

Maternity safety recommendations

1 April 2024 to 31 March 2025



Please note some recommendations published as part of this information sharing process will lack the context within which they were made. We would encourage any trust wishing to learn more about a safety recommendation to email enquiries@mnsi.org.uk.

Please see glossary for understanding of acronyms <https://www.mnsi.org.uk/publications/maternity-investigations-glossary-of-terms/>

Duplicates are intentional to show the frequency of making the same recommendations.

Recommendations:

Cardiotocograph (CTG) analysis and categorisation must be done in line with national guidance (National Institute for Health and Care Excellence (NICE), 2022c), when all CTGs are asked to be reviewed. This will ensure that prompt intervention is carried out and the urgency of expedition of birth is considered.
For the Trust to review the process of maintaining clinical oversight and multidisciplinary involvement for high-risk mothers on the labour ward to support a category 2 being done as soon as possible and within 75 minutes in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021).
GP practice (B) to ensure pregnancy is actively excluded by a healthcare professional when a woman presents with amenorrhea and blood tests show a raised prolactin level.
HSIB recommends that a system is put in place within the hospital to enable reliable transfer of past and current medical history, so that key information is easily accessible at every communication interface/handover. This is to ensure a shared understanding of clinical risks.
HSIB recommends that the GP practice and the hospital Trust work with the Integrated Care Board, to ensure there are robust referral pathways to enable timely and direct review by obstetric services, for pregnant and postpartum mothers. This pathway must be communicated with all staff involved in care of pregnant and postpartum mothers.
HSIB recommends that the GP practice develops a system where pregnant and postpartum mothers are given priority for urgent face to face appointments, to enable full assessment with consideration of the increased risk of sepsis in this group. If appointments cannot be accommodated within the GP service, alternative options for assessment, and safety net advice, must be offered.
HSIB recommends that the hospital considers how staff are supported to carry out a holistic review of patients to improve recognition of deterioration and inform escalation. Holistic review must take into account all changes in clinical features including observations and alterations in patients'
HSIB recommends that the hospital enable staff to view track and trigger observation charts (graph format) by default on the electronic patient record system, to support the recognition of a patient's clinical deterioration.

Maternity safety recommendations
1 April 2024 to 31 March 2025



HSIB recommends that the hospital ensures a robust system is in place to allow the obstetric team to maintain oversight of pregnant, or postpartum, mothers on outlying wards.
HSIB recommends that the hospital works with partner organisations to develop the electronic system, to review how an early warning score is displayed when incomplete observations have been recorded. Consideration should be given to the development of tools to clearly prompt or alert staff when incomplete clinical observations have been recorded.
HSIB recommends that the hospital works with staff to understand the barriers and facilitators to recording clinical observations in full on each occasion. The findings should inform the development, implementation and evaluation of an action plan to ensure that early warning score calculations are accurate, to inform escalation in line with guidance.
HSIB recommends that the hospital works with the regional maternal medicine network to develop a process to ensure hospital teams (both maternity and other specialty teams) receive advice and support in the care of mothers with significant medical conditions, that develop in pregnancy or the postpartum period.
HSIB recommends that the system for reviewing patients on ward rounds supports consultant oversight, prioritising those patients most at risk of deterioration to be seen by a consultant.
HSIB recommends that the Trust's maternity electronic patient record enables staff to easily locate a mother's management plan so that her wishes can be taken into consideration during labour.
In line with national and local guidance, it is recommended that a clear plan is documented in a mother's record if she should present with signs of labour before her planned caesarean date. This will assist staff caring for mothers with additional risk factors which may require multi disciplinary team (MDT) input.
In order to promote accurate assessment of fetal wellbeing: It is recommended that the Trust embeds multidisciplinary training and working for all staff that undertake scanning in order to improve parity of opportunity and access to resources.
In order to promote accurate assessment of fetal wellbeing: It is recommended that the Trust review the quality of all ultrasound measurements by complying with NHS England (2023) and British Medical Ultrasound Society (BMUS 2022) guidance on audit and continuous learning in relation to third trimester assessment of fetal wellbeing (growth ultrasounds). This is to support uniform quality of ultrasound measurements.
is recommended that the Trust reviews their process for non-triage women requiring non urgent care, to ensure they are reviewed and followed up in a timely manner.
It is recommended that the Trust assures itself that referral to a pharmacy for blood pressure checks is not custom and practice and that all mothers identified as needing blood pressure monitoring receive it as part of a full in-person holistic assessment.
It is recommended that a clear process to request, plan and change elective caesarean dates, based on emerging risk factors are embedded across the Trust.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that a mother's cumulative risk factors are considered to ensure that a holistic review is completed and individualised induction of labour pathway is assigned and followed.
It is recommended that a newborn early warning score system is used to assist in the recognition of babies whose condition may deteriorate.
It is recommended that a structured approach to communication is used when escalating concerns to ensure that appropriate and relevant information is relayed, received and understood.
It is recommended that a structured handover is used at all points where there is a transition of care.
It is recommended that all clinical staff are supported to seek urgent review and support when there is difficulty in locating a baby's heart rate.
It is recommended that all events, including medications, during an emergency are documented in accordance with professional standards.
It is recommended that all healthcare providers (which includes the Integrated Care Board, GP and NHS Trusts providing maternity and mental health care) review how the care of a pregnant mother with complex medical and social problems is coordinated. Clear leadership of all health professionals who need to be involved will help to provide a holistic package of care for a mother.
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It is recommended that all healthcare providers (which includes the Integrated Care Board, GP and NHS Trusts providing maternity care) review how the care of a pregnant mother with complex social needs is coordinated across geographical borders. Clear leadership of all health professionals who need to be involved will help to provide a holistic package of care for a mother.
It is recommended that all healthcare providers (which includes the Integrated Care Board, GP and NHS Trusts providing maternity care) review how the care of a pregnant mother with complex social needs is coordinated across geographical borders. Clear leadership of all health professionals who need to be involved will help to provide a holistic package of care for a mother.
It is recommended that all mothers are provided with information in the antenatal and postnatal periods in an accessible format about the risks of sudden unexpected postnatal collapse (SUPC) and how to reduce this, in line with national British Association of Perinatal Medicine's (BAPM) guidance. This should include individual care planning, risk assessment and guidance for the mother.
It is recommended that all mothers have an appropriate and robust risk assessment completed on admission to area of the maternity unit to include previous obstetric history, and any concerns of the mother in order that a safe level of care is provided.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that all mothers transferred to the labour ward receive a holistic review by an obstetrician. The full findings of the review, including fetal monitoring, are discussed at a senior level to inform ongoing care planning.
It is recommended that all mothers with a known risk of shoulder dystocia receive appropriate counselling about mode of birth options. This will support mothers to understand the risks and benefits of different options, enabling them to make an informed choice about their own care.
It is recommended that an effective and robust system should be in place to record and retain evidence of patient consent including when paper, electronic and verbal consents are taken.
It is recommended that an obstetric consultant is only allocated the responsibility of completing the antenatal and post-natal ward rounds on a daily basis so that all mothers requiring an obstetric review are reviewed daily.
It is recommended that barriers are explored to achieving continuous fetal monitoring during the siting of an epidural and until the point of birth in order to adequately assess the wellbeing of the baby.
It is recommended that barriers of using structured communication when giving and receiving clinical information are explored, to support staff when the maternity unit has staff shortages.
It is recommended that barriers to expediting birth from maternity triage are explored, to support mode and timing of birth when the cardiotocograph (CTG) is identified as being abnormal.
It is recommended that discharge care plans completed within the Trust include detailed information around an individual's medical and social complexities to enable ongoing holistic care in the community.
It is recommended that guidance for the care of pregnant or recently pregnant mothers, in all areas of the hospital, follows agreed clinical pathways, supported by universal guidance that is available and easily accessible.
It is recommended that if staff are unable to ascertain fetal wellbeing following admission, they escalate quickly using the emergency call bell to enable prompt senior review.
It is recommended that low molecular weight heparin is only dispensed after the Trust's pharmacy checks are completed in full using essential information as stated by national guidance. This needs to be done for all patients across the Trust.
It is recommended that mothers attending for induction of labour who are being transferred to the birth centre, receive a holistic assessment and plan of care by the obstetric team.
It is recommended that mothers receive an holistic risk assessment at every contact including on admission to a birth centre and at any stage of their labour.
It is recommended that mothers receive ongoing, relevant information regarding the risks and benefits of options during the induction of labour pathway to enable them to make informed decisions for their care.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that obstetric decision making around the categorisation of the urgency of birth is based upon a mother's holistic clinical picture, not influenced by other factors that may impact the time frame for birth.
It is recommended that out of hospital teams develop communication links with specialist neonatal teams within the region. This will support the provision of specialist neonatal advice and practical support in an out of hospital setting.
It is recommended that pregnant or recently pregnant mothers presenting with acute onset hypertension receive a holistic assessment with senior clinical oversight to inform ongoing care planning.
It is recommended that pregnant or recently pregnant women have their observations recorded on a maternity early warning score chart, in all clinical areas including the emergency department, to support the recognition and escalation of observations outside the normal range for pregnancy and the postnatal period.
It is recommended that processes for communicating change in guidance are reviewed, to ensure that all staff and departments the guidance relates to are aware and updated. This will support changes in guidance to be followed and embedded in practice.
It is recommended that roles and responsibilities of the Ambulance Service team in attendance at a maternity emergency are allocated to ensure there is a skill mix which supports safe maternity care for both the mother and the baby.
It is recommended that SBAR (Situation, Background, Assessment, Recommendations) is embedded across the Trust when discussing any patient's care, for a handover or when escalating a concern or query. This will enable staff to fully understand all patient risk factors to support decision making and ongoing care planning.
It is recommended that staff are supported to clearly categorise a caesarean birth to enable the multidisciplinary team to work to a shared sense of urgency when there is potential compromise of a baby.
It is recommended that staff are supported to recognise and prioritise essential care treatments and interventions, during the first hour following admission to the neonatal unit, in order to provide care in line with guidance and best evidence.
It is recommended that staff are supported to undertake regular and meaningful checks of all emergency equipment on the resuscitaire to ensure readily assessable equipment is available for immediate use during an emergency. It would be best practice for a supraglottic airway device to be included in the equipment checklist as per national guidance.
It is recommended that staff attending emergency situations are familiar with the equipment available in the emergency trolley, in order to provide prompt access to equipment and not delay treatment.
It is recommended that staff prioritise observations when mothers arrive to the maternity unit and report being unwell. This is to inform ongoing care and management and support safe care.
It is recommended that staff providing neonatal resuscitation are supported to adhere to the national guidance to ensure airway management, chest compressions and optimal thermoregulation, meaning treatment is optimised for the baby.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that that staff should have heightened suspicions in the approach to care planning in response to a mother's changing clinical picture, including ruptured membranes or a need for more pain relief.
It is recommended that the accuracy and timeliness of documentation is prioritised to ensure patient records are complete and support continuity of
It is recommended that the Ambulance Service ensure emergency algorithms are followed when a postpartum haemorrhage is first identified or when signs of shock are present.
It is recommended that the care of pregnant and recently pregnant mothers with a suspected pulmonary embolism, in all areas of the hospital, follows agreed clinical pathways, supported by universal guidance that is available and easily accessible.
It is recommended that the GP partnership implement the guidance published by the Royal College of General Practitioners in relation to the induction, preceptorship, supervision and scope of practice of Physician Associates working in general practice.
It is recommended that the GP practice review their guidance, referral pathways and training requirements for staff when making assessments of mothers during pregnancy to ensure that they are seen face to face by a suitably trained clinician.
It is recommended that the Local Maternity and Neonatal System (LMNS) collaborate with multiprofessional groups across primary and secondary care to support standardised postnatal care, in line with national guidance, in the community.
It is recommended that the local maternity and neonatal system (LMNS) develop a robust process for prescribing low molecular weight heparin for women at a high risk of venous thromboembolism (VTE), as soon as their need is identified; so that mothers have a reduced risk of developing VTE in the first trimester.
It is recommended that the management and escalation of fetal bradycardia includes a holistic review that expedites birth in a timely manner.
It is recommended that the maternity triage helpline service supports staff to discuss normal patterns of babies' movements with mothers. When assurance cannot be given, to advise that assessment is required in the maternity hospital to assess a baby's wellbeing.
It is recommended that the maternity triage helpline service supports staff to undertake a holistic review of a mother and a baby, recognising risk factors that indicate assessment is required as part of individualised care planning.
It is recommended that the multidisciplinary team has oversight and input into the production of a personalised birth plan when mothers choose to birth outside of guidance.
It is recommended that the NHS acute Trust and the NHS ambulance Trust work together to develop a process to communicate and record relevant clinical information so that decisions for care are made based on the whole clinical picture.
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It is recommended that the process for sharing and embedding new guidance is reviewed, to ensure all those who need to understand and use the guidance are aware.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the process to review risk factors and care plans at each antenatal contact ensures mothers understand their risks in relation to their chosen place of birth.
It is recommended that the role of the flow co-ordinator is supported to effectively implement the Trust policy; ensuring all staff are supported to deliver safe care alongside their own wellbeing by taking regular breaks.
It is recommended that the Trust (Trust A) support staff to complete a comprehensive risk assessment with regard to previous obstetric complications such as small for gestational age (SGA) and placental insufficiency. This will inform staff of the need to start aspirin in line with national guidance.
It is recommended that the Trust achieve and embed the national guidance to support the role of a dedicated clinical midwife to be solely responsible for the telephone triage service. This would ensure that mothers receive safe clinical assessment and care.
It is recommended that the Trust actively reviews processes in the operating theatre to support decision making for achieving birth as early as possible when a category 1 caesarean birth is needed, to include consideration of the time lapse since fetal wellbeing concerns arose.
It is recommended that the Trust actively seek information from staff to understand the barriers to documenting informed decision making discussions about birth options and timing of birth in full. The findings would inform system change to support staff to capture key details about informed decision making.
It is recommended that the Trust actively seeks information from preceptorship midwives about their experience of support and confidence in escalating concerns particularly out of office hours. The finding should inform the development, implementation and evaluation of an action plan as
It is recommended that the Trust address the barriers to escalating concerns and acting in response to ensure the safe wellbeing of mothers and babies. The findings need to inform the development, implementation and evaluation of an action plan as required.
It is recommended that the Trust address the barriers to escalating concerns and acting in response to ensure the wellbeing of the baby. The findings should inform the development, implementation and evaluation of an action plan as required.
It is recommended that the Trust align their cardiotocograph (CTG) categorisation tool to support staff with CTG assessment in line with national guidance (National Institute for Health and Care Excellence (NICE), 2022). This will support consistent assessment of fetal wellbeing in labour.
It is recommended that the Trust are able to dynamically address staffing within the maternity department in order to maintain an effective telephone triage service.
It is recommended that the Trust are able to dynamically address staffing within the maternity department in order to maintain an effective telephone triage service.
It is recommended that the Trust clarify the pathway for mothers who require a category 3 caesarean birth within a specified timeframe for identified clinical concerns. This is to facilitate clinical oversight and safe expedition of birth.
It is recommended that the Trust clarify their guidance and prompts on the electronic systems regarding the recommended care plan for women who present with reduced fetal movements from 39+0 weeks onwards in order to support fetal wellbeing.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust consider developing a resuscitation guideline and that they bring the management of a baby with meconium liquor into line with national guidance.
It is recommended that the Trust consider having access to standard resuscitaires in the birth unit for when babies require active resuscitation as opposed to support of transition or stabilisation at birth.
It is recommended that the Trust considers how staff are supported through guidance and training to manage and escalate a cardiotocograph (CTG) when it is not normal from the outset to ensure a timely response.
It is recommended that the Trust considers the business case that has been submitted in relation to increasing the number of diabetes clinics to meet the current demand on the service, to ensure women are seen within one week of diagnosis to allow for safe management of diabetes in pregnancy.
It is recommended that the Trust create a prompt for clinicians to review previous cardiotocograph (CTG) traces when conducting new assessments. This is to support timely detection of changes in the fetal heartrate and guide decision making around methods of fetal monitoring and plans of care to support fetal wellbeing assessment.
It is recommended that the Trust creates a specific categorisation tool for non-computerised antenatal cardiotocographs (CTGs) to facilitate accurate assessment of fetal wellbeing and identify babies at risk of hypoxia.
It is recommended that the Trust develop a formal process for communicating and handing over information about all clinical factors which supports recognition of all risk factors and shared understanding .
It is recommended that the Trust develop a local maternity unit escalation policy outlining the Trusts internal escalation processes which supports clinicians, irrespective of their role or grade, to escalate and inform managers and consultants when concerns arise.
It is recommended that the Trust develop a robust person centred process when mothers have unresolved pain at home during the latent phase of labour, to inform ongoing care planning.
It is recommended that the Trust develops a comprehensive and structured 'fresh eyes' review process to strengthen the objectivity and effectiveness of the local buddy system, to support hourly assessment of the whole clinical picture.
It is recommended that the Trust develops a process to know what laboratory samples have been sent and to review and act on the results in a timely manner.
It is recommended that the Trust develops a robust person and systems centred process to support dynamic and holistic assessment of a mother and baby during labour, including recognition that clinical needs may evolve, and where these require timely discussions for earlier birth.
It is recommended that the Trust develops a structured and standardised telephone triage process to support staff in conducting consistent and comprehensive maternity assessments both over the phone and in person. This should include a system for documenting and storing telephone consultations and a record of the advice provided.

