant support and services, including where safeguarding concerns are identified
- participation, supported decision making and the upholding of rights are central to care, particularly for young people who may be vulnerable due to their circumstances, including those who are care experienced.

2.8 NHS boards ensure that women who have experienced gender-based violence receive trauma-informed and person-centred maternity care. This includes ensuring staff can access specialist expertise and clear referral pathways for:

- child and adult protection and safeguarding
- sexual exploitation
- gender-based violence.

2.9 NHS boards deliver maternity care for LGBTQIA+ people that ensures they feel welcomed, safe and visible because they are:

- supported by staff who have appropriate knowledge and training in LGBTQIA+ inclusive maternity care and use appropriate and inclusive language
- asked for their preferred form of address, including pronouns
- asked how they wish their relevant personal information to be shared with the wider maternity care team
- are supported to involve their care partners.

What does the standard mean for women and their babies?

- You can be confident that your care will be fair, equitable and nondiscriminatory.
- You will be able to access the translation and interpreter support you need.
- Your personal circumstances, preferences, culture and beliefs will be respected at all times.
- If you have experienced gender-based violence, staff will help you to access the care and support you need.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- take a person-centred and trauma-informed approach to maternity care that facilitates informed decision making
- listen and actively engage with women to understand their needs and preferences
- put women's rights to non-discrimination at the centre of their work and support women to uphold their rights
- can access and uptake education and training to deliver responsive maternity care
- signpost to current information and support appropriate to individual needs.

What does the standard mean for the NHS board?

NHS boards:

- ensure staff undertake inequalities training and programmes
- ensure equitable access to high-quality, evidence-based maternity care for women in all circumstances and in all areas, including remote and rural communities
- understand, monitor and plan services to improve health outcomes in underserved populations
- identify local population groups who face barriers to accessing maternity care and take action to address these barriers
- ensure women can access translation and interpreter services, when required
- take an intersectional approach to reducing health inequalities and supporting women to uphold their rights
- ensure that young people and adults at risk of harm receive tailored advice and support, with appropriate referrals to specialist services when required.

Benchmarking and measuring performance	
Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
2.1	Development and implementation of anti-racism and anti-discrimination policies.
2.2	Feedback from women on being supported by non-judgemental and compassionate staff.
2.3	Strategies, policies and action plans to tackle health inequalities.
2.4	Audit of maternal and neonatal mortality, including MBRRACE-UK collaborative activities.
2.5	Improvement work focused on understanding local health inequality data and maternity outcomes, including feedback from women, staff and students.
2.6	Training plans to support staff to understand the impact of health inequalities and intersectionality on women's experiences and to improve the outcomes of all women.
2.7	Development of policies informed by UNCRC policies and Child Rights and Wellbeing Impact Assessments.
2.8	Referrals for specialist gender-based violence support.
2.9	Documented process for recording pronouns, preferred names and care partners in clinical systems.

Standard 3: Leadership and culture

Standard statement

Maternity services have effective leadership, robust clinical governance and a culture of openness and learning.

Rationale

Clinical and staff governance is an integral and essential part of the delivery of high-quality, safe and effective clinical services. NHS boards requirements are provided in the Blueprint for Good Governance and supported by Healthcare Improvement Scotland's clinical governance standards. NHS boards should ensure that maternity services are underpinned by reliable and effective organisational governance and leadership, including quality and clinical risk management processes.

Reports and inquiries into maternity care have emphasised the importance of robust clinical governance, effective leadership and an open and learning culture.[1, 3, 4] NHS boards should ensure a clear line of sight between staff and leaders, including senior managers.[3] Maternity services benefit from a triumvirate leadership structure that brings together medical and midwifery expertise, professional insights and managerial and/or operational skills. A nominated Board-level maternity services lead, such as a non-executive director, should provide essential leadership, oversight and assurance. Multidisciplinary teams should be supported by visible, accountable leaders who demonstrate openness, candour, good communication and accountability.

NHS boards should develop a culture of trust in maternity care by fostering compassionate, visible and inclusive leadership and ensuring robust systems for safety, continuous learning and effective communication.[16, 17] This involves supporting staff and genuinely listening to women and their families.[3, 18] When a women's experience is unexpected or results in unwanted outcomes, involving them in reviews and investigations helps ensure their voices are heard and leads to a better understanding of what happened. Clear, respectful communication, support to ask questions and opportunities to discuss care promote transparency, strengthen trust and contribute to continuous improvement in maternity services.

A whole-systems approach to quality and safety is required for maternity care services.[16] A structured risk management approach using national guidance will ensure that issues, adverse events or near misses are identified, assessed, managed and escalated appropriately.[19] Staff should be supported to be able to raise concerns in a confidential and psychologically safe way.[3] NHS boards should also ensure staff are aware of national whistleblowing processes and their organisational and professional Duty of Candour responsibilities.

An effective quality management infrastructure is essential for the delivery of high-quality care. It enables NHS boards to respond to changing healthcare needs through continual monitoring, planning, improvement and assurance. NHS boards benefit from sharing data, identifying 'bright spots' and planned improvement.[20] A learning system that brings together data and intelligence from different sources supports services and systems to understand performance, plan more effectively and share good practice.

Criteria

3.1 NHS boards enable a positive and open workplace culture by:

- creating conditions that empower staff to safely share their experiences and escalate concerns, including those relating to leadership and culture
- supporting effective teamwork
- tackling discrimination and prejudice and promoting an inclusive and respectful working environment
- acting promptly and effectively to identify and mitigate clinical and organisational risks and staffing concerns
- having visible and supportive leadership
- supporting staff to be role models for effective and compassionate leadership at all levels of their practice.

3.2 NHS boards ensure governance and oversight of maternity services, in line with national policy, guidance and standards, including Healthcare Improvement Scotland's clinical governance standards.

3.3 NHS boards have effective leadership and staffing governance arrangements for all maternity services that:

- include a clearly defined and accessible triumvirate leadership structure with designated relevant professional and managerial leads
- set out clear roles and responsibilities for the escalation and management of clinical risk
- enable line of sight from 'floor to board'
- support direct reporting to the multidisciplinary maternity leadership team and the Executive Board
- establish regular reporting and review cycles.

3.4 NHS boards have effective governance of:

- clinical safety and risk management
- quality management and continuous improvement
- clinical effectiveness
- engaging, listening and responding to feedback from women, care partners and staff.

3.5 NHS boards ensure staff have capacity to participate in, and contribute to:

- inquiries and reviews, including but not limited to adverse event reviews and maternal and infant death reviews
- internal and external quality assurance activities
- the implementation of national standards, pathways and clinical guidance
- benchmarking and reporting, for example key performance indicator data
- research and evaluation
- learning and improvement work.

3.6 NHS boards have processes for the management of adverse events, near misses, and complaints, which are aligned with local and national guidance and include:

- a standard and consistent approach to reporting
- clear accountability and responsibility for local response, investigation and review
- detailed actions and learning to reduce likelihood or impact of recurrence
- mechanisms to report progress against actions and improvement plans
- processes for sharing anonymised, thematic learning with multidisciplinary teams, governance structures and national learning processes, as appropriate
- mechanisms to provide timely supportive, constructive and blame-free feedback on the outcomes of reviews to the staff involved.

3.7 NHS boards ensure maternity services have processes in place to support staff to:

- celebrate success and share good practice
- talk openly about errors and raise concerns safely
- act in accordance with national whistleblowing and Duty of Candour requirements
- respond promptly and in line with professional guidance and national policy if they think patient safety is, or may be, seriously compromised.

3.8 NHS boards provide women (and, where appropriate, their care partners) with clear information on how to raise concerns relating to their care, including the complaints process. This information:

- is easy to access, understand and complete
- is accessible in a range of formats and languages
- includes signposting for further support, information and advocacy
- includes timelines and process for response and, where appropriate, action.

3.9 When a women's experience is unexpected or results in unwanted outcomes, women are:

- supported to understand clinical or technical information with explanations provided in plain, accessible and jargon-free language
- supported to ask questions, share their experiences and raise any concerns, with clear, compassionate communication and access to appropriate staff for support
- offered a meeting with relevant staff to discuss their experience, which may include review or investigation findings and any reports produced.

3.10 NHS boards implement an evidence-based whole-systems quality management approach for maternity services, which includes:

- identification of potential emerging safety issues that require urgent attention and action
- identification of priorities for improvement, learning and good practice
- collection and monitoring of feedback and data to inform planning and improvement
- participation in local and national improvement work, datasets, evaluation and research.

3.11 Maternity services use local and national data and intelligence, including staff and women's experiences of services, to:

- identify and learn from positive outcomes and 'bright spots'
- identify issues with quality and safety
- address gaps or inconsistencies in data collection
- develop intelligence-led improvement plans
- monitor the impact of improvement plans on quality or safety.

NHS boards have processes to demonstrate how they use this information to improve care.

3.12 NHS boards have systems and processes to ensure maternity services align with all relevant national standards, pathways and clinical guidance. This includes mechanisms for benchmarking and monitoring progress towards full implementation.

3.13 NHS boards ensure local care and referral pathways:

- clearly set out staff roles and responsibilities for each element of maternity care
- specify the standard documentation and communication required
- identify processes for the management, escalation and communication of risks and issues, where appropriate
- are regularly reviewed and approved through relevant local governance committees.

3.14 Where there is a post-mortem examination following a maternal or neonatal death, NHS boards provide oversight and assurance of:

- timelines, including actions to minimise delays
- feedback to staff and families.

3.15 NHS boards have a culture of openness and transparency and publish reports on data and intelligence from feedback, reviews, quality assurance activities, adverse events and complaints that:

- are easily accessible to women, staff and the public
- include improvement action plans
- demonstrate where learning has led to improvements in maternity care and services.

What does the standard mean for women and their babies?

- You will have high-quality maternity care and support.
- Your care and support will be based on current evidence and best practice.
- You can be confident that maternity services are safe, well organised, monitored and regularly reviewed to make sure they keep improving.
- You will be able to share your experiences, give positive feedback, raise concerns or make complaints, and these will be addressed in a timely and fair manner.
- If something in your care does not go as you had planned, or if you have an unwanted outcome, you will be supported to discuss this with staff and be involved according to your wishes.
- You will be supported to understand clinical or technical information with explanations provided in plain, accessible and jargon-free language.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting, are enabled to:

- experience effective and compassionate leadership and be recognised and supported as an individual
- be role models for effective and compassionate leadership at all levels of their practice
- deliver care in line with national, regional and local pathways, standards, protocols and guidance
- share what works well and be actively and meaningfully empowered to improve maternity care
- feel psychologically safe and empowered to share and escalate their concerns, including those relating to leadership and culture
- report and escalate concerns, feedback, complaints, adverse events to managers, leaders and the Board
- understand their role in improving quality across the whole system
- undertake and participate in internal and external quality assurance.

What does the standard mean for the NHS board?

NHS boards:

- promote a culture of openness, accountability and transparency
- have oversight and assurance of clinical, care and staff governance across maternity services

- have a clearly defined and accessible triumvirate leadership structure for maternity services with direct line of sight from floor to board
- have governance arrangements in place outlining roles, responsibilities and lines of accountability, including for the management of and timely response to adverse events, feedback and complaints
- ensure quality assurance and ongoing service improvement through routine collection, analysis and review of outcomes and other quality data
- ensure staff have capacity to undertake governance activities and take part in related activities, including adverse event reviews
- create and sustain a positive culture where all staff feel empowered and enabled to raise concerns safely
- enable staff to identify, share and celebrate what works well
- enable staff to deliver evidence-based care and support
- ensure staff who participate in reviews are appropriately supported and receive feedback and can access reports and action plans.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
3.1	iMatter results and action plans.
3.2	Action plans demonstrating implementation of national guidance and standards.
3.3	Triumvirate structure with designated midwifery and medical professional leads.
3.4	Evidence of use of the maternal and neonatal adverse event review process.
3.5	Evidence of staff participation in inquiries and reviews.
3.6	Review of data from perinatal mortality review tools and local significant adverse event review platforms.
3.7	Regular multidisciplinary huddles to review local data and prioritise improvement actions.
3.8	Complaints information provided in alternative formats and languages.
3.9	Evidence of women being supported to ask questions and raise concerns.
3.10	Evidence of participating in national Scottish Perinatal Network, Scottish Patient Safety Programme (SPSP), Essentials of Safe Care and other improvement forums.
3.11	Evidence of use of data dashboards, including progress against key indicators for quality reporting at board level.
3.12	Minutes from relevant governance meetings.

3.13	Local referral pathways with review and approval mechanisms.
3.14	Data on the timeliness of post-mortem examinations with action plans that outline improvement work.
3.15	Published reports on reviews and quality assurance activities.

Standard 4: Service planning and facilities

Standard statement

NHS boards ensure services and facilities deliver safe, high-quality maternity care.

Rationale

NHS boards should ensure maternity care is accessible and provided as close to home as possible. Where a woman/birthing person has to travel to receive maternity care, NHS boards should provide clear, accessible and fair policies for reimbursement of reasonable expenses in line with national guidance.

NHS boards should ensure robust systems and processes are in place to support the safe delivery of maternity care in all settings. This includes care delivered through midwifery-led and obstetric-led units, community midwifery services, multidisciplinary community hubs, and telemedicine. Arrangements should be in place to ensure seamless, coordinated care and to support the safe, timely transfer of women and their babies.[3, 21, 22]

All clinical and non-clinical environments should be designed to support trauma-informed care, uphold privacy and dignity and to meet the diverse physical, sensory and communication needs of all people using the service. Services should be configured to offer a range of birth options and environments (including home births), promote active labour and birth and enable maternal mobility. Non-clinical areas should be welcoming and, where possible, support family-centred care. Maternity care should be planned and delivered to ensure it is accessible, equitable and person centred. Services should be responsive to the different needs of women at all stages of pregnancy and throughout the postnatal period in line with the national maternity pathway and related guidance.

