



Reducing Major Obstetric Haemorrhage Through a Structured Obstetric Bleeding Strategy

'From insight to implementation for safer care'

Sarah Morris Consultant Midwife

BACKGROUND & WHY THIS MATTERS

In November 2024, Wye Valley NHS Trust identified higher rates of postpartum haemorrhage (PPH) and major obstetric haemorrhage (MOH) compared with national rates. Thematic reviews highlighted systemic issues:

- Delayed or inaccurate measurement of blood loss, especially in theatre
- Delayed escalation and management
- Minimal prevention, limited use of uterotonics and low awareness of risk factors
- Concerns around teamwork and situational awareness
- Guideline not fit for purpose
- Significant impact on women – physical, psychological and on breastfeeding and bonding

AIMS & OBJECTIVES



Primary aims:

Reduce PPH rate (>1000ml) from 18% to 12% of births (18.2 per month)

Reduce MOH rate (>1500ml) from 3.8% to 3.0% per 1,000 births



Secondary aim:

Reduce the unnecessary use of blood products through earlier recognition and improved management

OBSWVT

Obstetric Bleeding Strategy for Wye Valley Trust

Postpartum Haemorrhage Management Checklist

OBSWVT
Obstetric Bleeding Strategy for Wye Valley Trust (Pilot Copy)

Postpartum Haemorrhage Management Checklist

Designed to be used within the maternity setting. This is not a comprehensive guideline but a checklist to facilitate an appropriate escalating multidisciplinary team approach to postpartum haemorrhage and as an aid to documentation. To be used on all pregnant women birthing person.

Addressograph

Stage 0
PPH Risk Assessment
Complete for all women on admission (including ECLS) using BadgerNet PPH Risk Assessment

Most recent Hb = g/L
Reason for admission:
Antenatal or Admission Risk Assessment:
BMI = BadgerNet Score =
Current weight = kg 15%CBV

Stage 1
>500ml ongoing blood loss
Get Help
Notify Delivery Suite Co-ordinator
Name: Time arrived:
Allocate role to measure all blood loss
Name: Time started:
Other staff present:
Name: Role: Time arrived:

