Maternity safety recommendations 1 April 2025 to 31 March 2026

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:

All trusts involved with the MRI scanning referral system must ensure that a single, clear and robust system is in place in all relevant guidance to facilitate a collaborative approach to ensure that scans following therapeutic hypothermia for Hypoxic Ischaemic Encephalopathy are performed at 4 to 14 days after birth as recommended in national guidance (British Association of Perinatal Medicine (BAPM), 2023).
All trusts involved with the MRI scanning referral system must ensure that a single, clear and robust system is in place in all relevant guidance to facilitate a collaborative approach to ensure that scans following therapeutic hypothermia for Hypoxic Ischaemic Encephalopathy are performed at 4 to 14 days after birth as recommended in national guidance (British Association of Perinatal Medicine (BAPM), 2023).
All trusts involved with the MRI scanning referral system must ensure that a single, clear and robust system is in place in all relevant guidance to facilitate a collaborative approach to ensure that scans following therapeutic hypothermia for Hypoxic Ischaemic Encephalopathy are performed at 4 to 14 days after birth as recommended in national guidance (British Association of Perinatal Medicine (BAPM), 2023).

In line with national guidance (Thompson and Ramsay, 2011), it is recommended that mothers presenting at term with unexplained vaginal bleeding have a detailed discussion with a senior obstetrician to risk assess and plan for the remainder of a mother's pregnancy.
It is recommended (Trust A) that in person reviews are undertaken when clinical concerns are raised, to ensure that holistic reviews take place to support safe clinical care planning.
It is recommended all staff groups are supported to attend multidisciplinary team training to aid communication between clinicians and support leadership in emergency events.
It is recommended at the Trust works with neonatal staff on both sites to ensure they understand the criteria for therapeutic cooling and follow the network and national guidelines.
It is recommended for the trust to ensure cord prolapse is excluded after spontaneous rupture of membranes when risk factors are present and any clinical assessments are recorded contemporaneously in the medical records.
It is recommended for the Trust to support staff to effectively use the electronic patient record keeping system to record mothers' identified risk factors and to take these into account when making and recording a personalised plan of care.
It is recommended staff review the electronic medical records and document contemporaneously when receiving telephone calls to enable holistic risk assessment of all telephone calls.
It is recommended that a full clinical assessment including cumulative risks, and all indicators of fetal wellbeing are considered when there is a delay in the second stage of labour.
It is recommended that a mother and her full clinical picture is reviewed before oxytocin is prescribed and started, in line with local guidance.

It is recommended that a review of the roles and responsibilities between the maternity bleep holder and delivery suite coordinator, including emergency escalations is carried out to support consistent communication in all areas of the maternity unit.
It is recommended that abnormal ultrasound scans are reviewed on the same day by a member of the obstetric team who analyses the findings in relation to other risks and previous results, enabling a holistic overview and an appropriate plan of care.
It is recommended that all clinical staff are supported to seek urgent review and support when there are concerns regarding the mother and/or baby.
It is recommended that all clinical staff review and update antenatal risk assessments at every antenatal contact to allow for reassessments of mother's antenatal care needs and plans.
It is recommended that all mothers receive the routine schedule of antenatal care in line with local and national guidance (National Institute for Health and Care Excellence, 2021a).
It is recommended that all mothers receiving obstetric led care are reviewed on the consultant led ward round, and before an induction of labour is started, with ongoing obstetric oversight as required.
It is recommended that all mothers who attend the maternity triage are included in the Birmingham Symptom Specific Obstetric Triage System (BSOTS) system to ensure they are assessed in a timely manner.
It is recommended that all mothers with a large for gestational age baby receive appropriate counselling about mode of birth options available to them, with supporting leaflets, in a language and format accessible to them and allowing for the increased time for the use of an interpreter and relevant details of birth counselling documented. This will support mothers to understand the risks and benefits of different options, enabling them to make an informed choice about their care.
It is recommended that all patients who present with a major upper or lower GI bleed, either on admission or as an inpatient, should be discussed with the duty or on-call (out-of-hours) consultant responsible for major GI bleeds, within one hour of diagnosis (National Confidential Enquiry into Patient Outcome and Death (NCEPOD), 2015).

It is recommended that all staff are supported to comply with the Birmingham symptom-specific obstetric triage system guidance and to consider all cumulative clinical factors. This to include the right seniority of staff completing holistic risk assessments of mothers.
It is recommended that all staff groups are supported to attend multidisciplinary team training to aid communication between clinicians and support leadership in emergency events.
It is recommended that all women on the delivery suite receive multidisciplinary care to support holistic clinical oversight and monitoring, with multidisciplinary curiosity when there is a change in their clinical condition.
It is recommended that an assessment of a mother's communication and comprehension is done at the start of antenatal care, where English is the second language, to support identification of communication needs and the planning for appropriate support. This will enable clinicians to have confidence to use interpretation tool that clinical information is understood and it will support informed decision making.
It is recommended that any maternity early warning score thresholds that trigger are repeatedly escalated when indicated in line with Trust guidance. This is to ensure there is ongoing obstetric oversight, care planning and recognition of a deterioration in a mother's wellbeing.
It is recommended that births are attended by a neonatal doctor or Advanced Neonatal Nurse Practitioner (ANNP) to undertake neonatal life support in the presence of thick meconium and a raised fetal heartrate.
It is recommended that both access to electronic records on the midwife led birth unit and the criteria on the 'Intrapartum and Fetal Monitoring Risk Assessment Tool' are reviewed. This will allow staff to adhere to the locally agreed process for risk assessment and be able to identify risks effectively.

It is recommended that clear pathways of care support a personalised plan in response to a mother's individualised risk assessment and wishes. The electronic patient records' system should support staff to document this contemporaneously and to access it with ease at subsequent encounters.
It is recommended that clinicians within the Trust are supported to commence continuous fetal monitoring on women following the waters breaking when blood-stained liquor is seen.
It is recommended that consistent midwifery triage staffing levels in Trust B are maintained with appropriately experienced staff available to complete relevant allocated tasks.
It is recommended that continuous temperature monitoring is performed when a baby is undergoing therapeutic cooling treatment.
It is recommended that contraction frequency is assessed at least every 30 minutes, and that the Trust develops support strategies to maintain real-time documentation, including contraction frequency during the second stage of labour.
It is recommended that correct and consistent assessment of cardiotocograph (CTG) is undertaken as part of a holistic review, to support the timing of safe birth and escalation. This will ensure there is senior oversight and support during complex decision-making.
It is recommended that during neonatal resuscitation, the current national resuscitation algorithm is routinely consulted to confirm that all steps are considered and completed as needed. The Trust is to embed this through simulation training, skills drills and mandatory training.
It is recommended that every mother has a clearly documented care plan for the frequency of maternal and fetal observations in the latent phase of labour.
It is recommended that exhaled carbon dioxide monitors are available with intubation equipment to support assessment of successful intubation.
It is recommended that fetal monitoring equipment is readily available in the operating theatre to support the assessment of fetal wellbeing in an emergency situation.

It is recommended that in complex clinical situations that one clinician is allocated to provide a helicopter view and obstetric oversight to support all relevant aspects of information being utilised when clinical decisions are made.
It is recommended that in the emergency department, the Trust embeds the escalation process that is expected to occur when any early warning score tool triggers, including involving specialist support from critical care as required.
It is recommended that information relating to neonatal care is accurately documented at the earliest opportunity and that relevant forms and proformas (whether on paper or electronic) are fully completed and appropriately filed. This will help to provide a clear and immediately available picture of the care that a baby has received.
It is recommended that information relating to neonatal resuscitation is accurately documented at the earliest opportunity and this will help to provide a clear picture of the care that a baby has received which is in line with professional record keeping standards.
It is recommended that local care pathways are reviewed for the recognition and management of anaemia. The Trust must ensure that where a mother has a low level of haemoglobin, staff are aware of the significance of the results and that the correct clinical pathway is followed to ensure anaemia in pregnancy is treated and monitored in line with guidance.
It is recommended that local guidance for intrapartum fetal monitoring be updated to include: -clear escalation steps when a fetal scalp electrode fails to restore contact within a defined timeframe (to avoid delays caused by task fixation); and -alternative monitoring options (e.g. ultrasound) if equipment issues persist.
It is recommended that local services, involving Trust A, Trust B and the ambulance service work together to agree clear guidance for care of the newborn that requires transfer for emergency care.
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It is recommended that maternity triage has a specific escalation process, with a defined escalation response in place and with trigger points to identify activation -when initial triage assessment and ongoing clinical reviews are not meeting targets. This is to support timely triage assessment, and an expectation of what escalation actions will follow.

It is recommended that medical staff involved with emergency caesarean births are present during regional anaesthesia so that any fetal or maternal deterioration is recognised and acted upon immediately.
It is recommended that medicines are given following review by an appropriate clinician with the authority to prescribe. It is acknowledged that this may not be possible during emergency situations.
It is recommended that mothers are involved in the decision-making process during labour, and clinicians discuss all risks and benefits of the reasonable options available and document these. This is to support mothers and their birth partners to make informed choices.
It is recommended that mothers having an outpatient induction of labour with a cervical ripening balloon are invited into the Trust for clinical assessment if their waters break or they start in labour.
It is recommended that mothers who are at high risk of complications within the Trust have a senior obstetric review and an ongoing plan of care put in place during induction of labour, and that senior obstetric oversight continues when a mother is transferred to the antenatal ward.
It is recommended that mothers who attend with a history of recurrent urinary infections are referred for review by the obstetric team to support further treatment, investigations and ongoing care planning, in line with local and national guidance.
It is recommended that mothers who have had a previous caesarean birth, identified as needing an earlier birth, have a face to face review with a senior obstetric doctor. The review to include the reason for the induction of labour, alternative options available, the planned method and actions needed if the plan is to be changed. The plan must be clearly documented.
It is recommended that national and local guidance is followed when a mother becomes acutely unwell. This is needed to support the early attendance of consultant obstetric doctors and consultant anaesthetic doctors and other members of the multi-disciplinary team as needed.
It is recommended that newborn life support training for ambulance staff includes the importance of thorough assessment and observation as well as local and national guidance on airway management and use of oxygen.
It is recommended that non-technical skills are mandated in Trust multidisciplinary neonatal resuscitation training and simulation. This should include troubleshooting scenarios where team members are not following neonatal life support guidance, and practice the allocation of roles, including the team leader and scribe to strengthen team coordination and decision-making during emergencies.

It is recommended that obstetric staffing levels in maternity triage at Trust B are maintained with appropriately experienced staff in line with national guidance.
It is recommended that pregnant or recently pregnant mothers have their observations recorded on a maternity early warning score chart, to support the recognition and escalation of observations outside the normal range for pregnancy and the postnatal period.
It is recommended that processes for the recognition of a deteriorating cardiotocograph (CTG) are embedded in practice to allow clinical staff to act on signs of hypoxia. This will allow timely intervention to occur in line with local guidance.
It is recommended that Provider 3 continues to review its system for supporting and guiding health advisors when taking calls, in order for them to make accurate assessments and seek assistance as needed. This will further support patient safety.
It is recommended that resident doctors rotating to the neonatal unit receive ongoing support and opportunities to apply learning following initial newborn life support training. This is to allow immediate support to babies after birth to be delivered effectively and in line with guidance.
It is recommended that staff access to software systems across departments is reviewed. This will allow staff to access and provide relevant information to mothers.
It is recommended that staff are supported to adequately perform fetal monitoring antenatally with the use of pinards and handheld Dopplers to differentiate between fetal and maternal heart rate in line with local and national guidance.
It is recommended that staff are supported to commence cardiotocograph (CTG) monitoring and recognise, escalate and act upon concerns about CTG monitoring in accordance with local and national guidance.
It is recommended that staff are supported to complete fresh eyes reviews as in line with guidance, taking in to account all maternal and fetal risk factors, to provide a holistic risk assessment.
It is recommended that staff are supported to follow the principles of newborn life support (NLS) and onsite training to include newborn physiology, applying the algorithm to practice and the documentation of events.
It is recommended that staff are supported to give clear and accurate information on the reasons for offering induction of labour, and the associated risks as part of a detailed discussion of the options for an induction of labour in a prolonged pregnancy.
It is recommended that staff are supported to promptly recognise when vascular access is required more urgently than intubation to ensure each step of newborn life support is started in a timely manner.

It is recommended that staff are supported to recognise and understand the risk factors that indicate continuous fetal monitoring is required.
It is recommended that staff are supported to recognise loss of contact with a baby's heart rate on a cardiotocograph as a concerning feature requiring immediate emergency escalation.
It is recommended that staff are supported to recognise the significance of an abnormal cardiotocograph (CTG) when a mother is admitted with a history of absent fetal movements.
It is recommended that staff are supported to recognise when there are multiple demands on clinicians and that an effective multi-disciplinary response is enacted.
It is recommended that staff are supported to recognise when there is an indication for escalation and communication with the ambulance service, this will support early attendance and transfer of a baby if needed after birth.
It is recommended that staff are supported to review cardiotocographs (CTGs) in the context of a mother's cumulative pregnancy and labour risk factors and to recognise, escalate and act in response to CTG changes in line with local and national guidance.
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It is recommended that staff caring for mothers with a previous caesarean birth are provided with sufficient education and support to enable them to give care in line with the local guidance, which includes continuous fetal monitoring from the onset of regular contractions to enable ongoing assessment of fetal wellbeing.
It is recommended that staff in a midwifery led care environment are supported to recognise when labour is not progressing as expected, so that transfer to an obstetric unit can be initiated at the earliest opportunity.
It is recommended that staff in Trust A and Trust B are supported to give clear, accurate and unambiguous information to mothers about the reasons for offering induction of labour, and the associated risks of reduced fetal movements, of prolonged pregnancy and to discuss individualised factors that may increase the risk of stillbirth.
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It is recommended that staffing on the maternity triage unit is in line national recommendations (Royal College of Obstetricians and Gynaecologists,2023). Triage calls must be taken by a midwife whose duties at that time are solely for telephone triage.
It is recommended that structured communication, such as closed loop communication, is embedded into conversations between members of the neonatal team to support all parties having the same understanding of all the relevant clinical information, the discussion that has been undertaken, the advice that has been given, and an understanding of the possible next steps.
It is recommended that structured communication, such as closed loop, is embedded into conversations between the local paediatric teams and regional neonatal transport teams to support all parties having the same understanding of the relevant clinical information, the discussion that has been undertaken, the advice that has been given, and an understanding of the possible next steps.
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It is recommended that the admitting clinician completes and documents a Trust risk assessment on admission, including consideration of cumulative risk factors, in order to plan an ongoing care pathway, support appropriate escalation and allocation to obstetric-led care when indicated.
It is recommended that the advance prescription of terbutaline for induction of labour is removed from the bundle and only prescribed by medical staff when indicated.
It is recommended that the ambulance service seeks the advice of the regional neonatal operational delivery network and other stakeholders to clarify optimal local pathways of care when a baby is receiving out-of-hospital resuscitation. The ambulance service should seek to secure access to a single point of specialist neonatal advice during such events.
It is recommended that the ambulance Trust ensures that call handlers retain control of emergency response upgrades throughout the 999 call to enable immediate activation of a category 1 response when the 'sudden arrest button' is used.

It is recommended that the Ambulance Trust ensures that practice and guidance align to include clear structured communication of the current situation and background together with an understanding of roles and responsibilities of all team members during ambulance attendance at a homebirth. This is to support safe emergency care.
It is recommended that the ambulance trust reviews guidance relating to hospital pre-alerts and ensures that this is embedded into practice and efficiency of the process regularly reviewed. This will support timely clinical handover, enable early multidisciplinary planning, and reduce uncertainty for families during obstetric emergencies.
It is recommended that the Ambulance Trust shares this case with the NHS Pathway national team to prompt consideration of improvements in identifying life-threatening acute illness in pregnant mothers.
It is recommended that the current Daily Minimum Safety Standards Inspection Report is updated to show, not only that a check has been made, but the standards against which that check has been made. A more robust check will reduce the potential for equipment being unavailable or falling short of safety standards in emergency situations such as resuscitation.
It is recommended that the frequency of routine fresh ears assessments is clear to staff. This needs to be embedded in practice through training. This will reduce the chance of fresh ears assessments not being completed.
It is recommended that the frequency of routine fresh eyes assessment is clear to staff. This needs to be embedded in all areas of practice. This will reduce the chance of fresh eyes assessments not being completed.
It is recommended that the GP practice develops a process to personalise the approach when a vulnerable patient does not attend a two week wait clinic or a high risk appointment.
It is recommended that the GP practice have a pathway so that when a mother presents with reduced fetal movements, that in all circumstances, they are referred to the Trust straight away for fetal monitoring.
It is recommended that the Hospital Trust ensures that practice and guidance align to include clear structured communication of the current situation and background together with an understanding of roles and responsibilities of all team members during ambulance attendance at a homebirth. This is to support safe emergency care.
It is recommended that the Hospital Trust ensures that when clinical concerns develop as are stated in homebirth guidance, an ambulance is called promptly.
It is recommended that the Hospital Trust implement a sustainable staffing model in the community home birth setting, to minimise the impact of fatigue for clinicians who are providing care to mothers in labour.

It is recommended that the hospital Trust reviews the tools and training available to provide staff with the skills to have direct conversations with families in time critical situations. This will enable staff to facilitate urgent transfer when maternal or fetal concerns arise.
It is recommended that the Hospital Trust support staff to escalate where significant meconium-stained liquor and decelerations of a baby's heart rate are seen in a community setting, escalation and anticipation of complications mean that emergency procedures are implemented in line with local guidance.
It is recommended that the induction of labour escalation process must be embedded throughout the maternity unit. This will ensure that mothers waiting for induction of labour to start, receive consistent care regardless of the ward mothers are admitted to.
It is recommended that the local guidance for management of fever and sepsis (Trust, 2021a) is amended to reflect national guidance (National Institute for Health and Care Excellence, 2023). This will allow consistent escalation and management of mothers with raised temperature in labour.
It is recommended that the local maternity and neonatal system (LMNS), in conjunction with local GP practices and integrated care board (ICB), reviews access to maternity services to ensure that it is fair, equitable and inclusive at the point of first contact.
It is recommended that the local maternity and neonatal system (LMNS), in conjunction with local GP practices and integrated care board (ICB), reviews access to maternity services to ensure that it is fair, equitable and inclusive at the point of first contact.
It is recommended that the newborn observation scoring system embedded into the Trust's electronic patient records, is updated in line with national guidance (2023) to support a holistic assessment of wellbeing of a baby, including feeding at every interaction, and ensure that the scoring is reflective of a baby's overall condition.
It is recommended that the perinatal mental health service works with staff to review the documentation of the multidisciplinary clinical review meetings. The findings should inform the development, implementation and evaluation of an action plan as required.
It is recommended that the perinatal mental health services reviews their operational guidance to include the development of a standardised perinatal mental health birth plan care plan for all antenatal mother's. This is to support communication with the wider health team with regards a mothers mental health care.
It is recommended that the placental position is assessed and documented during any ultrasound scan.

It is recommended that the process of calling for senior help in a neonatal emergency is reviewed, including how to contact the neonatal consultant during working hours and the consultant on call, both when they are in the hospital and overnight from home. This will allow the process to be standardised and staff to have clarity in how to summon senior assistance.
It is recommended that the regional neonatal transport team consider how to prioritise the commencement of active cooling therapy in order to achieve target cooled temperature within 6 hours in line with national guidance.
It is recommended that the risks and benefits of all options following rupture of membranes, including induction of labour, are offered to mothers to ensure they have a choice and to support informed decision making.
It is recommended that the screening for GBS is performed using both low vaginal and rectum swab, in line with local and national guidance.
It is recommended that the staff are supported to use a systematic approach when undertaking a holistic clinical review to ensure all aspect of the mother's care is considered.
It is recommended that the telephone triage provider reviews and updates the information given during fetal movement assessment discussions to align with current national standards. This is to ensure that mothers attend maternity services for prompt assessment when there are any concerns about their baby's movements.
It is recommended that the tools and technology used to review and categorise cardiotocographs in the second stage of labour, support staff to effectively assess the wellbeing of the baby, which will aid effective and timely decision making.
It is recommended that the Trust (Trust B) cardiotocograph (CTG) categorisation following administration of dinoprostone incorporates a review of the contraction frequency. This is to support a low threshold for removal of dinoprostone if uterine contractions are present in line with local guidance.
It is recommended that the Trust (Trust B) update their guidance to ensure that the definition of hyperstimulation is in line with national guidance. This is to promote consideration of intervention when uterine activity is increased without fetal heart rate changes.
It is recommended that the Trust A and Trust B have a robust system to share information when a mother is receiving care from both maternity hospitals.
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It is recommended that the Trust A implements the national guidance regarding temperature monitoring when starting passive or active cooling.
It is recommended that the Trust a previous history of a small for gestational age baby (SGA) is included within the antenatal risk assessment for the use of aspirin when indicated, in line with national guidance.
It is recommended that the Trust A update their local hypertension in pregnancy guideline, to match national guidance, so that women are reviewed within 24 hours of diagnosis of hypertension and to ensure staff know when a protein creatinine ratio (PCR) sample should be sent for testing.
It is recommended that the Trust accurately record a fluid balance input and output during an emergency to assist in the holistic overview of mothers.
It is recommended that the Trust actively explore the different ways questions about changes in a baby's movements are asked during telephone triage. The findings from this review should be used to develop, implement, and evaluate an action plan to ensure that an in-person assessment is offered whenever there has been a change in the pattern of a baby's movements.
It is recommended that the Trust actively seeks information from midwives to understand the difficulties to listening to a baby's heart rate regularly in the second stage of labour. The findings should inform the development, implementation and evaluation of an action plan which ensures that monitoring of the baby's heartbeat increases in the second stage of labour and where this is not possible what action should be taken.
It is recommended that the Trust actively seeks information from telephone triage staff to understand the barriers to an in-person assessment of labour when the telephone assessment indicates one is needed. The findings should inform the development, implementation and evaluation of an action plan which ensures mothers contacting the maternity triage by telephone receive timely access to midwifery care during labour.
It is recommended that the Trust actively seeks information from triage staff about their experience of support and confidence in interpreting cardiotocographs (CTGs) and escalating concerns, particularly during the night shift. The findings should inform the development, implementation and evaluation of an action plan, including how to escalate if the Labour Ward is unable to support, as required.
It is recommended that the Trust adapts the alert system to notify the correct team needed in an emergency situation.

It is recommended that the Trust address barriers to listening and incorporating the voice of mothers when undertaking clinical assessments to ensure the full clinical picture is considered when care planning.
It is recommended that the Trust address the barriers to escalating concerns and act 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 when there is a difference in clinical opinion and provides staff with strategies or tools to use for structured communication and effective challenge in order to support safe care.
It is recommended that the Trust address the barriers to undertaking a full assessment of individual risk factors when a mother presents with reduced fetal movements, in order to inform an appropriate plan of care. This includes referral to an obstetric doctor where this is indicated, and discussion about induction of labour with all mothers reporting reduced fetal movements after 38+6 weeks.
It is recommended that the Trust address the barriers to using the escalation tools promoted within local training to support staff with a structured process to follow if concerns remain after initial escalation.
It is recommended that the Trust addresses the barriers to undertaking a full review of fetal growth at all antenatal contacts with the midwifery or obstetric team. It is also recommended that the Trust updates their processes to include serial measurement of symphysis-fundal height from 24+0 weeks in line with national recommendations (NHS England, 2025; National Institute for Health and Care Excellence, 2025). This will support the identification and appropriate management of small for gestational age and growth restricted babies.
It is recommended that the Trust adheres to national guidance that cooling is started when the baby has continuous monitoring, ideally with a rectal probe in place (British Association of Perinatal Medicine, 2020).
It is recommended that the Trust adopt a documented tool to aid with birth choice discussions and documentation. This will provide a formal way of supporting informed decision making, ensuring that both the family and the Trust are sharing a mental model for the birth plan.
It is recommended that the Trust align all guidance to support immediate escalation of fetal heart rate concerns in a midwifery led birth setting.

It is recommended that the Trust align practice with national guidance (National Institute for Health and Care Excellence (NICE), 2023), to identify cervical dilatation of 4cm with uterine contractions as established labour and commence one to one care and intrapartum fetal monitoring. This is to protect the wellbeing of the mother and the baby during active labour.
It is recommended that the Trust aligns local guidance with national guidance in relation to offering aspirin for the management of low PAPP-A.
It is recommended that the Trust aligns local guidance with national guidance to aid recognition of when a mother is having hyperstimulation (with or without fetal heart rate changes).
It is recommended that the Trust aligns the antenatal care pathway for mothers with gestational diabetes with national guidance.
It is recommended that the Trust aligns the fetal monitoring guidance with national guidance in relation to fetal heart rate variability, to support staff to identify concerning features.
It is recommended that the Trust aligns the local guidance with national guidance to ensure that all mothers presenting with reduced fetal movements after 38+6 weeks are offered a discussion about induction of labour. The discussion should include and document risk-based discussions and maternal preferences.
It is recommended that the Trust amend local induction of labour guidance, to advise staff to continue to observe fetal wellbeing when there is evidence of frequent uterine activity (tachysystole), in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021).
It is recommended that the Trust and ambulance service work collaboratively to establish a robust process for the timely transfer of neonates to a hospital with the equipment, facilities and clinical expertise needed for ongoing neonatal care and this process is embedded in practice and familiar to all staff who are involved in the care of neonates.
It is recommended that the Trust and ambulance service work collaboratively to establish a robust process for the timely transfer of neonates to a hospital with the equipment, facilities and clinical expertise needed for ongoing neonatal care and this process is embedded in practice and familiar to all staff who are involved in the care of neonates.
It is recommended that the Trust assigns specific responsibility for processing, interpreting, and closed loop communication of cord gas results to a designated clinical role, to prevent delays in the recognition and escalation of abnormal umbilical cord gas results.
It is recommended that the Trust assure themselves that intermittent auscultation is carried out within the required time frames.

It is recommended that the Trust assure themselves that staff are supported to follow Trust and national guidance for neonatal resuscitation and that this process is fully embedded.
It is recommended that the Trust assure themselves that the process for opening the overflow theatre is fully embedded for their staff, including familiarisation with this theatre which is not regularly used.
It is recommended that the Trust assure themselves that their maternity staffing policy, for triage, meets national guidance to ensure that safe care can be provided at all times.
It is recommended that the Trust assures itself that its staff involve mothers in the decision-making and care planning and to clearly document the information shared, discussions and agreements for ongoing care in the mother's clinical record to ensure individualised care.
It is recommended that the Trust audit its guidance and support staff to follow it when completing observations on newborns with risk factors at birth within the appropriate time frame.
It is recommended that the Trust audits the completion of the mental health screening. The findings should inform the development, implementation and evaluation of an action plan as required.
It is recommended that the Trust audits the effectiveness of the processes for reviewing and following up on abnormal blood test results and investigations, to include clear documentation for an ongoing plan of care.
It is recommended that the Trust audits the use of interpretation services at every maternity contact when it has been identified that a mother requires communication support.
It is recommended that the Trust B develops a robust system of escalation and support out of hours when a temporary closure/diversion in place due to extreme service pressures. This will support and protect the role of clinical staff who are providing direct patient care.
It is recommended that the Trust B provide a dedicated quiet space for the completion of telephone triage in line with national recommendations. The dedicated quiet space will support confidentially and reinforce the sole role of the telephone triage midwife.
It is recommended that the Trust board work with maternity staff to encourage and empower escalation in line with the local escalation policy.
It is recommended that the Trust clarify the expectations and indications for increasing fetal monitoring (intermittent auscultation) when it is suspected that a mother is in the passive second stage of labour in line with Trust guidance.

It is recommended that the Trust clearly defines the roles and responsibilities of advanced midwifery practitioners, in line with national guidance. This to include clear pathways for escalation, ongoing education and training programmes and structured supervision to support them in their role.
It is recommended that the Trust clinical documentation conforms to national standards of contemporaneous record keeping.
It is recommended that the Trust collaborate with staff to identify the challenges and support accurate assessment of fetal wellbeing during labour, and prompt escalation of concerns.
It is recommended that the Trust collaborate with staff to identify the challenges and support accurate assessment of fetal wellbeing during labour, categorisation and prompt escalation.
It is recommended that the Trust comply with the national standards for blood administration.
It is recommended that the Trust consider how staff are supported to provide all the information about risks and benefits of induction of labour, including discussions of their concerns, and alternative options. This will support mothers to make informed choices about their care.
It is recommended that the Trust consider reviewing the training and guidance provided to staff, to ensure fetal growth is consistently measured until a baby is born. This will provide staff with clarity regarding the frequency of external measurements and the referral process for growth scans.
It is recommended that the Trust consider the barriers that prevent staff from carrying out intermittent auscultation in line with local and national guidance for ongoing oversight of a baby's wellbeing during the second stage of labour.
It is recommended that the Trust considers audio recording calls to the maternity assessment unit to enhance the accuracy of the information recorded and promote timely, safe triage assessments.
It is recommended that the Trust considers how staff are supported through guidance and training to promptly review, manage and escalate any cardiotocograph (CTG) trace concerns, when it is not normal from the outset to ensure a timely response.
It is recommended that the Trust considers how staff are supported to recognise the clinical circumstances when an on-call consultant is required to provide care and how they should be contacted.
It is recommended that the Trust considers who reviews or assesses growth restricted babies to ensure they are ready for discharge to community care. This would include a review of the clinical picture between birth and discharge, ensuring a robust feeding plan which is shared with the parents with adequate fail safes in place.

It is recommended that the Trust consistently use their major haemorrhage documentation tool to act as a clinical prompt and documentation tool in a postpartum haemorrhage.
It is recommended that the Trust consistently uses formal interpretation and translation services in both hospital and community settings in line with local and national guidance to allow mothers to have access to the information they require, and to ensure their voices are heard during their pregnancy.
It is recommended that the Trust creates and implements clear guidance that supports requirements for provision of a safe homebirth service. It must as a minimum include training, equipment checks, escalation and risk assessment.
It is recommended that the Trust CTG classification tool is used when interpreting a cardiotocograph (CTG) to support decisions surrounding the timing of birth.
It is recommended that the Trust designs and implements a standardised process for the early recognition and management of hyperstimulation and adverse reactions to prostaglandin. This should include practical tools to support escalation and communication.
It is recommended that the Trust develop a clear pathway for escalation during shift handovers, so that clinical reviews for urgent concerns are not delayed.
It is recommended that the Trust develop a formal pathway requiring the obstetric team to be informed when a pregnant mother/birthing person receives care for a medical concern outside of maternity services, regardless of gestation or presenting complaint.
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 workforce plan/guideline to identify allocation of midwives to cover the home birth service to ensure staff are aware when they may be required to attend a home birth and to ensure mothers receive timely care at home.
It is recommended that the trust develop a mode of communication to update staff about changes to policies and guidelines, and a way to maintain oversight of staff awareness of new processes. This is to ensure that new processes become embedded in practice in a timely manner.

