Review and mapping of the Nursing & Midwifery Council (NMC) Standards of proficiency for midwives to recommendations from key UK maternity and neonatal reviews

Analysis and commentary report

17 February 2026

UK Network of Professors in Midwifery and Maternal and Newborn Health

Executive summary

This report summarises an independent review and mapping of the Standards of proficiency for midwives (NMC 2019[1]/2024) and the relevant practice elements of Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023) against the recommendations arising from the most recent UK maternity and neonatal reviews. The Nursing & Midwifery Council (NMC) commissioned the UK Network of Professors in Midwifery and Maternal and Newborn[2] Health to undertake the review and mapping as part of their Midwifery Action Plan (NMC 2025) and in response to ongoing national reviews of maternity and neonatal services.

The project was completed at pace (Nov 2025-Jan 2026) by a project team with expertise in midwifery and maternity education, research, practice and policy drawn from across the four countries of the UK. Following an initial pilot mapping activity, the mapping process was agreed and five pairs of mappers independently mapped recommendations relevant for midwives' practice from the following seven recent reviews:

- Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden 2020)
- Ockenden report - final: Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden 2022)
- 'Reading the signals': maternity and neonatal service in East Kent – the report of the independent investigation (Kirkup 2022)
- Enabling safe quality midwifery services and care in Northern Ireland (Renfrew 2024)
- National review of maternity services in England 2022- 2024 (Care Quality Commission [CQC] 2024)
- The independent review of maternity and neonatal services at Swansea Bay University Health Board (Chaffer 2025)
- Unannounced inspection report – maternity services and safe delivery of care inspection Ninewells hospital, NHS Tayside (Healthcare Improvement Scotland) (HIS 2025)

The mapping exercise confirmed that recommendations from all seven reviews that relate to the work of midwives are all addressed within the Standards of proficiency for midwives (NMC 2019/2024) and relevant practice elements of Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023). The mapping identified all of the proficiencies that related to each recommendation. No gaps were found - i.e. relevant recommendations that were not addressed by the proficiencies.

Whilst there were no gaps or mismatches between recommendations relating to the work of midwives and proficiencies, the impact of wider contextual issues in maternity and neonatal care was apparent in the mapping and should be taken into consideration. For example, midwives' ability to be effective in their role was recognised as being contingent on factors such as effective functioning within multidisciplinary teams (MDTs), clinical acuity, adequate staffing levels and skill mix, and/or other institutional decisions; this context also limited midwives' ability to work to their full scope of practice (e.g. delivering continuity of care and carer).

In a 'reverse mapping' element, the activity identified numerous proficiencies not included in review recommendations. This could be expected given the remits and focus of each individual review, however it also indicates the breadth and depth of opportunity within the detailed, holistic and evidence based

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[1] Originally published 18 Nov 2019. Updated standards were approved by NMC Council on 25 Jan 2023 and further updated on 29 July 2024 – for further information see Standards for pre-registration midwifery programmes

[2] https://www.councilofdeans.org.uk/partnerships/uk-network-of-professors-in-midwifery-and-maternal-and-newborn-health/

Standards of proficiency for midwives (NMC 2019/2024) to implement midwifery knowledge and skills to improve safety and quality for women, babies and families.

It is important to note that the data collection periods and publication dates of all the reviews mapped in this project were before full implementation of the Standards of proficiency for midwives (NMC 2019/2024). This exercise thus maps the preparation of the most recent and future cohorts of midwives, looking forward, not those who were in practice at the time many of the reviews were undertaken.

In conclusion, the findings of the mapping are reassuring; there were no gaps or mismatches between review recommendations and proficiencies. However, this analysis indicates an important missed opportunity to fully benefit from the knowledge and skills of midwives. The detailed, holistic and evidence based Standards of proficiency for midwives (NMC 2019/2024) include standards for care across the whole maternity journey that help to prevent complications and promote timely referral. Implementation of the full range of proficiencies is needed to improve safety and quality for all women, babies and families.

Contents

Executive summary 1

Gender inclusive language statement 4

Project team on behalf of the UK Network of Professors in Midwifery and Maternal and Newborn Health 5

Introduction 6

Methods and processes 7

Assembling the mapping team 7

Data sources 7

Data management 11

Findings and discussion 13

Conclusion 18

References 19

Appendix A: The Shrewsbury and Telford review (interim 22

Appendix B: The Shrewsbury and Telford review (final) 25

Appendix C: The East Kent review 30

Appendix D: The Northern Ireland review 39

Appendix E: The CQC review 45

Appendix F: The Swansea Bay review 47

Appendix G: The Ninewells review 50

Appendix H: 14 pertinent items in the 'Practice learning' section of Part 3: Standards for pre-registration midwifery programmes (NMC 2019/2023 p 11-12) included in mapping 54

Table 1: Overview of the domains within the Standards of proficiency for midwives (NMC 2019/2024), including total number of proficiencies and number of individual proficiencies identified within each domain. 9

Table 2: Summary of recommendations/constituent elements mapped to midwifery proficiencies by report and totals for all reviews 14

Table 3: Number of proficiencies mapped for each recommendation/constituent element per domain and total - Shrewsbury and Telford review (interim) 24

Table 4: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Shrewsbury and Telford review (final) 27

Table 5: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The East Kent review 32

Table 6: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Northern Ireland review 40
Table 7: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The CQC review 46
Table 8: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Swansea Bay review 49
Table 9: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Ninewells review 51

Figure 1: Timeline of review data collection periods/publications and implementation of Standards of proficiency for midwives (NMC 2029/2024) 16

Gender inclusive language statement

This report recognised that maternity and neonatal services are accessed by women, gender-diverse individuals and people whose gender identity does not align with their sex assigned at birth. Where the terms woman and women are used in this report (including text used in the reviews), they are intended to be inclusive and refer to all people who may become pregnant, give birth or access maternity and neonatal services, including birthing people and gender-diverse individuals.

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Introduction

The safety and quality of maternal and newborn care and services are major national concerns. The recommendations from several reviews conducted across the UK relate closely to the activity of midwives, working together with professional colleagues and services within wider systems of maternity and neonatal care.

As part of their Midwifery Action Plan (NMC 2025) and in response to ongoing national reviews of maternity and neonatal services (National Maternity and Neonatal investigation 2025; Welsh Government 2025; Scottish Government 2025), the Nursing & Midwifery Council (NMC) commissioned the UK Network of Professors in Midwifery and Maternal and Newborn Health to undertake an independent mapping of the Standards of proficiency for midwives (NMC 2019/2024) against the recommendations arising from the most recent maternity and neonatal reviews conducted in the UK.

This focused project (Nov 2025-Jan 2026) has been undertaken by a project team drawn from across the four countries of the UK. The project team has brought expertise in midwifery and maternity education, research, policy and practice. It comprised of a mapping team, a Steering Group drawn from the UK Network of Professors in Midwifery and Maternal and Newborn Health and critical readers.

The project team was tasked to review the alignment of the NMC Standards of proficiency for midwives (NMC 2019/2024) and the relevant practice elements of Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023) (i.e. in the 'Practice learning' section on p 11-12) with the recommendations of the seven review reports indicated below. A detailed mapping has been undertaken to meet the following objectives:

> *• assess the alignment of the Standards of proficiency for midwives (NMC 2019a/2024) and relevant standards within Part 3 Standards for pre-registration midwifery programmes (NMC 2019b/2024) with the recommendations from the identified publications regarding the knowledge, understanding and skills that midwives must demonstrate at the point of qualification.*
>
> *• identify any critical gaps and/or mismatches between recommendations and proficiencies that need to be addressed in order to deliver safe, effective, respectful, kind, compassionate, person-centred midwifery care.*
>
> *Focussing on recommendations that relate to the work of midwives, the mapping will identify:*
>
> *• all proficiencies that relate to each recommendation*
>
> *• any gaps where recommendations are not addressed by the proficiencies*
>
> *• proficiencies where there are no relevant recommendations, potentially indicating missed opportunities to implement midwifery knowledge and skills to improve safety and quality for women babies and families*
>
> *• recommendations that run counter to proficiencies and where consideration is needed, to include evidence from robust research*

Methods and processes

Assembling the mapping team

The project mapping team comprised of five pairs of mappers, each pair included a midwife and all involved at least one senior researcher or educator. The mapping team engaged with the Project Lead and Steering Group to operationalise the project brief, with meetings conducted virtually and one hybrid (in person and virtual) event.

Data sources

Reports from the seven most recent maternity and neonatal reviews undertaken in the UK were selected by the NMC for inclusion in the project. A brief context and overview for each unique review,[3] including the scope and number of recommendations, can be found in Appendices A to G. It is important to note that a range of terminology was used for the recommendations (or equivalents) arising from these highly individual reports (e.g. 'immediate and essential actions' and 'Key Action Areas'), and that the recommendations (or equivalents) often comprised of several constituent elements. As indicated on p 11, the language of 'recommendations and constituent elements' has been adopted for this report, to reflect the need for some recommendations to be disaggregated for mapping. The reviews included in the mapping were (in chronological order with a shortened name included):

Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (2020) (Ockenden report – interim) - referred to as the Shrewsbury and Telford review (interim)

Ockenden report - final: Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (2022) - referred to as the Shrewsbury and Telford review (final)

'Reading the signals': maternity and neonatal service in East Kent – the report of the independent investigation (2022) Dr Bill Kirkup - referred to as the East Kent review

Enabling safe quality midwifery services and care in Northern Ireland (2024) Prof Mary Renfrew - referred to as the Northern Ireland review

National review of maternity services in England 2022- 2024 Care Quality Commission (CQC 2024) - referred to as the CQC review

The independent review of maternity and neonatal services at Swansea Bay University Health Board (Chaffer 2025) - referred to as the Swansea Bay review

Unannounced inspection report – maternity services and safe delivery of care inspection Ninewells hospital, NHS Tayside (Healthcare Improvement Scotland) (2025) - referred to as the Ninewells review

[3] The term review is used throughout this document for consistency, noting however that the East Kent Report (Kirkup 2022) used the term investigation for its activity.

