There were **more than 660,000 births** in England in 2016 and having a baby is the most common reason for **hospital admission**. This report considers how NICE’s evidence-based guidance might contribute to improvements in the safety and personalisation of maternity care.

**Safety**  
Promoting safer maternity care and reducing stillbirths is a key priority for the NHS in England and NICE’s recommendations on **smoking in pregnancy** (p5) are an important element of the Saving Babies’ Lives care bundle. Survey results suggest improved uptake of NICE’s recommendations for **multiple pregnancy** (p7). However, national audit results suggest there may be room for improvement in the uptake of NICE’s recommendations for the care of women with pre-existing **diabetes in pregnancy** (p10). A new, NICE-recommended **fetal rhesus-D genotype test** (p12) has the potential to reduce unnecessary treatments in thousands of pregnant women and is being rolled out nationally.

**Personalisation and experience of care**  
Increasing choice and personalisation is one of the priorities of NHS England’s Maternity Transformation Programme. NICE recommends that women with uncomplicated pregnancies should be able to **choose their birth setting** (p14). Data show that more alongside midwife-led units are available, and that more women are being offered this option. The national maternity survey shows that most women felt they were **always involved in decisions about their care** (p16). Finally, we look at how a **maternity transformation early adopter site** (p17) have put NICE guidance into practice and increased choice for women.

This report highlights progress made by the healthcare system in implementing NICE guidance. We recognise that change can sometimes be challenging, and may require additional resources such as training, new equipment or pathway reconfiguration.

We work with partners including NHS England and NHS Improvement to support these changes, and we also look for opportunities to make savings by reducing ineffective practice.
Foreword

from Professor Lesley Regan and Gill Walton

NICE guidance provides the evidence base to help health professionals deliver ever more effective maternity care. As leaders of the professional bodies for midwives and obstetricians, we welcome this report on the impact of NICE guidance on key drivers in areas of improvement across the maternity system and the positive progress it highlights.

The healthcare professionals who care for women, their babies and their families need to be at the heart of any initiative to improve maternity care. The RCOG and RCM are committed to speaking with one voice on maternity safety and ensuring every woman has a good birth, with the best possible experience and outcomes for the mother and her baby.

We are also united in the aim of providing a shared vision of a modern maternity team whose common purpose is supporting best practice, respectful relationships, strong leadership and placing women at the centre of their care. Midwives are in a unique position to help achieve this goal, since they are the single healthcare professional whom all women will see during their pregnancy and birth. As a result they have a crucial role in ensuring maternity care is coordinated, safe and, most importantly, personalised.

We therefore welcome this impact analysis of NICE recommendations and recognise that further improvements are required to improve maternity care still further.

The RCM and RCOG collaborative audit programmes Each Baby Counts and the National Maternity and Perinatal Audit are making a useful contribution to the work of NHS Improvement, the Maternal and Neonatal Safety Collaborative and the Healthcare Safety Investigation Branch.

Together, we believe that we can build on the trust and buy-in we already have from frontline clinical staff for initiatives by providing them with the support they need to translate lessons learned into improvements in everyday care.

This report provides the practical means by which we can support frontline clinical staff to assess their own progress and learn from each other.
Why focus on maternity?

NICE impact reports review how NICE recommendations for evidence-based and cost-effective care are being used in priority areas of the health and care system, helping to improve outcomes where this is needed most.

NICE provides evidence-based guidance and advice to help improve health and social care services. The uptake of NICE guidance is influenced by close relationships with our partners in the system. NHS England has established a Maternity Transformation Programme to implement the findings of the National Maternity Review and so, in this report, we have focused on what we know about the uptake and impact of our recommendations in this area.

The National Maternity Review was commissioned by NHS England to assess maternity care provision and consider how services should be developed to meet the changing needs of women and babies. Better Births, the report produced by the review, highlighted that there remains variation in quality and outcomes across the country and laid out a vision for safer and more personalised services. This report considers how NICE guidance can contribute to achieving that vision.

NICE published its first maternity guideline, on antenatal care, in 2003. Since then we have produced a suite of maternity-related guidance and advice on a broad range of topics such as hypertension in pregnancy, preterm labour and birth, and antenatal and postnatal mental health, aimed at improving care at each stage of pregnancy, birth and the early weeks of a child’s life.

