Healthcare Improvement Scotland

Maternity care

Draft standards

September 2025

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 to notify us of any updates that might require consideration.

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Contents

Introduction

Maternity care in Scotland is provided by NHS boards and delivered by an integrated multidisciplinary team of healthcare professionals.(1) Women/birthing people and their babies should experience safe, effective and high-quality maternity and newborn care, wherever they live and whatever their circumstances.(2) The term women/birthing people is used within these standards to include women, girls, trans men, and non-binary and intersex people, who are pregnant or have recently been pregnant.

It is essential that women/birthing people are informed of their choices and the support available to them before, during and after birth.(3) This will enable care to be provided in partnership, and support women/birthing people to achieve the best outcomes and future health for themselves and their babies.(4)

Recent reports and audits have highlighted variations in the quality and consistency of maternity care experienced by women/birthing people, their babies and families.(5-8) Evidence indicates the need to improve health outcomes for women/birthing people from minority ethnic groups, and those living in poverty or with mental health conditions.(9, 10)

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/birthing people. This commitment is outlined in key policies, including The best start: five-year plan for maternity and neonatal care, Women's health plan, Programme for Government and Scottish Government: Population Health Framework.(11) These policies outline the importance of maternity care as a significant public health intervention. Maternity services should provide the right care for every woman/birthing person and baby, offer continuity of care and carer, and support every child to have the best start in life.(12)

The Best Start emphasises the importance of offering women/birthing people and their babies a family-centred, safe and compassionate approach to their care, which recognises their unique circumstances and preferences.(1) To support a family-centred approach, fathers, co-parents, partners and other family members, should be actively encouraged and supported, where appropriate.

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

As part of a wider approach to improving healthcare across Scotland, Healthcare Improvement Scotland is currently working collaboratively with stakeholders to develop clinical governance standards. These standards will apply to all clinical services planned, commissioned or delivered within the health and social care system in Scotland. The standards for maternity care should be read in conjunction with these clinical governance standards.

Information and resources

There are a range of resources available to support women/birthing people and their care partners to make informed decisions about their maternity care.

Information and resources include:

- After a miscarriage
- Birthplace decisions: Information for pregnant women and partners on planning where to give birth
- Off to a good start: All you need to know about breastfeeding
- Pregnancy screening, newborn screening and vaccinations in pregnancy
- Planning for pregnancy
- Ready Steady Baby!

Related guidance, policy and legislation

These standards are informed by national and international evidence and best practice, including the principles of person-centred and trauma-informed care, human rights and equality.(13-19) The standards are aligned with clinical guidance and pathways, national policy and key legislation.(20-25)

They form part of a suite of documents and pathways that support the delivery of high-quality, person-centred maternity care. The standards for maternity care should be read alongside the following:

- Delivering together for a stronger nursing and midwifery workforce
- Healthcare Improvement Scotland: Clinical governance standards for Scotland
- Healthcare Improvement Scotland: Pregnancy and newborn screening standards
- Healthcare Improvement Scotland: Scottish Patient Safety Programme (SPSP)
- Maternity pathway and schedule of care: clinical guidance and schedule
- National Bereavement Care Pathway for pregnancy and baby loss
- Scottish Government: Breastfeeding and infant feeding strategic framework
- Scottish Government: Early child development transformational change programme
- Scottish Government: Health and Social Care Service Renewal Framework
- Scottish Government: Maternity services policy: DL (2025) 02

- Scottish Government: Population Health Framework
- Scottish Government: Programme for Government 2025 to 2026
- Scottish Government Women's Health Plan
- SIGN: Perinatal mental health conditions
- UNICEF UK: The baby friendly initiative.

Scope of the standards

The standards apply to:

- all women/birthing people experiencing maternity care in Scotland
- all babies receiving core newborn care, until their care is transferred to the universal health visiting service (usually at ten days old)(26, 27)
- care partners, where appropriate, of people experiencing maternity services.

The standards aim to support current and future provision of maternity services. They also promote improvement in the delivery and coordination of care and support, for all women/ birthing people and their babies. The standards cover maternity care delivered in all settings, including hospitals, primary care, midwifery units, prisons, and community or home settings.

These standards apply to all NHS Scotland staff involved in the multidisciplinary delivery of maternity services.(6) In Scotland, midwives are often the main coordinators of maternity care and all pregnant women/birthing people are offered midwifery care when they first book for antenatal care. Women/birthing people with complex obstetric or medical needs will be referred to an obstetrician (specialist doctor in maternity care or medicine) to lead their care.

Midwives and obstetricians deliver maternity care in partnership with other relevant healthcare professionals, including anaesthetists, dietitians, family nurses, general practitioners (GPs), gynaecologists, healthcare support workers, health visitors, infant feeding support nurses, maternity care assistants, maternity support workers, neonatal nurses, paediatricians, pharmacists, physiotherapists and sonographers. The standards apply to all staff involved in the delivery of maternity services, including locum staff, contracted staff and those covered by reciprocal work arrangements, students and trainees.

The standards cover:

- principles of care
- leadership and culture
- high-performing and functioning teams
- core care: antenatal, intrapartum and postnatal assessment and care
- unscheduled and additional care
- mental health and wellbeing: women/birthing people and babies
- loss and bereavement.

The standards should be read as a collective rather than a linear document. For example, the criteria in Standards 4-7 should be provided in line with the principles set out in Standards 1-3.

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 if you are a women/birthing people
- 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.

Implementation

The Healthcare Improvement Scotland Quality Management System (QMS) Framework supports health and social care organisations to apply a consistent and coordinated approach to 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 and their babies (and their care partners, where appropriate) and the organisations caring for them.

The standards outline the fundamental and minimum standards for maternity care in Scotland. They provide a benchmark for progress towards nationally consistent, integrated maternity services that will ensure the best experiences and outcomes for all women/birthing people and their babies.

The standards are aligned with existing Scottish Government policies, which will support the development and improvement of maternity services. Regular quality assurance activities, including inspections, will highlight areas for improvement, provide examples of good practice and contribute to assuring equity of maternity care.

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

Terminology

Wherever possible, we have used generic terminology that can be applied across all health and social care settings. Terms and definitions are provided in the glossary.

How to participate in the consultation process

We welcome feedback on the draft standards and review every comment received. We use different methods of capturing feedback during consultation, including:

- targeted engagement with people who use services (and their care partners) and service providers (including maternity healthcare staff at the point of care)
- circulation of the draft standards to relevant staff, professional groups and networks, including staff working in healthcare and third sector organisations
- an online survey: https://www.smartsurvey.co.uk/s/6O6MLB/

Submitting your comments

Responses to the draft standards should be submitted using our online survey: https://www.smartsurvey.co.uk/s/6O6MLB/.

The consultation closes on **7 November 2025**. If you would like to submit your comments using a different format, please contact the project team at his.standardsandindicators@nhs.scot

Please note, consultation comments will not be accepted after the closing date, or in an alternative format, unless previously agreed with the project team.

Consultation feedback

Feedback on the draft standards will be reviewed and themed by the project team. The development group will reconvene following consultation, to review feedback on the draft standards and agree on amendments to the standards.

A summary of the responses to the consultation will be made available on request from the project team at his.standardsandindicators@nhs.scot.

The final standards will be published in spring 2026.

Standards summary

Standard 1: Principles of care

All maternity care is high-quality, personalised, integrated and coordinated, promotes choice and enables decision making.

Standard 2: Leadership and culture

Maternity services have effective leadership and governance and encourage a culture of openness and continuous improvement.

Standard 3: High-performing and functioning teams

Maternity care is delivered by high-performing teams, which are responsive to the individual needs of women/birthing people, and are adequately and appropriately staffed.

Standard 4: Core care: antenatal, intrapartum and postnatal assessment and care

Women/birthing people are offered compassionate and high-quality antenatal, intrapartum and postnatal care.

Standard 5: Unscheduled and additional care

Women/birthing people have timely access to high-quality, safe, effective and person-centred unscheduled and additional care.

Standard 6: Mental health and wellbeing: women/birthing people and babies

NHS boards promote positive mental health and wellbeing for women/birthing people and their babies.

Standard 7: Loss and bereavement

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

Standard 1: Principles of care

Standard statement

All maternity care is high quality, personalised, integrated and coordinated, promotes choice and enables decision making.

Rationale

A human rights approach to maternity care is essential for the provision of timely and equitable access to high-quality healthcare that is safe, effective, efficient and person-centred.(22, 26) Such an approach optimises the physiological process of pregnancy and birth, identifies and prevents complications, and provides appropriate interventions where necessary.(6, 28, 29) Maternity care should empower and enable women/birthing people to care for themselves and their babies and attain the highest possible standards of health.(30) This will enable people to live longer, healthier and more fulfilling lives.(2)

Throughout all stages of maternity care, women/birthing people should receive advice, information and support to enable them to plan and make choices that are right for them and their babies.(4) This includes providing women/birthing people with timely, person-centred and evidence-based information to support discussions and enable decisions.(6, 12) Women/birthing people report positive experiences and outcomes when they are fully informed and supported to make decisions about their maternity care, including place of birth.(20, 21, 31, 32)

Where appropriate, and with the agreement of the woman/birthing person, care partners should be involved throughout maternity care, and encouraged and supported to become an integral part of all aspects of maternal and newborn care.(1)

Evidence indicates that good staff communication improves the experience and safety of patients, and increases workforce efficiency.(33) People are empowered when they are supported to communicate what matters to them and when they feel respected and listened to.(21, 34) Women/birthing people who are supported to have choice and control, report more positive experiences and enhanced feelings of safety and trust.(19, 35-37) Women/birthing people also report better outcomes when staff and services understand and respond appropriately to the impact of trauma on their experience.(18, 19)

Trust is developed through relationship-based, respectful, kind and compassionate interactions with healthcare professionals. Women/birthing people should always be respected and supported in their choices and decisions, including when they decline care, request a second opinion, or seek care outside of guidance.(34) If a woman/birthing person seeks care that is outside of guidance or current best practice, their human rights for bodily autonomy should be respected. Staff should support women/birthing people to understand any risks or implications of their decisions.(34)

Continuity and consistency of midwifery care, and carer, improves outcomes and experiences within maternity services.(1, 12, 38, 39) All pregnant women/birthing people in Scotland will be offered a primary midwife, who is part of a multiprofessional maternity care team. The primary midwife is the lead professional and coordinates maternity care. The primary midwife supports safe physical, psychological, social, cultural and spiritual care. This will promote positive outcomes and support the anticipation and prevention of complications.(27)

The primary midwife will also ensure timely collaboration with, and escalation and referral to, interdisciplinary and multiagency colleagues where appropriate. The primary midwife has specific responsibility for continuity and coordination of midwifery care, providing access to the multidisciplinary team, if required. The primary midwife will act as an advocate for the woman/ birthing person and their baby, to ensure that they are always the focus of care. An integrated, personalised care and support plan supports transition throughout the maternity pathway.(40, 41) There should be clear pathways and protocols for the safe transfer of care between healthcare settings, facilities and providers, including Scottish Ambulance Service, if required.

Many women/birthing people will also have a named consultant obstetrician, for example, if they have complex medical needs. Where clinically appropriate, some women/birthing people may also be supported by an anaesthetist or other specialist doctor.