The Standards of proficiency for midwives (NMC 2019/2024) used for the mapping set out the knowledge, understanding, skills and attributes (stated as outcomes) that all midwives must achieve at the point of registration.[4] These standards were approved by the NMC in October 2019 as part of the their duty to periodically review professional standards of education and proficiency, to ensure they remain fit for purpose, contemporary and evidence based (Renfrew *et al* 2014). The Standards of proficiency for midwives (NMC 2019/2024) are operationalised by Approved Educational Institutions (AEIs) and their practice learning partners, aligned with the following standards education i.e.:

- Part 1: Standards framework for nursing and midwifery education (NMC 2018a/2023)
- Part 2: Standards for student supervision and assessment (NMC 20218b/2023)
- Part 3: Standards for pre-registration midwifery programmes (NMC 2019/2023)

Whilst the Standards of proficiency for midwives (NMC 2019/2024) are explicitly holistic in nature, they are grouped within six inter-related domains and comprise of 356 proficiencies.[5] The Standards of proficiency for midwives (NMC 2019/2024) state what a newly qualified midwife can be expected to:

> '*know, understand and be capable of doing safely and proficiently, at the start of their career. This approach aims to provide clarity to the public and the professions about the knowledge, understanding and skills they can expect every midwife to demonstrate*' (NMC 2019/2024 p 9).

Table 1 provides an overview of the six domains within the Standards of proficiency for midwives (NMC 2019/2024) and the number of individual proficiencies within each domain.

To ensure all relevant midwifery practice requirements were included in the mapping, in addition to the Standards of proficiency for midwives (NMC 2019/2024), 14 pertinent items were identified in the 'Practice learning' section of Part 3: Standards for pre-registration midwifery programmes (NMC 2019/2023 p 11-12) (see Appendix H). Hereafter in the report, for ease these are collectively referred to as the proficiencies.

[4] They also provide a benchmark for midwives from overseas seeking to join the UK register and midwives returning to practice after a period of absence.

[5] The outcomes that a midwife should be able to demonstrate at the point of registration are expressed in a range of formats within the Standards of proficiency for midwives (NMC 2019/2024) e.g. some as a single proficiency and others with main stems and a range of sub stems indicating further detail. The denominator of 356 proficiencies was reached by adding all single statement proficiencies and proficiencies within overarching stem statements. These totals were reviewed and checked by members of the project Steering Group.

Table 1: Overview of the domains within the Standards of proficiency for midwives (NMC 2019/2024), including total number of proficiencies and number of individual proficiencies identified within each domain

Description of domain (number of available proficiencies) (NMC 2019/2024) (Total number of proficiencies in all domains n = 356)
Domain 1: Being an accountable, autonomous, professional midwife (n = 29) *'Midwives are fully accountable as the lead professional for the care and support of childbearing women and newborn infants, and partners and families. Respecting human rights, they work in partnership with women, enabling their views, preferences, and decisions, and helping to strengthen their capabilities. They promote safe and effective care, drawing on the best available evidence at all times. They communicate effectively and with kindness and compassion'* (p 12)
Domain 2: Safe and effective midwifery care: promoting and providing continuity of care and carer (n =12) '*Midwives promote continuity of care, and work across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum, and the early weeks of newborn infants' life. They work in the woman's home, hospitals, the community, midwifery led units and all other environments where women require care by midwives. The midwife is responsible for creating an environment that is safe, respectful, kind, nurturing, and empowering, ensuring that the woman's experience of care during her whole maternity journey is seamless'* (p 15)
Domain 3: Universal care for all women and newborn infants (n =36) *'Midwives work in partnership with women to care for and support all childbearing women, newborn infants, and their families. They make an important contribution to population health, promoting psychological and physical health and wellbeing. Midwives optimise normal physiological processes, and support safe psychological, social, cultural and spiritual situations, working to promote positive outcomes and to anticipate and prevent complications'* (p 17) 3A. The midwife's role in public health, health promotion and health protection 3B. The midwife's role in assessment, screening and care planning 3C. The midwife's role in optimising normal physiological processes and working to promote positive outcomes and prevent complications
Domain 4: Additional care for women and newborn infants with complications (n =15) '*Midwives are ideally placed to recognise any changes that may lead to complications. The midwife is responsible for immediate emergency response and first line management and in ensuring timely collaboration with and referral to interdisciplinary and multiagency colleagues. The midwife has specific responsibility for continuity and coordination of care, providing ongoing midwifery care as part of the interdisciplinary team, and acting as an advocate for women and newborn infants to ensure that they are always the focus of care'* (p21) 4A. The midwife's role in first line assessment and management of complications and additional care needs 4B. The midwife's role in caring for and supporting women and newborn infants requiring medical, obstetric, neonatal, mental health, social care, and other services

Domain 5: Promoting excellence: the midwife as colleague, scholar and leader (n =26)
'Midwives make a critically important contribution to the quality and safety of maternity care, avoiding harm and promoting positive outcomes and experiences. They play a leading role in enabling effective team working, and promoting continuous improvement. Midwives recognise their own strengths, as well as the strengths of others. They take responsibility for engaging in continuing professional development and know how they can support and supervise others, including students and colleagues. They recognise that their careers may develop in practice, education, research, management, leadership, and policy settings' (p24) 5A. Working with others: the midwife as colleague 5B. Developing knowledge, positive role modelling and leadership: the midwife as scholar and leader
Domain 6: The midwife as skilled practitioner[6] (n = 238) Note this Domain includes the detailed skills required to meet the standards in Domains 1-5. *'Midwives make a critically important contribution to the quality and safety of maternity care, avoiding harm and promoting positive outcomes and experiences. They play a leading role in enabling effective team working, and promoting continuous improvement. Midwives recognise their own strengths, as well as the strengths of others. They take responsibility for engaging in continuing professional development and know how they can support and supervise others, including students and colleagues. They recognise that their careers may develop in practice, education, research, management, leadership, and policy settings' (p 27)* • Communication, sharing information and relationship management skills: shared skills for **Domains 1, 2, 3, 4 and 5** • Being an accountable, autonomous, professional midwife: skills for **Domain 1** • Safe and effective midwifery care: promoting and providing continuity of care and carer: skills for **Domain 2** • Assessment, screening, planning, care and support across the continuum: shared skills for **Domains 3 and 4** • Evidence-based medicines administration and optimisation: shared skills for **Domains 3 and 4** • Universal care for all women and newborn infants: skills for **Domain 3** • Additional care for women and newborn infants with complications: skills for **Domain 4** • Promoting excellence: the midwife as colleague, scholar and leader: skills for **Domain 5**

[6] Domain 6 'proficiencies have all been mapped for assessment in clinical practice via the Midwifery Ongoing Record of Achievement (MORA) in England & Northern Ireland, the Scottish Midwifery Practice Assessment Document in Scotland and the Once for Wales Midwifery Practice Assessment Document (MPAD) in Wales (i.e. Applying Part 2 SSSA:2 Standards for student supervision and assessment (NMC 2018b/2023).

Data management

At the outset of the project all mapping team members conducted a detailed (re)familiarisation with the current versions of NMC Standards of proficiency for midwives (NMC 2019/2024) and the practice elements of Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023).

The NMC provided the project team with excel sheets, one each to map to recommendations from the individual reviews. An initial mapping team task was to review the excel sheets and agree the mapping process.

A pilot mapping exercise was undertaken where all mapping team members independently mapped one review (the CQC, 2024 review) to the proficiencies, using a copy of the excel sheet format provided by the NMC. A colour code of green (applicable i.e. proficiencies that could clearly map to recommendations), yellow (partially applicable i.e. where it was unclear or challenging to determine applicability) and red (not applicable i.e. proficiencies and recommendations that did not map) was used to map/reverse map the proficiencies to the review recommendations. Mapping team members then met online to share reflections and learning from this exercise. Key observations and discussions led to agreement of the following actions and processes to use for the mapping exercise:

1. ***Observation***: Some review recommendations contained several constituent elements, which made it very challenging to accurately map the proficiencies. ***Action***: Revisions were made to the excel sheet for each individual review to disaggregate multi-constituent recommendations to enable accurate mapping. This was undertaken using the original wording within the recommendation to meaningfully separate out its constituent elements. Single element recommendations were unchanged. From an initial total of 98 individual recommendations within the seven reviews, 283 recommendations/constituent elements were identified for mapping (see Table 2). The terminology of 'recommendations/constituent elements' was adopted to capture this action and has been used for consistency throughout this report.

2. ***Observation:*** Some review recommendations were clearly not relevant for/directed at midwives' practice, e.g. being the responsibility of non-clinicians, organisations or institutions and were therefore not relevant for mapping according to the project brief. ***Action***: Two project team members independently reviewed the target population/group for action and/or the responsibility of all recommendations/constituent elements to determine the relevance to midwives' practice and thereafter met to discuss, agree and record decisions. Recommendations/constituent elements deemed not to be relevant to midwives' practice were then greyed out in the excel sheets (i.e. not to be mapped), leaving only recommendations/constituent elements relevant to midwives' practice and thus to be mapped to the proficiencies.

3. ***Observation:*** In some instances, it was challenging to decide whether a proficiency was applicable to review recommendations/constituent elements and therefore to assign a colour code in the excel sheet. ***Action***: It was anticipated that actions for 1 and 2 above

would significantly reduce this challenge, however mappers also agreed to (where possible) limit the use of 'partially applicable' when undertaking the final mapping (i.e. to map as 'partially applicable' by exception), to maximise the utility of the mapping findings.

A mapping pair was then allocated to each review[7] and two pairs were required to map two reviews. Mapping pairs were selected to ensure no conflict of interest (e.g. no links to former or current reviews or clinical sites being reviewed). Each pair was given the agreed remit[8] and mapping instructions as follows:

- Familiarise themselves with their review report.
- Independently map the review recommendations/constituent elements identified as relevant for midwives' practice (checking and challenging any relevant decisions as necessary) to the proficiencies, using the updated excel sheets provided.
- Use the agreed colour coding to indicate mapping and reverse mapping decisions.
- Thereafter come together as a mapping pair to discuss/agree and record mapping consensus (i.e. complete a jointly agreed excel sheet), record observations and reflections on the mapping of the review recommendations/constituent elements to the proficiencies and identify any areas where further resolution was needed beyond the pair to complete the review mapping.
- Provide a brief written summary of the review (e.g. its inception, remit and the number and focus of recommendations/constituent elements) and findings from mapping to the proficiencies.

