Maternity & Neonatal Trust Board Safety Report



Board of Directors / Quality Committee Monthly Report

October 2026 reporting September 2026

Presented by Jo Lavery, Divisional Director of Nursing and Midwifery, Women's and Children's Division

Wirral University Teaching Hospital NHS Foundation Trust

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Executive summary

	RAG	Key Message
Safety		Robust governance process; some noted workforce gaps in neonates
Quality & Learning		Various opportunities for learning
Workforce		Neonatal workforce gaps identified to ensure BAPM compliance
Equity		Priority to undertake NHSE perinatal programme
Governance & oversight		Exception governance and oversight with sub committees providing additional assurance including

What is going well: MIS Year 7 achieved; working towards MIS Year 8 confidently; Ockenden and AMOS reports reviewed, and gap analysis demonstrate positive position with identified improvements all deemed to be achievable within agreed timeframes; 10 Point Plan baseline analysis completed and a focus on the implementation of Martha's Rule for maternity and neonates

What is of concern: Deep dive into neonatal deaths and thematic review undertaken

Emerging risks: Neonatal workforce and requirement to work towards BAPM compliance

Improving/deteriorating trends: Cultural quality improvement project with Neonatal Consultants

Key system actions underway: Enhanced Neonatal governance process

Board assurance statement:

The Board can be fully assured that perinatal safety systems are in place.
Outcome measures are stable
However, concerns remain regarding key risks, and further work is required to demonstrate sustained improvement.

Actions required from Board:

- ☐ Decision / approval
- ☐ Support / escalation
- ☐ Assurance only

Executive summary

Wirral University Teaching Hospital NHS Foundation Trust

Safety & Quality

- Maternity and Neonatal services continue to provide safe care with ongoing monitoring through governance, quality and performance frameworks.
- Focused improvement work continues across maternity, neonatal and obstetric services in response to national standards, learning reviews and local quality priorities.

Workforce

- Recruitment and retention initiatives continue to strengthen workforce sustainability.
- Continued review of workforce and skill mix to ensure safe staffing and support future service demand.

Key Risks

- Ongoing delivery of actions associated with BAPM compliance and neonatal service requirements.
- Capacity and demand pressures across maternity pathways and neonatal services continue to be monitored through divisional governance structures.
- Progression of improvement work relating to governance, oversight and assurance arrangements.

Quality Improvement

- Ockenden, CNST and Perinatal Quality Surveillance actions continue to be monitored and progressed.
- Continued focus on learning from incidents, patient experience, staff engagement and service improvement programmes.

Board Assurance Required

- Note the continued delivery of maternity and neonatal improvement programmes.
- Note current risks and mitigating actions.
- Receive assurance regarding the ongoing oversight of safety, quality and workforce performance across Women’s and Children's Service

Executive summary

Wirral University Teaching Hospital NHS Foundation Trust

The maternity and neonatal service continues to demonstrate strong, sustained improvement across all key domains of quality, safety, and workforce. Progress remains aligned to national priorities including AMOS, Ockenden, East Kent, MOSS, and the 10 Point Plan. Governance structures are now more robust, safety culture is strengthening, and workforce stability is improving, with the majority of deliverables rated Blue or Green.

The service reports no MOSS safety signals, high compliance with fetal monitoring training, and timely review of all moderate-and-above incidents. Staff feedback indicates improved psychological safety and confidence in escalation, reflecting the impact of strengthened leadership and multidisciplinary learning.

Personalised care continues to be embedded, with five enhanced Continuity of Carer teams sustained in areas of vulnerability. Maternity achieved full UNICEF BFI accreditation in October 2025, and neonatal services are progressing on a two-year accreditation plan. Service-user involvement remains strong, supported by an active MNVP.

Workforce indicators show a positive trajectory. The BR+ report (March 2025) has been received, the Trust remains funded to establishment, and recruitment to midwifery, MSW, and obstetric consultant posts is stable, with consultant vacancies. Turnover, sickness, and leaver rates are improving and within expected ranges. A small number of data-quality issues have been identified in PWR reporting, and a regional meeting is scheduled to resolve these.

Workforce for neonatal nursing staff and allied professionals requires investment to ensure compliance with BAPM.

One area requiring strengthened assurance is compliance with the Accessible Information Standard, where recent Board papers indicate limited assurance. The Trust has submitted updated policy evidence, and further monitoring is underway.

Overall, the service is performing well, with clear evidence of maturing governance, improved safety culture, and sustained progress against national standards. Remaining risks are known, monitored, and supported by active improvement plans

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10 Point Plan for maternity and neonatal services

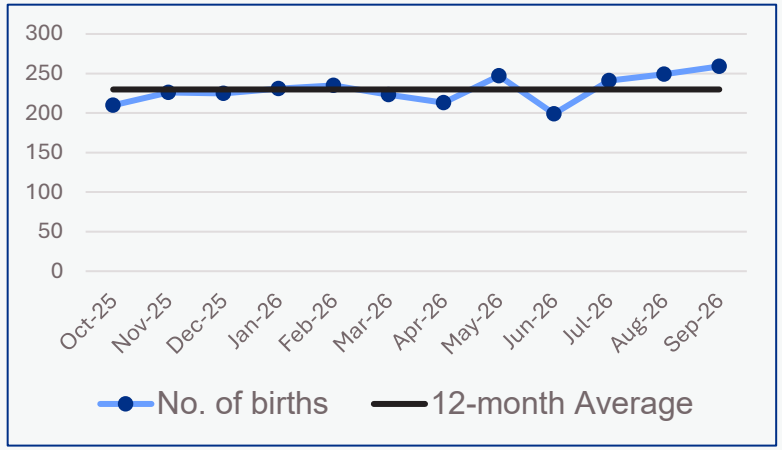
Action required	Progress	Action	Responsible (role)	By when
1. Listening to women and their families by rolling out Martha's Rule	Develop a dedicated pathway to roll our Martha's rule; awaiting further guidance	Empower women and families to raise concerns and seek rapid clinical review when they feel their condition or care is deteriorating.	DoM	31/12/2026
2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	Establish a Maternity and Neonatal Board Report incorporating patient experience	Collect, monitor and transparently report patient experience, outcomes and audit data, ensuring findings are reviewed and acted upon at Board level.	DoM	30/11/2026
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	Review of Trust governance and oversight commenced	Strong leadership oversight through shared accountability between the Medical Director and Chief Nursing Officer embedded for maternity and neonatal service. In addition, MD will become be a Safety Champion	MD/ CN	CLOSED
4. 'Amos into action' staff listening exercise	Staff briefings in place and other options being explored to meet staff needs	Promote an open culture where staff concerns are heard, addressed and used to drive service improvements.	DoM	31/12/026
5. Addressing inequalities in maternity and neonatal outcomes	First meeting held of the perinatal culture leadership 9 month programme	Identify and reduce disparities in maternity and neonatal outcomes, particularly for disadvantaged and ethnically diverse populations.	Senior Team	30/06/2027
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	Safe staffing levels monitored via BAPM and BR plus; gaps require BoD oversight	Ensure maternity and neonatal services have appropriate staffing, expertise and support available at all times	DoM / CD's	30/12/2027
7.Trusts to review their homebirth services	Review completed and all parameters met to continue	Trusts should evaluate the safety, sustainability and effectiveness of their homebirth services; review of WUTH highlights all parameters will be met	DoM	CLOSED
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	W&C governance processes in place; recent changes to Neonatal losses to ensure in line with PSIRF plan	Manage safety incidents, concerns and complaints with openness, candour, compassion and a trauma-informed approach	DoM / Q&S Lead	31/12/2026
9. Deliver safe and effective triage in maternity services (already committed by Government)	Triage meets the specification; audits being reviewed and an open access service; Risk register entry for theme of doctor delays to review patients	Ensure all women and pregnant people have timely access to high-quality maternity triage services, with appropriate clinical assessment, risk identification, escalation and decision-making to support safe and effective care 24 hours a day	DoM	31/03/2027
10. Post death care (already committed by Government)	Bereavement team for maternity in place; support neonates as no specific role which required SoC; Human Tissue Authority (HTA) undertook review including Mortuary services – July 2026	Ensure compassionate, personalised and high-quality care is provided to families following the death of a baby or mother. This includes bereavement support, clear communication, emotional and psychological care, and access to specialist services, while treating families with dignity, respect and sensitivity throughout their bereavement journey.	Senior Team	CLOSED

Maternity Overview

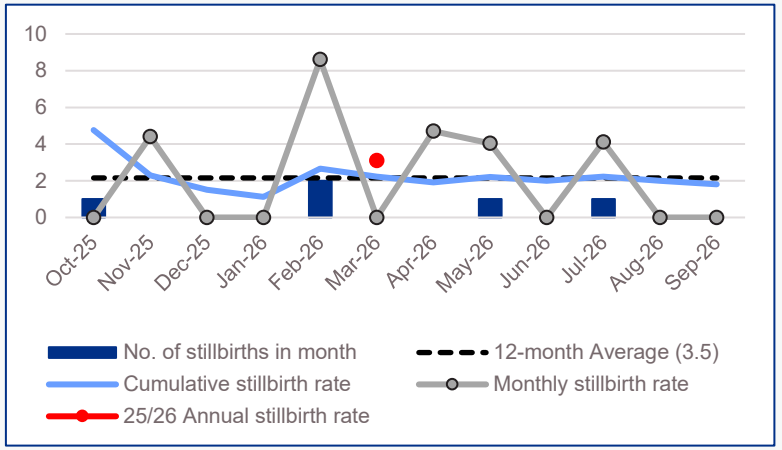
Data is taken from our Maternity dashboard, MBRRACE-UK and BI Portal

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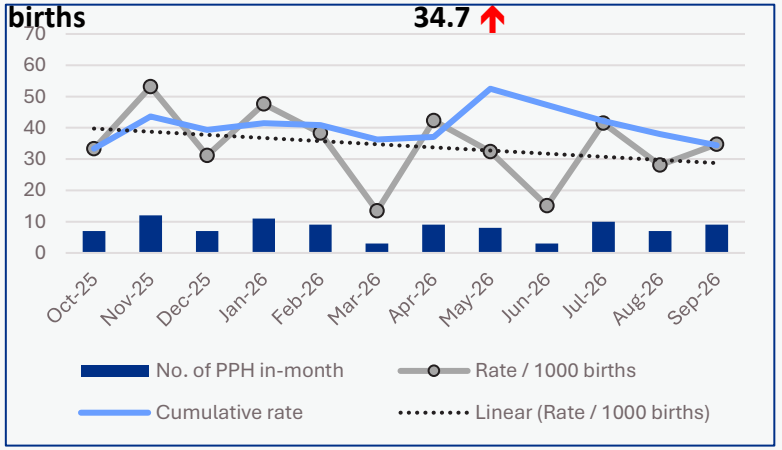
Latest month Sept 2026
Number of births **259**



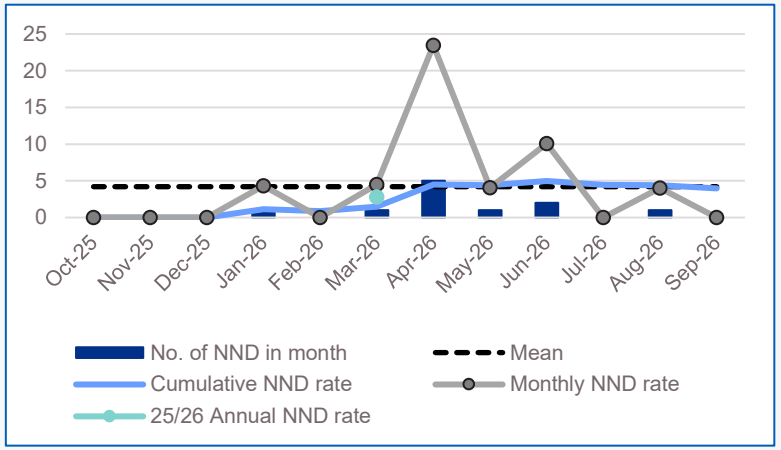
Latest month Sept 2026
No. of stillbirths **0**
Cumulative rate / 1000 **2.1**



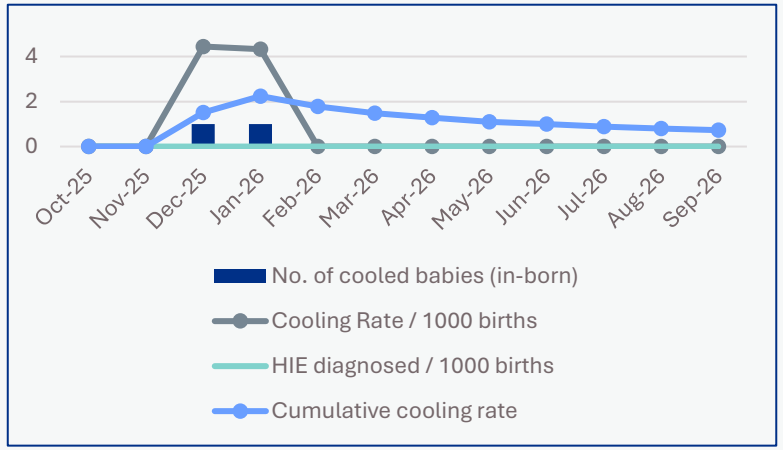
Latest month Sep 2026
PPH >1500ml /1000 births **34.7**



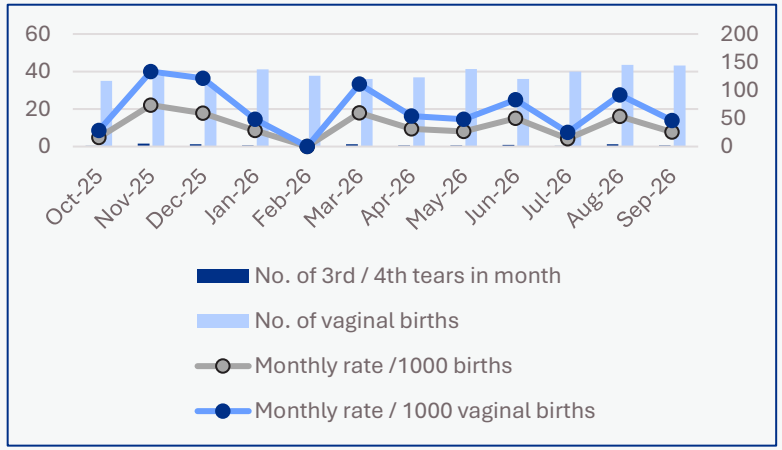
Latest month Sept 2026
No. of neonatal deaths **0**
Cumulative rate / 1000 **3.9**



Latest month Sept 2026
HIE rate/1000 **0.0** =



Latest month Aug 2026
3&4 degree tears /1000 vaginal births **13.8**



Reported incidents and thematic learning from investigations

Reported incidents from SPEN,PMRT/ MNSI/ MOSS/ PSIRF findings / National reports

Incident type	Incident	What actions have been implemented	Family view / DoC	External Reviewer
No reportable cases				

No MOSS Alerts for September 2026 - Drill performed as per MIS Year 8 requirements and reporting to Board of Directors and Quality Committee. The maternity service maintains compliance with national MOSS surveillance requirements, with no triggers necessitating a Critical Safety Check

Drill Completion (MIS Year 8 Requirement):-

As part of national Maternity Incentive Scheme (MIS) Year 8, a MOSS-related safety drill/exercise has been completed.

Drill Objectives:-

- Test recognition of a potential safety signal
- Assess escalation pathways
- Validate communication across teams
- Demonstrate situational awareness and leadership response

Outcome:-

✅ Drill successfully completed within required timeframe

✅ Staff demonstrated appropriate escalation and response

✅ Systems and processes validated as effective

Perinatal Loss data

There were 0 stillbirths in September and 0 neonatal deaths.

Learning from PMRT reviews

1 stillbirth was discussed at PMRT MDT panel (including external Midwifery, Neonatal & Obstetric representation) in September:

Case type	Grading	Learning Themes	Actions
Stillbirth 34+6	**AN care: B**	CO reading not completed at every appointment due to lack of equipment	Outpatient Matron to ensure all Community midwives have access to a working CO monitor, and that monitoring is carried out at each antenatal contact as per guideline.
	Care after baby died: C	Mother felt that the midwives who diagnosed IUD lacked compassion and asked that they were not involved in her care during or after birth - unfortunately this request was not upheld.	Feedback to be shared with the midwives individually, and general learning about respecting families' wishes regarding who they wish to be involved in their care to be shared with the hospital team.

Grading criteria

A	No care issues identified
B	Care issues identified which the panel considered would have made no difference to the outcome
C	Care issues identified which the panel considered MAY have made a difference to the outcome
D	Care issues identified which the panel considered were LIKELY to have made a difference to the outcome

Reported incidents and thematic learning from investigations

Learning From incidents

Summary of learning and actions from MNSI and NHS EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports

Theme	What learning and actions have been prioritised	Outcome / Learning /Actions/ Improvements	What impact have earlier actions had	What support do you need from executive board
Obstetric incidents are reviewed weekly, including PPH >1500ml, 3rd degree tears, shoulder dystocia, with monitoring of themes and actions.	Themes identified in September: interpretation of CTG – reviews found occasions where CTGs were over-classified as pathological, thus leading to potentially unnecessary interventions.	• The new Fetal Monitoring Lead Consultant is reviewing teaching and considering whether more frequent training would be beneficial • PPH was managed very well overall, with excellent documentation.		N/A
Ward-related incidents are also reviewed weekly. A theme has been identified regarding communication and documentation during discharge, related to completion of SBARs during admission	Sharing the learning	• Learning has been shared via safety huddles for both maternity ward and delivery suite and the issues will continue to be monitored through incident reviews.		N/A

Perinatal Mortality Rate

The graphs above demonstrate how the Trust is performing against the national safety ambition.

All stillbirths, neonatal deaths are subject to both internal and external investigations

Ref. No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
1	PPH's >1500mls	All reviewed and CIF and no themes/trends noted	JKL / Obstetric Labour Ward Lead	Ongoing

Theme	Issue	Actions	Responsible (role)	By when
1	3/4th Degree Tears	Outlier of the national average; QI project underway including training; since commenced consistent reduction noted since March 2026	JKL/ Pelvic Health Lead	Updated as QI project ongoing to 31/12/2026

Maternity and Newborn Safety Investigation Programme (MNSI)

Investigation progress update:--

No new referrals made in September 2026
No active cases
Historic case (2022) – Final received and approved

MNSI Ref	Reason for referral	Date of confirmed investigation	Family Informed	Duty of candour complete Y/N	Early notification, external notifications and other investigations

Learning from MNSI Investigations :-

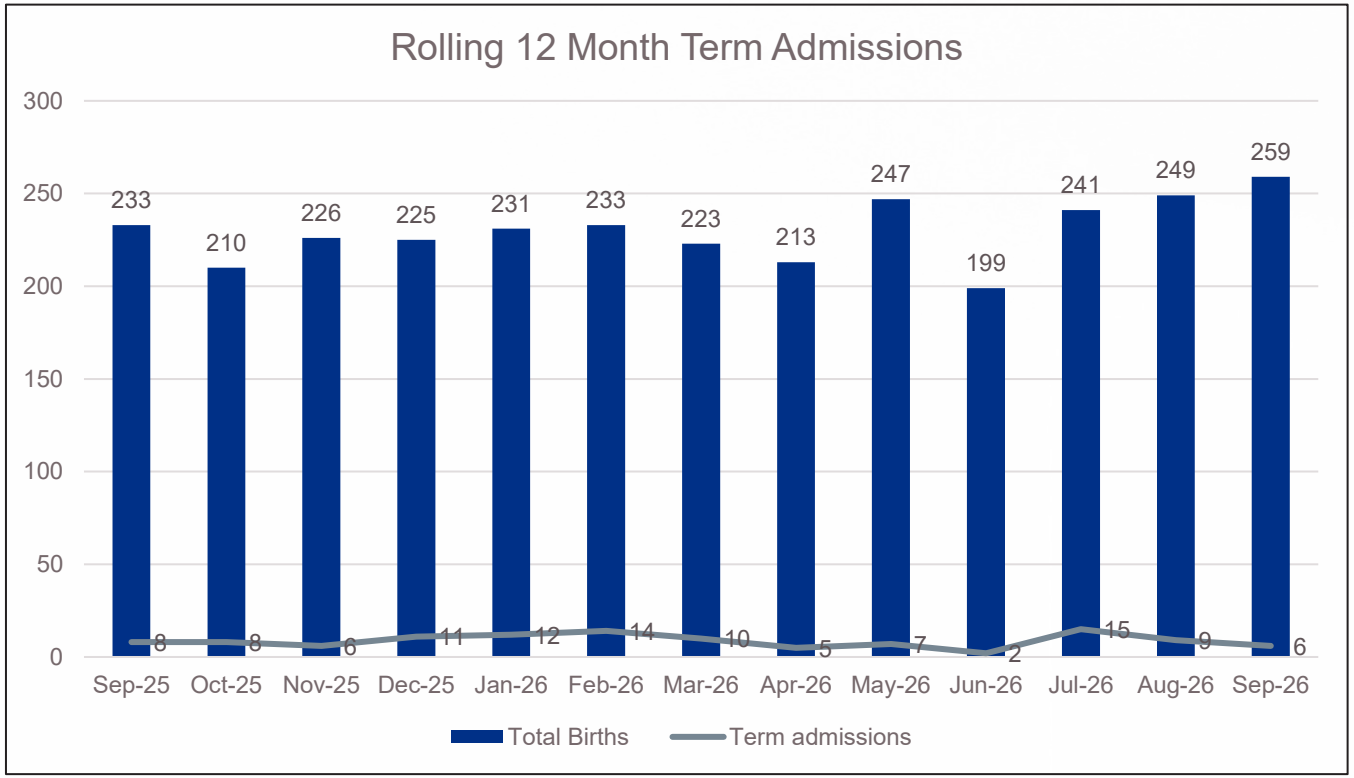
One final MNSI reports was received in September 2026, Nil new identified

Theme	Issue	Actions	Responsible (role)	By when
Historic MNSI case	Recommendations identified and gap analysis completed if remain relevant and potential audits to ensure embedded; action plan and evidence underway	It is recommended to the Trust that the timing of routine antenatal care is delivered in line with local guidance to support abdominal measurement and accurate assessment of fetal growth. It is recommended to the Trust that guidance is written to support continuity teams to document mobile telephone call and text contacts with mothers to support safe care planning. It is recommended that the Trust review how clinicians document and conclude clinical conversations when concerns are raised during face-to-face, telephone, or community maternity contacts.	Q&S Lead for Maternity	31/10/2026

Avoiding Term Admissions Into NICU (ATAIN)

Wirral University Teaching Hospital NHS Foundation Trust

There were 6 term babies admitted to NICU in September 2026 – that's 2.3% of babies born at WUTH. Term admissions are babies born at 37 weeks or after, and who are admitted to the neonatal unit from the birth room or the postnatal ward. Babies who were born elsewhere and transferred to WUTH for ongoing NICU care, and babies who have been discharged and return to be admitted to the children's ward, are not included in the Term admission data. This is to focus attention on keeping mothers and babies together following birth wherever possible. All term admissions are reviewed in a weekly MDT meeting including representation from neonatal unit, obstetrics, and midwifery.



- 6 Term babies born at WUTH were admitted to NICU in August. 5 were unavoidable, with 1 felt to have been potentially avoidable:

Reasons for admission		Themes
4	Respiratory	Thermoregulation
2	Congenital anomaly	None identified

- WUTH continues to maintain low rates of Term Admissions compared to other Trusts in the region, as per the Neonatal Network separation report.

Maternity and Neonatal Patient Safety Incidents (PSII's)

Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region.

There were no Patient Safety Investigation Incidents (PSII's) declared in September 2026 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there is one active case.

There were no Patient Safety Investigation Incidents (PSII's) declared in September 2026 for neonatal services.

