Provider line of sight table on report recommendations for submission to the funders	
Please can the provider complete the following details to allow for ease of access and rapid review	
Project and Title of report, including HQIP Ref. ***e.g., Ref. XXX, Project and report title***	**Ref 545, National Maternity and Perinatal Audit (NMPA)** **State of the Nation Summary, Based on births in NHS maternity services in England, Scotland and Wales during 2023**
1. What is the report looking at/what is the project measuring?	**Maternity and neonatal care outcomes at NHS trusts and boards**
2. What countries are covered?	**England, Scotland and Wales**
3. The number of previous projects (e.g., whether it is the 4th project or if it is a continuous project)	**5th annual clinical report**
4. The date the data is related to (please include the start and end points – e.g., from 1 January 2016 to 1 October 2016)	**1 January 2023 to 31 December 2023**
5. Any links to NHS England objectives or professional work-plans (only if you are aware of any)	**Saving Babies' Lives: A Care Bundle for Reducing Stillbirth** • Risk assessment and surveillance of pregnancies for fetal growth restriction). • Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. • Effective fetal monitoring during labour. **Saving Babies' Lives Care Bundle version 2.0.** • Risk assessment and management of babies at risk of fetal growth restriction (FGR). • Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. • Effective fetal monitoring during labour. • Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented **Saving babies' lives: version 3** 2.21 Trusts should determine and act upon all themes related to FGR that are identified from investigation of incidents, perinatal reviews, and examples of excellence. 2.22 Trusts should provide data to their Boards and share this with their ICS in relation to the following: a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation. b) Ongoing case-note audit of <3rd birthweight centile babies not detected antenatally and born after 38+0 weeks, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur). c) Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies. d) Percentage of babies >3rd birthweight centile born <39+0 weeks gestation 2.23 Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified.

	2.24 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 3.3 Maternity care providers should examine their outcomes in relation to the interventions and trends and themes within their own incidents where the presentation and/or management of RFM is felt to have been a contributory factor. 3.4 Maternity care providers should ensure whether inequalities (particularly relating to ethnicity and deprivation) are being adequately addressed when there are incidents relating to presentation with or management of RFM. 3.5 Individual trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 3.6 Maternity providers are encouraged to focus improvement in the following areas: a) Signposting to information regarding RFM to pregnant women by 28+0 weeks of pregnancy. b) Appropriate care according to local guidance in relation to risk stratification and ongoing care for women presenting with RFM. c) Ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks). 4.6 Maternity care providers should examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor. 4.7 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 4.8 Maternity providers are encouraged to focus improvement in the following areas: a) Risk assessment of the woman/fetus at the beginning and regularly during labour. b) Interpretation and escalation of concerns over fetal wellbeing in labour. 5.28 All providers are encouraged to draw upon the learning from the four BAPM toolkits and a range of resources from other successful regional current programmes (e.g., PERIPrem resources, MCQIC) 5.29 Maternity & Neonatal care providers should determine and act upon all themes related to preterm birth that are identified from investigation of incidents, perinatal reviews and examples of excellence, particularly focusing on prediction, prevention, preparation and perinatal optimisation, including: a) Risk assessment of women in their first pregnancy for the risk of preterm birth and timely triage to the appropriate care pathway. b) Management of women at high risk of preterm birth, including appropriate cervical length surveillance and use of cervical cerclage. c) Implementation of optimisation interventions as a whole preterm perinatal optimisation pathway, including measurement and reporting of overall optimisation pathway compliance 5.30 Maternity and Neonatal care providers should demonstrate continuing improvement by regular reassessment of the process and outcome indicators below. These data can be accessed through a number of national and network level data sources including the National Neonatal Audit Programme (NNAP) and Neonatal ODN data. Data completeness via electronic maternity and neonatal record systems is vitally important, and data quality should be monitored frequently. Provider Trusts should seek to support data quality assurance, including support for data clerk or data manager time.(https://nnap.rcpch.ac.uk/) 5.31 Benchmarking: Maternity and Neonatal care providers should examine their process and outcome indicators in relation to similar provider Trusts to understand variation and inform potential improvements.

5.32 Sharing learning & improvement: The preterm birth teams (see 5.1) within each Maternity and Neonatal care provider setting should:
a) Review and share their process and outcome indicator data across the perinatal team on a regular basis (at least quarterly) to drive continual improvement.
b) Share process and outcome indicator data, and evidence of improvement with their Maternity and Neonatal Board level safety champions, LMNS (Local Maternity & Neonatal System) and ICS (integrated care system) quality surveillance teams on a quarterly basis.