We routinely collect data which give us information about the uptake of our guidance. To produce this report, we have worked with national partners to select those data which tell us about how NICE guidance might be making a difference to safety and personalisation in priority areas of maternity care. The data also highlight areas where there remains room for improvement.

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<td>Guidelines</td>
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Safety

The stillbirth and neonatal mortality rate in England has fallen by over a fifth in the last 10 years. However, there is wide regional variation and rates remain higher than in some other countries. Reducing stillbirths and promoting safer maternity care is a key priority for the NHS in England.

The Better Births report highlights that there are wide regional variations in rates of perinatal death in England, from around 4 per thousand births in some areas to over 10 per thousand births in others. The report notes that variation persists between areas after adjustment for the effects of deprivation and maternal age, making it likely to be associated with differences in the effectiveness of care. Overall, 1 in every 200 babies is stillborn in the UK; this is more than double the rate in Iceland, the nation with the lowest rate.

Promoting good practice for safer care is one of the priorities of the Maternity Transformation Programme. In this section of the report we have considered 4 areas where NICE recommendations could support safer care for mothers and babies. We have looked at the NICE guideline on stopping smoking in pregnancy, which is a key element of the Saving Babies’ Lives care bundle. We have reviewed data on the uptake of NICE recommendations which might improve outcomes in higher risk pregnancies, in women with diabetes or a multiple pregnancy. Finally, we have looked at the uptake of a new prenatal test for fetal rhesus-D genotype.

Wide regional variation in perinatal death rates in England are likely to be associated with differences in the effectiveness of care.

Smoking in pregnancy

There is strong evidence to show that reducing smoking in pregnancy reduces the likelihood of stillbirth. The proportion of women who smoke during pregnancy has reduced but a new audit reports that fewer than 1 in 5 women who smoke at their booking appointment stop before they give birth.
In June 2010, NICE published a guideline on stopping smoking in pregnancy and after childbirth. It contains recommendations on identifying women who need help to quit, referring them to stop smoking services and providing support to help them stop. Since then, data from the Public Health Outcomes Framework (PHOF) show that the proportion of women in England who smoke at the time of delivery has dropped, from 13.5% in 2011 to 10.5% in 2016/17. However, there is wide regional variation.

NHS England has developed a care bundle, Saving Babies’ Lives, which is designed to tackle stillbirth and early neonatal death. It brings together 4 elements of care that are recognised as evidence-based or best practice, including reducing smoking in pregnancy. It highlights that there is strong evidence to show that reducing smoking in pregnancy reduces the likelihood of stillbirth. Element 1 of the care bundle provides a practical approach to reducing smoking in pregnancy by following the NICE guideline.

The NICE recommendations highlighted in the care bundle are that a carbon monoxide test and a record of smoking status should take place during antenatal booking appointments, and women who smoke should then be referred to NHS Stop Smoking Services. Data from NHS Digital show that around 46% of pregnant women who set a quit date through NHS services say they have been successful at a 4 week follow-up.

However, these data only measure success among women who have set a quit date. The new National Maternity and Perinatal Audit reports that, of women who are recorded as smokers at their booking appointment, only 19.5% have quit by the time they give birth. Alongside the wide regional variation in smoking rates, this audit finding suggests that there is room for improvement in this important area.

One initiative seeking to drive improvement is NHS Resolution’s Clinical Negligence Scheme for Trusts (CNST) incentive scheme. This scheme aims to reward local services that take steps to improve the delivery of best practice in maternity and neonatal services. Ten safety actions have...
been identified, including demonstrating compliance with all elements of the Saving Babies’ Lives care bundle. Implementing these actions should lead to improved performance in improving maternity safety and reduce incidents of harm.

Multiple pregnancy

NICE recommends that women with a multiple pregnancy should receive additional care. Survey results suggest that this is happening more often since the publication of our guidance, although a NICE-supported project has shown that there is room for further improvement.

Data from the Office for National Statistics show that 10,786 women gave birth to twins, 160 to triplets and 5 to quads and above in 2016. Multiple pregnancy is associated with a higher risk of stillbirth, infant death and child disability. A report from the Twins and Multiple Births Association (TAMBA) on twin pregnancy and neonatal care in England found that, although outcomes have improved in recent years, multiple pregnancies are about 2.5 times more likely to result in a stillbirth and over 5 times more likely to result in a neonatal death, in comparison to singleton pregnancies.