During the mapping period, online meetings were held and asynchronous communications used to discuss and share any key/overarching observations and to resolve any issues arising between pairs. Following completion of the mapping, a hybrid meeting was held for mapping teams and steering group members to discuss findings and consensus from the mapping of each individual review, and to consider findings and analysis across the mapping of all reviews according to the project brief.

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[7] When preparing/checking the excel sheet provided for mapping 'Reading the signals': maternity and neonatal service in East Kent – the report of the independent investigation (Kirkup 2022) it was noted that 'Key areas for action 1-5' and elements within them presented in Chapter 1 were included in the excel sheet. However, further actions and recommendations were also in 'Chapter 6: Areas for action'. Following consultation with the NMC these were added for inclusion in the mapping exercise to ensure completeness.

[8] The reviews included in this mapping project were conducted for a range of key, stated purposes, with common drivers of seeking to enhance the quality, safety and effectiveness of kind, compassionate and person-centred maternity and neonatal care. In addition to recommendations for action, some reviews also included strengths, such as improvements noted in the Swansea Bay review (Chaffer 2025) and areas of good practice identified in the Ninewells review (Healthcare Improvement Scotland 2025). It is noted that it was beyond the project to map to these positive elements to the midwifery proficiencies.

Findings and discussion

Table 2 summarises the mapping of all seven reviews to the proficiencies. Summary commentaries for each review, including observations on their individual mapping, are provided in appendices A to G. All pairs reached consensus within their mapping without the need to seek further resolution beyond the pair. It was observed that each review required different lengths/depths of discussion to reach agreement, depending on how challenging they were to map (i.e. some straightforward - others more nuanced).

When mapping the recommendations/constituent elements for each review in context, pairs concurred with the initial decisions made to exclude those recommendations/constituent elements deemed as not being relevant to midwifery practice (see Action 2 on p 11) for six of the seven reviews. The mapping pair for the East Kent review identified a further two recommendations/constituent elements which fitted this category, which were therefore deemed not relevant to map to the proficiencies (please see Appendix C for further details and rationale). The entry for the East Kent review in Table 2 was updated to reflects this.

The seven highly individual reports yielded a total of 283 recommendations/constituent elements following the disaggregation (where needed) of the 98 recommendations (see Action 2 on p 9). Following exclusion of the 176 recommendations/constituent elements deemed as being the responsibility of non-clinicians, organisations or institutions etc (see Action 2 on p 11 and above), the 107 recommendations/constituent elements identified as relevant for midwives' practice were mapped to the proficiencies.

Across the reviews all 107 recommendations/constituent elements were mapped to relevant proficiencies.[9] There were no recommendations/constituent elements that were relevant for midwifery practice which could not be mapped to the proficiencies. **The mapping activity thus confirmed that for all seven reviews all recommendations/constituent elements that were relevant to midwives' practice, were addressed within the proficiencies**.

The mapping summaries (Appendices A to G) include a table for each review which describes:

- domain(s) within the Standards of proficiency for midwives (NMC 2019/2024) which each relevant recommendation/constituent element mapped to, the number of proficiencies mapped within each domain and the total number of proficiencies mapped to each relevant recommendation/constituent element;
- mapping to the practice elements of the Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023), indicating the total number of elements mapped to each relevant recommendation/constituent element.

Tables 3 to 9 in the mapping summaries for each report (Appendices A to G) provide more granular detail than the summary Table 2. The detailed mapping showed considerable variation in the number of proficiencies mapped to each individual recommendation/constituent

[9] As noted in Action 3 on p 11-12, mapping as 'partially applicable' was avoided by mappers wherever possible. Proficiencies mapped as 'partially applicable' have therefore not been included in Table 2 or the individual tables (Tables 3-9) for each review in appendices A-G.

Table 2: Summary of recommendations/constituent elements mapped to midwifery proficiencies by report and totals for all reviews

Review	Total number of recommendations in each review (disaggregated number of recommendations and constituent elements in each report) †	Number of review recommendations/constituent elements aimed at non-midwifery clinicians and/or organisations or institutions (e.g. NHS Trust boards or management, Local Maternity and Neonatal Services (LMNSs), national bodies) and thus not relevant to map to the proficiencies	Number of review recommendations/ constituent elements directly relevant for midwifery practice which were mapped to the proficiencies	Number of review recommendations/ constituent elements relevant for midwifery practice which could not be mapped to the proficiencies
Shrewsbury and Telford review (interim) 2020)	7(25)	9	6	0
Shrewsbury and Telford review (final) (2022)	15 (92)	65	27	0
East Kent review (2022)	5 (53)	25	28	0
Northern Ireland review (2024)	32 (50)	26	24	0
CQC review (2024)	6 (13)	10	3	0
Swansea Bay review (2025)	10(27)	21	6	0
Ninewells review (2025)	23 (23)	10	13	0
Totals for all reports combined	**98 (283)**	**176**	**107**	**0**

† see rationale on p 11 for terminology use of recommendations/constituent elements

element, which ranged between 1-226 proficiencies. This appears to reflect the unique nature and purpose of each review, its report and recommendations, noting that no review exclusively focused on the work and role of midwives as a profession in isolation.

This mapping exercise provides assurance that the knowledge, understanding and skills that midwives must demonstrate at the point of qualification contained within the Standards of proficiency for midwives (NMC 2019/2024) and the relevant practice elements of the Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023) address all relevant recommendation/constituent elements within the seven reviews mapped. There were no gaps and/or mismatches between recommendations/constituent elements and the proficiencies indicating that no additional proficiencies are required to meet the recommendations of the reviews included in the project.

During the mapping it was observed that wider contextual issues in maternity and neonatal care could lead to review recommendations which limited midwives' ability to work to their full scope of practice, e.g. delivering continuity of care and carer (Domain 2 of the Standards for pre-registration midwifery programmes NMC 2019/2023) within the Shrewsbury and Telford interim report (see Appendix A). The mappers observed that many report recommendations/ constituent elements that could be mapped to the midwifery proficiencies needed to be viewed contextually, i.e. where the effectiveness of midwives was often contingent on factors such as functioning within effective and supportive multidisciplinary teams (MDT), clinical acuity, adequate staffing levels and skill mix and/or institutional decisions. Similarly, across many of the reviews, midwives could contribute to improvements, but many recommendations/ constituent elements required organisational commitment and action, e.g. to set up specific services or governance pathways. A further example is that some recommendations/ constituent elements within the midwife's remit were contingent on the wider MDT and organisational structures. For example, in the Swansea Bay report, several recommendations such as optimising care in triage, midwives using Maternity Early Warning Score (MEWS) charts and escalation were all within the midwife's remit, however, safe and effective care was contingent on factors such as robust systems and processes, sufficient staffing, appropriate skill mix and adequate resourcing with timely attendance by the wider MDT. These findings align to UK Network of Professors in Midwifery and Maternal and Newborn Health policy briefing (2025) Safe, effective, equitable, compassionate and respectful maternity and newborn care for all – i.e. recognising midwives' contributions to maternity and neonatal services within system-wide, solutions-based, collaborative, evidence-informed approaches.

It is important to note that individual review recommendations were produced in response to each unique review remit, that is, to focus on specific failings and to make recommendations for practice and service improvement and not for the purpose of an exclusive focus on midwives' practice. Aspects of care that were functioning well were not always included in the review recommendations. When undertaking the reverse mapping (identifying proficiencies not relating to recommendations/constituent elements) the mapping team were unsurprised to note numerous individual proficiencies which remained unmapped to the review recommendations/constituent elements. These unmapped proficiencies detail a wealth of knowledge, understanding and skills that midwives must demonstrate at the point of registration which were not captured in the recommendations of the seven reviews.

Figure 1:Timeline of review data collection periods/publications and implementation of Standards of proficiency for midwives (NMC 2019/2024)