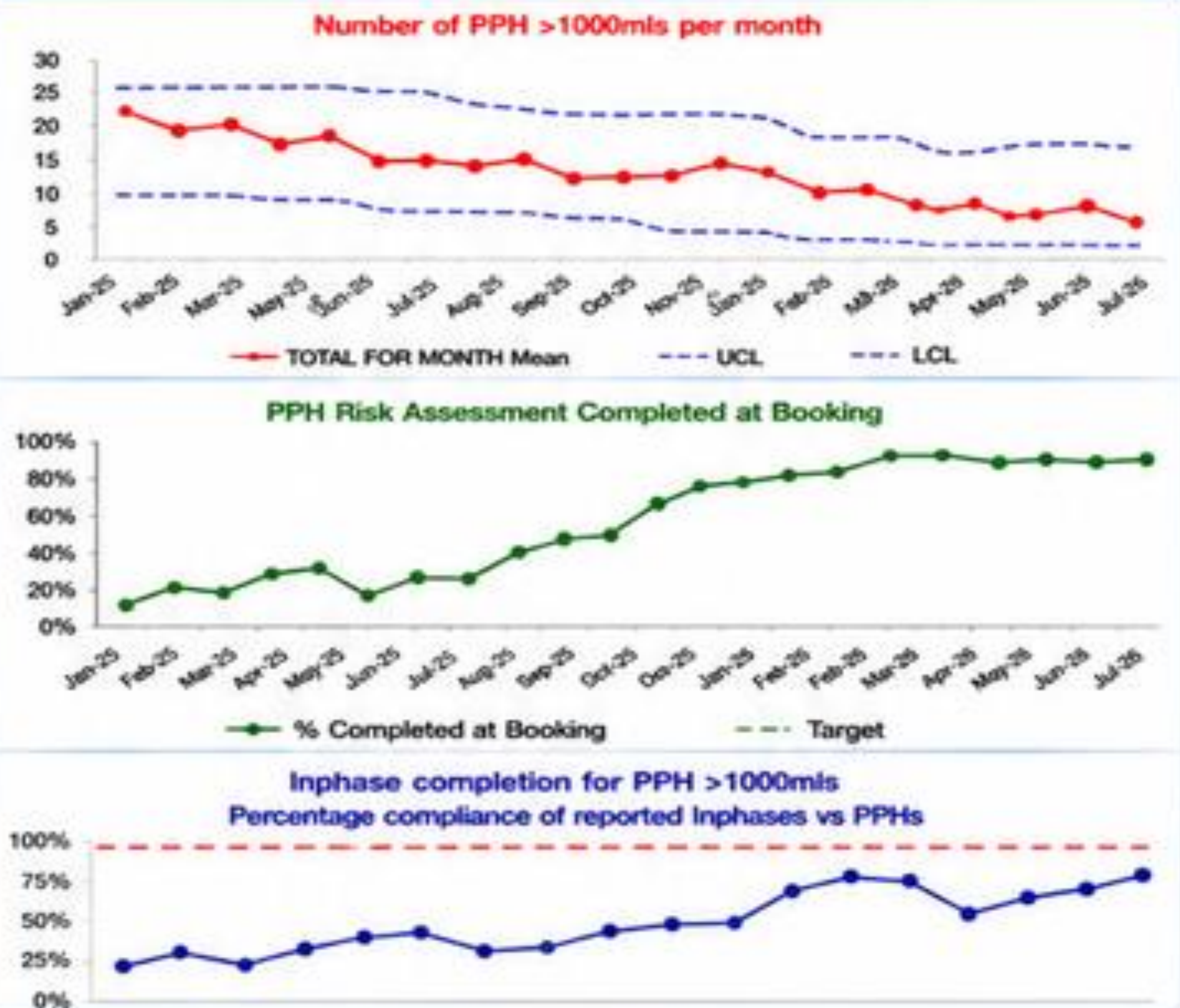
ACT
Measure all Blood Loss
Record observations
Woman/family updated
Record observations
IV Access & bloods
IV Access & bloods
What is the cause of bleeding?
Tone / Trauma / Tissue / Thrombin
TREAT
Uterine massage
Give uterotonics
Inspect genital tract
Consider TXA IV line
Empty bladder
Check placenta & membranes
Bimanual compression
If bleeding stopped:
Please record MEL here
Completed by: Date: Time: Location:

New **OBSWVT** checklist implemented 1st October 2025 alongside new guideline and new PROMPT training programme 2026

WHAT WE DID IN 2025 – MULTIDISCIPLINARY APPROACH

- LEARNING**
 - Standardised audit tool for MOH to identify learning opportunities
 - Triangulation of PPH incidence data vs Inphase reporting
- QI PROGRAMME**
 - MDT-developed QI programme focusing on prevention, recognition/escalation and management
 - Learning from reviews directed priorities
- GUIDELINE**
 - New guideline: OBSWVT – Obstetric Bleeding Strategy for Wye Valley Trust
 - Accompanying PPH checklist
 - Workshops and staff training to support implementation.
- PREVENTION**
 - Digital PPH Risk Assessment in BadgerNet at booking, 34/36 weeks, on admission and during labour
 - Fibrinogen levels on admission for high-risk women
 - Personalised circulating blood volume (weight & BMI) to enable earlier escalation
- RECOGNITION / ESCALATION**
 - Emphasis on key escalation points and PROMPT education
 - Mandatory training in accurate blood loss measurement, especially in theatre
- MANAGEMENT**
 - Use of OBSWVT checklist to identify cause and guide appropriate management
 - Increased use of uterotonics and TXA
- WOMEN'S EXPERIENCE**
 - Debriefs highlighted breastfeeding difficulties after PPH
 - Women with PPH placed on Amber feeding chart to ensure enhanced postnatal breastfeeding support