NHS Long Term Plan

2.14. The burden of obesity isn't experienced equally across society [36]. The NHS will therefore provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity), where we know we can have a significant impact on improving health, reducing health inequalities and reducing costs.
3.8. Maternal mortality occurs in fewer than 1 in 10,000 pregnancies. Significant regional variation in extended perinatal mortality still exists.[72] Of the term babies who died in 2016, different care might have led to a different outcome for 71% [73]. Women from the poorest backgrounds and mothers from Black, Asian and Minority Ethnic (BAME) groups are at higher risk of their baby dying in the womb or soon after birth [74].
3.9. Through the Long Term Plan, the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

3.10. An independent evaluation of the Saving Babies Lives Care Bundle (SBLCB), which supports the ambitions set out in Better Births, has shown a 20% reduction in the stillbirth rate at maternity units where it was implemented. We aim to roll out the care bundle across every maternity unit in England in 2019
3.11. However, the prevalence of pre-term birth is increasing [76], and more focus on pre-term mortality is needed to achieve substantial reductions in overall perinatal mortality rates and meet our national ambition[77]. An expansion to the SBLCB will be published in 2019. This will include a focus on preventing pre-term birth, which will minimise unnecessary intervention and define a more holistic approach to risk assessment during labour, alongside further improvements to cardiotocography monitoring, and reductions in smoking during pregnancy. To care for women with heightened risk of pre-term birth, including younger mothers and those from deprived backgrounds, we will encourage development of specialist pre-term birth clinics across England. The SBLCB will also encourage clinically appropriate use of magnesium sulphate – estimated to help reduce the number of pre-term babies born with cerebral palsy by up to 700 per year. We will support maternity services to fully implement the expanded SBLCB in 2020.
3.12. Recommendations from the *National Maternity Review*: *Better Births* are being implemented through Local Maternity Systems. These systems bring together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting. By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.
3.14. A Perinatal Mortality Review Tool is now used by all maternity providers, supporting high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.
3.15. Maternity Pioneers have commissioned and rolled out apps to help women to make choices about their care and access services and information in a more convenient and efficient way.
3.17. We will improve access to postnatal physiotherapy to support women who need it to recover from birth. About one in three women will experience urinary incontinence after childbirth [85], one in ten faecal incontinence86, and one in

twelve pelvic organ prolapse. Physiotherapy is by far the most cost-effective intervention for preventing and treating mild to moderate incontinence and prolapse [87].

3.18. All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019/20. Only 57% of babies in England are currently born in an accredited 'baby friendly' environment. Our breastfeeding rates compare unfavourably with other countries in Europe [88]. There is substantial variation between parts of England, with 80% of children breastfed at 6-8 weeks in London compared to 32% in the North East [89].

Better Births Four Years On

58. […] two core themes which run throughout all of its activities: providing safer care, and providing more personalised care to women.

62. In addition, further action targeted at change to clinical practice and service models is in the planning stage: […]

- Networked maternal medicine will enable every woman in England with acute and chronic medical problems to have timely access to specialist preconceptual advice and care during and after pregnancy from 2021/22.
- Rolling out a new NHS model for supporting pregnant women who smoke to give up from 2020/21. This will help reduce perinatal mortality and preterm birth.

63. The second group of initiatives will have an impact across the board by helping to create a culture which listens to women, values learning and builds multiprofessional team working through a common vision for safety:

- Improved data sources through version two of the Maternity Services Dataset. This contains a much richer source of data on clinical quality and a data viewer makes it easier for units to access data and make comparisons.
- Empowering women to get involved and co-produce developments in local services through Maternity Voices Partnerships.

74. A growing body of evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when people have the opportunity to actively shape their care. Personalised care also has a positive impact on health inequalities, taking account of people's different backgrounds and preferences, with people from lower socio-economic groups able to benefit the most from personalised care. Therefore, personalisation, based on a robust and continued assessment of an individual's circumstances and choices and, based on a relationship of trust between the woman and her clinicians, is a prerequisite for the safest care.

75 […] Better Births called for improvements to postnatal care, and the results of the CQC survey of women using maternity services shows that there remains less confidence in these services. The challenge is that good postnatal care needs to be personalised because the needs of individual women vary substantially. Local Maternity Systems have therefore been asked to develop local improvement plans for postnatal care focusing on:

- how women will receive personalised and kind care in the postnatal period; o effective transfer of care and quality information when returning home;
- support in the return to physical health after birth;
- support with infant feeding, including a tailored feeding strategy across the Local Maternity System;
- improved screening and access to emotional and mental health support, including for bereavement and neonatal care; and
- effective handover from midwifery to health visiting services and general practice – such as through closer working between midwifery and health visiting.