Ref No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when

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Coroners' reports

Outstanding report due

There are no outstanding reports due for WUTH maternity service

Identifier	Date listed	Summary

Regulation 28 report issued

There are no regulation 29 reports issued for WUTH maternity service

Identifier	Action required	Progress	Responsible (role)	By when

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Review of NHS Resolution Scorecard

A quarterly review of Trust's claims scorecard alongside incident and complaint data should be discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes identified from Claims Scorecard (10 years)	Themes identified from Complaints (current/most recent)
15 claims, incident date range 2017-2023, estimated value £59.7m Themes recurring: Intrapartum incidents Brain injury (neonate), Psychiatric/Psychological damage (Mother) Stillbirth/neonatal death	4 claims, incident date range 2015-2016, Recurring themes: • Immobility relating to epidural continuous monitoring • Wet Inco pads • Scarring • Sacrum Following tissue viability QI projects, no claims seen since 2016
Themes identified from Maternity Patient Safety Incidents	**Themes identified from other sources (e.g. staff feedback, family feedback, FSU etc)**
No triangulated themes between claims and safety metrics Separate Maternity PSIRF Plan required Mandatory PROMPT training to be in line with MIS Year 6	Quicker response rate to hot debriefs

Themes identified	Actions	Responsible	By when
Maternity PSIRF Plan required	To be drafted and approved at BoD	JKL	Completed
Impacted Fetal Head and brain injury nationally a cause of claims	Emergency completed in 2025 supported by ABC initiative; to ensure any new doctors are training in 2026; review of MIS Year 8 in August 2026 by external team	JKL	30/11/2026

Claims Analysis

New Claims received for Maternity services in September:	0
Maternity claims closed and settled in September:	0
Claims requiring feedback from the Division:	None
Inquests:	None

New Claims:
None
Settled Claims:
None

Perinatal Improvement Plan

Progress updates from National reports / MNIST action plans / CQC / Thematic review action plans as required.

Include actions relating to a local improvement plan utilising the patient safety incident response framework (PSIRF) and ensure they are reflected in the minutes of Board, ICB, Local and regional learning systems.

Escalations	Support required	Progress from previous escalations
Gap Analysis completed of Ockenden AMOS 2026	To be noted and included in appendices for discussion	Progressing action plan
Maternity Care Bundle toolkit completed	Awaiting further guidance from ICB on support to implement	50% compliance, LMNS supporting Trust to implement by 31/03/2027
Postnatal Toolkit	In progress	Baseline completed
Triage Specification	Completed and presented to BoD September 2026	NHSE have provided opportunity to submit revised version with costings by December 2026

Performance Metrics

Service Suspensions

Number of times services were suspended

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Obstetric unit	0	0	0	0	0	0						
Midwifery led unit	0	0	0	0	0	0						
Homebirth service	0	0	1	0	0	0						
Neonatal unit (internal)	0	0	0	0	0	0						
Neonatal unit (external)	0	0	0	1	0	0						

Women experiencing delays to induction >24hrs

Number of women whose commencement of induction of labour (IOL) is delayed >24 hours from point of admission for induction (from home or ward)

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Delays to induction >24hrs	0	1	6	6	2	12						

Women experiencing delays to elective caesarean section >24hrs

Number of women scheduled for an elective caesarean section who had this delayed by more than 24hrs

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Delays to elective c/section >24 hours	-	-	2	1	2	2						

Home births in the last quarter April – June 2026

No. home births / BBA	No. birthing at home against medical advice	No. of births at home where there is a multi-disciplinary plan in place	No. transferred into acute unit	No. of transfers with a delay
8	3	3	3	0

Learning and action taken from incident review and audits

Learning	Action	Progress on actions / impact
• Importance of initial risk assessment on arrival at home/ Seacombe BC • SBAR for delivery suite handover		

	Approved by	Date approved
Operational guideline inclusive of midwifery, obstetrics, neonates and ED	LWSG	Oct 2024
Guideline on birthing against medical advice	LWSG	Feb 2026

Triage

Metric	Month 1 - July 2026	Month 2 – August 2026	Month 3 – September 2026
1. % of women who have the initial assessment performed within 15 minutes	96%	96%	91%
2. % of women who took own discharge prior to medical review	0.9%	0.8%	Awaiting data
3. Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency.			
4. a) Proportion of women who experience a delay in assessment, review or onward care b) proportion of these where there is an outcome recorded.			
5. Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback			
6. Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage: % of shifts affected by re-deployment			

Improvement actions	Progress	Impact	Responsible
Metrics 1-2 are currently collated	Monthly statistics collated and are within the target metric	Positive impact on patient quality, safety and experience	DoM / ANP Triage Lead
Metrics 3 – 6	Data metrics to be collected within the new published triage specification framework	Standardised national approach	DoM / ANP Triage Lead

6. Training compliance – September 2026

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs & infant feeding team	Anaesthetists- Consultants/rotational	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle (Annually covered in PROMPT)	97%	93% Cons 47% Dr				
Fetal monitoring and surveillance	94%	86% Cons 50% Dr				
Multi professional Maternity Emergencies training	97%	93% Cons 47% Dr	95%	96% Cons 18% Rot An		
Equality/ equity and personalised care (3-yr Programme)	97%	93% Cons 47% Dr	95%	96% Cons 18% Rot An		
Care during labour and immediate post-natal period (3-yr programme)	97%	93% Cons 47% Dr	95%	96% Cons 18% Rot An		
Neonatal resus training	97%	93% Cons 47% Dr	95%	96% Cons 18% Rot An		
% QIS						

Training compliance- 30th September 2026

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training. *Refer to training report for additional information*

MIS Checkpoint Date 1: _____1st August -Met MIS Checkpoint Date 2: 30 November 2026 met/not met

	Midwives	Obstetricians		MSWs	Anaesthetists Consultants/ Rotational	Neonatal medical		Neonatal nursing (inc. ANNP)
		Consultants	Rotational Med Dr			Consultants	Other	
Obstetric emergency training (PROMPT)	97%	93%	47%	95%	96%/18%			
Fetal monitoring and surveillance	94%	86%	50%					
Neonatal resus training (including assessment)	97%	93%	47%	95%	96%/18%			
Mandatory & Stat training						X x%	X X%	X X%
% QIS								X X%

	Date & location of last simulation	MDT teams involved	Themes/learning identified & actions taken
Hospital In situ multi-professional perinatal emergencies simulations	w/c 23rd November		
Community In situ multi-professional perinatal emergencies simulations	4th September	Highfield Midwife, CofC Midwives & Paramedics	Learning from AAR.

Staffing Vacancy rates

Staff group	Vacancy rate
Midwifery	Perm vacancy: 4.52wte – recruitment in progress and appointments made 10.31wte vacancies due to maternity leave – recruited into and due to start Sept 2026
Midwife Support workers	0.5wte hours out to advert Vacancy rate <1%
Obstetric consultants **Resident doctors**	Establishment: 14.5, 1wte vacancy = 6.5% Establishment 7.6wte resident doctor x 2 wte trust doctors with, 1wte vacancy and x 1 on adjusted duties = 10% (Obs and Gynae)
Neonatal Nurses	1.6wte Band 5 Neonatal Nurse and 1.6wte Band 6 Neonatal Nurse – interviews scheduled
ANNP	0% vacancy rate
Neonatology consultants **Resident doctors**	Fully established to BAPM and no current vacancies 0% Tier 2: 1.5WTE vacancies (ANNPS filling approx. 0.5WTE to reduce vacancy gap from 2 to 1.5) Tier 1: 0.8 WTE vacancy (recent mat leave vacancy) (ANNPs filling 2WTE rota slots but also some sickness in ANNP team
Obstetric anaesthetists **Resident doctors**	Data requested

Risks	Mitigations	Escalations
Speicalist posts identified required for a Level III NNU to meet BAPM compliance	• Support from internal resources where possible	Escalation to BoD and an action place will be presented in Sept 2026 for consideration and BoD approval
Neonatal Matron also is specialist for governance (2 days) and identified gap in nursing governance	• W&C central team to offer support • Consultant lead identified	On risk register and statement of case being prepared
Midwifery vacancy increase dramatically due to maternity leave from approx. < 2% to >10%	• Escalation processes followed • All shifts out to NHSP • Posts out to advert and recruitment processes underway	Will be reliant on NQM in September 2026 Escalation to the Chief Nurse and NHSP rates reviewed with enhancements applies to Band 6 eligible midwives to maintain top of band rate

Safety Champions feedback

Feedback raised by staff	Feedback raised by staff
• Staff feedback positive about new refurbished environment and how space gives them the ability to care for families promoting better experience • Learning and development opportunities; shared learning and access to senior staff • Discussed the Trisomy 21 workstreams and impact on patients/families • Noted temporary air conditioning unit, temperature well controlled • IPC - CPE screening being commenced and ramifications to be explored • Discussion re: cameras in cots, implications and impact on families/staff	• 2 midwives allocated • Telephone triage paused until establishment /recruitment can support • With no eyes on waiting room mitigation suggested was a MSW to undertake rounding where appropriate • Suggestion to give women/birthing people a RAG rated card and expected time to be seen to manage expectations
• Feedback was positive, delivery suite had high acuity; shift leader demonstrated excellent oversight and management • Discussed compliance with K2 CTG package and staff outstanding as final deadline was 30/09/2026	• Over 700 vaccinations given in the month of September 2026 • One patient record discussed the significant benefits
Feedback raised by service users	**Action and progress**
Delays continue in doctor reviews within triage; discussed option of additional AMPs to support as an alternative; medical staffing levels suboptimal	Continue to report via incident reporting; consider AMP's; introduce telephone triage and statement of case require for additional medic to support core hours
Additional safety champions intelligence	**Action and progress**
Testing how staff receive learning communication	Post all communications with options and continue to seek feedback

Escalations	Support required	Progress from previous escalations

Themes and progress with Cultural surveys or equivalent

Theme	Progress	Support requirements
Staff Survey – Three Priority Themes include:- - Compassion and inclusivity - Health and well-being safety at work - Sharing learning from incidents	Staff Feedback session held in April 2026 to:- Identify team Champions for each of the 3 priority areas to lead the deliverables through a teamwork and ownership approach. Champions and senior leadership team to share staff survey action plan widely and arrange staff check in to sense check actions are reflective of staff survey results workshop. Action plan developed and will be monitored via monthly Divisional In Touch	Trust approach to the consistent message re: Racism and zero tolerance
Neonatal Culture	Group session and 1-2-1's with consultants, mediation being arranged and team charter exercise Extended session with Senior Nurses held in July 2026 Report produced by OD – shared and action plan developed in a 3-phase approach	OD continued support Executive and BoD oversight of progress
Perinatal Leadership Programme	Signed up to cohort and senior leadership team identified to commit and undertake programme First meeting held with NHSE and programme to commence September 2026	

Additional Service User feedback

Debriefs / Birth Afterthoughts	Action and progress
Birth outside of guidance in the community setting.	SoP and monthly MDT introduced in March 2026 to support both women and staff when requested to birth outside of guidance
Introduction of a toolkit	Monthly toolkit – slide 27 – 31 provides BOD oversight of feedback being recieved
Friends and Family test	**Action and progress**
Continue to increase maternity response rates in the maternity Friends and Family Test (FFT) response rate. PREM to be introduced	A targeted approach has seen a steady increase seen within maternity FFT response rates with ongoing monitoring demonstrating improvement; reflective and overall increase in Reponses Very Good and Good; Introduction of Posters. Ward folders and kiosk have demonstrated impact.
Areas of focus include: • Waiting times in Antenatal Clinic, • Not enough seating and chairs and unconformable when experiencing log waits • Thermoregulation during the heatwave days	Antenatal clinic workflow requires review and real time flow monitoring to support escalation and busy times A full audit of seating capacity and confirm has been undertaken in the waiting areas; funding being explored to support an order to replace and increase number of chairs Temperature has been reviewed and heaters have been ordered
Complaints and Compliments	**Action and progress**
Themes relating to delays in pain relief being received both on labour ward for epidurals and routine medications on the maternity ward.	In response the maternity team have escalated inconsistencies to the anaesthetic team, and an audit is underway to establish the reasons for delay. On the postnatal ward, self medication has been designed for implementation, supported by the Ward Manager undertaking the prescriber's course to support Doctor delays/ward rounds; In addition, ward staffing has been increased on the day shift to 4 midwives from 22 to support acuity and complexity

MNVP MONTHLY UPDATE FOR TRUST ASSURANCE

Introducing the Voice & Safety Intelligence Toolkit

This toolkit has been locally designed by Wirral MNVP to create a clear, consistent audit trail of our engagement, intelligence, escalation and impact. It is not currently a national or regional toolkit; however, we hope the approach may be shared and adopted more widely by other MNVP leads as a model of good practice.

33	94	9	11	4
voice log records	survey submissions / nominations	priority signals	actions logged	actions closed and validated

How MNVP and Trust can use it together

The toolkit has been designed to create a tangible, consistent and easily auditable dataset that evidences MNVP workstreams, service-user intelligence and partnership working with the Trust. It provides a clear record of what we have heard, how this has been escalated or shared, and what action or learning has followed.

01

MNVP captures

Survey themes, engagement voices, casework and positive practice.

02

MNVP codes

Pathway, theme, signal level, permission and whether action is needed.

03

Trust triangulates

Compare with incidents, complaints, PALS, audit and clinical intelligence.

04

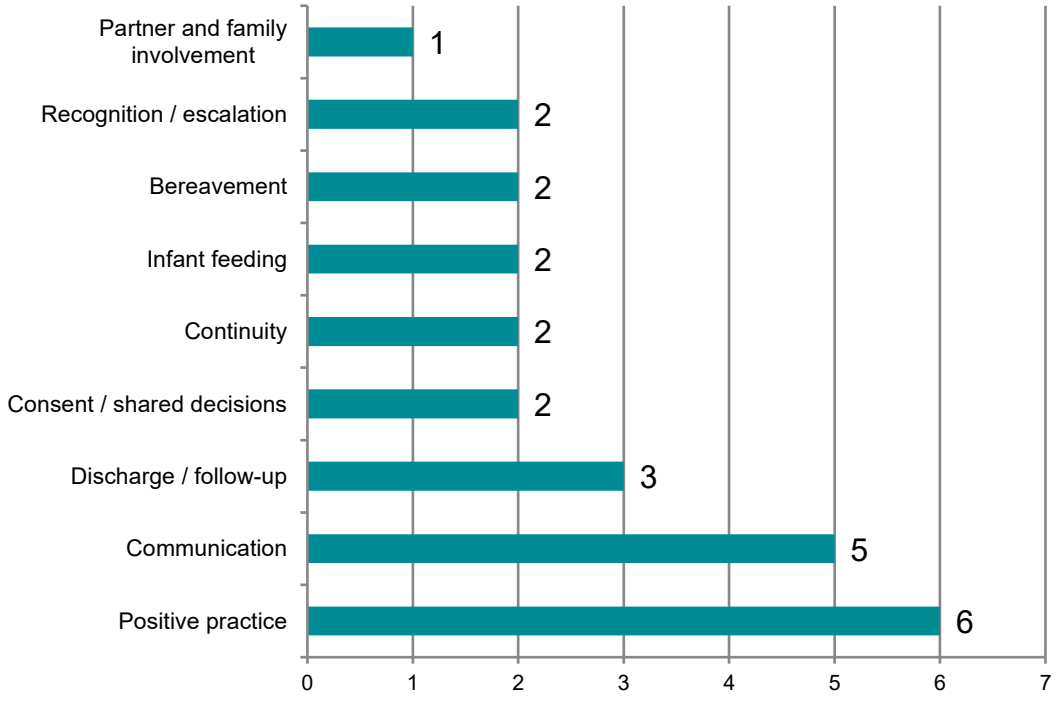
Both close loop

Agree owner, evidence, update to families and validation route.

For Trust Board assurance

The MNVP Voice and Safety Toolkit provides a structured record of service-user feedback, emerging themes, Trust responses and resulting actions. Used alongside existing quality and safety data, it gives Trust Board an additional source of independent service-user assurance and provides a clear evidence trail for LMNS, ICB and NHS England that family voice is being heard, acted upon and embedded within governance and improvement.

What we are seeing and hearing



Repeated themes in the voice log

Positive practice

Families repeatedly describe compassion, clear explanations, advocacy and being made to feel safe.

Postnatal responsiveness

Repeated improvement signals relate to communication, discharge/recovery information and pain relief.

Infant feeding

Themes include antenatal preparation, consistency of advice on the ward, timely specialist help and emotionally supportive care when breastfeeding is difficult.

Bereavement / debrief

Priority signals relate to compassionate communication, memory-making, and psychological safety when families seek answers.

Recent in-person engagement

Birkenhead Park Visitor Centre

12 AUGUST

1	**Continuity**	Different community midwife at each appointment; delayed GTT referral; GD identified at 39 weeks.
2	**Infant feeding**	Vietnamese service user described latch difficulties, engorgement, inability to express and ongoing guilt.
3	**Debrief dignity**	Reported inappropriate communication at a debrief; escalated to senior maternity leadership and closed after staff feedback.

Assurance use: watch/priority signals to triangulate with community midwifery, infant-feeding and debrief governance routes.

Bromborough Family Hub

19 AUGUST

1	**Positive practice**	New parents overwhelmingly described friendly staff and feeling safe in their care.
2	**Neonatal care**	Parents described the neonatal unit as excellent, with staff helping them feel like parents rather than witnesses.
3	**Postnatal ward**	Some concerns raised around delays in pain relief, echoing a theme already seen in the toolkit.

Assurance use: protect and spread neonatal positive practice while continuing to monitor postnatal ward responsiveness.

Updates and Asks

Maternity 15 Steps – scheduled for November 2026
The next Maternity 15 Steps visit is due within the coming months. I would like to agree a date with the Trust so that recruitment and advertising for service-user volunteers can begin in good time

Safe sleep following neonatal discharge
Regional soft intelligence has raised concern following a small number of serious incidents after neonatal discharge, including infant deaths and significant harm, where safe-sleep practice has been identified as a potential area for consideration. This has already been escalated locally through FiCare discussions

Cannabis use for nausea in pregnancy – emerging soft intelligence
MNVP has become aware of social-media discussions recommending cannabis as a remedy for nausea and morning sickness in pregnancy. In addition, multiple parents on the neonatal unit have disclosed using cannabis during pregnancy for this purpose. While this does not provide evidence of prevalence, it suggests that misinformation circulating online may be influencing real-world health behaviours locally.

Saving Babies Lives v3.2

	Compliance / progress / action	Responsible (role)	By when
EI 1: Smoking in pregnancy	100% Compliant – no current action plan		
EI 2: Fetal growth	100% Compliant – no current action plan		
EI 3: Reduced fetal movement	100% Compliant – no current action plan		
EI 4: Fetal monitoring	100% Compliant – no current action plan		
EI 5: Pre-term births	100% Compliant -– no current action plan		
EI 6: diabetes in pregnancy	100% Compliant – no current action plan		

What is going well	Sustained 100% compliance; internal audits monitored quarterly
What is of concern	Nil of note
What are the top contributors for under/over-achievement	Commitment to each element within the specialist teams to implement improvements and sustain

Board report summary: Implementation of the Maternal Care Bundle

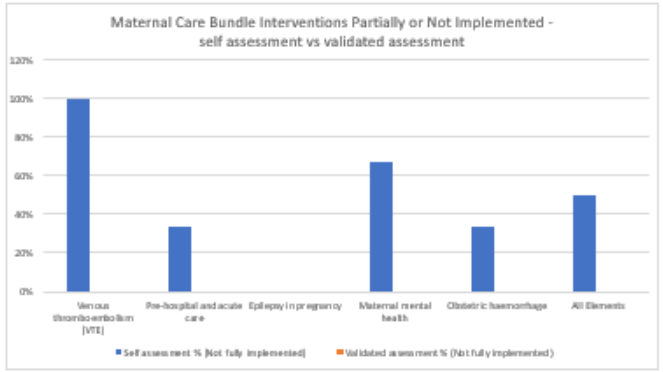
Implementation Report

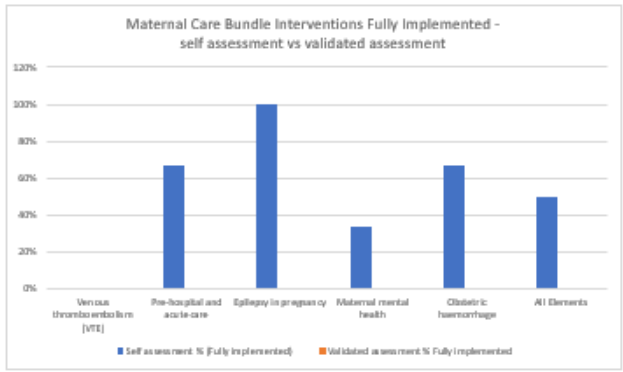
Trust	
Date of Report	
Trust Accountable Officer	
Trust Board Assessor	

Implementation Grading

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Not implemented	0%		0%	No
Element 2	Pre-hospital and acute care	Partially implemented	67%		0%	No
Element 3	Epilepsy in pregnancy	Fully implemented	100%		0%	No
Element 4	Maternal mental health	Partially implemented	33%		0%	No
Element 5	Obstetric haemorrhage	Partially implemented	67%		0%	No
All Elements	TOTAL	Partially implemented	50%		0%	*If yes, please refer to 'Board summary - action plans' worksheet for details.





Progress to achieve NHS Resolution, Maternity Incentive Scheme Year 8, 6 Safety Actions

	Assessment of compliance (met/partially met/not met)	Is there clear evidence to support compliance	Gaps requiring action
A – Workforce and Capacity	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Neonatal workforce required approved action plan
B - Training	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Nil of note; assurance from August 26 visit
C - Learning from reviews and investigations	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Nil of note
D - Service User Voice and Equity	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Nil of note
E - Care Bundles	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Gap analysis underway for both toolkits
F - Board Oversight, Governance, Culture and Leadership	In progress and working towards compliance with Board of Directors oversight – partially met	All evidence being reviewed and uploaded	Fully embedded

What is going well	Evidence collation for safety actions
What is of concern	Workforce for Neonates – will require BoD approval for approved action plan
What are the top contributors for under/over-achievement	Delivery of good high-quality care and oversight by leadership team and BoD

Data Measures – Perinatal Quality Oversight Tool

Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
Findings of review of all perinatal deaths using the real time data monitoring tool													
Findings of review of all cases eligible for referral to MNSI													
The number of patient safety incidents logged and what actions are being taken													
Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training													
Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively													
Service user voice feedback – themes													
Staff feedback from frontline champion and walk-abouts – themes													
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust													
Coroner Reg 28 made directly to Trust													
Progress in achievement of CNST MIS Year 8 6 safety actions (Multiple slides for discussion with risks identified relating to workforce)													
Proportion of midwives responding with ‘Agree’ or ‘Strongly Agree’ on whether they would recommend their trust as a place to work or receive treatment	Reported annually: Completed as part of staff survey												
Proportion of speciality trainees in Obstetrics & Gynaecology responding with ‘Excellent’ or ‘Good’ on how they would rate the quality of clinical supervision out of hours	Reported annually; Due 2026												

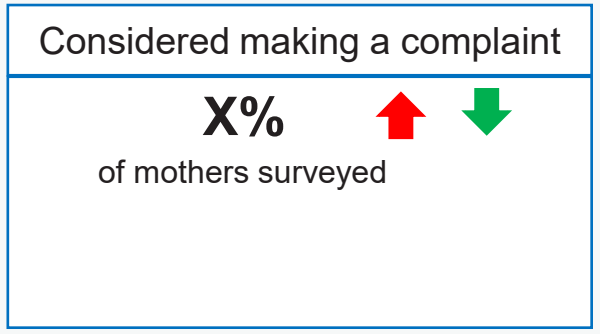
together we will
...deliver the best quality and safest care to the communities we serve

9.1 CQC national maternity survey action plan 2026

Theme	Progress	Support requirements/Timescales
Parents reported gaps in relevant feeding information during pregnancy and insufficient help and advice about feeding in the first 4 weeks after birth	MNVP gathered targeted parent feedback on infant feeding information and support across antenatal and early postnatal pathways, and produce a themed insight report with co-produced recommendations	Engagement completed and report shared by May **2026**
Some parents did not feel they received appropriate advice or support when contacting a midwife or the hospital at the start of labour	MNVP collection of qualitative feedback on experiences of contacting maternity services in early labour, focusing on communication, reassurance and responsiveness, and present findings to the Trust	Findings shared with Maternity staff in **February 2026**
Parents reported not always receiving adequate information about physical recovery after birth once at home	MNVP reviewing existing postnatal recovery information with parents and co-produce a summary of "what parents say they needed to know" to inform service improvements	Recommendations submitted by **April 2026**
Some parents felt midwives or doctors were not always aware of their medical history during antenatal care	MNVP gathering parent examples where lack of continuity or repeated history-taking impacted experience, and share themed feedback with relevant Trust leads	Feedback shared by **May 2026**
Parents need to see how feedback leads to change	MNVP to gather parent examples where lack of continuity or repeated history-taking impacted experience, and share themed feedback with relevant Trust leads	Quarterly review throughout **2025–26**

CQC survey: 2025 survey results due and will be reported at next BoD

Percentage of mothers that considered making a complaint during their maternity care journey



4.0 Safety Improvement Plan

Overall position:

The maternity service continues to progress against its Safety Improvement Plan, with actions aligned to national priorities including Maternity Safety, Ockenden, AMOS, East Kent, and MOSS requirements.