It is recommended that the Trust develops and implements clear, written guidance detailing the thresholds, actions, roles and responsibilities for when safe care of mothers and / or babies cannot be supported in one unit. This to include the presence of an obstetric consultant during periods of high activity or acuity and in line with national guidance (Royal College of Obstetricians and Gynaecologists, 2021 and Ockenden, 2022).
It is recommended that the Trust develops latent phase guidance to support staff to develop an individualised and holistic plan of care for mothers in the latent phase of labour that considers both maternal and fetal wellbeing. This to include timescales for fetal monitoring, support for mothers and thresholds for escalation to ensure the safety and wellbeing of mothers and babies.
It is recommended that the Trust does a dynamic risk assessment during pregnancy, labour or planned birth, to identify a mother's chance of having heavy blood loss after birth. This will allow for a decision about suitable place of birth to be made in the antenatal period.
It is recommended that the Trust embed a dynamic communication process to hand over the clinical risk factors for a mother requiring a caesarean birth. This is to ensure that all clinicians involved are aware of key clinical information and can prioritise care accordingly.
It is recommended that the Trust embed a robust system for assessment and documentation of infant feeding to support staff in the recognition and escalation of babies that aren't feeding well.
It is recommended that the Trust embed a system that enables oversight and communication within the operating theatre setting , so that staff can recognise and act quickly in the event of fetal compromise.
It is recommended that the Trust embed and monitor the use of the categorisation tool to assess intrapartum cardiotocographs (CTGs). This will support ongoing care-planning and decision making.
It is recommended that the Trust embed existing processes into practice, and develop a failsafe system for ensuring diabetic mothers are given the correct antenatal and ultrasound appointment schedule. This is to offer safe maternal and fetal wellbeing assessment for mothers with gestational diabetes.
It is recommended that the Trust embed guidance into practice and support staff to facilitate intermittent auscultation at least every 5 minutes when second stage is suspected or confirmed. This will support ongoing assessment of fetal wellbeing during the second stage.
It is recommended that the Trust embed guidance regarding the use of interpretation services for all mothers identified as requiring support with communication. This is to ensure effective communication with mothers and families.
It is recommended that the Trust embed the local guidance into practice by supporting staff to recognise a deteriorating cardiotocograph (CTG) in the second stage and the requirement for expedition of birth. This would support fetal wellbeing.
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Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust embeds a system and training which supports safe use of remifentanyl patient-controlled analgesia for labour (Royal College of Anaesthetists, 2023; National Institute for Health and Care Excellence, 2023).
It is recommended that the Trust embeds guidance into practice to support referrals for growth ultrasound scans when there is an indication from a symphysis fundal height measurement. This is to support effective fetal growth surveillance.
It is recommended that the Trust embeds interpretation of the early warning score system to ensure staff are supported to escalate when trigger points are reached. This is to support the recognition and response to clinical deterioration.
It is recommended that the Trust embeds processes to support a timely holistic review of risk during labour to assess the most suitable method for fetal monitoring, in order to assess fetal wellbeing.
It is recommended that the Trust embeds the use of a risk assessment based approach to managing the third stage of labour in an out of hospital
It is recommended that the Trust embeds the use of structured communication across the maternity service when giving and receiving clinical information in order to support safe care.
It is recommended that the Trust embeds the use of structured communication across the maternity service when giving and receiving clinical information, at all handover points, to support safe care.
It is recommended that the Trust embeds the use of systematic assessments during labour and birth in an out of hospital setting to objectively assess a mother's suitability to continue on a midwife led pathway at home in line with Trust guidance.
It is recommended that the Trust enhance the understanding and confidence when performing intermittent auscultation that if there is a fetal bradycardia, or a fetal heart rate is not heard when there has been no prior issue, that escalation using the emergency call bell is made.
It is recommended that the Trust ensure staff undertake a holistic and timely assessment of mothers reporting uterine activity and/or pain.
It is recommended that the Trust ensure that a baby having skin-to-skin contact has a documented plan for observation of their wellbeing, including monitoring their colour, tone and temperature.
It is recommended that the Trust ensure that clinical staff are aware that pink amniotic fluid in labour should be recognised and documented as bloodstained amniotic fluid, meriting a holistic review and plan of care.
It is recommended that the Trust ensure that clinicians are supported to access the electronic patient record system at the start of a call to the maternity triage service to support a consistent questioning approach and enable consideration of the full clinical picture. This would help completion of a comprehensive risk assessment and determine that the advice given to parents is clear, consistent and the appropriate course of action.
It is recommended that the Trust ensure that continuous cardiotocograph (CTG) monitoring is maintained during the second stage of labour and there is a pathway for timely management and escalation when there is difficulty in monitoring the fetal heart.
It is recommended that the Trust ensure that there is a robust system in place to support staff to follow up abnormal investigation results and that necessary action is undertaken at the earliest opportunity to minimise the risk of missing critical results.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust ensure the care for women with diabetes in pregnancy are managed in a joint antenatal clinic in line with national guidance. This means that endocrine, obstetric and midwifery assessments occur during the same appointment, along with ultrasound scans where possible.
It is recommended that the Trust ensure their training emphasises the importance of starting chest compressions once a clear airway has been obtained, evidenced by chest wall movement and 30 seconds of ventilation breaths have been given, and prior to securing a definitive airway.
It is recommended that the Trust ensure there are robust systems in place to support clinicians to provide safe care to mothers having an induction of labour (IOL), on the antenatal ward, during time of staff shortages.
It is recommended that the Trust ensure they have a functioning, failsafe, and effective referral system for gestational diabetes melitus (GDM) screening, so that mothers with gestational diabetes are identified and receive timely care from the obstetric diabetes service.
It is recommended that the Trust ensures all staff providing feeding support to mothers, including 'bank staff', have completed the required infant feeding training before supporting mothers with feeding.
It is recommended that the Trust ensures reliable neonatal oxygen saturation monitoring equipment is available in all areas providing neonatal care.
It is recommended that the Trust ensures that the obstetric consultant is an integral member of the labour ward multi-disciplinary team, role modelling leadership and behaviours expected in line with national standards (Royal College of Obstetricians and Gynaecologists, 2021).
It is recommended that the Trust ensures that there is a single, dedicated triage system available for all maternity calls 24/7, to fully assess and make ongoing care decisions, for all mothers, in line with national guidance (RCOG, 2023).
It is recommended that the Trust ensures there is clear shared responsibility between the midwifery and obstetric teams in providing care of a mother when the birth of the baby is required due to a pathological cardiotocograph (CTG).
It is recommended that the Trust explore strategies to provide adequate midwifery staffing to ensure mothers undergoing induction of labour (IOL) on the antenatal ward receive safe care.
It is recommended that the Trust explores and addresses any barriers to escalation so that all members of the multidisciplinary team are empowered to call for assistance when this is felt to be needed.
It is recommended that the Trust explores solutions that allow healthcare systems to be accessed from different departments and enables various methods of documentation to support communication about a mother's care.
It is recommended that the Trust explores the barriers to achieving an obstetric review before proceeding with an induction of labour. This is to ensure that medication is prescribed by an obstetrician, and that an appropriate and individualised care plan is in place which meets the needs of the mother and the baby.
It is recommended that the Trust has a process that enables the team leader to maintain a 'hands-off' approach, to ensure post-resuscitation care is provided in line with national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust has a robust process for the monitoring and maintenance of babies' temperature particularly during skin-to-skin contact post birth when staff are focused on other aspects of care.
It is recommended that the Trust has a robust process in place to facilitate the escalation of concerns when medical help is advised and is not
It is recommended that the Trust has a robust process in place to prompt a senior clinical review and discussion, where a plan of care is not accepted and there is significant risk of disease development.
It is recommended that the Trust has formal pathways that include the requirement for the obstetric team to be informed whenever a mother receives care for a medical concern outside of maternity services.
It is recommended that the Trust has guidance to support staff providing intrapartum care at home beyond 42 weeks of pregnancy. This should include the need for a face to face holistic assessment when the latent phase of labour is suspected.
It is recommended that the Trust have a robust escalation pathway for induction of labour delays to ensure oversight from the senior maternity team, this includes the prioritisation of mothers awaiting artificial rupture of membranes.
It is recommended that the Trust have a system used within triage, to prompt if fetal movements are not confirmed as normal, that the mother needs to be invited in for assessment to ensure the baby's wellbeing.
It is recommended that the Trust have processes for all relevant information to be shared, in a mother's first language and all mothers are able to give an account of their wellbeing and concerns in their first language without the reliance on using family members for interpretation. This to include guidance for staff with alternate options when an interpreter is not possible through the current interpreter service to reduce reliance on family
It is recommended that the Trust identify an achievable, effective system to ensure mothers are offered post-dates labour inductions from 41+0 weeks.
It is recommended that the Trust identify an achievable, effective system to ensure mothers are offered post-dates labour inductions from 41+0 weeks.
It is recommended that the Trust identify barriers that may prevent timely diagnosis of established labour and subsequent fetal monitoring.
It is recommended that the Trust identify the barriers within their triage unit that prevent Birmingham Symptom Specific Obstetric Triage System (BSOTS) from working effectively, to enable them to achieve the required initial assessment within 15 minutes of arrival.
It is recommended that the Trust implement consultant postnatal ward rounds to ensure senior oversight of unwell postnatal mothers.
It is recommended that the Trust implement the radiology department's Standard Operating Procedure for Obstetric Ultrasound Examinations, in order to provide consistent guidance for all staff undertaking obstetric ultrasounds in the Trust.
It is recommended that the Trust implements dietician led sessions that are accessible for women who do not speak English.
It is recommended that the Trust include cardiotocograph (CTG) categorisation as part of risk assessments in line with local guidance until the birth of the baby. This will support oversight, recognition and consideration of fetal wellbeing when counselling mothers on mode of birth.
It is recommended that the Trust introduce a process which identifies when a telephone system is not working and a contingency plan for how this is managed so mothers are able to contact the triage line at all times.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust promote the practice of activation of the emergency buzzer during a suspected bradycardia or ongoing loss of contact of the baby's heart rate to alert the multidisciplinary team to the potential obstetric emergency.
It is recommended that the Trust provide equipment identified in national guidance for the accurate monitoring of a fetal heart rate when undertaking intermittent auscultation.
It is recommended that the Trust provide mothers whose first language is not English with written information about the importance of reduced fetal movements in the mothers preferred language, to support their understanding of when to seek help.
It is recommended that the Trust provide non-English-speaking mothers with access to a variety of high quality, formal interpreting services, tailored to their needs. This will promote effective communication and support informed maternal choice. Effective interpreting services require reliable equipment, clear procedures, and regular staff training.
It is recommended that the Trust provide rectal probes to allow continual monitoring of the temperature of babies that are being passively cooled, in line with national guidance (British Association of Perinatal Medicine's (BAPM 2020)).
It is recommended that the Trust provides a clear and consistent system of documenting individualised plans of care within their assessments for place of birth, which would take account of when there is a change in the assessment of risk. This will allow staff to make sure that mothers are directed to the safest place for them to birth on their arrival to the maternity unit.
It is recommended that the Trust provides a single, dedicated triage system available for all maternity calls and attendances 24/7, to fully assess and make ongoing care decisions, for all mothers, in line with national guidance.
It is recommended that the Trust provides clear aligned guidance to allow staff to manage hypertension in pregnancy in line with national (National Institute for Health and Care Excellence (NICE), 2023) guidance.
It is recommended that the Trust provides clear and consistent guidance regarding when a symphysis fundal height measurement is required, including at the first labour assessment to support risk assessment at the onset of labour.
It is recommended that the Trust provides clear information to all mothers in their own language, on which department to telephone with concerns around a mother or baby's wellbeing, to enable a robust telephone clinical assessment to occur.
It is recommended that the Trust provides consistent information relating to the risks of prolonged pregnancy beyond 41 weeks to all mothers, to allow them the opportunity to request an earlier induction of labour in line with national guidance.
It is recommended that the Trust provides consistent information relating to the risks of prolonged pregnancy beyond 41 weeks to all mothers, to allow them the opportunity to request an earlier induction of labour in line with national guidance.
It is recommended that the Trust provides decision making tools to mothers offered antihypertensive medication in pregnancy to ensure that they are informed of the side effects and the risk of hypoglycaemia in the neonate.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust provides maternity service clinicians with automated digital blood pressure monitors in all settings, as recommended by NHS England (2023).
It is recommended that the Trust provides mothers with the full range of options, when their baby is large for gestational age, in order to make an informed decision.
It is recommended that the Trust provides sufficient equipment to ensure all mothers pulses can be monitored during a cardiotocograph (CTG) recording so that differentiation between a mothers and baby's heart rate is possible.
It is recommended that the Trust raises awareness, so staff recognise the need to escalate a cardiotocograph (CTG) when there is loss of contact to ensure the wellbeing of the mother and the baby.
It is recommended that the Trust recognises the risk and supports the department in providing a single, dedicated triage system available for all maternity calls and attendances 24/7, to fully assess and make ongoing care decisions, for all mothers, in line with national guidance (RCOG, 2023).
It is recommended that the Trust review and update the induction of labour guidance to support safe use of prostaglandins pessaries, in line with manufacturers guidance. This will support staff to facilitate individualised care planning and ensuring removal occurs when indicated.
It is recommended that the Trust review existing workforce plans to support senior midwifery clinicians to be supernumerary on delivery suite in order to enable them to maintain a 'helicopter view' and oversight at all times.
It is recommended that the Trust review how ultrasound images are stored to ensure that practice is in line with the radiology department's Standard Operating Procedure for Obstetric Ultrasound Examinations, to comply with information governance.
It is recommended that the Trust review labour ward obstetric staffing to comply with national guidance.
It is recommended that the Trust review local education packages to include learning about categorisation of antenatal cardiotocographs (CTGs). This is needed to support recognition of an abnormal antenatal CTG and consideration for earlier birth.
It is recommended that the Trust review local fetal monitoring guidance in light of the national requirement for an in-person obstetric review when evolving clinical concern is identified. This would facilitate clinical oversight and support assessment of maternal and fetal wellbeing.
It is recommended that the Trust review local guidance in light of the national requirement for an in person obstetric review for all mothers on the labour ward. This would facilitate clinical oversight and support assessment of maternal and fetal wellbeing.
It is recommended that the Trust review practice and guidance to facilitate individualised and ongoing assessment for mothers admitted in the latent phase of labour, to ensure care is being provided in the correct location, with support for escalation if transfer of location is needed.
It is recommended that the Trust review practice and training in order to support discussions with parents that promotes optimal baby airway positioning in the immediate post birth period.
It is recommended that the Trust review practice and training in order to support skin to skin contact that allows optimal thermoregulation and the transition in the immediate post birth period.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust review processes to support staff to escalate a request for an obstetric review when meconium-stained liquor is
It is recommended that the Trust review the accessibility for staff to obtain the required equipment to perform an episiotomy when indicated to expedite a baby's birth.
It is recommended that the Trust review the digital operating system within the community setting, including the internet availability, to ensure members of the community midwifery team can view a mothers up to date electronic maternity health record at all times.
It is recommended that the Trust review the environment and equipment available for neonatal resuscitation, to ensure ready access at all times when a baby is born, so not to delay or compromise any aspects of neonatal resuscitation.
It is recommended that the Trust review the local process of fetal growth measurements and Doppler studies to ensure that they are measured and recorded three times in line with national guidance (British Medical Ultrasound Society (BMUS) 2022) and give consistent and reproducible results.
It is recommended that the Trust review the midwifery and obstetric staffing within the triage department to ensure the timely and robust assessment of mothers who are admitted.
It is recommended that the Trust review the midwifery staffing model and escalation guidance within the triage unit in order to achieve safe care and to prevent mothers being placed at significant risk.
It is recommended that the Trust review the policy and processes within the prolonged rupture of membranes guidance for when neonatal observations are undertaken, to ensure that there is unambiguous language and clear expectations for the use of pulse oximetry to assess central cyanosis and skin perfusion. This would support staff to perform these observations regularly and ensure that this becomes embedded into routine practice.
It is recommended that the Trust review the process for escalating raised blood pressure during labour to ensure a timely obstetric review occurs and antihypertensive medication is given, if indicated.
It is recommended that the Trust review the process of cardiotocograph (CTG) categorisation in order to support staff to recognise a pathological CTG. This would support clinicians to assess and respond to fetal wellbeing concerns.
It is recommended that the Trust review the process of providing safety netting to mothers who attend triage, with particular focus on communicating with mothers who have language barriers to ensure understanding. This will support the ability of mothers to access care when needed.
It is recommended that the Trust review the processes and training that exist so that clinicians are equipped with the information and skillset to perform intermittent auscultation in line with local and national guidance.
It is recommended that the Trust review the processes and training that exist so that clinicians are equipped with the information and skillset to perform maternal observations in line with local and national guidance.
It is recommended that the Trust review the service provision and capacity in the young parents team to enable mothers who fulfil this criteria to receive specialist care and support.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust review the systems and processes for telephone triage, ensuring staff are able to take an account of a mother's clinical history and current clinical symptoms using comprehensive tools, to inform identifying the need for a face to face assessment.
It is recommended that the Trust review their escalation tools to support staff to clearly communicate concerns and what they need, to make patient care safer.
It is recommended that the Trust review their guidance and current unit practice on location of assessment when a mother attends in possible labour, to ensure care given is consistent with that expected.
It is recommended that the Trust review their guidance and process for when there are concerns with a baby's appearance, clinicians use an assessment tool (such as Newborn Early Warning Track and Trigger Tool 2) to document their findings and escalate where required. This would support clinicians to perform a clinical assessment and observations to facilitate a thorough assessment of a newborn.
It is recommended that the Trust review their guidance to ensure staff are supported to consider the possibility that labour has started in the presence of contractions. This should be consistent with fetal monitoring and risk assessment guidance.
It is recommended that the Trust review their homebirth service to provide mothers with timely midwifery care when they labour at home.
It is recommended that the Trust review their intrapartum, fetal monitoring and oxytocin in labour guidelines to ensure they reflect national guidance on contraction frequency. This is to support maternity staff to recognise and take action when frequency of contractions is higher than the recommended number and ensure the correct categorisation of a cardiotocograph occurs.
It is recommended that the Trust review their process for delivering therapeutic hypothermia, with a focus on clear guidance and an effective, ongoing training programme for staff. This can promote safe and efficient equipment use when monitoring and controlling babies' temperatures, with avoidance of potential adverse effects.
It is recommended that the Trust review their processes of referral, when a mother in the community presents with a maternal medical disorder, in order to provide senior obstetric oversight and a personalised care plan.
It is recommended that the Trust review their processes to ensure that relevant information from previous pregnancies, including any birth complications, is recorded on a mother's birth summary. Where a mother has a previous birth at the Trust, the documentation is accessed at the booking appointment and discussed with the mother in the presence of an interpreter where necessary, to support pregnancy and birth planning.
It is recommended that the Trust review their processes to maintain sufficient staffing in clinical areas so that all mothers receive care at the right time, in the appropriate clinical area, and from staff with the necessary skills and / or supervision. This is needed to ensure holistic assessments take place, including confirmation of fetal wellbeing.
It is recommended that the Trust review their systems and processes with regards to the booking and attendance at routine midwifery antenatal follow up to provide a schedule of antenatal care in line with national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust review their telephone triage system to ensure clinicians giving advice are supported to be able to recognise any prior risk factors, calls and attendances during a mother's pregnancy
It is recommended that the Trust review their telephone triage system, and the staffing structure to support this, to allow a thorough and timely clinical risk assessment, to inform care planning when a mother telephones maternity triage.
It is recommended that the Trust reviews and addresses staff understanding and implementation of guidance for intermittent auscultation and what action to take if unable to follow guidance. The findings from this should be used to ensure that birth centre staff can communicate concerns clearly and escalation can happen at the earliest opportunity.
It is recommended that the Trust reviews and addresses the barriers to ensuring that rapid escalation and action takes place when a baby's heart rate cannot be clearly determined. The findings from this should be used to ensure that multi-disciplinary clinical staff clearly communicate clinical information when faced with issues that require urgent attention to agree and expedite a shared plan of action.
It is recommended that the Trust reviews and brings its local maternity obstetric haemorrhage guidance in line with national guidance. This updated guidance needs to be embedded in practice.
It is recommended that the Trust reviews and embeds their local guidance to have paediatric attendance at a birth when there are concerns about meconium and /or other concerns about fetal wellbeing.
It is recommended that the Trust reviews clinical guidance and telephone assessment tools to support staff, so that mothers who telephone to report vaginal bleeding at any stage of pregnancy are advised to go into the maternity unit for in-person clinical assessment of maternal and fetal wellbeing.
It is recommended that the Trust reviews current systems in place to support clinicians to recognise and act upon ongoing concerns with fetal wellbeing as evidenced with an abnormal cardiotocograph (CTG following transfer to labour ward).
It is recommended that the Trust reviews current training to ensure staff expecting to do resuscitation have undergone newborn resuscitation training including how to communicate in an emergency.
It is recommended that the Trust reviews how clinical information is conveyed amongst clinicians between handovers with consideration of formal handover tools in order to support effective communication during clinical care.
It is recommended that the Trust reviews how intermittent auscultation of a baby's heartbeat in labour is done in practice (work as done), to ensure accurate, contemporaneous documentation in line with national guidance (work as prescribed).
It is recommended that the Trust reviews how mothers are provided with information in relation to the increased risks of a prolonged pregnancy to provide informed choice in line with national guidance.
It is recommended that the Trust reviews how the care of a pregnant mother with complex risk factors is coordinated. Clear leadership of all health professionals who need to be involved will help to provide a holistic package of care.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust reviews how the specific communication needs of mothers are recorded within the electronic records system. This is so that all staff can easily access essential information about a mother and how that might impact on the care being provided.
It is recommended that the Trust reviews how they can provide timely results of critical blood clotting tests in the management of obstetric
It is recommended that the Trust reviews its capacity to support mothers whose birth preference is a caesarean birth, in line with national guidance, so that they can be carried out at a time that is safe for the mother and her baby.
It is recommended that the Trust reviews its fetal monitoring guideline to clarify the need for proactive planning in cases where challenges are anticipated, such as raised maternal Body mass Index (BMI).
It is recommended that the Trust reviews its guidance so that staff escalate a single, acute deceleration of more than 60 seconds during intermittent auscultation immediately.
It is recommended that the Trust reviews its process for all mothers who have had a caesarean birth, to support timely and meaningful conversations about their birth preferences, taking into account individual risk factors and circumstances to ensure the mother's choices are central to the decision making process.
It is recommended that the Trust reviews its process for assessing reduced fetal movements after 38+6 weeks to ensure that guidance and chosen triage tools are embedded into practice.
It is recommended that the Trust reviews processes, to ensure that equipment required for use in an in an emergency, is available at all times, it is portable and all staff know where to find this equipment.
It is recommended that the Trust reviews staff training, understanding and practice regarding the assessment of a baby's growth. This will help to reduce inconsistencies by clinicians in the recognition and management of large for gestational age babies and appropriate referral for ultrasound scan in line with local and national guidance.
It is recommended that the Trust reviews the barriers to staff using the emergency escalation system when there are difficulties in locating a baby's heart rate to enable an immediate multidisciplinary response.
It is recommended that the Trust reviews the community midwifery on call system and surrounding processes, to minimise the impact of fatigue for clinicians when providing care overnight.
It is recommended that the Trust reviews the effectiveness of handovers to ensure all members of the multidisciplinary team have a shared mental model for the plan of care for mothers in labour to minimise the chance of misunderstandings.
It is recommended that the Trust reviews the existing tools in place to support staff when determining whether a baby is 'fit for labour'. This is to support holistic assessment of the clinical picture and a corresponding plan of care.
It is recommended that the Trust reviews the operating theatre capacity to ensure that there is capacity for category 3 and 4 caesarean births so that a mothers planned caesarean birth is not rescheduled.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust reviews the practice for clinical assessment when mothers experience XX during pregnancy to bring practice in line with local and national guidance. This will mean that all mothers receive obstetric clinical assessment when they have vaginal bleeding during
It is recommended that the Trust reviews the process and provides equipment, to help clinicians to check bilirubin levels of babies, in all areas of care in the neonatal period. This should include non-invasive methods that do not require a blood sample.
It is recommended that the Trust reviews the process for the ordering and preparation of intravenous immunoglobulin to ensure it is prepared in a timely manner and available for treatment when needed.
It is recommended that the Trust reviews the process when mothers attend the maternity day assessment unit, to support prompt recognition of an attendance and allow clinical care to be given in an expected timeframe.
It is recommended that the Trust reviews the systems used by staff during periods of increased acuity, to ensure that staff providing clinical care are able to maintain clinical oversight and can act when the need for obstetric review is required.
It is recommended that the Trust reviews the telephone triage risk assessment tool to assist staff to determine the safest plan of care for mothers.
It is recommended that the Trust reviews their establishment for the diabetes team, to ensure there are sufficient appointments to facilitate the demand in the joint diabetic clinic and for mothers to be monitored on an ongoing basis.
It is recommended that the Trust reviews their guidance to support clinicians in providing responsive, individualised care during induction of labour by combining parental concerns, clinical observations, and professional expertise to prompt holistic assessment and timely transfer to the labour ward.
It is recommended that the Trust staff maternity triage to maintain safety, in line with national recommendations, so women who attend can be seen within 15 minutes of arrival and those with the highest clinical need are identified.
It is recommended that the Trust staffs the maternity triage unit to maintain safety, in line with local and national recommendations, so women who attend have an initial assessment within 15 minutes of arrival which includes a fetal heart rate assessment, and those with the highest clinical need are
It is recommended that the Trust strengthens the communication pathway between maternity unit bleep holders, midwives providing home birth care and the labour ward team. This is to strengthen communication and support multidisciplinary oversight of care being provided to mothers in labour at
It is recommended that the Trust support all staff to escalate when there are challenges completing fresh eyes reviews in line with local and national guidance.
It is recommended that the Trust support clinicians to differentiate a baby's heart rate from a mother's heart rate during labour ensuring accurate recording of the baby's heart rate and confirm wellbeing.
It is recommended that the Trust support clinicians to use one unified approach for cardiotocograph (CTG) interpretation to reduce variation in CTG categorisation and subsequent management.
It is recommended that the Trust support review of antenatal cardiotocographs (CTGs) to facilitate decision making, clinical planning and escalation when there is an abnormal CTG.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust support staff to accurately assess a mother's ability to understand and communicate in English in line with local guidance from the time of her booking appointment when English is not her first language. If communication needs are identified, an individualised plan is required, revisited throughout her maternity care and documented in her electronic records.
It is recommended that the Trust support staff to ensure that a mother receives a holistic obstetric review prior to her being given terbutaline.
It is recommended that the Trust support staff to ensure that priority is always given to securing a safe airway to enable effective oxygenation before progressing to obtaining central access, in line with national resuscitation guidance.
It is recommended that the Trust support staff to escalate concerns immediately using the emergency call bell when a fetal bradycardia is identified.
It is recommended that the Trust support staff to escalate for obstetric review when there is blood-stained liquor to plan further care.
It is recommended that the Trust support staff to maintain and store contemporaneous documentation in line with professional standards.
It is recommended that the Trust support staff to monitor babies in line with national guidance on fetal monitoring when multiple risk factors are
It is recommended that the Trust support staff to prioritise the need for continuous electronic fetal monitoring where indicated and if barriers to this happening occur, prompt escalation to the obstetric team takes place to maintain oversight of fetal wellbeing throughout labour.
It is recommended that The Trust support staff to recognise when interpretation services are required to allow full communication with families when English is not their first language throughout the maternity pathway.
It is recommended that the Trust support staff to refer mothers with large for gestational age babies to an obstetrician, so that the implications of a large baby and options for birth, can be discussed in the absence of national guidance.
It is recommended that the Trust support staff to understand, implement, record and audit the need for escalation when there is a delay in providing labour care and fetal monitoring to mothers in an appropriate setting.
It is recommended that the Trust support staff to undertake a holistic review to identify and use developing risk factors during labour to inform the correct method of fetal monitoring required.
It is recommended that the Trust support staff to undertake an appropriate assessment of a baby when concerns about wellbeing are raised to enable the correct pathway of care to be determined.
It is recommended that the Trust support staff to use available methods of escalation to enable urgent support whilst continuing to listen to a baby's heart rate following a deceleration.
It is recommended that the Trust support staff to use the emergency buzzer to alert members of the multidisciplinary team to all obstetric emergencies.
It is recommended that the Trust support telephone triage staff to use a consistent questioning approach, to enable consideration of the full clinical picture and identification of risks; and ensure that appropriate escalation and safety netting advice is given.
It is recommended that the Trust support the multidisciplinary team to work together when staff cannot be reassured of a baby's wellbeing when a cardiotocograph (CTG) is started. This is an indication for a lower threshold for early intervention.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust support the recognition and categorisation of an abnormal cardiotocograph to inform onward care.
It is recommended that the Trust supports a process to maintain clinical oversight of mothers waiting for elective caesarean birth when the allocated clinician leaves to support mothers in the operating theatre.
It is recommended that the Trust supports and encourages staff to report and escalate using an acuity tool validated for maternity settings. This is required to enable a culture where staff feel confident to voice concerns and assured that their concerns will be listened to and acted upon. Using these data, minimum staffing levels are to be agreed with the local maternity and neonatal system (LMNS) in line with national guidance (Ockenden, 2022), and implemented.
It is recommended that the Trust supports clinicians to complete a full systematic review of a cardiotocograph (CTG) at the bedside, during peer reviews, and document the findings on the electronic trace and in the electronic maternity records ensuring that the documentation is signed, dated and timed in line with local guidance.
It is recommended that the Trust supports clinicians to complete a full systematic review of a cardiotocograph (CTG) at the bedside, ensuring all the features are taken into account. This will support recognition and escalation of ongoing concerns and support structured communication.
It is recommended that the Trust supports clinicians to complete a holistic assessment and identify any maternal and fetal risks at each encounter so that the correct review and escalations are carried out. (This recommendation has been made three times in sections 4.3, 4.5 and 4.7)
It is recommended that the Trust supports clinicians to document all medical information clearly and accurately at the time or as close as possible to the time care was given.
It is recommended that the Trust supports clinicians to facilitate timely obstetric reviews during the induction of labour pathway and to discuss relevant options of care to the mother when indicated in line with national guidance.
It is recommended that the Trust supports community staff to review a mother's birth preference when the symphysis fundal height measurement is plotting on or above the 97th centile on a customised growth chart. This supports the mother in exploring any concerns they may have and further supports safe planning care.
It is recommended that the Trust supports improved capacity and pathways for referral of women/young people who have multiple vulnerabilities.
It is recommended that the Trust supports mothers in vaginal birth after caesarean birth labour to receive a face-to-face obstetric review and discussion prior to the use of oxytocin to ensure informed consent for this intervention.
It is recommended that the Trust supports obstetric decision making around the categorisation of a cardiotocograph (CTG) and the urgency of birth based upon a mother's holistic clinical picture in order to reduce any delays in birth and reducing the risk of neonatal hypoxia.
It is recommended that the Trust supports staff to attend the local blood gas analyser training session to ensure up to date knowledge and accurate use of the equipment.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust supports staff to carry out regular and repeated holistic assessments of a mother's cumulative risk factors to inform decision making and the timing of birth, to reduce the chance of uterine rupture in women aiming for a vaginal birth after caesarean birth.
It is recommended that the Trust supports staff to correctly categorise and escalate concerns regarding cardiotocographs (CTGs).
It is recommended that the Trust supports staff to ensure that immediate escalation is made for any mother that presents with any signs of placental abruption, including constant pain; in order that they receive immediate holistic obstetric review to achieve timely recognition, decision making and to reduce any risk of a baby developing hypoxia.
It is recommended that the Trust supports staff to facilitate mode of birth discussions with mothers to ensure that they are aware of their risks and benefits to enable them to make an informed choice.
It is recommended that the Trust supports staff to recognise and document 'pink' amniotic fluid in labour is documented as blood-stained amniotic fluid, and transfer to obstetric led care is arranged.
It is recommended that the Trust supports staff to recognise and send a placenta for examination when it meets national guidance criteria.
It is recommended that the Trust supports staff to recognise that when a fetal heart cannot be heard this is an obstetric emergency and requires the use of an emergency buzzer to request the immediate attendance of senior staff. This is recommended in Trust and national guidance.
It is recommended that the Trust supports staff to take required action following a referral to the maternity triage unit when an ultrasound scan demonstrates slow or static growth.
It is recommended that the Trust supports staff to undertake a complete physical examination of a baby where it has been escalated the baby is jittery to enable a full assessment of their wellbeing.
It is recommended that the Trust supports staff to undertake contemporaneous record keeping to aid communication and handover of risk factors.
It is recommended that the Trust supports staff to undertake intermittent auscultation in the second stage of labour in line with National Institute for Health and Care Excellence (NICE) guidance and escalate concerns in a timely manner, to ensure a baby's wellbeing is confirmed.
It is recommended that the Trust supports staff who are providing intrapartum care at home following emergency algorithms when a postpartum haemorrhage is first identified or when signs of shock are present.
It is recommended that the Trust supports staff with guidance and training to recognise poor quality cardiotocograph recordings and the action to be
It is recommended that the Trust supports the staffing of the maternity diabetes team to allow review of all the blood sugar alerts in the app in a timely manner to identify if any changes to care are required.
It is recommended that the Trust supports the use of available feeding assessment tools to enable parents and staff to monitor the frequency and effectiveness of babies' feeds.
It is recommended that the Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (Evans et al 2022).