NICE’s guideline and quality standard on multiple pregnancy aim to improve outcomes by recommending additional care that should be offered to women with twin and triplet pregnancies.

In 2011, NICE published a guideline on multiple pregnancy. This recommends the additional care that women with twin and triplet pregnancies should be offered, above that routinely offered to all women during pregnancy. This was followed by a quality standard with 8 statements describing high-quality care in priority areas for improvement. Between 2011 and 2015, TAMBA and the National Childbirth Trust carried out 3 rounds of a maternity services survey, asking women whether the NICE recommendations on multiple pregnancy were followed in the care they received. The surveys show some encouraging changes over time.

For example, NICE recommends that women with a multiple pregnancy have the number of outer (chorionic) membranes surrounding their babies determined using ultrasound and recorded between 11 weeks 0 days and 13 weeks 6 days.
This is called chorionicity and is important because, if fetuses share a placenta, there is a greater risk of complications. Determining chorionicity allows women to be assigned the correct plan of care for their pregnancy. The most recent survey reports that 86% of women had the chorionicity of their pregnancy determined at first ultrasound, up from 74% in 2011.

However, other recommendations appear to have lower uptake. NICE recommends that women with multiple pregnancies are cared for by a multidisciplinary core team. The quality standard defines this as ‘a team consisting of specialist obstetricians, midwives and ultrasonographers, all of whom have experience and knowledge of managing twin and triplet pregnancies.’ Although there has been some improvement, the most recent survey suggests that a specialist sonographer is available for 33% of multiple pregnancies, and a specialist midwife for only 24%.
Despite these improvements in uptake, after the 2015 survey TAMBA estimated that the quality standard was fully implemented in only 10-18% of maternity units in the UK. They have therefore started a Department of Health and Social Care funded maternity engagement project, working with targeted maternity units to improve outcomes for multiple pregnancy families by promoting the use of the NICE quality standard. The project is being supported by NICE who have provided advice, facilitated a workshop and helped with the development of an audit tool.

By 2017/18, the second year of the project, the TAMBA team had conducted 30 onsite clinical audits and over 140 face-to-face interviews with consultants, midwives and sonographers. Each of the 30 audited sites now has a bespoke action plan and support package.

Baseline data from the first round of audits show variable rates of implementation of the NICE quality standard. TAMBA recorded the rates of poor clinical outcomes at each site, including stillbirth and neonatal death. In the 4 sites with the most complete implementation of the quality standard, which were identified as controls for the project, TAMBA has reported an interim finding of better clinical outcomes compared to the other project sites.

Each of the 30 sites will be re-audited after a year to measure progress in implementing the quality standard. As part of the project, TAMBA has developed an antenatal care pathway and an improvement tool which are underpinned by the NICE quality standard. These were submitted to NICE in January 2018 for endorsement. It is hoped this will help them become widely used across all maternity units.

'When we discovered we were having twins I was surprised but elated. Our twins shared a placenta. Initially we received fortnightly scans, in line with NICE guidance, although we rarely saw a midwife and when we did it was clear she’d never cared for a multiple pregnancy before. I was changed from fortnightly scans to monthly scans at 20 weeks and then developed concerning symptoms. When I was finally scanned it was discovered that I had feto-fetal transfusion syndrome, which should be screened for at least fortnightly through my type of pregnancy. The treatment was scary and very emotional but I felt I was in good hands at the unit I was referred to. They were adhering to the NICE guidelines in every way. They were very knowledgeable about my pregnancy and I finally felt safe so I moved my care to this unit. Luckily, both of my babies survived and I can attribute that to the care we received at the unit who followed the NICE guidelines.'  

Amy, mum of twins
Diabetes in pregnancy

Diabetes in pregnancy increases risks to pregnant women and their babies. NICE’s guideline and quality standard focus on areas where additional or different care should be offered to women with diabetes to reduce these risks.

Diabetes in pregnancy is associated with risks to the woman and to the developing fetus, including congenital malformation, miscarriage, preterm delivery, pre-eclampsia, macrosomia (big baby), and perinatal mortality. The most recent report of the National Pregnancy in Diabetes (NPID) Audit looked at over 3,000 pregnancies in women with pre-existing diabetes in England, Wales and the Isle of Man. It found that the stillbirth rate was more than twice, and neonatal death rate nearly 4 times the general population rate. Almost 1 in 2 babies had complications relating to maternal diabetes such as being large for gestational age or being delivered preterm.