Clinical Governance Strengthening — Governance structures have been refreshed, with clearer escalation routes and strengthened oversight through the Maternity Governance Group. Monthly thematic reviews continue to inform learning and improvement.

Workforce and Culture — Recruitment to key posts remains stable. Safety huddles and multidisciplinary training compliance remain above target. Staff feedback indicates improved psychological safety and confidence in escalation.

Intrapartum Safety — CTG training compliance remains high, and the service continues to embed the national Fetal Monitoring Programme. No MOSS signals were generated this period, and all intrapartum indicators remain within expected limits.

Learning from Incidents — All incidents graded as moderate or above have undergone timely review. Themes continue to focus on communication, documentation, and situational awareness. Resulting actions have been embedded into the safety huddle framework.

Service User Experience — Feedback from MVP engagement shows outstanding confidence in antenatal communication and continuity of carer where available. Work continues to strengthen personalised care planning

Recommendation

The Board of Directors/Quality Committee is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

Overview of progress on MIS year 8 safety action requirements

NHS Resolution

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	0	6	1	7
B	0	0	5	0	0	5
C	0	0	1	3	2	6
D	0	0	0	2	0	2
E	0	0	0	3	0	3
F	0	0	0	3	1	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	**0**	**0**	**6**	**17**	**4**	

Maternity Incentive Scheme Year 8

Mid-year assurance visit feedback report

Wirral University Teaching Hospital NHS Foundation Trust | Safety Action B: Training

Review date	25 August 2026
Scope	Supportive review of progress against Safety Action B only

Overall, the review team found the Trust to have a strong, well-organised and highly engaging approach to maternity training. The training faculty, narrative design of PROMPT, responsiveness to local learning and detailed compliance monitoring were significant strengths. The principal area requiring completion was delivery and follow-up of the two current-period in situ simulations, with further assurance also needed on practical neonatal resuscitation capability assessment.

1. Purpose and approach

The visit formed part of the supportive and developmental mid-year assurance review introduced for MIS Year 8. It provided an opportunity to reflect on progress, explore how implementation is working in practice, identify strengths and consider opportunities for further development. The visit did not form part of the formal assessment of MIS compliance, which remains subject to the year-end process.

This report brings together the reviewers' feedback from the discussion, presentation and evidence made available during the visit. It focuses on Safety Action B and should be read as constructive feedback to support continued delivery through the remainder of the MIS year.

2. Overall feedback

The Trust was welcoming and had prepared thoroughly. Reviewers were provided with a comprehensive evidence pack containing the training-needs analysis, PROMPT materials, fetal surveillance resources, monthly compliance reports, professional-group breakdowns, trend information and supporting governance material. The presentation was clear and data-rich, and the team demonstrated pride in its work alongside openness about the areas still to be completed.

The training faculty was an outstanding feature of the visit. The team appeared knowledgeable, enthusiastic and closely connected, with clear year-round planning and a strong commitment to developing training that is clinically relevant, interactive and responsive to learning. Training content was informed by national requirements, local incidents, governance themes, faculty review and staff feedback, and could be adjusted during the year rather than waiting for the next annual cycle.

The visit included senior maternity and operational leaders, training faculty members, governance and continuity leads, obstetric input and the MNVP. No neonatal or anaesthetic representative participated, which limited the depth of assurance regarding neonatal capability assessment and the wider neonatal contribution. The Trust also openly described challenges in securing consistent obstetric capacity for development activity, although reviewers saw clear evidence that obstetric colleagues contribute to training.

Governance and compliance-monitoring arrangements were clearly described. Reporting was broken down by professional group and training requirement, using monthly data and SPC charts rather than a single aggregated percentage. Quarterly MIS reporting, more detailed Quality Committee scrutiny and senior executive oversight provided Board visibility. The Trust was candid that releasing staff for training remains difficult where sufficient protected training headroom is not reflected in the funded establishment.

3. Obstetric emergency training

The Trust demonstrated a well-established rolling programme of multidisciplinary obstetric emergency training. The programme used the continuing journeys of two fictional women to connect antenatal, community, intrapartum and postnatal care. This allowed emergencies to be considered alongside personalised care, social circumstances, care outside guidance, communication, shared decision-making, escalation and human factors, rather than being taught as isolated technical stations.

The practical and taught elements were linked through the same patient journeys, creating continuity across the day. A varied range of methods was used, including scenarios, videos, clinical skills work, group discussion and true-or-false activities. Anaesthetists attended the emergency-scenario element, and wider colleagues including critical care, theatres, the ambulance service, students and other relevant teams were invited to participate where possible.

The programme was clearly responsive to learning. Local incidents, governance intelligence, faculty reflection, national requirements and staff feedback were reviewed collectively and could be incorporated during the training year. Impacted fetal head had been introduced following participation as an ABC pilot site, with refresher activity planned. Learning relating to a velamentous cord had also been incorporated. The perineal-protection example demonstrated how training had been introduced, reviewed against third- and fourth-degree tear rates and refined when practice and outcomes indicated a need for further intervention.

The MNVP lead was clearly included as a valued member of the wider team, and service-user feedback could inform training through governance routes. The faculty was receptive to further direct MNVP involvement in designing or observing training, subject to capacity.

Opportunities to strengthen this work

- Continue to evaluate the effect of training on practice and outcomes, linking specific local learning or incidents to changes in content and subsequent impact.
- Maintain and, where feasible, broaden direct obstetric and partner-service participation in faculty review, training delivery and future assurance discussions.
- Continue developing scenarios outside the main labour ward environment so that staff can rehearse escalation and response across community and cross-service pathways.
- Share the patient-journey PROMPT model more widely as an example of an engaging and integrated approach to multidisciplinary training.

4. Neonatal resuscitation training

Neonatal resuscitation was incorporated within PROMPT and practical emergency scenarios, supported by the updated NLS algorithm and faculty members with relevant expertise. The continuing patient-journey approach extended into neonatal care, helping to connect the birth emergency with the response required for the newborn.

The Trust described a clear approach for the Highfield home-birth team. All team members are expected to complete full NLS training, new team members are prioritised, and until trained they may attend births

only as the second practitioner. Targeted confidence-building and simulation activity had also been developed for community, continuity and home-birth staff, recognising the particular risks of working away from immediate hospital support.

Training compliance and outstanding requirements were monitored through the same detailed reporting system used across Safety Action B. However, the visit did not fully establish how every staff member who may act as an unsupervised first attender or primary resuscitator is practically assessed against the basic neonatal airway capability requirements. It was also unclear how an unsuccessful assessment would be managed, whether restrictions or extra supervision would apply, and how capability is maintained between annual sessions. The absence of neonatal representatives limited the review team's ability to test these arrangements directly.

Opportunities to strengthen this work

- Demonstrate how all relevant staff are practically assessed against the applicable neonatal airway capability requirements, rather than relying on attendance alone.
- Document the process for staff who do not initially demonstrate the required capability, including retraining, reassessment, supervision and any temporary restriction of practice.
- Clarify how capability is maintained and supported between annual training sessions.
- Include neonatal clinical and nursing colleagues in future assurance discussions to provide fuller evidence of joint maternity and neonatal ownership.

5. Fetal surveillance training

The Trust demonstrated a structured annual fetal surveillance programme combining underpinning fetal physiology with interpretation, clinical decision-making, communication and escalation. Training was interactive and included scenarios, CTG activities, examples and carefully designed learning resources rather than relying solely on passive or online learning.

The practice-development team worked with the fetal surveillance midwife and obstetric colleagues to develop and review the package. Content was informed through the wider faculty process and could respond to local incidents, regional and national themes and identified learning needs. Formal assessment followed training, with bespoke support available for staff requiring further development.

Compliance was monitored monthly by professional group and requirement, supported by SPC charts showing variation over time. Staff approaching or falling outside compliance could be identified, followed up and booked onto later sessions. The evidence demonstrated strong delivery and monitoring, although reviewers did not verify the exact assessment threshold, the complete process following an unsuccessful assessment or a specific measurable improvement in clinical outcomes attributable to this training.

Opportunities to strengthen this work

- Retain clear assurance on assessment thresholds and the support, reassessment and practice arrangements for staff who do not initially meet the required standard.
- Continue linking local fetal-monitoring incidents and themes explicitly to changes in training content.
- Develop evidence showing how training has influenced clinical decision-making, escalation or outcomes over time.

6. In situ multiprofessional perinatal emergency simulations

The Trust had previous experience of simulation, including evacuation exercises, transfers from maternity triage to theatre and confidence-building work for community, continuity and home-birth teams. The faculty

demonstrated a positive and inclusive approach and recognised that maternity emergencies require coordinated responses across professional and organisational boundaries.

At the date of the visit, neither of the two in situ simulations required during the current MIS reporting period had been completed. A community exercise was scheduled for 3 September 2026 and had been developed with the local ambulance service. A hospital-based simulation was planned for later in the reporting period, although the precise location and format were less developed. Relevant transfer risks involving maternity, the emergency department, neonatology, theatres and the ambulance service were identified as useful areas to test.

Because the current-period exercises had not yet taken place, reviewers could not examine after-action learning, agreed actions, governance reporting, retesting or evidence of system change. The Trust appeared to have credible plans and relevant previous experience, but completion and follow-through remained necessary.

Opportunities to strengthen this work

- Complete both required simulations within the MIS reporting period, with one beginning in a hospital setting and one in a community setting.
- Ensure participation reflects the teams that would respond in practice, including relevant ambulance, emergency department, theatre, neonatal and critical-care colleagues.
- Document the debrief, system learning, agreed actions, owners and timescales, and report these through governance.
- Retest significant changes where appropriate and retain evidence that simulation learning has influenced pathways, equipment, communication or behaviours.

7. Training compliance oversight and governance

The Trust demonstrated particularly strong operational monitoring of training compliance. Monthly reports covered each training requirement and relevant professional group, with staff-level monitoring and SPC charts used to show trends and variation. Reports identified whether required levels had been achieved and sustained, and staff approaching or falling outside compliance could be followed up, booked onto training and updated within ESR. Monthly posters also made the current position visible to staff.

The faculty showed a detailed understanding of where gaps and pressures existed, including rotating doctors, maternity support workers and the operational difficulty of releasing staff from clinical duties. Reporting progressed through maternity and neonatal assurance routes, with quarterly MIS information to the Board and more detailed scrutiny through the Quality Committee chaired by a Non-Executive Director. Dual executive leadership from the Chief Nurse and Chief Medical Officer was described, alongside feedback from Board to staff and additional assurance through Safety Champion walkabouts and spot checks.

The Trust was open about the continuing pressure created when protected training headroom is not built into the funded establishment. This can be particularly difficult for a smaller unit, which requires many of the same specialist functions as a larger service but has less workforce flexibility. The visit did not identify a specific example where Board scrutiny had led to recurrent resource, a staffing-establishment change or another direct intervention to address training-release pressures.

Opportunities to strengthen this work

- Continue using professional-group and trend-based reporting to identify emerging gaps early and support timely intervention.

- Make the Board response to significant compliance or staff-release risk more explicit, including decisions, resource action and follow-up.
- Consider whether the recurrent establishment provides sufficient protected headroom to sustain training requirements and escalate any residual risk through the appropriate governance route.
- Continue integrating maternity and neonatal training assurance so that Board reporting provides a complete perinatal view.

8. Multidisciplinary and pathway-wide assurance

The visit provided strong assurance regarding the maternity training faculty and the design, delivery and monitoring of the core programme. Obstetric contribution to training was evident, although the Trust described wider capacity challenges and future assurance would benefit from consistent direct obstetric participation in discussion and development activity.

No neonatal or anaesthetic representatives attended the visit, which limited the assurance available regarding neonatal capability assessment, neonatal ownership and the wider multidisciplinary experience of the programme. Future reviews would be strengthened by direct participation from these groups and by evidence showing how learning and compliance are jointly owned across maternity, neonatal, anaesthetic and partner services.

9. Areas of outstanding practice

The review team identified several areas of outstanding practice that may be valuable for wider sharing across the scheme.

Patient-journey design of PROMPT

Following the continuing stories of two fictional women across antenatal, community, intrapartum and postnatal care was a distinctive and thoughtful approach. It enabled emergencies to be taught within the wider reality of personalised care, social circumstances, communication, escalation and decision-making, creating a coherent learning experience rather than a sequence of unrelated technical stations.

Exceptional training faculty

The small faculty demonstrated considerable enthusiasm, creativity, knowledge and commitment. The team appeared closely connected to governance intelligence and staff learning needs and was able to adapt content during the year. This gave the programme a strong sense of relevance and ownership.

Interactive and inclusive learning methods

The use of videos, practical scenarios, clinical skills, group discussion, true-or-false activities and continuing patient stories supported different learning styles and made training realistic and memorable. Invitations to critical care, theatres, ambulance colleagues, students and other services reflected an inclusive view of multidisciplinary emergency response.

Targeted support for community and home-birth teams

Confidence-building sessions, simulation activity and the expectation that all Highfield home-birth team members complete full NLS training demonstrated awareness of the particular risks and support needs of staff working away from immediate hospital resources.

Responsiveness to local learning and outcomes

The faculty could incorporate incidents and emerging themes during the training year. The perineal-protection work provided a clear example of introducing training, monitoring outcomes and refining the intervention when rates began to change, demonstrating an active learning cycle.

Detailed and transparent compliance monitoring

Monthly professional-group reporting, staff-level follow-up, SPC charts, ESR updates and visible staff communications provided considerably more insight than a single aggregated compliance percentage. The faculty's detailed understanding of gaps and trends was a significant strength.

10. Conclusion

The review team found a strong, well-designed and improvement-focused approach to Safety Action B. The Trust demonstrated an exceptional training faculty, an innovative patient-journey PROMPT model, varied and engaging teaching methods, responsiveness to local learning and detailed operational oversight of compliance. The evidence indicated that obstetric emergency and fetal surveillance training were particular strengths.

The principal work remaining at the visit date was to complete both required current-period in situ simulations and demonstrate the resulting learning, actions and governance follow-up. Further assurance would also be strengthened by a clearer account of practical neonatal resuscitation capability assessment and maintenance, greater direct neonatal participation, and evidence of how Board oversight leads to action when staff release or training capacity creates risk.

The suggested areas for development are intended to build on a strong foundation. The Trust appeared well placed to progress the remaining simulation requirements during the reporting period, provided that delivery, multidisciplinary participation, learning and follow-up are fully documented.

The review team thanks colleagues for their thorough preparation, openness and enthusiasm. The Trust's training programme, and particularly its patient-journey approach to PROMPT, provides valuable learning that may be of interest to other organisations across the scheme.

To: Trust Chief Nurses
Trust Directors of Midwifery

cc. ICB Chief Nurses
ICB Directors of Midwifery

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 November 2025

Dear colleagues,

Urgent review of homebirth services following Prevention of Future Deaths report

We are writing to bring to your immediate attention the Prevention of future deaths report issued by the Senior Coroner for Manchester North after the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth. The report raises a number of concerns and we are asking you to urgently review the safety and quality of your homebirth services.

We would like you to consider the following issues which were highlighted in this case:

The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

Trusts have a continuing responsibility to offer homebirth as a choice for women. Where this review identifies concerns, please take prompt action to address them to ensure your homebirth service remains safe and high quality. While no formal response is required, we expect that the outcome of the review be reported to your Trust board and that you contact your regional NHS England team immediately if you identify any safety concerns requiring urgent attention.

Yours sincerely,





Kate Brintworth
Chief Midwifery Officer for England

Claire Mathews
Regional Chief Midwife, North West
NHS England

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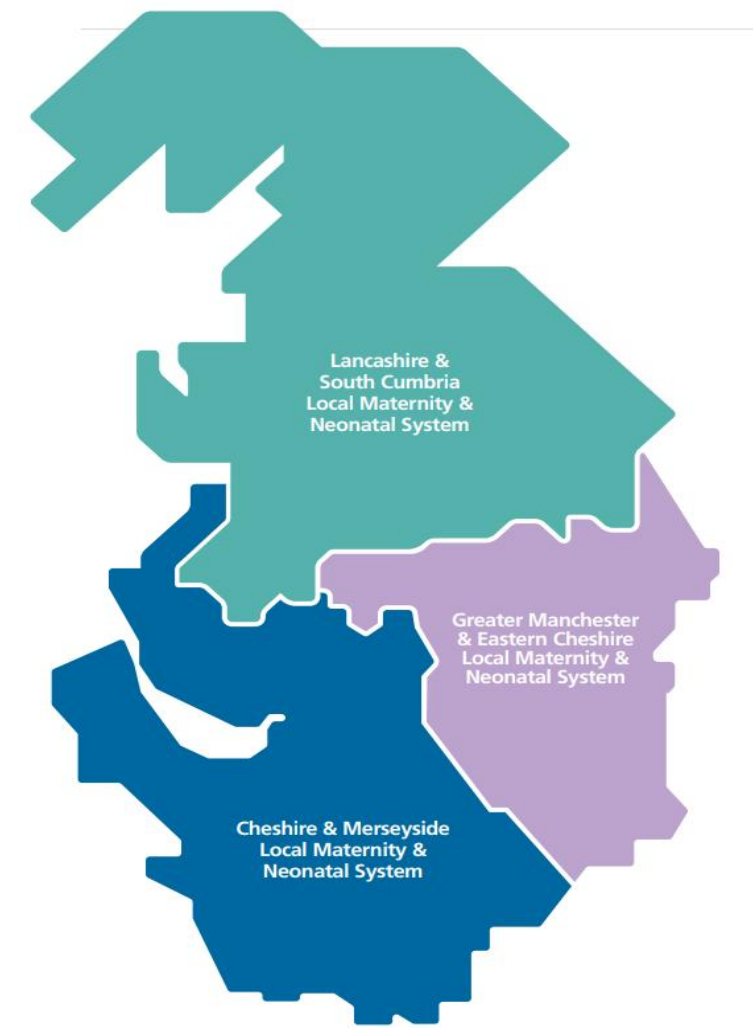
Department of Health & Social Care

NHS England

North West Region Home Birth Benchmark Thematic Analysis

North West Regional
Maternity Team

Overview of Maternity Services in the North West Region



3rd largest region in England
3 Local Maternity and Neonatal Systems (the maternity arm) of the ICB
17 Trusts providing maternity Services – which covers

- 21 Obstetric Units
- 17 Homebirth services
- 15 Alongside Midwifery Led Units
- 6 Standalone Midwifery Led Units – (2 currently closed to intrapartum services)
- 3 Maternal Medicine Centres

National Birth rate in 2024 was 594,677 and 71,580 of these birth was in the NW region.

North West region Home Birth Benchmark Thematic Analysis

Purpose and Introduction

The purpose of the North West Home birth Task & Finish Group is to develop a North West Home Birth Charter based on the findings in:

- NHS England National (Maternity Improvement Advisors team) Home Birth Service Review, (September 2024),
- The independent report by the Maternity and Newborn Safety Investigations (MNSI, January 2025)
- The Prevention of Future Deaths Report (PFD) Courts and Tribunals Judicial (November 2025),

The Task and Finish group will be developing this charter in collaboration with all 17 providers in the North West region, NWAS, and Cheshire & Merseyside (C&M), Greater Manchester (GM) and Lancashire and South Cumbria (LSC) Local Maternity and Neonatal Systems.

The following slides present a thematic analysis of a benchmarking exercise that was undertaken by the 17 providers in the North-west region in December 2025. The slides are presented into sections:

- Section 1 - Birth Choice Counselling / Care Outside Guidance
- Section 2 - Kit/Equipment
- Section 3 - Training/Education
- Section 4 - Oversight/Escalation
- Section 5 - Data/Digital/Documentation
- Section 6 - Coroners' questions

The regional maternity team would like to thank the senior leaders at each of the providers in the North west region for their engagement and commitment to take part in this project. This exercise has been extremely valuable and has provided us with a wealth of information that will help us shape the future of home birth provision in the NW region.

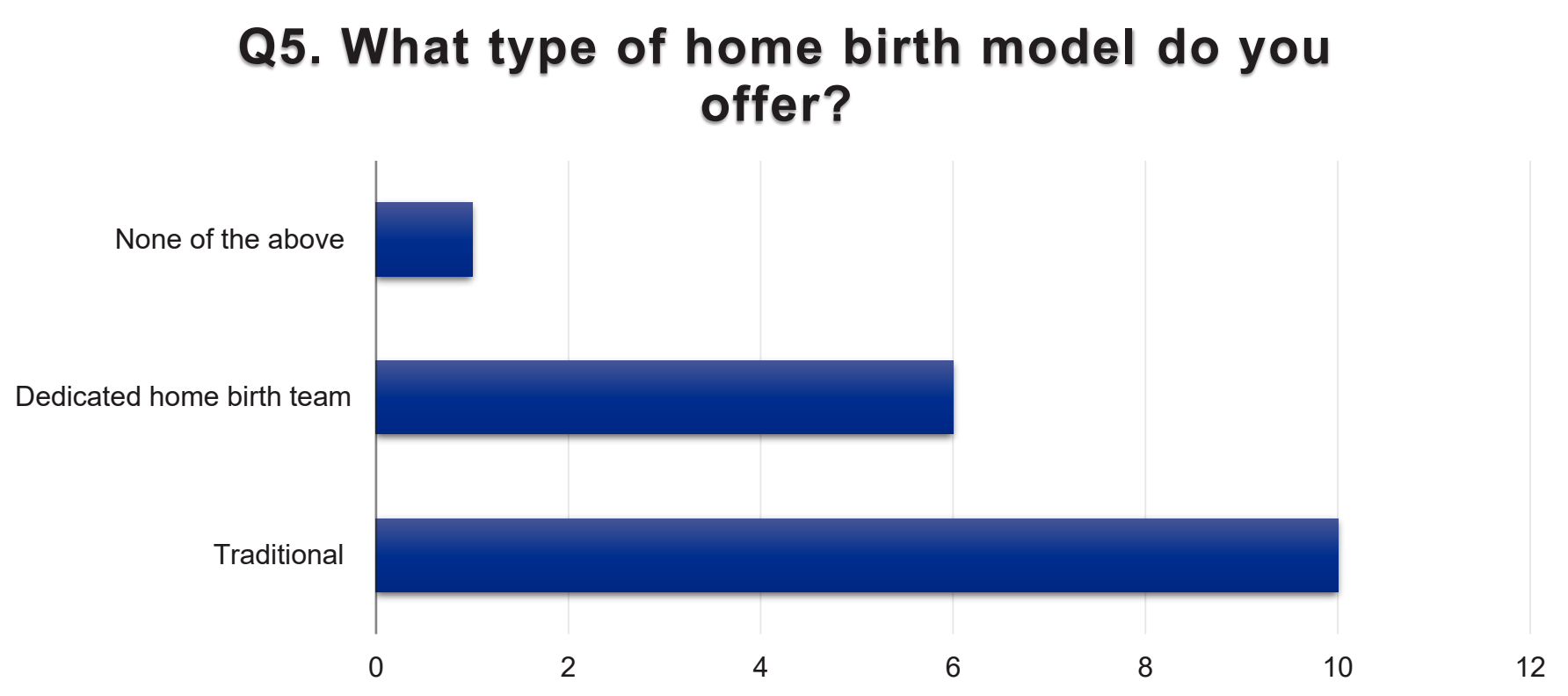
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Section 1:Birth Choice Counselling and Care Outside of Guidance

Q5-28

Q5. What type of home birth model do you offer?



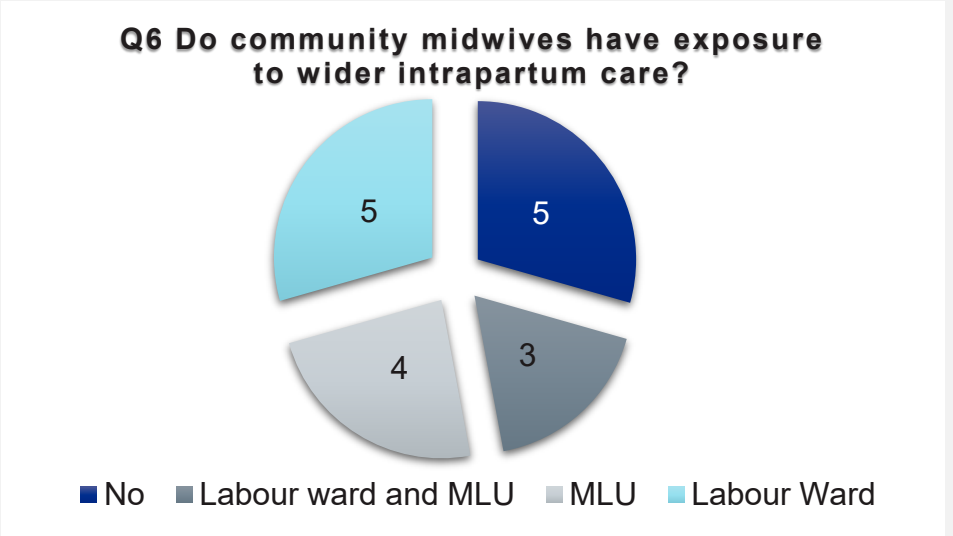
There are 6 providers in the NW region offering a dedicated HB team model. There are 10 providers offering traditional home birth models, 1 provider in the NW offers a team model for their home birth service.