Maternity safety recommendations
1 April 2024 to 31 March 2025



<p>It is recommended that the Trust to review the documentation of growth ultrasound reports to ensure that:</p> <ol style="list-style-type: none"> 1. All fetal growth measurements are documented on the ultrasound population charts (Chitty et al., 1994). 2. The content of the growth ultrasound reports complies with the Trusts Standard Operating Procedure for Obstetric Ultrasound Examinations. 3. Doppler ultrasound studies and Umbilical artery Doppler flow are reported and documented in line with national guidance (British Medical Ultrasound Society (BMUS) 2022).
<p>It is recommended that the Trust to review the maternity triage service, to include a review of triage telephone calls, and the criteria of triage</p>
<p>It is recommended that the Trust update its induction of labour guidance to reflect the manufactures recommendation on actions to be taken by staff, when mothers are regularly contracting and a prostaglandin pessary is in situ. This is to support prompt removal of the prostaglandin pessary when</p>
<p>It is recommended that the Trust update their guidance and training supports all staff, to reflect that when undertaking the skin colour assessment element of the Apgar score for babies to include:</p> <ul style="list-style-type: none"> - assess central oxygenation by looking inside the mouth at the mucous membranes and tongue - assess peripheral oxygenation by looking at the colour of the nail beds.
<p>It is recommended that the Trust update their guidance in relation to blood-stained liquor to reflect national guidance so that mothers receive the correct pathway of care.</p>
<p>It is recommended that the Trust updates local guidance for diabetes in pregnancy to ensure it is in line with national guidance (regarding all mothers with gestational diabetes being offered routine serial growth ultrasound scans). This is to ensure that guidance supports safe fetal surveillance for mothers with gestational diabetes.</p>
<p>It is recommended that the Trust updates their local jaundice guidance in line with national guidance to ensure babies who are being treated with phototherapy have their hydration monitored.</p>
<p>It is recommended that the Trust work with clinicians to develop a process which support clinicians to adhere to Trust and national guidance, ensuring placentas are sent for pathological and histological examination.</p>
<p>It is recommended that the Trust work with staff to support them to feel able to escalate when an agreed process is not available, and to explore the barriers to not escalating when this occurs.</p>
<p>It is recommended that the Trust works with clinicians to develop a process which support clinicians to adhere to Trust and national guidance, ensuring placentas are sent for pathological and histological examination.</p>
<p>It is recommended that the Trust works with clinicians to review and address the barriers to asking for an obstetric review when clinically required as stated in local guidance.</p>
<p>It is recommended that the Trust works with clinicians to review and address the barriers to completing cardiotocograph reviews to ensure the wellbeing of the baby. The findings should inform the development, implementation and evaluation of an action plan as required.</p>

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that the Trust works with clinicians to review and address the barriers to ensuring that rapid escalation takes place when a baby's heart rate cannot be clearly determined. This is so that concerns with a baby's heart rate can be quickly acted on. The findings should inform the development, implementation and evaluation of an action plan as required.
It is recommended that the Trust works with staff to promote the use of a structured communication with mothers so there is clear understanding of the expected timeframe for them to attend triage when absent fetal movements are reported.
It is recommended that the Trust works with staff to support them to feel able to escalate, and to explore the barriers to not escalating when this occurs, so that staff feel able to report important safety issues at all times and feel confident of a response.
It is recommended that the Trust's guidance for induction of labour is in line with national guidance, to reduce the risks associated with prolonged pregnancy.
It is recommended that the Trust's maternity guidance on low molecular heparin dosing is in line with national guidance and requires the involvement of the obstetric team.
It is recommended that the Trusts response to abnormal maternal observations/bedside tests include an obstetric review to assess both maternal and fetal wellbeing.
It is recommended that the Trusts review the operations to support telephone triage provision to ensure that the telephone is always answered to enable families to access advice 24 hours a day.
It is recommended that there is a robust process in place to enable all telephone calls that are made to the maternity triage unit to be accurately documented along with an expected time for a mother's arrival. To ensure there is a contemporaneous record of advice given.
It is recommended that there is a robust system for the sharing of patient information, including the storing and retention of medical records.
It is recommended that there is collaboration between the local hospital, regional maternal medicine centre, and tertiary hospitals, to identify local and regional pathways of care for pregnant or postnatal mothers who have complex needs and live [remotely]. This should include multidisciplinary care and account for the services that cannot be provided by [a remote] hospital.
It is recommended that there is collaboration between the local hospital, regional maternal medicine centre, and tertiary hospitals, to identify local and regional pathways of care for pregnant or postnatal mothers who have complex needs and live [remotely]. This should include multidisciplinary care and account for the services that cannot be provided by a [remote] hospital.
It is recommended that trainee midwifery clinicians are allocated to practice supervisors who are considered to have met the national standards for supervision and assessment.
It is recommended that Trust A ensure that mothers undergoing testing for a possible medical condition, receive an obstetric assessment to decide if any alteration in pregnancy care is required.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that Trust B develops a mechanism that allows staff from different departments in the hospital to access all the electronic health record systems at the Trust. This will enable relevant information to be reviewed and shared in a timely way, to support and maintain the multidisciplinary oversight of a mother's care.
It is recommended that Trust B enables critically ill mothers to receive enhanced care as soon as it is required, in line with national guidance (Royal College of Anaesthetists (RCoA), 2018).
It is recommended that Trust B ensures that a personalised care plan is documented on admission and regularly reviewed during a period of inpatient care, informed by input from the multidisciplinary team.
It is recommended that Trust B ensures wider diagnoses beyond common symptoms in pregnancy are considered when a pregnant woman is unwell, so that she is admitted to the clinical area that meets her primary clinical need and the required care pathway is commenced.
It is recommended that Trust B implements a process to facilitate the allocation of a named obstetric consultant for mothers admitted to the hospital, who are not yet booked at the Trust, to support daily oversight of their care plan.
It is recommended that Trust B review and develop the service for young mothers to ensure that their individual needs are met and that they are prepared for their birth and start of their parenting journey in line with national recommendations (National Institute for Health and Care Excellence (NICE), 2010, Public health England (2019)).
It is recommended that Trust B review and embed a process for mothers who transfer care in late pregnancy to ensure that their individual needs are met and that they are prepared for their birth and start of their parenting journey.
It is recommended that Trust B review and revise storage of cardiotocograph (CTG) recordings to ensure they are stored securely so that a review of all care is possible.
It is recommended that Trust B review the use, monitoring and ability to share information from the digital mobile application system to ensure that blood pressure monitoring is robust and safe, in order to ensure the correct pathway of care.
It is recommended that Trust B works with their electronic systems provider to consider how growth measurements are automatically viewed.
It is recommended that Trust guidance aligns with national guidance so that the identification of an antepartum haemorrhage in labour is recognised as a risk factor and triggers an obstetric review.
It is recommended that Trust guidelines align and are clear on the required actions when mothers plan a birth which deviates from guidance, to support safe planning of care.
It is recommended that Trusts A and B develop guidance and a system of clinical information sharing to ensure safe oversight of care of mothers who receive joint care by both Trusts.
It is recommended that Trusts A and B develop guidance and a system of clinical information sharing to ensure safe oversight of care of mothers who receive joint care by both Trusts.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended that Trusts work together to develop a regional framework for in-utero transfers that supports a consistent approach, to agree safe criteria for transfer and effective sharing of information to support continuity of care.
It is recommended that Trusts work together to develop a regional framework for in-utero transfers that supports a consistent approach, to agree safe criteria for transfer and effective sharing of information to support continuity of care.
It is recommended that when a mother has either a raised systolic or diastolic blood pressure measurement, this is recognised as hypertension and managed in line with guidance, including growth ultrasound scans.
It is recommended that when a mother reports abdominal pain/uterine activity requiring regular pain relief cardiotocograph monitoring is performed assess a baby's wellbeing.
It is recommended that when a mother reports an elevated blood pressure taken using a home blood pressure monitoring device she is invited into the unit for review without delay.
It is recommended that when a multidisciplinary review of abnormal day assessment unit test results takes place, a holistic assessment, reflective of all available clinical and laboratory information informs the time and location of subsequent care, supported by a digital record of the care planning
It is recommended that when guidance is updated and ratified the Trust reviews all associated guidance to ensure that relevant changes are reflected across all related policies. This would support consistent decision making in line with guidance.
It is recommended that when mothers contact the maternity triage unit, prior to logging the telephone call, staff review all relevant risks and previous admissions so that an ongoing risk assessment and management plan can be made.
It is recommended that when mothers with complex needs (learning support, mental health) are given difficult news during pregnancy, that extra support is provided to ensure the ongoing safety and wellbeing of both the mother and her baby.
It is recommended that when obstetric advice or plans are made by telephone this is followed up with an in-person obstetric review, and on-going treatment and care plans are documented and communicated amongst staff, for all women who present with symptoms of hypertension in pregnancy.
It is recommended that when performing neonatal resuscitation, all observations are reviewed and actioned in accordance with local and national guidelines and recommendations.
It is recommended the Trust actively seeks information from the multidisciplinary team about their experience of escalation and confidence in escalating concerns. The findings should inform the development, implementation and evaluation of an action plan.
It is recommended the Trust amends and embeds their local fetal monitoring guidance to align with the approach taught during training.
It is recommended the Trust ensure face to face holistic reviews, taking into consideration both maternal and fetal features, are undertaken when there is clinical suspicious of chorioamnionitis. This will ensure there is oversight, recognition and consideration for expediting birth.
It is recommended the Trust ensure placentas are sent for pathological examination including histology in line with national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



It is recommended the Trust identify and address the barriers of carrying out intermittent auscultation in a home birth setting, in line with guidance. This will support the Trust in developing, implementing and evaluating an action plan as required.
It is recommended the Trust identify and address the barriers to providing individualised assessments and responding to evolving clinical concerns during induction of labour. This will support staff to listen to the mother's needs and enable wellbeing assessments to be completed to inform ongoing care in line with guidance.
It is recommended the Trust identify and address the barriers to providing individualised assessments. This will support staff to listen to the mother's needs and enable wellbeing assessments to be completed to inform ongoing care in line with guidance.
It is recommended the Trust identify any barriers and support staff to escalate all blood stained loss, to include an obstetric review and continuous fetal monitoring, taking into account the mother's story, clinical picture, and pregnancy history.
It is recommended the Trust implements a communication system to categorise assisted births to support a shared understanding of the urgency amongst the multidisciplinary team.
It is recommended the Trust review the inconsistencies of care around the decision for induction of labour and reduced fetal movements, in accordance with national guidance in order to standardise and offer safe care, when a mother presents with reduced fetal movements at term.
It is recommended the Trust review the information that is shared with mothers when induction of labour is offered. This should include the timing of and risks and benefits of induction of labour. This will ensure mothers are supported to make informed decisions.
It is recommended the Trust review the process, so all women admitted for induction of labour, require a full clinical review before starting the induction and are seen daily on the consultant ward round as recommended by the National Institute for Health and Care Excellence (NICE) (2021) and the Ockenden Report (2022).
It is recommended the Trust review the processes for the suspension of the homebirth service to ensure effective communication to service users and clinicians.
It is recommended the Trust reviews the current neonatal airway management training and develops local neonatal guidance on difficult airway management, with reference to the British Association of Perinatal Medicine's (BAPM) framework for airway safety and managing the difficult neonatal airway.
It is recommended the Trust reviews the process to support a mother to have a repeat laboratory urine sample taken within 14 days of finishing oral antibiotics for a urine infection. This may include automatic scheduling of appointments and training.
It is recommended the Trust reviews the ways in which maternal observations are completed and documented in a home birth setting, with the aim of understanding if current systems support the identification of deviation from the expected ranges and the response required.

It is recommended the Trust reviews the workload, staffing and digital operating systems in the community antenatal clinics to achieve a complete antenatal examination in line with local and national guidance, including timely documentation and review of any findings and results. This is to aid appropriate escalation or referral when necessary.
It is recommended the Trust support staff to consider previous cardiotocograph (CTG) recordings when completing CTG reviews. This will ensure CTG changes are recognised and included within holistic assessments.
It is recommended the Trust support staff to ensure mothers to receive dynamic and personalised counselling regarding induction of birth, in response to the evolving clinical picture, including all risks and alternatives.
It is recommended the Trust support staff to escalate concerns immediately using the emergency call bell when fetal compromise is suspected.
It is recommended the Trust support staff to have a higher index of suspicion and implement prompt intervention when a cardiotocograph (CTG) is abnormal from the time of commencement and recognise the importance of the passage of time (time drift) during time sensitive emergency situations.
It is recommended the Trust supports staff to complete a full analysis of the features of a cardiotocograph (CTG) including the impact of conservative measures to inform the holistic picture of fetal wellbeing.
It is recommended to the regional maternal medicine centre that when an event is identified that presents a safety risk, a timely two-way communication between clinicians is undertaken.
It is recommended to the Trust that adjustments are made to ensure the birthing environment is suitable when providing care at births outside of the hospital setting, this should include lighting and space. This must be discussed with the family in advance to balance safe care and family choice.
It is recommended to the Trust that oxytocin infusions are managed in line with guidance and the use of infusions is responsive to a baby's heart rate whilst a senior review is sought.
It is recommended to the Trust that staff providing intrapartum care at home ensure that neonatal resuscitation equipment is in working order at the start of intrapartum care so that it is ready for use in an emergency in line with local and national guidance.
It is recommended to the Trust that staff providing intrapartum care at home maintain skills and experience in intrapartum care to support safe and effective recognition and responses when an emergency occurs.
It is recommended to the Trust that staff providing intrapartum care at home maintain skills and experience in neonatal assessment and resuscitation to inform ongoing care, escalation and actions required.
It is recommended to the Trust that those providing labour and birth care in and out of the hospital setting, have the confidence and skills in managing emergencies in those environments, supported by enhanced scenario-based training.
It is suggested the Trust reviews and updates guidance and training packages to include clear pathways and processes for when a fetal heart rate cannot be detected in a home birth setting. This will support recognition for escalation and ensure immediate transfer is achieved when required.