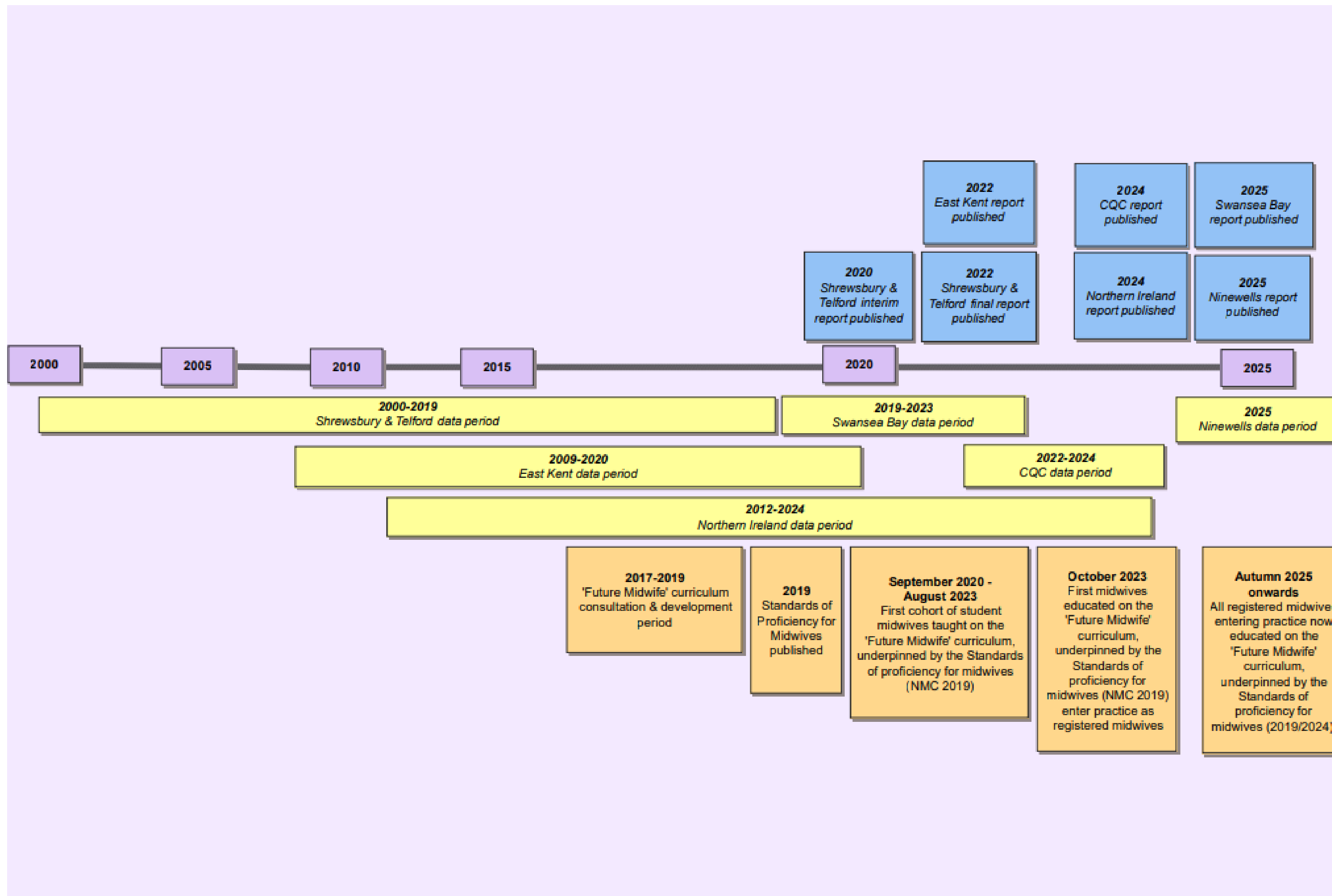

Figure 1 indicates the development, approval and operationalisation of the Standards of proficiency for midwives (NMC 2019/2024) together with the NMC education standards for midwives (see p 9) alongside the data collection periods and publication of the reviews mapped in this project. It is noted that the data collection periods and publication dates of all the reports mapped in this project were before full implementation of Standards of proficiency for midwives (NMC 2019/2024) - i.e. all newly qualified midwives graduating on the Standards of proficiency for midwives (NMC 2019/2024). The first cohort of registered midwives educated on curricula approved to meet the Standards of proficiency for midwives (NMC 2019/2024) graduated in autumn 2023, entering practice for a period of preceptorship (NMC 2020; Royal College of Midwives 2022) as Band 5 midwives, before seeking Band 6 posts. It is only since Autumn 2025 that all UK graduate midwives now register having met the Standards of proficiency for midwives (NMC 2019/2024). It is therefore anticipated that going forward, the full potential of the Standards of proficiency for midwives (NMC 2019/2024) can be realised in terms of midwifery knowledge, understanding and skills, contributing to improved safety and quality of care for women, babies and families.

Conclusion

The aim of this project was to map the Standards of proficiency for midwives (NMC 2019/2024) against recommendations arising from seven of the most recent reviews of maternity and neonatal services. Many of the recommendations were complex and multi-level. These required to be disaggregated before mapping could take place, resulting in 283 recommendations and disaggregated constituent elements overall. Many of these were not related to the work of midwives and were therefore removed from mapping, leaving a total of 107 recommendations/constituent elements to be mapped to the proficiencies. **The results clearly indicated that all recommendations across the seven reviews were addressed by the Standards of proficiency for midwives (NMC 2019/2024).**

Focussing on recommendations that related to the work of midwives within the seven reviews identified by the NMC, this project thus provides assurance that these can all be mapped to the Standards of proficiency for midwives (NMC 2019/2024) and relevant practice elements of the Part 3 Standards for pre-registration midwifery programmes (NMC 2019/2023). The mapping also highlighted that a wealth of proficiencies were not captured in the review recommendations/constituent elements. Collectively these holistic, evidence-based Standards of proficiency for midwives (NMC 2019/2024) which all newly qualified midwives are required to demonstrate at the point of registration provide a firm foundation to improve the safety and quality of maternity and neonatal care. As indicated in the timeline in Figure 1, educational programmes need the time to be delivered and embedded to fully realise their impact on clinical care. Further, midwives qualifying now will take time, and opportunities for post-registration education and experience, to develop and reach the leadership and specialist roles that are essential in delivering the highest levels of maternity and neonatal care.

The project remit was to focus on the work of midwives, however project mapping confirmed the multiprofessional nature of maternity and neonatal care and the need for strong and effective organisational actions and governance to deliver safe and high quality care – thus echoing many of the review recommendations. This project concludes that midwives cannot enact relevant recommendations from reviews in isolation, and that systemic approaches are required that recognise the key, integral role of midwifery within maternity and neonatal services and support effective implementation of the knowledge and skills of midwives. The mapping serves as a reminder that midwives work collaboratively within MDTs and organisations, and their role is contingent on working in appropriately resourced enabling environments, which maximise the full scope of midwifery practice, as articulated in the Standards of proficiency for midwives (NMC 2019/2024. These include standards for care across the whole maternal and neonatal journey that aim to promote positive outcomes and anticipate and prevent complications. Implementation of the full range of midwifery proficiencies is needed to improve safety and quality for all women, babies and families.

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Appendix A: The Shrewsbury and Telford review (interim)

Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (2020) (Ockenden 2020)

Review summary: The Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by the then Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by two of the bereaved the parents, whose babies both died after birth at the NHS Trust in 2009 and 2016 respectively. Since its commission, the review grew considerably. The independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019.

In line with the terms of reference, the review examined the Trust's internal investigations where they occurred. In addition, the review team considered external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner reports. The review considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result made a significant number of recommendations for improvement of care across each of the maternity disciplines. In total more than 60 'Local Actions for Learning' were identified specifically for the Trust.

It was also recognised that many of the issues highlighted in the review were not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. As such, the review team also identified 15 areas as 'immediate and essential actions' which were expected to be considered by all NHS trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

The review commented that there was an urgent need for a robust and funded maternity-wide workforce plan, starting immediately, without delay and continuing over multiple years. The team also highlighted that it was essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in maternity services, and that without this, maternity services will not be able to provide safe and effective care for women and babies. Additionally, any workforce plan must also focus on significantly reducing the attrition of midwives and doctors, as only with a robustly funded, well-staffed and trained workforce will the NHS be able to ensure delivery of safe, and compassionate, maternity care locally and across England. The review team published their interim report in 2020. A summary and observations from mapping for the final report, published in 2022, can be found in Appendix B.

Observations from mapping: The Shrewsbury and Telford review (interim) comprised seven overarching recommendations, called 'Immediate and essential actions', which were broken

down to 25 constituent elements for mapping (hereafter referred to as recommendations/ constituent elements). Of these 25 recommendations/ constituent elements, 19 were specifically the responsibility of the Trust and/or wider commissioners to implement. This is important to emphasise as clinicians, midwives included, typically do not have the power or responsibility to implement actions such as '*employing a lead midwife and lead obstetrician to champion fetal wellbeing*' or the '*development of a tertiary level Maternal Medicine Centre'* etc. Therefore, it is vital to view the mapping within this context.

Six recommendations/constituent elements related directly to midwifery practice, and all were mapped against the proficiencies. There was largely an even spread of proficiencies across all six domains that mapped to each recommendation/constituent element. Therefore, the mapping appears to indicate that the current scope of the midwifery practice (as articulated in the proficiencies) is appropriate and offers a vital contribution to addressing the review's recommendations/constituent elements. However, it must be noted that for midwives to practice to their full-scope of practice as per the Code (NMC 2018), they must work in enabling environments to maximise their effectiveness - this is the role and responsibility of NHS Trusts. In this context, we found most of Domain 2 ('Safe and effective midwifery care: promoting and providing continuity of care and carer') if not directly applicable, was indirectly applicable to all six recommendations/constituent elements. Therefore, from a midwifery perspective and to improve care outcomes, we suggest that were continuity of care (Domain 2) fully implemented, it would address all six of the review's recommendations/ constituent elements to a higher standard, as this would ensure greater oversight, accountability and responsibility for individual women's care journeys throughout the childbearing continuum. Securing continuity of care model implementation would contribute significantly to enabling midwives to realise their full professional remit.

Table 3: Number of proficiencies mapped for each recommendation/constituent element per domain and total - Shrewsbury and Telford review (interim)

Shrewsbury and Telford review (interim) Recommendations/constituent elements that directly relate to midwifery practice (n=6)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	19	4	8	12	11	71	6	131
2.All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	23	4	11	7	8	73	12	138
3.Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	23	3	10	8	7	69	4	124
4.All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care.	14	7	32	14	10	141	7	225
5.Women must be enabled to participate equally in all decision making processed and to make informed choices about their care.	23	0	15	1	4	89	3	135
6.Women's choices following a shared and informed decision-making process must be respected.	23	0	15	1	4	89	3	135

Appendix B: The Shrewsbury and Telford review (final)

Ockenden report - final: Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden 2022)

Review summary: This is the Final Report of the Review of the Maternity Services at Shrewsbury and Telford Hospital NHS Trust described in appendix A. The 15 areas of 'immediate and essential actions' were identified and broken down into 92 recommendations/constituent elements. Of these 92, 65 were identified as being aimed at non-midwifery clinicians and/or NHS Trust board/management level/LMNS. However, 27 were found to be directly relatable to the role of the midwife (in collaboration with other non-midwifery clinicians). Only one was exclusively applicable to midwifery.

Observations from mapping: During the mapping exercise all the 27 recommendations/ constituent elements relevant for midwifery practice were mappable to many of the proficiencies. Several recommendations/ constituent elements related to midwives working collaboratively within organisations to design and implement changes to policies/procedures and practice. These were able to be mapped to the proficiencies in two ways: those proficiencies which require midwives to undertake quality improvement and change management (e.g. including appraisal of evidence, implementing evidence-based practice, working with midwifery colleagues, multidisciplinary teams (MDT), outside agencies and stakeholders),and those proficiencies which require the midwives to carry out the changes to their individual clinical practice (e.g. undertaking of assessments, communication, documentation) as well as the knowledge and skills required for these across the antenatal, postnatal intrapartum and neonatal continuum.