NHS boards should ensure timely access to a fully-equipped and appropriately staffed obstetric operating theatre located within, or immediately adjacent to, the labour ward. Robust contingency plans should be in place to manage situations where simultaneous obstetric emergencies require simultaneous theatre access.

NHS boards should ensure effective infection prevention and control (IPC), regular environmental monitoring and the provision of well-maintained facilities and equipment. Maternity staff providing care in the woman's home, including during home births, should continue to follow IPC national procedures and appropriate safety measures to protect women, babies and themselves. Staff should undertake and document appropriate risk assessments for women and their babies and take timely action, including escalation, when required.

NHS boards should have robust processes in place to support innovation and changes in maternity care practice. This includes the safe and appropriate adoption of new technologies for appointments and home monitoring, participation in local and national quality

improvement initiatives and engagement in research activities that contribute to service development.

NHS boards should take appropriate measures to promote environmental sustainability. This includes monitoring Entonox® use, reducing reliance on single use items and offering home monitoring and video or telephone appointments where clinically appropriate.

Criteria

4.1 NHS boards ensure women and their babies receive maternity care that is accessible, appropriate to their care needs and provided as close to home as possible.

4.2 Where women have to travel to receive their maternity care, NHS boards:

- have clear, accessible and fair policies for reimbursement of reasonable travel costs in line with national guidance
- have clear accommodation policies for women and their babies (and, where appropriate, their care partners)
- provide women with tailored information about what costs are covered
- collaborate with community partners to address transport barriers.

4.3 NHS boards have clear pathways to ensure safe and timely transfer of women and their babies between different care settings and/or providers. These pathways cover:

- transfer between providers, including the Scottish Ambulance Service
- care delivered out with the board of residence, such as arrangements for island boards or access to regional specialist centres
- transfer between facilities and services, for example, midwifery to health visiting
- access to high-dependency and critical care, ensuring women and their babies can be escalated promptly, when required.

These pathways ensure equitable care for women and their babies.

4.4 When care is transferred or shared between teams, services or providers, NHS boards ensure safe and effective care ensuring all communication and care plans:

- are accurate and shared contemporaneously
- are robust and effective
- are clear and easily accessible to all care providers and to the woman
- clearly set out how and where care can be accessed in urgent or emergency situations.

4.5 NHS boards can demonstrate that reciprocal arrangements and processes are in place to ensure seamless and coordinated care of women and their babies.

4.6 NHS boards ensure that facilities for maternity care, including those used for examinations, screening and assessments, are designed to:

- maximise privacy, dignity and safety
- reflect the needs of their local population and be culturally-appropriate
- provide person-centred and trauma-informed care
- support women with additional or complex needs, including those with physical, visual or hearing impairments/needs
- provide a supportive, calming and therapeutic environment for birthing women, including features such as adjustable lighting, comfort items and music
- promote a range of birthing options and facilitate maternal mobility during labour
- enable family-centred maternity care
- provide separate accommodation for women who have experienced pregnancy or baby loss.

4.7 NHS boards have systems and processes in place to ensure appointments are equitable and person centred. This includes:

- providing in-person, remote (telephone or online) or digital (such as NHS Near Me) appointments, where appropriate or requested
- coordinated appointments to reduce unnecessary travel and improve continuity
- offering extended appointments to women with additional requirements, including people with communication needs, learning disabilities and complex social needs
- providing additional support during appointments, including the option for a care partner to attend
- using digital technologies to support remote patient monitoring when clinically appropriate.

Where care is delivered remotely or using digital tools, the principles of providing an inclusive, safe and trauma-informed environment still apply.

4.8 NHS boards monitor and review missed antenatal and postnatal visits or appointments to:

- understand the impact of health inequalities on attendance and access to services
- identify gaps, issues or trends
- develop improvement or action plans
- identify women who may require proactive follow-up and support to re-engage with maternity services.

4.9 NHS boards ensure timely access to a fully-equipped and staffed obstetric operating theatre located within, or adjacent to, the labour ward. Robust contingency plans are in place to manage situations where simultaneous obstetric emergencies require simultaneous theatre access.

4.10 NHS boards have effective cooperation agreements and collaborative working arrangements with other NHS providers and partners, including third sector organisations, to support the planning and delivery of services.

4.11 NHS boards ensure that all facilities, equipment and peripherals used in the delivery of maternity care are well maintained and comply with national or regulatory equipment specification and infection prevention control requirements.

4.12 NHS boards develop and implement policies to minimise the environmental impact of delivering maternity care in line with national sustainability policy and guidance.

What does the standard mean for women and their babies?
• Your maternity care will be as accessible and as close to your home as possible. • You will be offered appointments that meet your needs. • If you would like someone to attend the appointment with you or if you need additional support, staff will support you to arrange this. • If you have to travel to access services, you will be able to claim reasonable expenses. • If you need overnight accommodation, this will be discussed with you. • Maternity services will be welcoming, respectful and supportive. • If you need to receive any of your maternity care from another NHS board, this will be coordinated for you and your care plan will be followed. • If you have your baby in hospital, the birth environment (labour ward or maternity unit) will include specially designed spaces that will help you to feel comfortable and relaxed, including birthing pools, where available. You will be able to have your own music. • NHS facilities will be safe, clean and well maintained.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting, are enabled to: • offer pathways of care to support transition and transfer of care • promote active birth and mobility • provide care in a relaxed and welcoming environment. • offer appointments that are responsive to the needs of women • access facilities and provide equipment that is suitable, high quality and well maintained • implement practices that reduce the environmental impact of Entonox® and other medical supplies.

What does the standard mean for the NHS board?

NHS boards:

- deliver maternity care that is accessible and as close to home as possible
- have clear and accessible policies for reimbursement of travel or other expenses in line with national guidance
- work with other NHS providers and partners to ensure equitable and accessible access to maternity care
- minimise unnecessary delays in care when a woman has to travel or be transferred between care settings or providers
- ensure staff are supported to be responsive to women's additional care needs, for example offering flexible appointment times to accommodate translation and interpreter services
- review missed appointments and support the re-engagement of women with services
- provide high-quality equipment and healthcare facilities that are decontaminated in line with national protocols and subject to regular environmental monitoring
- have planned maintenance and replacement schedules, with mechanisms for routine checks and testing of equipment
- promote environmental sustainability.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
4.1	Evidence of supporting people in local, home or community-based services.
4.2	Reasonable travel and expense policies that align with national guidance.
4.3	Pathways, guidance and protocols outlining transfer of care between healthcare settings, facilities and providers, including Scottish Ambulance Service.
4.4	Robust communication plans and handovers that are shared contemporaneously.
4.5	Documentation such as service-level agreements describing reciprocal maternity care arrangements.
4.6	Provision of facilities that enable person-centred and trauma-informed care including active births and mobility.
4.7	Use of text reminders for appointments, online consultations and other technology to widen access to services.

4.8	Evidence of collection and review of data on missed visits and appointments with action plans.
4.9	Contingency plans for emergency access to obstetric operating theatres.
4.10	Formal cooperation agreements, memorandum of understanding or service-level agreements with neighbouring NHS boards, Integration Joint Boards, local authorities and third sector partners.
4.11	Environmental monitoring documentation to demonstrate compliance with decontamination protocols and the National IPC manual.
4.12	Regular audits and improvement plans for environmental sustainability, including use of Entonox® and single use disposables.

Standard 5: High-performing and functioning teams

Standard statement

Maternity care is delivered by high-performing and functioning multidisciplinary teams.

Rationale

Maternity care should be delivered by highly-trained staff working within a multidisciplinary team.[3] NHS boards have responsibilities under The Health and Care (Staffing) (Scotland) Act 2019 and associated statutory guidance to ensure appropriate staffing levels, skill mix, effective workforce planning and clear lines of accountability.

NHS boards are legally required to ensure that all clinical staff, including maternity staff, maintain their relevant professional registration. Staff must uphold the professional standards expected by their regulatory body and NHS Scotland.

Staff should work collaboratively across organisational and professional boundaries.[1, 3] NHS boards should ensure staff are clear about their roles and responsibilities and are enabled to work within their skills, competencies and scope of practice. This supports effective multidisciplinary team working and facilitates collaboration.

Staff should be enabled to participate in relevant national programmes of work, including the Scottish Patient Safety Programme and national networks. They should also have opportunities to engage in research and evaluation, contribute to the development of evidence-based tools and guidance (including national work such as guidance development groups) and share learning across services. Staff should also be supported to practice innovation in their teams and maternity services and to engage in improvement approaches and tests of change that promote safe, effective and person-centred care.

Core mandatory training is essential to ensure staff maintain the skills required for safe and effective practice. Scottish Government and Healthcare Improvement Scotland emphasise the importance of core training in fetal heart monitoring and the management of obstetric emergencies, enabling staff to recognise deterioration and respond promptly to complications. NHS boards should have robust systems to deliver this training and monitor uptake and completion. Where gaps or risks are identified, NHS boards should develop and implement targeted improvement plans.

Training and support should be provided to enable effective communication within and between teams, including at care transfer points and during handovers. Effective communication underpins safe multidisciplinary team working and helps ensure that any

concerns relating to the delivery of maternity care are escalated promptly and appropriately.[1] Multidisciplinary training supports a shared understanding of staff roles and responsibilities, enhancing team dynamics, communication and culture. Local, regional and national training can provide opportunities for shared learning, innovation and effective practice. This should include training that enables staff to understand and respond to the factors that matter to women during their maternity care.

NHS boards should ensure that staff have protected time and appropriate resources to attend both mandatory and role-specific training.

NHS boards should ensure a healthy and supportive working environment to optimise the wellbeing and performance of all staff.[23] This includes having policies and procedures in place to identify and minimise vicarious trauma. The provision of clinical supervision and restorative supervision are essential components of training, professional development and emotional wellbeing. Opportunities for mentoring, peer support and multidisciplinary learning and development should be available to all staff.

Maternity staff should have time for learning and reflection, support for innovation, access to restorative breaks and mechanisms to provide feedback to their senior leaders in a psychologically safe way.[3] Effective and visible clinical leadership is critical in supporting staff and fostering a positive culture (see Standard 3).

NHS boards that offer clinical placements to students should ensure these placements support the development of the knowledge, skills and experience required to deliver safe, effective and high-quality maternity care. Where possible, placements should provide opportunities for students to observe a range of women's experiences of physiological labour and birth.[3]

Criteria

5.1 NHS boards have multidisciplinary workforce plans to support the delivery of safe and high-quality maternity care. These plans should:

- detail the appropriate skill mix and numbers of suitably qualified and competent staff
- address recruitment, retention and succession planning
- clearly define roles and responsibilities across teams
- reflect service delivery models, for example, partnership working with island boards or regional centres
- implement the Health and Care (Staffing) (Scotland) Act 2019.

5.2 NHS boards have oversight and assurance of staffing and workforce data, including:

- staffing levels, including predicted and actual absence levels

- skill mix
- staff recruitment activity
- staff training and continued professional development (CPD)
- professional registration and revalidation
- access to, and uptake of, clinical supervision.

5.3 NHS boards review staffing and workforce data to:

- identify trends and gaps
- understand the impact of workforce gaps, skill mix and staff shortages on the safety and quality of care
- develop improvement plans.

5.4 NHS boards enable staff wellbeing by ensuring staff (and students, where appropriate) at all levels:

- feel able to raise concerns and escalate staffing risks in ways that support their wellbeing and psychological safety (see Standard 3)
- have time for learning and reflection
- can access restorative breaks
- can access both clinical and restorative supervision
- can access psychological support, if required.

5.5 NHS boards ensure all clinical staff delivering maternity care are:

- appropriately registered with their professional regulator or body
- supported to meet revalidation requirements, including collecting and submitting evidence.

5.6 NHS boards ensure effective multidisciplinary working across all maternity services through:

- good communication and collaboration within, and between, teams
- joined-up decision making
- accurate documentation and effective information transfer
- identification of, and support from, relevant clinical professional leads
- values-based, person-centred and trauma-informed leadership at all levels
- multidisciplinary education and training, where appropriate
- regular education and simulation training focused on local safety priorities.

5.7 NHS boards ensure that maternity staff work within defined clinical and professional competencies and:

- understand their (and their colleagues') roles and responsibilities in delivering safe and high-quality maternity care
- respect the professional competencies, contributions and decisions of all members of the multidisciplinary team
- recognise when to seek specialist advice, second opinion or further clarification where needed.

5.8 NHS boards ensure that training and education plans cover:

- competencies and proficiencies for all maternity staff, including specialist roles and students
- core mandatory training, in line with local and national guidance
- identifying, addressing and reducing health inequalities
- person-centred and trauma-informed practice
- effective team working and communication, including handovers
- CPD
- improvement methodology
- opportunities to support the development of standards, pathways and guidance
- evaluation and research activities.

5.9 NHS boards provide time and resources for staff to access and attend CPD and multidisciplinary training and education. Training and education resources are:

- quality assured and accredited, where appropriate
- underpinned by local or national professional standards, frameworks and guidance
- informed by systematic reviews of learning needs
- evidence based and informed by good practice
- delivered across a range of training mediums, including online learning
- appropriate to staff roles, responsibilities and workplace setting
- informed by feedback and the lived experiences of women.