Inclusive and locally accessible maternity services reflect the needs of the populations they serve. This involves NHS boards identifying populations and communities in their areas and assessing the impact of protected characteristics, cultural and socioeconomic factors and the geographical considerations of remote and rural areas.(42, 43) Impact assessments can support NHS boards to understand barriers people may face in accessing maternity services and to address these when designing or improving services.(44, 45) By understanding and responding to the needs of local communities, NHS boards can provide timely and consistent care across maternity pathways.(43)

Health inequalities are avoidable, unfair and systemic differences in health between different groups of people.(13, 46) Women/birthing people from Black and Asian ethnic backgrounds are significantly less likely to experience positive maternal health and outcomes than White woman. Mortality rates are higher for Black and Asian women/birthing people and their babies.(47) It is essential for NHS boards to demonstrate improved maternal health and high-quality maternity and newborn care for women/birthing people and babies of the global majority.(11, 48-52)

Maternity care should address the individual needs of women/birthing people and their babies. Maternity services should be responsive to the barriers experienced by lesbian, transgender, intersex and non-binary people.

Women/birthing people under the age of 18 years have rights protected under the United Nations Convention on the Rights of the Child.(53)

Ensuring informed consent for all interventions is essential for good maternity care.(34, 54) Information privacy should always be respected and consent to sharing information should be sought where appropriate and in accordance with legislation and national guidance.(55, 56)

It is important that maternity care is provided in a safe environment, with adequate staff, appropriately maintained equipment, and systems and processes to ensure prevention and control of infection.

Criteria

1.1 Women/birthing people have positive experiences of all maternity services because they are:

- fully informed and listened to
- respected for their culture and beliefs by non-judgemental and culturally competent staff
- recognised as experts in their own needs and preferences
- respected for their decisions about their care and support.

1.2 Women/birthing people and their babies are treated as one entity, and should not be separated unless there are clinical, legal or safeguarding reasons to do so. This should be fully discussed, documented and shared appropriately.(1, 55, 57)

1.3 Babies are recognised as separate individuals with legal rights after they are born, and their wellbeing is central to all decisions about their care and treatment.(23, 24)

1.4 Women/birthing people are supported to make decisions at all stages of their maternity care, including place of birth, and are enabled to:

- understand the benefits and risks of their options for care or proposed interventions
- raise questions or concerns at a time and pace that is right for them
- understand and communicate any changes in their condition and report their concerns to their maternity care team
- discuss options with appropriately knowledgeable, trained and unbiased staff
- seek a second opinion
- ensure their decisions are supported, respected, documented and shared appropriately
- provide, or decline, informed consent for clinical interventions, in line with national guidance.(54, 58)

1.5 Women/birthing people have timely access to high-quality information, advice and support that is:

- accessible, non-commercial and based on current practice and evidence
- in a format and language that meets their needs and understanding
- relevant to their circumstances and reflects what matters to them
- appropriate for the whole maternity care pathway, including preparation for pregnancy, and antenatal, intrapartum and postnatal care.

1.6 Women/birthing people are asked about their preferences for communication, including how they wish to receive results and are supported if they have additional communication needs.(59, 60)

1.7 NHS boards ensure women/birthing people have the same primary midwife throughout their maternity care.

Where appropriate, women/birthing people can also access consistent obstetric and specialist healthcare input from a named:

- obstetrician
- healthcare specialist.

1.8 Woman/birthing people have a single integrated maternity care plan, which:

- they co-create
- recognises their experiences, needs and concerns
- is regularly reviewed and updated with the woman/birthing person, and any changes or delays fully discussed and agreed
- documents any additional support needs, language requirements and personal preferences(61)
- includes their health and wellbeing needs, including physical, psychological, social, cultural and spiritual preferences
- includes all clinical information, including medical history, assessments, ultrasound scans and test results
- includes all decisions including where care is sought outside of guidance
- reflects the whole maternity pathway and covers all care and support, including antenatal care, birth plan and postnatal care for the women/birthing person and their baby.(60)

1.9 NHS boards ensure that all maternity care plans are shareable and readily accessible to all:

- women/birthing people
- members of the woman/birthing person's maternity care team
- staff providing unscheduled care outside maternity settings, including primary care and emergency departments.

1.10 NHS boards develop integrated pathways and protocols to ensure effective communication:

- between women/birthing people and maternity staff, including who to contact if they have questions or concerns, or if they wish to make an appointment
- to support multidisciplinary team working, including multiprofessional handovers between intrapartum and postnatal care, particularly following trauma during pregnancy or birth
- to support timely, safe and effective transfer of setting, care or healthcare provider, if required.

1.11 NHS boards enable women/birthing people to access timely and equitable antenatal, intrapartum care and postnatal care at home and in the community.

1.12 Women/birthing people and babies of the global majority experience equitable high-quality maternity and newborn care.

1.13 NHS boards demonstrate their commitment to addressing ethnic and cultural inequalities experienced by women/birthing people of the global majority by:

- recognising and responding to their individual needs and circumstances
- ensuring people feel listened to and are at the centre of decision-making
- maximising their physical and mental health wellbeing and psychological safety
- providing opportunities to build trust.

1.14 Women/birthing people with enhanced or complex needs, have continuity of care and carer, and consistent access to appropriate care and support from:

- their primary midwife and the maternity team at all stages of the maternity pathway
- their named consultant obstetrician and obstetric team, where required or requested
- multidisciplinary and specialist teams where required or requested.

1.15 NHS boards develop clear protocols for safe transfer of care between healthcare settings, facilities and providers, including the Scottish Ambulance Service, which:

- are based on best evidence and national guidance
- are included in training for all relevant staff
- are widely available and easily accessible
- outline clearly defined staff roles and responsibilities
- ensure effective transfer of all information required to provide continuity of person-centred care
- minimise unnecessary delays or interruptions in care.(33)

1.16 Women/birthing people have their needs, wellbeing and risk factors assessed and reviewed in line with relevant policies:

- at each antenatal appointment
- immediately at the time of birth
- postnatally
- prior to transfer to community care
- if concerns are raised by women/birthing people, or their care partners
- if incidents are escalated by staff
- during any admission to the emergency department or unscheduled non-maternity inpatient settings.

1.17 Women/birthing people who seek care that is outside of guidance or best practice:

- are provided with appropriate evidence-based information to understand any risks or benefits and the implications of their decision
- are informed they can change their mind at any time
- have their decision and human rights respected
- are supported by staff who are compassionate and non-judgemental
- have their experiences and outcomes monitored and reviewed to ensure that they continue to receive the best possible care.(34)

1.18 NHS boards enhance the wellbeing and positive outcomes of women/birthing people by ensuring maternity care facilities:

- support women/birthing people to feel welcome and safe(62, 63)
- provide privacy and dignity
- are accessible and as close to home as possible(2)
- provide in person appointments, with options for additional telephone or video appointments if requested by the woman/birthing person
- support different options for women/birthing people during labour and birth
- support care partners and family to attend appointments and birth if the woman/birthing person wishes and it is appropriate.

1.19 NHS boards demonstrate their commitment to addressing health inequalities by:

- undertaking population needs and impact assessments to inform service provision
- meaningful engagement with people with living and lived experience to ensure the design and delivery of inclusive services
- routinely collecting, and responding to, data on the impact of health inequalities and intersectionality on outcomes for women/birthing people and their babies
- monitoring improvement and developing action plans
- implementing learning from good practice, impact assessments, data, feedback, complaints, adverse events, reviews and inquiries
- offering a service that provides flexible appointment times to accommodate additional care or communications needs, including translation services
- responding to the needs and experiences of their communities, including the impact of health literacy, intersectionality and protected characteristics
- providing locally accessible public sector, social care and third sector support services, including support for housing and income maximisation.(64)

1.20 NHS boards design maternity services in partnership with women/birthing people, and their care partners where appropriate, using an evidence-based and evaluated service codesign approach.(65)

1.21 NHS boards provide nationally agreed, clear, accessible and fair policies for reimbursement of reasonable travel expenses to access maternity services.(66)

1.22 Women/birthing people are offered opportunities to involve their chosen care partner as they wish throughout their maternity care. Where appropriate, care partners will:

- receive tailored information and support
- be able to attend appointments and the birth
- be welcomed and recognised as an important part of the support network for the woman/birthing person and their baby.

What does the standard mean for women/birthing people?

- You will feel welcome and safe.
- Your privacy and dignity will be respected and maintained.
- Your care will be based on your, and your baby's, individual needs and circumstances.
- You will have a primary midwife who will work in a team to provide you with care and support throughout your pregnancy.
- If required or requested, you will have a named consultant obstetrician and a specialist team.
- Your care and support will be clearly explained and discussed and you will be given time to ask questions and think about your options.(60)
- You have the right to choose what is best for you and your baby and staff will respect your choices.
- You have the right to accept or decline the maternity care you are offered.
- You will be asked for your consent before all clinical examinations or interventions.
- If you have concerns, or wish to discuss anything, you will be listened to and taken seriously.
- Your choice of place of birth will be respected and you will experience the same high-quality care and support wherever you choose to receive maternity care or have your baby.
- You can involve your chosen care partner as much as you wish.
- You and your baby will stay together as much as possible.
- If you need to travel to experience maternity care you will be supported to claim reasonable expenses.
- You will be supported to access help for any housing and financial concerns, including accessing benefits.
- You will be able to give feedback, or raise concerns, about the service you receive.(33)

What does the standard mean for staff?

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

- provide safe, effective, evidence-based, person-centred and trauma-informed maternity care that supports choice and informed decision making, with opportunities for discussion and questions(67)
- provide empathetic, respectful and compassionate care and support
- provide continuity of care
- support women/birthing people to experience the same high-quality care and support, wherever they receive maternity services
- share relevant information appropriately to ensure consistency and continuity of care
- access resources including translation and interpreter services to support women/birthing people to actively participate in all aspects of their care
- signpost and refer women/birthing people to relevant information and appropriate additional support
- understand and respond to the needs and experiences of the communities in which they work
- support the decisions of women/birthing people, including if these decisions are for care outside of standard guidance
- be aware of the potential outcomes and risks associated with choices outside of guidance and take appropriate steps to ensure the safety of both the woman/ birthing person and their baby.(67)

What does the standard mean for the NHS board?