Most recommendations/constituent elements were also mappable to the more generic elements of Domain 1 of the Standards of proficiency (NMC 2018/2024) e.g. 1.1 *'understand and act in accordance with the Code'* (NMC 2018),1.3 via the protection of human rights of women and newborns, 1.14 acting in their interests at all times, 1.7 '*demonstrate knowledge and understanding of the role and scope of the midwife in the 21st Century'* and 1.25 '*act as an ambassador, uphold public trust and promote confidence in midwifery and health and care services*.'

During the initial part of the mapping where both team members mapped independently, some proficiencies (n = 80 across all 27 recommendations/constituent elements) were identified as partially applicable. However, during the consensus meeting firm decisions were made as to whether these were or were not applicable. Upon discussion, we found that it could be difficult to pinpoint the focus of some disaggregated recommendations which initially made it challenging to map them absolutely to specific proficiencies. For example, postnatal readmission reviews (recommendation 23 in Table 4 below). The specific focus is on the procedural timeframe of the review taking place (within 14 hours). However, it was also easy to link this (and similar) actions to the proficiencies a midwife needs to be able to undertake the full clinical assessment and ensure the review takes place.

Overall, we observed that many of the 'immediate and essential actions' could have been written in more specific, measurable, achievable and timebound ways to make them less open

to interpretation and nuance. It would also be helpful if the actions were broken down by the review authors into the specific groups (of clinicians, NHS Trust Boards, NHS policy makers or the government etc.) who would be responsible for implementing them.

Table 4: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Shrewsbury and Telford review (final)

Shrewsbury and Telford review (final) (Recommendations/constituent elements that directly relate to midwifery practice (n = 27)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	10	4	2	0	10	12	1	39
2.All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	14	8	2	4	8	34	2	72
3.All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	14	2	1	2	20	41	2	82
4.Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	7	3	0	2	12	17	2	43
5.All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	5	0	1	0	6	8	1	21
6.All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	6	0	0	1	11	18	2	38
7.Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	5	2	1	1	7	21	1	38
8.All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	10	1	0	0	17	69	0	97

9.There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	4	0	4	12	2	46	5	73
10.There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	4	1	0	2	12	12	1	32
11.Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	7	1	6	6	5	31	7	63
12.Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	9	2	5	6	5	30	7	64
13.Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	8	3	17	5	0	14	2	49
14.NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	8	1	23	12	1	67	3	115
15.When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	14	0	19	11	1	56	2	103
16.Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	12	2	11	9	0	49	0	83
17.Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	13	2	10	6	0	51	3	84
18.All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any	18	5	15	5	2	118	9	172

complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.								
19.Midwifery-led units must complete yearly operational risk assessments.	9	0	0	0	7	3	0	19
20.Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	9	0	2	9	10	37	0	67
21.It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	13	6	5	2	2	13	0	40
22.Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	8	2	0	0	5	7	0	22
23.Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	6	0	2	2	1	3	1	15
24.All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	14	4	2	4	0	26	0	50
25.Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	16	2	2	2	0	48	4	74
26.There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	11	2	4	5	0	29	1	51
27.Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	10	1	4	5	0	27	0	47

Appendix C: The East Kent review

'Reading the signals': maternity and neonatal service in East Kent – the report of the independent investigation (2022) Dr Bill Kirkup

Review summary: This independent investigation into maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust took place between 2009 and 2020. The review was commissioned by the UK Government in February 2020. Undertaken by Dr Bill Kirkup, it reviewed two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, both of which fell under the East Kent Hospitals NHS Foundation Trust. The review was published in October 2022. The investigation revealed that the service provided suboptimal clinical care, resulting in significant harm. It highlighted systemic weaknesses in clinical standards, multidisciplinary teamworking, organisational culture, and governance processes, as well as missed opportunities for learning and intervention over more than a decade. The review concluded that meaningful improvement requires organisation-wide change and sets out four cross-cutting priorities: strengthening the ability to detect and respond to concerns, raising expectations of professional behaviour, rebuilding cohesive teamworking, and embedding transparency, accountability, and candour across maternity systems. The review set out four key areas for action, with five distinct recommendations. Within the four areas for action, these were split into 53 recommendations/ constituent elements.

Observations from mapping: Of the 53 recommendations/constituent elements, 23 were excluded for mapping prior to beginning the exercise because they did not apply to midwifery practice at either the individual or organisational level and were noted to be of an NHS Trust strategic or institutional responsibility or at a regulatory level. This was agreed by external consensus before mapping commenced. A further two recommendations/constituent elements (1.155, 1.161) were noted independently by the mappers to relate to junior doctor training, belongingness, and reputation management at the trust level; therefore, these were excluded during the mapping process after a consensus discussion and 28 relevant recommendations/ constituent elements were mapped.

After independent mapping of the 28 recommendations/constituent elements against the proficiencies, the mapping pair met to compare and correlate, and consensus was reached easily. All 28 recommendations/constituent elements could be mapped against relevant proficiencies.

Themes from the review recommendations/constituent element that were directly applicable to the mapping exercise, were:

- teamworking and interprofessional relationships
- professionalism and compassion
- communication
- listening to women and families
- openness and candour
- challenging behaviours and escalating concerns
- leadership
- culture and environment including bullying

- lack of shared philosophies of care
- supervision of trainees and students

The mappers found that a key issue identified early in the process was that all recommendations/ constituent elements were expressed at a broad organisational and strategic level rather than being targeted to specific clinical practices, pathways or interventions or indeed midwifery practice. Similarly, a few constituent elements overtly stated that they were explicitly intended for midwives, obstetricians or other professions. Where recommendations /constituent elements specified a profession, but related to teamwork, relationships and raising concerns, these were included and mapped to demonstrate applicability for future-proofing interdisciplinary teamwork. The distribution of mapped proficiencies aligned to recommendations/constituent elements bears this out as they appeared to be distributed towards domains 1, 5 and 6 of the proficiencies.

Where reference was made to a specific element of clinical care in the absence of a clear indication to whom the recommendation was aimed, i.e. vaginal birth after caesarean and telephone triage, these were mapped against the proficiencies explicitly recognising that midwives operate within multidisciplinary team and vice versa. The delivery of safe, high-quality maternity care cannot be disaggregated into individual professional compliance; it depends on providing the conditions through governance, leadership, workforce, and culture that enable midwives to operationalise their education and midwifery educational standards into evidence-based practice.

Some proficiencies (for example, 1.1 in Domain 1) were relevant to the majority of recommendations and constituent elements and were therefore mapped across multiple areas. When mapping the overarching proficiencies, the associated sub-proficiencies were identified as more directly relevant, particularly where they related to teamwork and interdisciplinary working. Sub-proficiencies were therefore mapped in preference to the broader stem proficiencies, which were left unmapped to maintain clarity and specificity in the mapping process

The mappers, both independently and together, returned to the original review to sense-check and contextualise some of the recommendations, ensuring that the mapping remained authentic and aligned with proficiencies where uncertainty existed. While many aligned with the roles and responsibilities of midwives, only a few could be directly linked, in part because the review's recommendations were presented in a way that limited direct attribution. Similarly, many recommendations were repetitive. The mappers reached consensus quickly, without requiring third-party review or arbitration.

Table 5: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The East Kent review

East Kent review Recommendations/constituent elements that directly relate to midwifery practice (n=28)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.131 We have come to the view that something more reliable needs to be put in place, not only in East Kent but also elsewhere and nationally, to give early warning of problems before they cause significant harm. The aim must be for every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every trust; and for neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years	6	0	0	7	8	11	3	35
1.133 In essence, it is clear that in East Kent the Trust too often treated the concerns expressed by families as "noise" when they were in fact an accurate signal of real problems. One example is how the family of baby Harry Richford was treated, particularly when they sought answers to legitimate questions. But that is not the only such example. The accounts we have heard from families show persuasively that the Trust's mindset was too often to be defensive and to minimise problems; and that this mindset was itself a barrier to learning.	13	0	1	1	6	41	2	64
1.136 The frequent instances we have found of a distressing and harmful lack of professionalism and compassion are of great concern to us. Of course, we are aware that the majority of clinical staff do not behave like this; but, equally, it would be wrong to imagine that these behaviours are confined to East Kent's maternity services.	14	0	0	1	2	22	2	41
1.137 This is not a finding of technical incompetence. But the experience shared vividly with us by families and often confirmed by staff accounts has demonstrated that technical competence is not enough. In any clinical situation, not least the stressful circumstances of giving birth, there is an equal need for staff to behave professionally and to show empathy. The evidence of staff	12	0	0	1	2	21	1	31

not showing kindness or compassion and not listening or being honest has been both harrowing and compelling.								
1.138 Part of a professional approach is explaining what is happening or has happened honestly and openly – at the time, whenever possible, and certainly afterwards. But what we have found is that, too often, the response has been based on personal and institutional defensiveness, on blame shifting and punishment.	11	0	0	0	3	25	2	41
1.139 We have found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members. In fact, in a significant number of cases, the Panel has found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, when they questioned their care, and when they challenged the decisions that were made. Too often, their well-founded concerns were dismissed or ignored altogether.	14	2	0	3	4	31	2	56
1.140 A particular area of concern was the telephone advice given to mothers to stay at home if they were not adjudged to be in established labour. It is foolhardy to disregard the woman's voice, especially if she has experience of previous labour, and we saw evidence of distressing births before the mother's arrival in the maternity unit as a result. But it is dangerous when the caller has also reported other problems such as altered movements by the baby, and we saw examples of babies lost as a consequence of such advice.	11	2	9	14	5	57	8	106
1.141 We have also found a pattern of particularly stubborn and entrenched poor behaviours by some obstetric consultants, particularly at QEQM. We are clear that this has been damaging, not just to team relationships but also to the safety of women and their babies.	9	3	0	3	6	28	4	53
1.142 Some consultants did not attend when requested, although they were on call, and they did not attend scheduled labour ward rounds. They discouraged both junior staff and midwives from calling them at night, leading most staff to conclude that they just had to get on with it without the advice or presence of consultants	8	1	1	4	7	36	3	60