5.10 NHS boards ensure that women are supported by skilled and competent staff, who are enabled to:

- be compassionate and take time to understand and respect each woman's experience, wishes and personal outcomes
- respond to the individual needs of the woman and her baby, including offering extended appointments if needed (see Criterion 4.7)
- communicate effectively and respond appropriately to different communication or language needs
- access and use appropriate communication or language support, including translators and interpreters
- understand and respect the rights of women and their babies
- support women to uphold their and their baby's rights
- support women to improve their and their baby's health.

Students should be supported to develop and consolidate these skills throughout their clinical practice placements.

5.11 NHS boards ensure that staff have the time and resources to deliver high-quality, person-centred and trauma-informed care and support

5.12 Staff in leadership, supervisory and mentoring roles have the appropriate skills and knowledge to:

- create psychologically safe environments and apply trauma-informed approaches within their teams and services
- manage and support staff effectively, including providing coaching, supervision and assessment
- embed reflective practice to support continuous learning, insight and improvement
- support students effectively, including providing high-quality teaching, supervision, assessment, feedback and learning opportunities.

5.13 Staff are supported to provide honest and open feedback to their colleagues and leaders to help strengthen reflective practice and peer learning.

5.14 NHS boards ensure staff can assess workplace policies and support services that:

- encourage and support joy at work
- enable them to feel confident and supported in their clinical judgement and decision making
- promote their general health and wellbeing

- identify and minimise the impact of vicarious trauma, including after pregnancy or baby loss
- address any professional or emotional challenges they may experience.

5.15 Staff are supported to participate in local and national improvement work and are enabled to:

- use evidence-based improvement tools and approaches appropriately
- undertake tests of change and to safely apply innovation in their teams and maternity service
- engage actively in national improvement programmes.

What does the standard mean for women and their babies?
• Your care will be provided by staff and teams who work well together and are knowledgeable and skilled. • You will be listened to and supported to make decisions by well-informed staff and teams. • You can be confident that the maternity service will have the right staff available to deliver your care.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting, are enabled to: • understand their roles and responsibilities within a multidisciplinary team • hold and maintain the appropriate registration to practice • safely raise concerns and are supported to do so by compassionate and visible leadership • have time and resources to develop and expand their knowledge, skills and competencies • receive support for their own health and wellbeing • participate in improvement approaches, tests of change and practice innovation.

What does the standard mean for the NHS board?

NHS boards:

- provide clear leadership and oversight of staffing and skill mix to ensure continuity of care, support and carer in line with the Health and Care (Staffing) (Scotland) Act 2019
- have workforce resilience plans and implementation monitoring that reflects local service delivery models
- ensure staff have the time, resources and support to participate in education, training, reflective practice, supervision and CPD
- support staff and multidisciplinary teams through effective, values-based and trauma-informed leadership
- promote multidisciplinary team working through training and supporting effective communication, including care handovers.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.
5.1	Application of the common staffing method and use of workforce planning tools, for example, maternity staff level tool.
5.2	Workforce resilience plans, such as mutual staffing, cover arrangements during sickness absence and training.
5.3	Regular review of staffing levels and appropriate escalation processes implemented.
5.4	Feedback, such as iMatter, that staff feel safe and supported to raise concerns and risks.
5.5	Professional registration and revalidation reports.
5.6	Accurate document and effective information transfer between teams.
5.7	Feedback from staff, such as annual appraisals, that they feel respected by colleagues.
5.8	Agreed training plans outlining core and mandatory competencies.
5.9	Access to regional events, for example, larger NHS boards providing training for island boards.
5.10	Feedback from women, such as through Care Opinion, that they felt supported by compassionate and supportive staff.

5.11	iMatter reports and staff feedback.
5.12	Evidence of leadership training and development pathways and frameworks.
5.13	Staff huddles and reflective sessions.
5.14	Proactive provision of a range of appropriate measures to ensure prevention of vicarious trauma, chronic stress and burnout and reactive measures to support staff when needed.
5.15	Evidence of tests of change and practice innovation.

Standard 6: Antenatal care

Standard statement

NHS boards ensure timely, safe and effective antenatal care.

Rationale

High-quality, compassionate and integrated antenatal care has positive outcomes for both the woman/birthing person and her baby.[24] Timely access to antenatal care supports relationship building between the woman and her midwife and the wider maternity team as well as the early identification of care and support needs, including ultrasound scans, screening, vaccinations and referrals. NHS boards should ensure services and staff are supported to implement the national maternity pathway alongside other local and national clinical guidance.

Antenatal healthcare begins early in pregnancy (usually at 8-10 weeks gestation) with a first antenatal (or booking) appointment recommended to take place before 10-weeks' gestation. The primary midwife has specific responsibility for continuity and coordination of midwifery care, ensuring appropriate referral and access to the multidisciplinary team. Antenatal care incorporates evidence-based assessments, including monitoring of pre-existing or pregnancy-related medical conditions, mental health and social circumstances. Antenatal discussions should include nutrition, use of health-harming products (including tobacco), mental health (see Standard 10), gender-based violence and access to housing and financial support. Staff should refer to the national maternity pathway and local pathways on timing of antenatal visits, investigations, health visitor appointments, pregnancy screening and referral for other support opportunities.

Person-centred communication, monitoring and assessment within a continuity of care model supports planning for pregnancy and birth ensuring further investigation, referral for additional support or specialist care planning, where required. The maternity team may arrange home monitoring as appropriate, for example, blood pressure monitoring (see Standard 4). Where further investigation or specialist support is required, this should be in line with related guidance.

High-quality antenatal education equips women for childbirth and the transition to parenthood. Women (and, where appropriate, their care partners) should be signposted to antenatal classes**,** including those provided by the local NHS board, and national resources, for example, Ready Steady Baby!.

Fetal movement is an important indicator of fetal wellbeing. Women should have discussions about fetal movements in pregnancy with their midwife (or where appropriate obstetrician) and be advised to contact their local maternity unit or hospital maternity triage immediately if they have any concerns about reduced movement. Clear guidance on how to

access maternity triage assessment and when it may be required should also be provided (see Standard 9).

Where a woman has complex care needs, an obstetrician may be identified as the lead professional. The primary midwife should ensure timely collaboration with, and escalation and referral to, multidisciplinary and multiagency colleagues where appropriate. For example, obstetrician, obstetric anaesthetist, family nurse practitioner, social worker or specialist care team, depending on assessed need and in line with the national maternity pathway or related guidance.

Women with complex care needs may experience increased clinical risks during pregnancy, including risks associated with continuing their pregnancy. NHS boards should ensure staff provide tailored information to help women to understand these risks and consider their options. Providing care that is compassionate, person centred and trauma informed enables women to make informed and autonomous decisions regarding their pregnancy. NHS boards should ensure that clear and effective referral pathways are in place so that women can access the care and support most appropriate to their needs, including counselling and other specialised services.

NHS boards should have systems to ensure women who require antenatal anaesthetic referral are assessed by a senior obstetric anaesthetist within a suitable time frame in line with national guidance.

Towards the end of pregnancy, a primary midwife should revisit discussions to support the woman to plan labour and birth in line with the national maternity pathway. Discussions should be evidence and risk based and include the options available, for example, access to provision of a home birth service, induction, access to pain relief or likelihood of an obstetric supported birth. Women should be provided with the Birthplace decisions leaflet.

Criteria

6.1 NHS boards provide oversight and assurance that antenatal care is timely, safe and provided in line with the national maternity pathway and relevant clinical guidance.

6.2 NHS boards ensure that women are offered a first antenatal or booking appointment with a midwife in line with the national maternity pathway.

Where there is a delay, for example, in the woman contacting the service, the appointment should be offered as soon as possible.

6.3 A primary midwife provides and coordinates antenatal care in line with national and local pathways and clinical guidance.

6.4 Every woman has a primary midwife who offers a comprehensive and holistic assessment of their:

- current health and any pre-existing medical conditions or comorbidities
- mental health and wellbeing needs (see Standard 10)
- previous pregnancy, labour and birth history, for example, late or recurrent miscarriage, complications or preterm birth
- risk factors associated with multiple gestational pregnancies or maternal age
- existing care and treatment plans, including medication
- social and life circumstances (such as nutrition, use of health-harming products , mental health, gender-based violence and access to housing and financial support that could impact outcomes for women and their baby
- access to support networks.

6.5 NHS boards ensure that women are offered pregnancy screening in line with the relevant screening pathway.

6.6 A primary midwife, or obstetrician, ensures regular antenatal risk assessments:

- are undertaken to identify medical or obstetric conditions arising during pregnancy
- inform ongoing antenatal care, including timely referrals for specialist care and additional appointments, investigations or ultrasound scans
- support discussions with the wider multidisciplinary team, including obstetricians and other specialist staff
- are reviewed and escalated as appropriate.

6.7 Staff offer home monitoring for antenatal blood pressure or urinalysis to women who meet the eligibility criteria and have received appropriate equipment and training.

6.8 NHS boards ensure women are supported to understand their baby's fetal movements and to recognise and report changes.

6.9 NHS boards have pathways for the management of babies who require additional fetal monitoring or care, which cover processes to identify, escalate, prioritise and refer or safely transfer women.

6.10 Women are offered tailored information and support to help them prepare for intrapartum and postnatal care. This includes:

- signposting to local NHS antenatal education classes that are person centred and responsive to their individual needs
- signposting to local or national organisations and resources about antenatal care, including information on pain relief and infant feeding support
- information about birth choices (including induction and pain relief), likelihood of obstetric supported birth (including assisted vaginal and caesarean birth) and place of birth (including home birth)
- preparation for labour and birth and the benefits of keeping mobile, if possible
- support to co-develop their birthing plan
- potential requirements for intrapartum or postnatal obstetric and other clinical specialist care and support
- information about signs of early labour and how to access timely support.

6.11 Staff ensure women (and, where appropriate, their care partners) know who to contact if they have concerns about their or their baby's health during their antenatal care.

6.12 NHS boards have systems and processes in place for the management of women with medical complexity, which cover the:

- transfer of antenatal care to the appropriate lead professional
- documentation and sharing or relevant information with the wider maternity team and the woman.

6.13 A primary midwife ensures regular antenatal assessments are undertaken where there is medical complexity. Antenatal assessments:

- support timely referrals for management by a specialist care team with input from an obstetrician
- enable appropriate escalation, when required
- inform ongoing antenatal care, monitoring and/or screening
- support multidisciplinary team discussions, with obstetricians and other specialist staff, including tertiary care and Maternal Medicine Networks, as required
- are recorded and shared appropriately across the multidisciplinary team and with the woman.

6.14 Care of women with medical complexity is:

- undertaken in collaboration with staff with expertise in the medical condition in pregnancy, involving regional and national services as appropriate
- planned to enable continuity of midwifery care from a primary midwife
- led by a named obstetrician
- evidence based and aligned with national guidance and pathways
- documented, reviewed and shared appropriately across the multidisciplinary team and with the woman.

Where care is shared between local and regional centres, NHS boards ensure robust and contemporaneous communication and information sharing, in line with Criteria 4.4.

6.15 NHS boards have systems to ensure women who require antenatal anaesthetic referral are assessed by a senior obstetric anaesthetist within a suitable timeframe.

6.16 Women with complex care needs receive tailored support and guidance about the risks associated with continuing their pregnancy. Compassionate staff support women:

- to make informed decisions about continuing or ending a pregnancy
- to access appropriate care and support through referral pathways, including counselling where required
- with care that is person centred, trauma informed and responsive to their individual needs.

6.17 Women are assessed for their risk of venous thromboembolism (VTE) throughout their antenatal care, and appropriate action is taken based on the level of risk identified. This may include:

- surveillance to monitor for any changes or emerging risk factors
- preventive measures, such as mechanical/non-invasive devices or pharmacological prophylaxis
- further investigation, including timely referral for ultrasound or other imaging, when clinically indicated
- treatment, where VTE is suspected or confirmed.

6.18 Women are assessed for their risk of preterm birth, and appropriate action is taken based on the level of risk identified. This may include:

- preventive measures, such as evidence-based interventions to reduce the likelihood of preterm birth
- increased monitoring or, in some cases, planned birth for women with multiple pregnancies
- perinatal optimisation, to improve outcomes for the woman and her baby when preterm birth is anticipated
- planning the location of birth, ensuring access to appropriate neonatal and maternity care.

Women will be provided with tailored, clear and accessible information to support informed decision making throughout their care.

6.19 Women who develop pregnancy-specific conditions:

- have their care coordinated by a named obstetrician
- receive tailored information from the obstetric team on options for the timing, mode and place of birth
- have all discussions and decisions clearly documented in their maternity record
- have their care plan regularly updated to include their management plan, including monitoring for changes to their condition by the named obstetrician
- have their care managed by a multidisciplinary team as appropriate.

What does the standard mean for women and their babies?

- You will be offered your first antenatal (booking) appointment with your midwife at eight–ten weeks of pregnancy. If you first contact services after 10 weeks, you will be booked in as soon as possible.
- At your first appointment, you will be given a primary midwife. They will support you throughout your pregnancy.
- Your antenatal care will be coordinated by your primary midwife.
- When you are offered tests, scans (ultrasounds) or investigations, your midwife will explain why they are needed and what the benefits and risks are for you and your baby.
- You will be supported to make choices that are right for you and to support the health of you and your baby.