Q6 & Q7. Community Midwives Exposure to Intrapartum Care

There is **substantial variation** in how community midwives are exposed to intrapartum care outside home birth, with no consistent or standardised approach across services. Models range from **no routine exposure** or **very infrequent update-based activity**, to **planned rotational and hybrid working** that provides regular intrapartum experience.

Community midwives' intrapartum experience depends on:

- Service configuration
- Role type (core vs rotational)
- Availability of MLUs or labour ward access
- Geographical site



In many services, intrapartum exposure occurs primarily through **escalation during staffing pressures**, resulting in **reactive, unpredictable, and limited exposure** that is not designed to maintain competence. Some community midwives have little or no intrapartum exposure beyond home birth.

More sustainable practice is observed in services using **formal rotational or hybrid models**, where intrapartum care is embedded into routine rostering. These approaches offer **regular, structured exposure**, support skill retention, and improve workforce flexibility. Targeted individual placements are also used to address identified gaps, though these do not ensure universal exposure.

Themes:

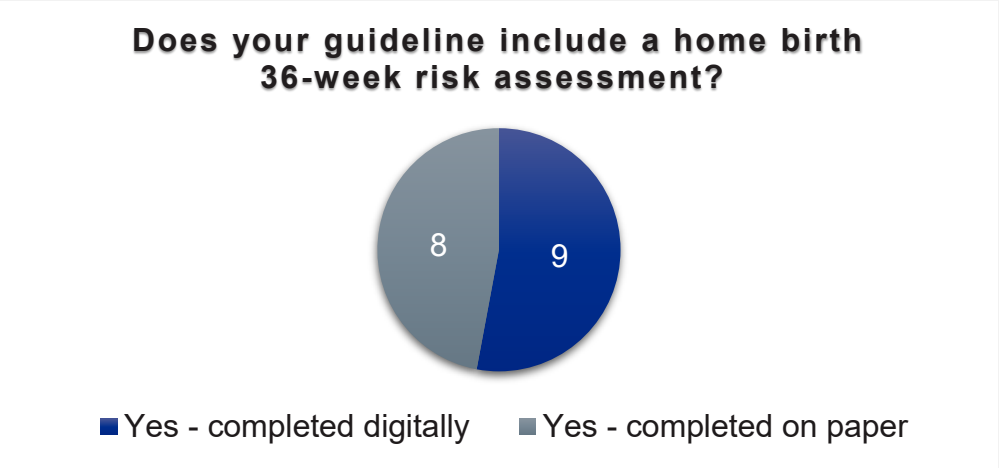
1. No exposure to wider intrapartum care
2. Exposure mainly through labour ward practice
3. Exposure through midwifery-led units (MLUs)
4. Role-dependent or rotational exposure
5. Geographical and organisational variation (variation within multi sites)

Q8, 9, 10, 11, 12, 13. (36-week risk assessment)

All 17 providers in the NW region have confirmed that the

36-week risk assessment is undertaken in the home.

Most responses indicate that **risk assessment is reviewed regularly**, but **how this is done varies**.



There is a clear distinction between:

Formal, routine re-completion of a home birth risk assessment at every contact, and
Ongoing clinical risk review, with the formal home birth risk assessment only updated if risks change.

Completion of the 36-week low-risk home birth assessment is **most commonly undertaken by Band 6 community midwives**, with **variation across services** involving Band 5 midwives, Band 7 midwives, or **dedicated home birth teams**.

There is **no single, fixed time allocation** across services. While **60 minutes** is the most commonly cited benchmark, the dominant theme is **flexibility**, with time tailored to the woman's needs and the complexity of discussion.

Many services emphasise a **person-centred, non–time-limited approach**, particularly where assessments are conducted in the woman's home.

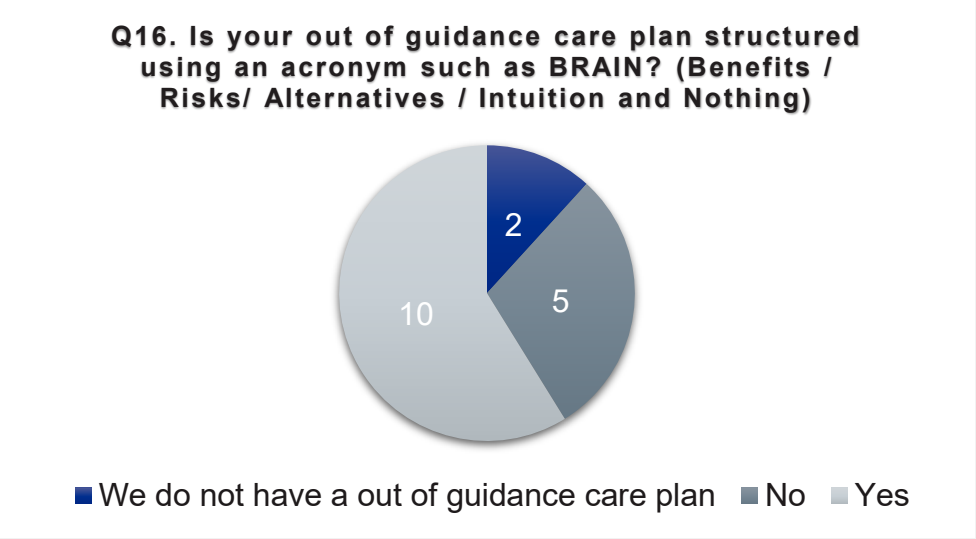
Q14,15,16. Outside of Guidance

15/17 providers have reported they have a birth outside guidance pathway. Of those 15 providers 12 have confirmed that their birth outside guidance pathway contains an out of guidance care plan template

Care plans are ideally prepared by 36 weeks gestation but remain flexible, individualised, and responsive to evolving maternal or clinical circumstances, with early referral encouraged for any out-of-guidance requests

10/17 providers have indicated they use BRAIN when completing an out of guidance care plan. (2 providers do not have an out of guidance care plan)





Q17/18. Who routinely completes the 'out of guidance' home birth care plan? At what gestation is the out of guidance home birth care plan completed?

Headline finding

Completion of *out of guidance* home birth care plans is predominantly consultant-led or senior midwife–led, with strong emphasis on multidisciplinary oversight. While community midwives may initiate or contribute, finalisation and governance sit largely with consultant midwives, consultant obstetricians, or Band 7 leaders, reflecting the complexity and risk associated with care outside guidance.

Themes Identified

Standard Target Gestation (36 weeks)

Many responses specify 36 weeks as the key target for completing the care plan.
Responses reflecting this: 1, 2, 5, 8, 9, 10.
Interpretation: This aligns with typical maternity practice to formalize birth planning in the late third trimester after risk assessments are complete.

Flexible / Risk-Dependent Timing

Several responses note that the timing depends on when the “out of guidance” risk is identified. Gestation may vary widely based on clinical circumstances or maternal request.
Responses reflecting this: 3, 4, 6, 7, 11, 12, 15, 16, 17.
Interpretation: The process is patient-centered and adaptive to evolving risk factors, consistent with NICE recommendations for individualised care.

Early Identification Encouraged

Some responses emphasize initiating the process as early as possible, sometimes in the second trimester, particularly if risks are identified or a woman requests birth outside guidance.
Responses reflecting this: 7, 13, 14, 16.
Interpretation: Early planning allows time for informed discussion, multidisciplinary review, and shared decision-making.

Range / Fluidity in Timing

Responses highlight that gestation can be fluid, with multiple consultations required as the pregnancy evolves.
Responses reflecting this: 6, 11, 16, 17.
Interpretation: Recognises the dynamic nature of risk and the need for ongoing review, which aligns with NICE guidance on continual risk assessment and updating care plans.

Q19 & 20 Outside of Guidance MDT and Skill Mix

Q19. Do you have an MDT panel / process for out of guidance care regardless of setting? Please include details i.e. people involved where required - ODN, anaesthetics

Approach varies across services
- Case-by-case escalation **or** formal MDT panel
- MDT convened based on risk rather than routine

MDT composition (risk-dependent)
- Core: Consultant Midwife, Consultant Obstetrician, senior midwives, named midwife
- As required: Anaesthetics, Neonatology, ODN, safeguarding/legal, operational leads

Scope & governance
- MDTs may be setting-specific or regardless of setting
- Formal MDTs support documentation, consistency, and governance

Standards alignment
- Meets NICE individualised MDT care
- Formal panels align strongly with Ockenden escalation & oversight

Sites with formal MDTs align closely with Ockenden's emphasis on structured escalation and governance.
Sites with case-by-case MDT activation meet NICE standards for individualised care but may need additional governance structures to ensure consistent oversight.

Q20. How would you consider skill mix and support for midwives attending an out of guidance homebirth?

Staffing model
- Minimum two midwives present
- Skill mix considered (often Band 6+)

Experience & expertise
- Use of dedicated / experienced homebirth teams
- Senior midwife or consultant support available

Training & escalation
- Regular skills drills & simulation
- 24/7 senior advice and clear escalation pathways

Workforce planning
- Daily staffing review, supervised induction, contingency planning
- Aligns with Ockenden & NICE safety principles

Responses indicate that services actively plan for appropriate skill mix, training, and support when attending out-of-guidance homebirths.
Practices such as pairing midwives, dedicated teams, 24/7 senior support, and ongoing skills drills reflect alignment with Ockenden and NICE recommendations.

Q21. Do you have a process that outlines which out of guidance care plans are reviewed by the trust legal team?

Themes Identified

Dependence on Complexity / Risk

No Formal Process / Ad Hoc Legal Involvement

ad hoc, MDT-initiated legal review

Yes / Formal Process Exists

MDT determines whether a plan requires legal review

Legal review is generally triggered by

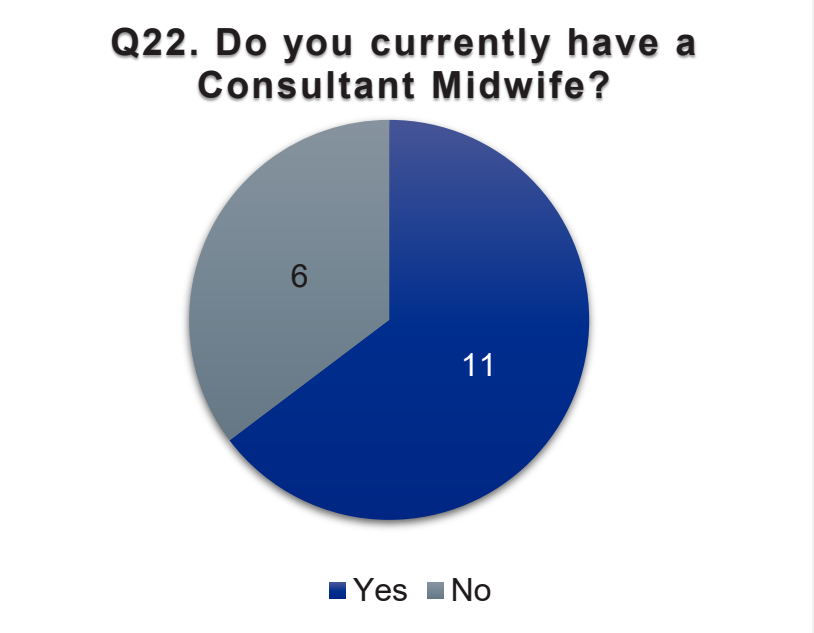
Dependence on Complexity / Risk

MDT-Led / Case-by-Case Decision

Dependence on Complexity / Risk

Q22, 23, 24 Supporting Women/Birth Choices Clinics

Responses show wide variation in provision for Birth Choices Clinics, ranging from well-established specialist clinics to informal or planned services.
Most services cluster around birth choices/options and birth reflections/debrief, with growing focus on complex or out-of-guidance (OOG) decision-making and trauma-informed care.
Overall, provision appears evolving rather than standardised.

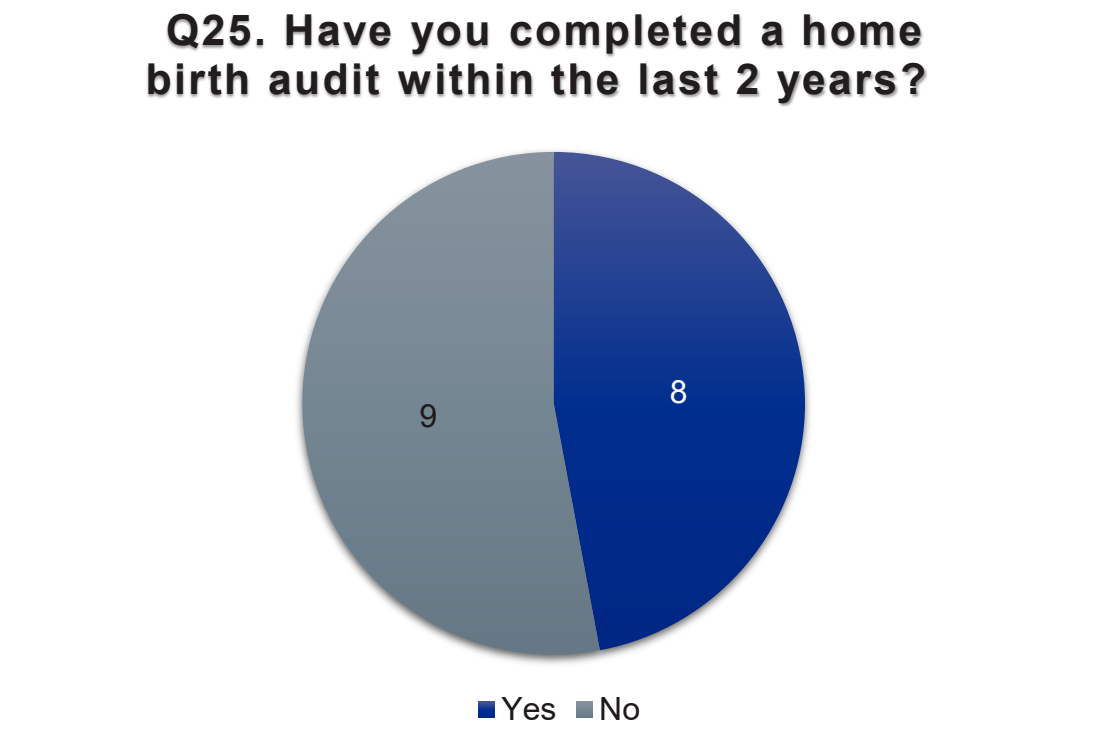


Key Themes Identified

1. Birth Choices / Birth Options Clinics (Most dominant)	~10/17 responses
2. Birth Reflections / Debrief / Afterthoughts (Most consistent)	~12/17 responses
3. Planned but Not Yet Implemented Services	~5/17 responses
4. Complex / Out-of-Guidance (OOG) Birth Choice Support	~5/17 responses
5. Consultant Midwife Leadership & Senior Staffing	~5/17 responses
6. Specialist Pathways (VBAC, Breech, Maternal Request CS)	~4/17 responses
7. Trauma-Informed & Holistic Approaches	~2/17 responses
8. Alternative & Community-Based Models	~1/17 responses

Facilitation is predominantly delivered by senior midwives (Band 7+) and consultant midwives, with Band 6 midwives commonly supporting or leading standard clinics. A smaller number of services involve multidisciplinary facilitation or are not yet operational.

Q25, 26, 27 Home birth audit finding in the last 2 years



Audit findings are most commonly shared through formal governance and assurance structures, particularly maternity safety, quality, and leadership forums. Some services demonstrate transparent and inclusive dissemination to staff and the public, while others report no audit activity or sharing at present.

Themes from the audits

Theme	Approx. Frequency
Documentation & record-keeping	High (≈5)
Adherence to IIA/guidance	Moderate (≈4)
Risk assessment & escalation	Low–moderate (≈2)
Equipment & neonatal care checks	Low–moderate (≈2)
Personalised / OOG care	Low (≈1)
Transfer analysis	Low (≈1, high detail)
Incident-based learning	Low (≈1)
No audit / not yet completed	High (≈8)

Where home birth audits have been completed, learning is largely operational and safety-focused, centring on documentation, guideline adherence, and risk management. However, the high proportion of services without completed audits indicates variable audit maturity and an opportunity for standardised home birth audit frameworks, particularly around transfers, documentation, and personalised care.

Q28. Documents shared

Provider	Documents received
1	1. Homebirth Guideline 2. Maternal Transfer by Ambulance 3. 4 screenshots of EPR - birth plan / discussion pages / Risk Assessment
2	1. Home birth Guideline 2. Home Birth Care plan document
3	1. Homebirth Guideline 2. Out of Guideline Flowchart
4	1. Home Birth Guideline and Care Outside of Guidance Guideline (one document)
5	1. Homebirth Guideline 2. Care for women who request care outside of Trust guidelines 3. Homebirth Scoping Group TOR 4. HB Delivery Data Presentation
6	1. Intrapartum Care for all birth settings guideline 2. HB Risk Assessment and Preparation 3. RA and planning place of birth ante and intra period guideline 4. Referral to Birth Options and Management of OOG Guideline
7	1. Home Birth Guideline 2. Home birth 36 Week Risk Assessment 3. OOG Guideline 4. All 36-week assessment 5. Responses to MNSI report OOG
8	1. Homebirth Guideline (including BBA) 2. Consultant Midwife clinic - OOG, birth choices SOP

Provider	Documents received
9	1. Personalised Care, Choice and Birthplace Planning Guideline
10	1. Homebirth guideline (including BBA) 2. HB BadgerNet User guide 3. Referral to Consultant Midwife Guideline 4. EXAMPLE of OOG Care plan (anonymised)
11	1. Planning Place of Birth Guideline 2. Maternity Record Keeping Guideline 3. The Nest and Team Lunar Operational Policy 4. Smart homebirth assessment BadgerNet 5. Urgent review of HB services -response
12	1. Homebirth Guideline (including BBA) 2. SMART Homebirth Assessment BadgerNet
13	1. Homebirth Guideline 2. Supporting Individualised Birth Choices, Incorporating Birth Outside of Guidance and Freebirth SOP
14	1. Homebirth Guideline 2. Individualized Care plan (OOG) 3. Non-Concordance Policy 4. NHS England and NHS Improvement – North-West Maternity Team & North-West Ambulance Service NHS Trust
15	1. Homebirth guideline 2. Birth Choice - care requests OOG guideline
16	None received
17	None received

Section 2: Kit and Equipment

Q29-35

Q29, 30, 31 'Baby Lifeline' equipment bag as standard, Adaptations and Governance

Provider	Q28. Does your organisation use the 'Baby Lifeline' equipment bag as standard? If no, please state what you use by selecting the 'other' option
1	Yes
2	Yes
3	Yes
4	Yes
5	Yes
6	A similar bag with similar kit.
7	Yes
8	Bag content based on baby life-line recommended equipment; alternative bag adopted due to size and manual handling concerns
9	Standard bag
10	Yes
11	Yes
12	Yes
13	Resuss Box with bag and mask, IGel, torch, tongue depressor and manual suction kit
14	Yes
15	Yes
16	Yes
17	Yes

15/17 providers in the NW region opted in to NHS England's offer of the Baby lifeline bag in 2020.

Only a minority of respondent's report using the Baby Lifeline bag **exactly as originally supplied**. Most services have **modified contents**, not due to omission, but to:
Reflect **updated national guidance**
Ensure **compatibility with trust stock and restocking processes**
Improve **clinical usability and safety**
Respond to **incident learning and MDT review.**

Most services have **adapted the Baby Lifeline bag intentionally and appropriately**, driven by **patient safety, evolving clinical guidance, and operational sustainability**, rather than dilution of standards. Variability exists in how closely services align to the original specification, suggesting value in **nationally agreed minimum equipment standards with flexibility for local adaptation**. One provider has adopted the bag content based on baby life-line recommended equipment; alternative bag adopted due to size and manual handling concerns.

Q32-35. Homebirth Equipment Themes

What is the current checking process for your homebirth equipment when in the home/attending homebirth

- Individual Midwife Responsibility for Equipment Checks
- Standardised Checklists and Documentation
- Theme Tagging Sealing, and Visual Assurance Systems
- Multi-Stage Checking (Routine, After Use, On Arrival)
- Focus on Emergency and Neonatal Resuscitation Equipment
- Digital Systems and Governance Oversight (My Kit Checks/Audits)
- Management Oversight, Spot Checks, and Audit
- Equipment Set-Up in the Home Environment

What is the current strip down and checking process for your homebirth equipment following a home birth?

- Return to Base for Centralised Re-stocking and Checking
- Individual Midwife Responsibility After Each Birth
- Use of Standardised Checklists and Inventory Control
- Cleaning, Decontamination, and Infection Control
- Re-sealing, Tagging, and Visual Assurance
- Integration with Routine / Monthly Checking Processes

Is there an auditable trail for checking this equipment

- Clear and Established Auditable Trail
- Checklist-Based Audit Trails (Paper or Electronic)
- Robust Governance Oversight and Escalation
- Partial or Developing Audit Trails
- No Auditable Trail

If further equipment is required, how would this be arranged? Example - additional gases

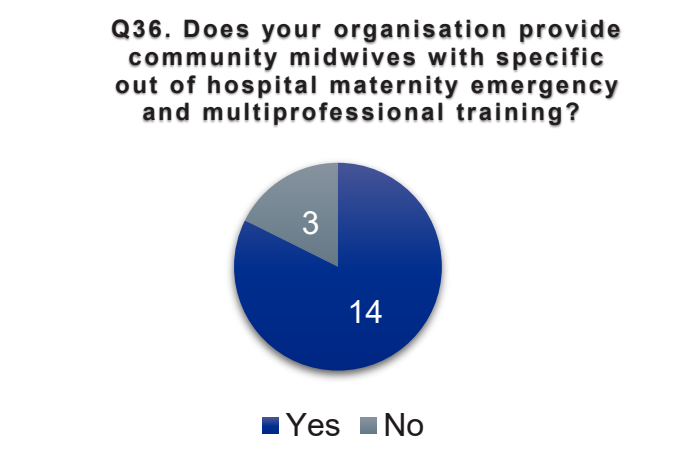
- Unit / Birth Centre Coordination
- Use of Transport Services for Delivery
- On-Call and Additional Midwifery Workforce
- Time-Dependent (In-Hours vs Out-of-Hours) Pathways

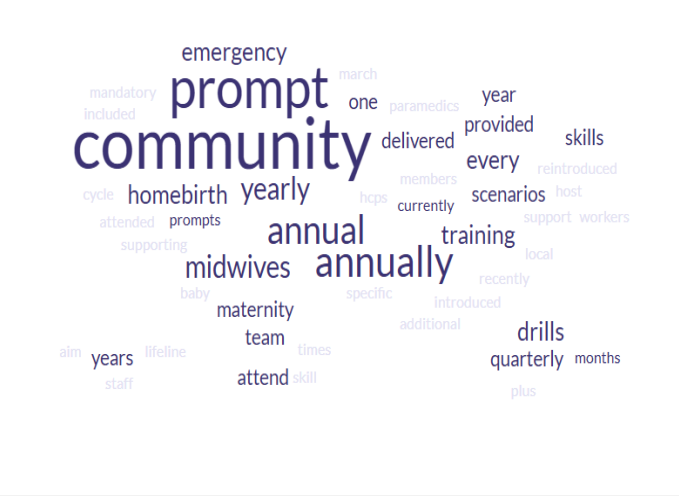


Section 3: Training and Education

Q36-47

Q35, 36. Specific out of hospital maternity emergency and multiprofessional training/Frequency





Key Themes

1. Annual Training (Most Common Pattern)

- The majority of services provide **annual PROMPT** or **annual emergency skills drills**.
- Annual training is often the **minimum mandatory requirement** for maternity staff.
- Some services include **community-specific scenarios** within their annual PROMPT days.

2. Quarterly Training

- A smaller group deliver **quarterly PROMPT** or **quarterly community emergency training**.
- Quarterly sessions are typically used to **reinforce skills** between annual mandatory updates.
- Often led by homebirth or community teams.

3. Monthly Training

- One service reports a **monthly skills-drill programme**, with multidisciplinary attendance (e.g., NWAS).
- Topics rotate and are informed by **recent cases**, **staff requests**, and **learning needs**.
- Represents the most intensive and structured model described.