when those consultants were on call. These concerns were known to the Trust, having been clearly identified in the RCOG report of 2016 and confirmed subsequently by the Trust itself in an audit conducted in April and May 2016. The RCOG did not immediately offer to be involved in how these problems might be resolved, and was rebuffed by the Trust on offering to revisit six months later.								
1.145 There is a pressing need to understand better the gross lapses of professionalism, compassion and willingness to listen that these events illustrate, including their prevalence, the underlying causes, and – most importantly – how they can be changed. Unless we address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively and safely, the problems evident in East Kent will recur elsewhere.	14	2	0	1	10	24	4	55
1.146 We have found that teamworking in East Kent maternity services was dysfunctional. This was clear in the accounts we have heard from families and was consistently supported by the evidence of the staff interviews and available records. Many staff described "*toxic*", "*stressful*" working environments. Arguments between staff were played out in front of families just at the time when truly effective teamwork was required and just when families needed to see that teamwork at work.	15	1	0	3	12	23	2	
1.147 Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.	13	1	0	3	2	33	5	57
1.148 In sometimes suggesting that the relationships between midwives and obstetricians and neonatologists were satisfactory, staff revealed the limitations in their concept of teamworking. This was, at most, a concept of each discipline doing its own job to an acceptable standard, but within rigidly demarcated and sometimes conflicting roles. In part, this resulted from an inflexible	19	1	0	3	1	34	5	63

interpretation of a wider maternity debate, positioning midwives as the defenders of women against intervention and obstetricians as the inflictors of over-medicalised models of care.								
1.149 This is no basis for effective teamworking in maternity services. Midwives and obstetricians each bring a unique set of skills and experience to maternity care. They should contribute to maternity care as equal and valued partners. But it is inconceivable that they might have objectives that differ. There is not a separate role to promote “normal” birth or to reduce caesarean sections, or to be the “guardians of normality”, any more than there is a separate role to promote safety. A team that does not share a common purpose is not a team.	19	1	0	3	3	34	5	65
1.150 We have not found any systematic policy in East Kent maternity services of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. Those we interviewed were careful to say that there was no such policy. We have found, however, that the way in which “normal birth” was spoken about and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve. On some occasions, this pressure of expectation seemed to contribute to staff decisions not to escalate concerns or to intervene, decisions that were otherwise inexplicable.	18	0	0	0	2	28	3	51
1.151 One particular example is the Vaginal Birth After Caesarean (VBAC) Clinic, which started at QEQM in 2005 and was operational across the Trust by 2007. The inherent expectation of the clinic was clearly the promotion of VBAC, and it certainly operated in that way. While VBAC is a welcome and appropriate plan for some women, the benefits must be weighed against the risks, particularly of uterine rupture, taking into account any adverse factors. There were clear examples of women who were at high risk from VBAC where we could find no evidence that these risks were discussed, or that a decision which placed a woman at high risk was communicated to her or flagged to inform her future care. Such decisions need to be taken carefully, free from inherent prejudice about the “best” method of delivery.	25	2	7	6	4	60	7	111

1.152 We believe that insufficient attention has been given nationally to the language that is used around “normality” and to the presentation of information, or to the expectations that both can create among both maternity staff and mothers. Language and information that are helpful in the majority of cases can have disastrous consequences when labour does not progress physiologically. We are aware that some recent steps have been taken to improve this, but these are insufficient in our view to remove the risk of misunderstanding and misinterpretation.	14	0	4	9	1	14	6	48
1.153 Trainees in all disciplines contribute significantly to the work of maternity teams, providing care while gaining experience. For this to be effective, they need to feel supported, both by their peers and by senior staff, and they also need to take part in supervised learning. We found that clinicians in training did not feel supported; they felt isolated, exposed and vulnerable, and they sometimes worked unsupervised in complex situations beyond their experience. This applied equally to midwives and obstetricians, as well as to paediatricians in some cases.	3	0	0	0	0	21	18	42
1.154 We found that bullying and harassment were frequently reported, working relationships with other disciplines did not feel comfortable, and more senior staff could be undermining and unhelpful. There were shortages of junior medical staff and posts often had to be filled by locums, further impeding the development of teamworking. New staff were made to feel unwelcome, were excluded from cliques, and were given challenging cases and expected to manage them without support.	14	3	0	0	11	28	2	58
1.156 A more longstanding difficulty is the separation of early training into different clinical disciplines, when staff’s future ability to work in teams in a mutually supportive way will be crucial. Staff who work together should train together from the outset, at least in part, and not just in rehearsing emergency drills (which is the most common form of joint training claimed).	3	1	1	2	4	16	2	29
1.157 We believe that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made for good reasons have had unintended consequences. More generally, we believe that it is time to think about a better concept	1	1	0	3	7	29	2	43

of teamwork for maternity services – one that establishes a common purpose across, as well as within, each professional discipline.								
159 With families, this was evident in the way in which their concerns were dismissed. Where there were complaints, too often the Trust's instinct was to manage those complaints rather than to consider what was being said as feedback and learning.	7	0	0	0	4	18	3	32
6.19 Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised. Every interaction with a patient, mother and family must be based on kindness and respect. This will not be achieved through well-meaning exhortation in classrooms or by professional leaders, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff	10	0	0	1	3	14	2	30
6.20 Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels. It must not be something learned during the earlier academic stages of training, only to be forgotten later	10	0	1	1	1	6	2	21
6.21 There is a need for all staff to acknowledge and accept the authority of those in clinical leadership roles. These are not sinecures to be done for a couple of years on a rotating basis: they are integral to the effective and safe functioning of services. While some clinicians accept this, it is clear that many do not. Those in clinical leadership roles need to have the skills and time to carry them out effectively.	3	1	0	0	25	29	2	61
6.23 The importance of listening to patients must be re-established as a vital part of clinical practice. This will require it to be embedded not only in continuous professional development, but also in the academic components of early training. The rapid rise in technical and diagnostic possibilities understandably puts pressure on academic curricula, but this must not be to the detriment of skills such as listening	9	0	2	1	1	34	4	51
6.29 We need to find a stronger basis for teamworking in maternity and neonatal services, based on an integrated service and	10	5	4	9	9	21	2	60

workforce with common goals, and a shared understanding of the individual and unique contribution of each team member in achieving them. Crucially, this must be based on an explicit understanding of the contribution of different care pathways and when and how they are best offered. National guidance on this must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives. Agree applicable to midwifery practice.								
6.30 Teams who train together work better together. The most frequent claim of joint training is that it is used in emergency drill training. This is very valuable, but it is not enough. There are opportunities at every stage of training – from undergraduate education onwards – not only to increase understanding of others' roles and responsibilities, but also to become used to working with other disciplines and the contributions they make. Agree applicable to midwifery practice.	5	0	1	1	4	18	4	33

Appendix D: The Northern Ireland review

Enabling safe quality midwifery services and care in Northern Ireland (2024) Prof Mary Renfrew

Review summary: This review was commissioned by the Department of Health, Northern Ireland in May 2023 as part of a broader programme of work to provide assurance on the safety of maternity and neonatal services. The review was initiated following firstly a request from the coroner of Northern Ireland following the death of a baby which raised questions about the care in freestanding midwifery led units (MLUs) and secondly in response to other local and national reports concerning the safety of services. The review was led by Professor Mary Renfrew with the remit of:
(1) providing a comprehensive review of the number of staff experience, training and policies required for freestanding MLUs
(2) consider the need for further guidance to all HSC Trust in relation to the coroner's findings regarding the management of Body Mass Index (BMI) and shoulder dystocia
(3) further work to inform a consistent approach to the provision of midwifery services, including the integration across wider maternity services.

The full review was published on the 22nd October 2024 by the Department of Health, Northern Ireland. Overall, it found that maternity and newborn care across the region suffered from serious and systemic weaknesses: fragmented services, inconsistent standards, chronic midwife staffing shortages, high intervention rates (induction, caesarean), and poor post-natal support, all of which are a risk to the physical, psychological and cultural safety of women and babies. It proposed 32 evidence-informed, system-wide recommendations, including a new regional strategy, improved planning, funding and governance, reinvesting in community and midwife-led care (including homebirths), better data and accountability, and a cultural shift to supportive, interdisciplinary and learning-driven care. The review was accepted by the regional government, which has committed to developing an implementation plan.

Observations from mapping: Of the 32 evidence-informed, system-wide recommendations, to support the mapping exercise, these were broken down into 50 recommendations/constituent elements, of which 24 were found to be applicable to midwifery care and were thus included in the mapping. The 26 recommendations/constituent elements not included in the exercise were excluded mainly on the basis that they focused on commissioning and regional re-configuration of services rather than midwifery care.

Consensus was generally achieved without prolonged debate. Where differences arose, these were largely related to interpretation of how recommendations applied to clinical midwifery practice. This reflected the nature of the review, which predominantly focused on regional-level, organisational and governance issues. Also, the breaking down of the recommendations prior to the mapping whilst making them more specific meant some of them lost their context. In cases where this occurred, the mapping team considered the original complete recommendation to gain context prior to mapping the disaggregated recommendation.