OUTCOME DATA OVER TIME (Jan 2025 – Jul 2026)



IMPACT & OUTCOMES (Jan 2025 – Jul 2026)



KEY LEARNING

- Staff engagement early in the process improves uptake of changes.
- Use the OBSWVT checklist as a pause-and-check tool at each stage.
- PPH/MOH will still occur. Accurate measurement in complex scenarios (e.g. instrumental delivery, suturing) remains a challenge.

NEXT STEPS FOR 2026

- Continue to review/audit MOHs and feed learning into MDT
- Support accurate blood loss measurement in all settings
- OASI bundle
- Review anaemia protocol to optimise pregnancy
- Continue monitoring compliance and effectiveness of OBSWVT
- Improve PPH Risk Assessment compliance (target >95%)
- Re-run Maternal Escalation Survey

STAFF FEEDBACK SUMMARY (2026 SURVEY)



Improvements in blood loss measurement, early escalation, PPH risk assessment, prevention, MDT working and confidence to escalate. Strongest gains linked to structured PPH processes and multidisciplinary learning.

ACKNOWLEDGEMENTS

Huge thank you to all maternity and theatre teams across Wye Valley NHS Trust for their support, ongoing feedback and for implementing the OBSWVT and PPH Risk Assessments.



CONCLUSION

A structured, multidisciplinary approach focusing on prevention, recognition, escalation and management has led to measurable improvements in PPH and MOH rates, stronger governance, improved teamwork and enhanced support for women and their babies.

Change takes time – but together, we are making a difference.

REDUCTION IN BLOOD PRODUCT USAGE



Monthly blood product utilisation fell by **39.5%**, from an average of 6.4 units to 3.9 units per month.

Estimated potential annual saving: £9,500–£13,500

Standardising the Assessment of Threatened Preterm Labour (TPTL): Improving Risk Stratification Using Actim Partus, Cervical Length and QUIPP

A Quality Improvement Audit at Frimley Health NHS Foundation Trust

Hafiza Ateeqa Mubarak (Senior Clinical Fellow), Saadia Hassan (Clinical Fellow), Sarah Smyth (Consultant)
Maternity Services, Frimley Park Hospital & Wexham Park Hospital, Frimley Health NHS Foundation Trust

BACKGROUND & WHY?

Preterm birth remains a leading cause of neonatal morbidity and mortality.

Accurate risk stratification of women presenting with threatened preterm labour (TPTL) is essential to ensure timely intervention while avoiding unnecessary admissions and treatments.

Current Trust guidance recommends risk stratification using Actim Partus and/or cervical length assessment with QUIPP scoring, alongside timely administration of appropriate interventions and senior obstetric review when the risk of birth within 7 days exceeds 5%.

AIM & OBJECTIVES

To evaluate the consistency and robustness of assessment and management of women presenting with TPTL in accordance with local guidance.

Objectives:

- To assess adherence to recommended risk stratification using Actim Partus, cervical length and QUIPP.
- To evaluate the appropriateness and timeliness of interventions and senior clinical involvement.
- To identify areas for improvement to enhance outcomes and reduce variation in practice.

OUR INTERVENTION / INITIATIVE

- Developed a standardised TPTL pathway: Actim Partus testing for all eligible women with symptoms → Cervical length assessment → QUIPP risk calculation.
- Increased use of the QUIPP app to support consistent risk prediction.
- Targeted training for junior and middle grade doctors in cervical length assessment in collaboration with Oxford Fetal Medicine team.
- Improved senior obstetric involvement when risk of birth within 7 days >5%.
- Reinforced documentation standards, including Actim Partus lot numbers and complete recording.
- Re-audit registered – data collection ongoing to assess impact of interventions.