NICE’s guideline and quality standard on diabetes in pregnancy cover managing diabetes and its complications in women who are planning pregnancy or are already pregnant. They focus on areas where additional or different care should be offered to women with diabetes and their newborn babies. They include recommendations for the care of women with pre-existing diabetes as well as those who develop gestational diabetes. The NPID audit measures uptake of some of the key NICE recommendations for women with pre-existing diabetes.

When planning for pregnancy, NICE recommends that women with diabetes should take high dose (5mg a day) folic acid, which is available on prescription. This reduces the risk of having a baby with a condition called a neural tube defect, such as spina bifida. When a woman with pre-existing diabetes has her pregnancy confirmed, NICE recommends that contact with a joint diabetes and antenatal clinic should be offered immediately so that care specific to women with diabetes can be provided. The first appointment should be in the first 10 weeks of pregnancy.

NICE recommends that women with pre-existing diabetes should take high-dose folic acid while planning for pregnancy and be offered contact with a joint diabetes and antenatal clinic as soon as pregnancy is confirmed.
NICE recommends that women with pre-existing diabetes should have their HbA1c levels recorded at their booking appointment to determine the level of risk. The guideline highlights that the level of risk increases with an HbA1c level above 48 mmol/mol and so the audit records the percentage of women whose first reading in pregnancy is below this.

Overall, the audit report suggests that there has been little change in uptake of the NICE recommendations over the last 3 years, which it describes as 'a concerning lack of progress'. It also highlights regional variations in both uptake and outcomes. This suggests that there is room for improvement in the maternity care offered to women with pre-existing diabetes.

### Diagnosing diabetes in pregnancy

Most women with diabetes in pregnancy have gestational diabetes. This is high blood sugar that develops during pregnancy and usually disappears after birth. The NICE costing statement developed to support the diabetes in pregnancy guideline estimates that gestational diabetes affects around 28,000 women a year.

The 2015 report on stillbirths from the Maternal, Newborn and Infant Clinical Outcome Programme found evidence of failures to identify risk factors for gestational diabetes and to refer women for testing as recommended by NICE.

The updated 2015 NICE guideline lowered the fasting plasma glucose threshold for diagnosis and we published a news story to publicise this. Three years on it remains one of our most popular news stories. Around 20,000 people viewed it in 2017, more than any other story, and most viewers arrived from a web search. Because we know that people are interested in these thresholds, and we understand how important it is that women are diagnosed appropriately, we have developed a summary graphic to share when we get enquiries.
Fetal rhesus-D genotype testing

For women who have rhesus negative blood, anti-D prophylaxis is recommended to reduce the risk of complications in future pregnancies. A new test means that only those women who actually need prophylaxis receive it, preventing unnecessary treatments and protecting stocks of anti-D immunoglobulin.

Since 2002, NICE has recommended that women who are rhesus-D (D) negative and are not known to be sensitised to the D antigen are given an injection of anti-D immunoglobulin to reduce the risk of potential problems in future pregnancies. Without it, the anti-D produced by the mother can cross the placenta and destroy her baby’s blood cells. This can cause severe fetal anaemia, leading to fetal heart failure, fluid retention and swelling, and intrauterine death. However, only around 62% of women who are D negative actually need anti-D prophylaxis, because their baby is D positive.

In November 2016, NICE recommended the use of high-throughput non-invasive prenatal testing (NIPT) for fetal RHD genotype. This new test is the first reliable way of testing the D status of the baby before it is born. By ensuring anti-D immunoglobulin is only given to women who need it, the test has the potential to protect stocks of this finite resource. NICE’s resource impact report calculates that, each year, this could save the NHS more than £370,000 and avoid unnecessary treatment in around 35,000 women who currently receive anti-D when they do not need it.

If the new test was available to all eligible women, it could protect 35,000 women from unnecessary treatment and save the NHS more than £370,000 a year.