It is recommended that the Trust develop a pathway with a clear understanding to optimise safety when providing information and engaging in discussions with women who choose care options outside of recommended clinical guidelines. This pathway is to support staff in offering personalised respectful care who choose care options outside recommended care.
It is recommended that the Trust develop a process to support staff to escalate appropriately and in a timely way when there is no fetal heart rate found.
It is recommended that the Trust develop a process where clinical test results are reviewed as soon as they are available, and actions taken in a timely manner.
It is recommended that the Trust develop a reliable system for alerting the medical and midwifery teams working in the obstetric theatres or maternity high dependency unit, when the emergency call bell has been activated.
It is recommended that the Trust develop a robust system to recognise and escalate abnormal observations and results in all locations where maternity care is provided. This will ensure that abnormal observations and results are reviewed by the relevant clinicians to support ongoing care decisions.
It is recommended that the Trust develop a robust system to support staff to perform timely and holistic assessments during labour, taking into account both antepartum and intrapartum risk factors as part of the clinical decision-making process.
It is recommended that the Trust develop a structured pathway to support staff to discuss all birth choices early in pregnancy. These choices need to be revisited regularly throughout pregnancy, be clearly documented, and include options for mothers who choose not to have an induction of labour, including where to refer them for further information and discussion.
It is recommended that the Trust develop an implementation strategy for centralised cardiotocograph (CTG) monitoring in line with the Ockenden recommendation to help maintain clinical oversight and recognition of fetal heart rate abnormalities.
It is recommended that the Trust develop and implement a pathway to allow for mothers with suspected growth restriction at term, including in the absence of other concerns to be seen by the obstetric team at times when ultrasound appointments are not available such as at the weekend. This will allow updated care plans to be made in partnership with mothers and staff to be aware of risk factors.
It is recommended that the Trust develop and implement a process for baseline assessments to be completed following a new diagnosis of [a rheumatological disease], in line with national guidance (British Society for Rheumatology, 2018).

It is recommended that the Trust develop and implement clear guidance for cerebral function monitoring (CFM) that ensures timely review and accountability, with specific time intervals and named responsibility for CFM review.
It is recommended that the Trust develop clear guidance for the administration of any opioid pain relief in maternity triage during the latent phase of labour. This will help ensure that mothers receive pain relief appropriate to their level of pain and that the potential impact of pain relief on the perception of labour progress and contractions is recognised in future care decisions, including when discharge home is considered.
It is recommended that the Trust develop strategies to support staff when continuous cardiotocograph (CTG) monitoring cannot be maintained during an epidural procedure to ensure the wellbeing of the baby.
It is recommended that the Trust develop strategies to support staff when continuous cardiotocograph (CTG) monitoring cannot be maintained in labour or during an epidural procedure to ensure the wellbeing of the baby can be monitored.
It is recommended that the Trust develops a communication process to ensure that the obstetric team are informed, for mothers admitted to the emergency department with a medical problem. This process must include a specified timeframe, with seniority of staff involved specified, and communication of the modified early obstetric warning score (MEOWS).
It is recommended that the Trust develops a dedicated telephone triage service which is separate from the face-to-face triage service. This should include dedicated trained midwifery staff who take the calls.
It is recommended that the Trust develops a process that provides staff with a personalised support plan in place to consolidate their skills, competence and confidence in all clinical areas in which they may work. This is needed to ensure staff only to work in areas in line with their skill set and experience.
It is recommended that the Trust develops a process to embed local guidance into clinical practice to ensure that mothers have an in-person obstetric review before starting a second cycle of induction of labour.
It is recommended that the Trust develops a process to ensure that the neonatal nursing team are notified of a resuscitation happening within the maternity unit to allow early attendance and provide necessary support during the resuscitation.
It is recommended that the Trust develops a process to follow up and where necessary reschedule missed ultrasound scan appointments which related to checking the position of a placenta. The process must include a way of recording missed ultrasounds scans that is available to all staff providing care to mothers, so that concerns are quickly identified and acted on.
It is recommended that the Trust develops a robust person and systems centred process to strengthen holistic risk assessments and compliance with local and national guidance when a mother attends with a first episode of altered movements from the baby after 39+0 weeks.

It is recommended that the Trust develops a robust person, team and system centre process, to support the recognition and management of a fetal bradycardia in accordance with the '3-6-9-12 minute rule'.
It is recommended that the Trust develops a robust person-centred system for sharing information to ensure fully informed choice for mothers choosing homebirth and that a full risk assessment is completed and documented.
It is recommended that the Trust develops a robust process for booking an induction of labour with clearly defined responsibilities which is supported by local guidance.
It is recommended that the Trust develops a robust process to support management of excessive uterine contractions in a mother's labour. The process should support staff to recognise excessive uterine contractions and to implement a management plan that includes continuous cardiotocography, consideration of tocolytics, and transfer to the central birth suite when needed.
It is recommended that the Trust develops a series of simulated emergencies relating to birth outside clinical areas of the hospital to allow the multi-disciplinary team to practice the emergency response detailed in the Trust's new Standard Operating Procedure (SOP).
It is recommended that the Trust develops a structured information transfer method and robust process to achieve a timely transfer from the birth centre to the labour ward in an emergency. It is recommended that this is monitored.
It is recommended that the Trust develops a structured information transfer tool to strengthen communication between clinicians when escalating concerns about mothers who are attending labour ward in a triage capacity. This is to ensure active listening, a full understanding of the clinical situation to facilitate escalation and support clinical decision making with family involvement.
It is recommended that the Trust develops an education programme for staff to understand the need for all relevant information to be shared and discussed in a mother's first language. This includes supporting all mothers to give an account of their wellbeing and concerns in their first language.
It is recommended that the Trust develops an effective system to enable oversight of all mothers waiting to start/continue induction of labour, that includes documentation of the mother's/baby's risk factors.
It is recommended that the Trust develops and embeds a system to ensure all laboratory test results are visible to all staff needing to access a mother's electronic records and reviewed in a timely way. This will support safe and effective care planning for mothers.

It is recommended that the Trust develops and embeds an effective system that supports clinicians to check a mother's healthcare records before agreeing to change a plan of care. This needs to include a designated place for senior staff to document/sign off any discussions. This will ensure all available information is considered when making any decisions about plans of care.
It is recommended that the Trust develops and embeds guidance for when a mother cancels antenatal clinic and ultrasound scan appointments to ensure there is escalation to maintain ongoing clinical oversight of care.
It is recommended that the Trust develops and embeds guidance to support clinicians to recognise when a mother is requesting care outside of guidance to support effective discussion and care planning between relevant clinicians and a mother.
It is recommended that the Trust develops and embeds local guidance to ensure that all locum paediatric staff have attended annual neonatal basic life support training to support attendance at births when neonatal resuscitation may be required.
It is recommended that the Trust develops and implements a formal framework to support clinical oversight, decision-making, and the review and documentation of care plans when a mother chooses to access care outside of standard clinical guidance or no longer follows an agreed obstetric plan. This framework should ensure emerging risks are clearly recorded and visible to all relevant staff.
It is recommended that the Trust develops and implements a guideline which details the escalation process for all staff in the emergency department to follow escalation when capacity and / or acuity means a patient cannot be seen in line with triage assessment timeframes. This is to include responsibility for the steps needed to ensure a patient's condition has not deteriorated.
It is recommended that the Trust develops and implements a mechanism to ensure that agreed management plans, particularly those involving time sensitive decisions such as cardiotocograph (CTG) monitoring and escalation are clearly communicated, documented, and reviewed at the point of clinical handover. This will assist staff in maintaining a helicopter view and help recognise the importance of the passage of time (time drift) during time sensitive emergency situations to support a safe birth.
It is recommended that the Trust develops and implements a structured information sharing tool to strengthen communication between colleagues to support team working and clinical decision making similar to the Royal College of Obstetricians & Gynaecologists (RCOG's) 'Team of the Shift'.

It is recommended that the Trust develops and implements a structured information sharing tool to strengthen communication between colleagues to support team working and clinical decision making similar to the Royal College of Obstetricians & Gynaecologists 'Team of the Shift'.
It is recommended that the Trust develops and implements formal guidance for the management of test results, including clear responsibilities for reviewing and acting upon results, particularly when care is shared across more than one site.
It is recommended that the Trust develops clear directions for staff to identify, support and provide reasonable adjustments for mothers with any form of disability in line with the Equality Act (2010) and provide resources suitable to meet individual needs.
It is recommended that the Trust develops guidance for checking of the neonatal resuscitaires. Which includes: -review of equipment required on the resuscitaire, ensuring all essential equipment, including stethoscope and airway equipment, is on the checklist. -the checks required to ensure the resuscitaire is working correctly. -roles and responsibilities for checking of resuscitaires. -frequency of resuscitaires checks.
It is recommended that the Trust develops robust systems and processes relating to obstetric referrals and appointments in the outpatient antenatal clinics to ensure that mothers are offered and receive the required care.
It is recommended that the Trust develops strategies to reduce the risk of handovers affecting ongoing clinical care and the planned timing of reviews, to ensure mothers continue to receive safe and timely care.
It is recommended that the Trust develops training, guidance, and standardised assessment tools to strengthen recognition of the complexities and risks associated with Type 1 diabetes in pregnancy. This should support timely escalation for senior review, specialist input, and appropriate clinical decision making when a pregnant woman with Type 1 diabetes presents as unwell, regardless of whether admission is anticipated.
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 consistent use of pain assessment into holistic risk evaluations, enabling staff to determine urgency and escalate care when a mother's pain is not effectively managed in the antenatal period.
It is recommended that the Trust embed guidance into practice to support staff to recognise indications for a caesarean birth during breech labour care.

It is recommended that the Trust embed latent phase of labour guidance to support staff to give mothers in the latent phase of labour compassionate and safe care in an appropriate environment.
It is recommended that the Trust embed the importance of differentiating between a mother's and a baby's heart rate, at all times, and if this cannot be quickly achieved that emergency escalation occurs.
It is recommended that the Trust embed the principles for effective escalation, to ensure the escalation is performed by a person who has knowledge of the critical clinical details using the Advice, Inform, Do (AID) framework promoted in training with closed loop communication. This is to support effective escalation steps to ensure the correct and timely clinical response occurs.
It is recommended that the Trust embed the use of the Newborn Early Warning Track and Trigger (NEWTT2) tool to ensure timely recognition, structured assessment, and appropriate escalation when a baby presents with signs of respiratory distress at birth.
It is recommended that the Trust embed their guidance on missed and rescheduled antenatal appointments so that mothers receive the correct pathway of care.
It is recommended that the Trust embeds a process for resuscitaires and neonatal emergency equipment to be stocked and maintained consistently throughout the Trust with protected time for equipment checks to be performed. This will support any member of staff using the equipment to be assured that all the tools they need are present.
It is recommended that the Trust embeds a process to ensure that mothers are able to make an informed decision about the timing of induction of labour when their waters (membranes) have broken.
It is recommended that the Trust embeds a process to ensure that when the waters (membranes) have broken, information and advice are given so that mothers are able to check for, recognise and alert staff if concerning symptoms develop. This is to prevent delayed access to care when escalation may be needed.
It is recommended that the Trust embeds a process which ensures a structured handover is given to support staff rest breaks and maintain oversight of patient care.
It is recommended that the Trust embeds a programme of staff education to support mothers to understand and apply the principles of safe positioning of their baby, in line with national guidance (British Association of Perinatal Medicine, 2022). This is to reduce the risk of sudden unexpected postnatal collapse.
It is recommended that the Trust embeds a robust, time sensitive system for monitoring, reviewing and actioning thyroid function test results in mothers with known hypothyroidism (under active thyroid gland).

It is recommended that the Trust embeds a structured information transfer tool including direct communication to an identified lead, between the maternity assessment unit and delivery suite. This will support clinical decision making and timely transfers.
It is recommended that the Trust embeds a system, with effective fail-safes, that ensures mothers with gestational diabetes are offered diabetes care in line with local and national guidance (National Institute for Health and Care Excellence, 2020).
It is recommended that the Trust embeds and improves the quality of handovers using structured communication tools across the maternity service when giving and receiving clinical information at all handover points. This will ensure that all clinical risk factors are communicated and understood for clinical assessment and care planning.
It is recommended that the Trust embeds existing guidance on assessing and escalating pregnant and recently pregnant mothers who present outside of maternity areas. This will enable safe pathways of care to be followed and obstetric team oversight.
It is recommended that the Trust embeds in practice and local guidance the need to offer mothers a face-to-face assessment when any type of vaginal bleeding is reported.
It is recommended that the Trust embeds in practice the use of formal tools when assessing a cardiotocograph (CTG) to recognise the level of concern with regards to the baby's wellbeing to support timely care planning.
It is recommended that the Trust embeds one to one care provision when a mother has been given tocolysis to assess the efficacy and impact on maternal and fetal wellbeing.
It is recommended that the Trust embeds processes for the safe management of mothers undergoing induction of labour on the antenatal ward in line with Trust guidance. This will ensure timely monitoring, escalation, and transfer when labour progresses, and reduces the risk of delays in care.
It is recommended that the Trust embeds processes to ensure that a mother is involved in discussions to support informed decision-making in developing management plans for her care. These discussions should allow for the exploration of a mother's concerns and wishes, as well as the risks and benefits of any treatment options.
It is recommended that the Trust embeds processes to ensure that the cardiotocograph (CTG) assessment proforma is completed by each staff member reviewing a CTG. This is needed to support a holistic assessment of known risk factors.
It is recommended that the Trust embeds the emergency triage processes to ensure that red-flag neurological symptoms are recognised to enable patients to be triaged correctly.

It is recommended that the Trust embeds the use of a dynamic approach to risk assessment of mothers, to ensure evolving risk factors are recognised and fetal heart rate monitoring is undertaken when indicated.
It is recommended that the Trust embeds the use of a single system for summoning emergency support from the multidisciplinary team.
It is recommended that the Trust embeds the use of a structured tool to support staff in preparing and administrating medicines during a neonatal resuscitation and includes this within simulation training.
It is recommended that the Trust embeds the use of decision making tools into practice to ensure that families are provided with clear, evidence based, individualised information, including benefits, risks and alternatives, so that they are supported to make a fully informed decision.
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 tool across the maternity service when giving and receiving clinical information to support safe care.
It is recommended that the Trust embeds the use of the Modified Early Obstetric Warning Score (MEOWS) and the subsequent escalation process in all areas where a pregnant mother receives care. This is to ensure that assessment and escalation of an unwell mother takes place from all clinical areas.
It is recommended that the Trust embeds understanding of their guidance so that regular uterine activity requiring analgesia during induction of labour (IOL) prompts a fetal wellbeing assessment with a cardiotocograph (CTG).
It is recommended that the Trust enables clinicians during the induction of labour process to recognise when risk factors or the clinical picture has changed, to support fetal heart rate monitoring when required.
It is recommended that the Trust enables obstetricians to document and communicate their clinical care plans, so that continuing obstetric oversight is maintained of fetal heart rate monitoring, allowing timely care decisions to be made.
It is recommended that the Trust enhance the awareness of the use oxytocin for induction and augmentation of labour. This will support a timely recognition and management of slow progress in labour. This is to support and facilitate effective decision making.
It is recommended that the Trust enhances their training to support staff to expedite the birth of a baby when a non-recovering fetal bradycardia is recognised, following the rule of 3 as a guide to facilitate birth within the recommended timescale.

It is recommended that the Trust ensure a full holistic assessment is carried out for a mother and baby prior to her waters being broken including a review of contractions and cardiotocography.
It is recommended that the Trust ensure a full holistic review is carried out for a mother and baby prior to her waters being broken including a review of contractions and the cardiotocograph.
It is recommended that the Trust ensure a good quality cardiotocograph is maintained to enable the assessment of fetal wellbeing, with consideration given for a fetal scalp electrode or a change in maternal position.
It is recommended that the trust ensure all staff complete interpreting services training and are competent to use these services from any area of maternity, including during incoming calls.
It is recommended that the Trust ensure discussions are held with mothers about the risks of prolonged pregnancy to support informed decision making, in line with national guidance.
It is recommended that the Trust ensure examination lights are available on the resuscitaires in accordance with national medical equipment requirements.
It is recommended that the Trust ensure guidance is embedded in practice to enable staff to recognise situations where a full holistic view review is needed. This will ensure timely diagnosis of labour and ongoing care.
It is recommended that the Trust ensure guidance is followed when diagnosis of ruptured membranes is uncertain.
It is recommended that the Trust ensure local guidance is in line with national guidance in response to blood stained liquor and its ongoing management. This will support staff to recognise and escalate blood stained liquor and support safe care planning.
It is recommended that the Trust ensure local practice is in line with national guidance in response to blood stained liquor and its ongoing management.
It is recommended that the Trust ensure local practice is in line with National guidance in response to blood stained liquor and its ongoing management.
It is recommended that the Trust ensure newborn observations are completed in their entirety in line with national guidance, to enable a holistic understanding of a baby's condition, ensure correct Newborn Early Warning Score (NEWS) scoring and required escalation.
It is recommended that the Trust ensure placenta are sent for pathological examination including histology as indicated in national guidance (Evans et al, 2022).

It is recommended that the Trust ensure staff align practice with guidance to carry out routine and systematic assessments of a baby at birth in line with national guidance. This will support the recognition of an unwell baby, to support prompt interventions and escalation.
It is recommended that the Trust ensure staff are aware of local translation and interpreting policies and reinforce the importance of utilising professional interpreters where English is a second language. This guidance should involve a process to aid staff in assessing service user's comprehension to ensure that a mother and a father can fully participate in decision making and understanding is not assumed.
It is recommended that the Trust ensure staff are supported to complete neonatal resuscitation documentation to ensure times, and events are accurately and thoroughly documented.
It is recommended that the Trust ensure staff are supported to undertake a holistic review when concerns about a fetal heart rate are raised so that ongoing care plans, including management of the second stage of labour, are based on a complete assessment of all risk factors.
It is recommended that the Trust ensure staff have clear guidance on where and how risks (potential or confirmed) are documented in the electronic records.
It is recommended that the Trust ensure that a baby's condition is monitored and responded to in a timely way when other clinical tasks are being undertaken.
It is recommended that the Trust ensure that accurate, contemporaneous clinical records are completed. This will ensure that high quality information is maintained to support clinical care decisions, incidents can be reviewed effectively, and that staff and families have an opportunity to understand what has happened.
It is recommended that the Trust ensure that all category 1 caesarean births are responded to by the whole neonatal team irrespective of the anaesthesia used and the guidance is clarified so that it is understood by all.
It is recommended that the Trust ensure that all clinical information is documented and shared amongst the multidisciplinary team to support a shared mental model, clinical decision making and ongoing care planning.
It is recommended that the Trust ensure that all conversations about mode of birth planning are documented clearly within a mother's records. These conversations must be individualised to take into account a mother's risk factors.
It is recommended that the Trust ensure that all relevant information with regard to the risks and benefits of all options for care and treatment are explained to mothers so as to enable them to make an informed choice and give informed consent.

It is recommended that the Trust ensure that all risk factors are considered when babies have high oxygen requirements from birth. This is to support timely intubation to support their breathing and safe transfer to the neonatal unit.
It is recommended that the Trust ensure that all staff are aware of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report that states the importance of a post-mortem examination being carried out for mothers who die during pregnancy and the first 42 days following the birth of a baby to gain maximum learning from maternal deaths. Where a coronial postmortem is not required, the option of a hospital postmortem is discussed and offered to the next of kin in line with the Royal College of Obstetricians and Gynaecologists best practice guidance (2024).
It is recommended that the Trust ensure that babies undergoing resuscitation and stabilisation maintain a temperature within the normal range.
It is recommended that the Trust ensure that consideration of intraosseous cannulation of babies is embedded into training and clinical practice to ensure clinicians are competent and confident in its use and effective neonatal resuscitation continues where there is difficulty obtaining umbilical venous access.
It is recommended that the Trust ensure that formal cardiotocograph (CTG) assessments are completed every hour in line with Trust and national guidance.
It is recommended that the Trust ensure that if there are concerns about differentiation of the fetal heart rate from the maternal heart rate, or if a fetal heart cannot be heard; then an urgent review by an obstetrician or senior midwife is obtained in line with national guidance.
It is recommended that the Trust ensure that information systems support clinicians to plot and interpret symphysis fundal height measurements, refer when indicated and share this information with mothers so that they can make informed decisions about their care.
It is recommended that the Trust ensure that Maternity Early Warning Score (MEWS) scores cannot be overridden and implement training in all areas to ensure consistent use of MEWS, with escalation pathways aligned to maternity physiology.
It is recommended that the Trust ensure that mothers whose first language is not English receive personalised antenatal care and information is shared in a way that they can access and understand, including communication outside of their appointments.
It is recommended that the Trust ensure that oxygen is available at all times and that the maternity staff have the skills to change oxygen cylinders in an emergency setting.

It is recommended that the Trust ensure that risk assessments are robust and dynamic and include a holistic overview of care including evolving risks to ensure that the right place of birth is discussed, planned and continually reviewed from the start of labour. The risk assessments should not be impacted by resources available at the time.
It is recommended that the Trust ensure that staff advise immediate attendance at an appropriate area of the maternity unit for a cardiotocograph (CTG) when a mother is unsure about the baby's movement pattern or describes an alteration or reduction in her baby's movements.
It is recommended that the Trust ensure that staff are supported to escalate information in relation to maternal observations to enable full clinical assessments and care planning.
It is recommended that the Trust ensure that staff are supported to explore potential causes of anaemia with the multidisciplinary team and adapt timely management plans as new information is available. This will enable the management of anaemia to be prioritised accordingly and blood transfusions given when indicated.
It is recommended that the Trust ensure that staff are supported to recognise emergency neonatal resuscitation situations and to escalate promptly, using the 2222 call system to request an extended neonatal team.
It is recommended that the Trust ensure that staff carry out cardiotocograph (CTG) monitoring for mothers in the operating theatre when preparing for an expedited birth, in line with local and national guidance for ongoing oversight of a baby's wellbeing during established labour.
It is recommended that the Trust ensure that their local guidance for newborn resuscitation is updated to be in line with important national guidance in a timely way and ensure that all staff are familiar with these changes through training and other forms of communication.
It is recommended that the Trust ensure that there is adequate fetal monitoring equipment available to staff in all areas where fetal monitoring is carried out.
It is recommended that the Trust ensure that there is effective monitoring of a baby's temperature, with the use of rectal probes, whilst passive cooling is taking place in line with local and national guidance - British Association of Perinatal Medicine (BAPM), to prevent the risk of overcooling.
It is recommended that the Trust ensure that when a baby requires a higher level of neonatal care, there is a clear transfer plan that helps keep mothers and babies together in the same hospital when a baby is moved to a specialist unit. This supports better care and reduces parental stress from being separated from their baby.

It is recommended that the Trust ensure that when a mother in advanced labour is requesting additional pain relief, the request is discussed by the multidisciplinary team, including the anaesthetist with the mother as part of individualised care planning discussions. This must include the option for regional spinal anaesthesia in the obstetric theatre.
It is recommended that the Trust ensure that when a mother reports a change in the pattern of a baby's movements the initial triage is undertaken within the required time frame.
It is recommended that the Trust ensure that when mothers have a very abnormal glucose tolerance test result, there is immediate multidisciplinary involvement with a view to commencing urgent treatment.
It is recommended that the Trust ensure that when the quality of the cardiotocograph (CTG) trace is poor, this is escalated and managed before an oxytocin infusion is started.
It is recommended that the Trust ensure that when there is increased uterine activity during induction of labour, that an overview of fetal wellbeing is maintained by continuous fetal monitoring.
It is recommended that the Trust ensure the Birmingham Symptom Specific Obstetric Triage System (BSOTS) is embedded with sufficient resources to support midwifery staff to complete a risk assessment within 15 minutes of admission to inform prioritisation of care.
It is recommended that the Trust ensure timely recognition and escalation of abnormal observations of the mother and baby, including cardiotocography patterns such as sinusoidal features, by improving tools, guidance and staff confidence in decision making.
It is recommended that the Trust ensures a mother's observations are consistently recorded, using a recognised tool and reviewed in line with national and local guidance.
It is recommended that the Trust ensures a robust system is in place to confirm that mothers know how to, and are accessing, their pregnancy records and the information contained within them via the online app. Where issues are identified, the process needs to ensure that barriers are explored and resolved.
It is recommended that the Trust ensures all staff are provided with training in the identification and treatment of neonatal hypoglycaemia, including the communication of clinically critical tasks for babies with severe hypoglycaemia.
It is recommended that the Trust ensures any maintenance work undertaken within the maternity unit has a comprehensive risk assessment to identify and mitigate risk.

It is recommended that the Trust ensures availability of the obstetric team on the maternity assessment unit so that face to face reviews occur when requested, to facilitate early recognition of an abnormal antenatal cardiotocograph (CTG) and need to expedite birth.
It is recommended that the Trust ensures clinicians support mothers whose first language is not English; this includes accurately assessing a mother's understanding of English, planning for the requirement of translation and interpretation services and documenting a plan of care.
It is recommended that the Trust ensures emergency neonatal equipment is clearly distinguishable from other medical equipment in maternity operating theatres.
It is recommended that the Trust ensures passive cooling is started after admission to the neonatal unit once stability is achieved and continuous temperature monitoring can be provided.
It is recommended that the Trust ensures patients admitted to escalation areas of the hospital receive timely medical reviews and care planning to support safe and effective care.
It is recommended that the Trust ensures staff are aware of the threshold for category 1 caesarean birth in line with local guidance.
It is recommended that the Trust ensures staff are supported to complete neonatal resuscitation documentation in a timely manner, using all the records available and to ensure times, and events are accurately documented.
It is recommended that the Trust ensures staff use the emergency buzzer and bleep system (2222) when there is an emergency to ensure there is prompt and senior support available and recognition of an emergency.
It is recommended that the Trust ensures telephone triage is carried out by a dedicated, trained clinician to minimise interruptions and manage workload effectively, ensuring that the triage systems and processes are in line with national guidance to support clinicians in delivering safe and consistent practice.
It is recommended that the Trust ensures that all local guidance and proformas are in line with national guidance to support staff of when it is required to send a placenta for pathological examination.
It is recommended that the Trust ensures that all staff are aware of local and national guidance regarding advice to be given to mothers should they have concerns about fetal movements. The advice should be to contact the local maternity unit immediately and not include advice such as drinking fluids or eating foods and observing movements for a period of time before contacting.

It is recommended that the Trust ensures that all staff consistently use the intrapartum cardiotocograph (CTG) assessment tool and complete fresh eyes reviews in line with local guidance so a systematic review is recorded, independently scrutinised and concerns are escalated promptly to the senior clinical team.
It is recommended that the Trust ensures that all staff use closed loop communication in all maternity settings and during emergency situations.
It is recommended that the Trust ensures that at the point of prescribing medicines, clinicians check that inpatients have had a medical review (clerking) and have a plan of care in place, to support the safe and appropriate prescribing of medicines.
It is recommended that the Trust ensures that community staff are supported to carry out a holistic assessment, including auscultation of a baby's heart rate, when concerns are identified in a mother during an antenatal check.
It is recommended that the Trust ensures that conservative measures are adopted in accordance with the clinical situation so that a decision to expedite birth is not delayed.
It is recommended that the Trust ensures that continuous core temperature monitoring is started during or immediately after resuscitation and maintained throughout transfer and admission to the neonatal intensive care unit in line with national guidelines for babies that may require active cooling (British Association of Perinatal Medicine 2016; National Institute of Health and Care Excellence, 2010).
It is recommended that the Trust ensures that escalation to a senior obstetric doctor takes place when an antenatal cardiotocograph (CTG) is abnormal. This is to support the timely assessment of a baby's wellbeing and develop an appropriate plan of care.
It is recommended that the Trust ensures that fetal monitoring equipment is accessible and readily available on the antenatal ward so that delays in fetal wellbeing assessments do not occur.
It is recommended that the Trust ensures that local and national neonatal hypoglycaemia policy is embedded to support staff to recognise that neonatal hypoglycaemia in the context of potential hypoxic ischaemic encephalopathy is to be managed promptly, with senior neonatal oversight to aid decision making. This is to avoid exacerbating the hypoxic ischaemic encephalopathy.
It is recommended that the Trust ensures that local guidance is followed when unknown fetal movements are reported and staff are supported to recognise 'unknown/unsure' as abnormal, requiring obstetric oversight.
It is recommended that the Trust ensures that mothers are provided with clear, documented discussions and information of their risks to support informed decision making in line with Trust and national guidance.

It is recommended that the Trust ensures that mothers identified as being at risk of having a small baby follow a serial growth ultrasound scan pathway, in line with national guidance (NHS England 2025).
It is recommended that the Trust ensures that mothers views, needs and priorities are considered as part of an obstetric review alongside consideration of all known risk factors. This will enable staff to decide about the requirement for holistic, face to face review.
It is recommended that the Trust ensures that neurosurgical patients receive consultant review in line with national guidance.
It is recommended that the Trust ensures that obstetric reviews incorporate the full clinical picture to include a review of and request regular updates about the cardiotocograph (CTG), antenatal and intrapartum risk factors to support decision making and communication to mothers about ongoing management of their labour and birth.
It is recommended that the Trust ensures that staff are supported to actively listen, take concerns seriously, and explain any differences in perspective or clinical priorities.
It is recommended that the Trust ensures that staff are supported to follow national guidance in relation to management of suspected rupture of membranes without over reliance on bed side testing.
It is recommended that the Trust ensures that staff are supported to recognise time critical obstetric emergencies by way of simulation training schedules in line with core competencies, which is provided in a manner that captures all staff groups irrespective of shift/working patterns to prevent delays or variations in care.
It is recommended that the Trust ensures that staff are supported to undertake regular cardiotocograph assessments including fresh eyes fresh reviews in line with local and national guidelines (Saving Babies' Lives care bundle v3 (2023) and that this is not impeded by workload demands so that time-critical escalation takes place when needed.
It is recommended that the Trust ensures that staff are supported to use the emergency bell when there is an obstetric emergency, to enable immediate review and a shared mental model for care planning.
It is recommended that the Trust ensures that substance use is explored when complex needs are identified, at each midwifery or obstetric appointment, in order that when substance use is disclosed, mothers are offered advice and referral on to local drug rehabilitation services where indicated.
It is recommended that the Trust ensures that the clinicians are supported to recognise when to trigger the difficult airway algorithm to maximise the help and available expertise in an emergency.
It is recommended that the Trust ensures that the initial triage assessments of mothers attending with absent fetal movements are conducted in line with the local guidance (Trust 2022).