METHOD

Design: Retrospective audit

Setting: Frimley Park Hospital & Wexham Park Hospital

Period: October – December 2024

Participants: 114 women presenting with symptoms of TPTL between 22+3 and 34+6 weeks' gestation

Data collected using a standardised proforma:

- ✓ Presenting symptoms & risk factors
- ✓ Actim Partus testing
- ✓ Cervical length assessment
- ✓ QUIPP scoring
- ✓ Senior clinical involvement
- ✓ Interventions, transfers
- ✓ Pregnancy outcomes

Findings measured against the Trust Preterm Labour Guideline.

KEY FINDINGS (BASELINE AUDIT)

Summary of Key Gaps Identified (n = 114)

Discharged after assessment but later delivered preterm	8/114
Incomplete assessment despite multiple presentations	4/114
Actim Partus not offered to eligible women	28/114
Incomplete documentation of Actim Partus lot number	11/114
Cervical length scan performed	9/114
QUIPP app assessment used	1/114
Senior clinical review documented	63/114

Pregnancy Outcomes – Preterm Births
(Total 20 women)

Extreme PTB (<28 wks)	Very PTB (28+0–31+6 wks)	Moderate PTB (32+0–33+6 wks)	Late PTB (34+0–36+6 wks)
3	6	9	9

Interventions Required
(n = number of women)

Admission	Steroid (Antenatal)	MgSO ₄ (Neuroprotection)	Transfer
12	12	5	3

OUR ASSESSMENT TOOLS

Actim Partus
Rapid test to detect Fetal Fibronectin (fFN) in vaginal secretions.

Cervical Length Assessment
Transvaginal ultrasound to measure cervical length.

QUIPP App
Evidence-based tool calculating risk of preterm birth within 7 and 14 days.

IMAGING EXAMPLES

Transvaginal cervical length measurement.

QUIPP app risk calculation example.

Actim Partus test (Positive result)

IMPACT WE AIM TO ACHIEVE

- Improve identification of women at increased risk of preterm birth.
- Ensure timely and appropriate interventions.
- Reduce unnecessary admissions, antibiotics and interventions.
- Enhance documentation and traceability.
- Promote consistent practice across all staff groups.

CONCLUSION

This audit highlighted significant variation in assessment and management of women presenting with TPTL. Standardising the use of Actim Partus, cervical length assessment and QUIPP risk prediction, alongside improved training and senior involvement, has the potential to improve outcomes, support safer decision-making and optimise use of resources.

We are committed to re-auditing to measure the impact of these changes.

PROJECT TIMELINE

Audit Period
Oct – Dec 2024
Baseline data collection

Interventions
Jan – Mar 2025
Training, pathway implementation, awareness

Re-audit
Apr – Sep 2025
Data collection ongoing

Evaluate Impact
Oct 2025 onwards
Analysis & sustained quality improvement

REFERENCES

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- Melka S, et al. QUIPP app: a preterm birth risk prediction tool. BJOG, 2014.
- Moore A, et al. Role of fetal fibronectin in the assessment of preterm labour. Ultrasound Obstet Gynecol. 2017.
- NICE. Preterm labour and birth: management. NICE Guideline NG25. 2021.





From Uncertainty to Informed Choice: Co-Producing an Accessible Shared Decision-Making Tool for Suspected Large-for-Gestational-Age Pregnancies