4. One-Off or Not Currently Delivered

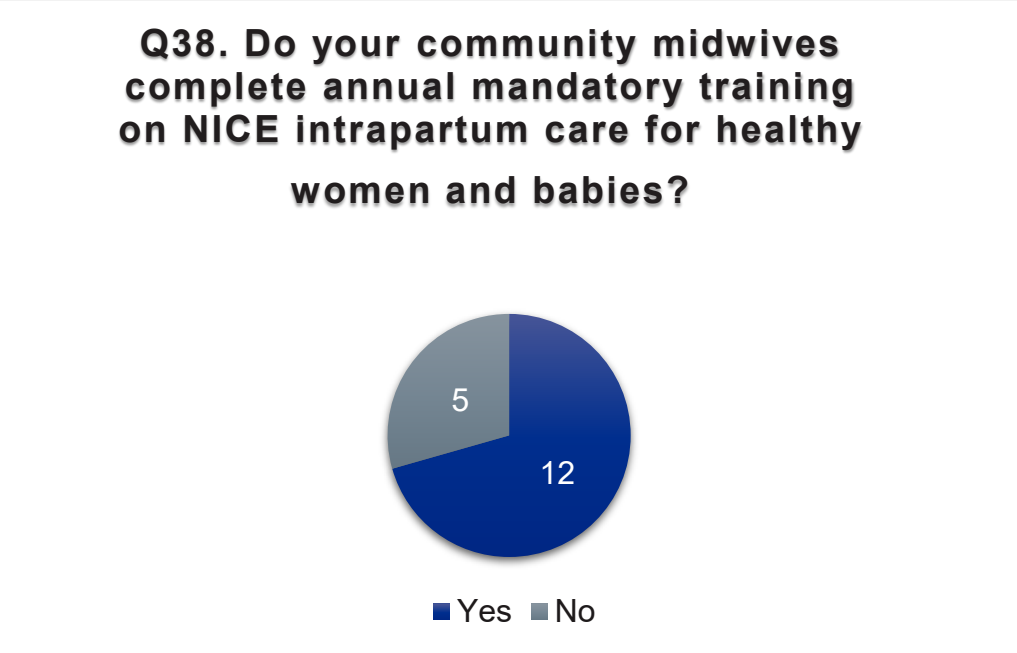
- A minority report **no current training**, or **one-off sessions** delivered in previous years.
- Some services are in a **transition phase**, planning to reintroduce or expand training.

5. Mixed-Frequency Models

Several services combine annual PROMPT with:

- **3-yearly** additional emergency training
- **Monthly** skills drills
- **Ad-hoc refreshers** based on appraisal or incident review
- **Two-yearly community PROMPT**, with plans to move to annual delivery

Q38/39. NICE intrapartum care for healthy women and babies/ Fetal monitoring and surveillance training



Of the 17 units 5/17 are not providing any community midwives training on NICE intrapartum care for healthy women and babies

Q39. What percentage of your community midwives have completed and passed the Fetal monitoring and surveillance training? (in the antenatal and intrapartum period)

Very High Compliance (95–100%) — *Dominant Theme*

The overwhelming majority of services report **very high compliance**, typically **95–100%**. This is by far the strongest theme across the dataset.
Responses reflecting this theme:

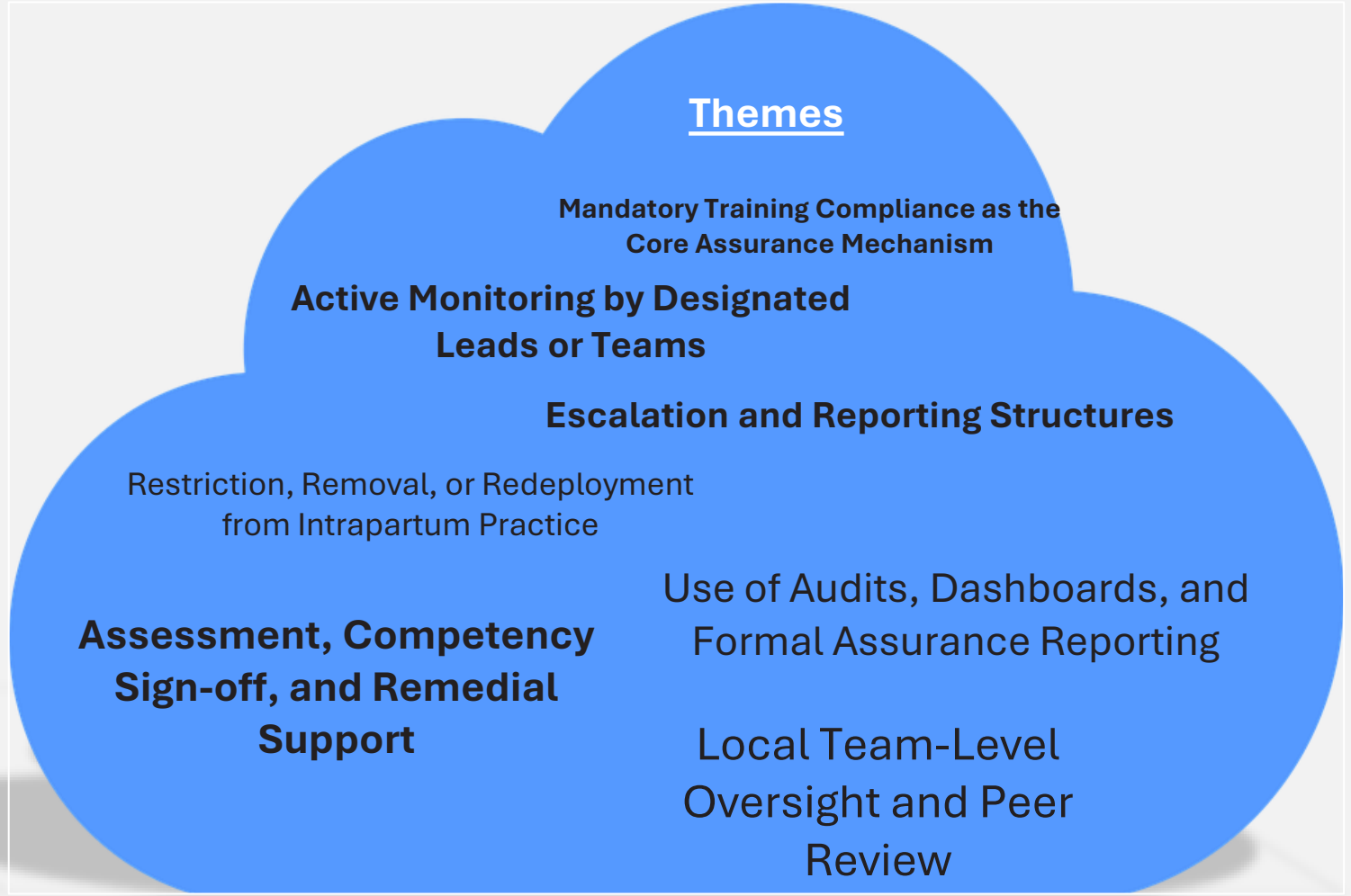
100% (1, 7, 12, 14, 15)
>90% (3)
91% rising to 100% (4)
98–100% (5, 11, 16)
94% (6)
96% (9, 10)
95.56% (17)

Interpretation: Most services maintain extremely high compliance, often supported by monitoring systems, mandatory requirements, or restrictions on practice for non-compliant staff.

Q40. Please describe your governance process for assuring all staff providing intrapartum care regardless of setting, who attend home births have passed the above training

Overview

Across responses, governance arrangements are generally **well-defined, multi-layered, and enforcement-focused**, with strong emphasis on **monitoring compliance**, **restricting practice when Local Team-Level Oversight and Peer Review training lapses**, and **formal escalation routes**. A small minority report **uncertainty or lack of awareness** of the process.



Q37. What training is provided to community midwives on informed consent / shared decision making?

Overall, training on informed consent and shared decision making for community midwives is **largely embedded within mandatory, personalised care–focused training**, rather than delivered as standalone education.

There is **variation in visibility and specificity**, with some services offering explicit sessions and others relying on implicit integration into broader frameworks.

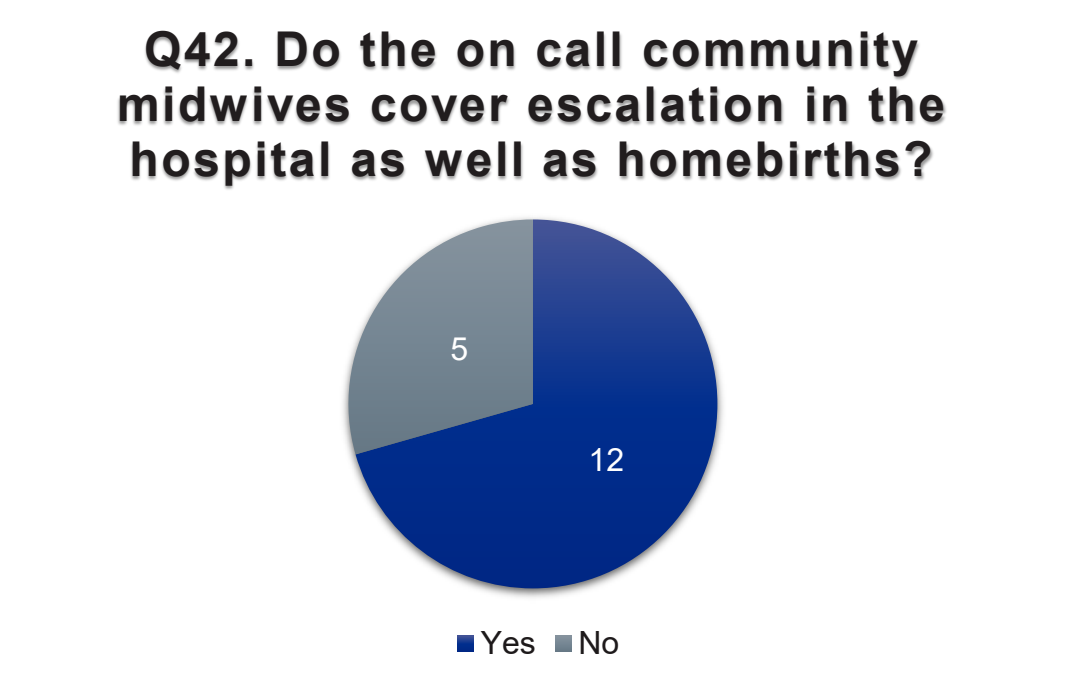
Themes

- Mandatory / Annual Training as the Primary Mechanism
- Integration into Personalised Care Frameworks
- PROMPT Training as a Key Delivery Route
- Use of Structured Decision-Making Tools (e.g. BRAIN)
- No Standalone or Explicit Training

Summary of Key Patterns

✓ Informed consent training is **widely present but rarely standalone**
✓ Delivery is **predominantly through mandatory, personalised care, and PROMPT training**
✓ **Variation exists** in clarity, depth, and explicitness across services
✓ Some evidence of **advanced practice** (decision tools, motivational interviewing), but this is not universal

Q42. Do the on-call community midwives cover escalation in the hospital as well as homebirths?



12/17 providers have confirmed that they use the on-call community midwife service to cover escalation in the unit in times of high acuity.

4 of the providers who use community midwives to cover escalation have stated they do not complete annual mandatory training on NICE intrapartum care for healthy women and babies

Q43. How many of your community midwives have completed the Resuscitation Council UK NLS (Newborn Life Support) or OH-NLS (Out-of-Hospital Newborn Life Support) Course?

Overview

Responses show **high prioritisation of NLS training**, particularly for **home birth teams**, but with **variation in coverage, reporting clarity, and models of delivery**. While many services report full or near-full compliance, others provide partial figures, are mid-rollout, or are unable to confirm numbers.

Prevalence: Common (Responses 4, 5, 6, 8, 9, 11, 12, 14)
Several respondents report **100% completion** or near-complete compliance:
Entire home birth teams trained (often explicitly stated as *100%*).
In some cases, all community midwives have completed NLS.
Compliance is sometimes framed as a **condition of practice** (e.g. not allowed on the on-call rota without NLS).

Theme 2: Differential Training Between Home Birth Teams and Wider Community Midwifery
Prevalence: Very common (Responses 5, 7, 8, 9, 11)
Many responses distinguish between:
Dedicated home birth teams (usually fully NLS trained)
Wider community midwives, who may:
Not attend NLS
Receive alternative newborn life support training
Be in the process of being trained

Theme 3: Partial Compliance with Clear Forward Plans
Prevalence: Common (Responses 1, 6, 8, 15, 16)
Several services report:
Most midwives trained, with **new starters or small numbers outstanding**
Courses **already booked** or rollout programmes underway
Clear timelines (often into 2026) for achieving full compliance

Theme 4: Conditional Practice Based on Training Status

Prevalence: Moderate (Responses 4, 16) In some services:

- NLS accreditation is mandatory for being on the on-call rota
- Failure to pass assessments results in **temporary restriction of duties**

Theme 5: Alternative or Non-NLS Newborn Life Support Training
Prevalence: Limited (Response 7)
One response notes that:
Community midwives do not attend formal NLS
They instead complete **annual newborn life support training**

Q44. How is the NLS 4-yearly compliance monitored/audited?

Overview

Overall, responses show **multiple monitoring mechanisms**, mostly **role-led and database-driven**, but with **variation in clarity, formality, and governance linkage**. One response indicates **no monitoring**, suggesting inconsistency across areas.

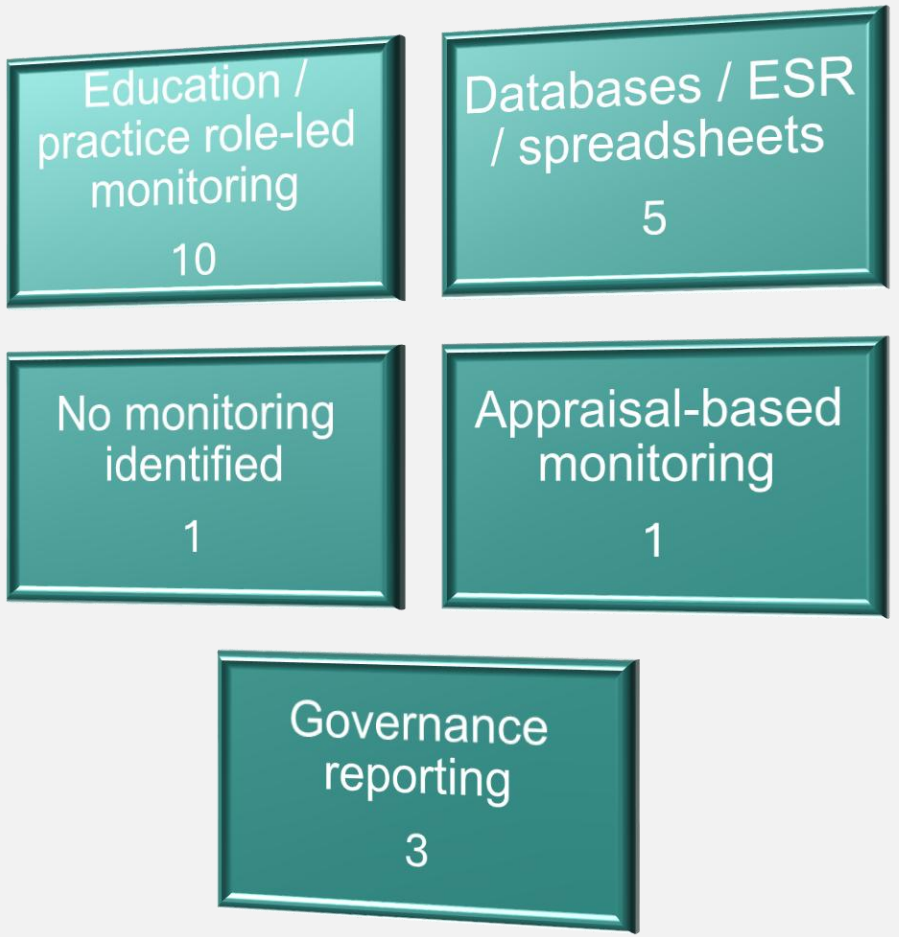
Observations

Variation in clarity: Some responses are very brief ("Monitored by PDM"), while others describe robust systems.

Role vs system dependency: Monitoring is often **person-dependent**, which may pose sustainability risks.

Escalation mentioned but not standardised: Only some responses describe escalation pathways.

Audit vs monitoring: Most responses describe *monitoring*, fewer explicitly reference *audit* or formal assurance cycles.



Q45. What is the frequency of perineal infiltration / episiotomy / suturing training for community midwives, does this include a competency assessment and how is this audited?

Overview

The responses demonstrate **high variability** in training frequency, **inconsistent mandatory status**, and **uneven approaches to competency assessment and audit.** Training is most robust for **newly qualified (Band 5) midwives**, while ongoing assurance for established community midwives is largely **ad hoc, self-directed, or absent**.

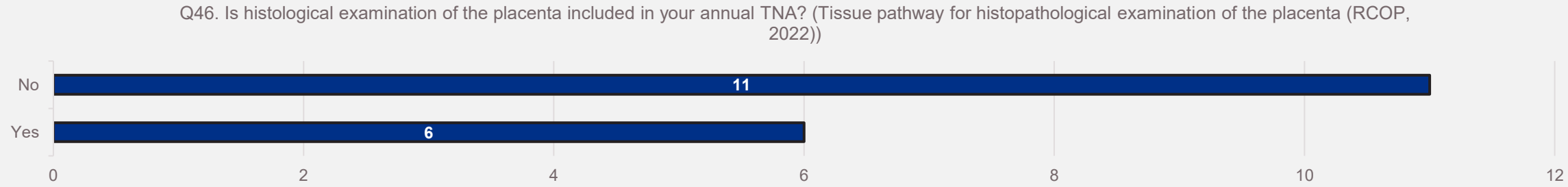
Overall Interpretation

Training and competency assurance for perineal infiltration, episiotomy, and suturing in community midwifery is **fragmented and inconsistent**. While **initial competency at preceptorship is well established**, there is **limited mandatory refresher training, inconsistent audit, and heavy reliance on self-identification of learning needs** for experienced staff. Several services acknowledge these gaps and are planning future improvements, but current governance assurance remains variable.



Q46/47. Is histological examination of the placenta included in your annual TNA? (Tissue pathway for histopathological examination of the placenta (RCOP, 2022) What are the barriers to sending the placenta for histological examination in an out of hospital birth setting

Regional comments: 11/17 Provider do not include histopathology training; however, some providers have indicated that it is included in the bereavement and SBL training.



Overview

The dominant narrative is that **most respondents perceive no significant barriers**, as placentas are routinely **returned to hospital following out-of-hospital births**. However, a small number of responses identify **practical, operational, and cognitive barriers** that may impact timely or appropriate submission for histology.

Overall Interpretation

Most respondents report **no barriers** to sending placentas for histological examination following out-of-hospital births, largely due to **robust processes for returning placentas to hospital settings**. However, a minority identify **latent risks**, including **out-of-hours laboratory constraints, lack of familiarity, delayed recognition of indications, and parental choice**, which could affect timely submission. These findings suggest that while systems are largely effective, **ongoing education, clear escalation pathways, and awareness of laboratory limitations** remain important for governance and quality assurance.

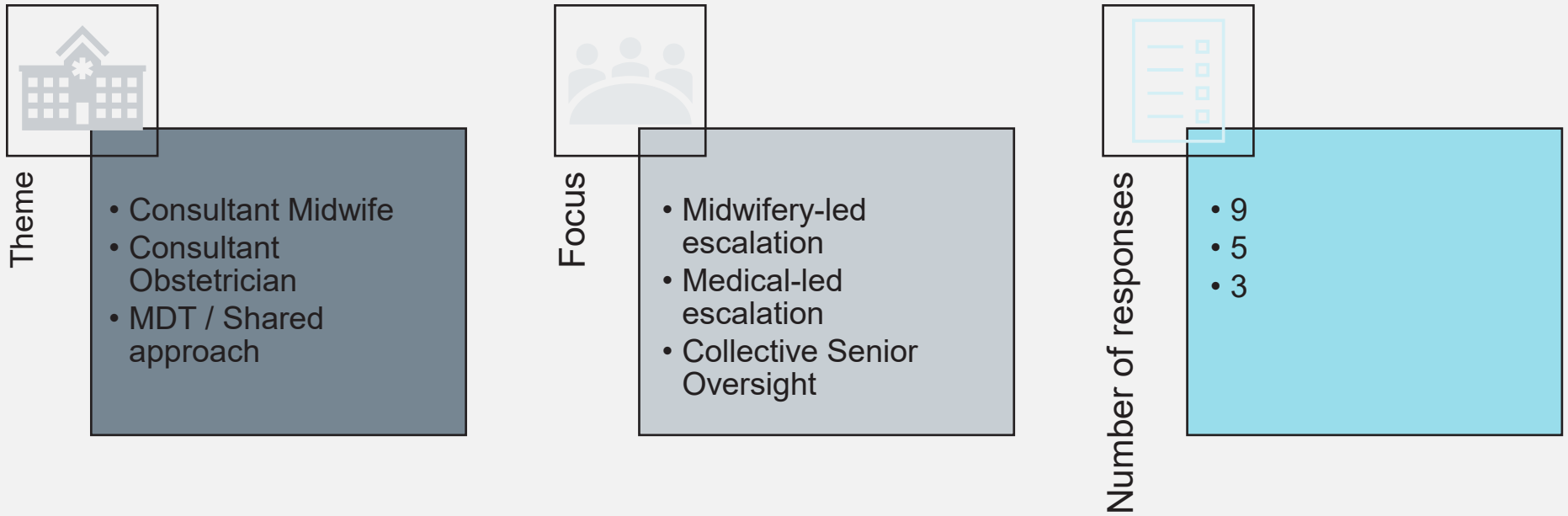
Theme	Description	No. of Responses
No perceived barriers	Routine return to hospital	13
Logistical/environmental	Formalin, lab hours	2
Knowledge/recognition	Unfamiliarity, clinical judgement	2
Parental choice	Retention of placenta	3
Hospital process dependency	Reliance on obstetric unit	1

Section 4: Oversight and Escalation

Q48-52

Q48, 49 Escalation of out of guidance requests

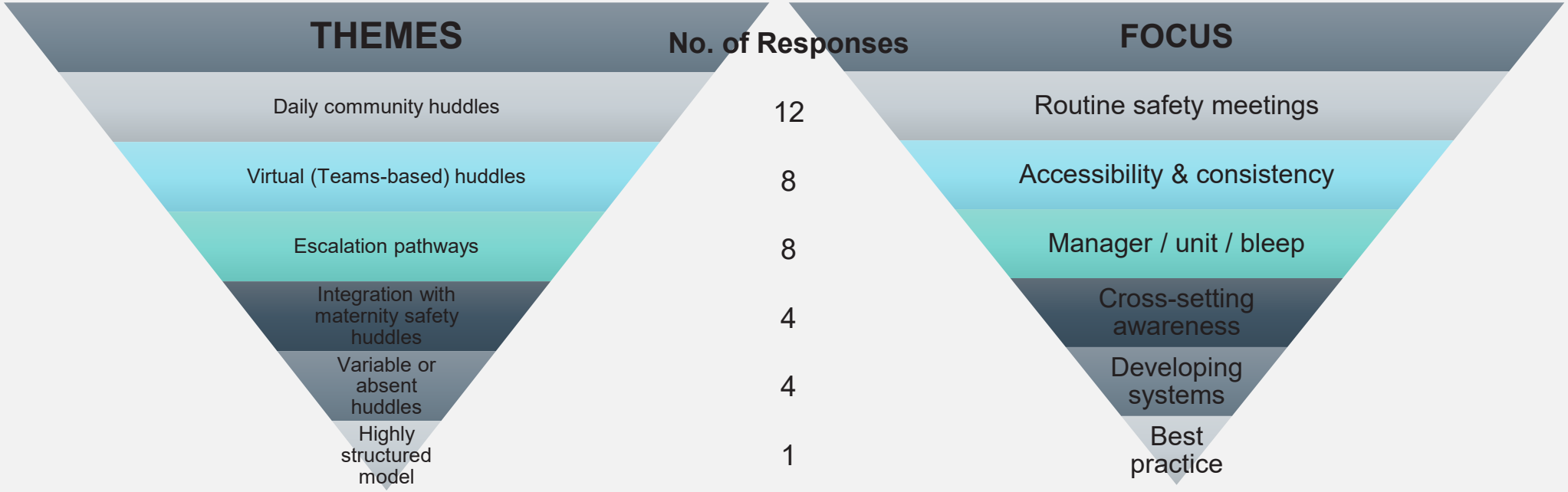
Responses demonstrate **strong recognition that escalation to senior clinicians is required**, but there is **variation in who is seen as the primary lead**—Consultant Obstetrician, Consultant Midwife, or a **multidisciplinary approach**. This variation suggests **inconsistent interpretation of escalation pathways**, though senior involvement is universal.