It is recommended that the Trust ensures that the provision of homebirth services aligns with the Nursing and Midwifery Council code to ensure that fatigue and person safety is maintained.
It is recommended that the Trust ensures that the systems and processes are sufficient for the safe operation of the maternity assessment centre at all times, regardless of how busy the unit is or becomes. This to include safe staffing levels and support to staff in the comprehensive, safe and effective use of the telephone triage template and a consistent and timely response to escalation (Kenyon et al, 2017, Royal College of Obstetricians and Gynaecologists, 2023 and Trust, 2025).
It is recommended that the Trust ensures that the use of tools intended to monitor and escalate a mother's clinical condition, such as the Modified Early Obstetric Warning Score (MEOWS) and sepsis screening tools, are regularly evaluated to inform any additional training and guidance development.
It is recommended that the Trust ensures that there is a standardised approach to the growth assessment of a baby and that personalised Gestation Related Optimal Weight (GROW) charts are used by all team members when providing advice and formulating clinical care pathways.
It is recommended that the Trust ensures that there is adequate equipment and a robust process for preparation of a birth environment to support timely care and assessment of a mother's and baby's wellbeing on admission.
It is recommended that the Trust ensures that there is suitable service provision to support and deliver triage care in line with national and Trust guidelines.
It is recommended that the Trust ensures that when a fetal heard rate cannot be heard during a homebirth, the Trust's homebirth escalation of concerns in labour guidance is activated.
It is recommended that the Trust ensures that when cardiotocograph (CTG) monitoring is indicated, the fetal heart rate is effectively monitored, including a process that confirms differentiation from the maternal pulse to enable timely recognition and escalation of fetal compromise.
It is recommended that the Trust ensures the examination done in the maternity triage unit reflects the whole clinical presentation of a mother to inform ongoing care planning.
It is recommended that the Trust ensures there is a robust system to identify and act on early warning signs that key performance indicators (KPIs) for pregnancy care may be about to breach national guidance (National Institute for Health and Care Excellence NG201, 2021 and Royal College of Obstetricians and Gynaecologists, (2023) standards for triage.

It is recommended that the Trust ensures there is a system in place that ensures all displayed prompt aids for use in an emergency are in line with national guidance and Trust policy.
It is recommended that the Trust equips staff with the skills, education and guidance to enable them to interpret antenatal cardiotocographs (CTGs) in the context of the clinical situation, in order to support clinical decision making and clear escalation of concerns.
It is recommended that the Trust equips staff with the skills, education and guidance to use the available electronic assessment tools to enable them to interpret antenatal cardiotocographs (CTGs) in the context of the clinical situation. This is to support clear escalation of concerns about a baby's wellbeing, holistic review and clinical decision making.
It is recommended that the Trust establish a clearly defined pathway for mothers in the latent phase of labour. This pathway should consider the best location for care and must include a full assessment of pain, uterine contractions, and a vaginal examination if requested, to ensure that labour is assessed holistically before discharge home.
It is recommended that the Trust establish a robust multidisciplinary system and processes to ensure timely, collaborative, and informed care for pregnant mothers presenting to non-maternity services, including early involvement of obstetric expertise.
It is recommended that the Trust establish a robust system for reviewing oral glucose tolerance test results to avoid misinterpretation and delays to commence treatment.
It is recommended that the Trust establish a robust systematic process for sharing and embedding new guidance, ensuring that all relevant staff are informed, understand its implications, and are supported in applying it effectively in practice.
It is recommended that the Trust establishes a robust system that ensures pregnant mothers who are contracting regularly during induction of labour and require additional pain relief, receive consistent and timely fetal wellbeing assessments throughout the induction process, to maintain fetal safety and address the risk of delayed recognition of fetal compromise.
It is recommended that the Trust establishes and enforces a clear policy to ensure all medicine administration by student midwives is directly supervised by a qualified midwife at every stage of training. This policy must align with the Nursing and Midwifery Council (NMC) Code (2018) and legal requirements and include mechanisms for monitoring compliance.
It is recommended that the Trust establishes clear expectations of the escalation pathway, including use of safety critical language and understanding of effective escalation, to achieve a timely response and action to pathological cardiotocographs (CTGs).

It is recommended that the Trust explore and address barriers to storing emergency neonatal blood products in closer proximity to obstetric theatre to support shared understanding and ease of access in an emergency.
It is recommended that the Trust explore and address the barriers to planning and delivering care that includes listening and responding to a mother's wishes and changes in her clinical presentation.
It is recommended that the Trust explore and remove barriers that prevent the documentation and escalation of observations for babies on the Newborn Early Warning Track and Trigger (NEWTT2) pathway. This is to support clinical oversight for babies at risk of deterioration.
It is recommended that the Trust explore and remove barriers to completing documentation of clinical assessments in the postnatal period to ensure staff maintain holistic oversight of a mother and baby's well being.
It is recommended that the Trust explore barriers to providing mothers with clear, individualised discussions about their maternity care options, and ensure structured decision-making tools are available and used in practice, in order to support informed decision-making and personalised care planning, to address the risk that women may not be fully informed of their options.
It is recommended that the Trust explore barriers to recognition and diagnosis of gestational hypertension when mothers experience raised blood pressure in pregnancy. This will support ongoing risk assessment and care planning in line with local and national guidance.
It is recommended that the Trust explore staff experience of support for preceptee midwives, to understand the barriers experienced. The findings can be used to inform changes in practice to support preceptee midwives to consolidate their knowledge and develop their confidence in line with nationally recommended frameworks.
It is recommended that the Trust explore staff perception of the accuracy of digital blood pressure machines and audit their use, to encourage consistency of their use and the accurate recording of maternal blood pressure. It is further recommended that the Trust reviews the implementation, training and education around the use of digital blood pressure machines, to enable confidence in the in the blood pressure readings generated and, when readings fall outside the expected ranges, there is consistency of referral for further assessment and obstetric review to inform care planning.
It is recommended that the Trust explore the barriers to clear communication within the multidisciplinary team to support decision-making so that procedures are discontinued when clinically indicated.
It is recommended that the Trust explore the barriers to effective communication and leadership to achieve a team response to neonatal resuscitation.

It is recommended that the Trust explore the barriers to using the pictorial tool in the partogram to aid documentation and interpretation of intermittent auscultation to provide the required standard of fetal monitoring.
It is recommended that the Trust explore the barriers to using the tools to support informed decision making and embed the local guidance in this area.
It is recommended that the Trust explore the blockers for staff to undertake and document intelligent intermittent auscultation at the recommended intervals to safely monitor a baby's wellbeing during labour.
It is recommended that the Trust explore the blockers for staff to undertake and document intermittent auscultation at the recommended intervals to safely monitor a baby's wellbeing during labour.
It is recommended that the Trust explores and addresses the barriers to starting a labour pathway of care when mothers are having their labour induced. This will ensure that transition between the latent phase and first stage of labour is promptly identified, and the optimum level of fetal monitoring is provided.
It is recommended that the Trust explores barriers to the real-time entry of fetal heart rate monitoring on the midwifery led unit to ensure prompt recognition and escalation of concerns.
It is recommended that the Trust explores how staff are supported to use birthing pools safely in line with local guidance, to promote safe use of the birthing pool and reduce the risk of unsafe pool entry during labour.
It is recommended that the Trust explores how the electronic patient record can better support staff to ensure that all mothers presenting with pre-labour rupture of membranes at or after 37+0 weeks are consistently offered both options (Induction of labour as soon as possible, or expectant management for up to 24 hours) outlined in national (National Institute for Health and Care Excellence (NICE), 2021) and local guidance. This must include detailed discussion of the benefits and risks of each option, to enable informed decision-making.
It is recommended that the Trust explores how the maternity and neonatal service can meet the needs of vulnerable mothers with complex social factors by adopting a coordinated and multidisciplinary team approach, provided by staff who are trained to meet the additional and complex needs of this group.
It is recommended that the Trust explores how they confidentially ensure the psychological safety of the multidisciplinary team during their shift, in line with national guidance (Royal College of Obstetricians and Gynaecologists, 2022). This will enable actions to be put in place to protect the health and wellbeing of staff and mothers (Nursing and Midwifery Council, 2019).

It is recommended that the Trust explores staff's understanding of local guidance on the management of the second stage of labour in the community setting. This will enable the Trust to respond to any interpretation issues relating to local guidance.
It is recommended that the Trust explores the barriers and potential solutions with the obstetric team in relation to the use of the cardiotocograph (CTG) categorisation tool on the electronic patient record; in order to document a systematic review that categorises the CTG and supports a management plan.
It is recommended that the Trust explores the barriers and processes when babies meet the criteria for immediate transfer to neonatal intensive care services and take action to ensure local practice aligns with guidance and referral pathways. This is to ensure prompt referral to the regional neonatal transport team.
It is recommended that the Trust explores the barriers experienced by staff to admitting mothers with moderate/severe bleeding directly to the delivery suite, and act on the findings of this to support staff to follow local and national guidance.
It is recommended that the Trust explores the barriers of using structured communication when giving and receiving clinical information for the purpose of handover of care and escalation of clinical concerns.
It is recommended that the Trust explores the barriers preventing timely escalation and review of mothers following transfer from the antenatal ward with an abnormal cardiotocograph (CTG).
It is recommended that the Trust explores the barriers to performing and documenting the baby's and mother's heart rate at a homebirth in the second stage of labour, as recommended in national and local guidance.
It is recommended that the Trust explores the barriers which prevent consistent use of the cardiotocograph (CTG) categorisation tool by all relevant members of the multi-disciplinary team. This is to support use of systems enabling a systematic review that categorises the CTG and supports a management plan.
It is recommended that the Trust explores the culture in the unit and takes steps to strengthen professional accountability and team behaviours to improve maternity safety standards and the experience of mothers.
It is recommended that the Trust facilitate staff to complete a partogram throughout labour. This will provide a pictorial representation of progress in labour, fetal heart rate, contractions and enable intervention when progress is outside of the expected range.
It is recommended that the Trust follow national guidance (National Institute of Care Excellence, 2021), by using intrapartum cardiotocography interpretation during induction of labour, when uterine activity is seen.

It is recommended that the Trust follow national guidance relating to the categorisation of urgency of caesarean birth. This will support staff to plan timely intervention when concerns are identified with either the mother or the baby.
It is recommended that the Trust follows the National bereavement care pathway standards (2022).
It is recommended that the Trust formalise a pathway of care when a mother chooses to delay her planned induction of labour. This will allow maternal and fetal wellbeing assessments to be completed and support discussions on risks and benefits of delaying the induction of labour.
It is recommended that the Trust further supports staff in the recognition of artefacts and non-interpretable computerised cardiotocograph traces. This is in order to promote safe care.
It is recommended that the Trust further supports staff in working to reduce patient safety health inequalities in line with the NHS England Patient Safety Health Inequalities Reduction Framework (2025).
It is recommended that the Trust guideline for immersion in water during labour is updated to include difficulty in obtaining a fetal heart rate as a criteria for required action/ exiting the pool and that this is embedded through regular training.
It is recommended that the Trust has a clear process for rapid communication between services when the telephone lines and bleeps are out of operation.
It is recommended that the Trust has a system in place for training staff to understand the difference between symphysis fundal height measurements and ultrasound scan measurements to monitor the fetal growth.
It is recommended that the Trust have a clear process for staff training for Growth Assessment Protocol (GAP) and Gestation Related Optimal Weight (GROW), which includes auditing of accuracy of plotting measurements on the GROW charts.
It is recommended that the Trust have a clear process for staff training to support accurate plotting of symphysis fundal height measurements on growth charts.
It is recommended that the Trust have a clear process to escalate obstetric emergencies if the midwifery and obstetric team (including the on call obstetric consultant) are not available, and that this process is fully embedded for all staff.
It is recommended that the Trust have a holistic review of mothers with multiple risk factors to ensure that they remain under the care of a specialist obstetrician to support their individual needs.
It is recommended that the Trust have a pathway to support staff in escalation when intermittent auscultation cannot be carried out in line with guidance to confirm ongoing wellbeing of the baby.

It is recommended that the Trust have a robust and consistent process for the documentation of telephone assessments and plans of care ensuring clinical details are consistently documented when women contact the maternity unit for advice, supporting comprehensive clinical decision making.
It is recommended that the Trust have a robust process in place to ensure that all cardiotocograph (CTG) traces, completed in the operating theatre, are connected to and continuously recording on the electronic system or as a paper-based copy and are retained to ensure that the well-being of a baby prior to birth can be reviewed.
It is recommended that the Trust have a robust process in place to support staff escalating any concerns regarding a fetal heart rate immediately.
It is recommended that the Trust have a robust system in place to ensure that when a request for an obstetric review is made, this occurs in a timely way.
It is recommended that the Trust have an effective system to support clinical oversight during an assisted vaginal birth to aid recognition of when a change to a caesarean birth is required in line with local and national guidance.
It is recommended that the Trust have clear processes for reviewing, actioning and communicating test results to support prompt clinical care.
It is recommended that the Trust identifies and addresses the barriers of carrying out fresh eye cardiotocograph (CTG) reviews. This will support staff to escalate when there are challenges completing fresh eyes reviews in line with local and national guidance and support safe care.
It is recommended that the Trust identifies and addresses the barriers to completing accurate cardiotocograph reviews, incorporating a holistic assessment 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 identifies the barriers to effective multidisciplinary working which prevents them from working together to plan recommended care, enabling consistent information to be shared with a mother, and supporting accurate risk assessments and clinical decision making.
It is recommended that the Trust identifies, and where possible removes, the barriers which prevent staff from providing the level of care recommended for mothers who are in active labour in the maternity triage department, in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023).
It is recommended that the Trust identify and address operational barriers in accessing language support when it is required. This should include perceived limitations around out-of-hours access.

It is recommended that the Trust identify and address the barriers to carrying out and documenting maternal and fetal wellbeing assessments when mothers are admitted in the latent phase of labour. This will support the early recognition of new risk factors and escalation of concerns.
It is recommended that the Trust identify and address the barriers to completing accurate cardiotocograph reviews and incorporating a holistic assessment 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 identify and address the barriers to completing accurate cardiotocograph reviews, incorporating a holistic assessment 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 identify and address the barriers to following local escalation guidelines. This will support staff to recognise and escalate concerns to ensure senior oversight and recognition of red flags throughout shifts to support safe care.
It is recommended that the Trust identify and address the barriers to recognising and escalating when a fetal heart cannot be heard during auscultation in the latent phase of labour. This will ensure prompt escalation and urgent care.
It is recommended that the Trust identify barriers that when 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.
It is recommended that the Trust identify, explore and review the local barriers to completing documentation. This will ensure that staff are supported to complete documentation in line with recommendations by the General Medical Council (GMC)/Nursing and Midwifery Council (NMC).
It is recommended that the Trust identify, explore and review the local barriers to completing documentation. This will ensure that staff are supported to complete documentation in line with recommendations by the General Medical Council (GMC)/Nursing and Midwifery Council (NMC).
It is recommended that the Trust identify, explore and review the local barriers to continuous monitoring and one to one care when high risk mothers are experiencing the onset of regular, painful uterine contractions. This will support staff to practice in line with local and national guidance (Trust, 2024 and Royal College of Obstetricians and Gynaecologists, 2015).

It is recommended that the Trust identify, explore and review the local barriers to the counter signatory of student midwife documentation. This will ensure that staff are supported to demonstrate their professional responsibility and accountability when working with student midwives in line with recommendations from the Nursing and Midwifery Council (NMC).
It is recommended that the Trust implement a maternity specific early warning score system in all clinical areas where pregnant or recently pregnant mothers may attend to ensure early recognition and escalation of a deteriorating pregnant or recently pregnant mother.
It is recommended that the Trust implement a robust handover process for when a member of staff takes a designated break in the maternal and fetal assessment unit, to ensure pending clinical tasks are allocated and there is continued oversight of a mother's and baby's wellbeing.
It is recommended that the Trust implement a robust, person and system-centred process to ensure early recognition and timely treatment of neonatal hypoglycaemia across the multi-professional team, to include standardised, time-specific escalation protocols.
It is recommended that the Trust implement a structured communication and handover process for neonatal transfers, supported by clear protocols that define roles and responsibilities and include Situation, Background, Assessment, Recommendations (SBAR) and closed-loop communication.
It is recommended that the Trust implement a sustainable staffing model that ensures consistent access to break relief and additional on-site senior clinical cover during high-demand periods, to mitigate cognitive fatigue, protect patient safety, and reinforce operational resilience during peak service pressures.
It is recommended that the Trust implement a telephone triage with a dedicated telephone line, dedicated staff and standardised documentation to ensure mothers contacting the maternity unit are safely assessed.
It is recommended that the Trust implement and embed a structured, closed loop communication tool when escalating concerns, to ensure assurance of action even at times of high activity.
It is recommended that the Trust implement measures to confirm that continuous fetal heart rate monitoring is maintained when required, and that the use of a fetal scalp electrode is considered when the quality of cardiotocograph (CTG) monitoring does not allow for a clear and systematic assessment or reassurance of fetal wellbeing.

It is recommended that the Trust implement measures to confirm that monitoring of uterine contractions is maintained when required through both the cardiotocograph transducer and abdominal palpation, to support assessment of a mother in labour.
It is recommended that the Trust implement measures to ensure the cardiotocograph tracing is viewed to confirm that continuous fetal heart rate monitoring is maintained. This is to support recognition of the need for the use of a fetal scalp electrode when the quality of cardiotocograph (CTG) monitoring does not allow for a clear and systematic assessment or reassurance of fetal wellbeing.
It is recommended that the Trust implement processes to ensure mothers who require urgent obstetric reviews are seen overnight and that staff are supported with escalation processes to ensure mothers who require one to one care are identified during periods of high acuity.
It is recommended that the Trust implement structured approaches to shared decision-making in the emergency department (ED) and acute care settings, ensuring that patients and families are given adequate time, information, and support when discussing complex or high-risk diagnostic and treatment decisions.
It is recommended that the Trust implements a method to ensure that when clinical conversations and escalation are being performed, including by telephone, a shared mental model is created, informed by a mutual understanding of the full clinical picture. This will support ongoing care planning and decision making.
It is recommended that the Trust implements a process and provides specific guidance for staff to ensure all pregnant mothers are given information relating to Group B Streptococcus to allow them to make an informed choice regarding screening, in line with national guidance (Royal College of Obstetricians & Gynaecologists (RCOG), 2017).
It is recommended that the Trust implements a process for the antenatal referral and subsequent review of high-risk mothers by the anaesthetic team, with dedicated anaesthetic time provided in line with national guidance.
It is recommended that the Trust implements a standardised equipment verification protocol to ensure that all essential items - particularly those required for airway management, medicine administration and documentation - are present, functional, and immediately accessible.
It is recommended that the Trust implements a standardised neonatal resuscitation equipment checking process on the delivery suite that must be met before a mother is admitted to any birth room. This will ensure neonatal resuscitation equipment is complete, functional, and immediately available, and that all birth rooms meet defined safety criteria prior to use.

It is recommended that the Trust implements a structured process to support effective handover of information between the multi-disciplinary team in emergency situations. This will ensure that all crucial clinical information and assessments are shared to support the ongoing plan of care.
It is recommended that the Trust implements a system to support clinical decision making when a mother, having an induction of labour, cannot be transferred promptly to continue care. The tool must take into account all clinical and social factors (including ethnicity and deprivation), to ensure a dynamic approach to risk assessment.
It is recommended that the Trust implements and embeds a clear process which includes a formal handover of responsibility for the mother and supervision of all students, irrespective of the level of training, to a qualified midwife during any staff rest breaks.
It is recommended that the Trust implements local guidance for the management of intrahepatic cholestasis of pregnancy to ensure clear protocols are in place for the prompt investigation of symptoms such as itching and liver blood tests that are above the normal range.
It is recommended that the Trust implements personalised care plans for all mothers, ensuring they have a full understanding of all of the risks and benefits of all care options to facilitate informed decision making.
It is recommended that the Trust implements the new national maternity early warning score across all birth settings as soon as is practically possible. This will help staff to know when to escalate any abnormal observations during labour and how frequently observations need to be rechecked.
It is recommended that the Trust improve staff knowledge base and practice to include consideration of possible causes when cardiotocograph (CTG) features are outside of the normal ranges. This will support continual assessment of the whole clinical picture to inform ongoing care.
It is recommended that the Trust improve their follow up pathway and failsafe procedures for mothers who do not attend antenatal appointments to offer ongoing antenatal care. This is to ensure that antenatal care is provided for all mothers.
It is recommended that the Trust improves the process of how blood test reports are reviewed and communicated to enable accurate and timely clinical information transfer. This will enable mothers to receive the required care.

It is recommended that the Trust includes training on fetal monitoring, labour and birth with twins in its local multiprofessional mandatory training programme. This is to support staff to understand how local guidance is applied in practice, how to use available equipment to improve fetal monitoring, and to strengthen shared understanding of roles and responsibilities during twin vaginal births.
It is recommended that the Trust instigate practices to ensure normothermia during admission and stabilisation of any baby admitted to the neonatal unit for ongoing monitoring and care, unless a baby is intentionally being cooled.
It is recommended that the Trust introduce guidance on Antenatal Care aligned with national guidance, with reference to the importance of urinalysis as a screening and diagnostic tool.
It is recommended that the Trust introduce the second version of the newborn early warning trigger and track tool to all areas who care for newborn babies, with clear guidance and education, to allow clinical staff to recognise and identify a standardised escalation process for a deteriorating baby.
It is recommended that the Trust introduces a process to ensure that birthing pool water temperature is maintained within national guidance limits throughout labour.
It is recommended that the Trust introduces an 'interruption system' that creates a clear 'pause and review' moment during assisted births when concerns are being raised.
It is recommended that the Trust local resuscitation training and induction for doctors includes principles of neonatal stabilisation and decision-making, including limitations of the use of a capnograph, with reference to the British Association of Perinatal Medicine (BAPM) neonatal airway safety standard.
It is recommended that the Trust make early use of the thromboelastogram point of care coagulation testing to enable early replacement of clotting products when a mother has a major post-partum haemorrhage, in line with local guidance.
It is recommended that the Trust modifies guidance and information about smoking, referrals to the tobacco dependency team and routine carbon monoxide testing so that it is consistent. This will ensure that all staff understand and follow the guidance.
It is recommended that the Trust monitors the frequency and efficacy of the use of the electronic cardiotocograph (CTG) categorisation tool, to assure themselves that this is being used effectively for fetal heart rate assessment and communication of any concerns.
It is recommended that the Trust neonatal service ensures there is a system in place that supports the team with timely delivery of emergency resuscitation drugs during complex or high-stress clinical events.

It is recommended that the Trust offer induction of labour from 41+0 weeks in line with national guidance (National Institute for Health and Care Excellence (NICE), 2021).
It is recommended that the trust offers professional interpretation services at every contact, to confirm a mother's communication needs and preferences at every point of care.
It is recommended that the Trust optimise their neonatal life support training to ensure that the neonatal life support algorithm is followed including timely cardiac massage.
It is recommended that the Trust proceeds with implementation of the national Maternity Early Warning Score (MEWS) across the organisation, including within the emergency department, to ensure that, maternity-specific physiological monitoring is used to support recognition and escalation of maternal deterioration in line with national guidance.
It is recommended that the Trust produces local guidance for the maternity booking process, to support mothers to have their booking appointment within the recommended timeframe, in line with national guidance.
It is recommended that the Trust promote and embed the culture of escalation from any grade of maternity staff where there are scenarios that may impact the provision of safe clinical care.
It is recommended that the Trust promote the activation of the emergency call bell during a suspected fetal bradycardia and a 2222 emergency response call when it is confirmed in order to alert all team members to the emergency situation as soon as possible allowing them to initiate a co-ordinated response.
It is recommended that the Trust provide a robust system for staff to make a concurrent 999 call while remaining on the telephone line to support a mother or her family.
It is recommended that the Trust provide mothers with personalised information of the risks and benefits of interventions or taking no action during obstetric reviews, to enable informed decision making.
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 (BAPM) 2020).
It is recommended that the Trust provide staff with clear guidance and training for when and how to provide an emergency blood transfusion for babies who require resuscitation or for major neonatal haemorrhage.
It is recommended that the Trust provides and embeds a single, clear and robust system to facilitate the handover of a mother's care to ensure all relevant risk factors and information are understood to support safe maternity care.

It is recommended that the Trust provides clear information about the availability of the homebirth service to mothers planning a homebirth. This should include options available if the homebirth service is suspended when their labour starts and supporting mothers to make alternative birth plans.
It is recommended that the Trust provides local guidance to prompt staff about what actions may be taken when a mother reports experiencing urges to push.
It is recommended that the Trust put processes in place to support the completion of accurate, contemporaneous records. This will help provide high-quality information to guide clinical decisions, enable effective review of incidents, and give staff and families a clear understanding of what occurred.
It is recommended that the Trust puts in place systems and processes that are effective for assuring staff have the knowledge, skills and competence needed to perform neonatal resuscitation in line with national guidance.
It is recommended that the Trust puts processes in place to support the completion of accurate, contemporaneous records. This will help provide high-quality information to guide clinical decisions, enable effective review of incidents, and give staff and families a clear understanding of what occurred.
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It is recommended that the Trust reinforces its current fetal monitoring guidance to ensure that a clinical review is requested, for any cardiotocograph (CTG) categorised as abnormal.
It is recommended that the Trust reinforces its instrumental birth guidance, to ensure staff routinely categorise assisted births to support a shared understanding of the urgency amongst the multidisciplinary team.
It is recommended that the Trust reinforces its oxytocin safety protocol by ensuring that midwifery staff are supported to discontinue oxytocin infusions upon identification of a pathological cardiotocograph (CTG). This action should be embedded in training, clinical guidelines, and culture to prevent delays in response to fetal compromise.

It is recommended that the Trust reinforces protocols around the use of terbutaline during labour, when indicated due to contraction frequency.
It is recommended that the Trust reinforces the necessity that during complex technical tasks and/or every emergency situation a senior clinician is assigned to take the 'helicopter view', to prevent important information from being overlooked, anticipate problems earlier and raise awareness of the passage of time.
It is recommended that the Trust requires all staff to undertake a full assessment whenever concerns about a baby's heartrate are raised. This will ensure timely further escalation if required.
It is recommended that the Trust review all local guidance to ensure clearly reflects national guidance on blood-stained liquor. This will support staff to recognise that blood-stained liquor is a risk factor and to escalate any concerns.
It is recommended that the Trust review and adapt the systems and processes that support staff to identify and act on maternal observations recorded outside of the normal range at homebirth in line with local guidance. This will support staff to recognise, escalate, and recommend transfer to the maternity unit when needed.
It is recommended that the Trust review and align the local maternity triage service with the Royal College of Obstetricians and Gynaecologists' (2023) standards for triage, to support a safe and effective system for mothers when accessing care.
It is recommended that the trust review and align the processes for the management of unstable lie at term. This should reflect risk assessment and ensure mothers are informed and supported with care choices in line with local and national guidance.
It is recommended that the Trust review and amend their maternity escalation process to support staff in all clinical areas including the pregnancy assessment unit to use defined thresholds to proactively escalate. Embedding this will help to maintain the safe and timely initial triage assessment, ongoing review and medical assessment of mothers.
It is recommended that the Trust review and clarify how the cardiotocograph categorisation tool is used during all cardiotocography reviews, including expectations for documenting the categorisation and agreed actions, in order to ensure changing features are analysed together, alongside any evolving risks, and plans are consistent, to address the risk of variable interpretation.
It is recommended that the Trust review and embed a process to ensure that when a mother presents with bleeding this information is considered as part of a holistic review.
It is recommended that the Trust review and embed a standardised process for calling for senior help in the operating theatre during an emergency, including neonatal emergencies.

It is recommended that the Trust review and embed the local guidance for checking and acting upon test results to ensure a consistent process throughout maternity services, including correlation with the mother's clinical picture. This is to ensure that test results are reviewed in a timely manner and actioned according to the mother's holistic needs.
It is recommended that the Trust review and embed the triage system to ensure that the requirement for initial triage including fetal heart rate assessment is met within 15 minutes of arrival in line with the local guidance.
It is recommended that the Trust review and embed their guidance for vaginal breech birth to ensure that all staff understand their roles and responsibilities, and that clinical oversight of all information, including a structured handover, is maintained by one nominated leader. This is to support communication and understanding of whether a caesarean birth is required.
It is recommended that the trust review and implement quality assurance of third trimester growth scans to ensure compliance with national guidance.
It is recommended that the Trust review and revisit their prostaglandin pessary benchmarking to support their safe use, in line with manufacturers' and updated National Institute for Health and Care Excellence (NICE) guidance. This will ensure Trust guidance remains up to date and in line with current national guidance.
It is recommended that the Trust review and risk assess their current available water birth resources and assures themselves of the suitability of the equipment being used. This should take into consideration current information from the manufacturer about the equipment's intended purpose.
It is recommended that the Trust review and update of local guidance for low-risk care in labour to explicitly include standardised communication to ensure that in the presence of meconium (regardless of perceived significance) mothers are informed of: -The potential implications of meconium for fetal wellbeing. -Their options for escalation to obstetric-led care. -The availability and purpose of continuous cardiotocograph (CTG) monitoring.
It is recommended that the Trust review and update the induction of labour guidance to support safe use of prostaglandin pessaries, in line with manufacturer's guidance. This will support staff to facilitate individualised care planning and ensure removal occurs when indicated.
It is recommended that the Trust review and update the local guidance for prelabour spontaneous rupture of membranes at term in line with national guidance. This will support staff to offer all mothers who have prelabour spontaneous rupture of membranes at term the choice of expectant management or induction of labour as soon as possible.