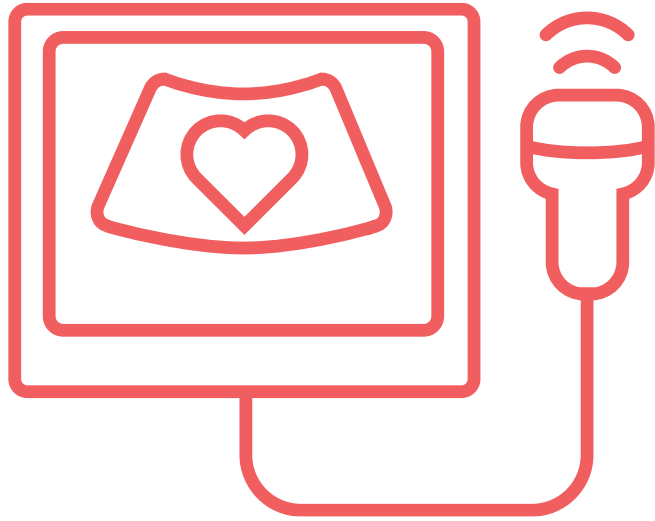


Annie Lester^{1,2}, Sadia Haqnawaz¹, Samantha Russell¹, Mairead Black³, Abi Merriel⁴,
Peter Chilton¹, Will Parry-Smith^{1,5}, Caroline Gillett¹, Richard Lilford¹

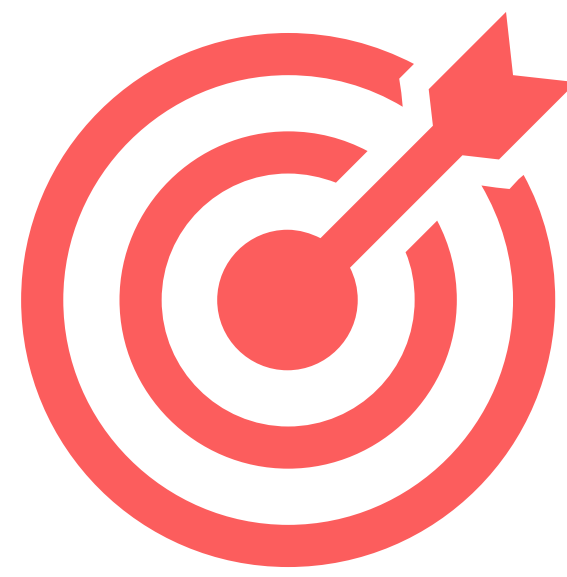
1. Midlands Patient Safety Research Collaboration, University of Birmingham; 2. University Hospitals Birmingham; 3. The University of Aberdeen;
4. The University of Liverpool; 5. The Shrewsbury and Telford Hospital NHS Trust

The Challenge: Stakeholder engagement across our Patient Safety Research Collaboration maternity research programme identified a need for clearer, more accessible and culturally appropriate information to support choice, effective risk communication and shared decision making between women and clinicians.

Topic choice: Suspected large-for-gestational-age (LGA) pregnancies present particular challenges, as discussions regarding birth options are based on predicted weights, whereas the outcomes come from actual birth weights. Scans late on in pregnancy are not very accurate at predicting birth weight. Decision making can therefore be complex.



In a recent study, only **4 out of 10** babies predicted to be big were actually big at birth.



The Aim: Co-produce a patient-facing decision aid to improve risk communication and support women to make informed choices about their care when their baby appears to be big on scan at term.