MNSI notes that an exchange transfusion is a high-risk procedure and that it should only be performed when clearly indicated based on interpretation of recent and accurate test results. Trust B to ensure that there is a process to confirm that testing prior to an exchange transfusion is facilitated in a manner that does not rely on human memory alone, and that results are considered as part of a trend in patient data.
MNSI recommends that the Trust reviews adherence to local guidance for timing of initiation of birth when pre-eclampsia is diagnosed and ensure that this is embedded into practice.
MNSI recommends a holistic risk assessment is undertaken for every mother attending maternity services to identify all risk factors to facilitate a robust management plan.
MNSI recommends all abnormal findings during an ultrasound scan are required to be documented in the scan report (whether previously known or not).
MNSI recommends that a system is put in place to ensure that all pre-made equipment packs contain the required equipment for the procedure they are intended to be used for.
MNSI recommends that after the completion of a cycle of medication during an induction of labour, that a discussion about options for further management occurs, in line with local and national guidance.
MNSI recommends that all calls made by mothers seeking advice are directed to the relevant clinical area so that a mother's clinical record can be reviewed and plan of care agreed and documented in line with national guidance (RCOG, 2023).
MNSI recommends that all telephone calls made by mothers seeking advice are directed to the relevant clinical area so that a mother's clinical record can be reviewed and plan of care agreed and documented in line with national guidance (RCOG, 2023).
MNSI recommends that calls made by mothers seeking advice are directed to the relevant clinical area so that a mother's clinical record can be reviewed and plan of care agreed and documented in line with national guidance (RCOG 2023).
MNSI recommends that during counselling about mode of birth, clinicians discuss all risks and benefits of the reasonable options available. This is to support mothers to make an informed choice. The discussion should be documented within the clinical records.
MNSI recommends that maternity triage calls are audio recorded at the Trust to enhance the accuracy of the information recorded and promote timely safe triage assessments.
MNSI recommends that placentas are sent for pathological examination including histology in line with national guidance (Evans et al 2022).
MNSI recommends that staff are supported to recognise the importance of regular uterine activity and when this indicates the need to monitor the baby with a cardiotocograph.
MNSI recommends that the Trust actively reviews their telephone maternity triage service to ensure all telephone calls are answered, logged and actioned to provide safe clinical assessment of mothers and babies.
MNSI recommends that the Trust actively seeks information from staff to identify the barriers to, and the enablers of, staff awareness when there are guideline changes. The findings should inform a review of the process for communicating guideline changes to achieve assurance of staff awareness.

MNSI recommends that the Trust and Ambulance Service support staff to consistently use written resources in alternative languages and formal interpretation services to aid communication at all stages of care. This should include an assessment of a person's understanding.
MNSI recommends that the Trust and Ambulance Service support staff to consistently use written resources in alternative languages and formal interpretation services to aid communication at all stages of care. This should include an assessment of a person's understanding.
MNSI recommends that the Trust develops a clear, consistent and reliable process for supplying and prescribing aspirin during pregnancy to ensure that women who need it receive aspirin.
MNSI recommends that the Trust develops a formal pathway for performing regular neurological assessments on babies who have required resuscitation at birth, to enable them to be identified for cooling treatment, if necessary.
MNSI recommends that the Trust develops a robust process to ensure guidelines and assessment tools are reviewed and updated in a timely manner and reflect national guidelines.
MNSI recommends that the Trust develops a robust process, that in the presence of an abnormal or pathological cardiotocograph, continuous electronic monitoring is provided to achieve an uninterrupted record of a baby's heart rate.
MNSI recommends that the Trust develops a system that supports a mother requiring urgent assessment to be seen immediately on arrival to the maternity reception area.
MNSI recommends that the Trust develops a system to support the assessment of unit activity when obstetric staffing is at out of hours levels. This should include multidisciplinary decision making for the requirement of attendance of a tier 3 doctor.
MNSI recommends that the Trust develops an education plan to train staff to use cardiotocograph analysis tools effectively and monitor compliance to aid decision making.
MNSI recommends that the Trust develops cultural competence and unconscious bias training for all maternity staff to strengthen staff awareness and responsiveness to pain and concerns from women of diverse ethnic backgrounds, to support equitable care and reduce disparities in maternal and neonatal outcomes.
MNSI recommends that the Trust embeds into clinical practice the need for assessing the urgency of caesarean birth in the presence of suspected fetal hypoxia.
MNSI recommends that the Trust embeds processes to support a timely holistic review of risk during labour to assess the most suitable method for fetal monitoring, in order to assess fetal wellbeing.
MNSI recommends that the Trust embeds the use of a structured tool to ensure effective handover of important information to inform ongoing care or emergency escalations.

MNSI recommends that the Trust ensure observation of antenatal ward cardiotocography is not impeded by workload demands so that time-critical escalation takes place when needed. Involving learning from staff involved with providing care in the antenatal ward area so that it is based on work as done, rather than work as imagined, will support effective safety learning.
MNSI recommends that the Trust ensure staff undertaking cardiotocograph (CTG) reviews take a holistic approach considering the stage of labour and any risk factors to support decision making regarding the timing of a baby's birth.
MNSI recommends that the Trust equips staff with the skills, education and consistent guidance to enable them to interpret cardiotocographs (CTGs) in the context of the clinical situation in order to support clinical decision making and clear escalation of concerns.
MNSI recommends that the Trust explores the barriers to maintain a consistently safe maternity triage service, this should include escalation (staffing and acuity) guidance and maintaining oversight of activity as part of maternity unit function.
MNSI recommends that the Trust identifies barriers to using communication tools and the variations in how they are used. This information will support the consistent use of structured communication tools in all escalation conversations. Consistent use of communication tools will provide shared understanding of escalation requests and the level of urgency.
MNSI recommends that the Trust includes any deficits in the numbers and required skills in the medical staff rota as an escalation trigger in the Trust policy. The policy must include the actions to be taken when this occurs.
MNSI recommends that the Trust introduces training to ensure in all cases where neonatal resuscitation is ongoing that staff refer directly to the newborn life support algorithm at the time of the resuscitation.
MNSI recommends that the Trust reviews and aligns local guidance with national guidance regarding fetal monitoring in the presence of blood-stained liquor to assess fetal wellbeing.
MNSI recommends that the Trust reviews and re-develops its guidance to be clear and consistent in its advice in line with national recommendations to support staff to assess and offer mothers to attend triage if there is any uncertainty about whether prelabour rupture of the membranes has occurred.
MNSI recommends that the Trust reviews guidance relating to neonatal assessment to ensure that it is consistent to support staff to recognise and escalate signs of clinical deterioration in newborns. This is in order to provide timely, safe clinical care.
MNSI recommends that The Trust reviews how they record and act upon Apgar scores following resuscitation. This will support clinicians to identify babies who meet criteria A for cooling.
MNSI recommends that the Trust reviews how they support relevant staff to be made aware of the availability and use of cerebral function monitoring, and how to safely store the records.
MNSI recommends that the Trust reviews its guidance to meet national recommendations to develop a robust person, systems-centred process and environment to support the role of dedicated midwifery staff to be solely responsible for the telephone triage advice line service and provide a space to facilitate this.

MNSI recommends that the Trust reviews its induction process to ensure that fetal well-being is confirmed prior to starting any induction procedure. Local guidance must be embedded to ensure that any indication of chronic hypoxia halts induction and prompts expedited birth if necessary.
MNSI recommends that the Trust reviews the effectiveness of staff training on shoulder dystocia. This should be used to inform future training and development of tools so there is assurance that staff have the knowledge and skills needed to perform the McRoberts' manoeuvre effectively, and to contemporaneously document full details of the actions taken.
MNSI recommends that the Trust reviews the process and expected timescale for informing the neonatal intensive care unit when emergency blood products are relocated from the labour ward blood storage refrigerator so that they can be obtained without delay when needed.
MNSI recommends that the Trust reviews the process for reviewing and actioning laboratory test results prior to the discharge of women from the gynaecology emergency assessment bay to support the identification of women who require either follow-up investigations or referral to specialist services.
MNSI recommends that the Trust reviews the process to identify the barriers to, and the enablers of, staff identifying women who need to be on the pregnancy of an unknown location pathway. The findings should inform changes to the process to achieve assurance that women are on the correct care pathway.
MNSI recommends that the Trust reviews the training provided to clinicians around the importance of obtaining central line access (such as umbilical venous catheters) for babies requiring advanced resuscitation. Additionally to support clinicians to consider alternative central line access such as intraosseous access.
MNSI recommends that the Trust should ensure that consistent information relating to the risks of prolonged pregnancy beyond 41 weeks, including the increased likelihood of stillbirth and neonatal death is provided to all mothers, to support informed decision making, in line with national guidance.
MNSI recommends that the Trust should ensure that the locally developed cardiotocograph (CTG) interpretation tool and guidance supports staff to recognise concerning fetal heart rate features and when escalation is required.
MNSI recommends that the Trust should review the system and process to enable timely, holistic obstetric review when escalation is indicated.
MNSI recommends that the Trust should support staff to ensure that women and their families are listened to with their voice heard (Independent Maternity Review - Ockenden 2022).
MNSI recommends that the Trust support staff to recognise, escalate and act upon a pro-longed deceleration of the fetal heart rate in line with local and national guidance.
MNSI recommends that the Trust supports and encourages staff to report and escalate using an acuity tool validated for maternity settings. This is required to enable a culture where staff feel confident to voice concerns and assured that their concerns will be listened to and acted upon.
MNSI recommends that the Trust supports clinicians to consider early intubation of a baby that is not responding to initial resuscitation and where there is little or no breathing effort.

Maternity safety recommendations
1 April 2024 to 31 March 2025



MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing .
MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.
MNSI recommends that the Trust triage guidance includes details of the standard clinical assessment to be undertaken on women and birthing people within 15 minutes of arrival in triage.
MNSI recommends that the Trust works with staff to promote the use of a structured communication pathway to support the sharing of information about the number and content of calls a mother makes to the triage telephone advice line when transferring to another area to inform clinical decision-
MNSI recommends that the Trust, in collaboration with system partners, establish processes to ensure patients are promptly moved from the emergency department (ED) to wards, thereby enabling ambulance handovers within 15 minutes and minimising delays in redeploying Ambulance
MNSI recommends that the Trust's guidance reflects the system currently in use with a particular focus on the number of calls made by a mother and how this is communicated to relevant members of staff.
MNSI recommends that there is provision of a 24 hour telephone triage service, using staff trained to deliver a consistent approach to giving advice, planning care and recording in the electronic record. Audit is required to evaluate that care provided has been accurate timely and clear.
MNSI recommends that Trust A and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care.
MNSI recommends that Trust A and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care.
MNSI recommends that Trust B reviews the system for the requesting of clinically urgent blood tests, so that the results can support holistic decision making and inform ongoing care in a timely way.
MNSI recommends that Trusts A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, ultrasound scan (USS) reports/imaging, and test results to inform on-going clinical decision making and management of care.
MNSI recommends that Trusts A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, ultrasound scan (USS) reports/imaging, and test results to inform on-going clinical decision making and management of care.
MNSI recommends that when staff are aware of cardiotocograph (CTG) changes which require intervention and senior decision makers are directly involved in care elsewhere, staff are able to informally escalate to other senior colleagues as indicated in the guideline.

Maternity safety recommendations
1 April 2024 to 31 March 2025



MNSI recommends the Trust aligns local guidance with national guidance to ensure that mothers are offered a fetal growth ultrasound scan following a static fundal height measurement.
MNSI recommends the Trust ensures that staff have the means to urgently contact colleagues when immediate support is required in the operating theatre.
MNSI recommends the Trust follow the guidance for an in person maternity triage process, as identified in the national good practice paper (RCOG, 2023).
MNSI recommends the Trust to facilitate safe staffing levels in maternity triage in order to support the service being provided in line with the national good practice paper (RCOG, 2023).
MNSI recommends there is a robust process for neonatal alerts which communicates across the Trust's IT systems to support a comprehensive handover of information and plan a baby's care at birth.
MNSI recommends there is a robust process in place to ensure cardiotocographs are archived so that staff are only visualising the current cardiotocograph.
MNSI recommends there is a robust system to maintain oversight of a mother's care when moved from a fetal medicine pathway.
MNSI recommends that a system is put in place to enable staff to promptly recognise and escalate a change in a baby's observation trends.
The NHS Ambulance Trust ensure that call handlers receive robust training to ensure that the script in place, is always used to describe ambulance responses. This is of particular importance during ambulance delays to ensure that honest and unambiguous language is used and that patients have clear expectations of options to wait for an ambulance or to make their own way.
The Trust to ensure mothers with anterior low-lying placenta and previous caesarean birth are managed as if they have placenta accreta, with appropriate preparations for surgery made (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) 2022).
The ambulance service to ensure all callers are provided with a realistic wait time for an ambulance to assist mothers with decision making regarding making their own way or waiting for an ambulance to take them to the Trust.
The ambulance service to ensure all callers are provided with a realistic wait time for an ambulance to assist mothers with decision making regarding making their own way or waiting for an ambulance to take them to the Trust.
The Ambulance Service to ensure that the team is supported to recognise the passage of time to facilitate timely transfer to an emergency department.
The Ambulance Service to report to the triage software provider (Medical Priority Dispatch System(MPDS)) the possibility of selecting an incorrect 'pregnancy / childbirth' pathway when a mother's level of consciousness has not been established.
The ambulance service to support staff to recognise that any amount of bleeding after 20 weeks gestation is abnormal and requires management as a time critical obstetric emergency with immediate transport to the maternity unit.
The Ambulance Trust to ensure that staff attending maternal cardiac arrest calls are supported to recognise the need for time-critical access to perimortem caesarean in line with national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Ambulance Trust to review how staff are supported to prioritise effective crew communication when there is a change in the clinical circumstances during transfer to a receiving Trust.
The Ambulance Trust to review how they support crews to manage and respond to time critical obstetric emergencies, to ensure transfer occurs to the appropriate location.
The Ambulance Trust to review the storage and availability of equipment to ensure there are no environmental barriers for effective resuscitation of both babies and children.
The Ambulance Trust to support staff to use the maternal assessment tool and available national guidelines consistently when assessing pregnant women and birthing people to identify any red flags warranting urgent transfer to the maternity unit and the need for a pre-alert call.
The general practice reviews their management of patients with alcohol use disorders, so that their management reflects National Institute for Health and Care Excellence (NICE) guidance. This will ensure patients receive the right level of counselling, treatment and support when making decisions relating to their treatment.
The Integrated care board (ICB) and the GP surgery to ensure that information provided via the online consultation platform is considered in full, with a low threshold for a telephone call or face to face assessment where further context to information provided is needed.
The Integrated care board (ICB) and the GP surgery to ensure that when a pregnant mother attends and infection is being considered, a full set of observations are taken and documented, in line with national guidance.
The Integrated Care Board (ICB) undertake a formal review of the abnormally invasive placenta service in the region.
The Maternity triage line to ensure that staff advise all mothers who are unable to assure staff of fetal movements to attend the maternity unit.
The NHS Trust review and improve the antenatal clinic senior obstetric oversight. This is to support high risk women having face to face senior reviews when decisions are needed about their care pathway, including the timing of birth.
The regional maternal medicine network to work with their network hospitals to develop flexibility within pathways to ensure safe and timely management of critically unwell mothers.
The Trust (Trust A) to ensure mothers with genital tract symptoms have the diagnosis of genital herpes simplex virus (HSV) infection considered, with prompt virological testing and commencement of treatment.
The Trust (Trust A) to ensure testing for herpes simplex virus (HSV) is available via both blood testing and viral swab analysis.
The Trust (Trust A) to ensure that for critically ill mothers a risk assessment is undertaken and documented by a senior clinician to determine the level of anticipated risk during interfacility transfer.
The Trust (Trust A) to ensure that the outcome of the risk assessment determines the required competences of the staff accompanying a mother during transfer in line with national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust (Trust A) to ensure when a mother has significant derangement of her liver function tests, alternative non-pregnancy related causes are considered along with the involvement of a liver specialist as part of multi disciplinary team (MDT) discussions.
The Trust and GP to ensure the commencement of anti-seizure medication follows that recommended in national guidance, or if a decision to start treatment outside of national guidance is made this is clearly shared with the patient and with the clinician providing ongoing prescriptions for the
The Trust are to ensure their guidance for preterm prelabour rupture of membranes, early onset neonatal infection including Group B Streptococcus (GBS) and pyrexia in labour align to each other and are in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021). The guidance clearly states actions to be taken and time frames which are to be achieved for all members of the multidisciplinary team.
The Trust are to ensure there is a clearly defined and auditable process and pathway for identifying babies at risk of early onset newborn infection. To make sure these babies are seen by a paediatrician immediately following birth in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021).
The Trust develop a clear process for women who develop complications whilst awaiting a planned caesarean and deviate from standard planned caesarean pathway. The development of this process would provide clarity for staff.
The Trust ensure that appropriate induction is arranged for new starters, including storage of equipment and familiarisation of equipment.
The Trust ensure that staff are aware of the holistic signs and symptoms of sepsis to enable early recognition and treatment of chorioamnionitis.
The Trust ensure there are robust systems of communication between clinicians in place to support effective escalation and timely review of cardiotocograph (CTG) concerns.
The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment.
The Trust ensures the medication management system in place within the maternity service supports staff to follow local and national guidance, to prevent accidental or incorrect administration of medicines.
The Trust guidance to reflect national guidance in supporting staff to have discussions with mothers relating to the increased risk of stillbirth when their pregnancy goes beyond 41+0 weeks.
The Trust introduce a clear pathway for referral and completion of ultrasound scans and to ensure that ultrasound scans are booked based on clinical urgency and not method of referral.
The Trust is to ensure that when mothers are unable to be reviewed by an obstetrician, in line with guidance, follow up arrangements are made to facilitate safe on-going, personalised care.
The Trust must ensure staff are supported to recognise, escalate and act upon a pathological cardiotocograph (CTG) in a timely way.
The Trust must provide support and oversight to all clinicians new to the Trust tailoring this support accordingly as more familiarity and confidence is gained to provide safe and effect care.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust must review processes to enable staff to obtain hourly cardiotocography (CTG) peer review, supporting them to identify fetal heart rate features that require escalation for assessment of fetal wellbeing.
The Trust must review their emergency bleep system to gain assurance all urgent bleep requests have been received by the requested clinician. A guideline to support to be available to reflect the process in place and actions required in an emergency.
The Trust need to review their guidance to make it clear for clinicians to understand when a paediatrician would be expected to be called for the birth of a baby.
The Trust needs to ensure that any medications used as part of neonatal resuscitation are prescribed and documented in line with local guidance.
The Trust review how staff confirm understanding of the information given to women whose first language is not English, to support the recognition of need for interpretation services.
The Trust review their triage staffing and escalation processes in line with Trust guidance, acuity, and assessment of clinical risk in order to ensure that triage staffing is adequate to provide safe care and assessment to all women and babies under their care.
The Trust reviews the barriers to staff using the emergency escalation system when there are difficulties in locating a baby's heart rate and develop an action plan based on the findings.
The Trust reviews the process for issue of O negative red blood cells to enable rapid availability direct to the maternity operating theatre for emergency transfusion to a neonate.
The Trust reviews the system for vulnerable mothers and mothers with language barriers to enable them to access urgent advice and assessment.
The Trust should ensure that there is a clear multidisciplinary approach to managing pregnant mothers in the intensive care unit.
The Trust should ensure that there is a robust mechanism of communication that supports contact of all necessary staff members in emergency situations at all times.
The Trust should ensure there is a robust process for the checking and oversight of emergency equipment for neonatal resuscitation to support its availability for the resuscitation for a baby.
The Trust should implement a system to ensure that placental histology is undertaken consistently and in line with Trust and national guidance.
The Trust should implement a system to ensure that placental histology is undertaken consistently and in line with Trust and national guidance.
The Trust strengthen and embed the process for storage of unused medication to prevent accidental or incorrect administration of medicines.
The Trust to actively support staff to increase the frequency of intermittent auscultation when second stage of labour is suspected.
The Trust to adopt the national guideline (British Association of Perinatal Medicine, 2024) for management of neonatal hypoglycaemia and ensure it is embedded in practice through training.
The Trust to agree on a consistent approach to undertaking and recording maternity early warning scores. This will support staff to undertake, record, recognise and escalate abnormal maternal observations.