It is recommended that the Trust review and update their induction of labour guidance at the earliest opportunity to reflect national guidance and to ensure there are discussions with mothers regarding the risks of continuing their pregnancies beyond 41+0 weeks.
It is recommended that the Trust review and update their local guidance and associated training to support the recognition of the start of the second stage of labour. This is to ensure that mothers receive second stage of labour care when indicated including increased monitoring of a baby's heart rate and more accurate assessment of the timing of the second stage.
It is recommended that the Trust review and update their local guidance for management of gestational hypertension in relation to advice given about timing of birth and shared decision making with mothers, so that it is in line with national guidance.
It is recommended that the Trust review current guidance for hypertension in pregnancy in relation to performing growth scans in new onset hypertension, taking into consideration the mothers risk factors in order to plan a scan schedule and timing of birth.
It is recommended that the Trust review dissemination of local guidance and training to strengthen staff understanding and awareness of the increased chance of an umbilical cord snapping in a water birth.
It is recommended that the trust review fetal growth surveillance pathways in relation to smoking as a risk factor for fetal growth restriction to ensure compliance with national guidance.
It is recommended that the Trust review guidance and training for fetal monitoring to support staff to recognise fetal heart rate changes during intrapartum care undertaken at home. This will support staff to recognise, escalate, and recommend transfer to the maternity unit for an obstetric review.
It is recommended that the Trust review guidance for intermittent auscultation and consider how staff could be supported to understand the actions needed when there are challenges in undertaking intermittent auscultation in line with guidance. This would include the identification of situations where timely change to cardiotocograph (CTG) monitoring is indicated, to ensure the effective monitoring of all babies' wellbeing in labour.
It is recommended that the Trust review how cardiotocographs (CTGs) are interpreted to ensure there is timely recognition and appropriate management of an abnormal CTG.
It is recommended that the Trust review how clinical information is conveyed amongst staff at handovers and optimises the use of formal handover tools in order to support effective communication and understanding of ongoing situations.

It is recommended that the Trust review how clinical information is conveyed amongst staff between handovers and optimises the use of formal handover tools; in order to support effective communication and understanding of ongoing care plans.
It is recommended that the Trust review how communication with an interpreter is used and facilitated in practice to ensure local and national guidelines are met.
It is recommended that the Trust review how local and national guidance for the fetal growth surveillance is embedded into practice to support staff to accurately monitor, document and refer when indicated.
It is recommended that the Trust review how midwifery staff access senior midwifery advice and support out of hours.
It is recommended that the Trust review how they provide support to staff during obstetric emergencies to accurately record the details of information sharing as part of the verbal consent process.
It is recommended that the Trust review its home birth service provision to support midwives' wellbeing, working hours and working environment. This will support safer care for mothers in labour.
It is recommended that the Trust review its list of emergencies for 2222 calls, and these are communicated to staff and embedded into practice.
It is recommended that the Trust review its local guidance on twin fetal monitoring during labour and birth. This is to ensure consistency between local guidance documents and to support a structured approach to identifying and reviewing twins' heart rate patterns.
It is recommended that the Trust review its processes for inducing labour for mothers who have multiple risk factors when the labour ward is busy. This is to support a multi-professional plan of care to be developed by the full team so that, before intervention, there is a shared understanding of mothers' and babies' clinical needs.
It is recommended that the Trust review local guidance and education for staff to support them to consider triggers for neonatal infection, such as babies who have feeding difficulties in the first 24 hours in line with national guidance.
It is recommended that the Trust review local guidance around the use of terbutaline to ensure that this is aligned to national guidance.
It is recommended that the Trust review local guidance regarding the conversations that need to be held with mothers with regards to receiving Group B Stretococcus (GBS) antibiotics, to enable informed and shared decision making between the mother and the right clinicians. A clear plan detailing the discussion must be documented in the mother's care record to support ongoing care planning.

It is recommended that the Trust review national guidance and recommendations (British Medical Ultrasound Society (BMUS), 2022) to ensure the Trust allocates enough time to growth ultrasound scan appointments to ensure image optimisation, accurate fetal biometry measurement and reporting (NHS England (NHSE), 2025, BMUS, 2022).
It is recommended that the Trust review pathways with GP partners to support extremely vulnerable women in accessing medication in pregnancy and information provision on the benefits of taking aspirin in pregnancy.
It is recommended that the Trust review practice, staffing and training in order to support skin to skin contact. That allows a plan for observation of babies during skin-to-skin contact and for parents concerns to be responded to immediately.
It is recommended that the Trust review processes ensuring that staff are supported to maintain awareness of all risk factors during neonatal resuscitation, in order to recognise when alternative ventilation methods are required prior to and during the transfer of a baby by ambulance.
It is recommended that the Trust review the antenatal cardiotocograph (CTG) guideline to include the expectation of frequency of categorisation, and obstetric and midwifery oversight if an antenatal CTG is continuing because of concerns about a baby's heart rate.
It is recommended that the Trust review the arrangements for neonatal consultant cover across its sites so that staff are provided with prompt and direct access to senior clinical support and an equitable service is provided to families, regardless of where they choose to give birth.
It is recommended that the Trust review the assessment and waiting times in the Maternal and Fetal Assessment unit, in reference to local and national guidelines.
It is recommended that the Trust review the assessment and waiting times in the Maternal and Fetal Assessment unit, in reference to local and national guidelines.
It is recommended that the Trust review the barriers to offering mothers with gestational diabetes mellitus care in line with national National Institute for Health and Care Excellence (NICE, 2020) guidance, and develop a process to ensure all women with complex pregnancies have their care overseen by a named consultant lead in line with Ockenden (2020) recommendations.
It is recommended that the Trust review the barriers to the effective use of the emergency buzzer to ensure that when a fetal bradycardia is present the whole team is alerted to the urgency of the situation. This will allow additional staff to attend and support with tasks like making contemporaneous documentation. This review should include the differing practice between the labour rooms and the induction of labour rooms.

It is recommended that the Trust review the barriers to the linking of the one stop gynaecology records with the main hospital records particularly where women are under the care of the Trust already.
It is recommended that the Trust review the contents of the neonatal resuscitation trollies, to ensure the immediate availability of equipment to support venous access during neonatal resuscitation.
It is recommended that the Trust review the current systems in place, to ensure that mothers contacting the maternity unit are risk assessed and that they receive the correct safety netting advice. This should include advice for postnatal mothers and babies, and communication with relevant teams for ongoing care.
It is recommended that the Trust review the emergency bell set up in theatre 7 to ensure it sounds in the labour ward office when activated.
It is recommended that the Trust review the factors preventing consistent use of a formal cardiotocograph (CTG) classification tool, to strengthen interpretation of fetal monitoring, support timely recognition of concerns requiring obstetric review, and inform decision-making regarding the timing of birth.
It is recommended that the Trust review the fetal assessment tool, and address the barriers to the recognition and escalation of deteriorating cardiotocographs (CTGs). This will support accurate assessment of fetal wellbeing in labour, and escalation of concerns.
It is recommended that the Trust review the fetal growth pathway to consider what guidance and tools are needed to support staff to deliver care that effectively monitors fetal growth in line with national guidance.
It is recommended that the Trust review the guidance to determine the frequency of observations required by a mother with a raised temperature in labour in line with national guidance (National Institute for Health and Care Excellence, 2019). This will optimise oversight of the evolving picture and recognition of a mother's clinical condition.
It is recommended that the Trust review the hypertension and antenatal care guidance available to support clear decision making in the community setting when referring mothers for obstetric review.
It is recommended that the Trust review the intrapartum cardiotocograph categorisation tool, to support staff to effectively categorise intrapartum cardiotocograph and to support decision making and care planning.
It is recommended that the Trust review the local guidance and training to support staff to recognise a deteriorating cardiotocograph (CTG) and the requirement for expedition of birth to support ongoing fetal wellbeing.

It is recommended that the Trust review the local guidance which supports staff to consider the full clinical picture on assessment in the presence of an abnormal cardiotocograph (CTG) trace and repeated ST events, and the requirement for expedition of birth.
It is recommended that the Trust review the local guidance, triage assessment cards and pre-labour rupture of membrane check list. The Trust are to ensure the documents in use support staff to identify when an obstetric review is required for mothers who attend triage with bloodstained liquor, to ensure they receive a timely and appropriate review, enhancing safety and consistency in care delivery.
It is recommended that the Trust review the local oxytocin guidance to reflect national guidance on the use of oxytocin during labour to support fetal wellbeing.
It is recommended that the Trust review the location and set up of the maternity triage department, taking account of national guidance to ensure that safe care can be provided whilst avoiding unnecessary delays.
It is recommended that the Trust review the maternity escalation pathway for out-of-hours care, in order to ensure it is clear to all staff how to escalate for additional senior obstetric support in times of high acuity.
It is recommended that the Trust review the obstetric staffing provision for triage to support timely assessments in line with the local Birmingham Symptom Specific Obstetric Triage System (BSOTS) timeframes.
It is recommended that the Trust review the oversight of care provided by students and how this is documented. This will ensure that safe and effective learning experiences are provided for students whilst also providing safe and compassionate care to mothers, in line with the Nursing and Midwifery Council (NMC) Code (2018).
It is recommended that the Trust review the planned caesarean birth pathway to ensure that the process is robust and consistent when the need arises for a planned caesarean birth at short notice. This will support staff and mothers with a standardised approach to care.
It is recommended that the Trust review the process for electronic prescribing of dinoprostone to ensure that it can be prescribed and administered safely.
It is recommended that the Trust review the process for ongoing clinical assessment and consideration of transfer to labour ward when a mother has been transferred to the birth centre. This is to ensure ongoing risk assessment and safe care planning.
It is recommended that the Trust review the process for the obstetric review of mothers undergoing induction of labour, prioritising those who have additional risk factors. This is to ensure that mothers receive holistic obstetric oversight and safe care planning.

It is recommended that the Trust review the process for transferring mothers to the safest intrapartum area. This would include a review of the communication, acuity and escalation between clinical areas. This is to ensure that birth is facilitated in the safest clinical setting.
It is recommended that the Trust review the process of following up test results so that any results that require treatment or action are communicated to mothers and are flagged in the record so that appropriate action can be taken.
It is recommended that the Trust review the provision, organisation, and accessibility of equipment required for neonatal resuscitation in the operating theatre, ensuring that essential items are consistently available and arranged in a manner that supports rapid and effective clinical response.
It is recommended that the Trust review the sepsis guidance to support staff to have a clear understanding of the pathway.
It is recommended that the Trust review the system to ensure all staff attend annual fetal monitoring training and completion of competency assessment and that staff do not care for mothers in a birth setting without annual completion. This is to ensure compliance with national expected standards.
It is recommended that the Trust review the telephone triage system in order to ensure that the telephone calls are answered consistently 24 hours a day as set out in the Trust guideline.
It is recommended that the Trust review the triage provisions and process, including the staffing model to ensure that mothers consistently have access to care in line with expected practice.
It is recommended that the Trust review the usability and application of the cardiotocograph (CTG) review tool and associated processes during busy periods and consider how staff confidence in using the recently introduced physiological terminology can be supported over time, to ensure consistent documentation and interpretation in line with local guidance.
It is recommended that the Trust review the usability and usefulness of tools to support the recognition of induction of labour demand in the maternity unit to actively plan and manage patient flow.
It is recommended that the Trust review their acuity tool so that accurate reporting of acuity and midwifery and obstetric staffing can be made contemporaneously.
It is recommended that the Trust review their communication pathway to ensure that when neonatal assistance is requested, it is effectively actioned and supported with closed loop communication.
It is recommended that the Trust review their communication processes between main theatre and maternity services so that main theatres are ready for an obstetric emergency when needed.

It is recommended that the Trust review their fetal monitoring guideline to provide staff with clear and consistent advice on the use of Dawes-Redman analysis for fetal monitoring, including its use in the presence of uterine activity and criteria for escalation. This will support standardised clinical decision-making, reduce variability in practice and allow timely obstetric review where indicated.
It is recommended that the Trust review their guidance and training to ensure that all staff are aware of the safety features and functionalities of the cardiotocograph (CTG) machines in use, which will include the 'pulse delay' and 'coincidence alarm' features.
It is recommended that the Trust review their guidance and training to reinforce staff awareness and use of the safety features and functionalities of the cardiotocograph (CTG) machines and fetal monitoring system. This is with the aim of ensuring that staff are confidently monitoring the fetal heart at all times and the mother's heart rate can be clearly differentiated in line with national guidance.
It is recommended that the Trust review their guidance on induction of labour to ensure it reflects national guidance. This will support staff to have informed discussions with families about induction of labour for post maturity, that includes information about the risk of continuing a pregnancy beyond 41 weeks to support informed decision making.
It is recommended that the Trust review their guidance so that it is consistent and in line with national guidance to manage raised blood pressure.
It is recommended that the Trust review their guidelines (Gestational Diabetes and Neonatal Hypoglycaemia) to ensure they are consistent in timings. Including when babies of mothers with diabetes are expected to have had their first feed by and if this cannot be achieved; advise how to manage this in line with national guidance.
It is recommended that the Trust review their guidelines and training (Diabetes and Neonatal Hypoglycaemia) to ensure they are consistent in timings. Including when babies of mothers with diabetes are expected to have had their first feed by and if this cannot be achieved; advise how to manage this.
It is recommended that the Trust review their induction of labour booking and prioritisation process to include consideration of capacity when booking an induction of labour. The risk factors considered when prioritising daily induction of labour admissions should include twin pregnancy.
It is recommended that the Trust review their local guidance and practice regarding the frequency of recording symphysis fundal height measurement in line with national guidance to support recognition and management of slow and static fetal growth.

It is recommended that the Trust review their local guidance regarding referral for a growth ultrasound scan in line with national guidance to support recognition and management of slow and static fetal growth.
It is recommended that the Trust review their local guidance to ensure it aligns with national guidance on the timing of induction of labour.
It is recommended that the Trust review their priorities for the Information Technology (IT) worklist to ensure that the software package for fetal growth surveillance is available urgently so that clinical decisions can be made with correct information.
It is recommended that the Trust review their process and management of all antenatal investigations that are performed in the antenatal clinic. This is to ensure that any abnormal results are recognised and acted upon in a timely manner.
It is recommended that the Trust review their process for assessing a cardiotocograph (CTG) so that staff are able to consistently categorise them in line with guidance to ensure abnormal features are recognised and acted upon quickly.
It is recommended that the Trust review their process for implementing a fetal surveillance plan when indicated so this can commence in a timely manner after ongoing concerns are identified.
It is recommended that the Trust review their process of urine testing in the antenatal clinic setting to ensure all requests are actioned and sent for testing as indicated.
It is recommended that the Trust review their process to ensure that there is clear, contemporaneous and complete documentation of cerebral function monitoring in a baby's medical records. This will ensure that there is a robust and systematic process for documentation of decision making and management where cerebral function monitoring has been started whilst therapeutic hypothermia is being considered. This may include a review of Trust guidance and audit of documentation.
It is recommended that the Trust review their process, so staff can recognise and refer, when testing for gestational diabetes is needed.
It is recommended that the Trust review their processes for cardiotocograph (CTG) assessment to ensure CTG interpretation is done every 30 minutes in the second stage of labour using a systematic tool, and categorised using terminology in the local guidance. This will support the identification, communication and escalation of CTGs showing signs of hypoxia.
It is recommended that the Trust review their provision of suction equipment for staff working in the community to ensure that the equipment is fit for purpose and staff are appropriately trained how to check the equipment and in its use.

It is recommended that the Trust review their systems to support recognition of when the early labour care bundle is required and strategies to implement this irrespective of the location of the mother.
It is recommended that the Trust review their training to ensure staff understand the guidance for fetal monitoring during an induction of labour. This should include knowledge of when to use Dawes-Redman analysis or an antenatal categorisation tool. This will support clinical decision-making and reduce variability in practice.
It is recommended that the Trust review their training to ensure that all staff are confident in re-escalation and supported to challenge decisions in line with the Royal College of Obstetricians and Gynaecologists (2022) escalation framework.
It is recommended that the Trust reviews access to and use of interpretation services for mothers whose primary language is not English, including those who speak conversational English and may experience difficulty understanding complex clinical discussions. This review should support consistent and equitable use of interpretation at all points of care, with practical steps to improve timely access to language assistance devices, documentation of interpreter use, and staff training to promote personalised communication and informed decision-making.
It is recommended that the Trust reviews access to, and use of, interpretation services for mothers whose primary language is not English, including those who speak conversational English and may experience difficulty in understanding clinical discussions. This will support consistent use of interpretation at all points of care and include support for clinicians in making on-going language needs assessments for mothers and families to promote personalised communication.
It is recommended that the Trust reviews all related clinical guidance documents to promote consistency in wording. Better alignment across documents can reduce ambiguity and support clearer interpretation by staff in time-sensitive situations.
It is recommended that the Trust reviews all relevant local guidance and training packages relating to transfer to theatre in an obstetric emergency, so that they are consistent and align with national guidance. This should support staff in their decision making and actions when transfer to the operating theatre is needed during an emergency.
It is recommended that the Trust reviews anaesthetic and other multi-disciplinary team out of hours cover for the hospital site and align with national guidance to ensure that they are able to immediately respond to an obstetric emergency.
It is recommended that the Trust reviews and addresses any barriers to care pathways in the antenatal day unit, to make sure that mothers with multiple risk factors receive a review by a senior obstetric doctor to agree the timing of the baby's birth.

It is recommended that the Trust reviews and addresses any barriers to care pathways in the antenatal day unit. This is to make sure that mothers with multiple risk factors receive a review by a senior obstetric doctor to agree a plan for the timing of the baby's birth and possible earlier induction of labour.
It is recommended that the Trust reviews and addresses barriers to effective neonatal resuscitation, with the aim of improving timely clinical care, communication and accurate documentation. This should include, but is not limited to: -Ensuring that all staff involved in maternity and neonatal resuscitation-including those not based in hospital settings-participate in regular, structured multidisciplinary training for obstetric emergencies. -Promoting the use of closed-loop communication during critical events to enhance clarity, reduce errors, and support coordinated team responses.
It is recommended that the Trust reviews and addresses the barriers for staff to declare and escalate obstetric emergencies on the antenatal ward to ensure prompt review and action by the obstetric team. This may include direct transfer to the operating theatre.
It is recommended that the Trust reviews and addresses the barriers to staff reviewing the electronic patient records for mothers contacting telephone triage and completing contemporaneous documentation of the calls and advice given. This will support care planning, advice and oversight for mothers making repeated calls to the telephone triage service.
It is recommended that the Trust reviews and aligns their current induction of labour guidance with national recommendations (National Institute for Health and Care Excellence, 2021).
It is recommended that the Trust reviews and aligns their induction of labour guidance and clinical practice with national recommendations to offer postdates induction from 41+0 weeks (National Institute for Health and Care Excellence, 2021b).
It is recommended that the Trust reviews and changes the induction of labour booking process. It is important that staff responsible for the bookings are fully aware of the multiple risk factors of mothers and the urgency of the request.
It is recommended that the Trust reviews and develops the risk assessment and screening criteria for gestational diabetes to support early identification of and care planning for mothers with gestational diabetes in line with national guidance.
It is recommended that the Trust reviews and strengthens its systems for dignity, communication, bodily autonomy and consent during emergency situations particularly when mothers are experiencing high levels of distress, so that care remains respectful and person-centred.
It is recommended that the Trust reviews and strengthens its systems for intrapartum maternal monitoring to screen for sepsis, in order to ensure that clinical deterioration is promptly identified, escalated, and acted upon.

It is recommended that the Trust reviews and strengthens its triage process so that: -it is clearly known when a mother arrives on the triage unit. -all staff are trained in the use of Birmingham Symptom Specific Obstetric Triage System (BSOTS). -data can be captured in real time. -staff are aware of when and how to escalate when timeframes cannot be met. -work plans and workflow are clearly captured.
It is recommended that the Trust reviews and strengthens training and competency packages in neonatal airway management, to include the use and limitations of colorimetric CO2 in low cardiac output states.
It is recommended that the Trust reviews and updates its escalation policy to include clear guidance on when and how clinicians should escalate concerns about staffing levels or clinical decision-making, in order to provide safe specialist care.
It is recommended that the Trust reviews and updates its induction of labour guideline to align with national guidance, in order to ensure equitable care and information sharing for all women. This is to support personalised care plans and decisions being made, with information relevant to the mother being shared.
It is recommended that the Trust reviews and updates its local guideline for managing changes in fetal movement patterns to ensure alignment with the Saving Babies' Lives Care Bundle (Version 3). The review should include ensuring that a process is in place to regularly check that the guideline remains current and is being followed.
It is recommended that the Trust reviews and updates the Group B streptococcus information provided to mothers once a positive result has been returned. This is to ensure the relevant information is shared.
It is recommended that the Trust reviews and updates the neonatal resuscitation guideline and associated documentation to ensure consistency with national guidance on drug dosing. This will help ensure that babies undergoing resuscitation receive appropriate and effective doses of emergency medications.
It is recommended that the Trust reviews existing cardiotocograph (CTG) interpretation tools used by staff to ensure that these support ongoing, dynamic assessment and a holistic review of the clinical picture, including recognition of uterine activity and mothers' pain.
It is recommended that the Trust reviews guidance to support holistic risk assessment, to include all a mother's confirmed and developing risk factors; to ensure that the correct level of risk can be identified and timely escalation to obstetric led care takes place if indicated.

It is recommended that the Trust reviews how a clear risk assessment and induction of labour plan is made and documented, with regard to the type and frequency of maternal and fetal monitoring. This is to help sharing of information and plans being transferred between clinicians to support ongoing clinical care and decision making.
It is recommended that the Trust reviews how communication is facilitated with a mother when discussing her options for mode of birth, to support personalised care, to ensure she has sufficient information and her choices are supported.
It is recommended that the Trust reviews how comprehensive neurological assessments are completed and documented, with reference to regional and national guidance, when undertaking therapeutic cooling.
It is recommended that the Trust reviews how information and decision making regarding the urgency category of birth is communicated. This is to ensure there is a shared mental model and understanding of the plan of care and treatment and the time in which this is required to be achieved.
It is recommended that the Trust reviews how maternal observations and fetal assessment are entered onto electronic patient record systems and considers methods to assess the effectiveness of this process. This review should ensure accurate documentation and reliable activation of automated alerts to support safe patient care, while addressing the risk of overreliance on electronically generated alerts.
It is recommended that the Trust reviews how pain is assessed, responded to and managed during assisted vaginal birth, particularly when there are language barriers, to ensure that the birth is safe and not traumatic for mothers and their birth supporters.
It is recommended that the Trust reviews how staff carry out relevant clinical assessments to gain information. This should support making accurate risk assessments and clinical decisions, including the implementation of the latest Newborn Early Warning Track and Trigger (NEWTT2) that includes listening to family/carers concerns.
It is recommended that the Trust reviews it process for maternity staff having access to main theatres to ensure that there are no delays in gaining entry during emergency situations.
It is recommended that the Trust reviews its home blood pressure monitoring process, ensuring that the rationale and frequency of measurement is clear to mothers and clinicians. This will ensure that clinicians have an accurate picture of a mother's blood pressure to exclude or diagnose hypertension, and abnormal readings at home or in hospital are escalated.
It is recommended that the Trust reviews its induction of labour processes for high-risk mothers to ensure plans are clearly defined, documented and mothers are reviewed by an obstetric doctor.

It is recommended that the Trust reviews its local guidance on which members of the neonatal team are required to be present for the neonatal resuscitation and that when their attendance is requested the reason is clearly and accurately communicated.
It is recommended that the Trust reviews its maternity triage midwifery and obstetric staffing and senior oversight in line with recommendations in national guidance. This will support the recommended model for maternity triage assessment and admissions.
It is recommended that the Trust reviews its neonatal doctor induction programme to support new staff to be confident in the location of emergency equipment in maternity operating theatres.
It is recommended that the Trust reviews its processes to ensure that all medicines administered during neonatal resuscitation are documented in accordance with national standards, including the dose, route, time of administration, and the clinician responsible. Compliance should be monitored to provide assurance that care is delivered and recorded in line with recognised guidance.
It is recommended that the Trust reviews its risk assessment process at booking so that potential risk factors which may impact on care during pregnancy can be identified. This should involve provision of clear guidance for staff and facilitating access to all of the relevant medical records to allow a comprehensive assessment.
It is recommended that the Trust reviews its sepsis 6 processes and identify any barriers to providing treatment as soon as possible, to support the delivery of prompt safe care for mothers and babies.
It is recommended that the Trust reviews its sepsis 6 processes and identify any barriers to providing treatment within the recommended hour, to support the delivery of prompt safe care for mothers and babies.
It is recommended that the Trust reviews labour assessments to strengthen the recognition of clinical deterioration and escalation. This should include consistent monitoring of fluid balance, completion of a full and accurate Maternity Early Warning Score (MEWS), appropriate fetal monitoring, and consideration of other relevant clinical indicators.
It is recommended that the Trust reviews local guidance and processes to support staff, in understanding what maternal and fetal assessment is required, when pain relief is administered during the induction of labour process. And that guidance is in line with product manufacturer recommendations on when to remove a prostaglandin pessary. This is to maintain full oversight of a mothers and baby's wellbeing during an induction of labour.

It is recommended that the Trust reviews local guidance on where to bring a baby for neonatal review following intervention or resuscitation at homebirth. This will support staff understanding and clear communication between teams.
It is recommended that the Trust reviews local guidance on where to bring a baby for neonatal review following intervention or resuscitation at homebirth. This will support staff understanding and clear communication between teams.
It is recommended that the Trust reviews local guidance to ensure a communication framework is in place that includes escalation for senior clinical advice during neonatal resuscitation and when decisions to withdraw lifesaving treatment are being made.
It is recommended that the Trust reviews local guidance to ensure the dating scan from overseas organisations are used to inform decision-making to support ongoing management and timing of birth when mothers transfer their care to the Trust.
It is recommended that the Trust reviews local staffing, guidance and processes to support delivery of telephone triage for mothers accessing care at both hospital sites in line with the Royal College of Obstetricians and Gynaecologists good practice paper (2023).
It is recommended that the Trust reviews midwifery staffing and skill mix to align with local and national guidance to provide experienced clinicians in maternity triage so that a mothers management plan is personalised based on holistic assessment.
It is recommended that the Trust reviews multiprofessional team working and communication to achieve birth as quickly and safely as possible once the decision for birth is made.
It is recommended that the Trust reviews practice in relation to the administration of oral morphine under the patient group directive in the latent phase of labour. This might include an audit of compliance with the required observations set out in the patient group directive and clarification of actions required when a mother is already taking a medicine which advises caution with oral morphine.
It is recommended that the Trust reviews practice in relation to the administration of oral morphine under the patient group directive. This might include a review of local guidance or an audit of compliance with the required observations set out in local guidance (Trust, 2025).
It is recommended that the Trust reviews processes and local guidance relating to monitoring and recording temperatures during resuscitation and therapeutic cooling.
It is recommended that the Trust reviews referral pathways and oversight processes for antenatal women with multiple risk factors, to ensure senior obstetric doctor review to support personalised care planning.

It is recommended that the Trust reviews the 2222 emergency call system in operation, taking into account equipment design, call handling, and team communication to identify and reduce risks that may affect the timeliness of an emergency response.
It is recommended that the Trust reviews the accessibility, the processes in place for electronic documentation and the back-up plan when electronic documentation is not available. This will ensure consistency in practice when electronic systems are not available and reduce the chance of missed or delayed documentation.
It is recommended that the Trust reviews the admission and handover process in the maternity triage unit to make sure that all information is considered during a mother's care.
It is recommended that the Trust reviews the antenatal care guidance for the maternity booking risk assessment to ensure it aligns with other maternity guidance. This will support mothers to be booked on the correct maternity pathway, with adjustments to their planned care made as required.
It is recommended that the Trust reviews the arrangements for neonatal consultant cover across its sites so that staff are provided with prompt and direct access to senior clinical support and an equitable service is provided to families, regardless of where they choose to give birth.
It is recommended that the Trust reviews the barriers to referring mothers in for further assessment when hypertension is identified in the community, in line with national guidance.
It is recommended that the Trust reviews the barriers to the electronic input for the risk assessment at booking for fetal growth restriction and implements an action plan. To ensure risk factors are not missed when inputting data to generate a care plan.
It is recommended that the Trust reviews the care planning, assessment and discharge process supports safe care when there are abnormal observations.
It is recommended that the Trust reviews the current systems that support handover of care and embeds the use of a structured approach to ensure there is a shared understanding of the care recommended.
It is recommended that the Trust reviews the delegation of operational and clinical tasks ensuring staff are not required to balance both roles simultaneously to improve leadership relating to patient flow through the maternity unit.
It is recommended that the Trust reviews the effectiveness of communication between teams when an urgent birth is needed, to ensure that there is a shared understanding of the level of urgency.

It is recommended that the Trust reviews the electronic booking system, including the training of staff, to support midwives in completing the maternity booking appointment. This will support mothers to be booked on the correct maternity pathway, with adjustments to their planned care made as required.
It is recommended that the Trust reviews the flow and capacity throughout the maternity unit, to enable prompt transfer from the maternity triage when indicated. This is to support the clinicians to be able to perform timely triage reviews, ongoing assessments and ensure that mothers are having their care provided in the correct location.
It is recommended that the Trust reviews the governance of the homebirth birth group to make sure it is clear. This needs to include the Trust taking accountability for the information shared, if a midwife is present at this group.
It is recommended that the Trust reviews the guidance and criteria for labour care in the midwifery led unit, to ensure it is in line with national guidance and is clear to staff. This will enable them to identify when a mother does not meet the criteria for admission.
It is recommended that the Trust reviews the guidance available to staff in relation to administering opioid medication during labour with a particular focus on discussions around risk, maternal and fetal observations, and ensuring that any risk discussion and assessment are documented.
It is recommended that the Trust reviews the guidance notes for the maternity booking risk assessment to support midwifes completing the maternity booking appointment. This will support mothers to be booked on the correct maternity pathway, with adjustments to their planned care made as required.
It is recommended that the Trust reviews the implementation of the Birmingham specific obstetric triage system, the staffing levels to maintain it and how audit data can identify its strengths and weaknesses.
It is recommended that the Trust reviews the information within the regional patient information leaflet and current practice of delayed oxytocin augmentation for mothers who have already had a baby to ensure that it meets current National and Trust guidance (National Institute of Health and Care Excellence, 2021c, Trust 2023d). These actions will help mothers to be fully informed of the choice of starting oxytocin augmentation immediately after a mother's waters are broken and are aware of the risks of any delay.
It is recommended that the Trust reviews the local governance process to ensure that any change in guidance is fully ratified and disseminated before being put into practice.
It is recommended that the Trust reviews the maternity day assessment unit's workload and staffing, in order to support staff in delivering care. This is in order to further promote safe care.