Wording of title uses woman centred non-ambiguous language

Graphic of mother and baby have neutral colours/shapes

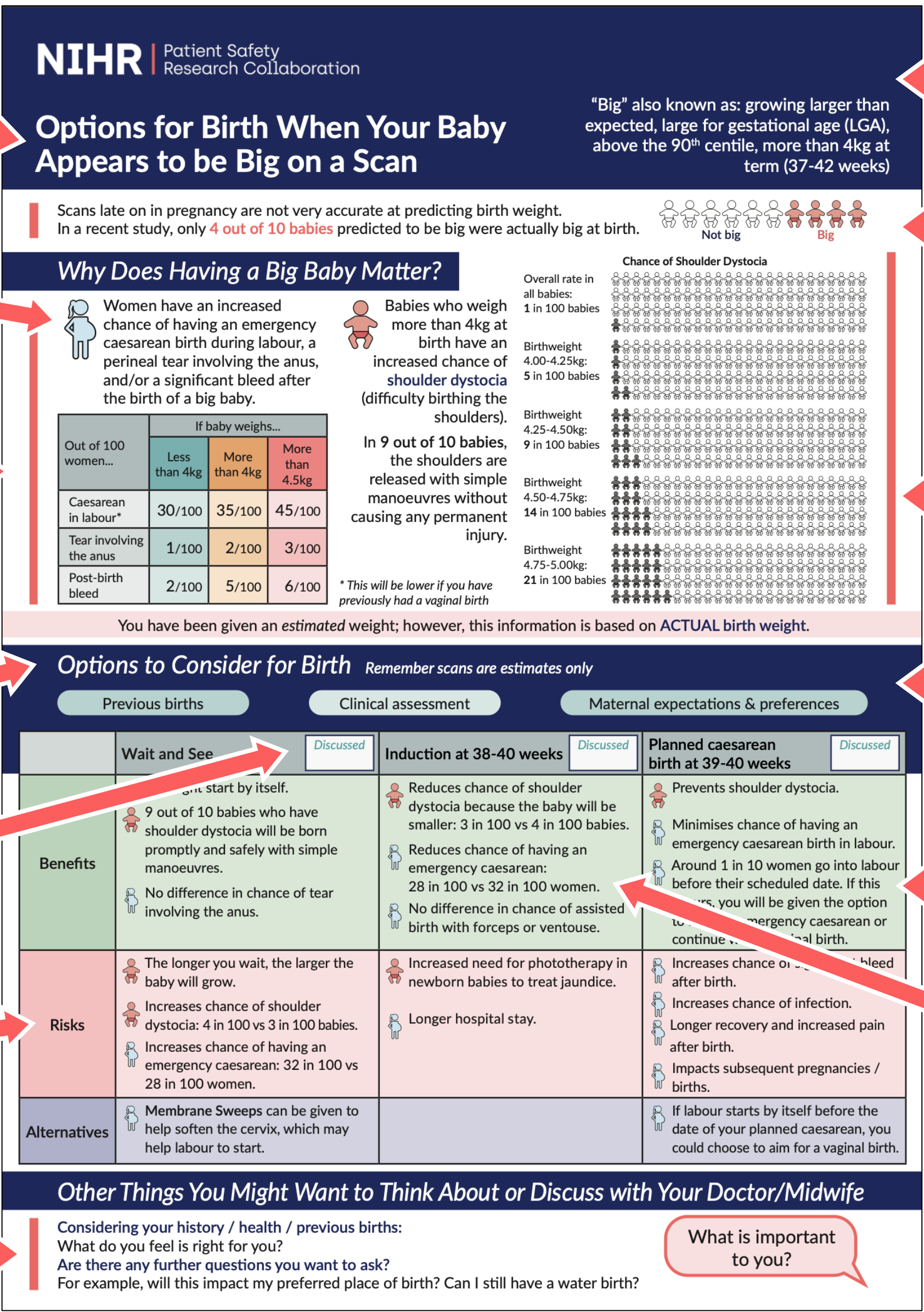
Information layered to not overwhelm. The other side is a patient info leaflet that explains terms used and offers links to further resources

Prompts to support the clinician to personalise the information

Tick boxes ensure the clinician discussed ALL options

Based on commonly used Benefits-Risks-Alternatives-Intuition-Nothing (BRAIN) framework

Questions to support the woman to make an informed choice



Decision aid on one side of A4 for ease of clinician use

Decision made on predicted birth weight – acknowledges inaccuracy of scan and that outcomes are on actual birth weight

Infographic to support understanding of risk

Language, colours and graphics designed to be accessible and inclusive, e.g. dyslexia

Neutral language so all options are given the same importance

Data quoted from: Al-Qudah et al. (2026). Elective induction versus expectant management for suspected large-for-gestational-age fetuses: a systematic review and meta-analysis. *BMC Pregnancy Childbirth*. 26: 338.