Good postnatal care will be supported by the new check in general practice for each woman six to eight weeks after the birth of her baby.

Maternity Transformation Programme

- Increasing choice and personalisation

			• Promoting good practice for safer care, including the 'halve it' target for stillbirths and neonatal brain injuries. • Improving prevention – pre-conception counselling on the risks of having diabetes, hypertension, a high BMI, smoking in pregnancy and ethnicity specific risks. • Sharing data and information – improving data quality and availability, harnessing digital technology				
Please can the provider complete the below for each recommendation in the report							
No	**Recommendation**	**Intended audience for recommendation**	**Evidence in the report which underpins the recommendation** *(including page number)*	**Current national audit bench-marking standard if there is one**	**Associated NHS payment levers or incentives**	**Guidance available (for example, NICE guideline)**	**% project result if the question previously asked by the project (date asked and result). If not asked before please denote N/A. This is so that there is an indication of whether the result has increased or decreased and over what period of time**
R1	*Government health departments[#] should work with stakeholders to develop national and local level initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate.* [#] The term 'Governments health departments' refers to the governing body responsible for overseeing healthcare in each nation, this means NHS Scotland, NHS Wales and, after June 2025, the replacement for NHS England.	English, Scottish and Welsh Government health departments	- 26.7% of women and birthing people had their booking appointment after 10+0 weeks of gestation. **Results at a glance, page 5** - In 2023, 1 in 4 (26.7%) women and birthing people attended their first (booking) appointment with a midwife after 10^{+0} weeks of gestation, with a wide distribution of rates between maternity care providers (IQR 16.7–30.2%). **Timing of pregnancy booking, page 7**	73.3% of women and birthing people had their booking appointment before 10+0 weeks of gestation	N/A	Antenatal Care, NICE guideline [NG201], 19 August 2021 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors, NICE guideline [CG110], September 2010 Guidance on Access to Maternity Care for Women Affected by Charging, RCM/RCOG/ Maternity Action, April 2024	Question not previously asked
R2	*Government health departments[#] should incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used to:*	English, Scottish and Welsh Government health departments	- 33.9% of women and birthing people had an induction of labour **Results at a glance, page 5** - Around 1 in 3 women and birthing people experienced an induction of labour, rates between England, Scotland and Wales were similar (33.7%, 36.1% and 33.6% respectively)	None known	N/A	Inducing Labour, NICE guideline [NG207], 04 November 2021 Midwifery Care for induction of labour, RCM Blue Top Guidance September 2019	All previous rates are overall rates taken from our most recently published report on births in 2018/19 in England and Wales.

	- *Anticipate and respond with appropriate allocation of resources, such as workforce, bed/cot and obstetric theatre capacity, and finances, to optimise the options women and birthing people have for when and where they choose to give birth.* [#] The term 'Governments health departments' refers to the governing body responsible for overseeing healthcare in each nation, this means NHS Scotland, NHS Wales and, after June 2025, the replacement for NHS England.		**Mode of birth, page 8** **Summary Results Tables, page 10** - 49.4% of all births were vaginal births without the use of instruments. - The rate of vaginal birth with the use of instruments was 11.1%. - 23.1% of women and birthing people had a caesarean birth that was unplanned (emergency) - 16.4% of women and birthing people had a caesarean birth that was planned (elective) - One in seven (14.2%) births following a previous caesarean birth were vaginal (VBAC). **Results at a glance, page 5** - Just under half (49.4%) of all births were vaginal births without the use of instruments compared with 60.0% in 2018/19. The rate of vaginal birth with the use of instruments has fallen from 12.3% in 2018/19 to 11.1% in 2023. Caesarean birth rates have increased considerably since our previous report (unplanned caesarean birth: 2018/19 15.5%, 2023 23.1%; planned caesarean birth: 2018/19 12.1%, 2023 16.4%). - One in seven (14.2%) births following a previous caesarean birth were vaginal (VBAC), this is lower than the rate in our previous reports (24.5% in 2016/17 and 22.5% in 2018/19). **Mode of birth, page 8**			Intrapartum Care, NICE guideline [NG235], 29 September 2023 Assisted Vaginal Birth, RCOG GTG No 26, April 2020 (updated June 2023) Caesarean Birth, NICE guideline [NG192], 31 March 2021 All Wales Midwifery-Led Care Guideline 6th Edition, Wales Maternity and Neonatal Network, October 2022 Birth after Previous Caesarean Birth, RCOG GTG No. 45, October 2015 Safe midwifery staffing for maternity settings, NICE guideline [NG4], February 2015 A snapshot of neonatal services and workforce in the UK, RCPCH, September 2020 Neonatology, GIRFT Programme National Specialty Report, January 2022 The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the	- Induction of labour: 33.5% - Vaginal birth without the use of instruments: 60.0% - Vaginal birth with the use of instruments: 12.3% - Unplanned caesarean birth: 15.5%, - Planned caesarean birth: 12.1%, - Vaginal birth after caesarean (VBAC): 22.5%