- You will be supported to feel more confident about managing your pregnancy and to help you to prepare for your baby's birth.
- Your midwife will ask questions about your health and wellbeing. This will help make sure you are offered the right care and support at the right time.
- You will be offered information and support about how to keep well in pregnancy, which will include advice on self-care, eating well and smoking cessation.
- You will be asked about your social circumstances, such as your housing and financial situation. This is to ensure you can access help or support that you need.
- If you have concerns about your pregnancy, you will know who to contact. You can be confident that your concerns will be taken seriously and responded to quickly.
- If you have complex care needs that place your pregnancy at higher risk, you will be offered information and support. This will help you make informed decisions, including decisions about continuing your pregnancy. Respectful and compassionate staff will support you to access the care and support that meets your needs.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- provide safe and effective antenatal care from the first booking appointment, in line with the national maternity pathway
- support women to develop personalised care plans and access additional support, such as parental education, preparation for labour and birth
- undertake holistic and timely assessments of health, wellbeing and other antenatal needs, including pregnancy screening
- discuss and refer any antenatal risks or concerns to obstetrics or other specialist care as appropriate, in line with relevant guidance
- offer women tailored information and support to prepare for intrapartum and postnatal care
- provide appropriate care for women with complex care needs and make referrals for specialist care, when required
- ensure women know who to contact if they have concerns during their antenatal care about their or their baby's health.

What does the standard mean for the NHS board?

NHS boards:

- have governance structures in place to ensure the safe and timely delivery of antenatal care in line with the national maternity pathway and relevant guidance
- offer a first antenatal or booking appointment and antenatal care
- ensure women have a primary midwife, coordinated care and continuity of carer
- ensure women have all appropriate assessments and referrals for antenatal care
- have systems in place to identify, nominate and communicate the appropriate lead professional to coordinate antenatal care
- offer pregnancy screening in line with the relevant screening pathway
- have referral pathways in place to support the self-management of antenatal care.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
6.1	Action plans demonstrating implementation of the national pathway and standards.
6.2	Audit of timeliness of antenatal care data for booking, assessments and referrals, including PHS antenatal booking collection dataset submission.
6.3	Audit of implementation of pathways and guidance.
6.4	Evidence of holistic assessments.
6.5	Audit of screening data and KPI submission data.
6.6	Demonstration of regular risk assessment with appropriate review and escalation.
6.7	Audit of local pathway or use of clinical guidance for eligibility criteria for home monitoring.
6.8	Feedback from women on their confidence levels for fetal monitoring.
6.9	Local pathway for reduced fetal movement based on RCOG guidance.
6.10	Audit of referral or signposting to national information sources, including Ready Steady Baby! and to local advice and support.
6.11	Feedback from women that they had received, understood and could access the correct contact information if they had concerns about their own health or their baby's health.
6.12	Care pathways for women with medical complexity.
6.13	Audit of frequency of antenatal assessments for women with medical complexity, and onward referral and escalation.

6.14	Multidisciplinary team meeting discussion notes, referral requests to specialists, monitoring data of time from referral to specialist appointment for women with medical complexity.
6.15	Protocols and guidance for reviewing referrals for antenatal anaesthetic.
6.16	Evidence of tailored support for women to support informed decision making.
6.17	Review of assessments and interventions for VTE.
6.18	Review of assessments and interventions for preterm birth.
6.19	Protocols and guidance for monitoring the care of women who develop specific conditions in pregnancy.

Standard 7: Intrapartum care

Standard statement

NHS boards ensure timely, safe and effective intrapartum care.

Rationale

NHS boards should ensure that intrapartum care for women/birthing people, regardless of setting, is safe, person centred and evidence based. Multidisciplinary planning, safe staffing, timely access to care and informed decision making will improve the birth experience and outcomes for women and their babies.[21] The principles of intrapartum care include respectful maternity care, effective communication and continuity of carer (see Standard 1). Women's antenatal birth preferences and informed decisions should be supported wherever possible, including their choice of care partner or companion throughout labour and birth (see Standard 6).

Throughout labour and birth, maternity staff should carry out regular monitoring, clinical assessment and ongoing risk assessment based on evidence-based guidance. This includes options for monitoring maternal and fetal wellbeing during labour.

Staff should have a clear understanding of escalation procedures if any risks, concerns, complications or need for transfer arise for the woman and/or her baby. NHS boards should establish local, regional and national pathways for the transfer of care in line with national guidance and that include the Scottish Ambulance Service.

Pain management interventions and techniques during labour should be discussed as part of the woman's birthing plan and revisited as labour progresses. Women should have access to analgesia appropriate to their birth setting in line with relevant guidance. Early referral to an obstetric anaesthetist is required for complex analgesia, such as epidural or remifentanil patient-controlled analgesia.

Women should receive appropriate care without unnecessary delay to minimise stress and improve outcomes.[3] NHS boards should routinely monitor, review and report on care delays within maternity services, including delays in initiating the induction of labour to improve safety and patient outcomes.

Criteria

7.1 NHS boards provide oversight and assurance that intrapartum care is timely, safe and provided in line with the national maternity pathway and relevant guidance.

7.2 NHS boards have governance and oversight processes for the monitoring of quality and safety outcomes related to labour and birth. This includes but is not limited to:

- locally agreed staffing and skill mix
- delays in induction of labour
- delays in access to theatres.

7.3 A primary midwife supports women to co-develop a labour and birthing plan, which:

- begins during the antenatal period and is reviewed and updated during the intrapartum period
- is informed by evidence, risk assessments and outcomes (for example, screening results)
- includes the woman's decisions for all aspects of her labour and birth
- is shared with the wider team, where appropriate.

7.4 Women are supported to make informed decisions about labour and birth, which include:

- choice of place and mode of birth
- potential circumstances requiring transfer of care
- pain relief options
- potential outcomes or implications if clinical advice or recommendations are declined
- potential birth interventions, including assisted birth, caesarean birth and anaesthesia options.

7.5 A midwife will undertake and coordinate intrapartum care in labour and birth, in line with national and local pathways and guidance.

When intrapartum care is coordinated by an obstetrician for clinical reasons, this is documented and clearly explained to the woman.

7.6 NHS boards have policies to support women to involve, if they wish, their companion of choice during labour and birth.

7.7 Throughout labour and birth, women are:

- fully informed about what is happening, including being updated if there are any delays or recommended changes to care
- offered one-to-one care
- able to make informed decisions
- empowered to ask questions and raise concerns
- listened to and taken seriously
- actively involved in decision making
- supported to review and update their birth plans.

7.8 NHS boards ensure that any care or interventions clinically indicated or offered during labour are delivered in line with evidence-based clinical guidance. This includes, but is not limited to:

- care plans for women with medical complexity
- operative interventions
- pain management
- transfer of care between settings.

7.9 Where induction of labour is clinically indicated and recommended, this is delivered in line with clinical guidance and with the woman's consent.

7.10 Women who decline induction of labour, should be offered a timely consultant obstetrician discussion and increased monitoring in line with national and local guidance.

7.11 A midwife will undertake and coordinate fetal monitoring, in line with national and local pathways and guidance. Where clinically recommended or indicated, this will include a referral to obstetric care.

What does the standard mean for women and their babies?
• You will be supported to make informed decisions about where and how you want to give birth. These conversations will start during your pregnancy and will be reviewed again when you are in labour, so your choices can be updated if things change. • You will have one-to-one support throughout your labour, with the same midwife supporting you, where possible.

- You will be offered advice on practical ways to help manage your labour, including breathing exercises, movement and relaxation and birthing positions.
- You will be given clear information about all the available pain relief options available to you, including what they involve, how they work and any risks or benefits. You will be supported to choose what feels right for you.
- If you require a caesarean birth or assisted birth (such as forceps), your midwife or obstetrician will explain this to you and will answer any questions that you have.
- You will be told if there is likely to be any delay to your care.
- You will be regularly assessed to check your and your baby's health and wellbeing.
- Your birth companion (partner, friend, or family member) will be welcomed and supported to stay with you and take part in your birth experience.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- provide safe and effective care during labour and birth based on national and local evidence-based guidelines, standards and pathways
- escalate any risks during labour as appropriate
- undertake and update care plans based on appropriate assessments of health, wellbeing and other needs during labour
- ensure women receive support and regular communication during labour and birth including one-to-one midwifery support from a primary midwife
- ensure referrals or transfer of care are initiated and actioned as appropriate
- support women to make informed decisions about their labour and birth and ensure care plans are updated as appropriate.

What does the standard mean for the NHS board?

NHS boards:

- ensure intrapartum care is timely and safe and in line with the national maternity pathway and relevant guidance
- ensure safe staffing levels and provision of one-to-one midwifery care and support during labour and birth, regardless of setting
- have systems and processes in place for the escalation and transfer of care to obstetric care
- have policies in place to support a woman to have her companion of choice with her during labour and birth.

Benchmarking and measuring performance	
Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
7.1	Audit of data for improvement, including the Scottish Patient Safety Programme and Excellence In Care measures.
7.2	Audit of delays to accessing care during labour (for example, delay to the induction of labour) with themes identified and action plans developed.
7.3	Review of women's birth plans to provide evidence of co-design and demonstrate that women's decisions are recorded and reviewed.
7.4	Patient experience surveys and feedback from Care Opinion.
7.5	Audit of implementation of intrapartum care pathways and clinical guidance.
7.6	Local guidance on birth companions in labour and birth settings.
7.7	Evidence of women being fully informed during their labour and birth, including observations, documentary evidence and experience data.
7.8	Audit results demonstrating compliance with guidance for pain management.
7.9	Audit data demonstrating compliance with induction of labour clinical guidance.
7.10	Review of patient records to evidence obstetrician care and increased monitoring for women who decline induction of labour.
7.11	Audit data demonstrating compliance with fetal monitoring pathways.

Standard 8: Postnatal and newborn care

Standard statement

NHS boards ensure timely, safe and effective postnatal and newborn care.

Rationale

Postnatal care refers to care provided to the woman/birthing person and newborn in the period immediately after the birth (hours to a day) and extending up to six weeks (42 days). Effective postnatal care planning should promote consistency in care and continuity of carer and support the safe and person-centred transition of midwifery care to the health visitor. Where appropriate, the woman should offered additional support from the family nurse partnership.[21]

In line with the national maternity pathway and guidance, the first hour after birth (known as the 'golden hour'), should prioritise bonding and attachment, minimising the separation of the woman and her baby. Staff should support wider family-centred care and involvement. Tailored information and support should be offered to women enable early attachment and bonding and to provide practical help with the care of their baby. This includes offering assistance with initial and subsequent infant feeds and access to dedicated breastfeeding support, where requested.

Physical examinations and wellbeing assessments of the women or the baby in the first one to two hours after birth should minimise disruptions and avoid unnecessary separation. Ongoing risk assessments should be carried out using validated tools such as MEWS, with escalation in line with local pathways where concerns arise.

NHS boards should ensure that women and their babies who require inpatient, high-dependency or intensive care in non-maternity settings also receive appropriate postnatal midwifery and obstetric assessment and care. Standard 9 outlines the requirements for women and their babies who need unscheduled, emergency or critical care.

Local pathways should be in place to support safe transfer of care and discharge into community midwifery. Where the coordination of care should be undertaken by a specialist (including an obstetrician, neonatologist or paediatrician), this should be documented and shared with maternity and community teams.

A midwife is responsible for assessing individual needs and coordinating the postnatal care of both the woman and her baby, regardless of where the woman gave birth. Postnatal home visits should be tailored to the individual needs of the woman and her baby and follow the national maternity pathway. Newborn physical examination, screening and vaccinations should be carried out in line with national guidance. Additional support may be required after multiple or specific births, such as Caesarean births, and care plans should be updated at each visit to reflect changing needs.

Midwives should share relevant information with the woman's GP to support continuity of care and appropriate follow up for both the woman and her baby. When midwifery care is extended due to complexity or additional needs, this is clearly recorded and shared with the multidisciplinary team.

Midwives should offer guidance and support to help strengthen the parent–infant relationship, support infant development and build parental confidence, which will contribute to improved long-term outcomes. Provision of ongoing skilled feeding support, including breastfeeding support, should also be offered to help address early challenges and improve feeding success.

Discussion of sexual health, pelvic floor recovery and contraception are essential aspects of holistic postnatal care. Providing timely and tailored information enables women to make informed decisions, supports physical recovery and helps prevent unplanned pregnancy. Midwives should offer women tailored information and support about safe sleeping practices to help reduce the risk of sudden unexpected death in infancy.

Routine trauma-informed enquiry about gender-based violence should be an integral component of postnatal care. Ongoing assessment of social complexities and safety is required throughout the postnatal period to ensure that women receive appropriate support, safeguarding and referral where needed, in line with the national maternity pathway's requirement for continuous, trauma-informed assessments.

Clear information about local services and support networks ensures women and families know how to access additional help and helps reduce isolation.

Women (and, where appropriate, their care partners) should have meaningful opportunities to discuss their labour and birth experiences with appropriate healthcare professionals and services. These discussions should allow time for questions and take place both in the immediate postnatal period and in the months after birth.

Criteria

8.1 NHS boards provide oversight and assurance that postnatal care is timely, safe and delivered in line with the national maternity pathway and relevant guidance.

8.2 NHS boards should ensure that all women receive equitable postnatal care and community follow up regardless of their place of birth, including those who have a home birth.

8.3 A primary midwife provides and coordinates care in the postnatal period, in line with national and local pathways and guidance.

When, for clinical reasons, coordination of postnatal care is led by another member of the maternity team, such as an obstetrician (for the woman) or neonatologist (for her baby), this is documented and explained to the woman.

8.4 NHS boards have systems and processes in place to identify, prioritise and refer women who have experienced clinical trauma or clinically-significant injury associated with birth, including obstetric anal sphincter injury, perineal tears or complications arising from epidural or other analgesia.

8.5 NHS boards have systems and processes to identify and safely transfer women and their babies who require additional or enhanced postnatal clinical care.

See Standard 9 for unscheduled, emergency and critical care.