NHS boards:

- have systems and processes in place to provide services that are responsive to the needs of women/birthing people and their babies, including where care is sought outside of guidance
- ensure the provision of timely, accessible, evidence-based, non-commercial information and support
- ensure women/birthing people have a primary midwife and are supported by the same midwifery and maternity team as much as possible
- ensure professional, good practice and evidence-based guidance into person-centred and trauma-informed care
- ensure equitable access to high-quality evidence-based maternity care for women/birthing people in all areas, and in all circumstances, including remote and rural areas
- have mechanisms to record and respond to feedback from women/birthing people, their care partners and staff
- ensure services enable people to feel welcome and safe
- tackle inequalities and intersectionality and support women/birthing people to uphold their right
- ensure women/birthing people and babies of the global majority have equitable access to high-quality maternity and newborn care
- ensure staff are supported to be responsive to additional care needs, for example being flexible with appointment times to accommodate translation and interpreter services.(68, 69)

Examples of what meeting this standard might look like

- Use of tools and frameworks to support informed decision making including during care planning, providing consent or declining care.(34)
- Use of person-centred plans of care which are accessible electronically.
- Health Impact Assessments, Equality Impact Assessments, Remote and Rural Communities Impact Assessments and Children and Young People Children's Rights Impact Assessments, demonstrating evidence-based co-design of services and meaningful engagement with communities.
- Evidence that women/birthing people are provided with the name and contact details of their primary midwife, and where appropriate obstetrician and specialist.
- Evidence of support provided for travelling to access maternity care.
- Evidence of partnership working with other agencies to enable people to access appropriate support for housing and financial support, including income maximisation.
- Evidence of meeting additional care or communication needs including flexible appointment times and the use of interpreter services.
- Evidence of improved outcomes for women/birthing people and babies of the global majority.
- Evidence of enhanced and person-centred support for people with assessed social communication needs, neurodevelopmental conditions, learning disabilities or additional support needs.
- Evidence of achieving UNICEF UK Baby Friendly Initiative accreditation and working to implement Achieving Sustainability standards.(70, 71)
- Evidence of working with living and lived experience groups such as Maternity Voices Partnerships.
- Evidence of maximising the availability of community-based services for all women/ birthing people, including those with additional requirements.

Standard 2: Leadership and culture

Standard statement

Maternity services have effective leadership and governance and encourage a culture of openness and continuous improvement.

Rationale

An effective clinical governance infrastructure is essential for the delivery of high-quality maternity care. The implementation of a whole system approach to quality and safety is required for maternity care services.(72, 73) An effective quality management system enables NHS boards to meet changing healthcare needs through continual monitoring, planning, improving and assuring quality.(74, 75) Service delivery should be in line with the maternity pathway and schedule of care, national standards, clinical pathways and relevant statutory requirements.(72, 76)

Collective, compassionate leadership is essential to improve and sustain a culture of safety and quality within maternity healthcare.(77) It is important for staff at all levels of the organisation to promote a positive culture and learning environment within which the workforce thrives.(6, 7, 78) Staff should be supported by visible leadership with a commitment to openness and candour, good communication, accountability and transparent decision making.(79) NHS boards should ensure line of sight between staff and leaders, including senior managers. This will enable the unrestricted flow of data and intelligence to optimise effective team working and improve quality of care.

A triumvirate leadership structure aims to provide balanced leadership by combining medical expertise, professional midwifery or nursing insights, and managerial or operational skills.(80) A nominated board level lead for maternity services, such as a non-executive director, provides essential leadership, oversight and assurance.(6, 81) See Standard 3 for additional criteria on high-performing and functioning teams.

Maternity services require a commitment to safety and improvement at all levels of care. This involves creating a culture which enables compassion, empathy, teamwork, open communication and technical competence. A ‘no blame’ culture is essential, with transparency and honesty when responding to adverse events, incidents or near misses.(76, 82) System-wide critical safety information allows for early identification of concerns and improvement.(7) Outcomes that reflect what matters to women/birthing people drive improvement.(7) A systems approach to learning improves the experiences of service users by encouraging staff to listen to people’s experiences, respond to early warning signs and report incidents.(83)

It is important for NHS boards to collect and review feedback from people who access services, staff and partner organisations. This may include the use of impact assessments,

and qualitative or quantitative feedback. NHS boards should develop systems and processes for the escalation of, and response to, concerns raised by staff. NHS boards should promote a culture of inclusivity within maternity services. It is essential for staff to be supported to identify and address inequalities in experience and outcomes of maternity care, particularly within populations of the global majority.

Maternity services should be collaborative and effectively coordinate the delivery of care within their area. In addition, care pathways and protocols should be developed to support reciprocal working and enable seamless care and support for women/birthing people who receive maternity care outside of their NHS board area. It is also important for maternity services to share, and learn from, good practice across the maternity pathway, including with partner agencies.(84)

Opportunities for sharing learning and development should be available and aligned with legislation, national guidance and principles of good information governance.[85-87]

Considering the environmental impact of maternity services allows organisations to take appropriate measures to increase environmental sustainability and limit direct carbon emissions.(88) This includes monitoring the use of Entonox®, limiting single use items and offering video appointments.(45, 89)

Criteria

2.1 NHS boards demonstrate effective governance and oversight arrangements across all maternity services including, but not limited to, midwifery, obstetrics, anaesthesia and neonatology.

2.2 NHS boards provide oversight and assurance of:

- implementation of relevant national policies, pathways, frameworks, clinical standards and guidelines
- implementation of local clinical pathways, including referral pathways
- clinical effectiveness and outcome measures, including relevant key performance indicators
- appropriate targeting of resources to deliver safe, high-quality and evidence-based care
- the provision of adequate, appropriate and well-maintained equipment and facilities
- compliance with relevant legislation, national guidance and standards for service structure, equipment, staffing, infection prevention and control and data protection.(90, 91)

2.3 NHS boards demonstrate leadership and staffing governance across all maternity services, which include:

- a clear infrastructure to enable line of sight from 'board to floor'
- clear processes for direct reporting to the respective clinical leadership team, governance committees and the respective Board
- regular reporting and review cycles.

2.4 NHS boards have a triumvirate leadership structure for maternity care, which:

- is clearly defined, effective and accessible
- enables effective medical, midwifery and operational leadership, supervision and appraisal, relevant to staff roles and responsibilities.

2.5 NHS boards ensure the leadership structure for the delivery of maternity care includes:

- designated midwifery and medical professional leads or directors for all relevant clinical services, with direct lines of accountability to the respective Executive Nurse Director and Medical Director
- an operational and professional lead for midwifery, for example Head of Midwifery
- a designated general manager for maternity services.

2.6 NHS boards have a quality management system in place to demonstrate:

- Implementation of the maternity pathway and schedule of care
- effective workforce planning
- identification of, and response to, risks
- identification of priorities for continuous quality improvement, including processes to identify priorities for improvement
- collaborative improvement work with engagement in national improvement programmes
- maintenance of agreed levels of quality and effective early warning systems
- learning from human factors approaches and systems methodology(92)
- internal and external quality assurance against relevant guidelines, standards and professional codes of conduct
- implementation of the Health and Care (Staffing) Scotland Act 2019.(25)

2.7 NHS boards demonstrate their commitment to engaging with women/birthing people, and their care partners where appropriate, by:

- developing responsive and trauma-informed approaches(18, 19, 59)
- creating a culture of openness and learning(93)
- developing an effective infrastructure to support the collection and analysis of feedback
- using feedback to improve services and outcomes
- routinely providing information on how feedback has led to service development and improvement.

2.8 Maternity services promote a culture of listening and responding to the concerns of women/birthing people, and their care partners where appropriate.

2.9 NHS boards ensure all maternity services have a consistent and systematic approach to risk assessment, which:

- is in line with national and local guidance
- uses evidence-based assessment tools that are validated or recommended by professional bodies.

2.10 NHS boards ensure a rapid response to risk by establishing pathways and protocols that:

- are regularly reviewed and readily accessible to all staff across the maternity pathway
- align with current evidence and guidelines, including the national emergency care pathway(94, 95)
- have clear escalation pathways, in line with national policy and guidance
- outline roles, responsibilities and standard operating procedures
- minimise unnecessary delays
- include standardised documentation.

2.11 NHS boards monitor and respond to concerns about the quality of care through:

- timely escalation of concerns, incidents and near misses
- pathways and processes for management of complaints
- regular review and management of safety and risk by a midwife and doctor
- implementing learning from serious adverse event reviews (SAERs)
- structured review processes using the Perinatal Mortality Review Tool (PMRT)(96)
- regular feedback, audit and quality assurance to ensure sustainable, evidence-based improvement
- ensuring learning is shared with maternity staff, teams, partner agencies and service users.

2.12 NHS boards ensure timely response to all events and data related to safety and quality, including:

- risks
- complaints
- feedback
- adverse events
- near misses
- incidents
- safety-critical data, including staffing red flag events.

2.13 NHS boards collect and monitor demographic data, including ethnicity, when reviewing safety incidents in maternity care and use this data to reduce health inequalities.

2.14 NHS boards promote a culture of inclusive maternity care by:

- providing culturally competent services that take into account the preferences and aspirations of all women/birthing people
- enabling equitable and culturally appropriate access for all women/birthing people
- enabling women/birthing people to have positive outcomes and experiences
- supporting women/birthing people to co-produce person-centred care plans
- ensuring staff have appropriate skills and competencies to reduce inequalities including those associated with ethnicity, deprivation and additional needs.

2.15 NHS boards have effective processes for managing complaints, incidents and adverse events in line with national policy, including:

- standard and consistent approaches to reporting and responding
- ensuring reviews involve women/birthing people and, where appropriate, their care partners
- systems to ensure responses are within nationally recommended timelines
- documented escalation policies for response, investigation and review
- clear lines of accountability for local review and response
- processes to identify emerging or recurring themes
- systems for monitoring actions and sharing and implementing learning
- adequate resources, including staffing, to implement processes and learning(76)
- provision of information and support to all those impacted, including women/birthing people, care partners, if appropriate, and staff
- implementation of duty of candour.(97, 98)

2.16 NHS boards collect and manage data to:

- record, benchmark and report outcomes and performance
- participate in local, national and UK dashboards and audit systems
- improve safety, experiences, outcomes and quality of care(99, 100)
- demonstrate care is evidence-based and informed by current best practice.[87]

2.17 NHS boards demonstrate a commitment to continuous improvement by routinely reviewing and acting on:

- data and intelligence, including compliments and positive feedback
- examples of good practice, improvement and bright spots
- themes identified through reviews, inspections and inquiries
- response times, including for serious adverse event reviews
- data on staffing, skills mix and ratios
- staff concerns
- feedback and complaints
- patient-level data, including ethnicity.

2.18 NHS boards demonstrate a commitment to a whole system learning culture by sharing actions, learning, best practice, and feedback with:

- women/birthing people and their care partners, where appropriate
- multidisciplinary staff teams, including students and trainees, where appropriate
- appropriate governance structures and the Board
- other service providers
- national improvement programmes
- local populations
- wider learning systems such as national services and academia.

2.19 NHS boards have effective cooperation agreements and collaborative working with other NHS providers and partners, including third sector organisations, to plan and deliver services.

2.20 NHS boards demonstrate reciprocal arrangements and protocols to support women/birthing people who live in one NHS board area but receive some, or all, of their maternity care from, or within, another NHS board.

2.21 NHS boards commit to a culture of sustainability by developing and implementing policies to minimise the environmental impact of delivering maternity care, including:

- offering coordinated appointments
- using digital technology to enhance care and reduce the need to travel, where appropriate
- safe optimisation of resources
- limiting production of waste
- monitoring the use of Entonox®.

2.22 NHS boards implement a public health approach to improving the health and wellbeing of women/birthing people during pregnancy, childbirth, and the postpartum period, including providing relevant information and support to:

- minimise the impact of economic, social and cultural factors on their health
- reduce their use of health-harming products.