						UK, BAPM, November 2022 Maternity and Gynaecology, GIRFT Programme National Specialty Report, January 2021 RCOG Workforce Report 2022, RCOG, February 2022 Maternity Staffing Level Tool, Health Improvement Scotland, March 2024	
R3	*Maternity care commissioners and maternity networks (e.g., English local maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network) should use the evidence of variation in care processes and outcomes identified in this report, and the results for their local populations, when working with their constituent units to identify opportunities for improvements in service provision and clinical practice.*	Commissioners of maternity care in England, Scotland and Wales, and local maternity networks (e.g., English maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network	- 42.6% of babies born small for gestational age (SGA, were born at or after their estimated due date (40 weeks of gestation) - 6.34% of women and birthing people gave birth to a preterm baby (24+0 – 36+6 weeks of gestation) **Results at a glance, page 5** - 3.29% of women and birthing people experienced a third- or fourth-degree tear. - 24.5% of women and birthing people had an episiotomy - 3.08% of women and birthing people had an unplanned overnight readmission within 42 days of birth. **Results at a glance, page 6** - The rate of babies born small for gestational age (SGA) at or after 40 weeks has reduced in recent years from 55.4% in our first report on births in 2015/16, to 42.6% in 2023. **Variation in practice and outcomes, page 9** **Summary Results Tables, page 10** - Overall preterm birth rates were consistent between devolved nations. However, the rate of spontaneous preterm birth in Scotland (73.0%) was considerably higher than England (40.9%) and Wales (46.3%). There was wide variation between maternity care providers for both spontaneous and clinician recommended (iatrogenic) preterm birth.	None known	N/A	Investigation and Care of a Small-for-Gestational- Age Fetus and a Growth Restricted Fetus, RCOG GTG No 31, May 2024 All Wales Midwifery-Led Care Guideline 6th Edition, Wales Maternity and Neonatal Network, October 2022 Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation, RCOG GTG No 73, June 2019 Preterm Labour and Birth, NICE guideline [NG25], 10 June 2022 Intrapartum Care, NICE guideline [NG235], 29 September 2023	All previous rates are overall rates taken from our most recently published report on births in 2018/19 in England and Wales. - Small for gestational age babies born at/after 40 weeks: 48.9% - Preterm birth (including spontaneous /iatrogenic) N/A - Third- or fourth-degree perineal tear: 3.1% - Episiotomy: 24.6% - Unplanned maternal readmission: 3.3%

			Variation in practice and outcomes, page 9 **Summary Results Tables, page 9** - The rate of third- and fourth-degree perineal tears, also known as Obstetric Anal Sphincter Injury (OASI), was 3.29%. Across the devolved nations, the rate was higher in Scotland (3.82%) and lower in Wales (3.04%) than England (3.26%). **Variation in practice and outcomes, page 9** **Summary Results Tables, page 15** - Episiotomy rates in England (24.8%) than in Wales (18.3). **Variation in practice and outcomes, page 9** **Summary Results Tables, pages 15** - An unplanned maternal readmission occurred for 3.08% of women and birthing people across England and Wales, with the rate higher in Wales (4.14%) than England (3.05%), and rates varied by provider (IQR: 2.30–5.30% in Wales; 2.14–3.59% in England). Insufficient data means we are unable to report unplanned maternal readmission for Scotland. **Variation in practice and outcomes, page 9** **Summary Results Tables, page 16**			Third- and Fourth-Degree Perineal Tear, Management, RCOG GTG No 29, June 2015 The NHS Long Term Plan, NHS England, January 2019	
R4	*Digital teams[δ] in the Government health departments should review data definitions and descriptions of care processes and outcomes in the Digital Maternity Record Standard (DMRS) (and Scottish and Welsh equivalents), and their application to clinical practice in order to:* - *Objectively measure and record all volumes of blood loss during labour and birth.* - *Develop meaningful and consistent measures of:* • *skin-to-skin contact following birth in line with the UNICEF definition*	Digital teams in the English, Scottish and Welsh Government health departments, and Professional Record Standards Body (PRSB)	- 3.41% of women and birthing people had a PPH ≥1500 ml - 1.45% of babies were assigned an Apgar score of <7 at 5 minutes. - 71.8% of babies received breast milk at first feed. - 73.2% of babies received skin-to-skin contact within one hour of birth **Results at a glance, page 6** - Data quality (completeness and/or distribution) for postpartum haemorrhage (PPH) ≥1500 ml was insufficient for one quarter (27/120) of English trust. Some trusts appear to mainly report high-volume blood loss only, which renders the calculation of this indicator impossible for those trusts. Although there is a blood	None known	N/A	Prevention and Management of Postpartum Haemorrhage, RCOG GTG No 52, December 2016 Prevention and Management of Postpartum Haemorrhage, All Wales Maternity and Neonatal Network Guideline, April 2023 Intrapartum Care, NICE guideline [NG235], 29 September 2023	All previous rates are overall rates taken from our most recently published report on births in 2018/19 in England and Wales. - Postpartum haemorrhage PPH ≥1500 ml: 3.5% - Apgar score of less than 7 at 5 minutes of age: 1.1% - Babies receiving breast milk at first feed: 74.0%