The Trust to amend electronic records to support all maternity staff to plot symphysis fundal height measurements beyond 40 weeks of pregnancy, so that significant accelerations or decelerations in symphysis fundal height trajectory can be noted and escalated appropriately.
The Trust to collaborate with clinical staff to implement a process for ensuring all pertinent risks and history are communicated with the neonatal team. This would include the use of closed loop communication.
The Trust to consider a pathway that supports neonatal clinicians to exclude or diagnose a cardiac condition, by performing an echocardiogram, when a baby's condition is worsening or requiring higher than usual treatment for the working diagnosis.
The Trust to consider access to graded assertiveness training (a framework for speaking up for safety) to support staff to communication within the multidisciplinary team when staff attention is fixed on a specific task.
The Trust to consider categorisation of urgency of assisted birth to ensure a shared and understood expectation of time scale.
The Trust to consider how staff can recognise the potential deterioration of a mother whose Maternity Early Warning Score (MEWS) score is above 0 in any area of the maternity services, with support to recognise that hypoxia in pregnancy is always abnormal and requires urgent escalation.
The Trust to consider how they might provide support and escalation for the neonatal team when faced with unexpected workload or when a baby's poor condition is unexpected.
The Trust to consider its processes, which would support clinicians to undertake a holistic review of cumulative risk factors including the cardiotocograph (CTG) reviews to assist decision making for a management plan for labour and birth.
The Trust to consider multidisciplinary Newborn Life Support training to foster collaboration and help team members appreciate different perspectives, especially during high pressure situations.
The Trust to develop a process which ensures all equipment that may be required can be immediately accessible to clinicians during neonatal resuscitation and staff are familiar with the location of the equipment.
The Trust to develop a robust system of ensuring that where continuous cardiotocograph (CTG) monitoring is indicated this is undertaken for as long as possible prior to a baby's birth, including during period of transfer to maternity operating theatre.
The Trust to develop a robust system that supports clinicians to assess and monitor babies following an instrumental birth.
The Trust to develop a system to support clinicians to use a standardised approach to communication, when handing over care enabling care delivery in line with national guidance.
The Trust to develop a system, enabling clinicians to undertake a holistic assessment of a newborn baby, minimising cognitive bias and assisting them to use relevant guidance to develop management plan.
The Trust to develop and embed tools and training for staff to enable them to explore a mother's preferences and understanding of information provided, to improve communication of risk factors and support informed decision making.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to develop guidelines with advocacy groups and staff about the care for young mothers with multiple vulnerabilities. The guideline will support identification of cumulative risk factors and guide care planning for this group of mothers.
The Trust to develop the maternity triage service, including the criteria of triage admissions, and support a structured hand over of relevant information to other departments with a clear pathway of escalation.
The Trust to embed the use of structured handovers of care to the neonatal team to ensure resuscitation care takes into account all the relevant risk factors.
The Trust to ensure a baby's blood glucose level is monitored every 30 minutes during the treatment of hypoglycaemia in line with national guidance (British Association of Perinatal Medicine, 2024).
The Trust to ensure a clinical triage assessment tool is embedded into practice to support mothers being systematically assessed, and their care prioritised within 15 minutes of their arrival in maternity triage with a timely escalation where this is not achieved due to activity or acuity.
The Trust to ensure a continuous documented risk assessment throughout the induction of labour process, with prioritisation and an escalation plan when there is a delay in transfer, due to the safety and acuity of the unit.
The Trust to ensure a mother's perception of a baby's well-being is considered in the context of clinical assessment.
The Trust to ensure a process is implemented to ensure staff confirm the required ventilator settings prior to a baby being placed on a ventilator and perform regular checks of the ventilator settings whilst the baby remains ventilated. The Trust to develop and implement an induction training programme for all new staff in the neonatal unit on use of ventilators.
The Trust to ensure a prompt and brief assessment (triage) of the woman is undertaken by a midwife within 15 minutes of attendance, and the clinical urgency in which they need to be seen is determined in a standardised way, using a system that has been evaluated (e.g. Birmingham Symptom Specific Obstetric Triage System (BSOTS)). This system should have minimal variation in the assessment of urgency between midwives and include physiological assessment with use of a modified early obstetric/maternal early warning score (e.g. Modified Enhanced Obstetric Warning Score (MEOWS) or Maternity Early Warning Score (MEWS)).
The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.
The Trust to ensure a structured approach to communication is used to ensure that appropriate and relevant information is relayed, received and understood.
The Trust to ensure a system is in place to identify, communicate and escalate all risk factors when mothers are admitted for induction of labour.
The Trust to ensure adequate support is in place to provide one to one care in a timely manner when a mother is progressing from the latent phase to the active phase of labour.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure after an unsuccessful ventouse birth, careful consideration including discussion with the mother should take place to consider the safest mode of birth.
The Trust to ensure all members of the clinical team working in maternity understand the key principle of maintaining the helicopter view to ensure the safe management of complex clinical situations.
The Trust to ensure all members of the multidisciplinary team are involved in regular joint skills and drills training, which incorporates advanced neonatal resuscitation.
The Trust to ensure all mothers admitted to the hospital in the latent phase of labour, who present with prior or new risk factors, have an obstetric review, to enable an individualised care plan to be documented in their records.
The Trust to ensure all placentas are checked in line with local and national guidance (National Institute for Health and Care Excellence (NICE), 2017) and sent for pathological examination including histology in line with national guidance (Evans et al 2022) if they meet criteria.
The Trust to ensure all staff have simulation based, multidisciplinary training that includes the management of an impacted head which is based on guidance which has a systematic approach to disengaging a deeply impacted fetal head at caesarean birth in line with current published literature.
The Trust to ensure all staff who care for women in a birth setting are compliant with fetal monitoring and surveillance training that is yearly and in line with Saving Babies' Lives.
The Trust to ensure an assessment of fetal wellbeing by cardiotocography is performed following spontaneous rupture of membranes in a high risk induction of labour.
The Trust to ensure an effective process of assessing and communicating blood loss at regular intervals during operative procedures, including when cell salvage is being used.
The Trust to ensure an individualised care plan for the induction of labour pathway in mothers with a history of previous caesarean birth is produced in line with local guidance, including details of the method of the induction of labour and the frequency of maternal and fetal monitoring.
The Trust to ensure cardiotocograph (CTG) classification tools are consistent with national guidance and systems are in place to support staff to interpret and categorise CTGs.
The Trust to ensure clinicians are able to safely escalate care, to all required members of the multidisciplinary team, when an emergency occurs outside of the delivery suite.
The Trust to ensure clinicians are aware of the requirement and the local guidance to transfer a mother to a birthing room for enhanced monitoring after tocolysis has been administered for management of hyperstimulation.
The Trust to ensure clinicians are confident to assess collapsed patients immediately for potential cardiac arrest and escalate this in line with local and national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure clinicians are encouraged to investigate signs and symptoms of birth trauma independently to ensure there is prompt diagnosis and escalation.
The Trust to ensure during the initial assessment in the first fit clinic a personalised approach, which prioritises information sharing, is undertaken so that service users are aware of points of contact and safety advice in line with national guidance.
The Trust to ensure each woman has a documented review and management plan daily during induction of labour in the Maternity Unit.
The Trust to ensure escalation is informed by the mothers full clinical history and current condition, with the involvement of the multidisciplinary team to support ongoing clinical oversight and care planning.
The Trust to ensure guidance is in place for mothers who may book late in pregnancy or may have transferred her care mid-pregnancy, this includes guidance on how to add records from another provider to the local records.
The Trust to ensure it identify the root cause and corrective actions to prevent the re-occurring theme of placentas not being sent for histology.
The Trust to ensure mothers are referred for diabetes screening when fetal macrosomia is identified using an ultrasound scan.
The Trust to ensure mothers who have had a previous caesarean birth undergo continuous fetal monitoring in the presence of regular contractions, regardless of the stage of labour.
The Trust to ensure placentas are sent for pathological examination including histology in line with guidance.
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Maternity safety recommendations
1 April 2024 to 31 March 2025



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The Trust to ensure recognition, escalation and management of an abnormal cardiotocograph (CTG) is in line with national and local guidance.
The Trust to ensure recommendations of the Saving Babies' Lives care bundle (Version 3) are implemented for the assessment of a baby's growth by continuing ultrasound assessment of growth until birth.
The Trust to ensure resident doctors are supported to have escalation conversations with senior on-call staff when emerging emergency situations occur to provide clinical oversight and support decision making.
The Trust to ensure staff are able to recognise emergency situations and escalate for support in line with local and national guidance.
The Trust to ensure staff are aware of the need to respond urgently when an emergency 2222 call to reduce delays in the neonatal team arriving at the birth of a baby requiring resuscitation.
The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors.
The Trust to ensure staff are supported to carry out neonatal resuscitation in line with national guidance and that they access the requisite equipment required in a homebirth setting.
The Trust to ensure staff are supported to complete resuscitation documentation in a timely manner, using all the records available and to ensure times, events and medicine administration are accurately documented.
The Trust to ensure staff are supported to escalate early to the neonatal consultant when neonatal resuscitation is extensive.
The Trust to ensure staff are supported to follow local and national guidance to monitor symphysis fundal height measurements as a marker of fetal growth.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure staff are supported to identify mothers who require additional ultrasound growth surveillance due to the presence of fibroids in line with national guidance.
The Trust to ensure staff are supported to provide a holistic review of cumulative risk factors, considering the full picture including a mother's history, progress in labour, any antenatal risk factors and previous antenatal cardiotocographs (CTGs).
The Trust to ensure staff are supported to recognise when tests results are urgent and to establish a framework that supports them to be able to receive the results in a clinically appropriate timeframe, to aid decision making and timely management of a mother's risk factors.
The Trust to ensure staff are supported to recognise, escalate and act upon a pathological cardiotocograph (CTG) in a timely way.
The Trust to ensure staff are supported to request neonatal computed tomography when there is clinical suspicion of intracranial haemorrhage. This will enable timely diagnosis and earlier intervention.
The Trust to ensure staff are supported to take actions to escalate for additional support or transfer when intermittent auscultation cannot be achieved in line with guidance at a homebirth.
The Trust to ensure staff consider anaemia as a cause for ongoing resuscitation particularly in the presence of pallor and evidence of maternal blood loss or retroplacental clots.
The Trust to ensure that a categorisation of urgency is assigned to assisted vaginal births which may proceed the caesarean birth, to ensure a shared understanding of the timeframes required. If surgery is unable to proceed within the timeframe, staff should be supported to escalate accordingly.
The Trust to ensure that a clear escalation process is available for maternity patients in the recovery area to support an immediate review when clinically indicated.
The Trust to ensure that a collaborative process for missed scan appointments in pregnancy is implemented to mitigate against women not having necessary scans for monitoring fetal wellbeing.
The Trust to ensure that a full risk assessment is completed to ensure that there is a personalised care plan in place for all mothers.
The Trust to ensure that a helicopter overview is undertaken to ensure that when a decision for a caesarean birth is made, babies are born as soon as possible and within nationally mandated timeframes.
The Trust to ensure that a holistic assessment of the cumulative risk factors is used with regard to decision making and timing of birth.
The Trust to ensure that a holistic review is completed in the assessment and categorisation of antepartum haemorrhage. The intended care pathway, based on the categorisation of a mother's antepartum haemorrhage, is to be documented and implemented without delay.
The Trust to ensure that a mother with blood-stained liquor is transferred to obstetric care with continuous cardiotocograph monitoring in line with national guidance (National Institute for Health and Care Excellence, 2023; National Institute for Health and Care Excellence, 2022).
The Trust to ensure that a practical, reactive and flexible care pathway is developed to support an individualised plan of care after an assessment of a mother's complex needs.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that a robust system is in place for women with gestational diabetes to trigger a face-to-face specialist review when there are concerns with engagement and reduced compliance with blood glucose testing, in order to provide ongoing support to mothers, with timely commencement of medication when required.
The Trust to ensure that a system is in place to aid recognition of red flags for early onset infection (National Institute for Health and Care Excellence (NICE), 2021).
The Trust to ensure that accurate information is shared between relevant agencies to support effective multi-agency working.
The Trust to ensure that all actions have been taken to investigate and manage neonatal blood loss prior to consideration and commencement of therapeutic cooling. This will enable clinicians to evaluate that a baby is stable enough to commence treatment with therapeutic cooling.
The Trust to ensure that all cardiotocographs (CTGs) that are undertaken are systematically categorised, and if an antenatal CTG is found to be abnormal, a plan of care with a timeframe to expedite birth is documented.
The Trust to ensure that all clinical care is documented, retained and stored in the electronic systems they are using in order to support review and sharing of records.
The Trust to ensure that all clinicians are aware of their roles and responsibilities to ensure that there is full clinical oversight and escalation when there are concerns about fetal wellbeing during the second stage of labour.
The Trust to ensure that all clinicians are supported to follow the newborn life support guidance in the correct sequence.
The Trust to ensure that all clinicians use the local assessment tool when reviewing a cardiotocography (CTG) trace and to document findings of their independent systematic review.
The Trust to ensure that all clinicians working in the combined medical antenatal clinic have a system or process in place to identify and escalate concerns to a diabetologist. Enabling an individualised and holistic approach when risk assessing mothers ensuring all factors are considered in their
The Trust to ensure that all emergency equipment is correctly prepared for the intended purpose. Any emergency algorithm guidance displayed needs to be in date and ready for their intended use.
The Trust to ensure that all environments are equipped with the required resources for their intended use enabling clinicians to provide immediate clinical care without delay.
The Trust to ensure that all guidance and processes align with the expectation of a primary postnatal visit being undertaken face to face.
The Trust to ensure that all labour ward rooms have a computer and are equipped to enable staff to provide standard labour care as required in national guidance (National Institute for Health and Care Excellence (NICE), 2022b). This will enable standard labour care to be easily provided and facilitate contemporaneous holistic assessment of mothers in labour and use of observation and cardiotocograph (CTG) analysis tools.
The Trust to ensure that all mothers and babies receive a robust assessment of the effectiveness of their feeding, which includes observing a full feed prior to discharge home.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that all mothers are provided with options available for fetal heart monitoring in labour.
The Trust to ensure that all mothers have a named clinician maintaining oversight of their care, to ensure the provision of safe maternity care (Ockenden 2020).
The Trust to ensure that all mothers who report reduced fetal movements have a full risk assessment completed, including a computerised cardiotocograph, to assess fetal wellbeing in line with national guidance. (NHS England, 2023).
The Trust to ensure that all mothers who would like a birth experience which deviates from guidance, have personalised care plans co-produced with a senior clinician. This will facilitate front line staff to support mothers with their ongoing care.
The Trust to ensure that all mothers with risk factors for small for gestational age or other obstetric risk factors who have not given birth by 40 weeks, have an obstetric review to confirm the planned timing and method of birth.
The Trust to ensure that all staff are aware of how to manage unsuccessful escalation.
The Trust to ensure that all staff are supported to recognise and act upon and abnormal cardiotocography in line with local and national guidelines in all clinical areas.
The Trust to ensure that all staff are supported to take a holistic view of cumulative risk factors to inform decision making around mode and timing of
The Trust to ensure that all staff know how to summon support and the most effective way to achieve this.
The Trust to ensure that an antenatal cardiotocography (CTG) classification system is used consistently by all staff to aid the classification of a CTG (NHSR, 2019).
The Trust to ensure that antenatal scheduling and screening systems include failsafe procedures to provide assurance that all mothers receive safe care in line with national guidance (National Institute for Health and Care Excellence (NICE), 2020; NICE, 2021).
The Trust to ensure that any barriers which prevent timely induction of labour (IOL) are understood and addressed.
The Trust to ensure that at times of high capacity or low staffing, an individualised plan is implemented that ensures safe care, with consideration of a mother's risk factors and preferences.
The Trust to ensure that cardiotocograph (CTG) categorisation is carried out in line with local and national guidance and that staff are supported to recognise and escalate where there are concerns regarding CTG monitoring.
The Trust to ensure that cardiotocographs (CTGs) are categorised in real time and include a holistic assessment to inform a decision making for ongoing care.
The Trust to ensure that clear, robust multidisciplinary communication, with senior oversight, is evidenced to support and implement clear management and care plans when providing complex care particularly in end-of-life care in line with national guidance.

The Trust to ensure that clinical decisions are not based on cardiotocograph (CTG) interpretation alone. Healthcare professionals must complete a holistic review of cumulative risk factors, taking in to account the full picture including a mother's history, stage and progress in labour, any antenatal risk factors and any other signs that the baby may not be coping with labour (Royal College of Obstetricians & Gynaecologists (RCOG), Each Baby
The Trust to ensure that clinical entries are captured accurately and consistently throughout all sections of a patient's notes.
The Trust to ensure that clinical staff are aware that pink amniotic fluid is recognised and documented as blood-stained amniotic fluid, resulting in a holistic review and plan of care of a mother.
The Trust to ensure that clinicians are provided with effective ongoing training and support in the use of the electronic patient record, to promote confidence, competence and to maximise engagement with its use.
The Trust to ensure that clinicians are supported to carry out a holistic review of a mother and baby's wellbeing including all cumulative risk factors in order to support decision making including the timing of birth.
The Trust to ensure that clinicians are supported to follow guidance and commence variable rate insulin infusion when required while caring for women with diabetes in labour.
The Trust to ensure that clinicians are supported to follow national guidance relating to the management of shoulder dystocia.
The Trust to ensure that clinicians are supported to identify cumulative risk factors which may increase the risks for a baby in the postnatal period to support an ongoing plan of care.
The Trust to ensure that clinicians are supported to use cardiotocograph (CTG) categorisation tools, supported by a robust training programme, to allow accurate assessment of fetal heart tracing.
The Trust to ensure that clinicians have the ongoing training and support, to be able to access the correct clinical information without delay and distraction to support timely and informed decisions to be made.
The Trust to ensure that clinicians risk assessments of mothers include the suitability of the birthing environment and the availability of tools and technology when making decisions about care.
The Trust to ensure that clinicians take a holistic view of cumulative risk factors with regard to decision making regarding mode and timing of birth.
The Trust to ensure that communication and processes support birth taking place as rapidly as possible in the presence of an ongoing fetal bradycardia. This is to be embedded through training and simulation.
The Trust to ensure that communication with patients in the emergency department includes probable waiting times for initial triage assessment.
The Trust to ensure that concerning features on an intrapartum cardiotocograph (CTG) are considered together with additional risk factors, to support a holistic maternal and fetal wellbeing review involving the family to plan ongoing care.

The Trust to ensure that consistent information relating to the risks of prolonged pregnancy beyond 41 weeks is provided to all mothers, to allow them the opportunity to make an informed decision about induction of labour in line with national guidance.
The Trust to ensure that consistent information relating to the risks of prolonged pregnancy beyond 41 weeks, including the increased likelihood of stillbirth and neonatal death is provided to all mothers, to support informed decision making, in line with national guidance.
The Trust to ensure that continual risk assessments are carried out during a mother's antenatal pathway, that recognises the impacts of maternal smoking to include referrals for serial growth, liquor volume and uterine artery Doppler scans for mothers with risk factors for small for gestational age (SGA) or stillbirth.
The Trust to ensure that continuous rectal temperature recordings are undertaken during passive cooling therapy.
The Trust to ensure that decision making about timing of birth for mothers with gestational hypertension, informed by local guidance, reflects national guidance.
The Trust to ensure that discussions relating to induction of labour and pregnancy beyond 41 weeks are held in line with local and national guidance to support informed choice.
The Trust to ensure that discussions with mothers about their birth options are revisited at each step of their pregnancy and labour journey to enable supported decision making.
The Trust to ensure that during a neonatal resuscitation local processes support clinicians to recognise that when there is adequate chest wall rise, there is no immediate necessity to intubate, and if initial attempts to do so are unsuccessful, a return to facemask ventilation is acceptable.
The Trust to ensure that during discussion about birth choices, that mothers are aware they can have a maternal request caesarean birth.
The Trust to ensure that during periods of escalation, staff are supported to manage the workload to provide care in line with local guidance.
The Trust to ensure that education and guidance relating to intermittent auscultation is in line with national guidance and that a consistent approach is adopted.
The Trust to ensure that effective escalation steps support maintenance of oversight of the labour ward including the provision of support for newly qualified staff.
The Trust to ensure that escalation pathways are clearly understood, utilised and escalation actions documented when an obstetric review is required to support holistic review and care planning.
The Trust to ensure that face to face holistic review of cumulative risk factors is undertaken by healthcare professionals during labour, particularly if a management plan is changed. This should consider the full picture including a mother's history, progress in labour, any antenatal risk factors, evolving clinical concerns and any signs that a baby may not be coping with labour (Royal College of Obstetricians & Gynaecologists (RCOG), Each Baby Counts, 2015).