What does the standard mean for women/birthing people?
• You will have consistent and high-quality care and support. • The care and support you receive 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 give feedback, raise concerns or make complaints, and these will be addressed in a timely and fair manner.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting, are enabled to: • work within national, regional and local pathways, standards, protocols and guidance to provide women/birthing people with high-quality care • access referral pathways • experience effective and compassionate leadership • be role models for effective and compassionate leadership, at all levels of their practice • identify and address inequalities in experience and outcomes of maternity care • report and escalate feedback, complaints, adverse events, or concerns to managers, leaders and the Board • feel psychologically safe to escalate concerns, including those relating to leadership and culture • support the NHSScotland climate emergency and sustainability strategy by minimising Entonox® loss, waste and occupational exposure.

What does the standard mean for the NHS board?

NHS boards:

- have governance arrangements in place outlining roles, responsibilities and lines of accountability, including for the management of incidents, adverse events, compliments and complaints
- promote a culture of inclusive maternity care and deliver culturally competent services
- have effective clinical, care and staff governance across the maternity pathway
- ensure quality assurance and ongoing service improvement
- promote a culture of openness, accountability and transparency
- collect data and feedback to support continuous improvement and quality assurance
- ensure routine collection, analysis and review of outcomes and process reliability data
- comply with data protection legislation, information governance, confidentiality and safeguarding policies
- have protocols to ensure escalation processes are understood, implemented and support good governance
- promote, encourage, resource and support research and audit activity
- promote environmental sustainability.

Examples of what meeting this standard might look like

- Evidence of reporting, managing and review of risk, incidents and events, including clear routes for escalation.
- Evidence of review and learning from adverse events and safety-critical incidents.
- Evidence of monitoring health outcomes, including number of healthy births.
- Evidence of improved experience and outcomes for women/birthing people of the global majority.
- Evidence of a culture of inclusive maternity care.
- Evidence of compliance with recommended time frames for reviewing complaints, adverse events and safety-critical data.
- Use of case studies and examples of good practice to inform improvement plans.
- Evidence of a culture of learning, improvements and actions.
- Evidence of improvement work, qualitative and quantitative data collection and review of data, including feedback from women/birthing people, care partners, staff, students and trainees.
- Action plans that demonstrate implementation of national guidance or standards.
- Evidence of how feedback has led to service change.
- Evidence of effective and integrated working across maternal and newborn care.
- Evidence of learning from excellence.
- Evidence of learning from reviews of pregnancy and baby loss.
- Regular audits and improvement plans for environmental sustainability, including use of Entonox®.
- Evidence of system improvements.
- Evidence of improvements in culture following feedback such as staff surveys.
- Evidence of engaging with women/birthing people and their care partners and improving services as a result of feedback.
- Evidence of compliance with the NHSScotland climate emergency and sustainability strategy.

Standard 3: High-performing and functioning teams

Standard statement

Maternity care is delivered by high-performing teams, which are responsive to the individual needs of women/birthing people, and are adequately and appropriately staffed.

Rationale

Maternity care outcomes are improved by effective and supportive interdisciplinary and multidisciplinary team working.(6) Staff should be enabled to work collaboratively across organisational and professional boundaries.(1, 5, 6) It is important for team members to be clear about each other's roles and responsibilities and empowered to work within their skills and competencies. This will enable effective teamwork and ensure that clinical concerns are escalated promptly and appropriately.(5) Joint multidisciplinary training supports staff to understand each other's roles and responsibilities, can enhance and improve team dynamics and provides opportunities for shared learning, innovation and practice.

NHS boards should ensure a healthy and supportive working environment to optimise the wellbeing and performance of all staff.(67, 101) It is important to empower and enable maternity staff by providing them with education, training, resources and support to effectively deliver safe and high-quality care.

Empowering maternity staff enables a culture of autonomy and professional development.(27, 102-105) It is important for staff to be supported by effective and visible clinical leadership. Maternity staff should have time for learning and reflection, support for innovation, provision of restorative breaks and mechanisms to provide feedback to their senior leaders in a psychologically safe way.(6, 19, 106) There should also be clear pathways for clinical academic roles.(107, 108) Services should be appropriately staffed to provide timely, coordinated and continuity of maternity care.(67, 109, 110)

It is important for NHS boards to provide time and resources for education and training. These should be of high quality, evidence-based, accessible, and delivered by competent staff. Learning from excellence, as well as intelligence from public health patient safety data and events, should be included within staff education and training. Training should be informed by the experiences of people with living and lived experience.(111)

Staff should be provided with time and resources to enable inclusive, compassionate and respectful communication with all women/birthing people, and their care partners, where appropriate. Education and training will enable staff to deliver responsive care and support, and to understand what matters to people, including the impact of culture, social support, trauma and relationships. Access to appropriate training will enable staff to support

women/birthing people to make choices and informed decisions about their care and support. Supporting staff to identify and manage risk and complications will promote the health of women/birthing people and their babies.(111, 112)

Healthcare staff are required to uphold the standards of their relevant profession, regulator or professional body. Where appropriate, staff must uphold all relevant clinical registration. Staff should also ensure they are aware of, and implement, all recent relevant guidance.(2)

Throughout the maternity care pathway, clinical services are delivered by staff working collaboratively with trainees and students.(58, 113) The involvement of trainees and students can contribute to a more skilled and adaptable workforce for the future. A well-functioning team, including students and trainees, can enhance patient safety by providing a wider range of support and expertise. Principles of safe, effective and high-performing teams apply to trainees and students as well as staff.

Criteria

3.1 NHS boards clearly outline roles and responsibilities for all their maternity workforce in all settings, including:

- clinical and medical staff, students, and trainees
- staff across the whole maternity pathway
- staff in non-clinical roles
- multidisciplinary teams.

3.2 NHS boards implement multidisciplinary maternity workforce plans that:

- identify the required staffing levels and skills mix to deliver safe and high-quality care
- monitor recruitment and retention to build capacity and sustainability
- are in line with national safe staffing legislation, policies and professional or clinical competency frameworks(109)
- recognise the support and resources required to participate in training and education opportunities
- are regularly reviewed and updated to ensure they remain current and meet the needs of the population and staff
- ensure levels of staffing and skill mix are adequate to provide continuity of care and support in line with the Health and Care (Staffing) Scotland Act 2019.(25)

3.3 NHS boards demonstrate a culture of effective integrated and multidisciplinary working by:

- supporting communication and meaningful collaboration between midwifery and other clinical teams
- identifying and supporting professional leads
- ensuring all staff understand their responsibilities and respect the professional competences and contributions of all members of the care team
- implementing the NHS common staffing method(114)
- enabling staff to learn and develop together.

3.4 NHS boards have education and training plans that include:

- required competencies and proficiencies for all staff, including specialist, advanced and expert roles(27)
- students and trainees
- continuous professional development (CPD) and relevant national staff competency frameworks
- mandatory training, including regular cardiotocography (CTG) and emergency skills training(115)
- regular multidisciplinary training, including emergencies, human factors and systems methodology(116)
- opportunities to access and develop relevant research skills.

3.5 NHS boards enable staff, students and trainees to access:

- relevant individual and multidisciplinary team training opportunities, including specialist training
- appropriate education and CPD
- regular clinical supervision, mentoring and peer support, with time for feedback and reflection(112)
- restorative supervision(106)
- performance appraisal
- supportive and compassionate leadership, at all levels.

3.6 NHS boards promote a workforce culture and environment that:

- is physically and psychologically safe(77, 117)
- enables trauma-informed practice(19)
- responds to the experiences and concerns of staff, students and trainees
- encourages joy at work(118)
- enables staff, students and trainees to have confidence in, and support for, their clinical judgement and decision making.

3.7 NHS boards ensure a timely response to staff concerns by implementing:

- organisational duty of candour guidance
- national whistleblowing guidance.

3.8 NHS boards enable staff, students and trainees to:

- identify and minimise the impact of vicarious trauma, including after pregnancy or baby loss
- access support for health and wellbeing, including specialised, trauma-informed, individual or group support, as appropriate.

3.9 NHS boards enable staff, students and trainees to access appropriate education and training to deliver care that:

- is person centred and trauma informed
- respects and promotes the rights of women/birthing people and their babies
- reduces the impact of health inequalities, intersectionality and protected characteristics on people's experiences and outcomes
- improves health and life expectancy.

3.10 NHS boards provide collaborative, multidisciplinary training to all teams involved in maternity care, to improve knowledge and understanding of:

- use of clinical risk assessment tools and frameworks
- role and responsibilities of individuals, teams, and organisations
- national and local pathways and protocols
- professional codes of practice and values.

3.11 NHS boards enable staff to recognise and respond appropriately to:

- the need for urgent intervention to prevent harm to the woman/birthing person or their baby, including access to urgent support for escalation, resuscitation or emergency transfer
- safeguarding concerns for the woman/birthing person or their baby
- arrange timely transfer of care and support, including change of setting, if appropriate.

3.12 NHS boards ensure staff providing support for women/birthing people have the appropriate training and competence to:

- support physiological processes
- create enabling birth environments
- anticipate, recognise, respond to, escalate, report and review risks
- triage and provide telemedicine/telehealth support
- perform risk-based assessments of fetal growth.(7)

3.13 Staff are enabled, and supported, to use their professional judgement to recognise and respond to risk, including the requirement for:

- immediate obstetric, anaesthetic or neonatal review
- urgent or emergency transfer to an appropriate specialist setting.

3.14 NHS boards ensure all staff providing clinical maternity services are appropriately registered healthcare professionals.

3.15 Staff who mentor, support and supervise students and trainees are enabled to:

- provide effective coaching, supervision and assessment(58, 113)
- have protected time, including for reflective practice
- receive training in effective and supportive people management.

What does the standard mean for women/birthing people?

- You will be supported by compassionate, respectful and non-judgemental staff.
- You will be supported by a team of skilled and knowledgeable staff who will work together to provide consistent and continuous care.
- You will be listened to and your wishes and concerns will direct your care.
- You will be supported to make decisions about your care and support by a well-informed team.
- Your maternity care team may include students and trainees. You will be asked if you are comfortable with them being part of your care team. Your decision will be respected.

What does the standard mean for staff?

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

- provide person-centred care that is safe, evidence-based, and promotes positive experiences
- feel part of a high-performing team and be respected for their knowledge, contributions and expertise
- have access to appropriate CPD, education and training, with time for learning, reflection and feedback
- identify their learning needs
- attend mandatory, and other training, with protected learning time
- report and escalate concerns, complaints or adverse events, in an open and psychologically safe way
- use validated risk assessment tools and follow established escalation pathways
- use their professional judgement to act on concerns and escalate care as appropriate
- follow guidelines and protocols to identify and manage complications of pregnancy and childbirth.

What does the standard mean for the NHS board?

NHS boards:

- promote teamworking by providing multidisciplinary, multiagency and collaborative training
- ensure adequate levels of staffing and appropriate skill mix to ensure continuity of care and support in line with the Health and Care (Staffing) Scotland Act 2019(25)
- have plans for workforce development that are regularly reviewed and updated
- demonstrate a culture and environment that actively supports the wellbeing of staff, students and trainees
- support staff, students and trainees by creating a culture and infrastructure that supports and enables training, education and research(67)
- demonstrate their commitment to students and trainees
- ensure staff, students and trainees have appropriate education, training, supervision, supportive leadership, feedback and time for reflection
- provide mandatory training, including CTG interpretation, obstetric emergencies, resuscitation, human factors and systems methodology.