	and to include reasons for non-occurrence. • *establishing and supporting breast milk feeding beyond the first feed.* δ Digital teams include those who design, develop and operate national IT and data services, such as the former NHS Digital in England and the Scottish and Welsh equivalents.		loss variable in the Scottish dataset, this was only available for a minute number of records. - Rates of an Apgar score of less than 7 at 5 minutes in Scotland are 50% higher compared to England and Wales. The between country and between provider variation appearing in our results may in part be due to local demographics, especially for trusts/boards where there are fewer preterm births or women and birthing people from ethnic minority groups giving birth, but there may be other contributory factors. - Rates of babies receiving breast milk at first feed vary between provider and country, rates are higher in England (72.6%) than in Scotland (63.1%) or Wales (65.8%). Without longer-term breast milk feeding rates, it is difficult to interpret how meaningful breast milk at first feed is as a measure for influencing longer-term breast milk feeding rates. - Skin-to-skin contact is not available as a variable in the Scottish or Welsh datasets, and there was striking variation in the rates between English trusts. The vast variation between maternity care provider rates (IQR: 68.3–84.1%) may reflect uncertainty around what constitutes meaningful skin-to-skin contact in the context of these two definitions. No information is available on reasons for non-occurrence or if skin-to-skin occurred with someone other than the mother. **Data quality and capture, page 10**			All Wales Midwifery-Led Care Guideline 6th Edition, Wales Maternity and Neonatal Network, October 2022 Skin-to-Skin Contact, UNICEF	- Skin-to-skin contact within one hour: 80.0%

R5	*Digital teams[δ] in the Government health departments should work with maternity data controllers and software developers to incorporate processes and systems into the next version update of each dataset that support maternity care providers to optimise data quality. This should include stakeholder engagement to:* - *Minimise data entry burden while supporting trusts/boards to reduce areas of missing or incomplete data.* - *Standardise data definitions and data fields to support consistency, comparability and interoperability.* - *Ensure updates to the dataset technical specifications meet the needs of data users including frontline clinicians, analysts, researchers, and policymakers.* - *Align maternity data standards with SNOMED CT and the Digital Maternity Record Standard (DMRS), to support future interoperability and integration with other clinical systems* [δ] Digital teams include those who design, develop and operate national IT and data services, such as the former NHS Digital in England and the Scottish and Welsh equivalents.	Digital teams in the English, Scottish and Welsh Government health departments, maternity data controllers, and software developers	- Data quality (completeness and/or distribution) for postpartum haemorrhage (PPH) ≥1500 ml was insufficient for one quarter (27/120) of English trusts. Some trusts appear to mainly report high-volume blood loss only, which renders the calculation of this indicator impossible for those trusts. - Although there is a blood loss variable in the Scottish dataset, this was only available for a minute number of records. **Data quality and capture, page 10** - Insufficient data means we are unable to report unplanned maternal readmission for Scotland. **Variation in practice and outcomes, page 9** Skin-to-skin contact is not available as a variable in the Scottish or Welsh datasets, and there was striking variation in the rates between English trusts. **Data quality and capture, page 10**	None known	N/A	Prevention and Management of Postpartum Haemorrhage, RCOG GTG No 52, December 2016 Prevention and Management of Postpartum Haemorrhage, All Wales Maternity and Neonatal Network Guideline, April 2023 Intrapartum Care, NICE guideline [NG235], 29 September 2023 Postnatal Care, Nice guideline [NG194], April 2021 Skin-to-Skin Contact, UNICEF	