

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

<p>Project and Title of report, including HQIP Ref. <i>e.g., Ref. XXX, Project and report title</i></p>	<p>Ref 702, National Maternity and Perinatal Audit (NMPA) Multiple Births Outcomes of Maternity Care, Based on births in NHS maternity services in England, Scotland and Wales during 2023</p>
<p>1. What is the report looking at/what is the project measuring?</p>	<p>Maternity outcomes for multiple births at NHS trusts and boards</p>
<p>2. What countries are covered?</p>	<p>England, Scotland, Wales</p>
<p>3. The number of previous projects (e.g., whether it is the 4th project or if it is a continuous project)</p>	<p>2nd Multiple Births snapshot audit</p>
<p>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)</p>	<p>1 January 2023 to 31 December 2023</p>
<p>5. Any links to NHS England objectives or professional work-plans (only if you are aware of any)</p>	<p>Saving Babies’ Lives: A Care Bundle for Reducing Stillbirth</p> <ul style="list-style-type: none"> • 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. <p>Saving Babies’ Lives Care Bundle version 2.0.</p> <ul style="list-style-type: none"> • 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 <p>Saving babies’ lives: version 3</p> <p>2.17 Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with local ICSs following advice from the provider’s Clinical Network</p> <p>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.</p> <p>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.</p> <p>2.24 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.</p>

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[...]

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.

5.3 Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.

5.4 In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUIPP) to improve predictive accuracy of triage and enable collaborative decision making.

5.5 Networked Trusts should agree on the use of these tools within their ICS/LMNS.

5.6 Multiple pregnancy – risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.

5.19 **Place of birth** – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:

- a) less than 27 weeks gestational age (in a singleton pregnancy)
- b) less than 28 weeks gestational age (in a multiple pregnancy)
- c) any gestation with an estimated fetal weight of less than 800g

Appendix B: There are numerous causes of stillbirth, many of which are poorly understood. *MBRRACE-UK* highlights that stillbirth and neonatal mortality rates are higher in women from Black, Asian and minority ethnic backgrounds, those living in areas of deprivation and twin pregnancies.

Please can the provider complete the below for each recommendation in the report

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No.	Recommendation	Intended audience for recommendation	Evidence in the report which underpins the recommendation (including page number)	Current national audit benchmark -ing 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	Maternity care commissioners and maternity networks (including English Local Maternity and Neonatal Systems (LMNS), the Scottish Perinatal Network and the Wales Maternity and Neonatal Network) should seek assurance that maternity providers' local policies, procedures and care planning for multiple births are aligned with relevant national guidance, including NICE guidance on twin and triplet pregnancy and	Maternity commissioners and networks in England, Scotland and Wales	Rates of postpartum haemorrhage (PPH) >1500 ml for mothers of twins was 11.6% compared to singletons (3.4%) and 33.3% for triplets/more. Pages 7 and 9	None known	None known	Twin and triplet pregnancy , NICE guideline [NG137], 9 April 2024 Monochorionic Twin Pregnancy, Management – 2024 Partial Update , RCOG Green-top Guideline No. 51, 18 February 2025 Multiple Births Midwife Standard , Royal College of Nursing (RCN), 16 September 2024	Not previously asked

	<p>RCOG guidance on the prevention and management of postpartum haemorrhage.</p> <p>This assurance should confirm that multiple pregnancy is explicitly recognised as increasing the chance of experiencing a major postpartum haemorrhage and that local guidance supports appropriate care planning, preparedness and escalation to reduce the likelihood of anticipated blood loss progressing to major postpartum haemorrhage.</p>					<p>Twin and triplet pregnancy [1] Evidence reviews for interventions to prevent postpartum haemorrhage in the third stage of labour, NICE guideline NG137 Evidence review, September 2019</p>	
R2	<p>NICE should review, and update where appropriate, the current methods used in clinical practice for monitoring adequate fetal growth in multiple births and the use of singleton estimated fetal weight centile charts.</p>	<p>National Institute of Health and Care Excellence (NICE)</p>	<p>There is an absence of validated estimated fetal weight (EFW) centile charts and birthweight centile charts customised for multiple births babies.</p> <p>Pages 6 and 10</p>			<p>Twin and triplet pregnancy, NICE guideline [NG137], 9 April 2024</p> <p>Monochorionic Twin Pregnancy, Management – 2024 Partial Update, RCOG Green-top Guideline No. 51, 18 February 2025</p>	<p>Not previously asked</p>