Following an out-of-guidance home birth discussion, notification processes are **broad, multi-layered, and senior-led**, reflecting strong awareness of governance requirements. However, there is **variation in consistency, clarity, and formalisation**, with some services relying on informal communication and others using structured digital systems and MDT escalation. The presence of **risk-based proportionality** in several responses is a strength, though clearer standardisation of *who must be notified, when, and how* would improve assurance and reduce variability.

Q50, 51 Community Huddles

Most services have **embedded daily community huddles**, usually delivered virtually and linked to **clear escalation pathways** into maternity leadership and acute services. These huddles play a central role in **risk identification, staffing coordination, and safety assurance**. However, there remains **variation in consistency, weekend coverage, and formality**, with some services still developing their approach. More standardised structures and clearer integration with maternity-wide safety huddles would further strengthen governance and reliability.



Responses reveal **inconsistent attendance by community midwives** at maternity and neonatal huddles. While some services report **direct attendance**, others rely on **representation by managers or team leaders**, and several report **no attendance at all**—particularly for neonatal huddles. Overall, communication is often achieved **indirectly rather than through routine frontline attendance**.

Q52. Please explain your communication process between midwives at a home birth and the hospital

Theme	Sub-Themes	Summary of Findings
1. Structured Communication Pathways	- Initial notification on arrival - Ongoing updates during labour - Final notification after birth/departure	Most trusts have a clear expectation that midwives notify the hospital when they arrive at a home birth, maintain communication throughout labour, and update again after birth or when leaving.
2. Time-Bound Update Requirements	- 4-hourly updates (most common) - More frequent updates for higher risk (hourly / 2-hourly) - Flexible/no fixed timeframe in some trusts	The majority follow a 4-hourly update cycle. Some require hourly or 2-hourly updates depending on risk. A minority use flexible, situational updates without strict timing.
3. Escalation & Risk-Based Communication	- Early updates if concerns arise - Use of “fresh eyes” reviews - Communication during transfer	Nearly all trusts emphasise earlier communication if concerns develop. Several use structured fresh-eyes reviews. Some describe communication during ambulance transfer.
4. Variation in Roles Contacted	- Labour ward coordinator - Maternity bleep holder - Community team leader / manager of the day - Birth centre lead midwife - Obstetric team (via escalation)	There is significant variation in *who* midwives contact, depending on time of day, staffing model, and trust structure. No universal standard exists across responses.
5. Lack of Standardisation Across Trusts	- Different update frequencies - Different roles contacted - Variation in tools used (EPR, fresh eyes, huddles) - Some trusts acknowledge gaps	Processes differ widely between trusts. Some have highly structured systems; others rely on flexible or informal communication. One trust explicitly notes a lack of check-in processes.

Section 5: Data, Digital And Documentation

Q53-73

Q59-64 Homebirth Data – request for missing data gone out

Q59. Please provide: Number of home births booked in 23/24, 24/25

Q60. Please provide: Number of planned home birth labours commenced at home during 23/24, 24/25

Q61. Please provide: Number of planned home births achieved during 23/24, 24/25

Q62. Please provide: Number of transfers from planned home births to obstetric unit during 23/24, 24/25

Q63. How many of the labours at home were within guidance during 23/24, 24/25?

Q64. How many labours at home were known out of guidance during 23/24, 24/25?

Data incomplete unable to perform analysis



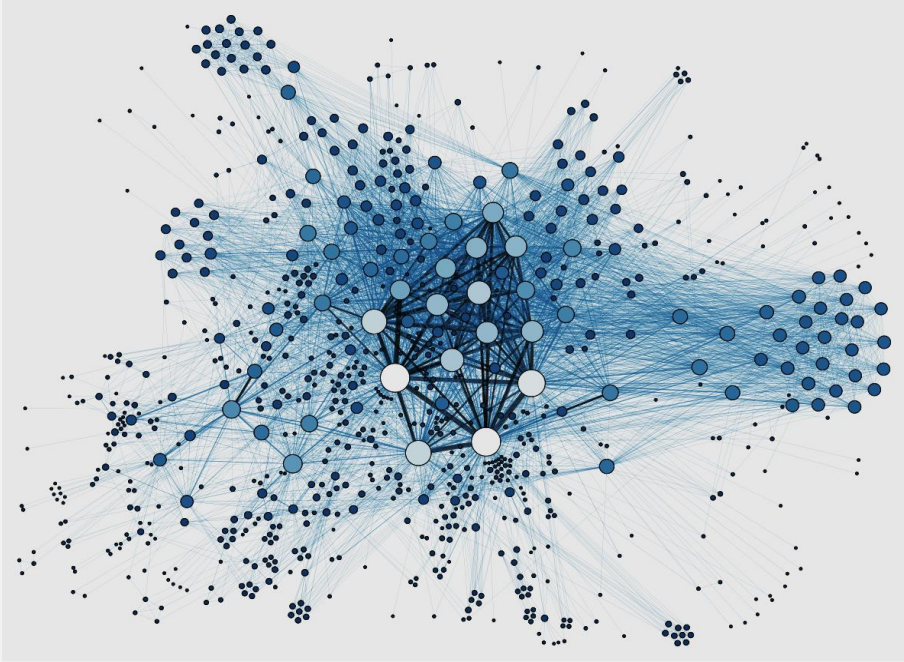
Q53,54,55 On call numbers

Q53. How many community midwives do you have in your organisation?

Q54. Are all the above community midwives on the on-call rota?

Q55. How many on calls does each community midwife cover a month?

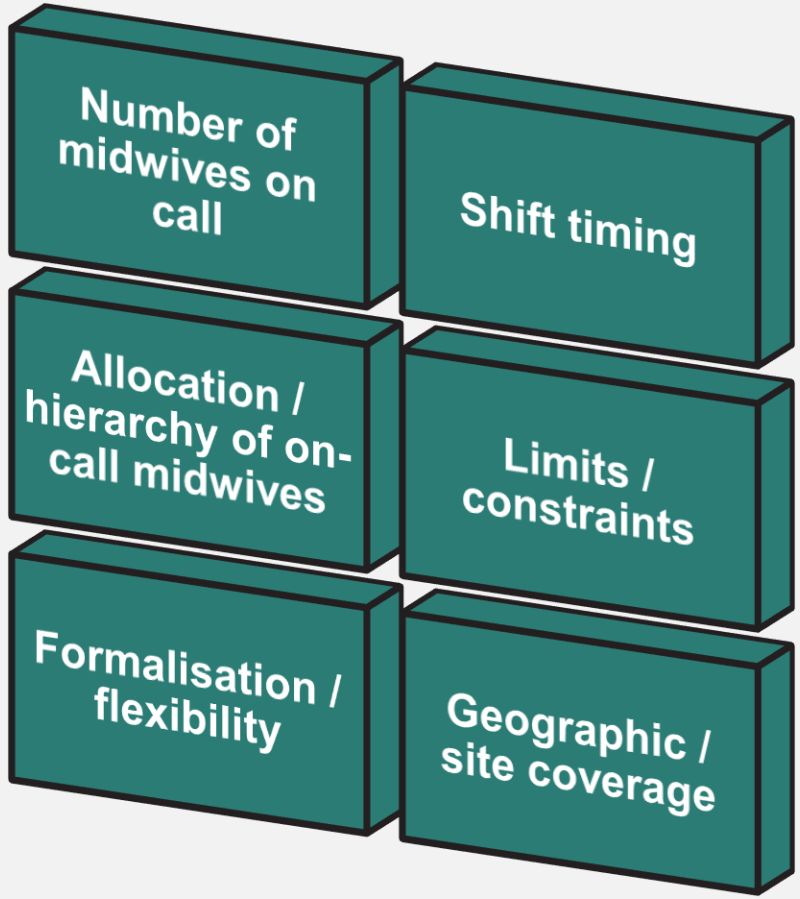
Data incomplete, unable to perform analysis



Q56. Briefly describe your current 'On Call' model.

Overall: Most models combine **structured rotas** with **first/second midwife hierarchy**, differentiate **day/night coverage**, and include **escalation to community or homebirth teams**. Night coverage is particularly variable, reflecting staffing levels and service demand.

Theme	Pattern across responses
Number of midwives	Ranges 1–4+, often 2–3; more midwives for night coverage or escalation.
Timing	Day vs night shifts common; night 16:30/17:00–08:30/09:00; some 24/7 coverage by homebirth teams.
Hierarchy	First/second midwife model common; escalation for multiple births or complex situations.
Constraints	Only one homebirth at a time in some trusts; capped hours, rest between shifts.
Geography	Some teams cover multiple sites; allocation depends on local boundaries.
Flexibility	Some trusts have formal rota; others adapting based on demand and staffing.



Q57. Please describe what parameters for compensatory rest are in place if a midwife has been called out

Theme	Pattern across responses
Formality	Mostly informal; few trusts have strict SOPs; some follow EWTD/WTD guidance.
Timing / Duration	Next-day rest common; minimum 8–11 hours for overnight call-outs; variable based on call-out length.
Proportional / accrued rest	Some services use 1:2-hour ratio; others provide payback day.
Autonomy	Midwives use professional judgement, with oversight from managers.
Factors considered	Time called out, length of call, shift next day, wellbeing of midwife.
Legal compliance	EWTD/WTD compliance referenced for safety and rest.



Overall:

- Compensatory rest is **highly variable**, often **individualised** based on call timing, duration, and midwife wellbeing.
- **Formal guidance is limited**; most Trusts rely on manager oversight and professional judgement.
- **Night call-outs trigger the clearest structured rest**, with many services providing **mandatory next-day off-duty** or **protected hours**.
- Some services align explicitly to **legal frameworks** (EWTD) to ensure safe practice.

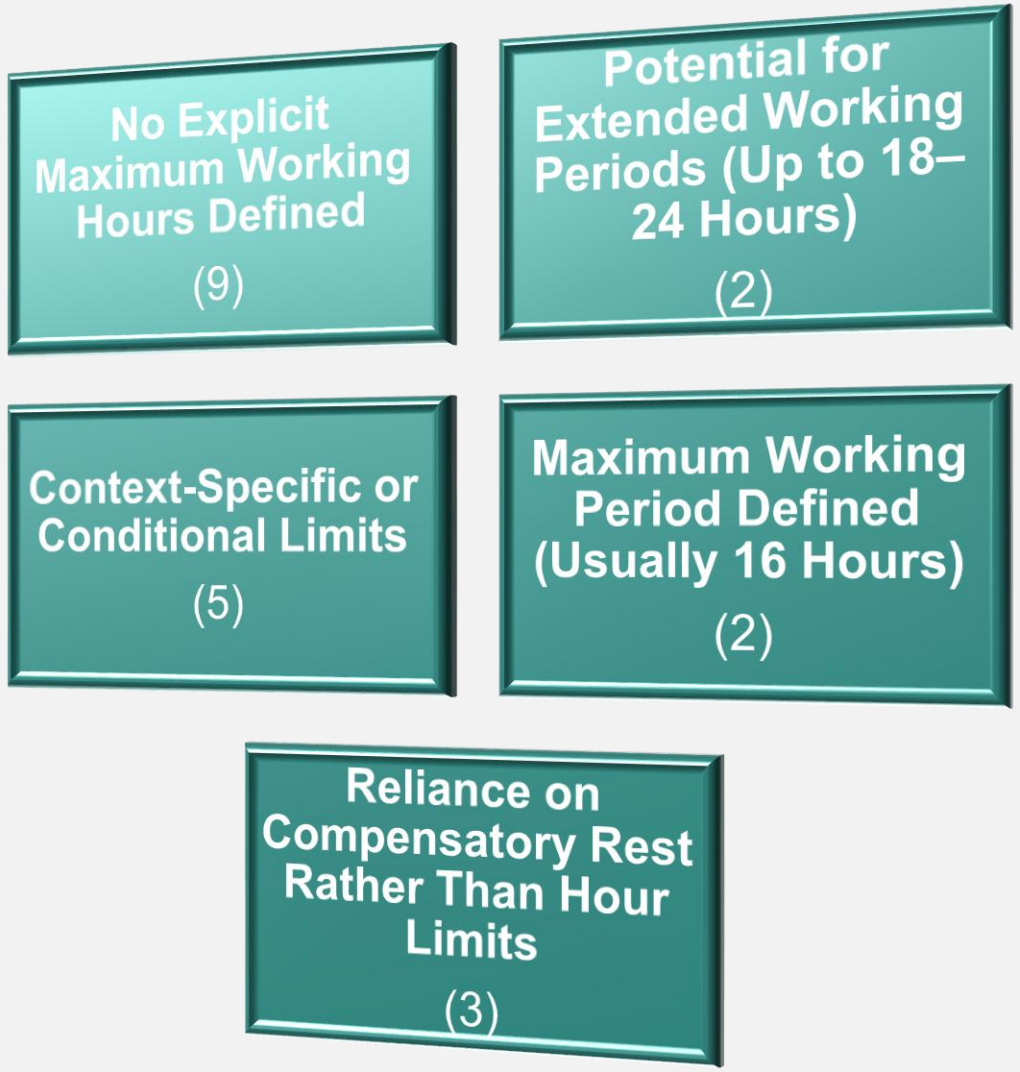
Q58. Does your service have any parameters in place for a maximum period of working in a 24-hour period?

Theme	Description	No. of Responses
No defined maximum	No parameters in place	9
Defined maximum (16 hrs)	Formal limits applied	2
Context-specific limits	Conditional caps	5
Rest-based mitigation	Focus on compensatory rest	3
Extended working periods	18–24 hrs possible	2

Overall Interpretation

Most services **do not have explicit parameters** defining a maximum period of working within a 24-hour period. Where limits exist, they are often **context-specific, inconsistently applied, or derived from external guidance rather than embedded local policy**.

Several responses acknowledge the potential for **very extended working hours**, particularly in homebirth models, with safety managed retrospectively through compensatory rest. This variability highlights a **significant opportunity for standardisation**, clearer fatigue-risk management, and alignment with workforce safety guidance.



Q65. Transfer Themes by Setting 1/2

Antenatal Transfers

Key Themes

- **Clinical reason in pregnancy**
- **Fetal conditions**
- **PROM**
- **Maternal choice / service factors**

Examples from responses

- Known fetal conditions (7, 17)
- PROM <24 hrs and >24 hrs (6, 13)
- APH (4, 7)
- Breech / malpresentation diagnosed antenatally (4, 14)
- Maternal preference (17)
- No homebirth service available / service suspension (10, 17)

Summary theme

Antenatal transfers are predominantly driven by **clinical risk factors identified during pregnancy**, with a substantial contribution from **maternal choice and service capacity issues**.

Intrapartum Transfers

Key Themes

Delay / failure to progress. Delay in **1st** / **2nd stage**

- **Fetal compromise**
- **Maternal request for analgesia**
- **Obstetric complications**
- **Maternal choice in labour**

Examples from responses

- Delay in 1st stage (1, 4, 5, 7, 10, 14, 15, 17)
- Delay in 2nd stage (4, 10, 15, 17)
- Failure to progress / advance (17)
- Meconium-stained liquor (1, 6, 7, 8, 14, 15)
- Blood-stained liquor / bleeding / APH (4, 6, 7, 15)
- Fetal bradycardia / tachycardia (4, 6, 14, 17)
- PROM observations (6, 13)
- Face presentation / breech / malpresentation (4, 14)
- Maternal choice in labour (4, 17)
- Analgesia request (2, 8)
- Obstructed labour / shoulder dystocia (13)

Summary theme

Intrapartum transfers are **most commonly due to delayed labour**, frequently combined with **fetal heart rate or liquor concerns**, alongside **analgesia requests and maternal choice**.

Q65. Transfer theme by setting 2/2

Postnatal Transfers

Key Themes

- **Obstetric emergency**
- **Perineal trauma**
- **Postpartum haemorrhage**
- **Neonatal assessment / observation**

Examples from responses

- PPH (3, 12, 17)
- Retained placenta / MROP / snapped cord (3, 17)
- 3rd-degree tear / complex perineal trauma / theatre repair (3, 14, 17)
- Postnatal suturing (6, 14)
- Neonatal condition / neonatal observations / NNU review (3, 5, 17)
- BBA requiring transfer (12)

Summary theme

Postnatal transfers are **predominantly emergency-driven**, with **PPH and perineal trauma** the most common maternal reasons and **neonatal observation** the main infant-related cause.

Cross-Cutting / System Factors

Key Themes

- **Service availability**
- **Staffing and hospital acuity**
- **Incomplete or unavailable data**

Examples

Suspension of homebirth service due to staffing/acuity (10)

No HB service available (17)

No data / data to follow (9, 11, 16)

Summary theme

System and service factors represent a **significant non-clinical driver of transfer**, particularly affecting antenatal and early intrapartum pathways.

Setting	Dominant Transfer Themes
Antenatal	Clinical pregnancy risk, fetal conditions, PROM, maternal choice, service availability
Intrapartum	Delay in 1st/2nd stage, fetal compromise, liquor abnormalities, analgesia request, maternal choice
Postnatal	Obstetric emergency (PPH, retained placenta), perineal trauma, neonatal observation
System-wide	Staffing, service suspension, data gaps

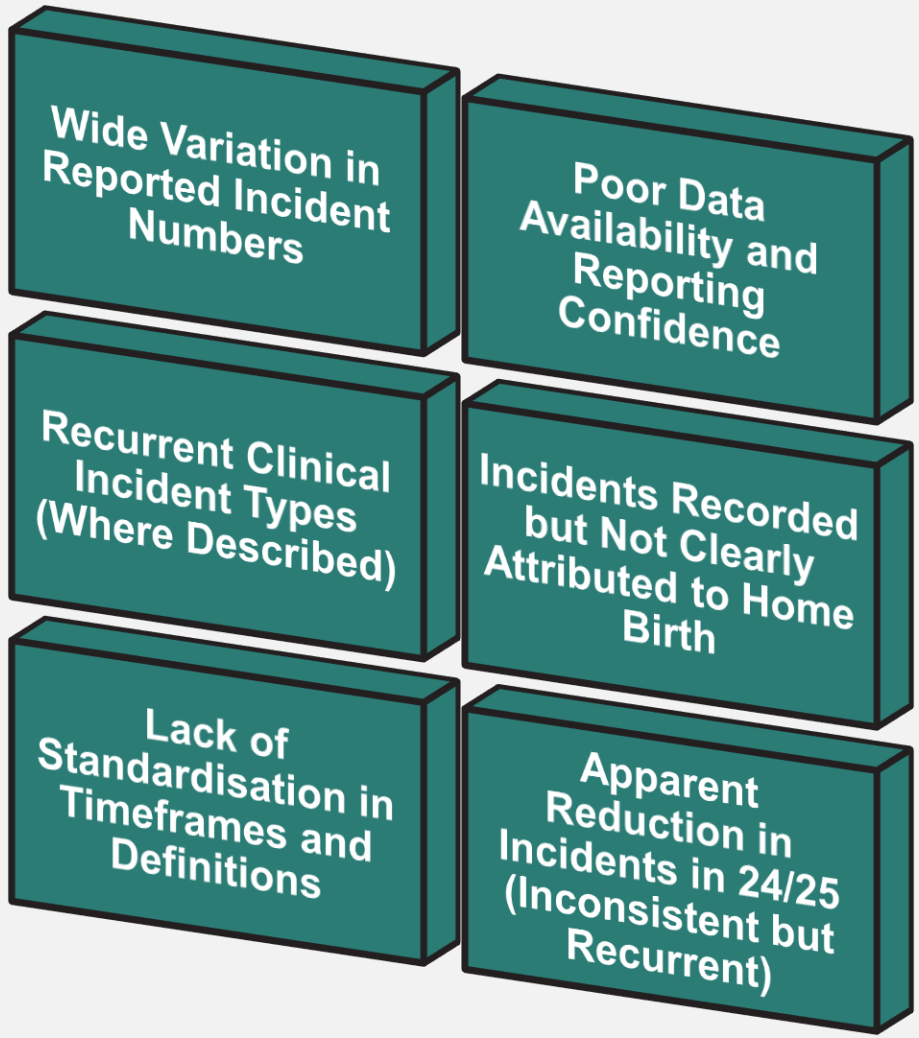
Q66. How many clinical incidents have been reported linked to home birth in 23/24, 24/25?

Overall Conclusion

Thematic analysis indicates that **clinical incident reporting linked to home birth is inconsistent, incomplete, and variably interpreted across respondents**.

While **PPH and neonatal compromise** are the most commonly described incident types, **data quality and standardisation issues** significantly limit meaningful comparison between 23/24 and 24/25.

Theme	Key Issue
Data variability	Incident numbers vary widely
Data gaps	Many respondents unable to supply data
Attribution	Home birth incidents not easily isolated
Incident type	PPH and neonatal compromise most common
Temporal trends	Possible reduction in 24/25, inconsistent
Standardisation	No shared definition or reporting approach



Q67. Please describe any learning from any home birth incidents during 23/24, 24/25.

Themes Identified

Poor documentation of management plans and holistic risk assessments

Communication challenges during hospital escalation

Need for contemporaneous notes in second stage

Absence of growth chart in notes for SGA baby

Equipment checking and standardisation

Training, Simulation & Skill Maintenance

Escalation, Transfer & Timeliness of Care

Staffing, Service Sustainability & System Risk

Documentation, Risk Assessment & Care Planning

Communication & Interface Working

Emergency Preparedness, Equipment & Training

Maternal choice to decline transfer highlighted as a risk requiring clearer escalation and documentation

Learning around offering transfer earlier for PPH >500ml

MOH stepped down too early, causing delay to blood transfusion despite good initial management

Q68, 69, 70, Induction of Labour / Services Withdrawn

Thematic analysis demonstrates **clear consensus** that women planning a hospital birth are routinely **offered induction at 41 weeks** if low risk, in line with national guidance. This is underpinned by a **risk-based, individualised approach**, with flexibility to extend towards 42 weeks where clinically appropriate and consistent with maternal preference.

Thematic analysis shows **near-universal agreement** that women planning a home birth are **offered induction of labour at the same gestation** as those planning hospital birth. Decisions are **risk-based and individualised**, with **place of birth not influencing the timing of the offer**. Where induction is declined to preserve a home birth plan, **formal obstetric review and documented care planning** are recognised as essential to ensure safety and governance.

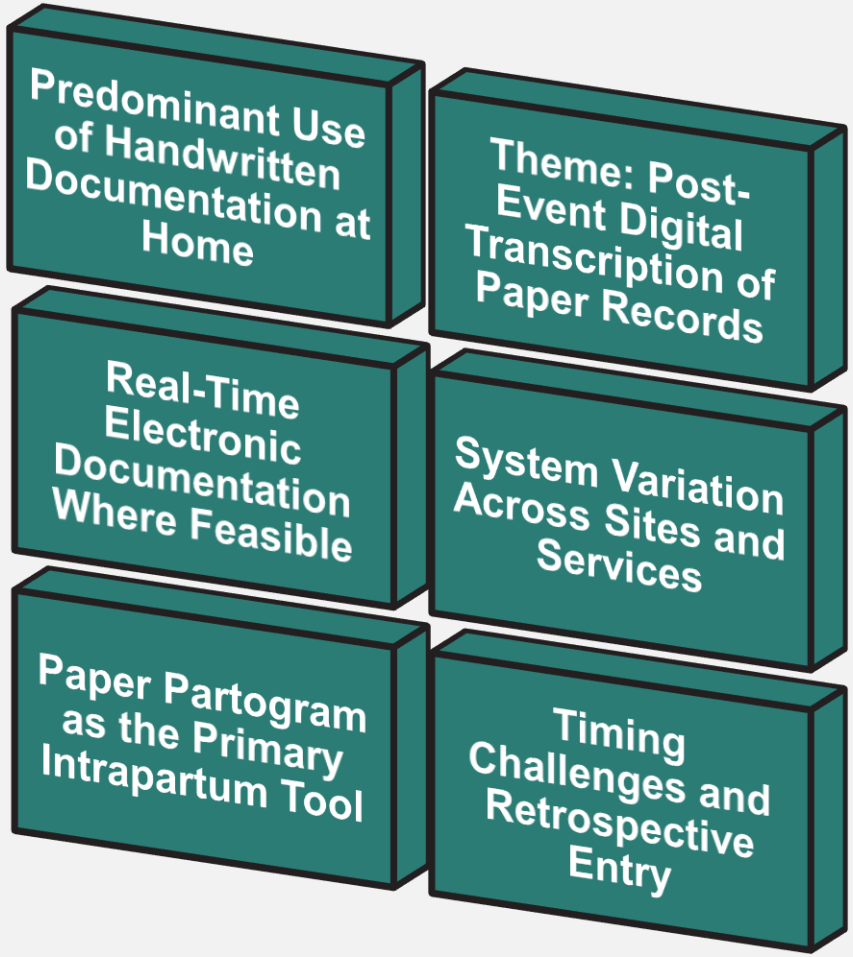
Thematic analysis demonstrates **no consistent gestational point at which home birth services are routinely withdrawn**. While **42 weeks** is commonly recognised as a **guideline threshold**, most services continue to provide home birth care beyond this point through **out-of-guidance pathways, MDT review, and personalised care planning**. Maternal choice, relationship-based care, and individualised risk assessment are prioritised over fixed gestational limits, reflecting both philosophical and pragmatic approaches to safety.