It is recommended that the Trust reviews the neonatal resuscitation simulation training to ensure it strengthens clinical competence (intubation, chest compressions and umbilical venous catheter insertion), teamwork, and decision-making during critical situations such as neonatal resuscitation, in line with Trust and national guidance.
It is recommended that the Trust reviews the process and distribution lists for obstetric and neonatal emergency 2222 calls to ensure the correct teams are alerted and attend.
It is recommended that the Trust reviews the process for communicating the categorisation of a caesarean birth to ensure that all members of the maternity team have a shared understanding of the urgency of the birth.
It is recommended that the Trust reviews the process for mothers whose risk factors change in pregnancy, so that their plan of care is clearly reassessed, documented and accessible to all staff who are caring for the mother.
It is recommended that the Trust reviews the process for requesting urgent additional assistance for staff providing care in neonatal resuscitation, including clarifying which emergency calls to make.
It is recommended that the Trust reviews the process for training, supporting and equipping staff to recognise cumulative risk factors. This knowledge should inform decision-making during holistic reviews when a baby's clinical condition changes over time. These processes should enable timely escalation and admission to the neonatal unit when clinically indicated.
It is recommended that the Trust reviews the process of obstetric clinical oversight following a scan after 39 weeks of pregnancy. This is to support/optimise safe maternal and fetal assessment.
It is recommended that the Trust reviews the rota system and allocation of doctors to different clinical areas to ensure obstetric oversight is provided to all mothers on the antenatal ward in line with local guidance (Induction of labour guideline, 2024).
It is recommended that the Trust reviews the safety and working culture of the unit and takes any necessary steps to maximise collaborative multiprofessional working and open, respectful discussion regarding clinical decision making.
It is recommended that the Trust reviews the senior staffing model of the labour ward assessment unit to ensure physical presence and senior clinical overview.
It is recommended that the Trust reviews the system and processes for booking planned caesarean birth with clear parameters of the required dates advised by clinicians.
It is recommended that the Trust reviews the system for telephone triage to ensure there is consistency of calls being answered or responded to.

It is recommended that the Trust reviews the systems and processes for antenatal cardiotocograph (CTG) reviews to support staff in completing them at the bedside, ensuring that mothers are informed and involved in decision making. Clinicians should be supported to systematically consider all relevant risk factors, including any new developments, as part of the whole clinical picture. This approach will improve recognition and escalation of concerns and promote clear, structured communication between the clinical team and the mother.
It is recommended that the Trust reviews the systems in place to support clinical preparation, timely escalation, and senior oversight during breech vaginal births.
It is recommended that the Trust reviews the use of gestation in the maternity system and the physical Gestation Related Optimal Weight (GROW) charts to make fetal growth surveillance more robust and less prone to input errors.
It is recommended that the Trust reviews the written information given to mothers about monitoring their baby's movements and the actions to take, in order to ensure that it reflects current evidence-based practice.
It is recommended that the Trust reviews their cardiotocograph (CTG) training programme to ensure staff who provide care on labour ward are confident in CTG interpretation and escalation.
It is recommended that the Trust reviews their culture of response when staff escalate concerns about the busyness and patient safety, to ensure that staff feel listened to and local and regional escalation guidance is followed.
It is recommended that the Trust reviews their escalation and de-escalation processes to ensure operational pressures escalation levels (OPEL) are applied consistently and in line with local guidance to ensure staffing, skill mix and unit acuity are considered, with the maintenance of senior, multidisciplinary clinical oversight during periods of high risk.
It is recommended that the Trust reviews their existing guidance to support mothers in early labour at home and staff caring for them to reflect recommendations in national guidance to continue an assessment for an hour with includes the expectations of fetal monitoring.
It is recommended that the Trust reviews their guidance to support discussions to take place about the risks and benefits of augmentation of labour, specific to the whole clinical picture, including the alternative options for mode of birth and a mother's birth preferences so that they can make informed choices, before augmentation of labour.
It is recommended that the Trust reviews their induction of labour processes to ensure that induction of labour can be arranged in a timely manner and booked on the system to provide daily data of expected admissions and plan workload. Since this case all midwives have received training on [computer system] and are aware of how to book an induction of labour within the Trust.

It is recommended that the Trust reviews their local guidance on indications to remove a prostaglandin pessary, when a mother is experiencing regular painful uterine activity irrespective of the fetal heart rate tracing, to prevent or remove an ongoing cause of hyperstimulation.
It is recommended that the Trust reviews their local guidance to include the monitoring of contractions so that they are regularly palpated, recorded and acted on during the induction of labour process.
It is recommended that the Trust reviews their processes of categorising a cardiotocograph (CTG), so that staff are supported to recognise and manage CTG concerns. This will ensure timely escalation in line with guidance.
It is recommended that the Trust reviews their processes of categorising a cardiotocograph (CTG), so that staff are supported to use the Trust's tools to recognise and manage CTG concerns. This will help to inform the degree of urgency to expedite birth when necessary.
It is recommended that the Trust reviews their processes of categorising a cardiotocograph (CTG), so that staff are supported to use the Trust's tools to recognise and manage CTG concerns. This will help to inform the degree of urgency to expedite birth when necessary.
It is recommended that the Trust reviews their processes so that mothers who have clinical risk factors are obstetrically reviewed prior to discharge from maternity triage to ensure a plan of care is in place.
It is recommended that the Trust reviews their systems and processes for contacting all the required staff during neonatal emergencies, to support an effective, consistent and accurate transfer of information so that all the staff needed are alerted to attend immediately.
It is recommended that the Trust reviews their therapeutic cooling guidance to ensure that there is a consistent approach to neurological assessments and decision making, including consultant discussion prior to treatment being started.
It is recommended that the trust reviews their timescales to achieving invasive respiratory support, to help identify any significant factors for delays and implement actions as required.
It is recommended that the Trust reviews their triage processes to enable an immediate review of maternal and fetal wellbeing, when labour is suspected, in line with local guidance. Local guidance should define a specific time range to describe the expectations of an 'immediate' review.
It is recommended that the Trust reviews the arrangements for neonatal consultant cover across its sites so that staff are provided with prompt and direct access to senior clinical support and an equitable service is provided to families, regardless of where they choose to give birth.

It is recommended that the Trust revise how guidelines and updates are shared and embedded across teams, to ensure the correct management of reduced fetal movements.
It is recommended that the Trust revise local guidance to align with national guidance (National Institute for Health and Care Excellence, 2021) relating to discussions with mothers about their birth preferences. This will include a mother being given verbal and written information about the implications, benefits and risks of all options to allow them to make informed choices about their care.
It is recommended that the Trust revise the role of the second band 7 midwife on delivery suite to ensure the midwife in charge remains supernumerary to maintain clinical oversight and support effective escalation.
It is recommended that the Trust revise their guidance for mothers presenting with recurrent reduced fetal movements to ensure it includes a holistic review and escalation to the obstetric team.
It is recommended that the Trust revise their local guidance and mandatory training on screening for babies that are small for gestational age. This should include practical training and assessment for symphysiofundal height (SFH) measurement, accurate plotting using standardised tools, alongside advice and guidance on how to interpret growth trends and referral thresholds.
It is recommended that the Trust revises how it supports mothers who report a previous traumatic birth to ensure they feel listened to, informed to understand their own individual risk profile and supported to make informed choices about their birth.
It is recommended that the Trust revises local guidance to clearly distinguish between antenatal and intrapartum cardiotocograph (CTG) interpretation, categorisation and corresponding plans of care, including advice on the urgency of care provision.
It is recommended that the Trust revises their guidance, so it is consistent, and reviews what visual aids are available for clinicians when monitoring fetal growth in the antenatal clinic environment. This will support clinicians to identify slow and static growth and enable growth ultrasound referrals to be made.
It is recommended that the Trust revises their process so that when mothers are unsure of fetal movements, they are invited to attend maternity triage for assessment straight away.
It is recommended that the Trust revisit their acuity tool to facilitate staffing level to meet the needs of the maternity unit.

It is recommended that the Trust seeks feedback from midwives to understand the challenges they experience when caring for women during quickly evolving situations when there are multiple competing priorities in providing care during the second stage of labour. This learning should inform the development, implementation and evaluation of an action plan that strengthens the processes supporting staff to identify and escalate concerning fetal heart rate changes in these circumstances.
It is recommended that the Trust should ensure that local guidance offers clarity for staff on reasons to transfer a mother to hospital from a homebirth, including where bloodstained liquor is present.
It is recommended that the Trust should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.
It is recommended that the Trust should undertake a review of ultrasound measurement quality control. Trusts are encouraged to comply with British Medical Ultrasound Society (BMUS) guidance on audit and continuous learning with relation to third trimester assessment of fetal wellbeing. It is recommended that the Trust should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.
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 identified.
It is recommended that the trust standardise a pathway for holistic and individualised ongoing care and risk assessment when a mother delays their induction of labour, to help staff know what care and monitoring is needed.
It is recommended that the Trust standardise the emergency equipment in the maternity and neonatal setting to enable timely intraosseous access when umbilical venous access is difficult.
It is recommended that the Trust strengthen and embed their recognised handover and communication tools to support the escalation process.
It is recommended that the Trust strengthen communication processes at birth to ensure staff are supported to relay a clear history to the neonatal team consistently. This should include issues relating to the full antenatal history and issues at the time of labour and birth such as suspected antepartum haemorrhage, placental abruption and neonatal sepsis. This is with the aim of reducing delays in care delivery and loss of information.

It is recommended that the Trust strengthen local processes for supporting mothers to attend appointments and monitoring attendance to ensure mothers do not slip through the net. This could be aided by the implementation of a case loading team for vulnerable mothers at risk of adverse maternity outcomes.
It is recommended that the Trust strengthen systems to ensure labour ward staffing, including a designated coordinator, is consistently maintained in line with national standards. A clear, auditable process for escalating and documenting staffing concerns should be implemented to support organisational oversight and timely action.
It is recommended that the Trust strengthen the process for referring mothers to the antenatal clinic for review by a doctor where there is no improvement in their iron levels.
It is recommended that the Trust strengthen the process of recording arrival times in maternity triage to support staff to ensure that women have their initial midwifery assessment within 15 minutes of arrival and to ensure that audit data relating to compliance of women being seen within 15 minutes of arrival is accurate.
It is recommended that the Trust strengthens arrangements to ensure labour ward staffing, including a supernumerary midwifery coordinator, is maintained in line with national recommendations to provide mothers and babies with safe care.
It is recommended that the Trust strengthens birth planning for all mothers, to ensure it reflects personalisation of their needs. This could include the development of prompts within the electronic medical records regarding previous birth experiences of any concerns. This will prepare mothers for their ongoing care in relation to their individualised risk factors.
It is recommended that the Trust strengthens its approach to intrapartum cardiotocograph (CTG) recognition and assessment by embedding structured review processes that prompt regular reappraisal of CTG features over time and support timely escalation where patterns evolve. This is to improve recognition of developing pathological changes.
It is recommended that the Trust strengthens its pathways for the investigation and management of suspected pulmonary embolism (PE) in pregnancy. These pathways to be embedded to reduce diagnostic uncertainty and hesitation around imaging.
It is recommended that the Trust strengthens radiology requesting processes for escalation of all abnormal investigation results, particularly in pregnant patients presenting with symptoms suggestive of pulmonary embolism (PE).
It is recommended that the Trust strengthens staff knowledge that when a cardiotocograph (CTG) is categorised as suspicious due to increased uterine activity, actions are taken to reduce contractions in line with local and national guidance.

It is recommended that the Trust strengthens systems and processes so that mothers attending the maternity assessment centre with urgent concerns are flagged and prioritised immediately on arrival.
It is recommended that the Trust strengthens the pathway for recognition and escalation when there is loss of contact of the fetal heart recording. This will support prompt and accurate assessment of fetal wellbeing for mothers whose babies are being continuously monitored.
It is recommended that the Trust strengthens the pathway to respond to loss of contact of the fetal heart recording. To support prompt and accurate assessment of fetal wellbeing.
It is recommended that the Trust strengthens their local guidance to ensure that non-attendance of appointments is explored to assist the identification of mothers who need additional individualised support.
It is recommended that the Trust support a consistent and timely approach to alert all relevant medical staff who are needed to attend the emergency department, including staff who are on-call from home, when there is a pre-alert for a mother who is critically unwell. This will enable the team to be present in the emergency department ready to receive and provide care to the critically ill mother.
It is recommended that the trust support all clinical staff in recognising a pathological cardiotocograph (CTG) in the second stage of labour to ensure prompt escalation and expedited birth when indicated, this is to include understanding of the concerns of using oxytocin on a pathological CTG.
It is recommended that the Trust support clinicians leading a resuscitation to follow the newborn life support (NLS) algorithm including escalating for help in a timely manner.
It is recommended that the Trust support clinicians to ensure that an adequate cardiotocograph (CTG) trace is recorded especially in the second stage of labour, regardless of whether clinicians anticipate that birth is imminent. This should include supporting staff to escalate concerns in line with Trust guidance.
It is recommended that the trust support clinicians to regularly assess risk and form an individualised plan of care when cardiotocograph (CTG) abnormalities are present and there are evolving risk factors.
It is recommended that the Trust support clinicians to take measures to manage oxytocin where there are concerns about a cardiotocograph (CTG).
It is recommended that the Trust support clinicians to undertake structured holistic assessment of the mother's and baby's wellbeing in labour. This is in order to consider the whole clinical picture including maternal observations, and offer safe, individualised care for women and pregnant people birthing after a caesarean.

It is recommended that the Trust support clinicians using intermittent auscultation, to recognise changes in a baby's heartrate patterns, including by utilising tools such as the partogram, to escalate for senior assistance when indicated.
It is recommended that the Trust support effective urgent follow up reviews of mothers, either to the day assessment unit or the community team, on discharge from triage.
It is recommended that the Trust support neonatal staff to undertake ongoing holistic assessment of a baby with colleagues, to enable reviews with fresh eyes in order to recognise subtle signs of deterioration. These would include: -The recognition of acute severe blood loss. -Optimal volume of blood transfusion in line with national guidance. -Recognition and management of abnormal blood results and subtle signs of abnormal clotting. -The optimal use of different blood products in the management of a hypotensive baby with an abnormal blood count and abnormal clotting.
It is recommended that the Trust support ongoing inpatient observation of mothers for a reasonable amount of time following antepartum haemorrhage, as set out in national guidance, to ensure that bleeding has fully stopped.
It is recommended that the Trust support recording and monitoring the maternal pulse and uterine contractions in the second stage of labour to enable this information to be used when interpreting and categorising a cardiotocograph (CTG). This will allow decision making on timing of birth to be based on a holistic picture of the baby's wellbeing.
It is recommended that the Trust support staff in accurately identifying the transition from the latent phase to active labour in order to ensure timely provision of one-to-one care, reducing the risk of delayed recognition of labour progression and optimising maternal and fetal well-being.
It is recommended that the Trust support staff in identifying when there is a need to transfer a mother's care to an obstetric setting for electronic fetal monitoring and obstetric review.
It is recommended that the Trust support staff in performing effective monitoring of a baby's temperature. Local and national guidance, British Association of Perinatal Medicine (BAPM), recommends monitoring with rectal temperature probes, both for passive and active cooling, to prevent the risk of overcooling.
It is recommended that the Trust support staff in undertaking regular training and emergency simulations for all potential obstetric emergencies in order to ensure staff are fully informed, skilled, and confident in implementing nationally recommended emergency actions, reducing the risk of delays or variations in emergency response.

It is recommended that the Trust support staff so when there are concerns regarding cardiotocographs (CTGs) and multiple risk factors, decisions are made to expedite birth.
It is recommended that the Trust support staff to ask the neonatal team to attend a birth when a cardiotocograph is pathological and a decision has been made to expedite birth, to support resuscitation of a baby.
It is recommended that the Trust support staff to assess and accurately document the rate of contractions during cardiotocograph reviews to enable accurate cardiotocograph categorisation and to inform decision making.
It is recommended that the Trust support staff to assess the potential change in risk of mothers who have had an induction of labour, in line with local and national guidance, to support the delivery of prompt, safe care for mothers and babies.
It is recommended that the Trust support staff to carry out holistic reviews when performing fresh eye reviews using centralising monitoring to support cardiotocograph (CTG) categorisation and ongoing care plans.
It is recommended that the Trust support staff to carry out regular observations of fetal heart rate in the second stage of labour, in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023).
It is recommended that the Trust support staff to complete fetal wellbeing assessments. This should include electronic fetal monitoring for all mothers who are undergoing an outpatient induction of labour and return to the Trust experiencing uterine contractions, in line with Trust and national guidance.
It is recommended that the Trust support staff to consider clinical causes for a sudden and prolonged loss of contact with a fetal heart during continuous electronic fetal monitoring, particularly in mothers with multiple risk factors. This should include embedding in guidance the management and escalation of loss of contact, especially in mothers with multiple risk factors and when there has previously been a good trace of the fetal heart.
It is recommended that the Trust support staff to consider potential factors when there is slow progression of the birth of a baby after crowning. This will support early escalation for support and the opportunity to expedite birth.
It is recommended that the Trust support staff to correctly interpret and categorise a cardiotocograph (CTG) trace and record this accurately with the tool provided.
It is recommended that the Trust support staff to discuss the risk and benefits of induction of labour to assist with informed decision making and personalised care.
It is recommended that the Trust support staff to ensure a change in categorisation of a caesarean birth is shared when there are concerns with the wellbeing of the baby. This will ensure there is escalation for senior neonatal attendance.

It is recommended that the Trust support staff to ensure effective communication in labour with mothers whose first language is not English.
It is recommended that the Trust support staff to ensure mothers understand their individual risk of post-date pregnancy to facilitate informed choice and offer induction of labour from 41+0 weeks in line with local and national guidance.
It is recommended that the Trust support staff to escalate cardiotocograph concerns in the second stage of labour even when birth is considered to be near, to support multidisciplinary oversight and input into care.
It is recommended that the Trust support staff to escalate when fetal heart rates are unable to be auscultated in line with guidance, this will support early assistance before situational awareness is compromised.
It is recommended that the Trust support staff to expedite birth as soon as is possible, in the presence of suspected sepsis and concerns with the fetal heartrate.
It is recommended that the Trust support staff to explicitly signpost and provide mothers with information about induction of labour for prolonged pregnancy which aligns with national guidance to offer induction from 41 weeks. This must include the need to document these discussions with the mother so that she remains fully informed of her options.
It is recommended that the Trust support staff to identify a clear leader when an obstetric emergency arises and that clinical overview is maintained. This to be supported by the use of clear communication so that an end goal is shared by the multi-disciplinary team.
It is recommended that the Trust support staff to maintain a helicopter view when managing scenarios where competing clinical priorities may cause staff to become task focused.
It is recommended that the Trust support staff to make clinical decisions based on 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, and not on cardiotocograph (CTG) interpretation alone (Royal College of Obstetricians & Gynaecologists (RCOG) Each Baby Counts, 2015).
It is recommended that the Trust support staff to manage scenarios where competing clinical priorities may cause staff to become task-focused. This includes the facility to maintain a helicopter view in order to identify and manage the prioritisation of competing tasks.
It is recommended that the Trust support staff to perform a holistic assessment of mothers with combined risk factors and fetal concerns when booking induction of labour. It should include an input from a senior obstetrician if there is a proposed change to the previous plan.

It is recommended that the Trust support staff to prioritise the delivery suite ward round to ensure the appropriate prioritisation of care can be made at the beginning of a shift.
It is recommended that the Trust support staff to pull the emergency Buzzer immediately following an antepartum haemorrhage and fetal bradycardia despite ongoing efforts to find the fetal heart.
It is recommended that the Trust support staff to recognise all risk factors and handover this information when requesting obstetric review, so that they are able to complete a full holistic assessment and make a clear ongoing plan.
It is recommended that the Trust support staff to recognise and act upon the need for fetal monitoring when there are evolving risk factors in line with local and national guidance.
It is recommended that the Trust support staff to recognise and act upon the need for intrapartum fetal monitoring in line with local and national guidance. This includes risk assessment to determine if a mother needs a cardiotocograph (CTG) or intermittent auscultation.
It is recommended that the Trust support staff to recognise and escalate concerns when caring for mothers in an out of hospital setting to allow for emergency support at the earliest opportunity.
It is recommended that the Trust support staff to recognise and escalate to the obstetric team when there are concerns about a baby's wellbeing.
It is recommended that the Trust support staff to recognise and inform mothers when there is an indication (as outlined within local guidance) to exit the birthing pool. This will support informed choice about their care.
It is recommended that the Trust support staff to recognise that not being able to hear a baby's heart rate is an obstetric emergency and must be escalated at the earliest opportunity via an emergency buzzer. This will allow mothers and their babies to have obstetric intervention in a timely manner.
It is recommended that the Trust support staff to recognise the importance of cardiotocograph (CTG) abnormalities as an early warning sign of impending uterine rupture in mothers attempting vaginal birth after caesarean birth, to include stopping augmentation of labour and expediting birth.
It is recommended that the Trust support staff to recognise the need to act quickly with early signs of fetal hypoxia in labour for vaginal breech births.
It is recommended that the Trust support staff to review all a mother's clinical history including her observations and ultrasound scan findings at each clinical contact to plan care. This should include clear, contemporaneous documentation.

It is recommended that the Trust support staff to review previous pregnancy records to support a holistic review when providing counselling in relation to a mother's birth options.
It is recommended that the Trust support staff to triage mothers to the appropriate care pathway, so that they are reviewed according to guidance. This includes updating the triage pathway when new clinical information is identified.
It is recommended that the Trust support staff to understand and meet the professional requirement to keep accurate and detailed records of the care provided. This will ensure that the care provided, and the reasons for it, are well understood.
It is recommended that the Trust support staff to understand how language used during telephone triage calls can affect a mothers decision making about their care.
It is recommended that The Trust support staff to undertake a full clinical assessment of babies who have multiple risk factors and document their findings in line with Neonatal Early Warning scoring systems pathway. This includes babies born to mothers who have gestational diabetes and who have received pethidine within 6 hours of birth. It is recommended that staff are supported to update the Newborn Early Warning Track and Trigger (NEWTT2) risk identification form to include maternal analgesia.
It is recommended that the Trust support staff to use available guidance and to consider whether a baby meets the criteria for therapeutic cooling, and when and where this should be started. This will ensure that babies are undergoing continuous temperature monitoring when therapeutically cooled in line with national guidance (British Association of Perinatal Medicine, 2020).
It is recommended that the Trust support staff to use fetal scalp electrodes when there is loss of contact on the electronic fetal monitoring when continuous monitoring is indicated. This will promote accurate assessment of fetal wellbeing during labour, ensuring staff are able to differentiate the fetal heart rate from maternal pulse and support the recognition and escalation of accumulating risk factors to the obstetric team.
It is recommended that the Trust support staff to use the SBAR (Situation, Background, Assessment, Recommendations) tool to support conversations when escalating concerns to ensure the full clinical picture is taken into account and help with decision making, in line with local guidance.
It is recommended that the Trust support staff with a clear process for identifying extremely vulnerable mothers who have frequently not attended maternity appointments and advising that they attend the maternity unit for assessment and review when they call telephone triage.

It is recommended that the Trust support the maternity and neonatal team to deliver airway management for newborn life support in line with local and national guidance meaning resuscitation is optimised for the baby.
It is recommended that the Trust support the maternity and neonatal team to deliver neonatal medicines for newborn life support in line with local and national guidance meaning resuscitation is optimised for the baby.
It is recommended that the Trust support the recognition when labour progress is not as expected, as defined by national guidance, to prompt discussion of birth options with mothers as part of a holistic review.
It is recommended that the Trust support the staffing model in the maternity triage to enable an initial assessment is completed within 15 minutes by a trained and experienced member of the midwifery team to allow mothers to be prioritised based on clinical need.
It is recommended that the Trust supports adequate staffing levels in the maternity triage to be maintained with appropriately skilled staff who are supported by staff familiar to triage in line with national guidance from the Royal College of Obstetricians and Gynaecologists (2023).
It is recommended that the Trust supports all mothers with current or suspected drug or alcohol use to have a named lead obstetric consultant doctor, with the service supported by a specialist clinician. This will enable oversight of mothers' care and ensure they receive integrated, holistic and individualised care, which is provided as standard and not part of an opt in service.
It is recommended that the Trust supports all staff, including those outside of maternity services, to embed the Trust's values in all interactions with staff and patients.
It is recommended that the Trust supports clinicians to complete a full systematic/holistic review of the clinical situation at the time of cardiotocograph (CTG) review. This will support recognition, escalation of ongoing concerns and help provide structured communication with the multi-disciplinary team for a shared mental model.
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. This will ensure the records are accurate, give a full understanding of the care provided and help identify areas for improvements in care.
It is recommended that the Trust supports clinicians to facilitate, and evidence, discussions of risks and potential consequences of a uterine rupture with mothers who have had a previous caesarean birth when the risks change and oxytocin is required in labour, to enable mothers to make informed choice about mode of birth.

It is recommended that the Trust supports clinicians to recognise loss of cardiotocograph (CTG) contact as an obstetric emergency and embeds a rapid escalation pathway.
It is recommended that the Trust supports clinicians to recognise that loss of contact and the difficulty of locating baby's heart rate during monitoring requires prompt escalation, ensuring early review and a management plan for ongoing care.
It is recommended that the Trust supports clinicians to recognise when a baby's wellbeing cannot be assessed, due to poor recording of a baby's heart rate and/or the mother's uterine contractions and take action or escalate promptly to a senior clinician.
It is recommended that the Trust supports face to face cardiotocograph (CTG) reviews to occur so that a full holistic review and plan of care can be made with the mother.
It is recommended that the Trust supports mothers in making fully informed choices by discussing all birthing options available to them.
It is recommended that the Trust supports mothers opting for a vaginal birth after caesarean section to receive a face-to-face senior obstetric review to make an individualised care plan prior to the use of oxytocin. This will ensure a discussion of all risks to support informed consent for this intervention.
It is recommended that the Trust supports mothers with complex pregnancy factors to have a named lead obstetric consultant, with specialist expertise in this area of practice, with sufficient time allocated, supported by specialist midwives. This will enable oversight of mothers' care and ensure they receive integrated and holistic care.
It is recommended that the Trust supports personalised decision making and birth planning to ensure mother's risk factors and preferences are all considered to enable informed decision making.
It is recommended that the Trust supports recognition of a baby's non-reassuring heart rate, to ensure prompt escalation by staff.
It is recommended that the Trust supports staff in ensuring that fully personalised discussions that explore a mother's wishes regarding how and where to labour and give birth are facilitated during all stages of a mother's antenatal care.
It is recommended that the Trust supports staff in having tools and training to consider when a mother may require interpretation or other communication methods to ensure that they are able to fully understand and can make informed decisions regarding birth choices.

It is recommended that the Trust supports staff in the application of local thermoregulation guidance during and after water birth, and to promote timely recognition and adjustment when conditions make this challenging, in order to reduce the risk of neonatal hypothermia.
It is recommended that the Trust supports staff in the effective communication with mothers about changes in baby movements in line with current evidence-based practice, and with a system to check mothers' understanding of the information given.
It is recommended that the Trust supports staff in the recognition of static growth of fetal biometry and ensures that there are holistic assessments to support robust planning for ongoing care.
It is recommended that the Trust supports staff in the steps to take before a controlled artificial rupture of membranes is done. This will include clearly defined roles and responsibilities and escalation pathways if concerns arise during or after the procedure.
It is recommended that the Trust supports staff to achieve a good quality trace on a cardiotocograph, and that they are enabled to recognise and escalate concerns with fetal monitoring in the second stage of labour.
It is recommended that the Trust supports staff to carry out carbon monoxide monitoring at each antenatal contact, in line with National and Trust guidance. This will ensure that referrals to support education relating to smoking and high carbon monoxide levels are made.
It is recommended that the Trust supports staff to categorise the urgency of births to ensure a shared understanding between the team.
It is recommended that the Trust supports staff to complete a holistic review and escalate for advice when clinical judgement suggests that deviating from guidance may be indicated.
It is recommended that the Trust supports staff to complete a systematic review of the cardiotocograph (CTG), within the context of the full clinical picture. This will enable recognition of changes showing gradual development of hypoxia.
It is recommended that the Trust supports staff to complete and document the recommended assessments and give the recommended advice to mothers when expectant management is planned following spontaneous rupture of membranes.
It is recommended that the Trust supports staff to complete fetal monitoring prior to the administration of prostaglandins in line with Trust guidance.

It is recommended that the Trust supports staff to complete full labour assessments, including symphysis fundal height measurements in line with national guidance and be supported to recognise findings that require escalation (National Institute for Health and Clinical Care Excellence, 2023). This is to ensure new risks factors are identified and/or if there is a symphysis fundal height measurement which is slowing, static or below the 10th centile, escalation is made for obstetric review.
It is recommended that the Trust supports staff to consider reversible causes when a baby does not respond adequately during neonatal resuscitation. This is to be supported by the rapid availability of blood approved for neonatal transfusion (paedipacks).
It is recommended that the Trust supports staff to consider the criteria for safe assisted vaginal birth, including pain relief and location of birth. Documentation should accurately reflect decision making.
It is recommended that the Trust supports staff to discuss care options including the offer of immediate induction of labour, their risks and benefits with all mothers on 'low risk' and 'high risk' pathways following confirmation of spontaneous rupture of membranes and clearly document within mothers' clinical records to ensure informed decision-making in line with national and Trust guidance.
It is recommended that the Trust supports staff to document the care and information provided to mothers and complete a written handover of care to ensure mothers have all the information needed to make informed decisions regarding their ongoing care.
It is recommended that the Trust supports staff to enable electronic healthcare records, local guidance and the triage call log to be viewed simultaneously to assist assessment and decision making.
It is recommended that the Trust supports staff to enable maternity records and the triage proforma to be viewed simultaneously to assist assessment and decision-making.
It is recommended that the Trust supports staff to ensure effective communication and a shared understanding of urgency when there has been a change in category of birth and that the category one birth call is made to alert the senior neonatal team.
It is recommended that the Trust supports staff to ensure that all mothers have awareness and understanding that they must seek immediate advice if they have uncertainty about their baby's movements, or if the movement pattern feels different or stops.