R3	<p>The National Institute for Health and Care Research (NIHR) should review existing and emerging evidence for estimated fetal weight charts customised for multiple births and plan research to assess optimal fetal growth in multiple births and develop birthweight centile charts for multiple births babies.</p>	<p>National Institute for Health and Care Research (NIHR)</p>	<p>There is an absence of validated estimated fetal weight (EFW) centile charts and birthweight centile charts customised for multiple births babies.</p> <p>Pages 6 and 10</p>			<p>Twin and triplet pregnancy, NICE guideline [NG137], 9 April 2024</p> <p>Monochorionic Twin Pregnancy, Management – 2024 Partial Update, RCOG Green-top Guideline No. 51, 18 February 2025</p>	<p>Not previously asked</p>
R4	<p>Improve the recording of chorionicity in the maternity datasets. This should include:</p> <ul style="list-style-type: none"> • NHS England[#] and the health departments in the Devolved Governments must ensure the digital maternity record standards in England, Scotland and Wales are updated to include chorionicity as a mandatory item for multiple births. • NHS England[#] should consider updating the Maternity Services Data Set (MSDS) to include chorionicity as a mandatory data item. NHS England[#] should include relevant 	<p>Govt. Health Departments, NHS England, Maternity commissioners and networks in England, Scotland and Wales</p>	<p>Chorionicity is still not available as a standalone data field in maternity datasets for England, Scotland or Wales, the national Digital Maternity Record Standard (DMRS) in England enables the recording of chorionicity, and the ability to record chorionicity using SNOMED CT concepts is in place. However, the DMRS does not mandate the collection of it. In the 2023 data, these codes were highly incomplete. We found fewer than 500 of 7 299 (6.8%) mother records had a SNOMED CT code for chorionicity.</p> <p>Page 11</p>	<p>None known</p>	<p>None known</p>	<p>Twin and triplet pregnancy, NICE guideline [NG137], 9 April 2024</p> <p>Monochorionic Twin Pregnancy, Management – 2024 Partial Update, RCOG Green-top Guideline No. 51, 18 February 2025</p>	<p>Not previously asked</p>

	<p>SNOMED CT codes in the MSDS SNOMED CT Mapping.</p> <ul style="list-style-type: none"> • Maternity commissioners and regional maternity networks should encourage their constituent units to routinely record chorionicity for all multiple births, including through local data quality expectations, audit, and feedback mechanisms. • Maternity commissioners and regional maternity networks should work with their constituent units to review local EPR configurations and clinical workflows to ensure chorionicity recording is clear and embedded into routine care. <p># NHS England or succeeding responsible organisation in England.</p>						
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R5	<p>NHS England[#] and the health departments in the Devolved Governments should ensure the digital maternity record standards in England, Scotland and Wales are updated to include assisted conception as a mandatory item.</p> <p>[#] NHS England or succeeding responsible organisation in England.</p>	Government health departments	<p>Despite a drop in the rate of multiple births following assisted conception from 22% to 3% between 2003 and 2023, the rate of all multiple births across Great Britain remained largely unchanged (1.35–1.64%). As the UK regulator the HFEA oversee treatment by licensed fertility clinics in the UK, and while so-called “fertility tourism” is not unique to the UK, the NHS end up providing care for women and birthing people who have become pregnant in regions where legislation and quality assurance differ.</p> <p>Page 11</p>	None known	None known	<p>Fertility problems: assessment and treatment, NICE Guideline [CG156], 06 September 2017</p>	Not previously asked
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