Q71 How do midwives document care including portogram

Overall Conclusion

Thematic analysis shows that **documentation during home birth is most commonly paper-based**, with handwritten notes and paper partograms used contemporaneously. Many services employ a **hybrid model**, transcribing paper records into electronic systems after the event, while a smaller number can document electronically in real time using laptops or tablets. Variation in digital infrastructure and connectivity leads to **inconsistent documentation practices**, with retrospective electronic entry commonly required to meet organisational record-keeping standards.

Theme	Strength
Handwritten documentation	Strong
Hybrid paper-to-digital approach	Strong
Real-time electronic documentation	Moderate
Paper Partogram use	Strong
System and site variation	Moderate
Retrospective digital entry	Moderate

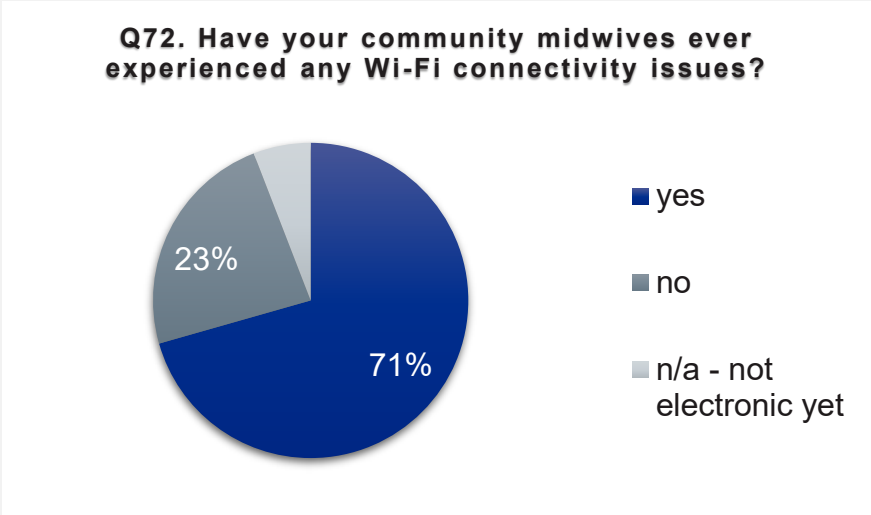


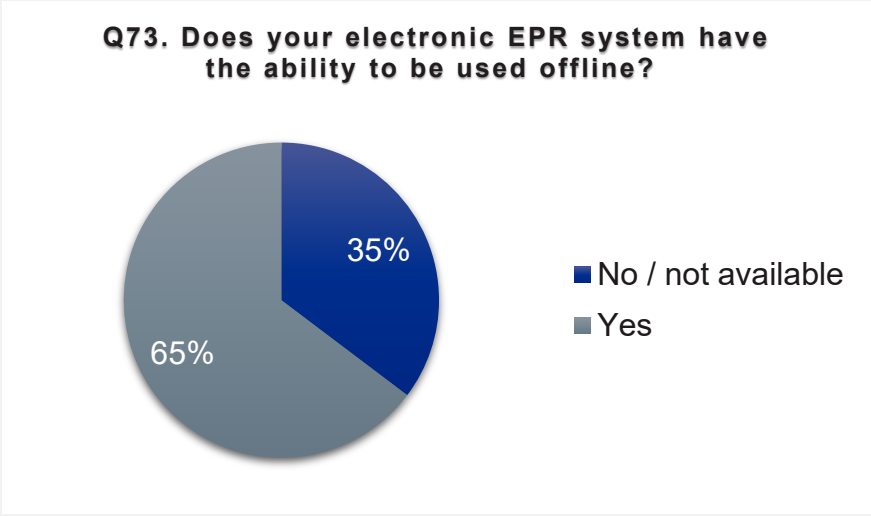
Q72, 73 Connectivity working in the Home Birth Setting

Overall Conclusion

Thematic analysis shows that **most community midwives have experienced Wi-Fi connectivity issues**, highlighting a significant **system-level constraint** on real-time electronic documentation in community and home birth settings. Variability across services suggests uneven digital infrastructure, while areas not yet fully electronic may be masking future risk. These findings reinforce the need for **robust offline documentation solutions and clear guidance on paper-to-digital workflows**.

Theme	Strength
Wi-Fi connectivity issues common	Very strong
Variability across services	Moderate
Digital maturity impacts experience	Moderate
Workarounds likely required	Implicit but strong





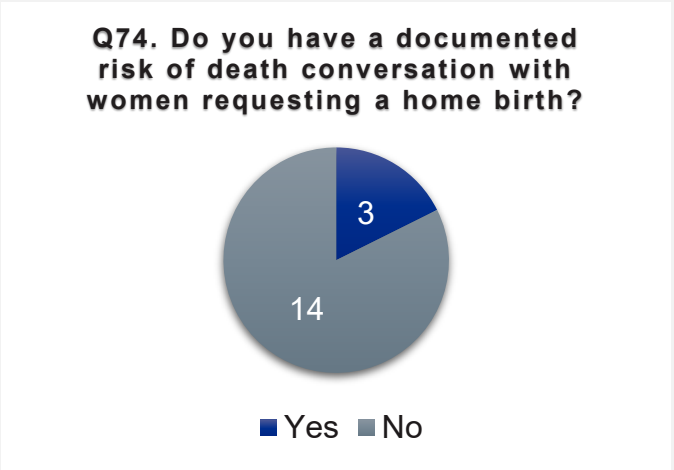
Section 6: Coroners Questions

Q74-76

PFD – Matters of Concern

PFD Matters of Concern Case 1	PFD Matters of Concern Case 2
1. There is no national guidance in respect of home births. Specifically, robust evidenced based guidance on home birth care, similar to that which is in place for intrapartum care in a hospital setting.	1. There is no national guidance in respect of home births and in particular the model of care. Linked to this, there is therefore no guidance on:
2. There is an increase in the number of women with 'high risk pregnancies' requesting home births where required interventions cannot take place or would be significantly delayed and there is no robust framework for midwives supporting home birth care. There is no national guidance to support consistent practice across the country including, for example, details of clinical scenarios where women, following robust assessment, have been considered too high risk to safely receive care in a home-setting.	a. The training that a midwife should undergo to ensure they are competent to manage a home birth, given the inherent risks involved when there is no hospital team behind you in an emergency.
3. The lack of national guidance means there are differing models of care and unlike other specialities home births are not a specialist commissioned service. There is no national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework.	b. The number of deliveries a midwife should have done in a hospital setting before being able to safely manage a home birth and/ or the number of deliveries a community midwife should be involved in to maintain their skills.
4. Even though there is a very small risk of death, this is not something which is discussed with women particularly in relation to maternal death, even if the woman has a recognised risk such as a post-partum haemorrhage. There is no guidance to ensure the risk of death to both mother and baby is discussed with any woman considering a home birth irrespective of being considered high or low risk.	c. The threshold for transfer to hospital.
5. NICE guidance on intrapartum care (2023 updated June 2025) Section 1.3.3 only refers to the potential risk of death to a baby. There is no mention in the guidance of risk to the mother.	d. Safe staffing and equipment levels, without which the service should be suspended.
6. Terminology around pregnancies describes them as 'high' or 'low risk pregnancy' and leads women to consider that pregnancy encompasses all stages through to delivery of a child. Practice does not personalise or individualise risk so women can fully understand what the level of risk is for them in actually being pregnant, or what the level of risk is for them in giving birth.	e. The supervision which should be provided during a home birth, for example through a midwife in the hospital accessing the notes.
7. In order to maintain their skills, there is no set number of deliveries a community midwife must conduct following qualification. There is no mandated number of deliveries that any midwife (irrespective of the settings in which they are working) must complete once they have qualified as a midwife in order to maintain their registration. The level of experience of community midwives in conducting deliveries is not information routinely provided to women to inform their decision whether to have a homebirth.	f. A system for back-up should electronic systems fail i.e. whether paper notes should be provided as a routine.
8. No bespoke training needs analysis has been conducted focusing on midwives practicing in home birth teams.	g. Information which should be provided to expectant parents around the risks of home birth/ the experience of the team to enable them to make an informed choice.
9. The lack of national data collection means there is no data to evidence the number of women who are transferred in during labour or after birth, maternal or neonatal outcomes, number of women who are considered out of guidance.	2. There is no national or local collection of data around home births such as number resulting in transfer to hospital, number involving injury to mother or baby. Such data would allow expectant parents to make an informed choice as to the risks of a home birth.
10. The no national guidance on the model of staffing, training and experience for midwives providing home birth care.	

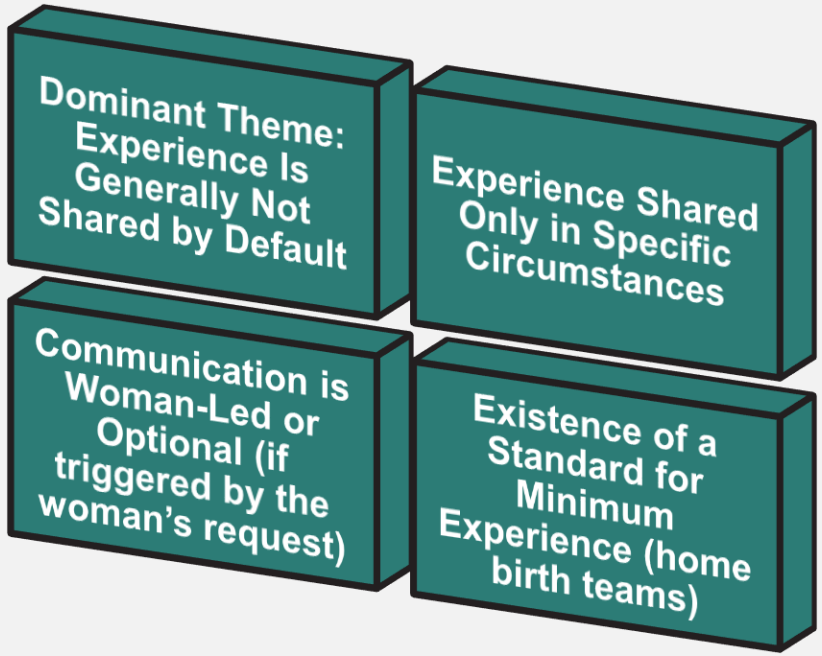
Q74/75. Documented risk of death conversation/level of experience the attending midwives have?



Overall Conclusion

Thematic analysis shows that **women requesting home birth are generally not routinely informed of the attending midwives' experience**, including recent intrapartum care. Sharing of experience occurs **only in exceptional circumstances**, such as births outside guidance or significant clinical risk, or when **requested by the woman**. Internal standards and experience requirements exist, but these are usually **implicit safeguards** rather than communicated information.

Theme	Strength
Experience not routinely shared	Very strong
Shared selectively for high-risk/out-of-guidance cases	Moderate–strong
Internal competence standards exist	Moderate
Woman-led or optional sharing	Moderate

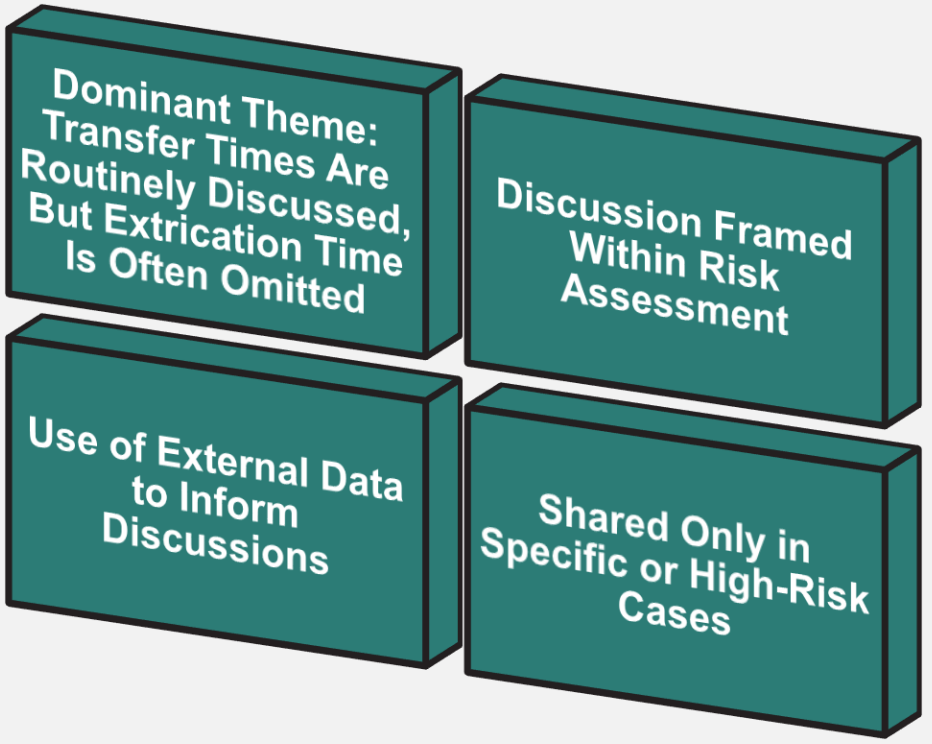


Q76. Do you share with a woman requesting a home birth, the average length of time it takes to extricate a women from her home in an emergency, in addition to the time to attend and time to transfer?

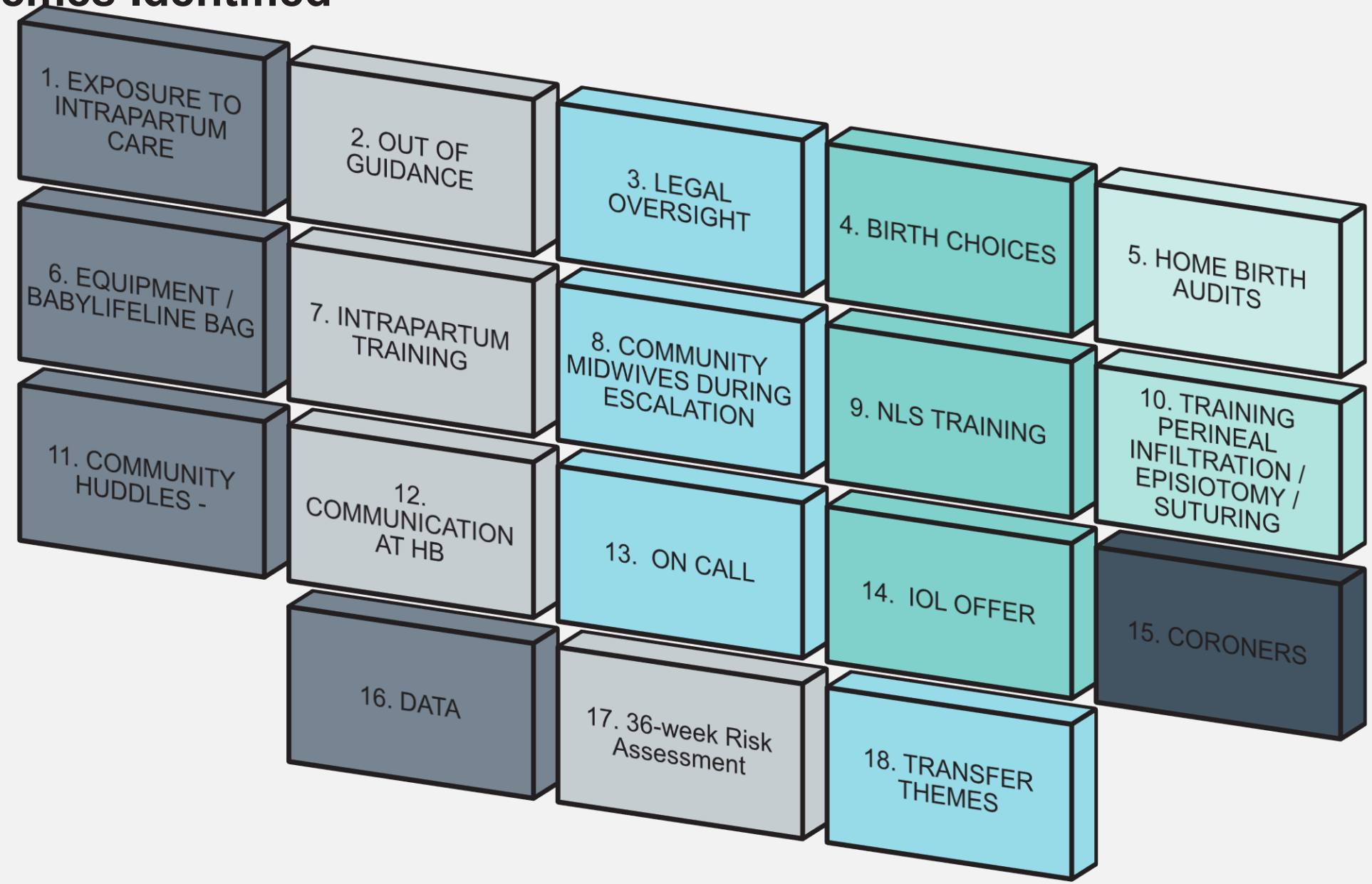
Overall Conclusion

Thematic analysis shows that **most home birth services discuss transfer times with women**, usually documented within **risk assessments around 36 weeks**. However, **explicit extrication times are not consistently communicated**, reflecting variability in home layouts and emergency circumstances. Some services use **ambulance service data** to guide discussions, and detailed discussions are often prioritised for **women with higher-risk or out-of-guidance births**. Overall, communication focuses on **informed awareness of potential delays rather than precise timings**.

Theme	Strength
Transfer times routinely discussed	Very strong
Extrication times less consistently shared	Moderate–strong
Discussion documented in risk assessment	Moderate–strong
External data (ambulance statistics) used	Moderate



Key Themes Identified



Theme No	Theme description	Allocation	Date allocated	Date presented by regional team	Date presented by trio	Brought back for sign off	
1	Exposure to Intrapartum Care	Savannah Dallas-Cross, Lisa Elliott, Abigail Hunt	13/01/2026	13/01/2026	20/01/26	03/02/2026	
2	Out of Guidance	Kylie Watson(lead), Chantelle Winstanley, MaryJo Waldron, Sarah Nuttie, Angela Kerrigan	13/01/2026	13/01/2026	20/01/26	03/02/2026	
3	Legal	Kylie Watson(lead), Chantelle Winstanley, MaryJo Waldron, Sarah Nuttie, Angela Kerrigan	20/01/26	13/01/2026	03/02/2026	03/02/2026	
4	Birth Choices	Mandy Jones, Jennifer Michaels Sarah Nuttie, Mandy Platt	20/01/26	13/01/2026	27/01/26	10/02/26	
5	Home Birth Audit			13/01/2026	06/01/2026		
6	Kit and Equipment	Jane Ingleby, Debby Gould, Jo Goss	27/01/2026	20/01/2026	27/01/26	10/02/2026	
7	Intrapartum Training	Karen Clough, Fiona McCarron, Rebecca Sessions	13/01/2026	27/01/2026	03/02/2026	? 24/02/2026	
8	Community Midwives during escalation	Savannah Dallas-Cross, Lisa Elliott, Abigail Hunt	03/02/2026	03/02/2026	03/02/2026		
9	NLS training	Karen Clough, Fiona McCarron, Rebecca Sessions, Catherine Owens	03/02/2026	03/02/2026	03/02/2026		
10	Training Perineal & Placenta Histology	Karen Clough, Fiona McCarron, Rebecca Sessions	03/02/2026	03/02/2026		24/02/2026	
11	Community Huddles	Laura Perkins, Rachel Mavers, Coralie Rodgers	03/02/2026	03/02/2026	03/02/2026		
12	Communication at Home Birth	Laura Perkins, Rachel Mavers, Coralie Rodgers		03/02/2026			
13	On call						
14	Induction of Labour						
15	Coroners						
16	Data						
17	36-week Risk Assessment						