Table 6: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Northern Ireland review

Northern Ireland review Recommendations/constituent elements that directly relate to midwifery practice (n=24)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.Services should ensure the support and care of women who have some elements of complexity and who may fall 'outside of guidance' but who would still like to discuss options for care in either an alongside midwifery unit, community midwifery hub, or at home. This should include women who have previous traumatic experiences and may wish to avoid the hospital environment. For the safety of women and babies, and the psychological wellbeing of midwives, women requesting care 'outside of guidance', or declining aspects of recommended care, must be given the option and support to plan birth in a labour ward, and where available a midwifery unit, as well as at home. Options for care should be strengthened in labour ward settings to improve care for women who wish care 'outside of guidance'.	11	4	4	5	0	18	0	42
2.All care, services, systems and processes must enable and respect the human rights of women and of babies. This includes the right of women to make decisions, informed by evidence-based information, and the right of women and babies to be enabled to stay together.	7	1	0	0	0	8	0	18
3.All interdisciplinary staff must have the knowledge and skills to listen to and work in partnership with all women, to offer evidence-based information and to discuss evidence-based options for care, to strengthen women's own capabilities, and to implement individualised assessment and planning.	2	0	0	0	0	19	0	21
4.They [all staff] must know how to implement cultural safety for all women and families	7	0	1	1	0	9	2	20

5.Fully funded evidence-based interdisciplinary regional standards for care and services should be developed and implemented. These should be used to inform commissioning, governance, policies and protocols, monitoring and review of services. These should be aligned with national/international standards where these exist and should be developed with participation and engagement of all professional groups and of advocacy and community groups. Regional standards should include behavioural and organisational factors as well as individual interventions.	1	0	0	0	5	2	0	8
6.Interdisciplinary education and training for emergencies should use effective educational approaches including team building, include human factors and training the trainers approaches, and be relevant to the context in which emergencies may occur	0	0	0	0	2	2	0	4
7.All hospital and community settings for maternal and newborn care should be supported to improve safety and quality. Regional and HSC Trust-based quality improvement work on maternity and neonatal safety must work to improve clinical, psychological, and cultural safety and equity for all women, babies, and families across the whole continuum of care and in all settings. The very high costs of litigation in maternity care should be addressed by investing in staff and in a regional evidence-based programme of quality improvement	0	0	0	0	6	9	0	15
8.Regional and HSC Trust-based quality improvement work on maternity and neonatal safety must work to improve clinical, psychological, and cultural safety and equity for all women, babies, and families across the whole continuum of care and in all settings	0	0	0	0	4	5	0	9
9.Important deficits in care for women and babies resulting in adverse outcomes must be addressed. They should be examined to understand the root causes, including system-wide barriers and assumptions.	1	0	0	0	4	1	0	6

10.Most notably, this includes • Antenatal education, preparation for birth, infant feeding, and parenting,	1	0	4	2	4	2	0	13
11.and provision of information and listening/discussion to enable women’s decision-making: based on current best evidence and using appropriate language and methods of communication for all women	1	0	0	0	0	45	0	46
12.Care in late pregnancy, during induction of labour and in early labour; to reduce anxiety, minimise delays, and enable informed decision-making.	1	0	0	0	0	12	1	14
13.Immediate and ongoing care following birth for women and babies both in hospital and at home to provide care for women, adequate pain relief, help with infant feeding, and support for attachment and the transition to parenthood	1	1	12	3	0	44	0	61
14.Consistent evidence-based regional information should be provided to all woman and families about options for care and services in pregnancy, labour and birth, and following birth • aligned with regional standards, policies and guidelines for staff. • in appropriate language and format; face to face, written, and digital. • informed by current best evidence. • taking into account their individual clinical, psychological, social and cultural circumstances	5	0	0	0	0	24	0	29
15.Implementation of CoMC should be prioritised in recognition of the strength of the evidence of its impact for women, babies, and the maternity system. Barriers to its implementation should be identified and addressed at regional and HSC Trust levels. There should be effective support from HSC Trusts including senior leadership and interdisciplinary support. Implementation should be fully supported by adequate resource, interdisciplinary involvement, and appropriate oversight, and robust data collection and evaluation. Safe staffing levels and support for midwives providing CoMC is essential. A regional approach is needed to	0	4	0	0	1	0	2	7

address cross-boundary concerns. Continuity of midwifery care is especially important for women with perinatal mental health problems including anxiety and should be available for women who need it.								
16.All labour wards should promote a positive, calm, supportive environment for women and families to prevent anxiety and optimise outcomes and experiences, and to offer an option for women who wish care ‘outside of guidance’.	1	0	2	0	0	8	2	13
17.Evidence-based practices including one-to-one care in labour, mobility in labour, delayed cord clamping, and skin-to-skin care at birth should be available for all women and babies – when feasible and safe to do so - regardless of complexity or mode of birth	0	0	6	0	0	7	1	14
18.A coordinated regional programme to promote and support the development of a psychologically safe, enabling environment for all staff and students in all HSC Trusts must be developed and implemented, drawing on evidence-based interventions for behaviour change, culture shift, and education. Timely de-briefing for staff following difficult and traumatic incidents should be available. This should include access to professional psychological support for all staff. Examples of strength and success should be celebrated	0	0	0	0	1	0	11	12
19.All midwifery students and NQMs must be enabled and supported to learn, consolidate, and practice the full scope of midwifery knowledge and skills as defined in the NMC Standards of Proficiency for Midwives, across the whole continuum of care and in all settings.	2	4	0	0	0	0	6	12
20.For safe, quality care for women and babies, midwives must have experience in the many ways in which women experience physiological labour and birth. Not enabling midwives to build their	0	0	3	0	0	3	1	7

knowledge and skills to the best possible standard would be a serious safety concern								
21.Midwives are the key professional group working with women and babies living in challenging circumstances. The importance of this work should be recognised, valued, and adequately resourced. The time needed for midwives to work with women with additional social complexities and for work in public health should be included in BirthratePlus® calculations.	0	0	0	0	1	0	0	1
22.Audit is an essential tool to alert the system to impact and unintended consequences of practices, and to inform and drive service improvement. All HSC Trusts should participate in and respond to regional and national audits of priority topics.	1	0	0	0	3	2	0	6
23.Core concept 'leadership' opportunities and development.	1	0	0	0	3	27	0	31
24.Key concepts of 'research' and clinical academic opportunities suggest that we include it has relevance to midwifery practice from early career onwards.	3	0	0	0	4	6	0	13

Appendix E: The CQC review

National review of maternity services in England 2022- 2024 Care Quality Commission (CQC) (2024)

Review summary: This national review was instigated and undertaken by the CQC across England. The review was launched in August 2022 in response to ongoing concerns and national security following numerous maternity reviews (such as East Kent and Shrewsbury and Telford). The review involved inspections of 92 NHS trusts across 131 locations that had not been inspected since before March 2021, with the findings published in September 2024.

The inspection programme aimed to provide an up-to-date assessment of maternity care across England and to explore the lack of progress in some services. The objectives of the review were to characterise what good safety culture looks like in maternity services and the factors underpinning it, and to evaluate the national maternity inspection programme to maximise learning.

The review set out six overarching recommendations, each aimed at NHS Trusts, Integrated Care Boards, NHS England, the Department of Health and Social Care, the Royal College of Obstetricians and Gynaecologists and the Nursing and Midwifery Council. These six recommendations were broken down into 13 recommendations/constituent elements.

Observations from mapping: Of these 13 recommendations/constituent elements, 10 were excluded prior to mapping by consensus, as they fell outside of the scope of the professional midwifery standards, for example those recommendations which focussed on NHS capital investments and estates or national workforce planning. The remaining three recommendations/constituent elements came under the overarching recommendations of NHS Trusts, Integrated Care Boards (ICBs) or NHS England, but were applicable to the role of the midwife, and hence these were mapped to the proficiencies. It is noted that the CQC review did not set out any recommendations specifically, or only, for midwives.

After independent mapping of the three recommendations/constituent elements against the standards of proficiency, consensus was reached. The first recommendation/constituent element focused on the availability of birth reflection services to women postnatally and was applicable to 54 proficiencies. The second recommendation/constituent element focused on policies around data collection and its use and was applicable to 26 proficiencies. The third recommendation/constituent element, which centred on leadership and succession planning was applicable to 48 proficiencies.

Table 7: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The CQC review

CQC review Recommendations/constituent elements that directly relate to midwifery practice (n=3)	Domain 1 (n=29)	Domain 2 (n=12)	Domain 3 (n=36)	Domain 4 (n=15)	Domain 5 (n=26)	Domain 6 (n=238)	Practice learning element (n=14)	Total
1. All women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline.	10	3	8	6	0	24	3	54
2.Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.	12	0	1	1	4	7	1	26
3.Ensures trusts are proactively managing succession planning in midwifery services and, in line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders. (core concept leadership training/development).	6	0	0	1	18	22	1	48

Appendix F: The Swansea Bay review

The independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board (2025)

Review summary: This review was commissioned to examine the safety and quality of maternity and neonatal services at Swansea Bay University Health Board (SBUHB) between 2019 and 2023, particularly focussing on data reported during those years by the reports of Mothers and Babies – Reducing Risk through audits and enquiries across the UK (MBRRACE-UK). As a persistent outlier in terms of MBRRACE findings, coupled with family concerns and that other reviews had not led to improvements, this review sought to make key recommendations for improvement. Ten priority recommendations were developed which included an element of accountability e.g. the recommendations were subject to a rolling audit and were situated within the wider context of maternity care in Wales nationally with key government recommendations directed at the All-Wales pathways.

Observations from mapping: For the purposes of this mapping, the 10 overarching recommendations were broken down into 27 recommendations/constituent elements. Of these, 21 were primarily related to the role and responsibilities of the Health Board, with some aimed at other professional areas such obstetrics and neonatology. This is important to emphasise as everyday clinicians do not have the power or responsibility to implement recommendations such as, '*the Board must ensure that, where there is a clear trigger for independence or external review, this is actioned; examples would be a very serious incident, serious birth injury, maternal death, or mortality review'* or '*review and revise all policies and procedures within the maternity and neonatal service to ensure consistent delivery of care.'* While clinicians can provide important contributions to many aspects to the 21 recommendations/constituent elements, the onus for most of these recommendations is on the Health Board to fund and implement them. For example, while clinicians can advise and support audit and equity of access to a debrief service, it is an organisational level responsibility to ensure the service is available, user friendly and enables effective midwifery engagement. Likewise, having a robust system in place to secure effective prioritisation of all women having an induction of labour is a managerial level remit. Lastly, whilst midwives can certainly contribute to reviews of clinical guidelines, it is incumbent upon the governance and midwifery managerial teams within a maternity Trust to ensure that clinical guidelines are in date, regularly reviewed, updated accordingly, and placed within ease of access to all clinicians.