8.6 Staff support the emotional wellbeing of women and their babies immediately after birth by providing:

- compassionate, dignified and culturally-sensitive care
- practical and person-centred support for bonding and early communication, personal care, skin-to-skin contact, newborn care and infant feeding
- information and support on safe sleeping for babies
- effective pain relief
- opportunities to ask questions about the early postnatal period, including after discharge
- practical and person-centred support delivered in-person or by video or telephone.

8.7 NHS boards ensure hospital environments promote the emotional wellbeing of women and babies immediately after birth by:

- providing low-level lighting and noise reduction to support rest
- ensuring women have access to appropriate and adequate food and drink
- providing safe, private birth and postnatal spaces that promote family-centred care.

This should be provided in conjunction with Standard 4.

8.8 Staff provide infant feeding support and practical advice that:

- enables women to make informed decisions
- supports all feeding choices
- is responsive to the individual needs of the woman and her baby, including multiple babies
- includes timely access to specialist support for babies with additional needs (for example babies born with cleft palate) or where feeding problems arise, including support for weight loss management
- is equitable across all settings, including home births and critical care settings
- is available immediately after birth and during home visits.

8.9 A primary midwife supports women to co-develop postnatal care plans, which are:

- reviewed and updated as required
- readily accessible to the woman
- shared across the multidisciplinary team including the woman's GP, health visiting team and the family nurse partnership team as appropriate.

8.10 Women are assessed for their risk of VTE throughout their postnatal care and appropriate action is taken based on the level of risk identified. This may include:

- surveillance to monitor for any changes or emerging risk factors
- preventive measures, such as mechanical or pharmacological prophylaxis
- further investigation, including timely referral for ultrasound or other imaging when clinically indicated
- treatment where VTE is suspected or confirmed.

Women receive tailored, clear and accessible information to support informed decision making about their care.

8.11 Women can access a full range of postnatal contraception options (including implant and intrauterine device insertion, where requested):

- immediately after birth
- at the six-week postnatal check.

8.12 NHS boards have processes and pathways in place to support the safe and effective discharge of women into community care. This includes:

- physical and psychological assessment
- medicines reconciliation, where appropriate
- onward referral for physical, psychological or social needs
- provision of appropriate pain relief
- communication with the community team, with contact details shared with the woman
- completion of summary of care documentation.

8.13 NHS boards have processes and pathways for the safe and effective discharge of babies into community care. This includes:

- physical assessment
- referral for screening, vaccination and other physical needs
- referral for social work support, where appropriate
- medicines reconciliation, where appropriate
- completion of the child health record
- ongoing community midwifery support.

8.14 NHS boards ensure that women have high-quality and person-centred community midwifery care that includes:

- continuity of care during transfer to health visiting teams
- regular health visitor and the family nurse partnership visits, where appropriate
- ongoing physical, psychological and social assessments with signposting and referral
- support and information for transition to parenthood, infant care and safe sleeping
- support to self-manage postnatal recovery, where appropriate
- access to early interventions for maternal and infant mental health and wellbeing (see Standard 10)
- signposting or referral for pre-pregnancy advice and counselling for future pregnancies
- gender-based violence risk assessment and appropriate follow-up.

8.15 NHS boards promote family-centred care by ensuring care partners, where appropriate, receive tailored information and support.

8.16 Women (and, where appropriate, their care partners) have opportunities to discuss their labour and birth experiences with appropriate healthcare professionals:

- in the immediate days following birth
- in the months following birth
- as part of care in any subsequent pregnancy.

What does the standard mean for women and their babies?
• You will be supported to develop a postnatal care plan that is right for you and your baby. • You and your baby will have postnatal assessments and examinations to make sure you are both well and recovering properly. This will ensure you receive the right care and support. • You will receive information and support to make decisions about your care and the care of your baby. • You will be asked to give your consent for any examination or interventions that you, or your baby, need. • If you, or your baby, need to receive care in another NHS board or from another service you will be supported to make decisions that are right for you. • You will be able to include your care partner in your support, if you wish to. • You may be asked to feedback on your labour and birth experiences and you can do so, if you wish.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • provide safe and effective postnatal care for all women and their babies in line with the national pathway and relevant guidance • undertake holistic assessments and timely risk assessments of postnatal health and wellbeing needs of women and their babies • identify and address potential postnatal complications or risks as appropriate • support women, and care partners, where appropriate, with practical newborn support including infant feeding and bonding in a calm and restful environment • support women to develop personalised postnatal care plans

- ensure all postnatal documentation is accurate and shared appropriately, including care plans, discharge plans, summary of care plans and personal child records
- provide meaningful opportunities for women to provide feedback and reflections on their labour and birth experiences.

What does the standard mean for the NHS board?

NHS boards:

- ensure postnatal care is timely, safe and provided in line with the national maternity pathway and relevant guidance
- have systems in place to identify, nominate and communicate who the appropriate lead professional is that will coordinate and provide continuity of postnatal care
- collect, review and respond to information on the quality of postnatal care obtained through regular audit and feedback from service users and staff
- ensure women and their babies are offered all relevant assessments, examinations and postnatal care, including vaccinations and screening
- support women to access sexual health and postnatal contraception services
- ensure referral pathways are in place to support the safe and effective transfer and discharge of women and their babies to community services.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
8.1	Audit of implementation of postnatal care pathways and clinical guidance.
8.2	Policies to ensure equity of access across settings (including hospital, home birth and community).
8.3	Demonstration of continuity of care during transfers of care, including health visitor and family nurse partnership.
8.4	Referral processes for treatment for tears and complications.
8.5	Audit of timeliness of immediate care data for triage, referrals and admission.
8.6	Feedback from women on their experience of postnatal support from staff.
8.7	Evidence of service design to support family-centred care.
8.8	Referral pathways for additional feeding support.
8.9	Evidence of facilitating co-design of postnatal care plan with a primary midwife, buddy or midwife present at birth.

8.10	Implementation of VTE clinical guidance, including referral and treatment.
8.11	Offer and uptake data for postnatal contraception.
8.12	Discharge protocols for community care.
8.13	Audit of referral and uptake of newborn assessments, investigations, screening and vaccinations.
8.14	Audit of timeliness of postnatal care data for booking, assessments and referrals.
8.15	Audit of information provided to care partners.
8.16	Dedicated birth reflection and follow-up services.

Standard 9: Unscheduled, emergency and critical care

Standard statement

NHS boards ensure women and babies receive unscheduled, emergency and critical care that is timely, safe and effective.

Rationale

It is essential that women/birthing people and their babies who require immediate care (unscheduled, emergency and critical care) can access the right care at the right time. Timely and equitable access to immediate care is fundamental for ensuring the safety and wellbeing of women and their babies. Care is delivered in line with related clinical guidance.

Clinical conditions in pregnancy can change rapidly and delays in assessment may increase the risk of preventable harm. Providing 24/7 access to assessment supports early identification of complications, enables prompt clinical decision making and ensures that women receive the right level of care at the right time.[26] Equitable access also helps reduce variation in outcomes by ensuring that all women, regardless of location or circumstances, can seek urgent assessment and receive appropriate maternity care without delay. The management of antenatal and intrapartum emergencies should always prioritise the wellbeing and safety of the woman. All unscheduled, emergency and critical care should be delivered in line with Standards 1 and 2. This includes ensuring women who receive unscheduled, emergency and critical care continue to be offered tailored information and are supported to make informed decisions.

Assessment for any unscheduled maternity care should be undertaken by appropriately trained midwifery staff working within a multidisciplinary team. Women should be triaged in an appropriately staffed and equipped unit that is accessible 24 hours a day, seven days a week (see Standard 4 on facilities).[1, 25] Maternity triage units should be located in, or have established links to, a maternity unit. All NHS boards should ensure the safe transfer of women and their babies who require emergency or critical care, by working collaboratively with the Scottish Ambulance Service.

Clear pathways for referral to alternative services, including early pregnancy care or services outwith the board of residence, ensure that every woman receives timely and appropriate assessment based on clinical need.

The multidisciplinary team, including an obstetric anaesthetist, should be involved at an early stage when women require complex analgesia, assisted birth, Caesarean birth or any other surgical intervention. Care should be coordinated through shared care plans, effective communication and integrated records.

Inspection reports from Healthcare Improvement Scotland highlight the importance of minimising delays when escalating care for women and/or their baby who show signs of clinical deterioration. Clinical deterioration can be identified using validated tools such as Maternity Early Warning Score (MEWS). Local protocols should clearly set out requirements for regular clinical assessment, prioritisation and escalation. Guidelines emphasise that subjective reports from women, and those of care partners, are a vital component of clinical assessment and safety. When a woman presents, or reports, warning signs or concerning symptoms, staff must escalate these concerns to the multidisciplinary team using a structured communication format, such as an SBAR (Situation, Background, Assessment, Recommendation).[27]

Women who require emergency or critical care may present in a range of clinical settings, not only within maternity units.[3] Clear pathways and protocols across non-maternity areas, such as emergency departments, hospital wards, neonatal settings and critical care units, are essential to ensure that women and their babies receive safe, timely and appropriate care wherever they present. Effective coordination of critical care by a multidisciplinary team, led jointly by a consultant obstetrician and a consultant anaesthetist, helps ensure that complex clinical decisions are well managed and consistent. Midwives, including specialist midwives, are key members of this team, contributing essential maternity expertise and continuity. Consistent standards of emergency and critical care across all settings ensure that women and their babies receive the same high-quality care as any other critically ill patients, regardless of location.

Keeping women and their babies together in emergency and critical care settings is a vital, evidence-based practice promoting better health outcomes for all. It supports recovery and strengthens early bonding, even when either the woman or her baby is critically unwell. NHS boards can support this through models such as supported transitional care, enhanced maternity units and family-centred models, including parental accommodation, where appropriate. NHS boards should ensure women and their babies who require inpatient, high-dependency or intensive care also receive appropriate postnatal assessment and care, regardless of the clinical setting in which they are treated. Providing compassionate, clear, coordinated support when a baby requires end of life care ensures that women (and, where appropriate, their care partners) receive timely information and are able to make informed decisions that reflect their needs and preferences and that are in the best interest of her baby.

Note: the standards apply to the care of newborn babies up to six weeks of age.

Deteriorating mental health is covered in Standard 10.

Criteria

9.1 Women and their babies can access immediate care that is:

- right for them
- in the right place
- at the right time.

9.2 Whenever and wherever women require immediate care, staff ensure women:

- are fully informed about what is happening
- feel empowered to ask questions and know how to raise concerns
- are listened to and taken seriously
- continue to be actively involved in decision making
- are supported to review and update their care plans.

Where appropriate, the care partner's concerns are listened to and taken seriously.

9.3 NHS boards ensure timely and equitable access to immediate care for all women and their babies (up to six weeks of age) 24 hours a day, seven days a week.

9.4 Women can access unscheduled and emergency maternity care through:

- self-referral
- referral by a community healthcare professional, including community midwife, GP or health visitor, or prison healthcare staff
- referral from ambulance clinicians, paramedics and the Scottish Ambulance Service
- referral or signposting from a community centre or third sector support agency.

9.5 NHS boards have systems and processes in place to ensure women can access appropriate immediate care:

- at any stage of their pregnancy, including early pregnancy
- during birth
- in the immediate postnatal period
- up to six weeks after birth
- wherever they live or choose to receive maternity care (for example home birth).

9.6 Women who require immediate care receive tailored information and are supported to make informed decisions and provide consent for any recommended interventions and treatment.

Where a woman is unable to consent, for example because of loss of consciousness or lack of capacity, clinical decisions should be based on her best interests. Involvement of the woman's care partner should be in line with relevant guidance.

9.7 NHS boards ensure that staff are enabled to deliver evidence-based immediate care, which includes:

- prioritising care appropriately based on clinical presentation, risk assessment and the urgency of the woman's or her baby's needs
- recording observations accurately and following local escalation pathways using nationally recommended and validated assessment tools such as MEWS
- interpreting and responding to assessment results within appropriate timeframes
- recognising and acting on clinical prioritisation in line with clearly defined local and national referral and escalation policies
- referring women to other appropriate services, such as early pregnancy services
- requesting clinical investigations and accessing advice and support, when required
- supporting the safe transfer of care of women or their babies who require immediate care in a different setting or service
- accessing evidence-based guidance relevant to the assessment and management of unscheduled, emergency and critical maternity care.

9.8 NHS boards have systems and processes in place for telephone assessments of women, that ensure:

- women know who to contact and when
- women receive a timely response
- midwives are appropriately trained and educated and use a structured tool to assess, identify, escalate and refer appropriately
- midwives can access the woman's case notes during the call
- women receive the right advice or support based on clinical need, including appropriate management of time critical emergencies
- women receive tailored, evidence based and accurate information to support informed decision making
- accurate and contemporaneous records of discussions, decisions and referrals are maintained and shared appropriately
- there is clinical oversight and assurance of the service, with improvement plans developed and implemented as appropriate.

9.9 NHS boards have systems and processes in place to ensure that women who do not attend a hospital appointment following a triage call are promptly identified, contacted, and offered appropriate follow-up care.

9.10 NHS boards provide early pregnancy assessment services for all pregnant women who are under 12 weeks pregnant. The service provides:

- same-day information and holistic assessment by an appropriately trained member of the maternity team
- onward referral, where appropriate, in line with relevant pathways.

9.11 Women who require immediate care within any clinical care setting have their care coordinated by an obstetrician. Continuity of care, and where appropriate of midwifery carer, should be supported and prioritised, wherever possible.

9.12 Women who are assessed as requiring emergency surgical interventions, including assisted or Caesarean birth:

- have a timely assessment by appropriately trained staff from across the multidisciplinary team
- are triaged for theatre appropriately, in line with local clinical pathways and national guidance
- are reviewed by an anaesthetist to plan appropriate anaesthesia
- receive care from appropriately trained theatre staff within theatres that are well equipped, safely maintained and ready for emergency use.