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that face to face holistic reviews include consideration of all risk factors and are not focussed on cardiotocograph (CTG) features alone.
The Trust to ensure that face to face senior Multi Disciplinary Team review informs the order of clinical activity when there are competing demands on the team.
The Trust to ensure that fetal monitoring in labour is maintained during the handover of care or transfer to another area, in line with local and national guidance and when no heartbeat is located escalation is made without delay.
The Trust to ensure that follow up plans are made when a mother self-discharges without an obstetric review.
The Trust to ensure that following a first seizure patients are seen in the first fit clinic within a locally agreed time frame, ideally based on national guidance .
The Trust to ensure that following commencement of induction of labour, when there is a contraction frequency more than 5 in 10 minutes, a holistic obstetric review is undertaken with continuation of fetal monitoring to assess fetal wellbeing and consideration of taking action to reduce contraction frequency in line with national guidance (National Institute for Health and Care Excellence (NICE), 2022).
The Trust to ensure that for a high-risk mother who presents with a cardiotocograph (CTG) abnormality in early labour, a holistic review along with provision of risk and benefit information of caesarean birth and expectant management is provided. This will ensure that a mother can make informed decisions about her care.
The Trust to ensure that Growth Assessment Protocol (GAP) or an alternative fetal growth surveillance protocol is fully embedded within all areas of the maternity service to provide assurance that it is utilised consistently and ensure that there is adequate guidance for staff in its application.
The Trust to ensure that guidance related to obstetric referrals is updated in relation to the criteria for an obstetric review.
The Trust to ensure that handover of care between clinical areas reflects a mothers full clinical history, current condition and includes relevant members of the clinical team, to inform ongoing care planning.
The Trust to ensure that holistic risk assessments, in mothers with diabetes and suboptimal fetal growth are carried out and documented throughout maternity care to enable clinicians to make informed decisions for timing of birth.
The Trust to ensure that if a Kleihauer test demonstrates a significant amount of fetal blood within the maternal system a holistic obstetric review is completed.
The Trust to ensure that in an emergency situation there is a member of the team that takes a helicopter view to ensure the wellbeing of the mother and baby.
The Trust to ensure that initial triage assessments are undertaken in line with Birmingham Symptom Specific Obstetric Triage System (BSOTS) including commencing continuous fetal monitoring when a mother presents with reduced fetal movements.
The Trust to ensure that local guidance is aligned with current national guidance in relation to induction of labour for prolonged pregnancy.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that local guidance is implemented in line with national guidance in a timely manner.
The Trust to ensure that local hypertension guidance is in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023). This will support staff to promptly diagnose mothers with gestational hypertension or pre-eclampsia, aiding planning of care.
The Trust to ensure that local policies support clinicians to identify and refer babies that require postnatal review to the appropriate services.
The Trust to ensure that local processes support staff to recognise and manage a difficult neonatal airway, and to nominate a member of the team to have oversight of the neonatal resuscitation, so the team can be supported to adapt to clinical challenges as they arise.
The Trust to ensure that loss of contact of the fetal heart rate is managed as a potential emergency. If fetal wellbeing cannot be demonstrated immediately after positional change, that other steps and/or emergency escalation is taken.
The Trust to ensure that maternity staff are supported to escalate for timely senior anaesthetic review when workload exceeds the capacity of the resident team.
The Trust to ensure that mothers are aware of all birth options available to them when they have diabetes and where fetal biometry is outside of the normal range to enable them to make an informed decision.
The Trust to ensure that mothers are given an option of immediate (or as soon as possible) induction of labour or expectant management following pre labour rupture of membranes in line with national guidance to ensure informed choice (Royal College of Obstetricians & Gynaecologists (RCOG))
The Trust to ensure that mothers are involved in discussions about fetal monitoring options available to them in labour.
The Trust to ensure that mothers are provided with information and discussion about the risks, benefits and options once a pregnancy reaches 41+0 weeks to support their involvement in the decision for and the timing of induction of labour.
The Trust to ensure that mothers attending maternity triage who require an obstetric review have this undertaken before they are discharged.
The Trust to ensure that mothers attending maternity triage who require an obstetric review have this undertaken before they are discharged.
The Trust to ensure that mothers presenting with vaginal bleeding are treated as having an antepartum haemorrhage until holistically assessed as otherwise, in line with national guidance (Royal College of Obstetricians & Gynaecologists (RCOG), 2011).
The Trust to ensure that mothers requesting epidural pain relief receive a timely clinical assessment to support decision making around the method of pain relief.
The Trust to ensure that mothers requiring a review by a different speciality are reviewed on the maternity unit where oversight can be managed by the obstetric team.
The Trust to ensure that mothers requiring continuous electronic fetal monitoring, can use toilet facilities without the monitoring being discontinued.
The Trust to ensure that mothers using the telephone triage system receive a timely risk assessment and ongoing plan for care.
The Trust to ensure that mothers who are high risk for placenta accreta, undergoing planned caesarean birth, have experienced gynaecological consultant presence at the start of their planned birth.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that mothers who have a reason to be worried about pregnancy or childbirth, are able to consult an obstetrician or a consultant midwife in line with Birthrights (2024).
The Trust to ensure that mothers whose waters break before labour are offered the option of induction of labour as soon as possible or after 24 hours and are fully informed of the risks and benefits of the timing of induction of labour in line with national guidance (National Institute for Health and Care Excellence (NICE) 2023).
The Trust to ensure that mothers with a previous caesarean birth receive continuous fetal monitoring from the onset of regular painful contractions to enable ongoing assessment of fetal wellbeing.
The Trust to ensure that mothers with previous trauma and current anxiety are referred to the specialist perinatal mental health team for support, care and planning for birth.
The Trust to ensure that mothers with risk factors identified in labour receive a face-to-face multi-disciplinary holistic review.
The Trust to ensure that neonatal staff have opportunities to update skills and training at regional neonatal intensive care units, as recommended by national guidance (British Association of Perinatal Medicine's (BAPM 2022)). This will ensure that staff have opportunities to maintain clinical skills and experience (relevant to their practice) that may not frequently be seen in local neonatal units.
The Trust to ensure that new local guidance being developed on antenatal cardiotocographs (CTGs) is implemented and embedded into practice. This needs to include when and how to escalate concerns with antenatal CTGs. This will ensure that abnormal features of an antenatal CTG are recognised, acted upon and effectively escalated in a timely way.
The Trust to ensure that observations outside of the expected ranges are escalated to the obstetric team as recommended in local modified early obstetric warning score and national Birmingham Symptom Specific Obstetric Triage System (BSOTS) guidance (Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham, 2020). This will enable required intervention to be provided and plans of care to be reviewed.
The Trust to ensure that ongoing monitoring for protein in urine is performed in line with local and national guidance, or individual management plans, to inform decision making and plans of care.
The Trust to ensure that passive cooling is only undertaken following a diagnosis of hypoxic ischaemic encephalopathy when there is a plan for therapeutic cooling.
The Trust to ensure that placentas are sent for pathological examination including histology in line with national guidance (Evans et al, 2022).
The Trust to ensure that placentas are sent for pathological examination including histology in line with national guidance (Evans et al, 2022).
The Trust to ensure that prompt fetal monitoring is commenced when mothers present with raised blood pressure in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023; NICE, 2022c; Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham, 2020).

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that relevant information that may influence choice regarding mode and timing of vaginal birth after caesarean birth (VBAC) or elective repeat caesarean birth (ERCS) are fully explored including previous obstetric history.
The Trust to ensure that results generated in the maternity triage unit areas have a formal pathway of follow up. This would include senior clinical oversight of abnormal results to allow appropriate management plans to be generated.
The Trust to ensure that routine checks are not delayed when a baby is sleeping, to support staff to undertake a holistic wellbeing assessment and to support timely identification of concerns.
The Trust to ensure that safe staffing levels are prioritised in maternity triage in order to support the service being provided in line with national good practice paper (Royal College of Obstetricians & Gynaecologists (RCOG), 2023).
The Trust to ensure that shared and supported decision making to include the benefits, risks and alternatives for expedition of birth or continuation of a pregnancy are explained effectively to a mother to allow her to make informed decisions about timing and mode of birth.
The Trust to ensure that simulation and emergency skills training supports staff in considering whether umbilical venous catheter insertion is required early in a resuscitation and further supports them to consider the optimal positioning at the resuscitaire to do this in a timely manner.
The Trust to ensure that staff are able to access mothers' histories and handover of care to enable full risk assessment when they attend in labour to facilitate care to be provided on the correct pathway.
The Trust to ensure that staff are enabled to carry out continuous monitoring of the baby's heart rate in theatre.
The Trust to ensure that staff are supported in implementing the Birmingham Symptom Specific Obstetric Triage System (BSOTS) to enable mothers to be seen in a timely manner by the obstetric team for a plan of care to be implemented.
The Trust to ensure that staff are supported staff are supported to establish an accurate recording of a baby's heart rate, in order to inform the degree of urgency of birth that is required.
The Trust to ensure that staff are supported to be able to complete a full clinical risk assessment at each appointment to allow an individual management plan to be clearly written in the records.
The Trust to ensure that staff are supported to care for mothers on the midwifery led unit, to include a dynamic risk assessment prior to admission or transfer, especially when the unit is on standby.
The Trust to ensure that staff are supported to categorise cardiotocographs (CTGs) in triage in line with local and national guidance, to support accurate, timely recognition of concerns and clear communication and escalation when an obstetric review of the CTG is required.
The Trust to ensure that staff are supported to continually monitor and assess fetal wellbeing during labour and up to the point of birth when heart rate concerns are identified to ensure the urgency for birth does not need to be increased.
The Trust to ensure that staff are supported to delegate someone to have helicopter view when performing competing tasks during the birth process and postnatal period to prevent cognitive overload.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that staff are supported to enact its maternity early warning score escalation process to ensure that mothers are seen by a senior member of the obstetric team within the recommended timeframes
The Trust to ensure that staff are supported to ensure that a full clinical assessment is made taking into account all the available information and where necessary escalation to a more senior clinician is made so that the correct care plan can be implemented.
The Trust to ensure that staff are supported to ensure that a full clinical assessment is made taking into account all the available information so that the correct care plan can be implemented and where necessary escalation to a more senior clinician is made.
The Trust to ensure that staff are supported to escalate clinical concerns in line with the local maternity triage standard operating procedure. This will result in mothers being seen by the obstetric team within the required target review times and any immediate intervention to be provided.
The Trust to ensure that staff are supported to follow guidance for fluid balance management in labour to reduce the risk of hyponatraemia in a mother or a baby.
The Trust to ensure that staff are supported to follow local guidance including the correct use of the tool to prompt the interpretation of cardiotocographs (CTGs).
The Trust to ensure that staff are supported to follow the Trust guidance regarding when to remove a pessary being used to induce labour, when a mother is experiencing regular painful uterine activity.
The Trust to ensure that staff are supported to have a shared mental model of the urgency and operational steps to be taken when a decision for a caesarean birth is made on the grounds of concerns regarding fetal wellbeing.
The Trust to ensure that staff are supported to identify a baby's risk factors and to recognise where escalation to the neonatal team is indicated in line with local guidance.
The Trust to ensure that staff are supported to identify, escalate, and act upon fetal bradycardia in a timely manner as recommended in national
The Trust to ensure that staff are supported to make an initial comprehensive assessment of a mother's labour to enable the correct pathway of care to be determined.
The Trust to ensure that staff are supported to make ongoing assessments during a mother's labour to determine the clinical picture.
The Trust to ensure that staff are supported to provide neonatal life support in line with guidance.
The Trust to ensure that staff are supported to recognise and escalate when cumulative risk factors are identified, indicating a need for continuous cardiotocograph (CTG) and obstetric review.
The Trust to ensure that staff are supported to recognise and escalate when intermittent auscultation cannot be performed in accordance with national guidance.
The Trust to ensure that staff are supported to recognise and escalate when the second stage of labour does not progress within the expected parameters.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that staff are supported to recognise concerns in fetal wellbeing and escalation is completed to the obstetric team in line with local and national guidance.
The Trust to ensure that staff are supported to recognise the need for maternal and fetal monitoring when regular contractions start during an induction of labour.
The Trust to ensure that staff are supported to recognise uncommon scenarios on delivery suite and promote a multi-disciplinary team approach to their management. This can include the use of pre-existing civility toolkits for example NHS England 'Supporting our staff' toolkit and Capital Midwife Civility Toolkit.
The Trust to ensure that staff are supported to recognise when a cardiotocograph (CTG) is pathological and that the birth of the baby is expedited.
The Trust to ensure that staff are supported to relay a clear history (to include events prior to and during birth) to the neonatal team, reducing delays in care delivery and loss of information.
The Trust to ensure that staff are supported to request and obtain a timely review of the cardiotocograph (CTG), including fresh eyes in line with national recommendations.
The Trust to ensure that staff are supported to undertake and document regular, holistic postnatal checks of babies on the postnatal ward, including assessment of feeding, to support recognition and escalation of concerns where appropriate .
The Trust to ensure that staff are supported to undertake and document systematic reviews of continuous cardiotocograph (CTG) monitoring that will form part of holistic assessments.
The Trust to ensure that staff are supported to undertake holistic fresh eyes reviews, to facilitate recognition of cardiotocograph (CTG) abnormalities and escalate as necessary.
The Trust to ensure that staff are supported to undertake ongoing risk assessments during fetal monitoring to identify when continuous electronic fetal monitoring is to be offered
The Trust to ensure that staff are supported to undertake robust triage of postnatal calls to identify red flag symptoms and to review mothers and babies face to face if required.
The Trust to ensure that staff are supported to use a standardised approach to communication during handover of information to the neonatal team, reducing delays in care delivery and loss of information.
The Trust to ensure that staff are supported to use the emergency bell when there is an obstetric emergency to enable immediate review and care planning.
The Trust to ensure that staff are supported to use the escalation process if they are not able to complete the initial triage risk assessment within the expected 30 minute timeframe in line with local guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that staff are supported to use the Trust's tools to recognise and manage cardiotocograph (CTG) concerns, in order to inform the degree of urgency of birth that is required.
The Trust to ensure that staff are supported with timely escalation to the regional neonatal specialist service, enabling babies to receive effective specialist and intensive treatment in line with local and regional recommendation.
The Trust to ensure that staff consider anaemia as a cause for ongoing lack of stability particularly in the presence of pallor and evidence of maternal blood loss including the presence of blood stained or pink coloured liquor as well as in frank haemorrhage.
The Trust to ensure that staff have access to interpretation services, including readily available equipment to facilitate this.
The Trust to ensure that staff have the necessary training and confidence to use equipment provided to deliver effective resuscitation during a homebirth in line with national guidance.
The Trust to ensure that staff identify a lead in a neonatal emergency who can have oversight of the clinical situation, and delegate roles including elements of resuscitation and real time record keeping.
The Trust to ensure that staff of all levels are supported in escalating concerns further regarding patient care to maintain the safety of mothers and their babies.
The Trust to ensure that staff recognise and act on signs of maternal sepsis to ensure that a full clinical review takes place and supports commencement of the sepsis pathway.
The Trust to ensure that staff undertake a holistic assessment to support the recognition of established labour in mothers who are undergoing induction of labour to provide monitoring of fetal wellbeing in line with guidance.
The Trust to ensure that staff undertake a holistic plan of care when reviewing mothers which would include exploration of malposition (by abdominal palpation, ultrasound or vaginal examination) as a reason for the lack of progress, escalation to the senior obstetric team and discussion with the mother as to the options available to her (National Institute for Health and Care Excellence (NICE) 2023).
The Trust to ensure that staff undertake a holistic review of the baby's growth velocity (rate) using all the available information (customised growth chart, detailed ultrasound report and recognition of maternal risk factors) to inform decision making.
The Trust to ensure that staff undertaking neonatal resuscitation undertake multidisciplinary team training to optimise team working.
The Trust to ensure that staff use and understand the checklist for determining if chronic hypoxia or pre-existing fetal injury is present to ensure that there is a consistent assessment of and management of cardiotocograph (CTG) findings.
The Trust to ensure that staff utilise robust escalation systems to provide safe care to mothers during times of staffing shortages.
The Trust to ensure that staff who are not familiar with working within a clinical area are supported to practice safely and ensure escalations are made in line with local and national guidelines.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that staff working conditions allow them the capacity to recognise abnormal findings in maternity triage and are empowered by the triage system to act and escalate their concerns to the senior obstetric or midwifery clinical team.
The Trust to ensure that suitable equipment is readily available to ensure that monitoring of a mother's contractions is maintained to enable accurate categorisation of the cardiotocograph.
The Trust to ensure that support is in place to allow staff to maintain a helicopter view during complex emergency situations, including the verbalisation of the passage of time.
The Trust to ensure that the decision making around reorientation of care is in line with national and regional guidance.
The Trust to ensure that the findings from vaginal examinations are accurately recorded and used alongside other clinical information to determine when transfer of mothers to a birthing room is needed.
The Trust to ensure that the full clinical picture of the mother is considered when determining the timing and mode of emergency birth.
The Trust to ensure that the induction of labour process for postdates pregnancy is individualised and clearly discussed with mothers to enable informed and shared decision making in line with national guidance.
The Trust to ensure that the local pathway for the management of massive blood loss in the neonate is embedded into practice to support timely emergency escalation, haematology support and blood product replacement.
The Trust to ensure that the maternity early warning score is used within the Theatre and post anaesthesia care unit (PACU) during the postoperative recovery period, to support the timely recognition and escalation of observations outside of the normal range for maternity patients.
The Trust to ensure that the most senior clinician should make the decision to cool or rewarm after discussion with the cooling centre even if the baby was not transferred out.
The Trust to ensure that the multidisciplinary team remains in the room after a mother presents with an antepartum haemorrhage until maternal and fetal wellbeing has been comprehensively assessed.
The Trust to ensure that the neonatal and maternity teams are supported to implement neonatal resuscitation in accordance with national guidance (resuscitation council UK 2021)
The Trust to ensure that the new process for booking induction of labour reflecting prioritisation of clinical need is embedded in clinical practice and the effectiveness is assessed in a suitable timeframe.
The Trust to ensure that the pathway for escalation of clinical concerns is uncomplicated and supported by clear guidance.
The Trust to ensure that the resources and tools within their local guidance are available for use on the labour ward to support the assessment and calculation of blood loss.
The Trust to ensure that the resuscitation team are supported to deliver newborn life support in the sequence as determined within national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that the safety and working culture of the maternity unit supports collaborative multi-professional team working to enable respectful discussion, escalation and shared clinical decision making.
The Trust to ensure that the smoking cessation service has a feedback process in place to ensure referrals have been received and that those mothers who accept, are receiving the support they require to help them to stop smoking in line with national recommendations (NHS England 2019)
The Trust to ensure that the system of assessment for babies accommodates both infant feeding support for well babies and triggers an escalation pathway for babies with risk factors and increased parental concerns. (Trust B)
The Trust to ensure that the telephone triage service is consistent, adequately resourced and staffed by dedicated clinicians trained in completing telephone triage assessments and supports complete, contemporaneous documentation with access to electronic records, which allow easy identification of a mother's risk factors, at the time of the call.
The Trust to ensure that the timing of an induction of labour (IOL) is booked in line with local guidance and consideration of all risk factors and that this is not changed without a clinical indication and discussion with the mother.
The Trust to ensure that the tools for cardiotocograph (CTG) interpretation support staff to recognise abnormal features to prompt escalation and consideration of expedition of birth when conservative measures do not result in an improvement of the CTG.
The Trust to ensure that the use of local triage telephone risk assessment cards for vaginal bleeding and reduced fetal movements are embedded into practice.
The Trust to ensure that the use of SBAR (situation, background, assessment, recommendation) is embedded into practice for all verbal and face-to-face handovers and requests for medical review.
The Trust to ensure that there are daily obstetric holistic reviews of all mothers awaiting transfer to the delivery suite for induction of labour. This will ensure that evolving risk factors are identified and transfer to the delivery suite is expedited.
The Trust to ensure that there are effective procedures and processes in place for staff to follow during events such as a planned power shut down, enabling them to deliver timely care.
The Trust to ensure that there are robust systems and processes for all aspects of maternity triage which are embedded in all clinical areas and supported by standardised operating procedures to ensure consistency in care and assessments across the maternity unit.
The Trust to ensure that there is a clear escalation policy and staff are supported to challenge decisions regarding the management plan for a mother when there are differing clinical opinions.
The Trust to ensure that there is a clear process and expectation of time frames for communicating scan referral decisions and the advised plan, to allow timely information to be given to a mother and support prompt care planning.
The Trust to ensure that there is a robust antenatal risk assessment process in place to support each mother's individual health and social situation needs, and that these needs are taken into consideration when planning care in labour at each point of contact.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that there is a robust process in place to provide a prescription for aspirin from 12+0 weeks for mothers who meet the criteria for aspirin administration
The Trust to ensure that there is a robust process in place to provide a prescription for aspirin from 12+0 weeks for mothers who meet the criteria for aspirin administration.
The Trust to ensure that there is a robust system in place in order that neonatal rectal probes are available for use at all times on the unit.
The Trust to ensure that there is a robust system in place to accurately and contemporaneously assess the baby using the Apgar score chart, document the information and escalate appropriately.
The Trust to ensure that there is a robust system to recognise and escalate the inability to transfer a mother from the antenatal ward to the labour ward, with a system to move staff when required to ensure mothers receive care in a safe environment.
The Trust to ensure that there is a robust system to record acuity and escalation within the triage unit and the delivery suite. This must include recognition, reporting and escalation of all red flag incidents, to ensure mothers and babies are cared for in a safe environment.
The Trust to ensure that there is an awareness of the possibility of task focus and that staff are supported to undertake a holistic review and risk assessment to inform care planning.
The Trust to ensure that there is an environment in the Trust where a second clinician can be asked to help when there is task overload to ensure adequate fetal monitoring is maintained.
The Trust to ensure that there is an obstetric review and contemporaneous cardiotocograph (CTG) assessment for all mothers and babies prior to an in-utero transfer to another Trust, for assurance that the plan of care is suitable, and that transfer/journey is safe to undertake.
The Trust to ensure that there is obstetric oversight, with ongoing clinical assessment and monitoring when induction of labour is not planned following reduced fetal movements at term.
The Trust to ensure that there is oversight of activity in the birth centre to enable staff providing care to prioritise mothers needing one to one care.
The Trust to ensure that they use a recognised management of change process to assess and manage significant organisational change with required mitigation and alterations identified to support the quality of the clinical care provided.
The Trust to ensure that triage advice for reduced fetal movements (RFM) is given in line with local and national guidance and is embedded into clinical practice.
The Trust to ensure that when a baby's birth requires expediting due to a pathological cardiotocograph (CTG), staff are supported to recognise the urgency to support the correct categorisation of an assisted birth.
The Trust to ensure that when a cardiotocograph (CTG) is pathological in labour, continuous fetal monitoring is provided to maintain ongoing assessment of a baby's wellbeing.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that when a mother attends for assessment following a concern that the full clinical assessment is documented and an ongoing plan of care is formulated and completed.
The Trust to ensure that when a mother attends with nausea and vomiting in pregnancy, a full assessment including a pregnancy-unique quantification of emesis (PUQE) score is completed to support decision making and ongoing management.
The Trust to ensure that when a mother presents with potential preterm prelabour rupture of membranes (PPROM), a full assessment, including a vaginal speculum examination is performed to support ongoing care planning.
The Trust to ensure that when a mother requires transfer between clinical areas, there is a robust and standardised process to assess fetal wellbeing. This includes the availability and usability of cardiotocographs (CTGs) within the operating theatre setting.
The Trust to ensure that when a mother requires transfer from the birth centre there is a robust and standardised process to document communication of urgency and concerns.□
The Trust to ensure that when a plotted symphysis fundal height measurement demonstrates an increased trajectory, actions are considered and initiated to screen for polyhydramnios and fetal size.
The Trust to ensure that when a specialist team makes a recommendation for another healthcare professional to start treatment if certain clinical events occur, the specialist team provides all the required medication details (name, route and dose of the medication) at the time of the recommendation to avoid delays in commencing treatment .
The Trust to ensure that when an urgent transfer occurs there are clear communication processes to ensure that information is given and received to support timely review and care planning.
The Trust to ensure that when care planning with mothers whose needs are complex, clinicians are supported to develop a holistic understanding of the clinical picture with protected time to review clinical information and liaise with mothers and other clinicians.
The Trust to ensure that when clinicians are conducting virtual (telephone) appointments they have access to all the available clinical information, to support informed decision making to plan mothers care.
The Trust to ensure that when complex clinical situations occur on the neonatal unit, a staff member is assigned the role of a leader, to maintain clinical oversight of the situation. This will ensure that the situation can be monitored with ongoing issues identified.
The Trust to ensure that when concerns with the fetal heart rate are identified on intermittent auscultation that this is escalated to the obstetric team for a review in line with national guidance (National Institute for Health and Care Excellence (NICE), 2022).
The Trust to ensure that when creating individualised care plans, consideration is given to the timing of intrapartum antibiotic prophylaxis for Group B Streptococcus (GBS). (Trust A)
The Trust to ensure that when fetal growth has been shown to have reduced/crossed centiles that clinicians assess and recognise a reduction in fetal growth, in line with other elements of a mother's care pathway.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that when induction of labour is being offered, all relevant information is taken into account to provide appropriate counselling to mothers to support their decision making.
The Trust to ensure that when induction of labour is being offered, alternative options are discussed with mothers and documentation made of what discussions were had to support informed decision making.
The Trust to ensure that when local guidance is updated that there is an effective pathway of implementation, with a process to ensure that it is accessible for staff.
The Trust to ensure that when mothers are reviewed by the obstetric team a risk assessment is completed, supported using a structured handover tool. This must include a mother's antenatal and intrapartum history and current clinical assessment of the mother and baby.
The Trust to ensure that when mothers request a caesarean birth in labour they are fully informed of their individual risks and benefits for this option to enable an informed choice.
The Trust to ensure that when mothers with risk factors are undergoing induction of labour, continuous electronic fetal monitoring is offered, in line with national guidance, when regular painful uterine activity starts.
The Trust to ensure that when regional analgesia for a category 1 assisted vaginal birth is required, the quickest method for adequate analgesia is provided.
The Trust to ensure that when reviewing a cardiotocograph (CTG) to decide the need for intervention, other risk factors present, such as the stage of labour, the presence of significant meconium and the period of time that a CTG has been pathological, are taken into account.
The Trust to ensure that when staff are escalating concerns regarding fetal wellbeing communication is done using an objective and structured method, such as SBAR (Situation, Background, Assessment, Recommendation) to allow for the whole clinical picture to be appreciated.
The Trust to ensure that when the clinical situation changes, and escalation to obstetric care is indicated, emergency transfers to the labour ward (LW) are carried out promptly, and in line with national guidance.
The Trust to ensure that when there are concerns with the fetal heart, staff make use of their emergency call systems to summon prompt senior obstetric support.
The Trust to ensure that when there are ongoing uncertainties as to whether a baby's heart rate is being monitored, ultrasound scan is used to confirm the presence and heart rate of the baby.
The Trust to ensure that when there is a clinical option that is not of overall benefit to a mother this must be clearly and repeatedly communicated to her, using feedback to ensure that mothers, families and clinicians have a common understanding.
The Trust to ensure that when there is unsuccessful escalation, staff are empowered with escalation tools including the use of the emergency call
The Trust to ensure that when women are identified as having Group B Streptococcus (GBS), staff are supported with a robust system that highlights this to all clinicians in order to facilitate intrapartum antibiotic prophylaxis administration in line with local and national guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure that where a mother's first language is not English, there is a documented discussion of language needs and support is provided to ensure effective communication and promote informed decision making throughout maternity care.
The Trust to ensure that where a mother's first language is not English, there is an assessment and documented discussion of language needs to provide support and ensure effective communication to promote informed decision making throughout maternity care.
The Trust to ensure that where a mother's first language is not English, there is an assessment and documented discussion of language needs to provide support and ensure effective communication to promote informed decision making throughout maternity care.
The Trust to ensure that, when the midwifery led unit is open, it is staffed and equipped to ensure the delivery of safe care.
The Trust to ensure the 2222 emergency bleep system is used, in cases of maternal emergencies, to enable staff to summon the required help in the most efficient way.
The Trust to ensure the additional needs of a mother are effectively and appropriately communicated throughout pregnancy to ensure individualised care and ongoing risk assessment.
The Trust to ensure the Birmingham Symptom Specific Obstetric Triage System (BSOTS) is embedded with sufficient resources to support staff to complete a risk assessment within 15 minutes to inform prioritisation of care.
The Trust to ensure the continuation of the maternal pulse tracing, alongside the fetal heart rate tracing in theatre to help clinicians recognise when there is accidental monitoring of a mother's heart rate with the equipment meant to monitor a baby's heart rate.
The Trust to ensure the escalation of mothers experiencing significant clinical deterioration includes the early involvement of clinicians with critical care skills, to optimise care planning.
The Trust to ensure the first fit clinic is staffed sufficiently so that the required multi disciplinary team (MDT) approach is consistent during times of planned and unplanned leave.
The Trust to ensure the indication for induction of labour (IOL) is accurately recorded in any location where this information may be referred to to enable subsequent decision to be made with the relevant information.
The Trust to ensure the Newborn Early Warning Trigger and Track (NEWTT 2) observation chart is used when a baby is at risk of hypoglycaemia, in line with national guidance (British Association of Perinatal Medicine, 2023).
The Trust to ensure the required action is implemented promptly when outstanding investigation results are reviewed after a mother has been discharged from the maternity assessment unit.
The Trust to ensure the safety of mothers during labour is maintained with the minimum staffing levels and skill mix.
The Trust to ensure the 'teach back' method of communication is used by clinicians to confirm information shared with the mother has been
The Trust to ensure the 'teach back' method of communication is used by clinicians to confirm information shared with the mother has been