Since publication of the NICE guidance, data from NHS Blood and Transplant (NHSBT) show an increase in the number of tests. A further 17 trusts are expected to offer the test by April 2018. NHSBT expect the annual number of tests to increase from around 13,000 in 2016/17 to around 90,000 in 2021/22 when the test is fully rolled out nationally.
NICE worked with 5 NHS sites who were already using the technology in routine practice to produce an adoption support resource and a series of shared learning examples. These resources are intended to help the NHS adopt the test more widely by learning from the experiences of those who have already put it into practice. The sites highlighted benefits such as a reduction in the number of antenatal anti-D prophylactic clinic appointments needed, and avoiding unnecessary painful injections for women where the test for fetal D is negative.
Personalisation and experience of care

**Better Births** sets out a vision for ‘personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.’

Increasing choice and personalisation is one of the priorities of the Maternity Transformation Programme. In this section of the report, we have looked at what we know about the uptake of NICE’s recommendations on offering women a choice of birth settings and convenient access to antenatal services.

All of NICE’s guidance is underpinned by our statement on making decisions about your care, which states that people have the right to be involved in discussions and make decisions about their care. We have reviewed what we know about women’s experiences of being informed and supported to make their own decisions about pregnancy and birth. Finally, we have looked at how NICE guidance has been put into practice by the Improving Me partnership in Cheshire and Merseyside, one of the sites chosen by NHS England to develop and test ways of improving maternity choice and personalisation.

**Choice of birth settings and antenatal services**

The Maternity Transformation Programme aims to widen and deepen choices available for women. NICE recommends that women should have the choice of different birth settings; more alongside midwifery units are now available and women are increasingly being offered this option.

NICE’s guideline on intrapartum care for healthy women and babies sets out the evidence for the safety of different birth settings and recommends that women should be given the choice of where to give birth. The guideline lists 4 birth settings which should be offered to women who are at low risk of complications: home, freestanding midwifery unit, alongside midwifery unit and obstetric unit.
The National Maternity and Perinatal Audit (NMPA) carried out an organisational survey which found that only 19% of trusts in England offered all 4 settings, although most offered an obstetric unit and one of the midwifery unit options. The number of alongside midwifery units has increased since the publication of the NICE guideline, from 87 in 2013 to 106 in 2017.

There were 29 more alongside midwifery units available in 2017 than in 2013.

The CQC maternity survey collected the experiences of over 18,000 women who gave birth in 2017. The survey asked whether they were given the option of different birth settings. There was very little change in the proportion of women who said they were offered a choice of giving birth at home since the previous surveys in 2013 and 2015; this remains at around 38%. However, the proportion of women who said they were offered a choice of giving birth in a midwife-led unit or birth centre has increased to 42%, up from 35% in 2013.

The NMPA organisational survey also looked at choice in antenatal services. NICE’s guideline on antenatal care for uncomplicated pregnancies recommends that antenatal care should be easily and readily accessible to all pregnant women. The survey reported that 73% of trusts and boards in England, Scotland and Wales offered women a choice of location for their antenatal appointments and 65% offered a choice of evenings or weekends.

NICE recommends that women are supported to access antenatal care by 10 weeks. The first appointment, known as booking, is when NICE recommends women should be given information about the pregnancy care pathway and their options for place of birth. They should also receive information about nutrition, diet, exercise and how the baby develops during pregnancy.

Data from NHS Digital show that around 55% of women in England had their booking appointment in the first 10 weeks of pregnancy, but that there is regional variation. There are many reasons why access to services may vary, but increasing choice may help to make access easier.
Decision-making and experiences of care

All of NICE’s maternity guidance is underpinned by the principle that women should be treated with respect and dignity, and involved in decisions about their own care. The CQC maternity survey records how well women feel these principles were achieved.

In order to make choices and decisions about their care, women need access to good quality information. NICE’s guideline on antenatal care recommends that, at each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, and should provide pregnant women with an opportunity to discuss issues and ask questions. The CQC maternity survey asks women if they were given enough time at their antenatal appointments to discuss their pregnancy or ask questions; 77% of women said that they were.

Continuity of care is also important. The NICE quality standard on antenatal care recommends that women should be cared for by a named midwife during pregnancy, and the Better Births report highlighted this as something women valued. The CQC survey found that only 38% of women saw the same midwife each time for their antenatal check-ups. The NMPA organisational survey identified that only 15% of trusts and boards use care models in which women see the same midwife for most contacts during pregnancy, labour and postnatal care.

The NICE guideline on intrapartum care recommends that healthcare professionals should ensure that the woman is in control of and involved in what is happening to her. More than three quarters of women who responded to the CQC survey said they were always involved enough in decisions.

88% of women said they were always treated with respect and dignity during labour and birth

More than three quarters of women said they were given enough time at their antenatal appointments to discuss their pregnancy or ask questions.