Examples of what meeting this standard might look like
• Audit and review of staff vacancies, staff retention and safe staffing levels, with action plans. • Board reports on compliance with the Health and Care (Staffing) Scotland Act 2019.(25) • Evidence of collaborative workforce planning between NHS boards and maternity teams. • Evidence of collaborative multidisciplinary, and multiprofessional, training and education. • Evidence of implementation of relevant guidance, standards and policies. • Clear organisational charts describing lines of accountability and defined roles and responsibilities.(33) • Evidence of supporting students and trainees with their professional development. • Evidence of timely responses to concerns raised by staff, students or trainees, implementation of improvement plans and feedback to staff. • Evidence of timely and appropriate transfers of women/birthing people and their babies to specialist facilities when required. • CPD audit and plans for education, training, research and CPD. • Evidence of participation in multiprofessional training such as PROMPT and Scottish Multiprofessional Maternity Development Programme.(119) • Provision of spaces for staff, trainees and students that support rest, reflection and decompression. • Involvement in governance and audit activity, including information sharing, using tools such as SBARD.(120, 121)

Standard 4: Core care: antenatal, intrapartum and postnatal assessment and care

Standard statement

Women/birthing people are offered compassionate and high-quality antenatal, intrapartum and postnatal care.

Rationale

High-quality antenatal, intrapartum and postnatal care is essential for all women/birthing and people. It reduces maternal and perinatal mortality and supports physical and psychological recovery from birth.(122) It also supports maternal physical and mental health, optimises infant feeding, and promotes attachment between the woman/birthing person and baby.(123)

The maternity pathway and schedule of care outlines the core care that women/birthing people and their babies should receive. NHS boards and maternity staff should follow the relevant clinical pathways and guidance for antenatal, intrapartum and postnatal assessment and care. All antenatal, intrapartum and postnatal care should be consistently high quality, regardless of where it is provided.(37, 123, 124)

The maternity pathway and schedule of care emphasises the importance of all maternity care being personalised. It should be used to guide discussions with women/birthing people, and provide information about benefits, risks and alternatives of care and support throughout the maternity pathway.(125, 126) Women/birthing people should be enabled to explore all the options and choices available to them throughout their pregnancy and maternity care (see Standard 1). The aim is to promote positive experiences and outcomes, and to anticipate and prevent complications.(27)

All core care should be high quality and evidence based. Women/birthing people should have timely access to relevant assessments and investigations, including ultrasound imaging, clinical tests and results, pregnancy screening and newborn screening.(127) There should also be equitable access to information and support, and referral where required, for the management of diet and weight, use of health or pregnancy harming products (including tobacco), social needs (including housing) and financial concerns (see Standard 1).

Pre-existing health conditions and social inequalities may have an impact on pregnancy. Deprivation can significantly increase the risk of complications during pregnancy by limiting access to healthy foods and antenatal care. Birth outcomes are also negatively affected by associated smoking and substance use. Evidence indicates that ethnic health inequalities exist regardless of social or economic status, for example, Black women are more likely to experience severe complications in pregnancy.(128)

Pregnancy can also influence the onset or progression of medical or mental health conditions. Collaborative working with the multidisciplinary team is essential to establish appropriate care pathways. This will improve the experiences of women/birthing people during pregnancy and after birth, and ensure continuity of safe, high-quality care.(129)

The experiences of women/birthing people are impacted by the relationships they have with maternity staff, and the quality, consistency and integration of their care.(11, 122) Women/birthing people should experience the same high-quality of care, including postnatal care, whether this is received within a hospital, community or home setting.

High-quality antenatal education and support prepares the woman/birthing person for birth and the transition to parenthood. This includes providing person-centred information about pregnancy, labour (including pain management options), birth, recovery from birth, early parenting, newborn care and infant feeding. Women/birthing people should be provided with clear information about access points for, and reasons to contact, maternity triage at any stage of their pregnancy.

Effective newborn care can improve health and wellbeing by promoting secure attachment and enabling each baby to thrive.(23, 26, 130) Families benefit from the postnatal support offered by midwives and the universal health visiting service. Core postnatal visits support women/birthing people to develop positive and trusting relationships with their multidisciplinary healthcare team.(131) They offer opportunities to raise concerns, discuss contraception, sexual health and how to access additional support, if required. Postnatal support can also provide additional care for women/ birthing people who experience difficult or traumatic experiences during labour and birth. Women/birthing people who experience Caesarean section also require enhanced postnatal care and support.(6)

During core antenatal, intrapartum and postnatal care, the use of national risk assessment pathways improves the experiences and outcomes of women/birthing people.(8) Avoidable harm can be reduced by regular monitoring and assessment, and the consistent use and interpretation of validated or standardised assessment tools.(8) Core intrapartum fetal monitoring can optimise outcomes for women/birthing people and their babies by enabling the early identification and management of complications.(132)

Unscheduled and additional care is outlined in Standard 5.

Criteria

4.1 NHS boards ensure women/birthing people are offered assessment, care and support that:

- commences as early as possible during their pregnancy, or, if requested before pregnancy
- is appropriate to their healthcare needs
- aligns with national guidelines and pathways.(4, 12)

4.2 Women/birthing people have holistic and person-centred assessments and care plans, which include:

- personal preferences
- capacity and consent, in line with national guidance
- medical, surgical, obstetric and anaesthetic history, including pre-existing and co-existing medical conditions
- mental health and wellbeing
- medication review, as required
- physical examination, clinical investigations and ultrasound assessments
- potential risk, including obstetric risk, and complications
- referrals to appropriate services, such as support to minimise the use of health and pregnancy harming products.

4.3 Staff who undertake assessments and support women/birthing people to develop personalised pregnancy, birthing and postnatal plans:

- can demonstrate appropriate knowledge of antenatal, intrapartum and postnatal care and support, in line with national pathways
- ensure discussions with women/birthing people are clearly documented
- use tools and approaches that are validated or recommended by professional organisations.

4.4 NHS boards provide staff with clear pathways for referral of women/birthing people to appropriate multidisciplinary teams or third sector organisations for additional support.

4.5 Women/birthing people receive person-centred information and support, in line with the maternity pathway and schedule of care, which covers:

- pregnancy
- screening
- recommended vaccines
- care options and possible interventions
- pain management during birth and postnatally
- maximising their health and the health of their baby
- options for anaesthesia, if required
- pelvic floor health
- physical and mental recovery after birth
- newborn care and infant feeding
- recovery after birth, including physical and emotional support, as appropriate
- postnatal contraception and follow-on pre-conception care.

4.6 Women/birthing people can access person-centred information to support informed decision making and preparation for birth, including options for:

- place of birth(31)
- type of birth
- birth positions and mobility
- pain management during labour, birth and postnatally
- care, support and possible interventions.

4.7 Women/birthing people receive person-centred information and support about preparing for parenthood and caring for newborn babies, in line with current evidence and best practice.(70)

4.8 Women/birthing people receive appropriate specialist assessment, interventions and support, including pre-conception care, if required for:

- pre-existing medical conditions
- mental health conditions requiring medication
- risks identified from previous pregnancies.

4.9 Women/birthing people can access birth reflection services, pre-conception care and inter-pregnancy counselling, as required.(133) (133)

What does the standard mean for women/birthing people?
• You will be offered your first antenatal or booking appointment with your midwife at eight–ten weeks of pregnancy, or as soon as possible if you contact services after ten weeks. • You will be supported by the same midwife throughout your maternity care. • You will be supported by the same obstetrician, if requested or required, during your maternity care. • You will also be supported by the same care team, as much as possible. • You will be offered the right care at the right time, including assessments and ultrasound scans. • Your needs will be assessed, and you will be able to discuss these with trained midwives, obstetricians and other members of the healthcare team. • You will be able to access the care and support that is right for you. • You will be supported to make the choices that are right for you and to maintain your health and the health of your baby. • You will be offered antenatal information and support during your pregnancy, to prepare you for birth and parenthood. • You will be signposted to support available within your community.

What does the standard mean for staff?

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

- support women/birthing people to develop personalised care plans
- offer assessment, care and support that aligns with the maternity pathway and schedule of care
- optimise the birth experience for women/birthing people experiencing all types of birth, in all settings
- identify and appropriately support women/birthing people who have additional needs and risks
- provide relevant evidence-informed information to support decision making
- offer person-centred antenatal, birth and parental education and support, to women/birthing people and their care partners, where appropriate
- access education, training, support and supervision
- have a consistent and systematic approach to risk assessment across the maternity care pathway
- have clearly defined and accessible risk escalation pathways and protocols
- use their professional judgement to identify, assess and respond to risk without delay
- monitor how risks are assessed, managed and reviewed, and develop action plans to improve services, experiences and outcomes.

What does the standard mean for the NHS board?

NHS boards:

- provide staff with the appropriate training, support and equipment to deliver core care across the entire maternity pathway
- ensure women/birthing people are offered routine support and care that is timely, high quality, safe, effective and person-centred
- develop protocols to ensure women/birthing people are offered timely review of medication and management of co-existing medical conditions, or conditions that occur during pregnancy
- have clearly documented referral pathways to appropriate multidisciplinary teams for women/birthing people who have co-existing medical conditions or complex needs
- provide women/birthing people with support, including referral if appropriate, to reduce use of health-harming products.

Examples of what meeting this standard might look like
• Audit of antenatal appointments and ultrasound scans to demonstrate alignment with national guidelines and pathways.(127, 134) • Evidence of personalised care plans. • Evidence of continuity of carer, care team and care. • Delivery of person-centred antenatal parental education and support. • Provision of a range of services and spaces that offer women/birthing people choice and optimise their birth experience. • Evidence of birth preparation and parental education. • Evidence of using validated tools to assess needs. • Evidence of risk assessments being used to direct person-centred pathways of care, including at booking. • Evidence of signposting to relevant third sector organisations, including support for housing or income maximisation, social support, and peer support. • Evidence of referral pathways from midwifery to obstetric and social care, and from obstetric to specialist and social care.

Standard 5: Unscheduled and additional care

Standard statement

Women/birthing people have timely access to high-quality, safe, effective and person-centred unscheduled and additional care.

Rationale

Women/birthing people should have timely and equitable access to unscheduled or additional maternity care, beyond their usual core care. This may be required at any time during pregnancy and in the weeks immediately after birth.(135) Unscheduled care is often required for concerns related to pregnancy or early labour and obstetric or medical emergencies.

Staff should assess women/birthing people who attend for unscheduled maternity care in an appropriately staffed and equipped triage unit. This will often be within a maternity setting but should be separate from the labour ward.(136)

Information about when, and how, to access maternity triage should be shared when the woman/birthing person first books for antenatal care and at all subsequent antenatal contacts. If maternity triage is not appropriate, there should also be systems in place to ensure women/birthing people are referred to an appropriate alternative department, such as early pregnancy services (EPS).(5, 135)

It is essential for NHS boards to implement a standardised assessment system to ensure clinical prioritisation of women/birthing people who require unscheduled care. There should be early involvement of the obstetric and anaesthetic teams, if required, for complex analgesia, instrumental birth or Caesarean section.

