Type of recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation	Updated notes on implementation (DHSC and NHS England)	Reviewed extent of Implementation
		MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England. (March 2015)	*cause for concern. In addition the Care Quality Commission and MBRRACE are establishing pursuing a data-sharing agreement which would allow inspectors to receive a regular update of all maternal deaths"* (p. 93)			A Perinatal Mortality Review Tool[51] was launched in January 2018 and has now been implemented in 100% of English Trusts. The tool aims to promote: systematic, multidisciplinary, high quality reviews of the circumstances and care leading up the death of the baby; active communication with parents and an invitation to be actively involved in the review process; a structured process of review, learning, reporting and actions to improve future care. The National Maternity Indicator dashboard enables clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. NMIs are annually published indicators drawn from external data sources such as the National Maternity and Perinatal Audit, MBRRACE-UK, CQC Maternity Survey, NHS Staff Survey, and the GMC Survey. These indicators have been selected to provide a holistic picture of the performance of maternity services and cover five different domains including mortality and morbidity. They allow for comparison with other units but given mortality data is based on MBBRACE-UK there is an associated time lag. The National Neonatal Audit Programme (NNAP[52]) is a national clinical audit run by the Royal College of Paediatrics and Child Health (RCPCH) on behalf of the NHS. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP). It aims to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care. NNAP produces an interactive data dashboard showing data on 10 performance metrics, including mortality, and is updated on a quarterly basis.[53]	
Improving patient safety	**39**	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.	Department of Health response (July 2015): Accepted in principle. *"The medical examiners system has been trialled successfully in a number of areas across the country …* *Medical examiners would scrutinise all deaths except for stillbirths (for legal reasons) and any death that requires a coroner investigation.* *However, the MBRRACE confidential enquiries provide independent scrutiny of all maternal deaths and topics related to stillbirths and neonatal deaths, which is sufficient to learn national lessons for improvement of care." (p. 94)* Hansard – September 2023	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **National Medical Examiner** NHS England, 'The national medical examiner system' **Hansard** HC Deb 4 September 2023, vol 737, cols 36-37		The Maternity and Newborn Investigations Programme[54] conducts independent investigations of specific perinatal deaths, including term intrapartum stillbirths, and neonatal deaths of all term babies born following labour when the baby died within the first week of life (0-6 days) of any cause. The programme was established in 2018 as part of the HSIB and has been hosted by the CQC since 2023. From 9 September 2024, all deaths in any health setting that are not investigated by a coroner are reviewed by NHS medical examiners.[55] The new statutory medical examiner system was rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice.[56] Medical examiners were introduced on a non-statutory basis from 2019 to provide independent scrutiny of the causes of all non-coronial deaths, to support the appropriate direction of deaths to the coroner. This includes neonatal deaths. NHS England progressed support for the introduction of medical examiners, specifically: • A national medical examiner has been appointed and a monthly National Medical Examiner Bulletin is published to communicate progress. • Regional medical examiners and regional medical examiner officers have been appointed to each region in England. • E-learning and face to face training is available for the medical examiner and medical examiner officer workforce.	**Implemented – Ongoing**

[51] Perinatal Mortality Review Tool | PMRT | NPEU
[52] National Neonatal Audit Programme (NNAP) | RCPCH
[53] National Neonatal Audit Programme - Data dashboard | RCPCH
[54] Home (mnsi.org.uk)
[55] NHS England » Contact details for medical examiner offices in England and Wales
[56] https://www.gov.uk/government/collections/death-certification-reform-and-the-introduction-of-medical-examiners