'I was offered a choice of places to give birth and chose my local freestanding midwife-led unit, but near the end of my pregnancy I changed my mind and chose a midwife-led unit in a larger hospital because I wanted the security of having consultants nearby. I felt that my choice was supported by my midwife and that her main objective was to make sure I was comfortable.' Louise, first time mum
about their care during labour and birth. Just 5% said they were not involved enough. The survey also reported that 96% of women felt, if their partner or someone else close to them was involved in their care, they were able to be involved as much as they wanted.

Maternity transformation in Cheshire and Merseyside

Improving Me is a partnership of 27 NHS organisations across Cheshire and Merseyside aiming to improve the experiences of local women and children. The partnership has been selected by NHS England as a Maternity Transformation Programme early adopter and a maternity choice and personalisation pioneer. Improving Me is developing new models of care which deliver many of NICE’s recommendations for increased choice and personalisation in maternity care.

As part of their commitment to offering women and their families meaningful choice, the partnership is opening a ‘pop up’ birthing centre at Seacombe Children’s Centre in Wirral. This is the first of its kind nationally; a midwife-led birthing unit in a community setting where mums and families are supported before, during and after pregnancy. Women at low risk of complications will be offered the choice of giving birth in this non-medicalised birthing unit, an option underpinned by NICE recommendations on the safety of birth settings.

The unit offers a continuity of carer approach, meaning that women are more likely to be looked after by a midwife who has helped them throughout their pregnancy. If successful, it could inspire the development of permanent freestanding midwifery units across the Cheshire and Merseyside region.

Another approach to increasing choice taken by the partnership is the development of Personal Maternity Care Budgets. These encourage women to choose where and how they receive their care throughout the maternity pathway, in line with NICE guidance on choice of and access to maternity services. The ‘budget’ element is notional but women are empowered to make choices which allow them to access NHS care in the most appropriate place, by the most appropriate health professional.
What happens next?

This report highlights some positive progress in the uptake of NICE recommendations for safe and personalised maternity care. More women with a multiple pregnancy are receiving NICE-recommended care processes, fewer women smoke during pregnancy, and most women feel they are involved enough in decisions about their own care. However, in some areas there remains room for improvement in the uptake of NICE recommendations.

We will draw the findings in this report to the attention of our system partners and continue to engage at a national and local level to encourage increased uptake of our recommendations.

As well as the recommendations considered in this report, NICE is continuing to develop new guidance. A guideline on intrapartum care for high risk women is due in 2019, which will cover care when either the woman or her baby is at high risk of adverse outcomes. In this report we have looked at NICE’s recommendations for women with diabetes and the new guideline will consider whether recommendations should be made for the intrapartum care of women with other conditions, such as cardiac disease.

We regularly update our existing recommendations in response to new evidence. The NICE guideline on multiple pregnancy, which we have reviewed in this report, is one of those being updated. Data show that a significant proportion of multiple pregnancy losses happen during birth. The updated guideline, now called twin and triplet pregnancy, will therefore be expanded to include recommendations on intrapartum care.

Many of the interventions supported by the Maternity Transformation Programme, on safety, prevention, workforce, women’s choice and the personalisation of care, are underpinned by NICE recommendations. The programme is also working with NHS Digital to improve the quality of data submissions to the Maternity Services Data Set.

We hope this will give us more information in the future about uptake and outcomes related to existing and new NICE guidance.
We would like to thank Matthew Jolly, National Clinical Director for Maternity Review and Women’s Health, for his input. We would also like to thank Improving Me, JDRF, the Maternity Transformation Programme, NHS Blood and Transplant, NHS Resolution, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and TAMBA for their contributions to this report.

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Any enquiries regarding this publication or any other enquiries about NICE and its work should be made to:

National Institute for Health and Care Excellence
10 Spring Gardens
London SW1A 2BU
Telephone: +44 (0)300 323 0140
Fax: +44 (0)300 323 0148

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester M1 4BT
Telephone: +44 (0)300 323 0140
Fax: +44 (0)300 323 0149

Email: impact@nice.org.uk
Website: www.nice.org.uk
Implementation of NICE guidance has contributed to reductions in stillbirth, neonatal mortality and maternal death but there is more work to do.
Some use affordability as a reason not to implement NICE guidance but in many cases best practice care saves money.
This report illustrates how significant improvements in care can be achieved through implementation of guidance.