NHS boards should have clear pathways and protocols for additional care within non-maternity clinical settings, including emergency departments, hospital wards and critical care areas. It is important that protocols include staff roles and responsibilities, timely communication with the primary midwife to coordinate care, regular assessments using validated tools, and clinical prioritisation and escalation. Staff should ensure early involvement of the midwifery team and, if appropriate, an obstetrician and anaesthetist, including for the management of conditions that seem unrelated to the pregnancy.(129)

Women/birthing people who become acutely unwell during pregnancy, birth or the postnatal period, should have immediate access to critical care, and the same high standard of care as other critically ill patients, irrespective of their location.(137) The management of antenatal obstetric emergencies should prioritise the wellbeing of the woman/birthing person.(137, 138)

If the woman/birthing person or baby has a condition that is likely to result in preterm, or high-risk birth, it may be necessary to arrange for them to be transferred to a specialist unit before the baby is born, also known as in-utero transfer. (139) Maternity staff should discuss the options with the woman/birthing person and support them to make informed decisions about their care and the care of their baby. Transfer of care and setting should be safe, timely and efficient and should always prioritise the wellbeing of the woman/birthing person.(140) Safe transfer of care is also included in Standard 1.(137, 138, 140)

Criteria

5.1 NHS boards provide women/birthing people with clear information about their local maternity triage unit, including:

- contact details
- location of the nearest unit
- reasons for contacting the unit
- when they should telephone
- when they should attend
- what to expect from the service.

5.2 Women/birthing people can access maternity triage by:

- self-referral
- referral by community midwife, GP, school nurse or other healthcare professional, community centre or third sector support agency.

5.3 NHS boards ensure timely and equitable access to maternity triage for:

- information, care and support, seven days a week
- same-day information and holistic assessment by an appropriate member of the maternity team
- onward referral pathways, if appropriate
- coordinated care, including pharmacy support.

5.4 Staff working in maternity triage units are enabled to:

- assess and appropriately prioritise women/birthing people who require unscheduled care
- appropriately refer women/birthing people to other departments, such as EPS
- keep accurate and contemporaneous records of all contacts, assessments and referrals
- access additional clinical advice and support, when required.

5.5 NHS boards ensure that systems and processes are in place for all pregnant women/birthing people to access unscheduled care:

- at any stage of pregnancy
- during birth
- immediately postnatally
- up to six weeks after birth.

5.6 Women/birthing people who require unscheduled care within any clinical care setting:

- experience timely assessment by an appropriate member of the maternity team
- have timely and appropriate referral or escalation of their care
- receive care and support from appropriately trained maternity staff, until transfer of care, as required.

5.7 Staff assessing women/birthing people who attend for unscheduled care are enabled to:

- use nationally recommended and validated assessment tools such as Maternity Early Warning Score (MEWS)(141)
- interpret and respond to assessment results within an appropriate time frame
- follow clearly outlined local and national escalation policies.(142, 143)

5.8 NHS boards enable staff to ensure timely assessment of women/birthing people within community settings and prisons with immediate escalation to secondary healthcare facilities, if appropriate.

5.9 NHS boards have clear pathways and protocols to ensure women/birthing people receiving care within non-maternity settings:

- are reviewed by their primary midwife as soon as possible
- have their care coordinated by the midwifery team, or obstetric team if appropriate
- have regular assessments using validated tools with clear escalation pathways
- experience the same high-quality care as non-maternity patients.

5.10 Women/birthing people with pre-existing medical or mental health conditions:

- experience continuity of high-quality care throughout their pregnancy and postnatally
- have their care coordinated by their primary midwife, to ensure effective communication and collaboration with the multidisciplinary team.(129)

5.11 NHS boards have systems in place for effective communication between staff from the multidisciplinary maternity team and:

- primary care
- non-maternity hospital settings, including emergency departments and critical care
- non-maternity healthcare services, including dentists and pharmacists
- Scottish Ambulance Service
- non-medical settings, including social care and prisons.

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

What does the standard mean for women/birthing people?
• If you are concerned about your pregnancy at any stage, you will be able to access advice, care and support from trained midwives, seven days a week. • You and your baby will receive the right care and support from the right healthcare team, at the right time. • 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 need to be admitted to hospital or seen by a specialist team, you will be safely transferred to the right place for you.

What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting are enabled to: • rapidly assess women/birthing people to identify their requirements for unscheduled care • provide appropriate immediate care and support • access information and advice from maternity, obstetric and other specialist teams, as appropriate • access investigations including ultrasound scans and laboratory tests • use nationally recommended and validated assessment tools • share assessment information with relevant healthcare professionals • understand their role in assessing, responding, escalating and transferring care of women/birthing people, and their babies as required • ensure women/birthing people and their babies receive the same high-quality of additional or critical care as other patients.
What does the standard mean for the NHS board?
NHS boards: • have accessible and effective triage systems, with clear referral pathways to and from the service • provide an appropriately staffed and equipped triage unit, separate from the labour ward • have clear systems and protocols for safe transfer of care, including in-utero transfer • have systems and processes to ensure women/birthing people and their babies receive timely, high-quality unscheduled and additional care.

Examples of what meeting this standard might look like
• Service specification for maternity triage and EPS.(144) • Accessible, efficient and responsive triage systems. • Documented pathways and referral protocols for service transfers, including in-utero transfers. • Evidence of implementation of guidelines and protocols for assessment and management of complications during pregnancy, labour and birth, and postnatally. • Improvement plans using data from managing risks. • Use of maternity-appropriate tools, such as MEWS, in non-maternity inpatient settings.(141) • Use of validated escalation tools.(145, 146)

Standard 6: Mental health and wellbeing: women/birthing people and babies

Standard statement

NHS boards promote positive mental health and wellbeing for women/birthing people and their babies.

Rationale

Good mental health and emotional wellbeing during pregnancy and birth can improve outcomes for women/birthing people and their babies.(147) Evidence indicates that women/birthing people with a history of poor mental health or trauma, benefit from early interventions to support mental health and wellbeing during pregnancy.(18) There should be timely access to person-centred and trauma-informed pre-conception advice, and multidisciplinary support.

NHS boards should provide a range of trauma-informed mental health support services, including pathways for referral to specialist services, if required.(148) It is important to ensure women/birthing people with a pre-existing or newly diagnosed mental health conditions have timely access to specialist services, including a dedicated specialist midwife with responsibility for perinatal mental health.(149) Staff should signpost to peer support and third sector organisations offering support for mental health and emotional wellbeing.

Access to good quality advice, information and support will enable women/birthing people to make informed decisions about their treatment, including the benefits and risks of continuing or changing their medication during pregnancy.(150) Enhanced access to urgent and unscheduled care at the point of crisis or emergency will also improve outcomes.(8, 147)

It is important that NHS boards assess and address inequalities in the risk of developing mental health problems during, and after, pregnancy in marginalised and underserved groups. Black and minority ethnic women/birthing people experience unique challenges that contribute to higher rates of mental health issues, including anxiety, depression and other mood disorders. They also face greater barriers to accessing mental health care. Mental health problems are also more common in women/birthing people who experience disabilities, are refugees or asylum seekers, homeless or in prison.(151-153)

Deprivation, alcohol or substance use, trauma and experience of domestic, sexual or gender-based violence, can also increase the risk of mental health problems during pregnancy and postnatally.(18, 148)

Women/birthing people who experience inadequate social support, have an unplanned pregnancy, termination of pregnancy, preterm birth, or pregnancy or baby loss, are more

likely to develop mental health problems.(148) Birth trauma and severe blood loss can increase the risk of postnatal depression and anxiety in women/birthing people, even when the experience occurred during a previous pregnancy.(148)

Continuity of care enables early identification and response to the need for additional mental health support. Good communication, compassion, practical support and effective pain relief can also improve mental health for women/birthing people. This is particularly true for women/birthing people experiencing birth trauma.(154)

Infant mental health benefits from positive early relationships between the woman/birthing person and their baby.(155, 156) Secure attachment can have a positive long-term impact on the baby and the woman/birthing person.(70) This includes providing a nurturing environment, with adequate nutrition and opportunities to sleep safely. It is also important to promote positive interactions between the baby and the woman/birthing person including regular communication, appropriate stimulation and responsive care. Family and caregiver support also enhances positive wellbeing outcomes for women/birthing people and their babies.

Criteria

6.1 Women/birthing people with complex or severe mental health conditions who are planning a pregnancy, receive timely:

- person-centred and trauma-informed specialist pre-conception advice
- multidisciplinary support to manage their condition and medication, if appropriate.

6.2 Women/birthing people have their mental health and wellbeing regularly assessed, in line with national pathways, by staff who are enabled to:

- use validated assessment tools
- recognise symptoms and signs of concern, and escalate as appropriate
- be responsive to individual needs
- can refer to timely specialist support or intervention, as appropriate
- provide person-centred information and signpost to support and resources.(147-149)

6.3 Women/birthing people are supported to recognise changes in their mental health and wellbeing:

- when they book for antenatal care
- throughout their antenatal care
- after birth
- after transfer of care to the universal health visiting system.

6.4 Maternity staff perform a comprehensive and holistic assessment of mental health and wellbeing, which includes:

- current mental health and emotional wellbeing
- previous mental health and wellbeing concerns
- risk factors for the development of mental health problems
- any relevant existing, or previous, care and treatment plan, including medication
- access to support networks.

6.5 Maternity staff are enabled to recognise and address inequalities in the risk of developing mental health problems during, and after, pregnancy in marginalised and underserved groups, including women/birthing people of the global majority.

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

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

- antenatal, intrapartum and postnatal care and support
- antenatal parental education
- community networks and social support, including peer support
- specialist third sector support
- specialist perinatal mental health support.

6.8 Staff support women/birthing people and their babies to improve their emotional wellbeing during and immediately after birth by providing:

- compassionate care and support which maintains dignity and is respectful of personal preferences and religious and cultural beliefs
- practical and person-centred support for personal care, newborn care, skin to skin contact and infant feeding
- effective pain relief.

6.9 NHS boards promote the emotional wellbeing of women/birthing people and their babies during and immediately after birth by providing:

- low-level lighting and noise reduction to promote rest
- appropriate and adequate food and drink for the woman/birthing person
- appropriate birth spaces that maintain safety and privacy
- appropriate spaces for care partners, where appropriate, including overnight accommodation.

6.10 Maternity teams support early attachment and bonding for women/birthing people and their babies by offering:

- person-centred parental education
- resources to promote interaction with the baby during pregnancy
- time, space and support for the transition into parenthood
- additional support from family support workers and services, if required.

6.11 Maternity teams support care partners to access information and support to promote the mental health of women/birthing people and babies.

What does the standard mean for women/birthing people?
• Your mental health and emotional wellbeing, and that of your baby, will be an essential part of your maternity care. You will receive the care that is right for you. • If there is a change in your mental health, you will receive the support you need as soon as possible. • You will receive the right information to make decisions that are best for you. • Staff will respect your decisions and treat you with kindness and compassion. • You will have the support you need to bond with your baby in your own time. • You will be able to have a care partner involved in your care if you wish.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting are enabled to: • routinely and systematically assess the mental health and wellbeing needs of women/birthing people • recognise and respond to concerns about deterioration in mental health and wellbeing and make timely referrals for specialist care and support • provide antenatal education and practical help to support new parents with their mental health immediately after birth • promote and support bonding and attachment in a calm and restful environment • provide information and support to help women/birthing people understand what happened during their pregnancy or birth.