It is recommended that the Trust supports staff to ensure that tools and guidance for the recognition and management of sepsis are embedded in clinical practice. This will support early identification and timely escalation and treatment for possible sepsis in line with local guidance.
It is recommended that the Trust supports staff to escalate concerns to the on call consultant neonatal doctor following a baby's admission when cerebral function monitoring is started. To include sharing of the cerebral function monitoring readings with the images shared to ensure a holistic review by the consultant neonatal doctor and support care planning.
It is recommended that the Trust supports staff to escalate for a timely obstetric review when there is loss of contact on the cardiotocograph (CTG).
It is recommended that the Trust supports staff to escalate when a cardiotocograph (CTG) trace has consistent loss of contact, and fetal well-being cannot be confirmed. This will support staff to interpret, recognise, and act on CTG changes in the context of a mother's cumulative risk factors.
It is recommended that the Trust supports staff to follow national and local guidance for mothers calling the triage line with abdominal pains and urinary symptoms.
It is recommended that the Trust supports staff to follow the newborn life support algorithm in line with national guidance (Fawke et al, 2021).
It is recommended that the Trust supports staff to follow their local guidance to ensure its fetal growth surveillance pathway is applied consistently so that any concerning symphysis fundal height pattern - slow, static, or accelerated - triggers referrals for ultrasound and obstetric review as indicated.
It is recommended that the Trust supports staff to give accurate advice to all mothers regarding fetal movements to ensure any concerns with fetal movements are escalated promptly.
It is recommended that the Trust supports staff to give individualised information to mothers considering a home birth which includes information on local ambulance response and transfer times.
It is recommended that the Trust supports staff to have fully informed, documented discussions regarding risks and benefits to ensure that mothers have all the information needed to make an informed decision.
It is recommended that the Trust supports staff to know that when umbilical venous access is difficult, an intraosseous needle can be inserted during ongoing attempts to insert an umbilical venous catheter. This will enable all required neonatal resuscitation to be given in a timely way.

It is recommended that the Trust supports staff to maintain a baby's temperature within the normal range when a baby is admitted to the neonatal unit for assessment.
It is recommended that the trust supports staff to open a second theatre when workload leads to delays in unplanned caesarean births, including escalation to the on-call consultant. This will prevent delay in the birth of a baby.
It is recommended that the Trust supports staff to perform dynamic risk assessments and escalates concerns to the obstetric team. Any new risk factors, including the possible implications and the options for care, are to be discussed with mothers to ensure their birth preferences are reflective of informed choice.
It is recommended that the Trust supports staff to recognise and act upon the transition between phases of labour to enable an increased frequency of fetal monitoring in line with national guidance (National Institute for Health and Care Excellence, 2022).
It is recommended that the Trust supports staff to recognise and act upon the transition between phases of labour to facilitate increased frequency of fetal monitoring in line with national guidance.
It is recommended that the Trust supports staff to recognise that when a fetal heart cannot be heard, or cannot be distinguished from the mother's heart rate, this is an obstetric emergency and requires the use of an emergency buzzer to request the immediate attendance of senior staff. This is to ensure timely escalation and response to fetal heart concerns.
It is recommended that the Trust supports staff to recognise the inability to locate a baby's heart rate during labour as a potential obstetric emergency.
It is recommended that the Trust supports staff to respond to concerns about maternal and fetal wellbeing during antenatal cardiotocograph (CTG) monitoring, through structured assessment and categorisation of the CTG, and in-person obstetric review of the mother's and baby's wellbeing. This will mean the full clinical situation is used to inform measures and actions that may be needed, including consideration for earlier birth.
It is recommended that the Trust supports staff to review a mother's previous history in the clinical records and perform a risk assessment at each antenatal visit in line with the Ockenden (2020) review.
It is recommended that the Trust supports staff to strengthen their understanding of the national guidance around cooling treatment (British Association of Perinatal Medicine, 2020). This would include recognising that passive cooling treatment is not to be started before a baby's temperature can be continuously monitored, before a formal neurological assessment has been done and before a detailed assessment of cardiorespiratory stability is carried out. This would expected to be once a baby is admitted to the special care unit.

It is recommended that the Trust supports staff to strengthen their understanding of the national guidance around cooling treatment (British Association of Perinatal Medicine, 2020). This would include recognising that passive cooling treatment is not to be started before a baby's resuscitation is complete, before they are cardiovascularly stable, before their temperature can be continuously monitored and before a formal neurological assessment has been done. This would expected to be once a baby is admitted to the special care unit.
It is recommended that the Trust supports staff to undertake immediate blood alcohol and urine toxicology testing if there are concerns that a mother has taken drugs or alcohol.
It is recommended that the Trust supports staff to undertake obstetric consultant led face-to-face reviews and ward rounds twice daily in line with the Ockenden review (2022), to support full holistic assessments of mothers.
It is recommended that the Trust supports staff to use factual information and the use of Trust and national guidance when considering a decision to start cooling therapy. This will ensure relevant clinical information is communicated, supporting accurate risk assessments and clinical decision making.
It is recommended that the Trust supports staff to use structured communication when planning a controlled artificial rupture of membranes. This will ensure that all relevant clinical staff are aware of when the procedure is being carried out and their roles and responsibilities in case any support or escalation is required.
It is recommended that the Trust supports staff to use the Situation, Background, Assessment, Recommendations (SBAR) tool in all communications with the neonatal team during escalation for support, in line with Trust guidance.
It is recommended that the Trust supports staff to utilise fetal scalp electrode monitoring to ensure that loss of contact is minimised.
It is recommended that the Trust supports staff training on the use and directions for [bedside test for ruptured membranes] in line with the manufacturer's instructions for use.
It is recommended that the Trust supports staff undertaking the situational report role to have a full understanding of the maternity Red, Amber, Green (RAG) rating priorities. This to include the maternity operational pressures escalation levels maternity framework (OPELMF) scoring and supporting staff to take the appropriate actions to keep mothers and babies safe. (Regional guidance, 2023 and NHS England, 2024).
It is recommended that the Trust supports the development of multi-disciplinary team working. This to be supported in the clinical setting, through the use of skills drills training with a focus on human factors.

It is recommended that the Trust supports the maternity unit in implementing and improving the process for mothers to be offered a first appointment to take place within 2 weeks of contact or referral, if possible, in line with national guidance.
It is recommended that the Trust supports the neonatal team with the appropriate equipment and training necessary to conduct core temperature monitoring of babies requiring passive cooling treatment.
It is recommended that the Trust supports the risk assessment of appropriate staff redeployment at times of high acuity to ensure high risk areas such as triage maintain appropriately trained staff.
It is recommended that the Trust supports the staff to complete a full systematic review of a cardiotocograph (CTG) at the bedside, when computerised cardiotocograph (cCTG) is not appropriate. Ensuring all the features of the CTG and the full clinical picture is taken into account. This will support recognition and escalation of ongoing concerns and support structured communication.
It is recommended that the Trust supports the staff to use the Situation, Background, Assessment, Recommendations (SBAR) process when escalating concerns. This will ensure the correct information is shared, and the urgency conveyed.
It is recommended that the Trust supports the use of robust tools to enable staff to recognise and identify hyperstimulation and expedite requests for clinical reviews to support ongoing care planning.
It is recommended that the Trust take steps to support all members of the team to recognise that providing any level of clinical care can impede the supernumerary status of the delivery suite coordinator by affecting the ability to maintain oversight and the quality and safety of care provided to mothers. This will support effective use of the escalation policy and framework.
It is recommended that the Trust takes action to ensure midwifery staff are enabled to provide personalised and holistic care to pregnant mothers undergoing induction of labour, so that the transition from latent to active stage of labour is consistently recognised and appropriately acted upon.
It is recommended that the Trust takes measures to embed understanding of the need to manage a baby's airway and inflate their lungs before moving on to chest compressions for all staff who attend neonatal resuscitation events. This will support optimal adherence to national guidance (Fawke et al, 2019) and increase the likelihood of positive outcomes for babies needing resuscitation.
It is recommended that the Trust takes steps to ensure that the rota system for porters on the emergency blood team ensures that a porter is always available in an emergency to deliver blood.

It is recommended that the Trust takes steps to improve workload and flow between the induction unit and the delivery suite. This is to support staff to provide personalised care that is responsive to individual needs.
It is recommended that the Trust to ensure that local guidance is consistent with regards to abnormal neonatal observations to support escalation.
It is recommended that the Trust to ensure that mothers are reviewed in line with local guidance and that comprehensive background and clinical records are reviewed and discussed with mothers attending triage at term.
It is recommended that the Trust to ensure that women and their families are listened to with their voices heard (Ockenden 2020).
It is recommended that the Trust to ensure when a blood fridge is out of working order there is prompt action to replace or repair, so that blood remains immediately available in the obstetric unit in case of an emergency.
It is recommended that the Trust to review their fresh eyes process to make sure it functions effectively during a mother's labour irrespective of acuity. This will support the recognition of concerns with a baby's heart rate.
It is recommended that the Trust to review their guideline so that staff are supported to recognise that blood-stained liquor is a risk factor requiring an obstetric review, as part of a holistic assessment for ongoing care.
It is recommended that the Trust training and education programme supports staff to understand health inequalities and the effects on outcomes when English is not a mother's first language and of the importance of utilising and providing translated documents to support understanding of verbal information given and facilitate informed decision making and choice.
It is recommended that the Trust trains all maternity staff to a competent level in effectively using the electronic patient record keeping system, to ensure there is clear, accurate and contemporaneous documentation in line with professional standards.
It is recommended that the Trust trains all maternity staff to a competent level, so that they effectively use the electronic patient record keeping system to maintain expected quality of recorded clinical care information.
It is recommended that the Trust understand the barriers for the process of booking an induction of labour when its clinically classified as urgent and cannot proceed due to high activity. To embed the process of escalation and ensure that mothers undergoing an induction of labour are prioritised correctly.
It is recommended that the Trust understand the barriers to recognition of an unsuccessful induction of labour cycle. This is to ensure an obstetric review occurs at the correct time, to plan ongoing management after an unsuccessful induction of labour with a cycle of prostaglandin.

It is recommended that the Trust undertakes a comprehensive review of the induction of labour (IOL) pathway, applying a systems-based approach to ensure robust oversight and accountability at every stage.
It is recommended that the Trust undertakes a review of neonatal resuscitation training record for staff attending births to ensure all staff attending births have received neonatal life support training within the last year.
It is recommended that the Trust undertakes a review of the management and process of neonatal resuscitation with a focus on ensuring all aspects of resuscitation are considered including administration of resuscitation medication.
It is recommended that the Trust undertakes a review of the management and process of neonatal resuscitation with a focus on ensuring all aspects of resuscitation are considered including management of reversible causes.
It is recommended that the Trust undertakes a review of the pathways for mothers when they are accessing unscheduled clinical advice in pregnancy. There should be clear signposting to the correct pathway for the individual mother. The findings will be used to inform the development of robust pathways and guidance to support the access to and provision of unscheduled telephone advice.
It is recommended that the Trust undertakes a review of uses the 2222 emergency call system to notify the correct team needed in an emergency situation.
It is recommended that the Trust update and implement cardiotocography (CTG) guidance and tools that align with National Institute for Health and Care Excellence (NICE, 2022), clearly identifying five or more contractions in 10 minutes as an amber (suspicious) feature. In parallel, a robust system is required to support staff in accurately categorising CTG traces using standardised tools, ensuring timely recognition, effective escalation, and appropriate response to abnormal features of the CTG.
It is recommended that the Trust update the antenatal care guidance on what measurements of a blood pressure are considered to be raised and what care pathway is then indicated.
It is recommended that the Trust update their fetal monitoring guideline and training in line with national guidance. This will enable staff to have the knowledge to check a mother's heart rate if accelerations are suspected in the second stage of labour to differentiate between the mother's and baby's heart rate.
It is recommended that the Trust update their guidance and tools to provide clear and consistent guidance for staff in the recognition and management of hyperstimulation, to include escalation and ongoing management if hyperstimulation continues after the administration of a tocolytic drug.

It is recommended that the Trust update their guidance on the management of blood stained liquor in line with national guidance (National Institute for Health and Care Excellence 2023) to ensure there is additional fetal wellbeing monitoring, transfer to obstetric led care and consideration of this as a risk factor when planning future care.
It is recommended that the Trust update their local newborn life support resuscitation guidance in line with up to date National (British Association of Perinatal Medicine (BAPM)) guidance.
It is recommended that the Trust update their standard operating procedure for ward rounds in the maternity unit to provide clear guidance to staff on the level of obstetric consultant cover and the processes for continuing obstetric oversight of mothers with an increased chance of birth complications in periods of high acuity. This is to provide safe clinical oversight, and comply with national recommendations for twice daily consultant-led multi-disciplinary ward rounds (Ockenden, 2020).
It is recommended that the Trust updates and embeds guidance which enables a structured SBAR (Situation, Background, Assessment, and Recommendation) approach to a formal two-way telephone dialogue when senior help is needed in a neonatal resuscitation and the consultant neonatal doctor cannot attend immediately. This guidance should follow the national recommended approach (Ockendon, D, 2022) to review the interventions tried and advice on actions to be taken pending the consultant neonatal doctor's arrival.
It is recommended that the Trust updates its cardiotocograph (CTG) interpretation guidance and the associated tools, including those within the electronic record system, in order to support staff in recognising concerning fetal heart rate features and identifying when escalation is required. Clinician feedback on the usability of the system while providing care should be used to inform future developments.
It is recommended that the Trust updates its fetal monitoring guidance when changes to clinical practice are introduced to support safe delivery of care.
It is recommended that the Trust uses a maternity specific early warning score in all clinical areas to ensure there is early recognition and recognition and escalation of a deteriorating pregnant or recently pregnant mother.
It is recommended that the Trust uses the expertise of cardiologists in developing and implementing a guideline for interpretation of an electrocardiogram (ECG) across the Trust. This is to ensure that a senior clinician with expertise in interpreting an ECG is involved when the computerised analysis of an ECG is discounted.
It is recommended that the Trust utilises the Local Maternity and Neonatal System (LMNS) and neighbouring trusts to agree a process that provides access to a mother's full maternity record when care is shared between more than one trust.

It is recommended that the Trust work collaboratively with staff to address the impact of unconscious and conscious racial bias on assessment and communication, and take steps to acknowledge, challenge and mitigate this bias when caring for mothers.
It is recommended that the Trust work to update and optimise fetal monitoring guidance, tools and practices. This is to ensure that staff are supported to recognise when there is a need to expedite the birth of a baby and immediately escalate for help.
It is recommended that the Trust work towards allocating the recommend 30 minutes for growth ultrasound scan appointments. This will help staff to optimise the quality of ultrasound images and support ongoing care planning.
It is recommended that the Trust work with clinicians to review and address the barriers to anticipating the need for neonatal resuscitation and preparing staff and equipment for this before the birth. This is to ensure that babies at increased risk of needing resuscitation have immediate access to appropriate equipment and the neonatal team, in line with national guidance (RCUK, 2021).
It is recommended that the Trust work with clinicians to review their regional guidance on therapeutic cooling and ensure the decision making is consistent with the structured neurological assessment.
It is recommended that the Trust work with staff to better understand the barriers to undertaking full assessments when deciding to perform an assisted vaginal birth.
It is recommended that the Trust work with staff to explore barriers that do not support a baby reaching target temperature within 6 hours of birth, when therapeutic cooling is occurring. This will enable a baby to reach the target temperature in the recommended 6 hours from birth.
It is recommended that the Trust work with staff to explore the barriers and contributing factors to completing the cardiotocograph (CTG) review on the electronic patient record prior to a CTG being stopped. This is to support accurate assessment of fetal wellbeing and escalation of concerns.
It is recommended that the Trust work with staff to explore the barriers and contributing factors which prevent recognition of deteriorating cardiotocographs (CTGs). This is to support accurate assessment of fetal wellbeing and escalation of concerns.
It is recommended that the Trust work with staff to explore the barriers and contributing factors which prevent staff from recognising the action to take when there are challenging or concerning cardiotocographs (CTGs) during the second stage of a mother's labour. This is to support accurate assessment of fetal wellbeing and escalation of concerns.

It is recommended that the Trust work with staff to explore the barriers and factors that support recognition of a rise in a baseline heart rate during intermittent auscultation. This will enable accurate assessment of fetal wellbeing in labour, and escalation of concerns.
It is recommended that the Trust work with staff to explore the barriers and factors that support recognition of deteriorating cardiotocographs (CTGs). This will enable accurate assessment of fetal wellbeing in labour, and escalation of concerns.
It is recommended that the Trust work with staff to explore the barriers and factors which support recognition of deteriorating cardiotocographs (CTGs). This is to support accurate assessment of fetal wellbeing in labour, and escalation of concerns.
It is recommended that the Trust work with staff to explore the barriers to starting a monitoring of a baby's heart rate when a mother raises concerns with her wellbeing. This will help inform a holistic assessment of a mother and baby's wellbeing.
It is recommended that the Trust work with staff to identify barriers and factors for providing a Situation, Background, Assessment, Recommendations (SBAR) handover, to ensure a complete clinical picture can be established to inform ongoing care.
It is recommended that the Trust work with staff to review their local guidance and clinical tools for facilitating and documenting a full discussion about fetal movements. This is to support clinicians to confirm fetal wellbeing prior to discharge home.
It is recommended that the Trust work with staff to support them to use the correct terminology when reviewing a cardiotocograph (CTG) to ensure a deteriorating CTG is recognised and correctly categorised.
It is recommended that the Trust work with staff, who provide specialist antenatal care, to optimise the design and use of documentation tools, and the use of maternal decision aids, for mothers pregnant with twins. This is to support shared decision making and comprehensive planning for vaginal births.
It is recommended that the Trust work with the electronic patient record supplier to explore whether the contraction frequency field can be made mandatory for completion. This would ensure the information always feeds into the cardiotocograph (CTG) categorisation and supports compliance with local and national guidance.
It is recommended that the Trust work with the Local Maternity Neonatal System to provide mothers whose first language is not English, written information in their own language during pregnancy to support their understanding and assist their decision making.
It is recommended that the Trust work with the manufacturer (medical records) to improve the access to all the past, relevant medical records, when inputting a new event so that clinicians can be fully informed.

It is recommended that the Trust works with clinicians and appointment teams to develop and implement an agreed process to ensure that that tests results are checked within a specified timeframe and that patients are followed up when their intended appointment does not take place.
It is recommended that the Trust works with clinicians and appointment teams to develop and implement an agreed process to ensure that when pregnancy bookings are completed in the outpatient antenatal clinic, mothers have follow-up appointments arranged within the specified timeframe to ensure their intended appointments do not get missed. The process must include a way of supporting effective, consistent, and accurate transfer of information between the outpatient antenatal clinic and the community midwifery teams.
It is recommended that the Trust works with clinicians to review and address the barriers to admission when an antepartum haemorrhage is reported over the telephone. This is to enable a holistic clinical assessment and ongoing plan of care.
It is recommended that the Trust works with clinicians to review and address the barriers to categorising and managing suspicious cardiotocographs (CTGs) in line with national and local guidance.
It is recommended that the Trust works with clinicians to review and address the barriers to completing a holistic clinical assessment when a fetal heart rate is not identified, so that all risk factors and clinical options are considered in a timely manner.
It is recommended that the Trust works with clinicians to review and address the barriers to completion and documentation of fresh ears reviews. The findings should inform the development, implementation and evaluation of an action plan as required.
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 clinicians to review and address the barriers to giving antibiotics to babies in line with national guidance when clinicians identify an increased risk of infection.
It is recommended that the Trust works with clinicians to review and address the barriers to the neonatal crash team being present when it is anticipated that neonatal resuscitation may be required. The findings should inform the development, implementation and evaluation of an action plan as required.

It is recommended that the Trust works with Deaf service users and Trust staff to co-produce systems and processes, that ensure there is consistent recognition and equitable access to British Sign Language interpretation.
It is recommended that the Trust works with neonatal staff to ensure appropriate clinical leadership and timely prioritisation, and effective escalation can be provided, particularly during periods of high clinical acuity on the neonatal unit.
It is recommended that the Trust works with staff to promote the use of a structured initial triage assessment, so that fetal heart rate is assessed in a timely manner in, so that any concerns with fetal heart rate can be quickly identified and escalated.
It is recommended that the Trust works with staff to promote the use of all available resources to engage effectively with vulnerable mothers, so that there is equal access to maternity services.
It is recommended that the Trust works with staff to review and address the barriers to a mother having a discussion with regards mode of birth. To ensure that mothers are fully informed of all options for mode of birth in line with local and national guidance.
It is recommended that the Trust works with staff to review and optimise the tools available to support the recognition and management of labour. This is to ensure holistic assessment of mothers during induction of labour, and to promote informed choice and fetal and maternal wellbeing.
It is recommended that the Trust works with staff to review the induction process to community midwifery. 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 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 works with the clinical teams and provide training to ensure staff feel safe to speak up in line with NHS England 'freedom to speak up'.
It is recommended that the Trust works with the maternity Information Technology (IT) system provider to introduce specific and accurate categories for neurodiversity (including dyslexia) or ensure that information recorded in free text fields is visible within risk assessments and clinical alerts.
It is recommended that the Trust, during periods of high activity or reduced staffing on the delivery suite, formulate clear contingency plans for maintaining enhanced monitoring and clinical oversight of mothers when immediate transfer to delivery suite is delayed.

It is recommended that the Trust, in collaboration with regional stakeholders, reviews and aligns regional guidance with national guidelines when there is uncertainly around ruptured membranes to ensure timely assessment and ongoing plans of care.
It is recommended that the Trust, in conjunction with regional networks, reviews and explores opportunities to improve cross site collaboration.
It is recommended that the Trust's local hypertension in pregnancy guideline is updated to come into line with current national hypertension guidance.
It is recommended that the Trust's processes facilitate shared communication about a baby's estimated weight at the start of newborn life support and that medicine calculations are performed each time using national guidance and local guidance and aids. This will enable resuscitation medicine doses to be accurately prepared and given to the baby.
It is recommended that the Trust's system supports staff to document requests for mothers to attend and that the mother is clearly informed of the urgency and timeframe for attendance.
It is recommended that there are robust mechanisms in place that support the recognition and escalation of abnormal physiological observations. This is to support clinical decision making and care planning.
It is recommended that there is a clearly defined and documented process that staff are supported to use when a second obstetric operating theatre team is needed.
It is recommended that there is a full, documented discussion of the risks and benefits of induction of labour or continuation of pregnancy to enable a mother to make an informed decision about options for care.
It is recommended that there is a multidisciplinary (obstetric and midwifery) approach to providing information when mothers request a homebirth outside of usual guidance. This should include exploring the reasons for, risks, benefits and alternatives for a birth to support fully informed decision making.
It is recommended that there is a process in place to ensure staff recognise the risk of uterine rupture in the presence of risk factors such as previous caesarean sections, the presence of a pathological cardiotocograph (CTG) and pain, and that the decision for the need to transfer to theatre is made immediately.
It is recommended that there is clear communication between different staff members to ensure effective oversight and decision making when there is a pathological cardiotocograph.

It is recommended that there is clear communication between different staff members to ensure effective oversight and decision making. The Trust ensuring that all members of the clinical team understand the key principles of maintaining situational awareness to ensure the safe management of complex clinical situations. (Royal College of Obstetricians & Gynaecologists (RCOG) 2017, Each Baby Counts 2015 full report).
It is recommended that there is consultant obstetric oversight of mothers with complex pregnancy factors throughout the postnatal period National Institute for Health and Care Excellence (NICE, 2021). This will enable a clear multidisciplinary postnatal management plan, including discharge, that is coordinated, tailored and holistic.
It is recommended that there is provision of a 24-hour telephone triage service, using staff trained to deliver a consistent approach to giving advice, planning care, recording all phone calls and documenting in the electronic record. Audit is required to evaluate that care provided has been accurate, timely and clear.
It is recommended that there should be a robust process in place to ensure mothers remain on the right care pathway until they deliver through a holistic risk assessment at each antenatal appointment.
It is recommended that to be able to provide a safe maternity triage system, the Trust ensures that safe staffing levels on the pregnancy assessment are maintained to manage the number of mothers attending. This would support mothers having an initial assessment by a trained midwife within the recommended local and national timeframes.
It is recommended that toxicology screening is offered to mothers when substance use is disclosed. This will enable staff to confirm which substances are being used during pregnancy and offer advice and support by specialist teams.
It is recommended that Trust (B) ensure that local guidelines on management of individual sexually transmitted infections, include pregnant mothers as a separate high-risk category/group and that staff are supported to recognise the increased risks to babies in the third trimester and to escalate to the obstetric team.
It is recommended that Trust (B) ensure that staff are supported to follow national and local guidance for care of pregnant women with [a sexually transmitted infection].
It is recommended that Trust A and B develop a robust guideline and pathway of care for cross trust/service working, to ensure the safety and wellbeing of mothers and babies receiving care from Trust B. This is especially significant for mothers who have outstanding treatments or clinical concerns which may impact the safety of their pregnancy and ongoing sexual health.
It is recommended that Trust A and B ensures that staff are supported to hand over and receive all available information so that clinicians can provide care that incorporates this and optimises care management plans.

It is recommended that Trust A and B ensures that staff are supported to hand over and receive all available information so that clinicians can provide care that incorporates this and optimises care management plans.
It is recommended that Trust A and B to develop a robust guideline and pathway of care for cross trust/service working, to ensure the safety and wellbeing of mothers and babies receiving care from Trust B. This is especially significant for women who have outstanding treatments or clinical concerns which may impact the safety of their pregnancy and ongoing sexual health.
It is recommended that Trust A and Trust B ensure that all mothers with insulin treated diabetes are educated to always have access to an emergency backup kit, including basic blood glucose testing strips to use as a default when treating a hypoglycaemic episode.
It is recommended that Trust A and Trust B ensure that all mothers with insulin treated diabetes are educated to always have access to an emergency backup kit, including basic blood glucose testing strips to use as a default when treating a hypoglycaemic episode
It is recommended that Trust A and Trust B provides further education, to support staff in recognising that protein in urine [1+ or more] requires further investigation, even in the absence of any other signs or symptoms, in line with local and national guidance.
It is recommended that Trust A and Trust B provides further education, to support staff in recognising that protein in urine [1+ or more] requires further investigation, even in the absence of any other signs or symptoms, in line with local and national guidance.
It is recommended that Trust A and Trust B review how clinical information is shared and communicated between teams when care is provided across different trusts.
It is recommended that Trust A and Trust B review how clinical information is shared and communicated between teams when care is provided across different trusts.
It is recommended that Trust A and Trust B support staff in working to reduce patient safety health inequalities in line with the NHS England Patient Safety Health Inequalities Reduction Framework (2025).
It is recommended that Trust A and Trust B support staff in working to reduce patient safety health inequalities in line with the NHS England Patient Safety Health Inequalities Reduction Framework (2025).

It is recommended that Trust A and Trust B work collaboratively to introduce a process for sharing and receiving maternity care records when a mother receives maternity care from more than one Trust provider. This will facilitate access and the sharing of clinical information between providers to plan and support the delivery of safe maternity care.
It is recommended that Trust A and Trust B work collaboratively to introduce a process for sharing and receiving maternity care records when a mother receives maternity care from more than one Trust provider. This will facilitate access and the sharing of clinical information between providers to plan and support the delivery of safe maternity care.
It is recommended that Trust A and Trust B work collaboratively to introduce a process for sharing and receiving maternity care records when a mother receives maternity care from more than one Trust provider. This will mean staff can access information in the maternity care records that is needed for planning and delivering safe maternity care.
It is recommended that Trust A and Trust B work collaboratively to introduce a process for sharing and receiving maternity care records when a mother receives maternity care from more than one Trust provider. This will mean staff can access information in the maternity care records that is needed for planning and delivering safe maternity care.
It is recommended that Trust A and Trust B work with the Local Maternity and Neonatal System and neighbouring trusts to agree a process that provides access to a mother's full maternity record. This is to include encouraging mothers to share their electronic records when care is given by more than one trust.
It is recommended that Trust A and Trust B work with the Local Maternity and Neonatal System and neighbouring trusts to agree a process that provides access to a mother's full maternity record. This is to include encouraging mothers to share their electronic records when care is given by more than one trust.
It is recommended that Trust A and Trust D review their processes and funding to establish a system of communication between obstetric and midwifery teams and the psychiatry services.
It is recommended that Trust A assesses staff's knowledge and review the reduced fetal monitoring checklist, so that all pregnant mothers who attend with reduced fetal movements after 38+6 weeks gestation are offered an obstetric review and induction of labour in line with Saving Babies Lives.
It is recommended that Trust A create a pathway for timely information sharing and communication between trusts within a maternal medicine network for mothers with complex medical conditions requiring or requesting shared care in pregnancy.
It is recommended that Trust A creates a checklist of questions for staff to use when speaking with someone with diabetes who is having a hypoglycaemic episode.