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure theatre recovery staff are trained in the use of the maternity early warning score, to support the timely recognition and escalation of observations outside of the normal range for maternity patients.
The Trust to ensure their new process supporting the expedition and prioritisation of induction of labours is utilised and effective.
The Trust to ensure there is a clear joint escalation plan made in the event of an obstetric emergency on the intensive care unit.
The Trust to ensure there is a clearly communicated process and tools for assessing risk factors and guidance on the escalation of a deteriorating newborn. Including a framework for assessing the urgency and timeframe within which a review is needed.
The Trust to ensure there is a comprehensive guideline for the expectation and use of a MEOWS (maternity early obstetric warning system), to support recognition of abnormal observations, and effective escalation to aid clinicians to prioritise their responses.
The Trust to ensure there is a process for early identification and referral for multidisciplinary review of abnormally invasive placenta, in line with NHS England (2020) guidance.
The Trust to ensure there is a prompt obstetric review when there are concerns about a baby's wellbeing. This review is to include holistic assessment of existing and developing risk factors to share with families to help them make informed decisions.
The Trust to ensure there is a robust and consistent mechanism within the electronic patient record system to ensure that plans of care are easily accessible and visible to all members of staff.
The Trust to ensure there is a robust communication mechanism in place to ensure staff are able to voice and escalate key pieces of information to work towards common and agreed management goals.
The Trust to ensure there is a robust pathway to ensure when a mother attends with multiple episodes of a reduced fetal movements (RFM) that the option of induction of labour at 39 weeks is discussed in line with local and national guidance.
The Trust to ensure there is a robust system that supports induction of labour to be booked for the gestation that has been clinically agreed and staff are supported to use this.
The Trust to ensure there is a robust way to prioritise induction of labour (IOL), with a clear process which allows the clinicians to maintain clinical oversight.
The Trust to ensure there is a systematic approach to triage and documentation of telephone calls regarding unwell babies to identify, assess and treat unwell babies in an acute setting.
The Trust to ensure there is an awareness of the possibility of task focus and task overload and that staff are supported to escalate when fetal monitoring does not provide assurance of fetal well-being.
The Trust to ensure there is an identified lead clinician who leads the care for mothers with evolving complex medical and obstetric needs.
The Trust to ensure there is clear guidance and escalation pathway in line with National guidance, to support staff where a mother does not smoke, and her carbon monoxide (CO) level is raised in pregnancy.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure there is effective support and awareness of possible task overload when staff are in the preceptorship period.
The Trust to ensure there is timely escalation to the obstetric team when fetal wellbeing cannot be assured, in line with local and national guidance.
The Trust to ensure they have a robust system to support staff to undertake a full holistic assessment to include all known risk factors to support decision making when considering inviting mothers to attend.
The Trust to ensure they have a SOP (Standard Operating Procedure) to ensure clinicians are aware of what the expected process is for escalation of an obstetric emergency located in the triage area.
The Trust to ensure tools and guidance for the recognition and management of sepsis are embedded in clinical practice, to identify and initiate timely treatment for sepsis, if required, and prompt early escalation for multidisciplinary involvement.
The Trust to ensure triage calls are taken by registered members of the team, completing a holistic assessment to inform the urgency of admission.
The Trust to ensure when a fetal heart rate abnormality is confirmed on the birth centre there is an embedded process to arrange timely transfer for ongoing care.
The Trust to ensure when a mother is admitted to the labour ward, undergoing an induction of labour after previous caesaeran birth that there is obstetric oversight of her care, with an intrapartum care plan in line with national guidance.
The Trust to ensure when a mother is transferred from triage to labour ward due to cardiotocograph (CTG) concerns, an obstetric review is requested immediately to plan the ongoing care.
The Trust to ensure when a mother spontaneously ruptures her membranes during the induction of labour process that a diagnosis is made promptly to ensure timely communication and transfer to labour ward for augmentation.
The Trust to ensure when a mother, having been provided with all the relevant clinical information, has concerns regarding her pregnancy and birth, that a collaborative individualised plan is produced including discussions and documentation of the risks and benefits related to the mother's concerns.
The Trust to ensure when an induction of labour is discussed following a previous caesarean birth that all relevant information is given, to support making an informed decision.
The Trust to ensure when any manoeuvres are started for the management of a diagnosed shoulder dystocia, that this is declared an emergency, to ensure there are sufficient clinicians present to be able to perform the manoeuvres effectively.
The Trust to ensure when large for gestational age (LGA) baby is identified on ultrasound scan (USS) that a robust process exists to support a consultant appointment occurs in line with guidance.
The Trust to ensure when mothers are requiring increasing analgesia during an induction of labour, especially when pain control is still not achieved, that the need for transfer to the delivery suite is reviewed, regardless of the cervical dilatation.
The Trust to ensure when observations are completed, staff are supported to recognise when they are outside of the expected range and escalate in line with local guidelines.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to ensure when rupture of membranes occurs during the induction of labour process, a prompt assessment takes place to review and consider any changes required to the plan of care.
The Trust to ensure when staff recognise observations outside the expected ranges, escalation to the obstetric team including clear communication of the actual values, occurs to inform a mother's ongoing care.
The Trust to ensure when there is a changing clinical picture during latent labour that staff are supported to complete a risk assessment to identify the most appropriate location for ongoing care.
The Trust to ensure when there is a recognised delay in the second stage of labour that a timely obstetric review occurs to plan expedition of birth.
The Trust to ensure where umbilical venous access is difficult, intraosseous cannulation can be carried out promptly to enable the early administration of adrenaline to support effective resuscitation.
The Trust to ensure women attending maternity triage in suspected labour are assessed quickly and have their baby's heart rate auscultated, alongside measurement of the mother's pulse, as part of that initial assessment.
The Trust to ensure women choosing care outside of local guidance are offered a personalised care and support plan that includes contingencies in line with the mothers preferences and values, considering possible scenarios which is shared with all relevant clinicians.
The Trust to ensure women choosing care outside of local guidance are offered a personalised care and support plan that includes contingencies in line with the mothers preferences and values, considering possible scenarios which is shared with all relevant clinicians.
The Trust to ensure women over the age of 40 are informed of the risks associated with post maturity in pregnancy and are offered a choice of induction of labour from 40+0 weeks onwards, in line with national guidance.
The Trust to ensure, that mothers are supported to make informed choice where there are intrapartum risk factors for shoulder dystocia when they have known diabetes and fetal biometry outside the normal range.
The Trust to ensure, that regardless of parity all mothers are provided with the opportunity for a discussion about pregnancy, labour and birth during pregnancy and that mothers are given the information required to support their decision making.
The Trust to evaluate the process of how patients are reviewed post admission, to include the handover between teams and to ensure clinical
The Trust to explore the barriers to using a written handover tool. This will inform the design and help embed the use of a tool to support the accurate communication from one clinician to another.
The Trust to explore the functionality available on the electronic patient record system to support a correct categorisation output during antenatal cardiotocograph (CTG) interpretation.
The Trust to explore unconscious bias affecting personalisation of care leading to health inequalities.
The Trust to explore use of tools to support shared decision making. This is to ensure mothers are actively involved in the management decisions and personalisation of their care.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to have a strategy so the cumulative risk profile is reviewed and updated at each antenatal contact. This is to support recognition of risk when planning ongoing care and timing of birth.
The Trust to have clear guidance relating to antenatal care planning for women choosing to birth at home. This should include discussions around choices available, when transfer into hospital is recommended.
The Trust to have clear guidance relating to antenatal care planning for women choosing to birth at home. This should include discussions around choices available, when transfer into hospital is recommended.
The Trust to liaise with regional stakeholders to ensure the correct mechanisms are in place to ensure timely advice is available from the regional specialist centre.
The Trust to notify NHS pathways of this scenario to support changes with the NHS pathways flow triage tool to improve the triage process and support changes in future maternity call categorisation.
The Trust to notify NHS pathways of this scenario to support changes with the NHS pathways flow triage tool to improve the triage process and support changes in future maternity call categorisation.
The Trust to provide additional specialist equipment and education in the use of such, to aid a caesarean birth operation when indicated, when there is the complication of a raised Body mass Index (BMI).
The Trust to provide an assessment tool for clinicians to aid assessment of risk when planning the location of an induction of labour.
The Trust to provide clarity for all staff regarding the circumstances under which they would call the regional neonatal intensive care unit or the regional neonatal transfer service for advice guidance and additional support.
The Trust to provide clinicians with the training, procedures and guidance to categorise and document cardiotocographs (CTGs) in the electronic patient record system in order to create a shared mental model and ensure ongoing escalation and care planning.
The Trust to provide mothers with accurate personalised information and to ensure their understanding of this, to enable them to make an informed choice regarding mode of birth.
The Trust to provide staff with the skills which will empower them to have informed conversations in challenging situations.
The Trust to provide visual prompts for staff of the neonatal life support algorithm for drug administration on all neonatal resuscitaires and emergency neonatal resuscitation trolleys.
The Trust to review and amend its local guidance to align with national guidance on fetal heart rate monitoring when meconium-stained liquor is
The Trust to review and amend local guidance on post-dates induction of labour in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021).