What does the standard mean for the NHS board?
NHS boards: • assess and address inequalities in the risk of developing mental health problems during, and after, pregnancy • develop and implement referral pathways for perinatal mental health • provide staff with adequate time and resources to assess and respond to mental health and wellbeing concerns • ensure access to specialist perinatal mental health teams • support staff by providing guidance, education and time for reflection • ensure women/birthing people, and care partners where appropriate, are supported to bond with their babies • provide person-centred and trauma-informed care and spaces that support and promote positive mental health and wellbeing • work in partnership with other organisations, including social care and the third sector, to support maternal and infant mental health.
Examples of what meeting this standard might look like
• Evidence of regular mental health and wellbeing assessments throughout maternity care. • Documented referral pathways and timely referrals to support services for mental health and emotional wellbeing. • Evidence of signposting to mental health and wellbeing NHS services, third sector or peer support for women/birthing people, and their care partners, where appropriate. • Evidence of supporting women/birthing people to bond and form secure attachments with their babies. • Documented risk strategies for women/birthing people who are identified as being at risk of developing mental health problems.

Standard 7: Loss and bereavement

Standard statement

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

Rationale

Loss of a pregnancy or baby is traumatic for women/birthing people.(157, 158) Evidence suggests that more than one in six pregnancies in the UK end in loss each year.(159-161) It is important that women/birthing people, partners and families are supported at all stages of pregnancy and baby loss.

Bereaved women/birthing people should receive continuity of care and support that is compassionate, person centred and trauma informed.(1, 162-165) This includes offering opportunities to make memories and mark their loss.(166, 167) Communication and informed decision making should be in line with the principles of care described in Standard 1.

NHS boards should ensure implementation of the National Bereavement Care Pathways and relevant clinical guidance to support the physical and psychological wellbeing of women/birthing people who experience pregnancy and baby loss. [132,] (134, 148, 168) There should be continuity of care between settings, including referral for specialist mental health support and support for the management of subsequent pregnancies, as appropriate.(169, 170) It is important for women/birthing people to receive timely support following pregnancy loss at any stage of their maternity pathway. Systems and processes should be in place for referral to locally available emotional and practical support, or specialist mental health support, if required. Information should be appropriately shared with the women/birthing person's GP. There should be timely clinical intervention, and access to relevant medication, including pain relief and venous thromboembolism (VTE) prophylaxis, where required.

NHS boards should have an identified strategic bereavement lead.(163) The strategic lead will provide oversight across the maternity pathway and ensure services work in partnership to deliver coordinated care for loss and bereavement at all stages of pregnancy and postnatally. This should include management of early pregnancy loss by EPS and palliative care for newborn babies. Staff supporting women/birthing people who experience pregnancy and baby loss should receive training in bereavement care and support and be able to access support for their own mental health and emotional wellbeing.

Women/birthing people should be supported to understand what has happened and be given the opportunity to have supported discussions with appropriately trained staff.

Women/birthing people, and where appropriate, care partners, should receive trauma-informed support and care in any investigation or review of their pregnancy or baby loss.

Maternity units should provide dedicated trauma-informed spaces to support women/birthing people who are at risk of, or have previously experienced, pregnancy or baby loss at any stage. Staff should provide person-centred, trauma-informed support within a private, comfortable, psychologically safe and non-clinical environment that minimises contact with other women/birthing people and babies.(165) Services should be designed collaboratively with people with living and lived experience and support the psychological safety of women/birthing people and their care partners.

Criteria

7.1 Women/birthing people who experience pregnancy or baby loss are:

- treated with dignity and respect
- supported by compassionate staff who take time to understand and respect the experiences of the woman/birthing person
- able to have their care partner with them if they wish.

7.2 Women/birthing people who experience pregnancy or baby loss are supported to:

- spend time with their baby, either at home or in hospital
- mark their loss and make memories
- make choices and informed decisions about suppressing lactation, or donating breast milk, if appropriate.

7.3 Whenever and wherever a woman/birthing person experiences pregnancy or baby loss, they will have the same high-quality of compassionate, person-centred and trauma-informed care and support.

7.4 NHS boards ensure that all care and support for pregnancy or baby loss:

- is compassionate, person centred and trauma-informed
- is informed by current evidence and best practice
- aligns with clinical guidance and the national bereavement care pathways.(163)

7.5 Women/birthing people who experience pregnancy or baby loss have:

- their privacy maintained
- their cultural, religious or spiritual needs addressed(171)
- opportunities to discuss their experience with a midwife or other appropriate healthcare professional(157)
- support to understand what has happened and what may happen next
- appropriate information and support to make decisions that are right for them
- continuity of carer
- continuity of care and support
- timely access to all relevant medication, including pain relief and VTE prophylaxis, where required.

7.6 Women/birthing people who experience pregnancy or baby loss have a holistic assessment, including:

- the possible requirement for immediate clinical intervention and onward referral
- mental health and wellbeing.

7.7 Women/birthing people are supported by compassionate staff and provided with information on:

- relevant community services, including funeral directors(163)
- registration services
- consent for post-mortem examination, if required
- how to access Specialist Perinatal Pathology services, if required.

7.8 Women/birthing people receive information about, and if appropriate, referral for:

- follow up bereavement care and support
- specialist emotional and mental health support.

7.9 Staff providing support for women/birthing people experiencing pregnancy or baby loss:

- are kind and compassionate and appropriately trained in bereavement care and support
- have time and resources to deliver high-quality, person-centred and trauma-informed care and support
- have access to services to address any emotional strain or challenges they may experience.

7.10 Care partners are:

- offered tailored information and support
- signposted to specialist support, if appropriate.

7.11 NHS boards appoint a strategic bereavement lead to provide consistent, high-quality care for women/birthing people and families experiencing loss. The lead:

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

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

- are trauma informed and compassionate
- are open and transparent
- are in line with national guidance and bereavement care pathways
- involve women/birthing people and their care partners, if they wish.

What does the standard mean for women/birthing people?
• You and your baby will be treated with dignity and respect. • You will be supported to spend time with your baby, if you wish to. • You will receive clear information about the loss of your pregnancy or baby in a language that is suitable for your needs. • You will be supported to understand what has happened, although sometimes a reason cannot be found.(172) • You will be supported by compassionate, sensitive and respectful staff. • Staff will support you with any practical arrangements you may need to make. • You will be able to have your care partner or family with you, if you wish. • You will be able to access specialist staff and services to support you. • Your personal wishes, culture and religious beliefs will always be respected. • You will receive the support that you need for your mental health and emotional wellbeing. • You will be able to ask about the loss of your pregnancy or baby, if this is right for you. • You can involve your chosen care partner as much as you wish, and they will also receive the support that they need.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting, are enabled to: • be compassionate, sensitive and respectful • access relevant training and resources • discuss palliative care and bereavement and offer appropriate support • fully implement national bereavement care pathways(163) • provide care in an accessible and trauma-informed environment that maintains privacy • support women/birthing people to spend time with their baby • support care partners to be involved if the women/birthing people wish • access support for their own mental health and emotional wellbeing.

What does the standard mean for the NHS board?

NHS boards ensure:

- women/birthing people who have experienced pregnancy or baby loss receive continuity of person-centred and trauma-informed care and carer
- women/birthing people and their babies are treated with compassion, dignity and respect
- staff are trained and skilled in discussing palliative care and bereavement and can offer appropriate support
- staff are enabled to implement the national bereavement care pathways and relevant clinical guidance[132,] (134, 148, 168)
- provision of dedicated, accessible, trauma-informed spaces that are physically separated from those used by other women/birthing people and babies
- appointment of a strategic bereavement lead
- bereaved women/birthing people, and their care partners and families, if appropriate, can access compassionate support that meets their needs
- clear referral pathways for women/birthing people who require specialist bereavement support
- women/birthing people who wish to be involved in any review or investigations are supported by trained and compassionate staff
- learning from any review or investigation supports continual improvement and is shared appropriately
- staff are enabled to access supervision, psychological support and time for reflection.

Examples of what meeting this standard might look like
• Documented integrated bereavement care pathways. • Evidence of additional support provided for bereaved women/birthing people to understand what has happened. • Evidence of implementation of national bereavement care pathways.(163) • Referral pathways and signposting to other organisations for bereavement support. • Availability of a dedicated space that is separated from facilities used by other women/birthing people and babies. • Capacity and resource planning to provide support, facilities and space for when more than one bereavement room is required. • Availability of specialist support across multidisciplinary teams, including complex analgesia, if required for birth, or postnatally. • Specialist bereavement staff and resources including nominated bereavement lead. • Referral pathways and facilities for palliative perinatal care.

Appendix 1: Development of the maternity standards

Healthcare Improvement Scotland has established a robust process for developing standards, which is informed by international standards development methodology.(173) 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 carried out 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, NICE, SIGN, NHS Evidence and Department of Health and Social Care websites. This evidence was also informed by equalities impact assessments. Standards are mapped to a number of information sources to support statements and criteria. This includes, but is not limited to:

- 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 the service and the public. The standards development process included:

- scope engagement and consultation period (the scoping report is available here)
- development group meetings held between November 2024 and June 2025
- an editorial review panel meeting on 4 September 2025.

The membership of the Standards Development Group and Editorial Review Panel is set out in Appendix 2 and 3.

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 his.standardsandindicators@nhs.scot.

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.

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)	Director of Midwifery	NHS Lanarkshire
Maree Aldam	Chief Executive Officer	Amma Birth Companions
Kate Boyle	Chair, Principal Educator, Senior Midwife for Neonatal Services	Scottish Neonatal Nurses Group, NHS Education for Scotland, NHS Lanarkshire
David Bywater	Lead Consultant Paramedic, Interim Director for Care Quality and Professional Development	Scottish Ambulance Service
Eilidh Clark	Senior Pharmacist–Women's Health	NHS Ayrshire and Arran
Aileen Cope	Clinical Director, Chair	NHS Forth Valley, National Obstetrician and Gynaecologist, Clinical Directors Group
Gwendolyn Cremers	Clinical Psychologist	NHS Borders
Justine Craig	Chief Midwifery Officer	Scottish Government
Emma Currer	National Officer–Scotland	Royal College of Midwives Scotland
Wendy Duffy	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

Name	Position	Organisation
Kirsteen Guthrie	Associate Director of Midwifery, General Manager for Women and Children Services	NHS Borders
Clea Harmer	Chief Executive	Sands
Rachel Hignett	Lead Obstetric Anaesthetist	NHS Lothian
Maria Velo Higueras	Midwifery Educator Researcher	Robert Gordon University
Angela Jenkins	Consultant Anaesthetist, Elected Member	NHS Greater Glasgow and Clyde, Scottish Board of Royal College of Anaesthetists
Jaki Lambert	Director	Royal College of Midwives Scotland
Jacqui Laurie	Strategic National Clinical Lead in Obstetrics	Healthcare Improvement Scotland, NHS Lothian
Frances Lowrie	Specialist Pharmacist	NHS Greater Glasgow and Clyde
Carsten Mandt	Senior Programme Manager	NHS National Services Scotland
Mairi McDermid	Associate Chief Midwife	NHS Greater Glasgow and Clyde
Thomas McEwan	Principal Educator–Nursing, Midwifery and Allied Health Professionals	NHS Education for Scotland
Alison McFadden	Professor of Mother and Infant Public Health, Co-lead Mother and Infant Research Unit	University of Dundee
Mathilde Peace	Maternity Voices Partnership Lay Chair	NHS Lothian
Mercedes Perez-Botella	Director of Midwifery, Gynaecology and Neonates	NHS Lothian
Alastair Philp	Information Consultant	Public Health Scotland
Ainharan Raveendran	Consultant Obstetrician and Gynaecologist	NHS Grampian
Pauline Smith	Clinical Midwifery Manager	NHS Lothian
Paula Stewart	Registered Nurse, Registered Midwife, Infant Feeding Advisor	NHS Lothian