It is recommended that Trust A develops a process to manage critically ill patients requiring endoscopy that includes identifying an appropriate location, facilitating early multidisciplinary decision making, preparation (including blood products) and intervention.
It is recommended that Trust A develops a robust person and systems focused process and guidance tool to support the review, action and documentation of test results sent from the maternity triage. This will facilitate consistent clinical decision making and care planning for mothers.
It is recommended that Trust A develops a robust system to ensure that all pregnant women with a significant mental health history or recent inpatient admission for psychiatric disorders have oversight by the obstetric and midwifery specialists for mental health.
It is recommended that Trust A develops and embeds systems and guidance that ensures robust working relationships and communication between departments when caring for pregnant and post-partum women.
It is recommended that Trust A develops guidance for staff to follow if a wellbeing check is needed, to include an agreed plan with the mother of when to call the next of kin.
It is recommended that Trust A embed guidance into practice by supporting staff to act when a baby's heart rate is heard below the normal range in the second stage of labour, and to escalate and offer care in response to this. This includes assessment of the fetal heart rate at the same time as the maternal pulse to distinguish between them.
It is recommended that Trust A embeds a robust local process to support staff to complete ward rounds in full, to ensure all mothers are reviewed.
It is recommended that Trust A embeds their local process within the maternal medicine team for reviewing test results and acting on abnormal results.
It is recommended that Trust A ensure that when a scan is requested there is assurance that it is booked, to promote consistent clinical care in relation to fetal growth surveillance.
It is recommended that Trust A ensures that clinicians are supported to assess and identify babies at risk of deterioration and that local guidance is aligned with national guidance (British Association of Perinatal Medicine (BAPM), 2023).
It is recommended that Trust A establish a robust pathway of care to include an obstetric review during pregnancy for women who are taking beta-blockers during pregnancy.

It is recommended that Trust A establishes a priority system for requesting and booking oral glucose tolerance tests when 2+ glucose is identified in the urine at an antenatal appointment. This system must be visible for all staff to access electronically to ensure there is consistent oversight.
It is recommended that Trust A implements a structured process to ensure a risk assessment is completed when a mother is booked at a different trust, to reduce the risk of missed referrals and to ensure appropriate care pathway.
It is recommended that Trust A improves processes surrounding record keeping during all care episodes, including out of hours GP appointments, endoscopy procedures, cardiac arrest and promotes methods to strengthen the safe storage of records so that they can be easily accessed when required for review.
It is recommended that Trust A modifies their current pathway and guidance to support the care of extremely vulnerable women so that they receive care which is appropriate for their physical and mental health needs throughout pregnancy. This may require input from a multidisciplinary team.
It is recommended that Trust A provides information in line with the British Association of Perinatal Medicine (BAPM) Framework to mothers to explain the risks of neonatal hypoglycaemia, together with information on how the likelihood of hypoglycaemia can be minimised, the signs that could indicate their baby was becoming unwell, and how to raise concerns about their baby's wellbeing or feeding pattern to staff.
It is recommended that Trust A provides staff with support in using tools to assist with checking families' understanding of information given about effective feeding.
It is recommended that Trust A review the governance processes relating to the development and ratification of clinical guidelines for obstetric ultrasound. This should include the systems for sharing and publishing guidelines to support staff to use them as a practical tool to guide clinical practice.
It is recommended that Trust A review the obstetric ultrasound guidance to support detection and follow-up of placenta praevia and abnormally invasive placenta. This should include clear guidance about when a repeat ultrasound is needed, particularly if there is a history of previous caesarean section and reflect the timeframes needed for escalation to specialist pathways.
It is recommended that Trust A review the processes and barriers to identifying where an urgent referral to the obstetric or fetal medicine team is required following ultrasound scan. These findings should be used to develop a robust and auditable pathway for escalation of concerns.

It is recommended that Trust A review the processes for thromboembolic risk assessment and prescribing of low molecular weight heparin to ensure that there is a clear and robust pathway in place, including recognition and escalation of contraindications to low molecular weight heparin.
It is recommended that Trust A review the processes that support holistic assessment of referrals into antenatal clinic to ensure that all risk factors are considered and support identification of when an urgent obstetric review is required.
It is recommended that Trust A review the systems and processes for planning out of guidance care, and information sharing practices amongst the multidisciplinary team. This will support clear, personalised plans so a mother is supported with her choice and staff are supported when providing out of guidance care.
It is recommended that Trust A review the systems and processes within the antenatal clinic to ensure that high risk women are seen by an appropriately experienced clinician to support accurate identification of risks and inform onward care planning.
It is recommended that Trust A review the training and support available to clinicians undertaking discussions with mothers about planning for birth in high risk circumstances, to ensure that principles for informed consent and shared decision making are upheld. This review should include how information is shared, how mothers are involved in decision making and how discussions are documented.
It is recommended that Trust A reviews and develops the tools and training that support staff with risk assessment, advice and care planning for mothers using the telephone triage service. This should include guidance on how to assess whether an ambulance or emergency department attendance is required, and what teams should be alerted when a mother is advised to attend in an emergency situation.
It is recommended that Trust A reviews the current rainbow clinic standard operating procedure to support clinicians to consider additional risk factors in the planning of the timing of birth.
It is recommended that Trust A reviews the current skill mix and clinical exposure within the department to ensure staff have the necessary competence and confidence to review and categorise a cardiotocograph (CTG) monitoring according to local and national guidance.
It is recommended that Trust A reviews the information contained in the feeding assessment tool in the flowsheet in the electronic patient record and works with staff to ensure that the tool is clinically relevant and straightforward to use. This is in order to support identification of emerging signs of concerns, including reluctance to breastfeed, and to inform all clinical decision-making.

It is recommended that Trust A reviews the practical tools, guidance and training available to staff to support the holistic assessment, diagnosis and care planning for mothers with pre-eclampsia. This will enable timely review of investigation results, diagnosis, counselling and clinical decision making in line with national guidance.
It is recommended that Trust A reviews the processes in place for recognition of deterioration, timely, effective escalation and coordinated clinical response when a mother is becoming critically unwell.
It is recommended that Trust A reviews the system for discharging babies in order to support effective communication between staff and to ensure that an assessment has been made that a baby is feeding effectively prior to discharge and that this has been fully documented.
It is recommended that Trust A reviews the system for ensuring that there is adequate staffing in place to deliver effective feeding support to mothers and babies on the maternity care unit.
It is recommended that Trust A reviews the system for producing discharge summaries, including the data inputted into the flowsheets and the coding, in order to ensure that all relevant information is included in the summary. This is to support the effective handover of information to clinicians taking over mothers' and babies' care in the community.
It is recommended that Trust A support staff to complete routine assessments of babies after their birth in line with their guidance, to confirm their wellbeing and for early detection of complications.
It is recommended that Trust A support staff to correctly assess a mother's risk factors before giving medicines to a mother.
It is recommended that Trust A support staff to do abdominal palpation and assess engagement of the presenting part in line with guidance, and to document their findings.
It is recommended that Trust A support staff to escalate a raised maternity early warning score (MEWS) and document it in a mother's records in line with Trust A guidance.
It is recommended that Trust A support staff to request a neonatal review of a baby with risk factors and complete Newborn Early Warning Track and Trigger (NEWTT2) assessments of babies at risk in line with national and Trust A guidance, to ensure a baby is on the correct care pathway.
It is recommended that Trust A supports and enables staff working in maternity triage to ensure a holistic approach when assessing maternal and fetal risk factors alongside any cardiotocograph (CTG) interpretation to inform safe and effective care planning.

It is recommended that Trust A works with staff to explore and overcome the barriers to implementing a clear division between the day assessment unit and the maternity triage that supports clinicians to perform their duties and establishes adequate staffing, support and training so that the recommended local and national pathway for maternity triage assessment can be followed.
It is recommended that Trust A, Trust B and the regional paediatric transport team work together with the neonatal transfer service to agree clear guidance and a shared understanding on responsibilities for the care of newborns born at home and/or in emergency departments to ensure they are provided with the right care at the right time in the right place.
It is recommended that Trust A, Trust B and the regional paediatric transport team work together with the neonatal transfer service to agree clear guidance and a shared understanding on responsibilities for the care of newborns born at home and/or in emergency departments to ensure they are provided with the right care at the right time in the right place.
It is recommended that Trust A, Trust B and the regional paediatric transport team work together with the neonatal transfer service to agree clear guidance and a shared understanding on responsibilities for the care of newborns born at home and/or in emergency departments to ensure they are provided with the right care at the right time in the right place.
It is recommended that Trust A's prescribing and dispensing processes, both ward and pharmacy based, include the required safety checks to ensure that mothers needing weight based medications in pregnancy and/or the postnatal period receive the correct dose for their weight, in line with national guidance.
It is recommended that Trust A's processes for mothers requiring low molecular weight heparin in pregnancy and the postnatal period includes a robust checking process to reassure staff that mothers are receiving the prescribed medication and/or if support is required for administration.
It is recommended that Trust B address barriers for staff to recognise and document the baby's fetal heart rate and maternal pulse in the second stage of labour in line with National Institute for Health and Care Excellence (2022) and Trust B (2024b) guidance.
It is recommended that Trust B adheres to the minimum safe staffing levels in the midwifery led birthing unit which does not rely on staff supporting the delivery of midwifery care whilst also working in maternity triage.

It is recommended that Trust B and C provide ongoing refresher training of the NHS PaCCS system for use by staff. This should include how to recognise and escalate symptoms of concern, even when presentations are ambiguous. The objective is to improve staff confidence and consistency in using Pathways Clinical Consultation System (PaCCS) to support symptom-led triage and categorisation of ambulance calls, and to address the risk of variable practice and reliance on individual clinical judgement.
It is recommended that Trust B and C provide ongoing refresher training of the NHS PaCCS system for use by staff. This should include how to recognise and escalate symptoms of concern, even when presentations are ambiguous. The objective is to improve staff confidence and consistency in using Pathways Clinical Consultation System (PaCCS) to support symptom-led triage and categorisation of ambulance calls, and to address the risk of variable practice and reliance on individual clinical judgement.
It is recommended that Trust B changes their fetal monitoring guideline to ensure it is in line with national guidance and embedded in practice.
It is recommended that Trust B develops a process for consistent monitoring and timely escalation of mothers with observations and symptoms outside of normal parameters in labour.
It is recommended that Trust B develops a protocol to ensure that clinical results requiring obstetric input are consistently referred, enabling accurate risk assessment and informed decision-making throughout maternity care.
It is recommended that Trust B develops a robust, person-centred and systems-focused process for booking induction of labour. This process is to include traceable documentation of confirmed dates and informed clinical discussions with mothers, ensuring records reflect these conversations in line with national guidelines.
It is recommended that Trust B establishes a system to support community midwives caring for pregnant women who are planning to give birth at Trust A with guidance and training to be able to accurately identify when a baby's growth is static or slow and requires additional assessments.
It is recommended that Trust B explore ways of coordinating care around the individual needs of mothers with multiple complexities and those at most risk of inequitable outcomes.
It is recommended that Trust B explores ways of wrapping the maternity service around the needs of mothers, ensuring ongoing reviews throughout pregnancy to support changes in care. This approach would benefit and support all mothers, especially those with multiple complexities and those at most risk of inequitable outcomes.

It is recommended that Trust B have a robust system for documenting and reviewing any cardiotocograph events which, in isolation, may indicate a baby is experiencing difficulty.
It is recommended that Trust B have a robust system for reviewing all mothers and considering their individual risk factors when an induction of labour cannot be scheduled within the required timeframe.
It is recommended that Trust B improves their ultrasound and antenatal systems and processes in place, in order to meet national screening standards.
It is recommended that Trust B modifies and strengthens their assisted vaginal birth guideline to support clinical decision making including when senior obstetric registrar or above involvement is required for trial of instrumental deliveries in theatre.
It is recommended that Trust B provides further education to the community midwifery team in the recognition that blood pressure equal to 140 mmHg systolic and / or 90 mmHg is a raised blood pressure requiring referral for further monitoring, in line with local and national guidance.
It is recommended that Trust B review guidance to support regional referral of suspected abnormally invasive placenta.
It is recommended that Trust B review the access to neonatal emergency medicines for use during a resuscitation to ensure babies receive the correct resuscitation drugs in line with national guidance (Fawke et al, 2021).
It is recommended that Trust B reviews how ambulance crews can be prompted to access the maternity decision making tool and national Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines when responding to a maternity call. It is further recommended that the Trust incorporates regular and mandatory training on the maternity decision making tool and national JRCALC clinical guidelines. This will support early recognition of a time critical maternity emergency to support early obstetric intervention.
It is recommended that Trust B reviews how community midwifery staff are risk assessing pregnant women at booking and how they are working in partnership with all surrounding trusts to enable relevant clinical information to be shared, communicated and acted upon.
It is recommended that Trust B reviews how current systems, technology, and workflows enable timely and accurate documentation during home visits to support community midwifery teams.

It is recommended that Trust B reviews the use of the maternity early warning score in all areas of the hospital outside of maternity. The review should support the identification of barriers, and development controls to support its use in pregnant or recently pregnant women who are cared for outside of the maternity department.
It is recommended that Trust B revises its process for the follow up of routine test results, to include a robust pathway for the follow up of urine results, to enable relevant clinical information to be communicated, supporting timely treatment.
It is recommended that Trust B support staff to make a category 1 '2222' call in all instances where there is fetal bradycardia, regardless of some staff having previously been called to attend theatre. This is in order to ensure that the emergency need for birth is recognised by everyone and that all necessary staff are present.
It is recommended that Trust B supports all community maternity teams to be aware of 'red flags' that are associated with neonatal infection so that they feel confident to call an emergency ambulance if required.
It is recommended that Trust B supports midwives in applying the maternal choice in pregnancy guidance when appropriate and encourage staff to seek help from the multi-disciplinary team, where care falls outside local and national guidance.
It is recommended that Trust B supports midwives in community midwifery teams to continually risk assess and recognise deviations from the norm that require escalation and transfer into the obstetric led unit.
It is recommended that Trust B supports midwives on the midwife birth centre to recognise when a mother is or becomes high-risk and that mothers are fully informed of the risks so that care can be provided in the most appropriate setting.
It is recommended that Trust B supports midwives to consider and use all the tools and processes set out in the local guidance and involve the wider multi-disciplinary team when there are concerns about a mother's care.
It is recommended that Trust B supports midwives to ensure that all the relevant history and information about a mother is known and discussed before suggested and necessary care is carried out. Also, that all referrals to the wider multidisciplinary team are made, to ensure mothers receive the necessary advice and discussions about care planning before they leave hospital care.
It is recommended that Trust B supports midwives to provide balanced, evidenced based information around postdates induction of labour to assist mothers in making informed decisions about their care. These should be clearly documented and shared with mothers as part of their personalised care plan.
It is recommended that Trust B supports staff to listen, acknowledge and enable mothers' choice of analgesia and birth environment in labour in line with national guidance and antenatal birth preferences (NHS England, 2023, Trust B, 2024c).

It is recommended that Trust B supports staff to recognise possible signs of the second stage of labour when undertaking intermittent auscultation and to consider what adjustments to the ongoing care are required.
It is recommended that Trust B's maternity and emergency departments collaboratively review local guidance for mothers with suspected deep vein thrombosis to: -support a holistic review when there is an initial negative ultrasound scan. -consider further investigations when mothers have respiratory symptoms, to align local guidance with national guidance (Royal College of Obstetricians & Gynaecologists (RCOG), 2015; National Institute for Health and Care Excellence (NICE), 2020).
It is recommended that Trust B's maternity and emergency departments collaboratively review the guidance for mothers with suspected deep vein thrombosis or suspected blood clot to: -support a process of holistic review when leg ultrasound scans have been completed. -consider further investigations when mothers have respiratory symptoms, to align local guidance with national guidance (Royal College of Obstetricians & Gynaecologists (RCOG), 2015; National Institute for Health and Care Excellence (NICE), 2020).
It is recommended that Trust C develops a structured approach, supplemented with written information, to support counselling mothers following confirmation that their waters have broken. This will support informed decision making and documentation of discussions.
It is recommended that Trust C embeds its severe diabetes ketoacidosis protocol to ensure it is aligned across all specialties and followed for all patients admitted with diabetes ketoacidosis in the Trust.
It is recommended that Trust C improves processes surrounding record keeping during all care episodes and promotes methods to strengthen the safe storage of records so that they can be easily accessed when required for review.
It is recommended that Trust C supports and embeds a multidisciplinary approach to the care of pregnant women with diabetic ketoacidosis.
It is recommended that Trust C's emergency department receives education, training and access to maternity early warning score charts so that pregnant and recently pregnant women can have their observations recorded as per national guidance.
It is recommended that Trust D develops a pathway for all pregnant women receiving inpatient treatment for acute psychiatric disorders, so that they have multidisciplinary reviews jointly with a named obstetrician and midwife.

It is recommended that Trust guidance aligns with national guidance so that the identification of fresh blood in labour is documented as bloodstained amniotic fluid and recognised as a risk factor which triggers an obstetric review.
It is recommended that Trust guidance aligns with national guidance; if blood is seen in the liquor it is documented as blood stained liquor. This will ensure that it is recognised and forms part of a holistic review.
It is recommended that Trust guidance reflects national guidance on treatment of infection in labour and to reduce the risk of neonatal infection.
It is recommended that Trust reviews multidisciplinary simulation training to include rarely encountered situations, including airway emergencies, to allow staff to understand their role and the roles of others.
It is recommended that Trust use national maternity specific guidance for thromboembolic disease in pregnancy and the puerperium acute management (Royal College of Obstetricians and Gynaecologists, 2015) in the emergency department for mothers with symptoms and signs of pulmonary embolism.
It is recommended that Trusts A and B review and develop information sharing practices and joint care planning processes to ensure that clinicians across both Trusts have access to all relevant patient records to support collaborative careplanning.
It is recommended that when a baby is born before arrival, any medical concerns are assessed and brought to the attention of relevant neonatal colleagues at the earliest opportunity, regardless of whether or not the unit is closed.
It is recommended that when a mother has known or new findings of risk factors that a personalised care plan is created, reviewed, updated if required, discussed with the mother and available for the staff to refer to. This will support recognition of when to start fetal heart rate monitoring to assess a baby's wellbeing.
It is recommended that when a mother reports a change in her baby's movements, advice for immediate assessment in the maternity unit is given and documented.
It is recommended that when a mother requests care that is not in guidance, the discussion and agreed care plan include the reasons for the care offered and the potential impact of any suggested alterations to care. This is to ensure informed choice.
It is recommended that when a mother whose first language is not English who decline interpreting services or are assessed as not requiring an interpreter, that the Trust use a recognised tool (such as closed-loop communication), to be assured of a mother's understanding to ensure informed consent and care planning.
It is recommended that when a mother's first language is not English and they are receiving complex information, the need to use interpretation services is reconsidered in partnership with the mother.

It is recommended that when a mother's labour is not progressing as expected, the options and timing for birth are discussed and agreed with the mother. This is needed to ensure a mother is able to make an informed decision about the birth of her baby.
It is recommended that when coagulopathy is suspected and is yet to be confirmed, timely request for and administration of clotting products is needed.
It is recommended that when concerns are identified on a cardiotocograph (CTG), continuous monitoring is maintained and escalation to the obstetric team happens in a timely manner.
It is recommended that when mothers express a wish to avoid intervention to expedite birth at a post-dates gestation, that the Trust ensures that there is a pathway to create an individualised plan of care to monitor fetal wellbeing, including an ultrasound scan assessment, in line with local and national guidance.
It is recommended that when new clinical information is raised during a telephone consultation, this is explored and escalated to the relevant clinical team for a face to face review.
It is recommended that when risk factors are identified that increase the likelihood that a baby may require stabilisation or resuscitation at birth, paediatric input is sought prior to birth. This will support timely access to specialist assessment and intervention.
It is recommended that when staff provide mothers with information on all aspects of a baby's movements, the mother's understanding and the importance of seeking support when a change is noted is confirmed, in line with national guidance.
It is recommended that when the Trust reviews women of childbearing potential with preexisting complex medical conditions, confirmation of choices of contraception and the understanding of pregnancy risks is documented at every contact.
It is recommended that when there are similarities between the maternal pulse and fetal heart rate, and fetal wellbeing cannot be confirmed, this is escalated for an urgent obstetric review.
It is recommended that when there is an indication for further assessment and obstetric review this is escalated in line with local guidance.
It is recommended that women with known Group B streptococcus in pregnancy are invited for face to face assessment if they think they may have spontaneous rupture of membranes. This will allow timely confirmation or exclusion of ruptured membranes and optimise care planning.

It is recommended that, in cases of augmentation of labour and where intrapartum risk factors are present, the obstetric team undertakes and documents a face-to-face obstetric review with a mother prior to commencing oxytocin. This supports shared decision-making, timely care planning, and holistic assessment of accumulating intrapartum risk factors.
It is recommended that, when a mother is given additional time to consider her options around timing and mode of birth, a timely obstetric follow up is booked to support ongoing discussions so that a definitive plan of care is in place before labour.
It is recommended the Integrated Care Board supports general practitioners to counsel mothers that any concerns in the antenatal period, including reduced baby movements, need an immediate review in maternity. This includes when prescribing medication which has the potential to affect the baby.
It is recommended the Trust adopts a holistic approach to supporting women with their choices in early labour.
It is recommended the Trust align the provision of maternity telephone triage services within the freestanding midwifery led-unit (birth centre) with the obstetric unit and national maternity telephone triage recommendations (Kenyon et al, 2023). This will support and ensure consistency and equity for maternity telephone triage services across the Trust.
It is recommended the Trust amends local guidance to support offering a caesarean birth to mothers when they do not wish to have an induction of labour when it is offered in line with national guidance (National Institute for Health and Care Excellence, 2021c).
It is recommended the Trust and the GP Practice work together to ensure that the local guidance around the booking appointment contains reference to the importance of accessing the GP record and provide training for clinicians to access these records.
It is recommended the Trust develops guidance and training packages in line with published educational resources to ensure staff are equipped to fully assess headache in pregnancy.
It is recommended the Trust embeds learning around the use of maternal early warning scores to support timely escalation to all members of the multidisciplinary team, including intensive care.
It is recommended the Trust embeds local and national guidance which advises taking the whole clinical picture into consideration in a mother with type 1 diabetes and not to rely on cardiotocograph (CTG) analysis in isolation.
It is recommended the Trust embeds local guidance which advises completing a Situation, Background, Assessment, Recommendations (SBAR) handover in a mother's electronic record, enabling staff taking over to understand care planning for a mother.

It is recommended the Trust embeds processes to support the holistic review of maternal and fetal wellbeing during induction of labour, including assessment of uterine activity. The holistic review needs to be responsive to a mother's expressed needs and pain and include the consideration of the need for one to one care.
It is recommended the Trust ensure the review of Gestation Related Optimal Weight (GROW) charts is embedded at every contact in the maternity pathway, and actions are taken when concerns are identified.
It is recommended the Trust ensures all staff (including community midwives and obstetricians) add alerts about risks identified in a pregnancy to the electronic system. This will support staff in maternity triage to complete a full risk assessment when assessing mothers.
It is recommended the Trust ensures clinicians always review all information at the booking appointment, including past pregnancy records held in the electronic patient record system, enabling them to carry out robust risk assessment of pregnancy and plan suitable care pathway to meet mothers' clinical needs.
It is recommended the Trust ensures joint haematology and obstetric clinics take place as recommended in local guidance to support joint, multidisciplinary reviews of mothers referred.
It is recommended the Trust ensures mothers who require interpreters are given advice that is understandable and meaningful when in contact the maternity helpline or attending triage.
It is recommended the Trust ensures there is tailored and individualised information given to mothers about when and how to seek advice in labour.
It is recommended the Trust establish comprehensive safeguarding processes that enable staff to accurately assess a mother's level of vulnerability, determine when and how to make safeguarding referrals, and ensure ongoing monitoring and support for mothers with complex needs throughout pregnancy.
It is recommended the Trust establishes a clear understanding of the expected timeframe for mothers to attend triage, which considers the reason for the call and a review of individual risk factors. This needs to be clearly communicated to mothers so they understand the urgency in which they need to attend.
It is recommended the Trust explores further the barriers to completing the specifically designed digital cardiotocograph analysis tool which supports correct categorisation so an appropriate management plan can be made.

It is recommended the Trust further reviews the process when a baby arrives on the local level unit and barriers to immediate treatment of severe hypoglycaemia. This should inform an action plan aimed at embedding the local and national neonatal hypoglycaemia policy.
It is recommended the Trust has processes when there are ongoing signs and symptoms and further exploration is supported when findings from investigations do not support initial diagnosis.
It is recommended the Trust have a pathway for mothers with obesity in pregnancy that ensures an individualised birth plan is developed through an informed discussion with an obstetrician in line with local guidance. This is required to promote information sharing and informed choice.
It is recommended the Trust have a robust process in place regarding the availability and maintenance of equipment suitable for rapid ultrasound assessment of a baby's wellbeing on the central delivery suite.
It is recommended the Trust identify and address any barriers to providing individualised labour assessments. This will ensure timely transfer to labour ward for mothers in labour, to receive one to one care and continuous cardiotocograph (CTG) monitoring.
It is recommended the Trust identify and address the barriers of carrying out and documenting intermittent auscultation in midwifery led care settings, 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 using the tool provided to support individualised cardiotocograph (CTG) assessments.
It is recommended the Trust implements a clear process for situations where the cardiotocograph (CTG) category assigned by an electronic system is not agreed with by the clinician, to include a holistic clinical review, fresh eyes and confirmation by a second qualified clinician before finalising the decision.
It is recommended the Trust provide a lead obstetrician for the diabetes service, to provide an overview of care decisions to mothers with gestational diabetes. This will support recognition of risk factors and clinical findings to inform personalised management plans, including consideration of the optimal timing and mode of birth.
It is recommended the Trust put processes in place to support staff in providing timely obstetric reviews and a holistic plan of care for mothers, who have a high chance of complications. It is further recommended that obstetric consultant oversight is maintained for mothers who have had a previous caesarean.

It is recommended the Trust puts in place a robust system for providing emergency blood during neonatal resuscitation, so that blood is immediately available, staff are fully aware of the correct procedure and have received appropriate training. Including the review of the process of blood collection, to avoid reducing the availability of clinical staff to deliver emergency care and the risk of delay in administration.
It is recommended the Trust require clinicians to document a detailed plan of care including information shared with mothers, considering her individual risks, including interpregnancy interval, to assist with making informed care decisions.
It is recommended the Trust review the current process of achieving continuous fetal monitoring during the siting of an epidural and review the problems that staff have in using cardiotocograph (CTG) monitors in theatre in order to adequately assess the wellbeing of a baby.
It is recommended the Trust review the process and culture, so all mothers undergoing an induction of labour receive a face to face review by the obstetric team as a minimum once a day, in line with local guidance. This supports continued obstetric oversight and so mothers can be involved in the decision making around their care.
It is recommended the trust review the process of oversight and communication of complex birth plans in line with Trust guidance. This will enable the sharing of complex plans and allow multidisciplinary input, professional challenge, ongoing risk assessment and support for clinicians providing care.
It is recommended the Trust review their processes, so all mothers admitted to the antenatal ward, including those admitted for an induction of labour are seen daily on the consultant ward round as recommended by the National Institute Care Excellence (2021) and the Ockenden Report (2022).
It is recommended the Trust reviews and clarifies induction of labour guidance to support staff to recognise when fetal and maternal wellbeing assessment is needed, including after oral morphine is given, especially for mothers with multiple risk factors. This will support personalised care planning.
It is recommended the Trust reviews and embeds the local induction of labour guidance to support the risk assessment, prioritisation and care planning for mothers when induction of labour is delayed.
It is recommended the Trust reviews guidance on 'Antenatal Care' to ensure that local guidance follows national guidance on the inclusion of urinalysis at every antenatal contact.
It is recommended the Trust reviews guidance to ensure that local guidance follows national guidance around timing of induction and that information is shared with mothers when induction of labour is offered. This will ensure all mothers are supported to make informed decisions.

It is recommended the Trust reviews its telephone triage assessment pathway to be consistent and to include a face-to-face obstetric or midwifery assessment prior to redirecting a mother to another area of the hospital.
It is recommended the Trust reviews locally agreed practices and guidance, ensuring consistent detection of new concerns after 36 weeks in mothers that are on an enhanced growth ultrasound pathway, aligning with national guidance.
It is recommended the Trust reviews the barriers preventing staff from escalating all maternity early warning scores above two. This should inform a locally agreed plan.
It is recommended the Trust reviews the current arrangement of postnatal care provision for mothers with babies admitted to the neonatal unit. This will ensure individualised care is considered and there is ongoing oversight of a mother's postnatal wellbeing.
It is recommended the Trust reviews the current process for arranging and monitoring low molecular weight heparin prescriptions in the antenatal and postnatal period, ensuring there is a clear pathway for access, oversight and support. This will enable the Trust to verify the correct prescription has been provided, and will support mothers in receiving the required instructions, advice and support on administering the medicine and accessing repeat prescriptions.
It is recommended the Trust reviews the number of cardiotocograph (CTG) machines available in each department and whether this meets service demand even during high levels of activity, to ensure there are no delays in starting fetal heart rate monitoring and to support safe maternity care.
It is recommended the Trust reviews the process so all resident obstetric doctors have access to training that reinforces supporting mothers' choice and locally agreed processes.
It is recommended the Trust reviews the process so all telephone calls to maternity where a mother is asking for clinical advice are managed consistently, with suitably trained staff in line with national guidance.
It is recommended the Trust reviews the regional induction of labour guidance to include management of breaking a mother's waters when a baby's head is not fixed in a mother's pelvis. This will support consistency of clinical practice and a shared understanding of midwifery and obstetric roles and responsibilities, ensuring safe, collaborative decision making.
It is recommended the Trust reviews the system to ensure a referral occurs to the fetal medicine unit when indicated. This is to allow specialist care when required, increased fetal scan surveillance and ensure full consideration of the scan findings occurs when planning the timing and mode of birth.
It is recommended the Trust reviews their guidance to support staff to recognise when a full holistic assessment including a vaginal examination is required during an induction of labour to ensure early identification of established labour.