For the six recommendations/constituent elements that were relevant for mapping to the proficiencies, there was a largely even spread across the six domains, thus reflecting the current scope of midwifery practice as appropriate and offering a vital contribution to addressing the issues raised in this review. However, it is important to note for midwives to be effective in role, they must work in enabling environments to maximise this effectiveness. For example, optimising care in triage (see the first recommendation/constituent element in the table below) requires effective systems and processes to be in in place and relies upon the multidisciplinary team (MDT), sufficient staffing, appropriate skill mix and adequate resourcing. Equally, midwives do have a responsibility to use the MEWS (Maternity Early Warning Score) chart and escalate as required, but safe, effective care is contingent on those referrals being

attended to by the MDT in a timely manner. This is then contingent on issues such as staffing levels and acuity. Therefore, it is challenging to isolate the midwife's role as their effectiveness is context dependent. However, the core principles of compassionate, personalised, equitable and skilled clinical care (the responsibility of all maternity and neonatal staff) are clearly reflected within the Standards of proficiency for midwives (NMC 2019/2024), as demonstrated in Table 1.

Table 8: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Swansea Bay review

Swansea Bay review Recommendations/constituent elements that directly relate to midwifery practice (n=6)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.This must include: improving the quality of calls and women's experiences when contacting the service; increased senior medical input; increased midwifery staffing to ensure all women have an initial assessment within 15 minutes; improvements to the environment (ensuring privacy for triage calls); and monitoring and reporting of the service, including inviting feedback from women.	22	4	21	14	15	102	7	185
2. Maternity early warning scores should be used for all pregnant and recently pregnant women.	20	8	21	15	12	122	7	205
3. Far greater focus is required on the delivery of compassionate care for all.	21	10	20	16	14	134	11	226
4. Healthcare delivery must be culturally informed and culturally sensitive with an enhanced understanding of specific religious needs and cultural practices.	21	10	20	16	14	134	11	226
5. Timely access to psychological support for women must be available, and all care should be based on trauma-informed principles.	21	10	20	16	14	125	11	217
6. Attendance for all maternity staff for fetal monitoring training.	7	1	2	8	5	19	5	47

Appendix G: The Ninewells review

Unannounced inspection report – maternity services and safe delivery of care inspection Ninewells hospital, NHS Tayside (Healthcare Improvement Scotland) (2025)

Review summary: This review arose from an unannounced inspection of maternity services at Ninewells Hospital in NHS Tayside, as part of NHS Scotland's programme of inspections to assess the safety of care in acute hospitals. Maternity services were investigated through an unannounced inspection visit in January 2025, followed by an unannounced revisit in February 2025, and discussion sessions with key members of staff in February and March 2025, with the review published May 2025. Items to action were presented as either:

A. Requirements, meaning *'the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women, birthing people and families using the hospital or service'.* These were expected to be addressed, with action taken to make improvements.

B. Recommendations, relating to *'best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.'*

Observations from mapping: The target audience for this review was NHS Tayside, and particularly their Executive Board. There were 23 recommendations/constituent elements within the 'items to action' in total (three recommendations and 20 requirements). Ten recommendations/constituent elements were deemed to be not relevant to midwifery (e.g. relevant for estates or senior Trust management) and therefore these were not mapped. The remaining 13 recommendations/constituent elements were mapped, four of which were identified as directly relevant to midwifery care and nine identified as related to systems, processes and/or oversight, where midwifery could support these actions. All 13 recommendations/constituent elements were mapped to at least one proficiency.

Several recommendations/constituent elements were very specific and only mapped to a small number of proficiencies e.g. in relation to interpretation services, organisation of triage, safe storage and access to medications, infection control, oversight of data collection and staffing/staff training. Where recommendations/constituent elements mapped to more proficiencies, these were typically in domain 6. Few proficiencies mapped to more than one recommendations/constituent elements.

The nature of this review, as the results of an unannounced inspection visit, meant that all recommendations/constituent elements were directed to NHS Tayside with almost all relating to systems and processes. The proficiency which mapped to most recommendations (n=3) was 1.19 *"understand and apply the principles of courage, integrity, transparency, and the professional duty of candour, recognising and reporting any situations, behaviours, or errors that could result in sub-standard care, dysfunctional attitudes and behaviour, ineffective team working, or adverse outcomes".* This reflects the nature of the review, e.g. where problems arose due to systems and/or processes, one of the few actions within a midwife's control is to highlight the issues and collaborate with senior staff to improve them.

Table 9: Number of proficiencies mapped for each recommendation/constituent element per domain and total - The Ninewells review

Ninewells review Recommendations/constituent elements that directly relate to midwifery practice (n=13)	**Domain 1 (n=29)**	**Domain 2 (n=12)**	**Domain 3 (n=36)**	**Domain 4 (n=15)**	**Domain 5 (n=26)**	**Domain 6 (n=238)**	**Practice learning element (n=14)**	**Total**
1.NHS Tayside should ensure improvement in their assurance of staff bereavement training.	0	0	0	1	0	18	0	19
2.NHS Tayside should ensure processes are in place to support mothers and babies to have access to family centred care with extended family members actively encouraged to engage in maternal and newborn care.	3	2	1	1	0	9	0	16
3.NHS Tayside should consider ways to improve oversight and staff feedback of interpretation services, to ensure any areas for improvement can be identified and addressed.	1	0	0	0	0	1	0	2
4.NHS Tayside must ensure a system is in place to monitor women requested to attend for review following telephone triage and should inform women of the urgency and timeframe for attendance. [This will support compliance with: Health and Social Care Standards (2017) 3.21]	0	0	0	0	2	1	0	3
5.NHS Tayside must ensure effective oversight of guidance and process within maternity triage to support safe delivery of care. [This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.5 and 2.6]	0	2	0	0	1	0	0	3
6.NHS Tayside must ensure medication required for emergency treatment is accessible to staff with effective oversight and assurance of staff knowledge of process. [This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.4 and 2.6].	0	0	0	0	0	2	0	2

7.NHS Tayside must ensure effective oversight to ensure essential patient equipment is in working order and ready for use. This includes, but is not limited to, fetal monitoring equipment. [This will support compliance with: Health and Social Care Standards (2017) criteria 4.14 and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6]	1	0	0	0	0	0	0	1
8.NHS Tayside must ensure improvement in governance and oversight of ethnicity completeness data for all women and birthing people booking for perinatal care. [This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.4 and 2.6]	1	0	0	0	1	0	0	2
9.NHS Tayside must ensure venous thromboembolism guidance and risk assessments in place are aligned to support staff during the risk assessment of venous thromboembolism. [This will support compliance with Quality Assurance Framework (2022) Criteria 2.6].	0	0	1	0	0	1	0	2
10.NHS Tayside must ensure compliance with SICPS. This includes, but is not limited to: a. hand hygiene b. linen management c. sharps management. [This will support compliance with: National Infection Prevention and Control Standards (2022).]	1	0	1	0	0	4	0	6
11.NHS Tayside must ensure the appropriate management and monitoring is in place to ensure the safe storage of medicines. [This will support compliance with: Royal Pharmaceutical Society on the Administration and storage of Medicines in Healthcare Settings (2019) and Nursing and Midwifery council (NMC) The code (2018)].	0	0	0	0	0	2	0	2
12.NHS Tayside must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real time staffing risk across all clinical professional groups within maternity services, to support consistent management of any identified staffing risks. This must include feedback to staff regarding decisions undertaken. [This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019].	0	0	0	0	1	0	0	1

13.NHS Tayside must ensure they are complying with the duty imposed by section 12II, ensuring that its employees receive time and resources to undertake such training essential to their role. [This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019].	0	0	0	0	0	2	0	2

Appendix H: 14 pertinent items in the 'Practice learning' section of Part 3: Standards for pre-registration midwifery programmes (NMC 2019/2023 p 11-12) included in mapping

The three items in brackets below were deemed N/A to the mapping remit of the project

'Approved education institutions, together with practice learning partners, must:
***(3.1** provide practice learning opportunities that enable students to develop and meet the NMC Standards of proficiency for midwives)*
***3.2** ensure students experience the role and scope of the midwife, enabling them to provide holistic care to women, newborn infants, partners and families*
***3.3** provide students with learning opportunities to enable them to achieve the proficiencies related to interdisciplinary and multiagency team working*
***3.4** provide students with learning opportunities to enable them to achieve the proficiencies related to continuity of midwifery carer across the whole continuum of care for all women and newborn infants*
***3.5** provide learning opportunities, across the whole continuum of care, that enables students to gain experience to:*
***- 3.5.1** support and care for women during pregnancy, undertaking no less than 100 antenatal examinations*
***- 3.5.2** support and care for no less than 40 women in labour and conduct the birth. Where 40 births cannot be reached owing to the lack of available women giving birth, it may be reduced to a minimum of 30, provided that the student is given the opportunity to assist with caring for an additional 20 women giving birth*
***- 3.5.3** participate in the support and care of women in labour and conduct a breech birth. Where there are no opportunities in practice to gain experience of breech births, proficiency may be gained by simulated learning*
***- 3.5.4** support and care for no less than 100 women postnatally and 100 healthy newborn infants*
***- 3.5.5** develop the required knowledge, skills and behaviours needed to support and care for no less than 40 women who have additional care needs or develop complications including those related to physical, psychological, social, cultural and spiritual factors*
***- 3.5.6** care for newborn infants requiring additional care or have complications, including in a neonatal unit and*
***- 3.5.7** care for women across the life course with additional sexual and reproductive health needs*
***3.6** ensure students gain experience of leadership and team working with different maternity providers*
***3.7** provide students with learning opportunities to experience midwifery care for a diverse population across a range of settings, including midwifery led services*
***3.8** provide learning opportunities that enable students to develop the required knowledge, skills and behaviours needed when caring for women and newborn infants when complication and additional care needs arise, including as they relate to physical, psychological, social, cultural and spiritual factors*
***(3.9** take account of students' individual needs and personal circumstances when allocating their practice learning opportunities, including making reasonable adjustments for students with disabilities)*

***3.10** ensure students experience the range of hours expected of practising midwives, and*
***(3.11** ensure students are supernumerary.)'*