Name	Position	Organisation
Joanne Thomson	Senior Improvement Advisor– Scottish Patient Safety Programme	Healthcare Improvement Scotland
Jacqueline Whitaker	Interim Deputy Director of Acute Services, Chief Midwife, Women's and Child Health Lead	NHS Shetland
Andrea Woolner	Honorary Consultant Obstetrician, Senior Clinical Lecturer, Chief Investigator, Early Pregnancy Lead	University of Aberdeen, NHS Grampian, Research work for Chief Scientist Office Scotland, National Institute for Health and Care Research, Tommy's charity Member of Scottish Early Pregnancy Network, Scottish Perinatal Network Association of Early Pregnancy Units, Miscarriage Care Framework

Standards Development Group: Scottish Government observers

Name	Position	Organisation
Kirstie Campbell	Head of Maternal and Infant Health	Scottish Government
Sarah Corcoran	Team Leader–Maternal and Infant Health	Scottish Government
Iona Duckett	Professional Advisor for Midwifery and Perinatal Health	Scottish Government
Antony Nicoll	Senior Medical Officer–Maternal and Women's Health	Scottish Government
Stephanie Rodger-Phillips	Senior Policy Adviser	Scottish Government

The Standards Development Group and review and editorial panels were supported by the following members of Healthcare Improvement Scotland's standards and indicators team:

- Lola Adewale – Programme Manager
- Dominika Klukowska – Administrative Officer
- Silas McGilvary – Project Officer (from October 2024)
- Mary Michael – Project Officer (until November 2024)
- Fiona Wardell – Team Lead.

Appendix 3: Membership of the standards review and editorial panels

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

* Editorial panel only

Glossary

Term	Definition
Adverse events	an event that could have caused, or did result in, harm to people including death, disability, injury, disease or suffering and/or immediate or delayed emotional reaction or psychological harm. (82)
All settings	any place where the woman/birthing person receives maternity healthcare and includes hospital, primary care, emergency departments, pharmacies, at home (including place of residence such as prison) and community.
Antenatal care	is the care experienced by women/birthing people from healthcare professionals throughout their pregnancy from conception until birth (or pregnancy loss).
Care outside of guidance	refers to when women/birthing people choose care and support, including birth, which does not follow local and national guidelines or standards. This might be to increase the women/birthing person's sense of autonomy and control, or because it follows their personal beliefs, values and preferences. Such care may also be referred to as 'alternative or non-standard birth choices.'
Caregiver	includes care partner, parents and family members.
Care partner	refers to any person or representative the individual wishes or chooses to be involved in their care, which might be a partner, family member or friend.
Carer	in these standards, carer refers to the primary midwife working within a continuity of care model, as described within Scottish Government policy. (1) Carers provide a significant amount of the women/birthing person's antenatal, intrapartum and postnatal care.

Term	Definition
Clinical governance	is a framework through which NHS organisations and their staff are accountable for continuously improving the quality of patient care.
Complications in pregnancy	may include, but are not limited to, hypertension, deep vein thrombosis, diabetes, sepsis, preeclampsia, haemorrhage, postnatal psychosis and risk of premature birth.
Core newborn care	refers to the essential health care provided to newborns, ensuring their protection from injury and infection, maintaining normal breathing, providing warmth, and ensuring adequate feeding. It includes immediate care at the time of birth and ongoing care during the newborn period, which is important for improving the health of women/birthing people and their babies. This care is necessary in healthcare facilities and at home, and involves skin-to-skin contact and early breastfeeding.
Global majority	refers to the group of people in the world who do not consider themselves, or are not considered, to be White.
Health-harming products	refers to products that can cause harm to the woman/birthing person or their developing baby. These include, but are not limited to tobacco, alcohol, certain medications and foods, substances and drugs.(174)
Health inequalities	are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience, and the care that is available to them. The overlap of characteristics and social factors is referred to as intersectionality and can also affect the care people experience.

Term	Definition
High-performing teams	refers to healthcare teams that are characterised by effective teamwork, excellent communication and a shared commitment to patient safety and quality care. These teams are well-led, promote continuous learning and collaborate effectively across professional boundaries. They also actively seek and act on patient and staff feedback to continuously improve.
High-quality	refers to healthcare that is person centred, safe and effective. This includes 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 support continuity and consistency in care.
Holistic assessment	is a comprehensive approach to assessing someone that considers all aspects of the person's wellbeing, including physical, emotional, social and spiritual factors. In maternity care, it helps to promote a safe and positive pregnancy and birth experience. It goes beyond physical health and considers factors such as relationships, beliefs and general lifestyle.
Human factors	refers to the principles of improving human performance by understanding the behaviour of individuals, and their interactions with each other and their environment.
Incidents	are any events (including near misses) that result in harm or could potentially have caused harm.
Income maximisation	increases the amount of money people receive and minimises the amount of money spent. It also makes sure people receive the amount of money they are entitle to, either through state benefits or government grants.
Infant	in the context of NHS Scotland, an infant refers to a child from birth up to 12 months of age.
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.

Term	Definition
Instrumental birth	is when forceps or a ventouse suction cup are used to help deliver the baby.
Integrated maternity care	aims to provide a safe, person-centred, and compassionate approach for all women/birthing people and babies. It emphasises continuity of care and carer, and partnership working between teams.
Inter-pregnancy counselling	focuses on maximising a women/birthing person's health and wellbeing between pregnancies. It aims to improve maternal and infant health outcomes in subsequent pregnancies.
Intrapartum care	refers to the care provided to women/birthing people during labour and birth.
In-utero transfer	refers to the transfer of a pregnant woman/birthing person to another setting before the baby is born, because the baby is likely to need care in a specialist neonatal unit.
Line of sight from 'floor to board'	ensures that NHS board members and senior managers and leaders are aware of the daily operations, challenges and successes on the maternity floor. It also allows staff on the floor to more easily communicate their concerns, issues and suggestions to the board and senior managers and leaders.
Near misses	are events that could have caused harm but did not, because of circumstances or intervention.
Newborn care	is care provided to any baby until their care is transferred to the universal health visiting service (usually at ten days old).
Non-commercial information	is information that is developed by statutory, third sector or not for profit agencies. It is evidence-informed and uses current best practice to support informed decision making. There are no commercial or financial gains from producing, sharing or accepting the information.
Non-medical setting	includes educational settings, police custody suits, prisons, community centres or third sector support agency settings.

Term	Definition
Postnatal care	focuses on the wellbeing of both the woman/birthing person and their baby after birth. This includes regular home visits by midwives for up to ten days, a six-eight week postnatal check-up for the woman/birthing person, and a six-eight week health check for the baby. The care also extends to advice and support on looking after a newborn (including feeding), wound care, contraception and mental health and wellbeing. 'Postnatal' is sometimes referred to as 'postpartum.' Home is defined here as place of residence at time of visiting and includes prison settings.
Pre-conception care	involves optimising health before and between pregnancies. It focuses on both physical and mental wellbeing, aiming to improve fertility and reduce the risk of complications during pregnancy. Key aspects include healthy eating, reducing consumption of health-harming products, maintaining a healthy lifestyle and weight, and taking nutritional supplements, including folic acid.
Primary midwife	refers to the midwife who has lead responsibility for midwifery care throughout the women/birthing person's pregnancy and birth. The primary midwife coordinates care planning for women/birthing people and is sometimes referred to as 'carer.' The primary midwife is also 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.

Term	Definition
Professional lead	an experienced healthcare professional who has leadership responsibilities within their clinical setting.
Safety-critical data	refers to information about maternity care that is essential for ensuring the wellbeing of both mother/birthing person and baby during pregnancy, labour and birth. This data is used to inform clinical decisions, monitor patient progress and improve care quality. Examples include vital signs, monitoring the baby and information about maternal health conditions.
Staff (maternity care)	refers to all staff involved in the delivery of maternity care and includes anaesthetists, dietitians, GPs, gynaecologists, health visitors, maternity care assistants, maternity support workers, midwives, neonatal nurses, obstetricians, paediatricians, pharmacists, physiotherapists, sonographers, educators and clinical researchers. 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. 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 (HIS).
Staffing red flag event	is a signal that an immediate response is required, such as urgent provision of additional midwives.

Term	Definition
Systems methodology	refers to an approach to healthcare that views problems as part of a wider dynamic system. It recognises the relationships and interactions between the components of a system and the effect these have on outcomes.
Trauma-informed	is a way of working and delivering services that recognises that a person may have experienced trauma and understands the effects that trauma may have on them. For healthcare services, it involves adapting processes and practices, based on this understanding of the effects of trauma, and seeks to avoid, or minimise the risk of, exposing the person to any recurrence of past trauma, or further trauma. A trauma-informed service will be able to demonstrate the ways in which it has been informed by feedback from people with living and lived experience of trauma. A trauma-informed system also supports workforce resilience and is supported by trauma-informed leadership and systems.(18)
Triage	is a process that prioritises the order in which patients receive care, according to clinical need. Maternity triage assessment areas are open 24 hours a day, seven days a week, for pregnant women/birthing people who may require urgent unscheduled care. Triage assessment and advice may be provided by telephone or in person.

Term	Definition
Triumvirate leadership structure	is a model which involves a team of three leaders within maternity services: usually a Clinical Director (often an obstetric consultant), a Head/Director of Midwifery and a General or Operations Manager. This model aims to provide balanced leadership, combining clinical expertise, professional midwifery/nursing insights, and managerial/operational skills. Other similar leadership models may be appropriate for maternity services.
Unbiased staff	provide evidence-based information, which facilitates informed decisions, and the co-development of care plans with women/birthing people. The aim is to avoid biases and treat all women/birthing people with dignity and respect, regardless of their background or circumstances.
Under-served groups	refers to people who experience social inequality, stigma, discrimination or lack of opportunity, which makes it difficult for them to make an informed choice or access maternity services. Many factors can contribute to being under-served, including homelessness, deprivation, mental health problems, disabilities, sensory impairment, neurodiversity or belonging to a minority ethnic group.
Unscheduled care and additional care	refers to any care that was not anticipated. This can include unscheduled maternity care as well as non-maternity inpatient care, or care received in an emergency department, ambulance or pharmacy. It is sometimes referred to as urgent care.
Vicarious trauma	refers to 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	refers to women, girls, trans men and non-binary and intersex people who are pregnant or have recently been pregnant.
Workforce	refers to all staff providing care and support throughout the maternity pathway. This includes students and trainees.

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