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to review and embed the process for admitting mothers from maternity triage who require inpatient maternity care to support mothers receiving safe clinical care, including continual risk assessments, robust fetal monitoring and ongoing emotional support.
The Trust to review and embed the process of offering immediate augmentation of labour following confirmation of ruptured membranes in line with local and national guidance.
The Trust to review and embed the process when care is delayed supporting mothers having a regular risk assessment and holistic clinical reviews led by a senior obstetrician.
The Trust to review and update their assisted vaginal birth guidance focusing on options for birth in the second stage of labour to fully support information given and maternal choice, in line with national guidance (Royal College of Obstetricians & Gynaecologists (RCOG) 2020).
The Trust to review and update their fetal heart rate guidance, so that it is in line with the current national guidance to support staff to recognise and escalate cardiotocograph (CTG) concerns correctly.
The Trust to review current systems and documentation to support timely, systematic and accurate handover of care and risk assessment for mothers in labour.
The Trust to review how clinical oversight is maintained every 15-30 minutes once a delay in the second stage of labour has been recognised in line with local and national guidance.
The Trust to review how information from other clinical areas is shared so that staff are able to make holistic assessments recognising all risk known factors. This is to support decision making and safe ongoing care.
The Trust to review how their staff confirm understanding of the information given to women whose first language is not English, so that mothers can access care when needed.
The Trust to review how they might support staff when prescribing and administering medicines within the local neonatal unit, so that medicines are given in a timely way. This may include the use of monographs and a Trust wide system for wards to search for stock drugs within other areas of the
The Trust to review how they support staff to obtain blood in an emergency situation, without activating the major haemorrhage protocol.
The Trust to review how well embedded and understood the use of the RAPP (respiratory, activity, perfusion and position) tool is amongst staff and confirm to staff that routine assessment can be undertaken whilst maintaining skin to skin.
The Trust to review its management of mothers with pre-eclampsia to ensure they are informed of the recommended timing of birth and offered induction of labour in line with local and national guidance.
The Trust to review its process of communicating caesarean birth categorisation to minimise misunderstanding and support maintaining a helicopter view to expedite birth.
The Trust to review local guidance and processes to prompt reassessment of a baby's wellbeing via cardiotocograph (CTG) monitoring or intermittent auscultation whilst mothers are awaiting a category 3 caesarean birth.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to review local guidance for the schedule of serial growth ultrasounds in line with national guidance (NHS England 2023) and ensure that staff are aware of the changes.
The Trust to review pathways of communication between maternity, emergency department (ED) and the paediatric service to ensure timely identification, referral and treatment of babies in the correct setting.
The Trust to review processes in recovery to ensure that there is appropriate clinical care of the baby prior to transfer to the postnatal ward.
The Trust to review processes to ensure staff are supported to continuously reassess a baby's heart rate during a resuscitation using a stethoscope in addition to an oxygen saturation monitor.
The Trust to review risk assessments in telephone triage to support staff to recognise when a category one ambulance transfer to hospital may be indicated.
The Trust to review staffing arrangements to support timely senior face-to-face obstetric review when a triage assessment identifies this is required to maintain senior obstetric oversight.
The Trust to review support for decision making around timing of birth for mothers who develop pre-eclampsia before 37 weeks gestation and ensure this is in line with national and local guidance.
The Trust to review systems and procedures for checking and replenishing of neonatal emergency equipment.
The Trust to review systems and technologies to support clear communication with and between senior staff, and support clinical oversight of high risk mothers on admission to labour ward.
The Trust to review systems of information provision to support mothers to understand expected feeding patterns and when and how to request breastfeeding support on the postnatal ward.
The Trust to review the barriers for staff around assessment of heart rate auscultation and early consideration for vascular access during neonatal resuscitation.
The Trust to review the barriers preventing staff from communicating with the on-call anaesthetist team when mothers with a body mass index above 50kg/m2 are admitted, to enable early anaesthetic involvement and multiprofessional discussions.
The Trust to review the birth environment to ensure that cardiotocograph (CTG) equipment is easily visible to clinicians as part of their information gathering source.
The Trust to review the current booking system to ensure that fail-safe mechanisms are in place to identify when mothers miss appointments, to minimise the risk of them not receiving care in pregnancy.
The Trust to review the electronic patient record system and telephone triage staffing arrangements to ensure that all telephone calls to the maternity triage are documented contemporaneously and that repeated calls can be easily identified by clinicians.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to review the electronic patient record system to ensure that at every clinical contact the mothers risk assessment is reviewed and updated to ensure on-going care provision by the relevant clinician.
The Trust to review the environment and support services for growth ultrasound scan appointments in the satellite hospital, to ensure they meet national guidance (British Medical Ultrasound Society (BMUS) 2022) to aid optimal ultrasound scans images and reports.
The Trust to review the governance processes supporting use of mobile phones and text messaging within community midwifery services to ensure shared understanding of the purpose of the system and how it is used. This will restrict the use of text messages for administration purpose rather than clinical conversations.
The Trust to review the pathway for escalation steps to be taken if an alarm continues to sound when there are similarities between the maternal heart rate and fetal heart rate recordings.
The Trust to review the process and staffing allocation so mothers are supported to receive a timely senior face to face assessment in line with national guidance (Royal Colleges Obstetricians Gynaecologists, 2023, Birmingham Symptoms Obstetric Triage Score, 2024). The investigation acknowledges a change in work practices has already started.
The Trust to review the process and staffing allocation so mothers are supported to receive a timely, senior, face to face assessment in line with national guidance (Royal Colleges Obstetricians Gynaecologists, 2023, Birmingham Symptoms Obstetric Triage Score, 2024). The investigation acknowledges a change in work practices has already started.
The Trust to review the process for arranging an urgent post-dates caesarean birth for mothers when the planned lists are full. This is to offer expedition of post-dates birth in line with national guidance.
The Trust to review the process for organising and reviewing maternal observations so that, at times of high activity there is increased awareness of recent observations, their indicated frequency, and indicated care plan including seniority and reviewing specialties.
The Trust to review the process of antenatal care provided by all stakeholders to ensure consistency with the national recommendations (NHS England, 2023)
The Trust to review the process of obstetric input after an ultrasound scan identifies clinical concerns to promote a full discussion with the mother about the options for her ongoing care.
The Trust to review the process of the fresh eyes cardiotocograph (CTG) reviews in labour to ensure they are independent and effective, to optimise the opportunity for recognising fetal heart rate abnormalities.
The Trust to review the provision of breastfeeding information, and the oversight and documentation of breastfeeding in the immediate postnatal period to support mothers and staff to recognise where an active feeding plan may be indicated.
The Trust to review the provision of dedicated senior obstetric support to enable staff to escalate clinical concerns in a robust and clear way.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to review the quality of ultrasound measurements by complying with NHS England (2023) and British Medical Ultrasound Society (BMUS 2022) guidance on audit and continuous learning in relation to third trimester assessment of fetal wellbeing (growth ultrasounds).
The Trust to review the senior obstetric oversight of the obstetric assessment unit (OAU) to ensure there is pro- active, forward care planning for mothers' pregnancies including the timing of the birth.
The Trust to review the system and process for achieving clinical review without delay when escalation is needed.
The Trust to review the system for booking serial growth ultrasound scans for mothers at risk of having a small for gestational age baby and that this includes ultrasound scan surveillance until birth, in line with national guidance, to prevent late onset fetal growth restriction being unrecognised.
The Trust to review the system in place to ensure that of all test results, regardless of the location of the patient are actioned.
The Trust to review the systems and processes in place to support staff to maintain oversight of infant feeding on the postnatal ward.
The Trust to review the use of, and the effectiveness of, the handover of care structured tool to minimise any barriers to support use in all situations when transfer of clinical information is required.
The Trust to review their antenatal triage assessment card to support staff when an antenatal cardiotocograph (CTG) assessment tool would be more suitable than an intrapartum CTG tool.
The Trust to review their cardiotocograph (CTG) interpretation tool to support an overall categorisation being required at every review.
The Trust to review their equipment used for intermittent auscultation (IA) so that all practitioners are aware of the limitations of when auscultating a fetal heart rate in labour, to enable them to escalate when there are concerns with fetal wellbeing.
The Trust to review their guidance on timing of birth when pre-eclampsia is diagnosed, to accurately and clearly reflect national guidance.
The Trust to review their induction of labour process to allow supported decision making for mothers around the timing of induction of their labours from 41+0 weeks gestation in line with national guidance.
The Trust to review their practice and guidance to ensure staff discuss options for the management of prelabour rupture of membranes, in line with national guidance.
The Trust to review their process and procedure for review and management of pathology results to provide timely action of, and information to, mothers who need treatment or changes to their care pathway.
The Trust to review their processes for admitting women onto the electronic system, so that all cardiotocograph (CTG) recordings are visualised on the centralised monitoring system in real time and with no delays to commencing this.
The Trust to review their processes in preparing for, and achieving of, fixation of endotracheal tubes. Trust guidance should be followed, evaluated and - if necessary - improved as part of regular multidisciplinary training.
The Trust to review their provision of pre pregnancy counselling to enable mothers with complex medical needs to access this service.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to review their service provision in line with National Institute for Health and Care Excellence (NICE) (2010) and NHS England (2023) core competency framework Version 2 guidance and design a robust education programme and process that supports clinicians to recognise the needs of mothers where English is not their first language. This should include offering interpretation services at every clinical contact.
The Trust to review their strategy for addressing and mitigating against unconscious bias and health inequalities that are known to exist within maternity care in order to improve mothers experiences of care.
The Trust to review their telephone triage system and ensure the service is a functional, robust service which provides their users with a dedicated line to provide immediate advice and reassurance for mothers.
The Trust to review their training and guidance, to reflect the agreed practice and manoeuvres during a vaginal breech birth. This is to create a shared understanding of the vaginal breech birth pathway and cohesive management between all members of the clinical team.
The Trust to review triage systems and processes for reviewing medical records to support staff to undertake accurate, holistic risk assessments and inform care planning for mothers attending maternity triage.
The Trust to revise the process so a standardised and structured process is used when providing telephone advise that supports a mother's personalised risks being immediately seen when staff access their electronic patient records.
The Trust to support a standardised approach to the location of management plans in the electronic records, to support staff in carrying out the recommended plan of care.
The Trust to support advice being given to a mother with a cervical ripening balloon (CRB) in place as to when they need to attend for reassessment in line with guidance.
The Trust to support clinicians to immediately use the emergency escalation system when a shoulder dystocia is recognised to ensure a multidisciplinary response.
The Trust to support clinicians to perform a cardiotocograph (CTG) immediately prior to the insertion of prostaglandins to confirm fetal wellbeing and assess uterine activity.
The Trust to support clinicians to recognise any signs of a shoulder dystocia and to escalate this as an obstetric emergency.
The Trust to support clinicians to use the emergency escalation system when a fetal bradycardia is recognised to ensure urgent obstetric support.
The Trust to support staff in being able to have oversight and maintain continuous fetal monitoring in the second stage of labour in high-risk women to provide reassurance of fetal wellbeing.
The Trust to support staff in easy identification of abnormal clinical signs, at any time, that require escalation to a paediatrician in a baby that has been allocated to the green pathway.
The Trust to support staff in facilitating fresh eyes reviews of cardiotocographs (CTGs) and escalation for senior obstetric review in line with guidance.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to support staff to acknowledge risk management actions to enable a baby's plan of care to be communicated and managed when separated from a mother and during periods of handover of care between staff.
The Trust to support staff to appreciate the significance of abnormal cord gases in a baby who appears otherwise well and to promptly escalate and communicate abnormal cord gas results to the neonatal team to allow for effective assessment and treatment.
The Trust to support staff to be able to complete the required tasks, including discussion about birth planning for pregnancy beyond the estimated due date at 38-week antenatal appointments.
The Trust to support staff to both recognise and manage a shoulder dystocia when mothers birth their babies in a birthing pool.
The Trust to support staff to categorise a birth according to the clinical picture at the time.
The Trust to support staff to categorise cardiotocographs (CTGs) and to ensure that CTG categorisation is documented in the maternity records, to support holistic risk assessment and a subsequent plan of care.
The Trust to support staff to complete a comprehensive clinical review, including assessment of all contacts, attendances and risk factors when mothers attend in the latent phase of labour, and prior to assessing suitability for discharge.
The Trust to support staff to complete a risk assessment of the clinical picture when undertaking an assisted birth, including the seniority of staff involved, to reevaluate whether a change of approach is required or discontinuation of the procedure is needed.
The Trust to support staff to complete robust documentation relating to plans of care and mothers' choices.
The Trust to support staff to consider terbutaline is administered in all circumstances where clinically indicated to do so, regardless of the plan for mode and timing of birth.
The Trust to support staff to correctly interpret and categorise the cardiotocograph (CTG) trace and record this accurately with the tool provided.
The Trust to support staff to document an individualised plan of care when risk factors are known prior to induction of labour, which should include a plan for frequency of cardiotocograph (CTG) monitoring.
The Trust to support staff to ensure early escalation for regional intensive care support and advice.
The Trust to support staff to ensure mothers to receive dynamic and personalised counselling regarding mode of birth, in response to the evolving clinical picture, including all risks and alternatives.
The Trust to support staff to ensure that escalation occurs to senior staff when there are concerns around the quality of the cardiotocograph (CTG) and the wellbeing of the baby can not be assured.
The Trust to support staff to ensure that prostaglandin is prescribed and administered in line with Trust and national guidance. This would avoid an increased risk of a mother having uterine hyperstimulation.
The Trust to support staff to escalate and act when there are difficulties in effectively monitoring a baby's heart rate during intermittent auscultation.
The Trust to support staff to escalate cardiotocographs (CTGs) for a holistic obstetric assessment when required.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to support staff to facilitate a full clinical assessment of the mother and baby's wellbeing that is holistic and includes the evolving clinical picture when care is planned.
The Trust to support staff to follow guidance in relation to induction of labour, including the offer of caesarean birth.
The Trust to support staff to follow local guidance and use continuous cardiotocograph (CTG) monitoring for mothers who have been assessed as 'high risk of fetal compromise' and who are regularly contracting.
The Trust to support staff to identify and escalate evolving clinical concerns in order to ensure maternal and fetal wellbeing.
The Trust to support staff to implement the escalation process when criteria are met in line with local guidance.
The Trust to support staff to perform symphysis fundal height (SFH) measurements at every appropriate antenatal contact and plot on a growth chart.
The Trust to support staff to promptly recognise and effectively manage babies who are at risk of hypoglycaemia.
The Trust to support staff to recognise accumulating maternal and fetal factors when not in established labour and consider timely intervention to expedite birth.
The Trust to support staff to recognise and clearly communicate with mothers when there are concerns about the wellbeing of a baby.
The Trust to support staff to recognise observations outside the expected ranges and ensure escalation to the obstetric team to inform a mother's ongoing care.
The Trust to support staff to recognise the importance of a helicopter view and team leadership in emergency situations, to ensure the newborn life support algorithm is followed and clinicians do not become task focused.
The Trust to support staff to recognise the second stage of labour and perform auscultation of the baby's heart rate in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023).
The Trust to support staff to recognise when an urgent obstetric review is required and to escalate in line with local guidance.
The Trust to support staff to recognise when oxytocin is to be stopped during times of loss of contact and/or a bradycardia.
The Trust to support staff to recognise when to trigger the difficult airway algorithm to maximise the help and expertise available in an emergency.
The Trust to support staff to reduce delays in the birth of a second twin in the presence of increasing concerns for their wellbeing.
The Trust to support staff to re-establish birth preferences at the point of care to ensure there is ongoing informed consent for birth choices.
The Trust to support staff to undertake a holistic review considering previous clinical history and blood results to inform a mother's ongoing clinical pathway of care prior to discharge.
The Trust to support staff to undertake assessment of fetal wellbeing when there is uncertainty relating to the baby's movements.
The Trust to support staff to use a structured approach to aid the diagnostic clarity between respiratory and cardiac disease.
The Trust to support staff to use the emergency buzzer to escalate concerns with a fetal heart rate to ensure a multidisciplinary review is carried out as soon as possible.

Maternity safety recommendations
1 April 2024 to 31 March 2025



The Trust to support staff to work together to undertake holistic review of mothers to facilitate decision making.
The Trust to support staff, in all areas, to recognise when there is a prolonged deceleration present for greater than 3 minutes and support management of this as an obstetric emergency.
The Trust to support the consistent and effective sharing of clinical information and management plans during handovers.
The Trust to support the neonatal team to recognise when the onsite presence of a neonatal consultant would improve care.
The Trust to undertake a review of the management and process of neonatal resuscitation with a focus on consideration of reversible causes.
The Trust to update its guidance to reflect the manufacturers recommendation on actions to be taken by staff when mothers are regularly contracting when a prostaglandin pessary is in situ, to ensure removal occurs when indicated.
The Trust to update the intrapartum fetal monitoring guideline and cardiotocograph (CTG) assessment tool in line with national guidance, to support robust interpretation of fetal heart rate tracings.
The Trust to update the telephone triage assessment tool to support recognition of any prior pregnancy risks and concerns during the assessment, to support correct advice being given and signposting to care in the most suitable location.
The Trust to update their local guidance to reflect the national fetal monitoring guidance.
The Trust to work with clinicians to explore barriers to contemporaneous documentation, and to implement an achievable plan to improve the contemporaneous documentation of conversations with mothers and their families.
The Trust to work with multidisciplinary staff providing inpatient care overnight to understand the barriers to implementing the current escalation process, and to identify how this process can be closer aligned with the needs of clinical staff.
The Trust to work with staff to explore the barriers and factors which support recognition, escalation and response to cardiotocograph (CTG) findings. This will inform development of a robust systems focused process to improve management of fetal wellbeing concern.
The Trusts to explore strategies to support clinicians to be aware of and respond to the amber and red flags in the Trust's sepsis guidance.
The Trusts to review the processes to support clinicians to consider an emergency blood transfusion when a baby presents with a low haemoglobin, particularly in the presence of a suspected fetal-maternal haemorrhage.
To aid decision making and holistic assessment of a baby's care the Trust to review the processes to support all clinical information being easily available to clinicians providing clinical oversight and support.
To ensure clinical oversight is maintained through labour, the Trust to support clinicians in establishing a clear plan incorporating obstetric and midwifery management of the birth of twins prior to commencement of the second stage.
To ensure follow-up of mothers who are at risk of pregnancy induced hypertension or pre-eclampsia, is completed in line with local and national guidance (National Institute for Health and Care Excellence (NICE), 2019).

Maternity safety recommendations
1 April 2024 to 31 March 2025



To ensure the Trust has appropriate monitoring in place to assess fetal wellbeing in high-risk induction of labour labours at the onset of regular uterine activity.
To promote a shared awareness of the passage of time during breech birth, it is recommended that the Trust ensure that there is a clearly identified clinician who has ownership of clearly verbalising time critical events.
To promote accurate assessment of fetal wellbeing during labour, it is recommended the Trust develop guidance to support staff in escalating to the obstetric team when the quality of cardiotocograph (CTG) monitoring does not enable a systematic assessment (fetal wellbeing cannot be assured) and other options, including fetal scalp electrode have been explored.
To promote accurate assessment of fetal wellbeing during labour, it is recommended the Trust support staff in exploring options, including fetal scalp electrode and escalating to the senior midwifery or obstetric team when the quality of cardiotocograph (CTG) monitoring does not provide assurance of a baby's wellbeing.
To promote the identification of babies whose growth may be slowing or static, it is recommended that the Trust works with partner organisations to develop the electronic system, to review how a baby's growth measurements are displayed. Consideration should be given to the development of tools to clearly prompt or alert staff when a baby's abdominal circumference or estimated fetal weight drops more than 50 centiles.
Trust 2 to ensure that a robust referral pathway is in place that will support clinicians in obtaining and considering all relevant information when making clinical decisions.
Trust 2 to ensure that there is a lower threshold for undertaking a face-to-face review in mothers with known complexities.
Trust 2 to ensure that when a mother requires an urgent review, arrangements for her attendance to the maternity unit follow the standard admission process so that her care is delivered in a timely way and without delay.
Trust A and the Ambulance Trust to collaborate to support the process of prompt emergency contact and pre-alert of time critical obstetric emergencies, to allow preparation for arrival of a mother to the most appropriate place of care.
Trust A and the Ambulance Trust to collaborate to support the process of prompt emergency contact and pre-alert of time critical obstetric emergencies, to allow preparation for arrival of a mother to the most appropriate place of care.
Trust A and Trust B to ensure that pregnant mothers with medical conditions have timely access to specialist input and care at all stages of pregnancy to ensure clinical leadership and the coordination of care with specialist doctors, midwives and nurses working together to optimise medical care in pregnancy.
Trust A and Trust B to ensure that pregnant mothers with medical conditions have timely access to specialist input and care at all stages of pregnancy to ensure clinical leadership and the coordination of care with specialist doctors, midwives and nurses working together to optimise medical care in pregnancy.

Maternity safety recommendations
1 April 2024 to 31 March 2025



Trust A and Trust B to ensure that there are robust processes, resources and tools to support the sharing of all relevant healthcare information when care is received from multiple organisations, to ensure timely diagnosis, care management and treatment is based on the full clinical picture.
Trust A and Trust B to ensure that there are robust processes, resources and tools to support the sharing of all relevant healthcare information when care is received from multiple organisations, to ensure timely diagnosis, care management and treatment is based on the full clinical picture.
Trust A to ensure it has the ability to provide high dependency services for enhanced maternal care in line with guidance with regards to environment and staffing resource.
Trust A to ensure that a documented and recognised communication tool such as SBAR (situation, background, assessment, recommendation) is used during all points of information transfer during episodes of care.
Trust A to ensure that a structured handover takes place between clinical departments, clinical areas and staff which includes key clinical information, risk assessments, and plans for ongoing care needs.
Trust A to ensure that all staff are aware of the impact of racial and cultural bias on clinical diagnosis, escalation and the provision of care, and take steps to acknowledge, challenge and mitigate this bias when caring for mothers.
Trust A to ensure that all suspected obstetric emergencies are verbalised and immediate escalation through the use of the emergency call bell and 2222 obstetric emergency response call takes place.
Trust A to ensure that escalation pathways are consistently used regardless of any changes to service provision.
Trust A to ensure that ethnicity and cultural bias does not impact upon clinical diagnosis, escalation or the provision of care.
Trust A to ensure that mothers, who are critically unwell, have early escalation and review to support urgent multi-disciplinary care and discussion with intensive care services.
Trust A to ensure that the care provided is in response to the clinical condition of a mother, and not restricted by her location.
Trust A to ensure that there is senior obstetric oversight of all mothers with an increased chance of birth complications and that clinicians are supported to consider the whole clinical picture, including a mother's previous birth history, to ensure a personalised plan of care is made.
Trust A to ensure they develop and embed a robust maternity warning score which meets national recommendations that 'In all instances where there have been changes in condition, new symptoms or deterioration in women with a recent pregnancy, there should be a structured approach to ward review to seek, investigate and diagnose the cause of altered clinical status or abnormal observations'. (Knight et al, 2023).
Trust A to ensure when expedition of birth is required, a decision and categorisation of the birth is made when this is indicated. This is to allow all team members to have a shared mental model, and transfer as soon as stabilised.
Trust A to review their Hypertensive Disorders in Pregnancy guidance pathways to support earlier consideration of second line intravenous medication when there is not a timely response of a mother's blood pressure to first line treatment, to minimise complications associated with sustained severe hypertension.

Maternity safety recommendations
1 April 2024 to 31 March 2025



Trust A to support systems to easily and accurately record amount of medication being administered to a mother to allow subsequent clinicians to plan ongoing care.
Trust B to develop a training package for the volumetric pump that includes training regarding error messages, alarms and infusion lines.
Trust B to ensure all placentas are sent for pathological examination including histology in line with national guidance (Evans et al, 2022) if they meet criteria.
Trust B to ensure clinicians are aware of the importance of undertaking fresh eyes reviews in line with local and national guidance (Trust B, 2023; National Institute for Health and Care Excellence, 2022) and to escalate to senior members of the midwifery or obstetric team if these cannot be
Trust B to ensure clinicians use the emergency call bell system when an emergency situation occurs.
Trust B to ensure mothers moving to an obstetric led pathway during the second stage of labour receive a holistic in person risk assessment to inform ongoing management of birth.
Trust B to ensure that a documented and recognised communication tool such as SBAR (situation, background, assessment, recommendation) is used during all points of information transfer during episodes of care.
Trust B to ensure that staff are supported to undertake and document intermittent auscultation in line with local and national guidance to maximise the opportunity to detect potential concerns with a baby's wellbeing.
Trust B to ensure that there is local guidance that is embedded within the emergency department (ED) to support clinicians in the management and escalation of pregnant or recently pregnant mothers when they attend hospital outside the maternity department.
Trust B to ensure that when a cardiotocograph (CTG) is categorised as suspicious due to uterine activity, that this is acted upon and escalated in line with local and national guidance (Trust B 2022 & 2023; National Institute for Health and Care Excellence, 2022).
Trust B to ensure they have a robust system so when mothers attend the antenatal clinic, they are seen by all planned / relevant clinicians during their attendance, so that all clinical information is included in care planning in a timely manner.
Trust B to review the process to ensure that when new clinical guidance is introduced it is disseminated to all staff and can be embedded into practice.
Trust B to review their antenatal clinic processes, so that the communication and sharing of information between clinicians is effective when there are identified deviations (for example observations outside the expected range/ checking urine tests) from the normal in a mother's care.
Trust guidance and information for mothers on prelabour rupture of membranes/induction is updated to reflect national guidance and embedded to ensure mothers are admitted for assessment at 24 hours after prelabour rupture of membranes (PRoM).
Trust to ensure staff are supported to recognise, escalate and act when a mother's observations and test results indicate possible sepsis.
Trust to ensure that all women for whom English is not their first language are offered interpreting services at every contact and are provided with information in their own language in order, to have a full understanding of the care and choices being presented to them and enable shared decision making.

Maternity safety recommendations
1 April 2024 to 31 March 2025



Trust to ensure that all women for whom English is not their first language are offered interpreting services at every contact and are provided with information in their own language in order, to have a full understanding of the care and choices being presented to them and enable shared decision making.
Trust to ensure that staff are supported to implement the escalation process for more senior obstetric support when there are acuity concerns that may delay urgent reviews of mothers when a baby's heartbeat cannot initially be found on auscultation.
Trust to ensure that the use of an electronic patient record (EPR) system is embedded and supports staff to undertake a holistic risk assessment to inform ongoing care.
Trust to ensure that when a mother is in recovery, there is a system to support handover of care at the bedside, to ensure close on-going observation of a baby.
Trust to review and support the use of additional resources and processes for emergency patient transport to theatre.
Trust to review the handover of information between the maternity helpline and other patient areas to ensure safe and timely assessment of maternal and fetal wellbeing.
Trust to support staff to complete documentation both during observations and at hand overs fully in line with local guidelines. This means recording pertinent aspects of babies care to inform wider teams of documented changes in presentation and/or observations . This is to support holistic care with full clinical information.
When a mother has received a general anaesthetic or opiate analgesia, the Trust to ensure there is a personalised ongoing approach to the risk assessment to inform the suitability of a baby being held by their mother after birth.
When caesarean births are booked, it is recommended that the Trust supports a system that facilitates the input of the correct information reflecting the medical risk of mothers.
When clinical events occur that meet a previously recommended threshold for commencing treatment, and the exact treatment details are unknown, GP practice (B) to ensure contact is made directly with the specialist team recommending treatment for the required information, or ensure it is confirmed with a patient that they have the correct details and the confidence to do so, if a patient led contact with the specialist team is planned .
When clinical events occur that meet a previously recommended threshold for commencing treatment, and the exact treatment details are unknown, GP practice (B) to ensure contact is made directly with the specialist team recommending treatment for the required information, or ensure it is confirmed with a patient that they have the correct details and the confidence to do so, if a patient led contact with the specialist team is planned.
When mothers choose a planned caesarean birth, the Trust to ensure that an individualised plan includes recommendations and the mother's wishes, should she go into labour prior to the scheduled caesarean birth. This needs to be documented in a formal place to enable staff to easily locate this information.

When the condition of the baby is unknown the Trust to ensure that staff are supported to recognise and escalate the requirement for neonatal attendance prior to the birth of the baby.