It is recommended the Trust support obstetric doctors to complete the 'Vaginal Birth After Caesarean Section VBAC' and 'Repeat Elective Caesarean Discussion and Care plan/ Shared Woman-Doctor/Midwife Decision Tool', and that details of discussions are recorded as part of birth counselling. This is to ensure it is clear what discussions have occurred to support women to make informed choice about their mode of birth following a previous caesarean birth.
It is recommended the Trust support staff to understand the need for urgent escalation when there are concerns about the fetal heartbeat.
It is recommended the Trust supports clinical staff to use more direct means of communication, for example a telephone call or a face-to-face conversation, to ensure immediate escalation to senior colleagues regarding clinical concerns of a mother.
It is recommended the Trust supports clinicians to follow Trust guidance when assessing mothers in maternity triage, including completing timely assessments and escalating concerns in line with Birmingham Symptom Specific Obstetric Triage System (BSOTS) timeframes. This includes recording observations on a maternity early warning score chart.
It is recommended the Trust supports clinicians to review the cardiotocograph (CTG) themselves and categorise to plan care, including in an emergency.
It is recommended the Trust supports staff to act on not being able to accurately assess a baby's heart rate and mitigate thinking or judgement that influences decisions and beliefs, with effective ongoing review of risks.
It is recommended the Trust supports staff with access to written safety netting advice regarding headaches and that staff are supported to check a mother's understanding of safety netting advice given before being discharged.
It is recommended the Trust supports the neonatal team by directly involving them in any plans which necessitate the relocation of essential neonatal resuscitation equipment away from the obstetric operating theatres.
It is recommended the Trust supports the neonatal team by ensuring staff follow the usual protocol of a 2222 crash call when planning their attendance to an emergency category 1 birth in the operating theatre.
It is recommended the Trust to ensure when concerns are identified on a growth scan, a face-to-face obstetric review is arranged to develop an individualised care plan, which considers all of the relevant risk factors. The Trust to review their scan reporting guidance to enable clinicians to be provided with information to compare and 6 recognise trends in the baby's growth throughout the pregnancy. This is to help recognise if slowing growth is present, and which of the baby's measurements are contributing to that so that care plans can change when required.

It is recommended the Trust to update their management of sepsis guidance to include a coagulation screen as part of the initial investigations in line with national guidance.
It is recommended the Trust update their guidance around homebirth planning to be in line with national guidance. This will support staff to give accurate and detailed information to mothers about the risks and benefits of their birth preferences, enabling informed decision making.
It is recommended The Trust will develop and implement clear guidance for staff on when and how to escalate to the paediatric consultant during extensive neonatal resuscitation to ensure timely expert intervention.
It is recommended the Trust works to address barriers to escalation and to embed the use of closed loop communication when concerns about a cardiotocograph are escalated. This will support timely, face to face review for a holistic assessment of the mother's and baby's wellbeing.
It is recommended the Trust works with the Local Maternity and Neonatal System and the Trust's Maternity and Neonatal Voices Partnership to carry out a listening exercise with mothers to understand the challenges some women face with adherence to low molecular weight heparin administration in the antenatal and postnatal period. This will support the Trust in developing, implementing and evaluating tools, strategies and pathways to support information sharing, education and adherence.
It is recommended the Trust's guidance for induction of labour and maternal age is in line with national guidance, in order to reduce the risks associated with maternal age and prolonged pregnancy.
It is recommended to the Trust that a system is developed to ensure that when a pregnant or recently pregnant woman is cared for in the intensive care unit, there is a named obstetric lead consultant and there is a process for planned and documented discussions that ensures inter-disciplinary teams are fully involved in all decision making.
It is recommended to the Trust that a system of documented assessment, reflective of national guidelines, is developed for patients with suspected devastating brain injury when lifesaving treatment is being stopped.
It is recommended to the Trust that when a pregnant or recently pregnant woman dies; a postmortem examination should always be offered to families to explore the mother's cause of death, to improve future care and to ensure any family counselling or testing is provided.
It is recommended to the Trust that when specialist services or investigations are not available on-site, discussion with the regional centre occurs and safe transfer of patients is facilitated if required.

It is recommended to Trust A that [a blood test] outside of the normal range in a symptomatic person is treated as a medical emergency, with [specialist] team advice sought, to consider starting [treatment]. An immediate repeat blood sample to be taken if there is any doubt about the initial result.
It is recommended to Trust A that local guidance directs clinicians to consider [blood test] levels to be taken, in a presentation of acute confusion to consider the possibility of diagnosis of a metabolic disorder.
It is recommended to Trust A that when pregnant women attend the emergency department, maternity staff are contacted to ensure a full clinical assessment can be provided.
It is recommended to Trust B that maternity triage telephone calls are answered in an appropriate location away from the triage department where relevant aids and tools are available.
It is recommended Trust A assesses the knowledge of their staff regarding what to do when a mother experiences pre-labour rupture of membranes and provides further education where needed so discussions of options available to a mother take place to support informed decision making.
It is recommended Trust A provides staff with user friendly, easily accessible equipment on which to record a maternity early warning score (MEWS). The MEWS recording system must clearly alert staff to the agreed escalation pathways as indicated by the generated score.
It is recommended Trust B works collaboratively with local trusts who share maternity care to review processes relating to shared maternity antenatal schedule of care. This will ensure mothers receive the correct antenatal appointments and are booked on the correct maternity pathway, with adjustments to their planned care made as required.
It is recommended when there is a clinical indication for a specialist review in pregnancy that urgent consultant to consultant referral is made to support a timely referral and review.
MNSI recommend that the Trust promote a culture that supports and empowers clinicians to escalate concerns promptly, enabling timely recognition and response to abnormal fetal heart rate patterns and facilitating earlier intervention when necessary to optimise outcomes.
MNSI recommends that all calls made by mothers or fathers/partners seeking advice are documented so that a mother's clinical record can be reviewed and plan of care agreed and documented in line with local and national guidance (Royal College of Obstetricians & Gynaecologists (RCOG), 2023) and (General Medical Council 2020).

MNSI recommends that staff are supported to conduct structured handovers between teams and across shifts in times of high acuity.
MNSI recommends that staff are supported to provide continuous monitoring of mothers and babies where required during periods of high acuity.
MNSI recommends that staff are supported to provide information in a balanced and clear way to enable a mother to make an informed choice when an induction of labour is offered. The detail of this discussion should be documented and a mother's understanding confirmed.
MNSI recommends that staff are supported to recognise when escalation of clinical care is needed and to act upon this without delay, in order to promote safe care. All of the guidance related to the recognition of sepsis should be aligned to support staff to understand when escalation is required.
MNSI recommends that the ambulance Trust ensures decision-support tools for assessing breathing are accessible during first party 999 calls and enhances training and guidance for call handlers on interpreting breathing descriptors within the Medical Priority Dispatch System, to support accurate recognition of ineffective breathing.
MNSI recommends that the ambulance Trust review the Computer Aided Dispatch (CAD) system breakdown that occurs during the clinical coordinator review, to support the identification and implementation of a system-level solution.
MNSI recommends that the diabetes team provide all newly pregnant mothers with diabetes with comprehensive advice on the risks of sudden low blood glucose levels, the potential of reduced awareness of symptoms in the first trimester, and the management and treatment needed.
MNSI recommends that the Trust (Trust B) updates its induction of labour guidance to reflect national guidance, including the relevant counselling around the use of dinoprostone for mothers that have undergone a previous caesarean birth if use is considered.
MNSI recommends that the Trust develops guidance to support staff to recognise a change in fetal movements and recommend mothers come in for an assessment.
MNSI recommends that the Trust ensure placentas are sent for pathological examination including histology in line with national guidance (Evans et al 2022).
MNSI recommends that the Trust ensure that all resuscitaires are checked by clinicians prior to use, in addition to the twice daily checks and after use.

MNSI recommends that the Trust ensure that mothers who develop blood pressure concerns are provided with appropriate information and any necessary equipment to support the agreed discharge plan. They should receive personalised safety netting advice tailored to their individual needs, and all guidance and plans must be clearly documented in their maternity records.
MNSI recommends that the Trust ensures robust training in neonatal life support is provided to all staff to provide assurance that they are competent to provide neonatal care in resuscitation situations.
MNSI recommends that the Trust ensures women are listened to when they are telephoning with symptoms of labour and offered the opportunity to come in for assessment.
MNSI recommends that the Trust improves the knowledge base and practice on when it is suitable to use computerised cardiotocograph (CTG) analysis.
MNSI recommends that the Trust raise awareness of the importance of a full clear assessment when mothers call reporting abnormal vaginal discharge and recognising circumstances when face to face reviews are required.
MNSI recommends that the Trust review the process for cardiotocograph (CTG) reviews by second checkers to ensure that the system is effective and to optimise the opportunity for recognising fetal heart rate abnormalities. This is to support safe care.
MNSI recommends that the Trust review the reduced fetal movements guideline and checklist to ensure that they are consistent and in line with national recommendations. Once embedded in practice, this will ensure that mothers are offered induction of labour when they present with reduced fetal movements after 38+6 weeks.
MNSI recommends that the Trust review the staffing of triage in order to ensure that all staff deployed there have been trained in the use of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) and assessment tools. This is to support safe care.
MNSI recommends that the Trust review the suitability of the current triage environment, engage staff in co-producing workable solutions, and establish a feedback mechanism to ensure that staff concerns are acknowledged and acted upon transparently.
MNSI recommends that the Trust strengthens the use of cardiotocograph (CTG) peer reviews and associated documentation to support ongoing care decisions.

MNSI recommends that the Trust support the community team to refer mothers to the relevant departments when they present with an initial abnormal blood pressure measurement in line with Trust and National guidance. This is to ensure mothers follow an appropriate maternity pathway of care in accordance with their individual needs.
MNSI recommends that the Trust supports clinicians to undertake the additional anaemia screening requirement for mothers with multiple pregnancy in line with local and national guidance (Royal College of Obstetricians & Gynaecologists, 2015; National Institute for Health and Care Excellence, 2019) between 20+0 weeks and 24+0 weeks.
MNSI recommends that the Trust take steps to ensure that the system in place in maternity triage is effective, so that when women attend with reduced fetal movements, a holistic assessment is carried out and a discussion takes place regarding the risks and benefits of an induction of labour after 39 weeks. This is to support safe care.
MNSI recommends that the Trust to review their clinical escalation pathways if a fetal heart cannot be heard, to enable a timely review by the obstetric team.
MNSI recommends that the Trust undertakes a review to identify any barriers to effective escalation and considers strategies to overcome these barriers to ensure that a clear, well-embedded pathway is in place to enable effective escalation. The review must consider three key areas: -An assessment of the escalation pathway to ensure it is clearly defined and consistently applied, that guidance for further escalation is included within local protocols, and that effective management of concerns is actively supported by a positive culture and working environment. -The need to develop clear guidance for the use of the remote observer function to support consistent decision-making and reduce reliance on brief observations or individual judgment. -The barriers to ensuring that the Computer Aided Dispatch (CAD) system is effectively used to support the escalation process by documenting concerns raised and actions taken as described in local guidance.
MNSI recommends that the Trust update their Newborn Resuscitation guideline to bring it in line with the Resuscitation Council newborn life support (NLS) 2021 guidance around resuscitation in the presence of meconium.
MNSI recommends that the Trust updates its diabetes guidance to clearly define the parameters of when blood glucose monitoring is required, to include care during antenatal admission and in active labour.
MNSI recommends that the Trust updates the guidance on Modified Early Obstetric Warning Score (MEOWS), to ensure that staff are supported to take a full set of observations each time the calculation of a MEOWS score is indicated.

MNSI recommends that Trust A ensures their process for assessment and support of mothers with complex social needs enables a designated midwife to support mothers to access care pathways, receive personalised care and engage in informed decision making.
MNSI recommends that Trust A provides systems to ensure cultural safety for mothers, reducing unconscious bias and ensuring that mothers and families are listened to during pregnancy and birth. This is to support safe and equitable care.
MNSI recommends that Trust A reviews the system for acting on referral information that interpretation services are required, in order to ensure that the service is offered at booking and for all planned and unplanned attendances throughout pregnancy, labour care and birth. This is to support safe and equitable care.
MNSI recommends that when preparing for an elective or emergency caesarean birth, all medical records of mothers are reviewed and an accurate and full reflection of medical and obstetric history is discussed and documented as part of the full consent process and safety checklist prior to commencing surgery to include the consideration of the cell salvage. This includes opportunities for a mother and birthing partner to participate.
MNSI recommends Trust A and Trust B are supported by the local maternity and neonatal system (LMNS) to share records to ensure mother's care plans are effectively communicated between trusts.
MNSI recommends Trust A and Trust B are supported by the local maternity and neonatal system (LMNS) to share records to ensure mother's care plans are effectively communicated between trusts.
MNSI recommends Trust A supports mothers to access records of their maternity care to enable a shared understanding of their plan of care.
Pregnant and lactating women should receive the same level of care as non-pregnant women unless there is a clear reason not to (Knight, Bunch et al. 2022).
The emergency alert is to be signalled by a distinct alarm that differs from other medical equipment. Where the Trust cannot address these issues, it is recommended that the Trust inform the emergency call device manufacturer of the safety impact identified.
The investigation recommend the Trust review the system of reviewing ultrasound scan reports of mothers with complex care needs and multiple risk factors in maternity triage, including the skills and support required for this.

The Trust (A) to ensure that staff are supported with their understanding of cerebral function monitoring (CFM) equipment and its limitations to promptly exclude an equipment issue to support clinicians to initiate management plans when there is an abnormal trace.
The Trust (B) to ensure that therapeutic cooling, once started is continued for the recommended 72 hours, unless continuing would be detrimental to the health and wellbeing of the baby.
The Trust are recommended to review their service provision for all socially complex mothers ensuring safe, equitable and accessible care is offered consistently.
The Trust ensures staff are aware of local translation and interpreting policies and reinforce the importance of utilising interpreters in cases where English is a second language. This guidance should involve a process to aid staff in assessing service user's comprehension.
The Trust is recommended to review their local complex social factors guidance relative to national guidance in order to support staff to use interpretation services when required.
The Trust is to support staff with the provision of clear Trust guidance in line with national guidance for the management of genital herpes in pregnancy. These guidelines are to include a clear process for staff to follow for the diagnosis, management and ongoing care planning for herpes in pregnancy.
The Trust should create clear guidance to support categorisation and timing of assisted births in the operating theatres to support safe delivery of care. This guidance should include escalation to the consultant on call.
The Trust should review the local Standard Operating Procedure (SOP) for Use of Aspirin in Pregnancy guidance (Trust, 2023) to ensure that it is in line with the recommendations from the The Saving Babies' Lives Care Bundle (SBLCB) V3 national guidance (NHS England, 2023). This should include 'previous small for gestational age baby (SGA) baby' and 'smoking' status as moderate risk factors which would lead staff to the consideration of aspirin in high-risk pregnancies.
The Trust to develop a failsafe option to provide structured contemporaneous intrapartum and partogram documentation when there is no access to electronic patient records. This is to support on-going clinical oversight and risk assessment, in line with national guidance (National Institute for Health and Care Excellence (NICE), 2023).
The Trust to develop a pathway for if a uterine anomaly or any deviation from normal (not covered in other pathways) is identified on an ultrasound scan and timely obstetric oversight. To ensure the ongoing personalised care plan is timely and appropriate.

The Trust to develop a process for contacting the neonatal consultant in the event of a neonatal emergency, that is clear and understood by the whole multidisciplinary team.
The Trust to develop internal escalation procedures and processes to support clinicians, irrespective of their role or grade, to escalate and inform managers and consultants when maternity service concerns arise.
The Trust to embed guidance into practice to ensure that staff consistently offer interpreting services to mothers who require language support. This would reduce health inequalities and improve communication and care for mothers who do not speak English as their first language.
The Trust to embed guidance into practice to support staff to recognise that loss of contact is a concerning feature on a cardiotocograph (CTG) trace, and requires escalation and consideration for obstetric review and ongoing care planning. This is to enable confirmation of ongoing fetal wellbeing and if this cannot occur consideration of whether expedition of birth is required.
The Trust to embed robust and effective processes of escalation and communication when a baby's heartbeat cannot be heard.
The Trust to empower all members of the multidisciplinary team to contact the consultant on call, to ensure that staff can ask for them to attend in person when there is a disagreement about a baby's clinical condition and monitoring.
The Trust to ensure adequate availability of the obstetric team on the antenatal ward so that face to face reviews occur when requested.
The Trust to ensure all staff are aware of guidance to offer induction of labour with one episode of reduced baby movements after 38+6 weeks.
The Trust to ensure local guidance is embedded for when a symphysis fundal height measurement is not following the slope of the curve, and a growth ultrasound scan is carried out to estimate the baby's weight. The result of the growth ultrasound should inform future care recommendations.
The Trust to ensure mothers with emerging risk factors (such as altered fetal movements at term) are counselled by a suitably experienced doctor to inform decision making around the timing of birth. The Trust may wish to consider the use of a structured decision making tool, to support informed decision making.
The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (Evans et al 2022).

The Trust to ensure recognition of an abnormal antenatal cardiotocograph (CTG) prompts an individualised risk assessment and consideration of the need to expedite birth.
The Trust to ensure staff are supported to complete documentation in a full and timely manner, using all the records available and to ensure times and events are accurately documented.
The Trust to ensure staff are supported to manage uterine hyperstimulation in line with local and national guidance, including the use of tocolysis to support a baby's well-being.
The Trust to ensure that a rectal probe is placed when passive cooling is started and ensure there is documentation to reflect the timing of this.
The Trust to ensure that all clinicians are aware that oxytocin is to be stopped when there are ongoing fetal wellbeing concerns, as part of conservative measures, to optimise the environment for the baby.
The Trust to ensure that all medical records are stored and kept in line with national guidance.
The Trust to ensure that all staff are trained, supported and expected to consider cumulative risk factors to inform decision making during holistic review in planning and expediting a baby's birth.
The Trust to ensure that an effective process exists to manage the impact of acuity on the transfer of mothers from the induction of labour ward to the delivery suite to avoid delays.
The Trust to ensure that centralised fetal monitoring is not overly relied upon in place of holistic, face to face obstetric reviews so that cardiotocograph (CTG) monitoring is not used in isolation to inform care planning and decision making.
The Trust to ensure that complications in labour are escalated to the on-call consultant in line with Trust and national guidance to ensure senior, multidisciplinary care planning.
The Trust to ensure that consistent information relating to the risks of prolonged pregnancy beyond 41 weeks is provided to all mothers. This should include discussion about ethnicity and increased risk to allow them the opportunity to make an informed decision about induction of labour in line with national guidance.
The Trust to ensure that during episodes of prolonged resuscitation that the staff have the ability to maintain a baby's temperature including the environment and that passive cooling is not initiated until the baby is stable.
The Trust to ensure that in line with local and national guidance, repeated requests for pain relief during induction of labour are considered a trigger for a holistic review and assessment of a mother's wellbeing and possible progression of labour.

The Trust to ensure that observations in line with the standard operating procedure for a mother and baby are reviewed and documented as part of handover in line with Trust guidance (2023).
The Trust to ensure that observations taken during triage assessment are charted on the digital system to enable a holistic medical assessment.
The Trust to ensure that risk assessments encompass all risks during the antenatal and intrapartum periods and these are clearly identified, with an individual management plan documented and an obstetric referral made when indicated. This is to help ensure personalised birth planning in the antenatal and intrapartum periods.
The Trust to ensure that staff are supported to carry out rapid reviews within 15 minutes of mothers arriving at the maternity assessment centre. When this is not possible immediate escalation is required.
The Trust to ensure that staff are supported to follow the local escalation policy and continue to escalate when they have cardiotocograph (CTG) concerns. This will enable further review of the clinical situation and an opportunity to adjust the care plan.
The Trust to ensure that staff are supported to recognise and escalate cumulative concerns immediately, especially in scenarios where there is an ambulance transfer required. This will minimise delays in obtaining the correct care.
The Trust to ensure that staff are supported to recognise when to instigate conservative measures when there are cardiotocograph (CTG) concerns and/or when an immediate review after escalation is not possible.
The Trust to ensure that staff on the neonatal unit receive training to support the use and interpretation of cerebral function monitoring in babies undergoing neurological assessment for neonatal encephalopathy.
The Trust to ensure that the local neurological assessment form is completed for babies undergoing assessment for neonatal encephalopathy in the first 6 hours of life, to support structured clinical assessment, shared decision making, treatment and care.
The Trust to ensure that the modified obstetric early warning score is used for all pregnant or recently pregnant women in all clinical areas.
The Trust to ensure that the neonatal emergency algorithm is embedded within multidisciplinary training to include the use of the 2222 emergency call, closed loop communication and human factors.
The Trust to ensure that the pathway of care for a women requiring admission to hospital in early pregnancy supports both their emotional and physical care needs.

The Trust to ensure that the process of continuous rectal temperature monitoring is embedded when passively cooling neonates to prevent overcooling a baby.
The Trust to ensure that there are continuous, documented risk assessments of mothers throughout the induction of labour process that support prioritisation for transfer to the delivery suite.
The Trust to ensure that there are provisions in place to ensure mothers with complex social needs are referred to specialist teams and followed up in a timely manner.
The Trust to ensure that when a clinical emergency occurs in the birth centre an appropriate '2222' emergency call is placed to summon help promptly to facilitate the transfer of a mother to the labour ward.
The Trust to ensure that when a request is made for more senior support and advice, particularly on a night shift, that consultant neonatal presence is easily achievable within a set timeframe. This is to ensure babies receive timely treatment when needed and that the neonatal intensive care team are effectively supported.
The Trust to ensure that when assessing and monitoring a baby's growth the Trust uses appropriate tools including plotting of the growth to enable staff to make informed decisions about a baby's growth.
The Trust to ensure that when mothers attend with potential complications in pregnancy they have a full, holistic review by a member of the obstetric team.
The Trust to ensure that when the local sepsis care pathway has been initiated, all actions are completed within the recommended time frame and transfer of care does not impact this.
The Trust to ensure there is a contingency plan for access to all clinical systems when there is a planned Information Technology (IT) downtime and that this plan is cascaded to all clinical teams.
The Trust to ensure when a mother attends the labour ward with significant vaginal bleeding a review of maternal and fetal wellbeing is carried out immediately and appropriate escalation to obstetric staff is made using a recognised communication tool.
The Trust to establish a system that supports personalised care, taking into account all relevant risk factors, to enable mothers to make informed choices about their mode of birth.
The Trust to explore the barriers to using the partogram tool in labour to aid recognition of changes in fetal heart rate that may indicate fetal compromise.

The Trust to explore the local management of proteinuria (1+ or more) identified on dipstick urinalysis and to implement clear guidance and care pathways when further testing is required to quantify proteinuria in line with national guidance.
The Trust to implement structured multidisciplinary approaches to care planning, communication and escalation, with emphasis on collaborative decision-making and robust review protocols. This is to address cognitive bias, clarity of professional roles, and mitigate the impact of hierarchical dynamics on escalation behaviours, leading to improved team working and safe care planning.
The Trust to implement the 24-hour flow coordinator role in the maternity unit and review additional strategies to support staff to maintain oversight of unit acuity in out of hours shifts.
The Trust to provide guidance for staff on the designation of a scribe and easily accessible proformas for neonatal resuscitation to support accurate, detailed, real-time documentation.
The Trust to provide guidance on respiratory management of babies within the neonatal department.
The Trust to provide training for staff within the neonatal unit on the wider use of the specific ventilators in use on the neonatal unit.
The Trust to review and audit compliance with the new digital sepsis screening tool to ensure effective and consistent use within the emergency department in line with the local performance target of 95%.
The Trust to review and embed the Royal College of Obstetricians and Gynaecologists' (2024) good practice paper for 'Managing Events Surrounding a Maternity Death' to ensure the effective support of families following a maternal death.
The trust to review and update guidance on care of women with a body mass index of >30kg/m2 during pregnancy, birth, and postnatal period to make sure that it reflects all the risks and benefits to be discussed when birth planning in line with national guidance.
The Trust to review and update their induction of labour guidance to align with national guidance regarding the discussion and recommendation of timing of induction of labour from 41 weeks to facilitate informed decision making by mothers.
The Trust to review and update their scan reporting guidance to ensure clinicians are provided with clear, accessible information that allows them to monitor trends in the baby's growth.
The Trust to review any barriers that enable them to perform regular, structured quarterly audits of growth ultrasound scan images to maintain high quality scan images within the department.

The Trust to review guidance to ensure consistent advice is provided based on local and national guidance when mothers telephone with suspected rupture of membranes.
The Trust to review how staff are supported to fulfil their professional responsibility to complete their documentation during the second stage of a mother's labour, or after the event if there are multiple clinical demands.
The trust to review its guidance on impacted fetal head and introduce multi-disciplinary training to improve communication and establish practice to facilitate safe birth.
The Trust to review its local guidance and assessment tools for intrapartum fetal monitoring, to ensure that the tools and the guideline are aligned and used consistently for the interpretation and management of fetal wellbeing.
The Trust to review others in maternity triage within the recommended timeframes of both local and national guidance (Royal College of Obstetricians and Gynaecologists, 2023, Birmingham Symptom Specific Obstetric Triage System, 2024).
The Trust to review the cardiotocograph (CTG) analysis tool and fetal monitoring training to support staff to recognise pathological CTG. This will enable staff to escalate and use holistic assessment for planning ongoing care.
The Trust to review the emergency department escalation policy to ensure it includes a trigger point and robust actions when the department is unable to triage patients within 15 minutes of arrival in the department.
The Trust to review the escalation process with a particular focus on maternity triage so that safe staffing levels are maintained to manage the number of mothers requiring care.
The trust to review the local escalation process for when there are clinical concerns requiring obstetric review, and on call obstetric staff are already busy with other clinical tasks. This may include consideration of contacting an alternative member of obstetric staff.
The trust to review the local escalation process so that staff are supported to escalate when they are providing care outside of guidance and to ensure there is obstetric oversight.
The Trust to review the local guidance and practice of consultant-to-consultant handover at 18:30 hours, to ensure multidisciplinary oversight, the handover of pertinent information and the facilitation of a shared mental model.
The Trust to review the maternity triage assessment tool to ensure this prompts obtaining the specific details of a mother's physical observations during calls for advice from another healthcare professional. This is to ensure that the care plan is made using local maternal observation parameters.

The Trust to review the process for contacting the neonatal consultant on call, to include the use of a structured multidisciplinary communication tool, to ensure effective communication and handover of information.
The Trust to review the process of recognition and escalation when blood-stained liquor is seen. This will support a holistic assessment and ongoing care planning.
The trust to review the provision of antenatal clinic services to support obstetric led care being provided by one named clinician through pregnancy in line with national recommendations. This will help consistency of the clinical decisions made and promote personalised care planning.
The Trust to review the provision of the safety and capacity coordinator in the maternity unit and review additional strategies to support staff to maintain oversight of unit activity and acuity during out of hours shifts.
The Trust to review the roles and responsibilities of the neonatal consultant on call, to support consultants to recognise when their attendance on the neonatal unit may be required on the basis of the clinical information received rather than having been directly requested to attend.
The Trust to review the standard operating procedure for patients requiring immediate assessment and prioritisation of care within the emergency department, to include pregnant or recently pregnant women as a priority for triage assessment within 15 minutes.
The Trust to review tools and processes to support staff in categorising cardiotocographs (CTGs) as part of a holistic assessment of a baby's wellbeing, particularly during times of high workload and cognitive fatigue. This is to support a baby's well-being and team decision-making.
The Trust to support clinicians to effectively trigger an escalation process during times of increased acuity to ensure senior midwives are available to maintain an oversight of the unit to facilitate the safe management of complex and evolving clinical situations.
The Trust to support clinicians to undertake holistic dynamic clinical risk assessment and robust cardiotocography interpretation with early escalation to senior midwifery and obstetric clinicians resulting in personalised care planning including a management plan to expedite birth.
The Trust to support staff in the recognition and management of blood loss in labour based on established guidelines.
The Trust to support staff to consistently use the cardiotocograph (CTG) categorisation tool when reviewing CTGs, and to document their systematic review of the clinical situation in the notes with an ongoing plan.

The Trust to support staff to deliver intermittent auscultation in the second stage of labour in line with local and national guidance, and to escalate when this is not possible.
The Trust to support staff to ensure that the fetal heart rate can be always differentiated from the mother's heart rate during electronic fetal monitoring.
The trust to support staff to manage loss of contact on the cardiotocograph (CTG) as an obstetric emergency until proven otherwise and simultaneously take actions to confirm the fetal heart rate.
The Trust to support staff to recognise the need to start continuous fetal monitoring promptly when fetal wellbeing cannot be assured by intermittent auscultation.
The Trust to support staff to undertake continuous electronic fetal monitoring in labour when there are cumulative risk factors including fresh per vagina bleeding and blood-stained liquor, in line with guidance.
The Trust to support staff training to ensure that they are able to effectively use the electronic patient record system to enable accurate risk assessment and support plan of care.
The Trust to support staff with guidance and education on how to recognise and respond to a pathological cardiotocograph (CTG) in line with national guidance, with a particular focus on education around the use of intravenous fluids as a conservative measure.
The Trust to support the introduction of maternity specific hyponatraemia guidance and to support all staff involved to be familiar with the risks of hyponatraemia and follow the guidance.
The Trust to support the neonatal team to make use of national guidance to clearly establish the eligibility and suitability of babies for therapeutic cooling. The neurological assessments and the decision for therapeutic cooling need to be clearly documented.
The Trust to support the prioritisation of safe staffing levels 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 update their guidance, in line with national and product manufacturer guidance, to support holistic clinical face to face reviews prior to commencing a second cycle of prostaglandins. This will support shared and clinical decision making between a mother and her healthcare team.

The Trust to update their guidance, in line with national and the manufacturer's guidance, about when to remove a prostaglandin pessary during an induction of labour.
To improve outcomes, maternity services should address systemic biases and assumptions by implementing: -Proactive pain assessment - Using structured tools to evaluate pain rather than relying on subjective interpretations of behaviour. -Cultural competence training - Educating healthcare staff on how cultural backgrounds influence pain expression. -Effective communication strategies - Ensuring closed-loop communication to verify understanding and validate mothers' concerns.
Trust A ensures that risk assessment is completed at every antenatal contact and when there is a rise in blood pressure, mothers are referred in for Obstetric assessment in line with guidance.
Trust A to take steps to ensure that the mixed system of electronic and paper patient records supports staff in being able to access a full obstetric history, including a full history of all of mothers attendances in triage, and that records are filed in line with professional standards.
Trust to ensure that if a mother attends for a planned earlier birth based on her risk factors, a full holistic review is performed and discussed with a senior obstetrician when this is delayed.
Trust to review the escalation process in initial triage assessment and ongoing clinical assessments and develop a process which is not reliant on staff who are performing clinical assessments.
When a death has occurred in the perinatal period, Trust A to offer the family a hospital postmortem to contribute to information regarding the cause of death and future care.
When there is concern about the fetal heart rate and slow delivery of the baby's head, the Trust to ensure the staff use the emergency buzzer to get multidisciplinary help.