Department of Health & Social Care

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		Trust	1	2	3	4	5	8
Section	Question Number	Please select your Trust	Countess of Chester Hospital NHS Foundation Trust	Tameside and Glossop Integrated Care NHS Foundation Trust	Northern Care Alliance	Wrightington, Wigan and Leigh NHS Foundation Trust	Manchester University NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
0	1	Identified link for Home Birth T&F Group	Abigail Hunt	Laura Perkins	Jennifer Michaels	Christina Lowe Community Matron	Kylie Watson/ Jen Sager	Jo Lavery
0	3	What is your role?	Community midwifery manager	Deputy Divisional Midwifery & Nursing Director	Lead Midwife for Community Services	Divisional Director of maternity and child health	Consultant midwife	Director of Midwifery
0	4	Please confirm your email	abigail.hunt5@nhs.net	laura.perkins@tgh.nhs.uk	jennifer.michaels@nca.nhs.uk	cathy.stanford@wwl.nhs.uk; christina.lowe@wwl.nhs.uk;	kylie.watson@mft.nhs.uk; jen.sager@mft.nhs.uk	jo.lavery@nhs.net
1	5	What type of home birth model do you offer?	Traditional ;	Traditional ;	Traditional ;	Traditional ;	Dedicated home birth team;	Dedicated home birth team;
1	6	Do community midwives have exposure to wider intrapartum care? Select all the apply	NO;	NO;	YES - alongside midwifery led unit ;	YES - labour ward ;	NO;Dedicated homebirth team does - not community midwives;	YES - labour ward ;
1	7	How often would your community midwives be exposed to intrapartum care in other settings, other than home birth? Please describe in detail how this is achieved.	Community midwifes are called in to the unit on escalation for times of high acuity and short staff. At these times the labour ward coordinators would usually request the community midwife work on MLU however the MLU figures for this unit are very low. In this event the coordinator will request that the community staff work on the maternity ward.	very rarely	Community midwives rostered to work on alongside MLU for 2-4 12 hour shifts per 8 week roster block.	Midwives are rotational however some have not moved from the community area for some time. There are growing numbers of Band 6 Midwives who have completed rotation in all areas who are working on community and several who have recently (within last 2 years) transitioned to community enhanced team.	The traditional community midwives are not exposed to intrapartum care in any setting. Each member of the homebirth team undertakes 37.5 hours of clinical exposure every 6 months on a consultant-led labour ward. This may be shadowing the coordinator or answering emergency bells so they are attending emergency situations such as neonatal resuscitation and management of PPH.	In escalation and reviewing a model to have more regular exposure to labour ward
1	8	Do you have a Home Birth guideline?	Specific Home Birth Guideline	Specific Home Birth Guideline	Specific Home Birth Guideline	Specific Home Birth Guideline	Specific Home Birth Guideline	Specific Home Birth Guideline
1	9	Does your guideline include a home birth 36-week risk assessment?	Yes - completed digitally	Yes - completed on paper	Yes - completed digitally	Yes - completed on paper	Yes - completed digitally	Yes - completed on paper
1	10	Where is the home birth 36-week risk assessment undertaken?	Home	Home	Home	Home	Home	Home
1	11	Is the home birth risk assessment revisited at every antenatal contact once complete?	Risk assessment should be completed at every contact	yes	Yes at community midwifery appointments.	Yes	The 36 week homebirth risk assessment is not revisited until care in labour begins at home. Place of birth risk assessment is revisited at every subsequent antentatal contact as per Ockenden requirements	Yes
1	12	Who routinely completes the 'low risk' home birth 36-week risk assessment? You can select all that apply.	Community midwife Band 6;	Community midwife Band 6;	Community midwife Band 6;Community midwife Band 5;Community midwife Band 7;	Community midwife Band 6;Community midwife Band 7;	Dedicated homebirth team member (often the Band 7 team leader). This is for all 36 week homebirth risk assessment irrespective of 'risk' profile;	Community midwife Band 6;Community midwife Band 7;
1	13	How long are midwives allocated to complete a 'low-risk' home birth 36-week risk assessment?	as long as necessary. usually at least 60 mins	60 minutes	60 minutes	Home visit probably half an hour . but would vary	1- 2 hours	MCoC team so would be up to an hour appointment
1	14	Do you have a 'birth outside of guidance' pathway, regardless of setting?	No	No	Yes	Yes	Yes	Yes
1	15	Does this pathway include a birth outside of guidance care plan / template?	We do not have an out of guidance pathway	We do not have an out of guidance pathway	Yes	Yes	Yes	Yes
1	16	Is your out of guidance care plan structured using an acronym such as BRAIN? (Benefits / Risks (including data/stats of risk-based profile) / Alternatives / Intuition and Nothing) Please indicate ...	We do not have a out of guidance care plan	We do not have a out of guidance care plan	No	No	Yes	Yes
1	17	Who routinely completes the 'out of guidance' home birth care plan?		consultant and matron/senior midwife	The plan is completed with a Band 7 Community Midwife and a Consultant Obstetrician.	Community Midwives with Consultant input after referral for Consultant review.	Homebirth team leader in partnership with a consultant midwife and the woman. Then discussed at an MDT team meeting (consultant obstetrician, consultant midwife, head of midwifery, homebirth team member, homebirth matron)	MDT approach to include consultant midwife, senior midwife, obstetric consultant, team leader and named midwife
1	18	At what gestation is the out of guidance home birth care plan completed?	by 36 week or as soon as identified	36	Varied depending on what gestation the risk is identified and maternal request for homebirth.	No specific date but when identified	36 weeks onwards following homebirth risk assessment	Aimed by 36 weeks
1	19	Do you have an MDT panel / process for out of guidance care regardless of setting? Please include details i.e. people involved where required - ODN, anaesthetics	no	women will be referred based on their individual needs and risk factors	Yes. Consultant Obstetrician and Band 7 Community Midwife invited as a minimum. The MNVP are invited. Other key stakeholders would be invited if required due to risk.	Not at present but is under proposal as part of outside of guidance care planning with a senior midlife and named consultant.	Yes for homebirths. For birth centre births the plans are reviewed by a consultant midwife and consultant obstetrician.	MDT approach to include consultant midwife, senior midwife, obstetric consultant, team leader and named midwife; implementing a monthly panel from Jan 2026
1	20	How would you consider skill mix and support for midwives attending an out of guidance homebirth?	community midwives attend all out of guidance births in pairs	We have some very experienced community staff plus staff that rotate to labour ward, etc	Skill mix of minimum 1 x Band 5 and 1 x Band 6. Band 7 available via phone 24/7 for advice.	currently the most senior Midwife would be Midwife 1 . Midwife 2 may be a Band 5 but both go out together	Midwives attending are from the dedicated homebirth team who have received additional training (including full day NLS training). On-calls also supported by senior community midwives if there are rota gaps. Support at home provided by bleep holders every 4 hours who contact the midwives at home - full SBAR and review of notes (electronic) is completed. Senior midwives also available for further support 24/7. Homebirth team members are all Band 6 or above.	Arrange for two midwives in attendance to go together, with the first being a dedicated homebirth midwife from the team; if unable for any reason home birth service is suspended; additional skills drills as identified in the care plan for support and to refresh
1	21	Do you have a process that outlines which out of guidance care plans are reviewed by the trust legal team?	No	No	Yes	No	Any plan that the MDT feels requires review by the legal team can be submitted and discussed	Not officially documented, but involve the legal team when required and included in the MDT ToR
1	22	Do you currently have a Consultant Midwife? If yes - please include email here	no	No	No	No	kylie.watson@mft.nhs.uk; rachel.bebbington@mft.nhs.uk	angelakerrigan1@nhs.net
1	23	Do you offer any specific specialist clinics relating to birth choice?	Birth options	No we are planning to implement one	Birth Reflections	Not at present but are planned to be implemented by March 2026	Post natal birth reflections/individual birth options appointments for women who request/require with matrons/team leaders or consultant midwives	Band 8b Consultant midwife clinical twice a week covers birth reflection; out of birth guidance (all women referred and offered an appointment, debriefs and trauma Band 7 midwife runs two clinics to include debrief (criteria in policy) and VBAC clinic
1	24	Who normally facilitates the above clinics?	Band 6	Band 8	Band 6	Band 7	Band 7 or consultant midwives	Consultant Midwife
1	25	Have you completed a home birth audit within the last 2 years?	No	No	Yes	Yes	Yes	No
1	26	Who are your home birth audit findings shared with?	SLT	n/a	Presented at Divisional Assurance Board.	senior managers and wider team . Added to Audit meeting agenda for wider dissemination	Shared with homebirth working group/maternity quality and safety committee/maternity and neonatal safety champions (including heads of midwifery) via maternity oversight delivery group chaired by Director of Midwifery.	Annual audit being commenced for 2025 in Jan 2026
1	27	If you have completed a home birth audit - what themes and learning were identified?	No specific home birth audit. We audit 2 home births per month as part of the care metrics. Themes, declining any VE's, declining observations. Midwives are not routinely documenting on EPR, still using paper records for home birth	N/A	Learning around IIA - individual learning provided. Paper notes not consistently uploaded following birth - individual learning and new process Some women classified as 'low-risk' had risk factors. New process for senior review (Band 7) for all women introduced.	Documentation and adherence to IIA.	Documentation of resuscitation equipment being set up and in working order/completion of neonatal observations within the first hour/	N/A can provide once completed
1	28	Where available please forward: Home Birth Guideline, Out of Guidance pathway, 36-week Risk Assessment and any other papers you feel would be useful to england.nwregional.maternityteam@nhs.net	I will send these now	N/A		Guidance to be forwarded as requested	MFT have already submitted this to the regional team	Forwarded
2	29	Does your organisation use the 'Baby Lifeline' equipment bag as standard? If no, please state what you use by selecting the 'other' option	Yes	no local kit	Yes	Yes	Yes	Bag content based on babyline recommended equipment; alternative bag adopted due to size and manual handling concerns

2	30	Is the 'Baby lifeline' bag being used with all the original items that was supplied with the purchase of the bag? If no, what is the reason the equipment has been altered?	Origonal	N/A	Replaced with NCA equipment when expired/used.	We use the original items but not the bag as it it is too cumbersome	Not being used with the original items as received the bags 5 years ago. New kit such as BP monitoring and guedel airways have been added. Kit that is used is in line with Trust policies such as blood taking equipment and to ensure kit can be re-stocked with Trust suppliers.	The baby lifeline bag is used with the same equipment, however from WUTH supply chain to refill; alternative choice of style bag adopted
2	31	If any adaptations have been made to the baby lifeline bag - please describe the governance process followed to achieve this	We are in the process of setting up home birth boxes which will include all of the same equipment as the baby lifeline bag	N/A	N/A	NONE.	Home birth policy contains updated equipment list following review by home birth working group. Changes ratified by Trust governance processes.	N/A
2	32	What is the current checking process for your homebirth equipment when in the home/attending homebirth?	Midwife checks their bag monthly currently	Midwife will check all equipment is present and woeking	Homebirth kit opened on arrival. 'Resus' area set up	Daily checklist in place and will be completed on arrival at the home.	Emergency equipment (eg neonatal resus equipment) is set up in the home and ensured all in working order including checking patency of oxygen tubing and bag and mask connected and in working order, suction working. All required to be documented in electronic record.	Individual responsibility to complete at least once a month (all have own bag), the team check more frequently and document; random audit to be implemented for governance oversight; bags are checked individually when attending a home birth
2	33	What is the current strip down and checking process for your homebirth equipment following a home birth?	We have an inventory that we write on and then replace all items used	The bag is returned to the birth centre for restocking	Homebirth kits checked x1 per month fully and sealed with red tags. Restocked following birth and sealed with red tags. Medicines in sealed boxes from pharmacy - once opened resent back to pharmacy.	all bags restocked and cleaned and checked and equipment remains in working order	Equipment is brought back to the unit and full re-check and re-stock of the bag is done in line with homebirth policy.	Individuals responsibility to replace and check against contents list
2	34	Is there an auditable trail for checking this equipment	yes	yes	Yes	Yes Checklist held within the teams	Yes	Partially - each bag has a check list - audits required to be implemented
2	35	If further equipment is required, how would this be arranged? Example - additional gases	Gas is delivered directly to the patient by transport	delivered to the womans house	In day hours - call to community coordinator (0730-2000) who would facilitate Out of hours - call to 3rd/4th oncall to bring. If 3rd/4th oncall already out call to bleep holder who would arrange.	Midwife 2 would attend the unit for refills. The home birth equipment carried by each midwife includes 1 small o2 and 1 small entonox	Additional equipment requested as per homebirth equipment policy. If any additional equipment is required at a homebirth this would be arranged to be delivered by taxi by the maternity bleep holder	All home birth stock available at the hospital as ordered via procurement to ensure stock is available at the Birth Centre
3	36	Does your organisation provide community midwives with specific out of hospital maternity emergency and multiprofessional training?	No	Yes	Yes	Yes	Yes	Yes
3	37	If yes, how often is this training?	not currently	every 12 months	One community PROMPT in 2025. Community PROMPTS to be reintroduced as mandatory for all community team from March 26.	annually	Yearly homebirth specific maternity training provided for homebirth team members and other staff supporting	Recently introduced quarterly training additional to the annual PROMPT; community scenarios included on a cycle
3	38	What training is provided to community midwives on informed consent / shared decision making?	Yearly mandatory training	n/a	Information provided as part of the PCSP training (LMNS devised) offered to all staff.	Included in the core competency framework as part of personalised care.	Yearly mandatory training provided for all midwives on this.	Included in 2025 PROMPT - session on personalised care; language and decision making delivered by Consultant Midwife to all staff in attendance
3	39	Do your community midwives complete annual mandatory training on NICE intrapartum care for healthy women and babies?	Yes	Yes	No	all mandatory training follows the core competency framework and the requirements for MIS . an additionla session is given to community midwives during community PROMPT	No	No
3	40	What percentage of your community midwives have completed and passed the Fetal monitoring and surveillance training? (in the antenatal and intrapartum period)	100	not known	Compliance maintained at >90%. Staff unable to attend homebirths if not complaint with fetal monitoring training.	91%. 4 Booked onto next session which will give 100% compliance	100% that are on the homebirth team. For all other midwives 98%	100% compliance; all midwives have completed K2 and Fetal physiology in the reporting period for 25%
3	41	Please describe your governance process for assuring all staff providing intrapartum care regardless of setting, who attend home births have passed the above training	All staff undertake mandatory training. They complete fetal monitoring study day and complete the e-learning aspects required. This is monitored by the PDM and fetal monitoring lead and reported to the SLT and LMNS monthly as part of SBL compliance. If anyone is not compliant, within 7 days is chased by the lead , if non compliant within 28 days, this is escalated to management.	not known	Midwives who are out of date for fetal monitoring & PROMPT flagged by practice education team to community managers and Lead Midwife for Community and removed from oncall. Monthly assurance meetings held by practice education team and ward managers to ensure compliance isn't missed.	Staff are not allowed to provide care for home births or in hospital births if not compliant with the above	All team members have a monthly CPD meeting where competencies and skills are discussed including review date for fetal monitoring training.	Monthly compliance prepared and reported; if non compliant policy to highlight restrictions on practice; monitored by Fetal Surveillance Midwife
3	42	Do the on call community midwives cover escalation in the hospital as well as homebirths?	Yes	No	No	Yes	No	Yes
3	43	How many of your community midwives have completed the Resuscitation Council UK NLS (Newborn Life Support) or OH-NLS (Out-of-Hospital Newborn Life Support) Course?	All except new starters who are allocated within 12 months of starting onto the next available course. We have 3 spaces on each course, at a local provider, these spaces are prioritised for community	not known	Awaiting confirmation of figures	All community midwives must be Accredited NLS trained or cannot be on the on call rota	All members of the homebirth team (100%) have undertaken full day NLS training	100% compliance with the dedicated homebirth team; roll out programme underway for continuity and community midwives
3	44	How is the NLS 4-yearly compliance monitored/audited?	Monitored by PDM	by the PBE	Not monitored.	In house data base managed by education team	Through CDP monitoring and appraisal.	Via the Practice development midwife
3	45	What is the frequency of perineal infiltration / episiotomy / suturing training for community midwives, does this include a competency assessment and how is this audited?	Observed competency completed as part of preceptor-ship and when new to the trust. OASI training as part of core competency frame work. Self assessed competency documents for band 6 and above new to trust.	12 monthly	Unknown - will review.	Completed annually on community PROMPT and mandatory training	In line with TNA midwives have a training session during their induction period on all aspects of perineal care and regular perineal suturing workshops are held for additional training opportunities. There is no competency assessment for post registration midwives.	Suturing workshops held at WUTH throughout the year and are attended in own time for CPD; currently not mandatory to attend within an agreed timeframe; Al NQ's attend as part of preceptorship sign off
3	46	Is histological examination of the placenta included in your annual TNA? (Tissue pathway for histopathological examination of the placenta (RCOP, 2022))	No, as this is not required as part of the core competency framework. And hasn't previously been highlighted as a local.	no	Yes	No	No. All midwives are trained to examine the placenta by sight and touch, and would send placentas for histological examination if meeting criteria	No
3	47	What are the barriers to sending the placenta for histological examination in an out of hospital birth setting	Location, no formalin at home deliveries. unfamiliarity.	none	No barriers - all community midwives return to the hospital following a birth so are able to send a placenta.	None	There aren't any - in line with guidance midwives will take the placenta back to the hospital site (using a placenta bag and bucket and correct labelling) if needing to be sent for further examination.	None identified; placenta brought to hospital to be processed; rare occasion a patient may wish to retain
4	48	When a woman requests an out of guidance home birth - which professional would the community midwife refer her to?	Consultant Obstetrician	Consultant Obstetrician	Consultant Obstetrician & Team Leader	Consultant Obstetrician	Consultant Midwife	Consultant Midwife
4	49	After the out of guidance discussion, who is notified within the organisation of a request for out of guidance home birth?	Community manager	DoM, DDoM, Co-ordinators, consultant community midiwves	Database maintained that the midwifery SLT have access to.	Senior Leadership team and Delivery suite manager and coordinators and Consultant body	Consultant midwife, community matron, process for MDT review is followed	HoM/DoM informed; Labour Ward Lead Obstetrician; Community Matron and Delivery Suite Manager. Birth plan drawn up and communicated amongst that team for distribution to L/Ward Sisters, Home Birth dedicated team and community/continuity teams who may attend as the second
4	50	Do you have community Huddles? If so, how are they set up / frequency / escalation process	Yes daily	yes daily	Daily 'Check-in' held each weekday on Teams Extend Safety Huddle once per week on Teams - with attendance of all	Not at present but will be starting (delayed due to ongoing sickness)	Dedicated homebirth team have a daily huddle as does the traditional community team	Not at present
4	51	Do community midwives attend maternity and neonatal huddles?	No	Yes	Yes	as above	attend dedicated community huddles, do not routinely attend other inpatient huddles	Would only attend if present caring for a patient on delivery suite or in on escalation

4	52	Please explain your communication process between midwives at a home birth and the hospital	Communication between labour ward coordinator when required. And to update with new risks.	they liase with the labour ward co-ordinator out of hours and the community manager and matron within hours	Day hours (0730-2000) - Communication with community team leader Out of hours (2000-0730) - Communication with labour ward coordinator or bleep holder Two midwives present at all homebirths, at all times. No process for 'check-ins' established - will review and implment.	Awaiting formal ratification but will be undertaking 4 hrly Virtual fresh eyes review with delivery suite coordinator, or more frequently as required	4 hourly update with maternity bleep holder to provide support, additional more frequent and/or more senior support available if required.	Midwives who attend a home birth notify Delivery Suite Shift Leader when called out; details on delivery suite board. Updates given at least 4 hourly, unless birth plan indicates otherwise; Delivery suite contacted via RED phone if escalation indicated
5	53	How many community midwives do you have in your organisation?	25	23	60	46	Headcount 8.0, WTE 7.64 for dedicated homebirth team. Across SM MCS approx 130 traditional community midwives	Home Birth Dedicated team establishment is 6.8wte; Community Midwife team establishment is 12.14wte; MCoC establishment is 33.7wte
5	54	Are all of the above community midwives on the on call rota?	23	no	No	Yes	No. All dedicated homebirth team on the rota plus an additional 6 experienced bespoke homebirth trained community midwives also support on-call rota	Home birth dedicated team always first; community midwives on call equates to 10.24 and all 33.7 MCoC on rota for second in attendance
5	55	How many on calls does each community midwife cover a month?	pro rata average 3-5	They self roster	1-3	2	approx 8-10	Home birth dedicated team do 12 on call a month for days and nights. For community midwives approx 1.0wte will do 3-4; 0.8 will do 3; 0.6 will do 2 and 0.4 will do 1
5	56	Briefly describe your current 'On Call' model.	3 midwives on call per night. time 16:30-08:30	2 community midwives attend	4 midwives allocated to be 'On Call' between 1800 and 0800. First and second oncall called out to attend a homebirth - time in attendance capped at 6 hours and then 3rd and 4th oncall would takeover care for remainder of shift. Service only able to faciliate one homebirth at once.	Current model 12 hour on call	Day on call 8am - 8pm, night on-call 8pm - 8am, (work 8am - 12 midday of night on call). Two midwives on call at all times (2 day and 2 night)	Home birth team first in attendance and the second follows an escalation rota due to model of MCoC
5	57	Please describe what parameters for compensatory rest are in place if a midwife has been called out	Compensatory rest is dependant on the time called and time returned back home. ie if they have been able to have 11 hour break between shift There is no SOP for this within our trust. It would be very useful to have a regional guide for this	use own judgement	Variable depending on time called out and length of duration. Minimum of 8 hours rest facilitated after attendance at a homebirth overnight.	Compensatory rest next day. Currently looking at different models for on call to reduce the length and provide rest before and after	Do not work following day if night on call and called out.	For all MCoC on call finish by 2pm on Day 1 and have 6 hours protected; if called out overnight next day rest/non-working Traditional community 08:30-16:30, if called out would only be for 4 hour period and then would change to next on rota; next day rest/non-working
5	58	Does your service have any parameters in place for a maximum period of working in a 24 hour period?	16 hours maximum in 24 hour period however this has been taken from another trusts document	no	Variable depending on time called out. Community Shifts 0800-1800 rostered (inclusive of homebirth cover). If in attendance at a homebirth during these hours the community midwife could remain on duty until midnight (this can be brought forward if the midwife feels unfit to work). If called out after 1800 - time capped at 6 hours or again altered if midwife feels unsafe.	No	Maximum of 16 hours (split by a break of 8 hours from 12 midday to 8 pm). Follows European working time directive	No - current model could be a max period of 18 hours for dedicated team if worked the morning and were then called out all night
5	59	Please provide: Number of home births booked in 23/24, 24/25	April 24-March 25 127	200-220	October 2024 - October 2025 119 women expressed an intention to birth at home during their pregnancy.	24 calendar year =61	23/24 118 24/25 66 (no homebirth service from October 24 - April 25)	2024 - 138 (home and free standing birth centre 72/38 2025 - 93 (home and free standing birth centre) 61/32
5	60	Please provide: Number of planned home birth labours commenced at home during 23/24, 24/25	61, 9 transferred in	not known	October 2024 - October 2025 65 women	24 calendar year = 31 25 calendar year =50	No data captured	2024 - data not collated; commenced in 2025 2025 - 67 to date
5	61	Please provide: Number of planned home births achieved during 23/24, 24/25	April 24-25 53	not known	October 2024 - October 2025 44 women	24 calendar year = 28 25 calendar year = 29	23/24 52 24/25 19 (no homebirth service from October 24 - April 25)	Community birth in 2023 was 71, 54 home and 17 birth centre Community births in 2024 was 54, 46 home births and 8 birth centre Community births in 2025 to date is 46, 32 home births and 14 birth centre
5	62	Please provide: Number of transfers from planned home births to obstetric unit during 23/24, 24/25	April 24-25 9	not known	October 2024 - October 2025 - 21 in total. 8 Intrapartum, 13 postnatal.	24 calendar year = 3 25 calendar year = 9	No data captured	2024 - Not collated until 2025 2025 - 21
5	63	How many of the labours at home were within guidance during 23/24, 24/25?	We don't collate the data separately	not known	Data not available - mechanism in place for collating / auditing moving forward	24 calendar year = 31 25 calendar year = 36	No data captured	Data not collated; to commence from 2026
5	64	How many labours at home were known out of guidance during 23/24, 24/25?	We don't collate the data separately	not known	Data not available - mechanism in place for collating / auditing moving forward	24 calendar year = 19 25 calendar year = 25	No data captured - current audit data shows 40-50%	Data not collated; to commence from 2026
5	65	Please provide: Transfer themes from each setting, i.e. delayed 1st stage, maternal choice, obstetric emergency ?	Delay in 1st stage, Meconium stained liquor	pain relief	Obstetric emergency - retained placenta, PPH Neonatal condition + neonatal observations required Complex suturing	•Delay in 2nd stage x 1 •Delay in 1st stage x 2 •Fetal Bradycardia in 1st stage x 1 •APH x 1 •Blood-stained liquor x 1 •Face presentation x 1 •Maternal choice in labour x 1 •Diagnosed breech presentation x 1	Transfer themes for last 40 homebirths - delay in first stage (primips), neonatal observations,	Analgesia and Meconium
5	66	How many clinical incidents have been reported linked to home birth in 23/24, 24/25?	1 MOH due to partially separated placenta	not known	Detail unknown as incidents submitted under multiple categories	8 overall	One (24/25)	2023 - x 1 Neonatal collapse post delivery; undiagnosed meconium aspirate 2024 - x 1 postnatal PPH; x1 bradycardia 2025 - x 3 PPH and bradycardia
5	67	Please describe any learning from any home birth incidents during 23/24, 24/25. If none have occurred please state n/a	The learning from this was that the indecent was stepped down on admission direct to theater as the patient was stable due to the immediate action of midwives and paramedics who fluid resuscitated her. The MOH was stepped down which caused a significant delay in the patient receiving blood	n/a	All women planning a homebirth 'referred' for virtual case review to esnure low risk & MDT care planning note Digital notes stopped for intrapartum care and paper notes reintroduced. Integration of birth centre/community care to facilitate intrapartum competence/confidence Centralised kits & medicines. Introduction of split oncalls and Band 7 support	Poor documentation re management plans and holistic ongoing risk assessments. monitoring, observations and escalations were all good.	Learning from the one reported incident (maternal and neonatal death) learning has been shared widely	Changed PPH so any patient >500mls if offered transfer in Resus equipment review and standardised equipment in line with baby lifeline bag and at least monthly checks Fixed resus station in birth centre with neo puff Resus and community birth training quarterly All home birth dedicated team only on call if NLS training and roll out programme for Community midwife and MCoC midwives
5	68	At what gestation would you offer a woman planning a hospital birth to be induced?	In the absence of any other risks 41 weeks for prolonged pregnancy	41	Variable - individual risk assessment	Term+7	Offer from 41 weeks per national guidelines.	41 weeks
5	69	Would you offer a planned home birth woman IOL at the same gestation? If not, please describe why	We would offer the same to her	yes	Yes. IOL offered based on risk assessment.	dependant on reason but predominantly yes.	Yes	Yes 41 weeks
5	70	At what gestation would you cease to provide a home birth service?	We have women who have declined any form of induction for an extended period.	42 weeks	Individual risk assessment, via out of guidance MDT, and maternal choice.	we attend all home births	I would depend on individual risk assessment and MDT discussion, no fixed gestation.	Guideline states 42 weeks; but outside of guidance may support beyond this on an individual basis
5	71	During a home birth how do midwives document care provided including the partogram	Hand written notes added digitally after event	Hand written notes	Hand written notes	Hand written notes	Electronically via laptop / tablet	Paper partogram completed in real time and free text electronic records kept in real time as far as possible or documented in retrospect as soon as possible after event
5	72	Have your community midwives ever experienced any Wi-Fi connectivity issues?	Yes	No	Yes	not currently electronic until new system in place	Yes	No
5	73	Does your electronic EPR system have the ability to be used offline?	No	No	Yes	Not in place currently	No but full business continuity paperwork is provided if any connectivity issues experienced	Yes
6	74	Do you have a documented risk of death conversation with women requesting a home birth?	No	No	No	No	No	Yes

6	75	Do you share with a woman requesting a home birth the level of experience the attending midwives have? Including recent intrapartum care experience.	no	yes	No	No	No	Not routinely however as a home birth dedicated established team to be within must have experience in community birth and at least 2 years Band 6 experience; level of experience has been shared with women on an individual basis if birth has been outside of guidance e.g. breech delivery
6	76	Do you share with a woman requesting a home birth, the average length of time it takes to extricate a women from her home in an emergency, in addition to the time to attend and time to transfer?	Yes	yes	No. Potential delays for NWAS discussed,	Yes	No but the homebirth risk assessment is being updated to capture this	Discuss ambulance transfer times as part of the risk assessment