9.13 NHS boards ensure timely, safe and effective transfer of care between clinical settings and healthcare teams for all in-utero transfers.

9.14 NHS boards have clear pathways and protocols to ensure women who require critical care have the same high-quality evidence-based care as:

- non-maternity patients in critical care settings
- patients in maternity settings, regardless of where they are cared for.

9.15 Where a woman or her baby requires emergency or critical care in a non-maternity setting, NHS boards enable them to remain together and to receive all the postnatal parenting support that is offered in a maternity setting, including support for early attachment and bonding (see Criterion 10.9).

9.16 NHS boards have clear pathways and protocols for babies under six weeks who require emergency or critical care including admission to a neonatal unit. This ensures babies:

- are appropriately and safely transferred, with accurate and accessible handover of case notes
- have their care coordinated by the multidisciplinary teams, with the consultant neonatologist leading and managing the care
- have regular clinical assessments using validated tools (such as NEWTT2) with clear escalation pathways
- are discharged with appropriate follow-up and support, including referral to relevant community and specialist services
- are enabled to have their parents and families attend wherever possible and appropriate.

9.17 NHS boards have oversight and assurance of the timeliness of assessing women who require unscheduled, emergency and critical care. This includes reviewing and monitoring data and developing action plans where appropriate.

9.18 NHS boards provide triage units in an environment that is appropriately staffed and equipped (see Standard 4):

- with access to specialist maternity, neonatal and non-maternity emergency care as appropriate
- that is located within, or has established links to, a maternity unit.

9.19 NHS boards ensure that high-dependency care is available to women who require enhanced monitoring and support during pregnancy, labour or the postnatal period. High-dependency care should:

- be available on or near the labour ward
- be provided by midwives trained in providing high-dependency care
- enable timely access to obstetric, anaesthetic and neonatal expertise, including senior decision makers
- include access to appropriate monitoring and resuscitation equipment
- use validated assessment and early warning tools, such as MEWS
- provide enhanced observation in line with clinical needs and national guidance
- support continuity of midwifery and obstetric care wherever possible
- enable the baby to remain with the woman, where clinically appropriate, including providing support for infant feeding.

9.20 Where a baby requires end of life care, NHS boards ensure women (and, where appropriate, their care partners):

- receive timely, compassionate and tailored information about palliative perinatal care options
- can access multidisciplinary specialist input, including maternity, neonatal, palliative care and psychological support services
- make informed decisions about their baby's care, including preferred place of care and birth planning
- experience coordinated care across settings, with clear communication between maternity, neonatal, palliative and community teams
- can access emotional and bereavement support, including support for care partners and families
- are offered follow-up care, including postnatal review, mental health services and referral to appropriate community resources.

What does the standard mean for women and their babies?

- If you or your baby needs unplanned or emergency care, you will receive the care and support that you need.
- You can access advice, care and support 24 hours a day, seven days a week.
- If you (or your care partner) are concerned about you or your baby, you will be listened to and taken seriously.

- You will have the opportunity to discuss what is happening and be supported to make decisions about your care, and the care of your baby.
- You will continue to have the care and support of your primary midwife.
- If you or your baby needs to be admitted, you can be confident that you are in the right place with the right team to care for you.
- You and your baby will be kept together as much as possible.
- If you or your baby need to be transferred to a specialist unit, you will be told what is happening.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- use nationally recommended and validated assessment tools
- use nationally recommended education tools for telephone assessments
- ensure appropriate escalation, referral and transfer of women and their babies
- respond to concerns from women appropriately and within agreed timescales
- ensure women are kept informed
- share information and care plans with the multidisciplinary care team
- ensure women and their babies receive the same high-quality critical care as other patients
- support women and their babies to stay together
- can order and review clinical investigations, information and advice from midwifery, obstetric and other specialist teams, as required.

What does the standard mean for the NHS board?

NHS boards:

- ensure oversight and assurance of unscheduled, emergency and critical care in maternity services, including data monitoring and review of outcomes
- have established pathways and processes for access to timely immediate or unscheduled maternity care
- ensure appropriately staffed and equipped triage service, with access to early pregnancy services, specialist maternity, neonatal and non-maternity emergency care as appropriate, delivered in line with national guidance and pathways
- ensure women can access a triage unit that has established links to a maternity unit
- have clear systems and protocols for safe and timely transfer of care, including in-utero transfer.

Benchmarking and measuring performance	
Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
9.1	Review of attendance data for immediate care, including timeliness of admission.
9.2	Evidence of informed decision making and communication with women in emergency maternity situations.
9.3	Service specifications confirming 24/7 maternity and postnatal urgent care.
9.4	Provision of local contact and referral information for unscheduled and emergency care.
9.5	Service specifications or service-level agreements outlining access to unscheduled or emergency care, including out-of-hours referral routes.
9.6	Application of consent to treatment guidance.
9.7	Demonstration of clinical care and treatment delivered in line with relevant clinical guidance, nationally recommended assessment tools and pathways.
9.8	Audit of call log data.
9.9	Local guidance to follow up women who do not attend.
9.10	Provision of early pregnancy assessment services.
9.11	Audit of patient records demonstrating obstetric coordination of care.
9.12	Provision of emergency surgical interventions.
9.13	Audit and review of referrals and admissions data for in-utero transfer.
9.14	Protocols for consistency in maternity care for women who require critical care.
9.15	Guidance to support infant bonding, including feeding in high-dependency care settings.
9.16	Local protocols for neonatal care.
9.17	Audit of timeliness of immediate care data for triage, referrals and admission.
9.18	Evidence of appropriately staffed, equipped and located triage units.
9.19	Documented observations and compliance with local escalation pathways using tools such as MEWS.
9.20	Provision of compassionate and tailored palliative care.

Standard 10: Mental health and wellbeing

Standard statement

NHS boards ensure women and their babies can access mental health and wellbeing support that is timely, equitable, consistent and trauma informed.

Rationale

Good mental health and emotional wellbeing during pregnancy and birth can improve outcomes for women/birthing people and their babies. Women with a history of mental-ill health or trauma can benefit from early interventions to support their wellbeing during pregnancy in line with national pathways and related guidance. Access to evidence-based advice, information and support enables women to make informed decisions about their care and treatment, including understanding the benefits and risks of continuing or changing mental health medication during pregnancy. Capacity to consent is covered in Criterion 1.6.

Risk of poor perinatal mental health is higher among women from marginalised groups, including those experiencing deprivation, seeking asylum, in prison or police custody or affected by alcohol or substance use.[2, 28, 29] Women who have experienced gender-based violence and those who are LGBTQIA+ may also be at increased risk.[30, 31] Women who have experienced trauma during pregnancy and birth are also at risk of developing mental health symptoms. Individualised support, ongoing monitoring and opportunities to talk through their experiences are recommended.

Mental health and wellbeing can be affected by the woman's existing physical health conditions or medical complications that develop during pregnancy. Concerns about the baby's health or development (for example, following screening or birth), as well as challenges with early postnatal bonding, can also have an impact on a woman's wellbeing.

NHS boards should provide a range of trauma-informed mental health support services, including clear pathways for timely referral to specialist services, when required. Enhanced access to urgent and unscheduled care at the point of crisis or emergency also improves outcomes.[2] The Perinatal Mental Health Network Scotland has established national care pathways for specialist perinatal mental health services. Services should include a dedicated specialist midwife with responsibility for perinatal mental health.[28] The Mother and Baby Unit pathway emphasises the importance of keeping the woman and her baby together when specialist inpatient care is needed.

Continuity of carer supports the early identification of mental health concerns and enables timely responses to women who need additional support. Good communication, compassion, practical support and effective pain relief can also contribute positively to women's mental health and wellbeing.

Infant mental health is supported by positive early relationships between the woman and her baby and secure attachment can have long-term benefits for both.[32] Maternity services should be responsive to the individual emotional wellbeing needs of babies and provide a nurturing environment with adequate nutrition and safe sleep opportunities. Positive interactions between women and their babies, including regular communication, appropriate stimulation and responsive care, are important. Support from family members further enhances wellbeing outcomes for women and their babies. All care for babies should be delivered in line with the principles of Getting It Right for Every Child (GIRFEC) and United Nations Convention on the Rights of the Child.

Pregnancy and baby loss is covered in Standard 11.

Criteria

10.1 Women are supported to understand their mental health and wellbeing needs, including recognising changes:

- throughout their pregnancy and postnatal period
- following pregnancy and baby loss (see Standard 11).

10.2 Staff ensure women (and, where appropriate, their care partners) know who to contact if they have concerns about their or their baby's mental health or wellbeing at any point in their care.

10.3 At their first booking appointment, women are offered a comprehensive and holistic assessment of their current and previous mental health and wellbeing. This covers:

- any relevant existing or previous care and treatment plan, including medication
- physical health risk factors for the development of mental health problems
- physical health and medical complications of their baby
- risk factors associated with multiple pregnancy
- access to support networks
- psychosocial factors, such as poverty, homelessness, alcohol or substance use
- risk of gender-based violence
- experience of trauma
- experience of pregnancy or baby loss (see Standard 11).

10.4 Women have their mental health and wellbeing assessed:

- throughout their antenatal care
- during and after birth
- during unscheduled, emergency or critical care (see Standard 9)
- after transfer of care to the universal health visiting system
- following pregnancy or baby loss (see Standard 11)
- when they report a change in their emotional wellbeing.

10.5 Women's care plans are regularly updated to reflect any changes in their mental health and wellbeing needs.

10.6 A primary midwife undertakes assessments of mental health and wellbeing in line with national pathways and relevant guidance and are enabled to:

- use validated assessment tools
- provide positive and supportive care for women with mild to moderate mental health difficulties
- be responsive to individual needs
- recognise symptoms and signs of concern and escalate appropriately
- provide tailored information and signpost to support and resources
- refer to timely specialist support or intervention, as appropriate.

10.7 NHS boards ensure women who require additional or enhanced mental health care have continuity of primary midwife.

10.8 NHS boards have processes to ensure the early identification of, and response to, the need for additional mental health support for women and their babies.

10.9 NHS boards have clearly defined referral pathways for mental health and wellbeing support throughout the maternity pathway, which include:

- evidence-based psychological interventions and proactive outreach
- signposting to community networks and social support, including peer support
- specialist third sector support
- specialist perinatal mental health support and support for suicide prevention
- specialist trauma, female genital mutilation or gender-based violence support.

What does the standard mean for women and their babies?

- Your mental health and emotional wellbeing, and that of your baby, will be supported throughout your maternity care and will be based on your needs.
- You will have the support you need to bond with your baby in your own time.
- If you need support for your mental health and wellbeing, or your baby's emotional wellbeing, you will receive this as soon as possible. It will be tailored to what is right for you.
- You will receive the right information to make decisions that are best for you and your baby.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- undertake holistic and timely mental health and wellbeing assessments
- support women (and care partners, where appropriate) to prepare for parenthood
- support women in early attachment and bonding with their babies
- offer women tailored information and support for their and their baby's mental health and wellbeing
- recognise and respond to concerns about deterioration in mental health and wellbeing and make timely referrals for specialist care and support
- signpost women (and, where appropriate, their care partners) to additional information and support as appropriate.

What does the standard mean for the NHS board?

NHS boards:

- have referral pathways to a range of perinatal mental health and wellbeing services
- review services to ensure they are person centred and trauma informed, including information or facilities
- ensure timely access to specialist perinatal mental health or other support services, for example, specialist trauma or gender-based violence support
- work in partnership with other organisations and services, including social care and the third sector, to support maternal and infant mental health and wellbeing.

Benchmarking and measuring performance	
Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
10.1	Signposting to (and provision of) national information to women (and, where appropriate, their care partners) about mental health and wellbeing.
10.2	Feedback from women.
10.3	Audit and review of patient records demonstrating quality and consistency of mental health and wellbeing assessments, including use of validated tools.
10.4	Documentation and observations showing timely action when a woman reports a change in their mental health or wellbeing.
10.5	Evidence of care plans being regularly reviewed and updated.
10.6	Evidence of staff using validated assessment tools appropriately.
10.7	Individualised care plans, including a named primary midwife.
10.8	Audit and review of referrals and admissions data and pathways.
10.9	Evidence of access to specialist services, for example, gender-based violence services.

Standard 11: Loss and bereavement

Standard statement

Women who experience pregnancy or baby loss have compassionate, person-centred, trauma-informed care and support.

Rationale

The loss of a pregnancy or baby can have a profound impact on women/birthing people, care partners and the wider family.[33] More than one in six pregnancies in the UK end in loss each year.[34] In addition, there is a higher risk of pregnancy or baby loss during a multiple pregnancy.[2]

It is important that women, care partners and families (including siblings) are supported at all stages of pregnancy and baby loss. Women should receive continuity of carer and support that is compassionate, person centred and trauma informed (see Standard 1). This includes offering opportunities to make memories and mark their loss. Communication, support and decision making should be in line with the principles of care described in Standard 1 and Standard 2.

NHS boards should implement the national bereavement care pathway for pregnancy and baby loss, the miscarriage framework and relevant guidance. There should be timely clinical intervention, referral for specialist mental health support and support for the management of subsequent pregnancies, as appropriate. Information should be appropriately shared with members of the woman's care team, including her GP.

NHS boards should have an identified strategic maternity specific bereavement lead to provide oversight across the maternity pathway. The lead will ensure services work together to deliver co-ordinated bereavement care at all stages of pregnancy and postnatally. This should include management of early pregnancy loss and palliative care for newborn babies. The lead should ensure partnership working with social care, third sector and spiritual and faith groups and services.

Staff should receive training in bereavement care and support and be able to deliver person-centred and trauma-informed care to women and their care partners and families. Women should be supported to understand what has happened and should be given the opportunity to have supported discussions with appropriately trained staff. Where there is an investigation or review of the pregnancy or baby loss, women, and where appropriate, care partners and wider family, should receive trauma-informed support and care.

Maternity units should provide dedicated trauma-informed spaces that are private, comfortable, psychologically safe, non-clinical and avoid contact with other women and their babies. Services should be designed collaboratively with people with lived experience to support the psychological safety of women, care partners and families, including siblings.

Staff should be able to access support for their own mental health and emotional wellbeing, including vicarious trauma (see Standard 5).

Criteria

11.1 Women who experience pregnancy or baby loss can be confident that they and their baby will receive compassionate, dignified and respectful care. Care and support should be responsive to the individual needs, belief, culture and preferences of the woman and her baby (see Standard 2).

11.2 Women are supported to mark their loss and make memories, including spending time with their baby whenever possible, either at home or in hospital.

11.3 Women can access person-centred, trauma-informed support in a private, comfortable, psychologically safe and non-clinical environment that actively avoids or minimises contact with other women and their babies.

11.4 NHS boards ensure that all care and support for pregnancy or baby loss is of the same high quality wherever and whenever someone experiences pregnancy or baby loss. Women will continue to receive continuity of midwifery and obstetric case, as required.

11.5 Women who have experienced the loss of one or more babies in a multiple pregnancy, including miscarriage or stillbirth, receive timely, compassionate and specialist bereavement support.

11.6 Women are supported to make informed decisions about suppressing lactation, or donating breast milk, if appropriate.

11.7 NHS boards ensure that all care and support for women who have experienced pregnancy loss aligns with the national miscarriage framework and the national bereavement care pathway for pregnancy and baby loss.

11.8 NHS boards ensure that all care and support for women who have experienced baby loss aligns with the national bereavement care pathway for pregnancy and baby loss.

11.9 Women who have experienced stillbirth are supported to make informed decisions about:

- care before and during birth
- when to have their baby
- birth options, including waterbirth
- analgesia.

11.10 Women have their physical health assessed, with referral, where appropriate, for immediate obstetric care, clinical interventions or investigations.

11.11 Women have their emotional health and wellbeing assessed with appropriate referral for specialist emotional and mental health support, for example, bereavement care and support, counselling or trauma services.

11.12 Staff providing support for women who have experienced pregnancy or baby loss:

- take time to understand and respect the experiences of the woman and her baby
- are appropriately trained and skilled in bereavement care and support
- ensure women have person-centred, trauma-informed, compassionate and culturally-sensitive care and support
- are enabled to access supervision, psychological support and time for reflection
- can access services to address any emotional strain or challenges or vicarious trauma they may experience (see Criterion 5.13).

11.13 Women are provided with tailored information and practical support to:

- register their loss and contact funeral and cremation services, where appropriate
- make informed decisions for post-mortem examination, if required
- contact Specialist Perinatal Pathology services, if required.

11.14 Women are supported to access ongoing care and support at a time and pace that meets their needs:

- from health visiting teams
- from relevant community, social care, third sector and spiritual and faith support services
- for follow-up bereavement care and support
- for future pregnancy planning.

11.15 NHS boards appoint a strategic maternity specific bereavement lead to provide consistent, high-quality care for women and families who have experienced loss. The lead:

- has oversight of all settings where pregnancy or baby loss may occur
- works in partnership across health and social care
- ensures learning from investigation or review is shared appropriately, including with all relevant care teams.

11.16 NHS boards ensure processes and procedures for the investigation and review of pregnancy or baby loss:

- are culturally sensitive, trauma informed and compassionate
- are open and transparent
- are in line with national guidance, national miscarriage framework and the national bereavement care pathway for pregnancy and baby loss
- involve women (and, where appropriate, their care partners), if they wish
- include sharing learning and recommendations with services, staff and women and their care partners, as appropriate.

11.17 NHS boards ensure women (and, where appropriate, care partners) can access timely post-mortems and are supported when they receive the results.

11.18 NHS boards ensure that care partners and wider family members, including siblings:

- feel welcomed by the service and are enabled to attend
- receive person-centred, trauma-informed, family-centred and age-appropriate information and support from compassionate and skilled staff
- can mark their loss and make memories
- have their wellbeing needs assessed, with referrals made for follow-up, as required
- are signposted to specialist support, where appropriate.

What does the standard mean for women and their babies?
• You and your baby will be treated with dignity and respect. • You will be supported to spend time with your baby, if that is possible.

- You will receive clear and sensitive information about the loss of your pregnancy or baby even if it has not been possible to find a reason for your loss. You will be supported to understand what has happened and given time and space to ask questions.
- Staff will support you with any practical arrangements you may need to make.
- You will be able to access specialist staff and services to support your health and wellbeing.
- You can involve your chosen care partner as much as you wish and they will also receive the support that they need. If you have other children, they will be offered support, if that is right for them.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- provide compassionate and respectful support to women (and their care partners and families), including supporting women to spend time with their baby, if possible
- are trained and knowledgeable in the provision of care and support for women experiencing pregnancy or baby loss, which is in line with national bereavement care pathway for pregnancy and baby loss and miscarriage framework
- ensure relevant health and wellbeing assessments are undertaken, including referral or signposting to appropriate specialist support
- have access to support for their own health and wellbeing
- are supported to take part in investigations and reviews, where required
- work in partnership with local strategic maternity bereavement lead, where required.

What does the standard mean for the NHS board?

NHS boards:

- have systems and processes to provide timely bereavement and support services in line with clinical guidance, the national bereavement care pathway for pregnancy and baby loss and miscarriage framework
- ensure referral pathways are in place for specialist palliative or bereavement support
- have policies and processes for undertaking investigations and reviews, including post-mortems

- ensure continuity of care and support is provided to women (and their care partners and families, where appropriate) who have experienced pregnancy or baby loss
- ensure women who wish a post-mortem or to be involved in any review or investigations are supported by trained and compassionate staff
- ensure staff have time and resources to deliver appropriate care and support
- enable staff to access supervision, psychological support and time for reflection
- support staff to take part in investigations or reviews
- have a strategic maternity specific bereavement lead
- learn from reviews and investigations and use this learning to support continuous improvement
- provide dedicated, accessible, trauma-informed spaces that are physically separated from those used by other women and their babies.

Benchmarking and measuring performance

Criteria	Examples of what meeting this standard might look like *Please note this list is not exhaustive and examples may vary according to the size and scale of the service or NHS board or delivery model.*
11.1	Feedback from women, their care partners and wider family members about their experiences at each stage of their bereavement care.
11.2	Availability of memory-making equipment (for example, handprint kits, photography support, blankets and memory boxes).
11.3	Provision of a dedicated space for women experiencing loss that is separated from facilities used by other women and their babies.
11.4	Capacity and resource planning to provide support, including access to facilities, specialist services and a nominated bereavement lead.
11.5	Feedback from women demonstrating that they received timely, compassionate and specialist bereavement support.
11.6	Evidence of accessible information for women on lactation suppression and managing milk supply safely.
11.7	Action and improvement plans supporting the implementation of the miscarriage framework.
11.8	Action and improvement plans supporting the implementation of the national bereavement care pathway for pregnancy and baby loss.
11.9	Evidence of tailored support for women who have experienced stillbirth.
11.10	Monitoring complications following pregnancy or baby loss (including vital signs, blood loss, infection rates and emergency attendances).

11.11	Review of patient records demonstrating timely access to specialist care, such as palliative perinatal care or Maternity and Neonatal Psychological Intervention Services.
11.12	Data on staff training in bereavement care, communication, support and supervision.
11.13	Local pathways for registration of loss and for guidance on offering information about funeral options.
11.14	Referral and signposting to social care, spiritual and third sector support agencies, such as Hospital to Home or Held in our Hearts.
11.15	Evidence of appointment of a maternity bereavement lead, with organisation charts showing the lead's position and reporting lines.
11.16	Evidence of learning from investigations and reviews of pregnancy or baby loss.
11.17	Evidence of timeliness of post-mortems.
11.18	Feedback, including compliments and thank you cards, from care partners and wider family members that show they felt welcomed, informed and supported.

Appendix 1: Development of the maternity care standards

Healthcare Improvement Scotland has established a robust process for developing standards, which is informed by international standards development methodology. This ensures the standards:

- are fit for purpose and informed by current evidence and practice
- set out clearly what people who use services can expect to experience
- are an effective quality assurance tool.

The standards have been informed by current evidence, best practice recommendations, national policy and are developed by expert group consensus. The standards have been cocreated with key stakeholders and people with lived experience from across Scotland.

Evidence base

A review of the literature was conducted using an explicit search strategy developed by Healthcare Improvement Scotland's Research and Information Service. Additional searching was done through citation chaining and identified websites, grey literature and stakeholder knowledge. Searches included Scottish Government, Public Health Scotland, National Institute for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), NHS Evidence and Department of Health and Social Care websites. This evidence also informed impact assessments, including an equalities impact assessment.

Standards are mapped to a number of information sources to support statements, rationales and criteria. This includes, but is not limited to:

- Scottish Government policy
- approaches to healthcare delivery and design, such as person-centred care
- clinical guidelines, protocols or standards
- professional or regulatory guidance, best practice or position statements
- evidence from improvement.

Standards development

The development of standards is underpinned by the views and expectations of healthcare staff, third sector representatives, people accessing maternity services and the public. The standards development process included:

- scope engagement and consultation period
- development group meetings held between November 2024 and February 2026

- editorial review panel meetings on 4 September 2025 and 13 March 2026.

The memberships of the Standards Development Group and the review and editorial panels are set out in Appendix 2 and 3.

Format of the standards

All Healthcare Improvement Scotland standards follow the same format. Each standard includes:

- an overarching standard statement
- a rationale explaining why the standard is important
- a list of criteria describing what is needed to meet the standard
- what the standard means to woman and their babies
- what the standard means if you are a member of staff
- what the standard means for NHS boards
- examples of what meeting the standard might look like in practice.

The examples provided are intended to support NHS boards in assessing, benchmarking, and evidencing their performance against the criteria. These examples are illustrative only and should not be regarded as an exhaustive or prescriptive list of all possible forms of evidence. Given the variation in scale, service configuration, population needs, and delivery models across NHS boards, the specific examples relevant to each service or organisation may differ.

Examples that NHS boards may use to demonstrate how they are meeting the standards, should reflect their local context including population, configuration of services and partnership working. The same piece of evidence can be used to demonstrate that NHS boards are meeting multiple criteria within these standards.

Consultation feedback and finalisation of the standards

Following consultation, the standards development group reconvened to review the feedback received on the draft standards and make final decisions and changes. More information can be found in the consultation summary and log report and the consultation change report, both are available on request from the standards and indicators team.

Quality assurance

All standards development group members were responsible for advising on the professional aspects of the standards. Clinical members of the standards development group advised on clinical aspects of the work. The co-chairs had lead responsibility for formal clinical assurance and sign off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All standards development group members made a declaration of interest at the beginning of the project. They also reviewed and agreed to the standards development group's terms of reference. More details are available on request from the standards and indicators team.

The standards were developed within the Operating Framework for Healthcare Improvement Scotland and the Scottish Government (2022), which highlights the principles of independence, openness, transparency and accountability. For more information about Healthcare Improvement Scotland's role, direction and priorities, please visit: Healthcare Improvement Scotland.

Implementation

The Healthcare Improvement Scotland Quality Management System (QMS) Framework supports health and social care organisations to apply a consistent and coordinated approach to the management of the quality of health and care services. By using standards as part of a quality management system, organisations can work in partnership to develop learning, plan improvement and understand their whole system. Central to this is the relationship between women/birthing people, their care partners and organisations.

The maternity care standards will support person-centred and trauma-informed approaches to care and support for all women and their babies accessing maternity services.

Healthcare Improvement Scotland may use these standards in a range of assurance and inspection activities. They may be used to review the quality and registration, where appropriate, of health and social care services.

Appendix 2: Membership of the maternity standards development group

Name	Position: Organisation
Isla Barton (co-chair)	Director of Midwifery: NHS Highland
Cheryl Clark (co-chair) until November 2025	Director of Midwifery: NHS Lanarkshire
Jacqui Laurie (co-chair) from November 2025	Consultant Obstetrician and Gynaecologist: NHS Lothian Strategic National Clinical Lead in Obstetrics: Healthcare Improvement Scotland
Maree Aldam	Chief Executive Officer: Amma Birth Companions
Kate Boyle	Chair: Scottish Neonatal Nurses Group Principal Educator: NHS Education for Scotland Senior Midwife for Neonatal Services: NHS Lanarkshire
Shetty Bhushan	Chair, Consultant Forum: National Neonatal Network Consultant Neonatal Medicine: NHS Tayside
David Bywater	Lead Consultant Paramedic, Interim Director for Care Quality and Professional Development: Scottish Ambulance Service
Kirstie Campbell (Observer)	Head of Maternal and Infant Health: Scottish Government
Eilidh Clark	Senior Pharmacist: Women's Health: NHS Ayrshire & Arran
Aileen Cope	Clinical Director: NHS Forth Valley Chair: National Obstetrician and Gynaecologist, Clinical Directors Group
Sarah Corcoran (Observer)	Team Leader - Maternal and Infant Health: Scottish Government
Gwendolyn Cremers	Clinical Psychologist: NHS Borders

Name	Position: Organisation
Justine Craig until January 2026	Chief Midwifery Officer: Scottish Government
Emma Currer	National Officer – Scotland: Royal College of Midwives Scotland
Wendy Duffy	Senior Inspector: Healthcare Improvement Scotland
Tara Fairley	Consultant Obstetrician: NHS Grampian
Rebekah Golding	Clinical Coordinator, Senior Midwife: NHS Forth Valley
Amanda Gotch	Consultant Midwife: NHS Grampian
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The following members of Healthcare Improvement Scotland's standards and indicators team supported the standards development group, review and editorial panels:

- Lola Adewale – Programme Manager (until December 2025)
- Stephanie Kennedy – Administrative Officer (from December 2025)
- Dominika Klukowska – Administrative Officer (until December 2025)
- Jen Layden – Programme Manager (from December 2025)
- Silas McGilvary – Project Officer (from October 2024)
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- Fiona Wardell – Team Lead.

Appendix 3: Membership of the draft and final standards' editorial panels

Draft standards: editorial panel membership

Name	Position: Organisation
Lola Adewale	Programme Manager: Healthcare Improvement Scotland
Isla Barton	Director of Midwifery: NHS Highland
Cheryl Clark	Director of Midwifery: NHS Lanarkshire
Safia Qureshi	Director of Evidence and Digital: Healthcare Improvement Scotland
Fiona Wardell	Team Lead: Healthcare Improvement Scotland

Final standards: editorial panel membership

Name	Position: Organisation
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Jen Layden	Programme Manager: Healthcare Improvement Scotland
Safia Qureshi	Director of Evidence and Digital: Healthcare Improvement Scotland
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Appendix 4: Patient information and resources

There are a range of resources available to support every woman/birthing person (and their care partners and families) to make informed decisions about their and their baby's care. Your midwife will offer you information and signpost you to resources.

Below is a list of national information sources that you may also find helpful. This is not an exhaustive list of all the resources available.

- NHS Inform contains a wide range of information including:
  - Planning for pregnancy
  - Pregnancy screening, newborn screening and vaccinations in pregnancy
  - Ready Steady Baby!
- Public Health Scotland:
  - Off to a good start: All you need to know about breastfeeding
  - You're pregnant! Scans and tests
- Scottish Government:
  - Birthplace decisions: Information for pregnant women and partners on planning where to give birth
- Scottish Perinatal Network:
  - Information for families.

Pregnancy and baby loss support

Pregnancy and baby loss is one of the most traumatic experiences any family can go through. If you have been affected by any of the issues raised in our standards, there is support available for you:

- NHS Inform: Finding support after baby loss
- Sands: Supporting bereaved families
- Scottish Government: Support if a child or baby dies
- Tommy's: Saving babies' lives: The pregnancy and baby charity pregnancy
- Twins Trust: Bereavement Service.

Appendix 5: Related guidance

These standards are aligned with clinical guidance and pathways, national policy and key legislation and should be read alongside the following. This is not an exhaustive list:

Clinical guidelines and pathways:

- British Association of Perinatal Medicine. A framework for neonatal transitional care.
- National Bereavement Care Pathway for pregnancy and baby loss
- NICE. Antenatal care.
- NICE. Fetal monitoring in labour.
- NICE. Intrapartum care.
- NICE. Intrapartum care for women with existing medical conditions or obstetric complications and their babies.
- NICE. Postnatal Care
- Royal College of Anaesthetists. Guidelines for the provision of anaesthesia services for an obstetric population.
- Royal College of Gynaecologists. Reducing the risk of venous thromboembolism during pregnancy and the puerperium.
- Royal College of Obstetricians and Gynaecologists. Maternity service standards framework.
- SIGN. Management of diabetes in pregnancy.
- SIGN. Perinatal mental health conditions.

Healthcare Improvement Scotland related sources:

- A national framework for reviewing and learning from adverse events in NHS Scotland
- Clinical governance standards
- Congenital heart disease standards
- Essentials of safe care
- Healthcare and forensic medical services standards
- Infection prevention and control standards
- Pregnancy and newborn screening standards
- Safe delivery of care in maternity units inspection programme
- Scottish approach to change: Framework
- Scottish Patient Safety Programme (SPSP)
- Sexual health standards.

Scottish Government related sources:

- Breastfeeding and infant feeding strategic framework
- Charter of patient rights and responsibilities
- Delivering together for a stronger nursing and midwifery workforce
- Delivering value based health and care: a vision for Scotland
- Early child development transformational change programme
- Health and Social Care Service Renewal Framework
- Health and Social Care Standards: my support, my life
- Maternity services policy: DL (2025) 02
- Miscarriage care in Scotland: delivery framework
- National health and wellbeing outcomes framework
- Race Equality Framework for Scotland 2016-2030
- Realistic medicine.

Other related sources:

- General Medical Council: Maternity care
- NHS Education for Scotland. Support around death
- NHS Scotland. Scottish perinatal network
- Nursing and Midwifery Council. Principles for support women's choices in maternity care.
- Nursing and Midwifery Council. Standards for midwifes.
- Royal College of Midwifes. Strengthening midwifery leadership.
- Royal College of Midwifes. Quality, standards and safety resources
- Royal College of Obstetricians and Gynaecologists. RCOG guidance
- UNICEF UK: The baby friendly initiative.

Glossary

Term	Definition
Adverse event	an event that could have caused, or did result in, harm to people. This includes death, disability, injury, disease, suffering or an immediate or delayed emotional reaction or psychological harm.
Assisted birth	is when a healthcare professional uses specially-designed instruments, such as forceps or a ventouse (vacuum cup), to help the baby be born through the birth canal.
Care outside of guidance	refers to situations where women choose care or support, including choices about birth, that do not follow local or national guidelines or standards. This may be to increase a woman's sense of autonomy and control, or because the choice aligns with her personal beliefs, values or preferences. Such care may also be described as *alternative* or *non-standard* birth choices.
Care partner	refers to any person the woman chooses to be involved in her care. This may include the biological father or parent of the baby, a partner, family member or friend. The care partner may change over the course of the pregnancy and may be the same person as the birth partner. Where appropriate, wider family members, including children, may also be involved, for example following pregnancy or baby loss.
Carer	in these standards, carer refers to the primary midwife working within a continuity of care model. Carers provide a significant proportion of a woman's antenatal, intrapartum and postnatal care.
Clinically-significant injury	including obstetric anal sphincter injuries, postpartum haemorrhage, severe perineal tears and complications from regional analgesia, and regional or general anaesthesia.

Term	Definition
Companion of choice	is someone the woman chooses to have with them during their maternity care, and most often during labour and birth. This may be her care partner, a family member, a friend, a birth partner, or a doula (a non-medically trained birth companion).
Complex care needs	refers to circumstances when a woman requires enhanced, personalised and often multidisciplinary maternity care due to medical complexity (see below), complications in pregnancy or social, communication or safeguarding factors that may affect her health, safety or wellbeing, or that of her baby. These needs may arise at any stage during pregnancy, birth or the postnatal period and require ongoing assessment and tailored support.
Early pregnancy assessment services	are services that provide assessment, advice and support during the early stages of pregnancy (usually before 12 weeks). They can offer help with symptoms such as bleeding or abdominal pain, or when a woman is concerned about miscarriage. These services are also known as early pregnancy units or early pregnancy assessment units.
Gender-based violence	is any harmful behaviour directed at someone because of their gender. It stems from gender inequality and abuse of power, and includes forms of domestic abuse, sexual violence, coercive control, stalking, commercial sexual exploitation, forced marriage and female genital mutilation. Women and girls are disproportionately affected, though anyone may experience gender-based violence.
Health-harming products	refers to products that can cause harm to the woman or her developing baby. These include, but are not limited to, tobacco, alcohol, certain medications and foods, substances and drugs.
High quality	refers to healthcare that is person centred, safe and effective. This includes care focussing on people's experiences, ensuring safety and preventing harm, and providing treatments and services that are appropriate, effective, compassionate, trauma informed, evidence based and supports continuity and consistency in care.
Income maximisation	are actions that increase the amount of money people receive and reduce unnecessary expenditure. It ensures that individuals receive all financial support they are entitled to,

Term	Definition
	including state benefits, government grants and other eligible assistance.
Infant mental health	is the capacity for babies to experience, regulate and express emotions, form close and secure relationships, and explore and learn about their environment.
In-utero transfer	refers to the transfer of a pregnant woman to another setting before the baby is born, because the baby is likely to require care in a specialist neonatal unit.
Line of sight from 'floor to board'	is the clear and transparent communication channel that ensure senior leaders and NHS board members understand the day-to-day realities, challenges and achievements within maternity services. It also enables staff working on the maternity floor to raise concerns, share issues and offer suggestions directly to senior managers and board-level leaders.
LGBTQIA+	stands for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual/Aromantic. It is used as an inclusive umbrella term to represent a broad spectrum of sexual orientations, gender identities, and lived experiences. The "+" symbol acknowledges that many additional identities—such as pansexual and gender-fluid—are also part of the community, ensuring the term remains open and inclusive of all people whose identities fall outside those explicitly named.
Medical complexity	refers to situations where a woman has significant medical problems complex health conditions that increase the risks associated with pregnancy, birth or the postnatal period. Medical complexity includes, but is not limited to, women who: • have pre-existing, long-term health conditions • have significant or very high-risk cardiac conditions • are experiencing a multiple pregnancy • have a previous history of stillbirth or miscarriage • have a raised body mass index • are aged 35 years or over • are assessed as being at increased risk of preterm labour.

Term	Definition
Near misses	are events that could have caused harm but did not, because of circumstances or intervention.
Non-commercial information	is information that is developed by statutory, third sector or not for profit agencies. It is informed by evidence and best practice. There are no commercial or financial gains from producing, sharing or accepting the information.
Peripherals	refers to equipment and devices used to monitor maternal and fetal wellbeing. These may include a handheld doppler, ultrasound scanning equipment, blood pressure cuffs and wearable sensors.
Primary midwife	is the midwife who has lead responsibility for midwifery care throughout a woman's pregnancy and labour. A primary midwife coordinates care planning for women and is sometimes referred to as 'carer.' A primary midwife may also be referred to as the 'named midwife.' In Scotland, the practice of midwifery is governed by several pieces of legislation, primarily the Midwives (Scotland) Act 1915, the Midwives (Scotland) Act 1951, and the Nursing and Midwifery Order 2001. These Acts outline the requirements for certification, regulation and supervision of midwives. This legislation establishes midwifery as a protected function and title, meaning only registered midwives or medical practitioners may attend childbirth, except in emergencies or under supervision during training.
Staff	in these standards, refers to all staff involved in the delivery of maternity care. This includes, but is not limited to, anaesthetists, dietitians, GPs, gynaecologists, health visitors, maternity care assistants, maternity support workers, midwives, neonatal nurses, neonatologist, nurses, obstetricians, paediatricians, pharmacists, physiotherapists, sonographers, educators and clinical researchers. Where appropriate the multidisciplinary team should also be supported by other multidisciplinary professionals including social workers and psychologists and staff from drug and alcohol teams or Maternal, Neonatal and Psychological interventions teams.

Term	Definition
	In Scotland, registered healthcare professionals are regulated by various bodies, including the Nursing and Midwifery Council (NMC), the General Medical Council (GMC), the General Pharmaceutical Council (GPhC) and the Health and Care Professions Council (HCPC). The NMC regulates nurses and midwives, while the GMC regulates doctors, physician associates and anaesthesia associates. The HCPC regulates a wide range of Allied Health Professions, including physiotherapists and dietitians. The GPhC regulates pharmacists and pharmacy technicians. Independent healthcare services in Scotland must also be registered with Healthcare Improvement Scotland.
Timely	is care that is provided without unnecessary delay, ensuring that women and their babies receive the right care at the right time. In NHS Scotland, timeliness is supported through a range of national waiting-time standards and guarantees designed to minimise avoidable delay, reduce stress and prevent deterioration in health. While not defined by a single measure, timely care is achieved through adherence to these standards across the maternity care pathway.
Trauma informed	is a way of working and delivering services that recognises a person may have experienced trauma and understands the effects that trauma may have on them. In healthcare, this involves adapting processes and practices based on that understanding and aiming to avoid, or minimise the risk of, re-exposure to past trauma or the experience of further trauma. A trauma-informed service demonstrates how it is shaped by anonymous feedback from people with living and lived experience of trauma. A trauma-informed system also supports workforce resilience and is underpinned by trauma-informed leadership and organisational systems.[35] Further information is available from National Trauma Transformation Programme.

Term	Definition
Triumvirate leadership structure	is a leadership model in maternity services involving three core leaders: a Clinical Director (usually an obstetric consultant), a Head or Director of Midwifery, and a General or Operations Manager. This structure provides balanced leadership by combining clinical expertise, professional midwifery insight, and managerial or operational skills. Other similar leadership models may also be appropriate for maternity services.
Underserved groups	are people who experience barriers accessing services and have less positive outcomes in maternity services. Being underserved is most often the result of discrimination, poverty or finding services geographically difficult to get to. It can also include not getting the right information or support to be able to make informed choices when receiving care. In maternity services, underserved groups include, but are not limited to: • people from minority ethnic groups, including Gypsy Travellers • people who have been in care • people under the age of 18 • people with complex social needs around housing, poverty and alcohol or substance use • disabled people, including people with a mental health condition, learning disability or who are neurodivergent • people with an LGBTQIA+ identity • asylum seekers, refugees and people from migrant backgrounds • people with experience of trauma, gender-based violence or female genital mutilation • people living in remote and rural areas • people in prison.
Vicarious trauma	is the emotional, psychological and physical distress that occurs when an individual is indirectly exposed to the traumatic experiences of others.

Term	Definition
Women/birthing people	includes women, girls, trans men and non-binary and intersex people who are pregnant or have recently been pregnant.

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