The Impact:

The Royal College of Obstetricians & Gynaecologists are including a link to the decision aid in the useful resources section in the new Green-top Shoulder Dystocia guideline.

Next Steps:

Implementation & Evaluation:

Evaluate the decision aid in practice to understand its impact & inform ongoing improvement.

Develop Accessible Versions:

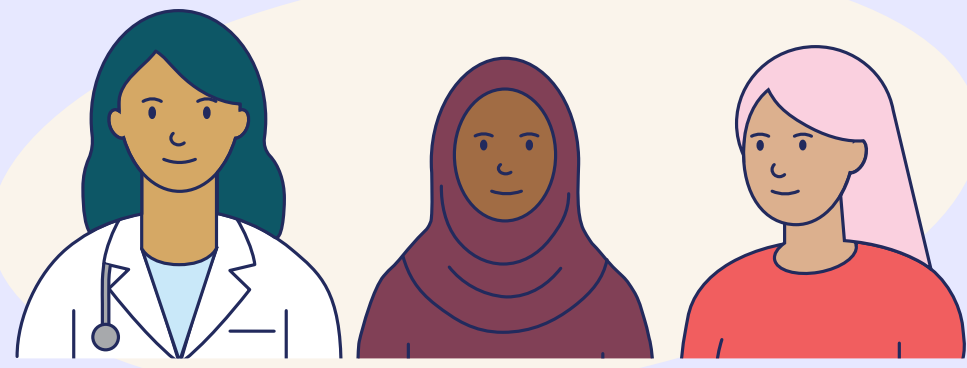
Co-produce animated versions in multiple languages to ensure inclusivity & accessibility for all.

Develop Further Decision Aids:

Support informed choice across new topics

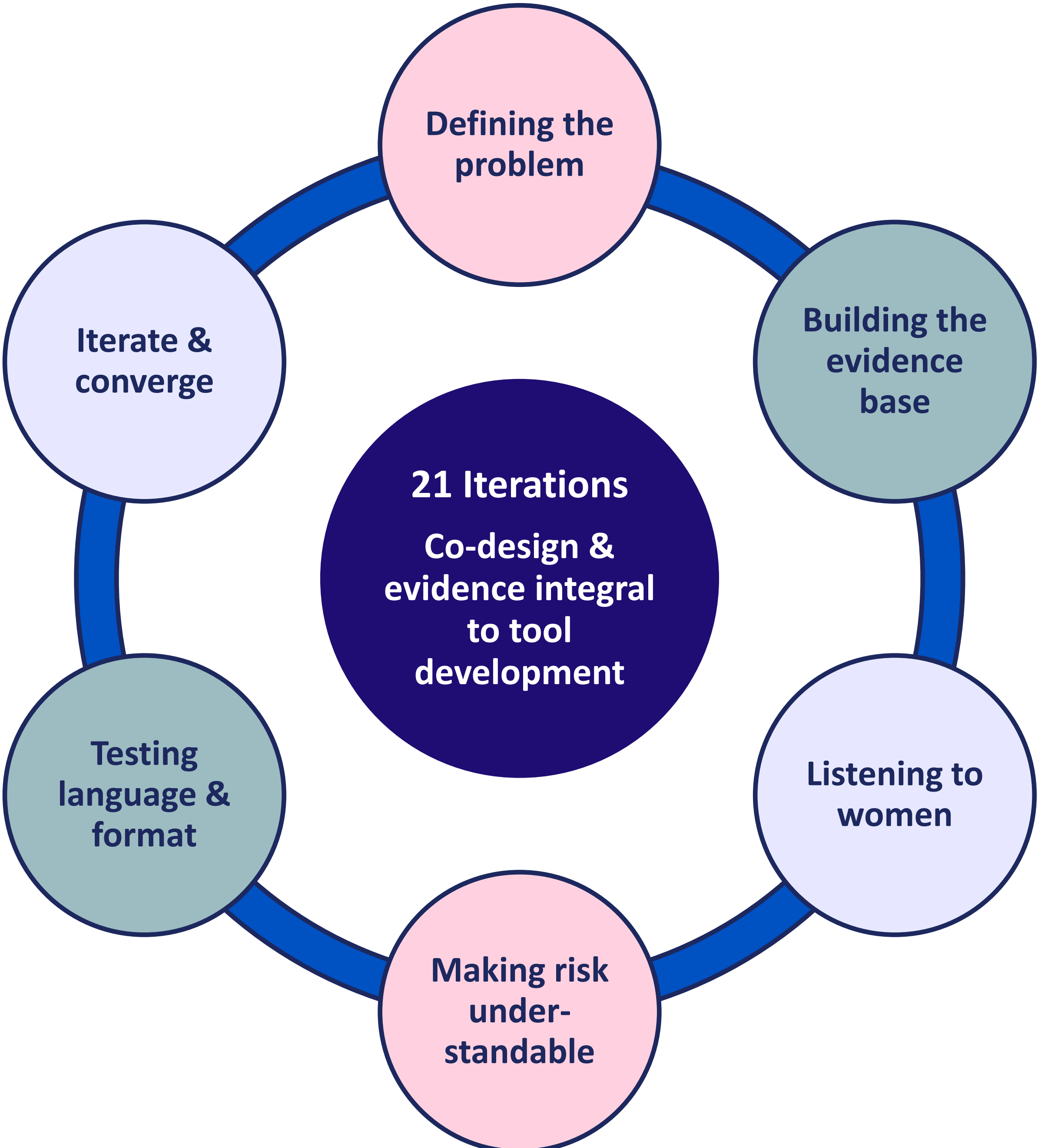
Working in Partnership:

Our working group included doctors, midwives, researchers & lived experience (PPI) voices

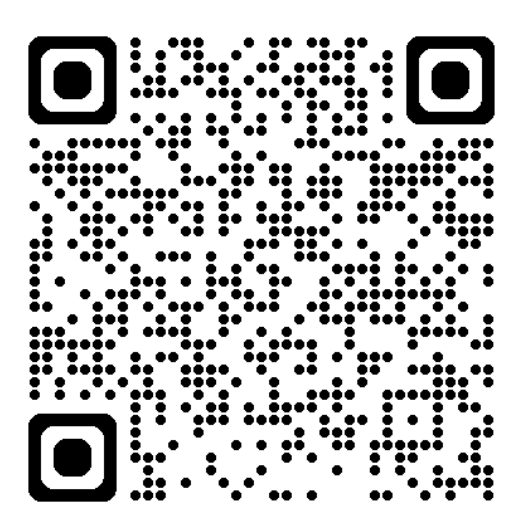


"I remember feeling afraid when I was told I was having a 'big baby'. I wish I had access to this type of decision aid tool, to remove some of the fear and answer important questions. I enjoyed working on this project, it was a lot of hard work but I felt listened to and I am so proud of the final version."

-- Sadia Haqnawaz, PPI Member



For more information, scan the QR code



Making digital safer: National learning related to EPR in safety investigations in maternity and neonatal care

Authors: Rose Kurian Thomas¹, Nicola Pusey¹, Zoe Hughes¹, Sonia Barnfield¹, Louise Page¹

Contributors: Andrew Bird, Naomi Kelly

¹ Maternity & Newborn Safety Investigations (MNSI) programme



Background

- Electronic Patient Record (EPR) systems are increasingly used across maternity and neonatal services in England to support information sharing, clinical decision-making, continuity of care and patient engagement, in line with the NHS long term plan for increased digitalisation (Department of Health and Social Care, 2025).
- While EPR systems can improve safety and efficiency, recurrent patient safety concerns linked to their design, implementation, and use continue to emerge.
- This review builds on Health Services Safety Investigations Body's recently published report on EPR and patient safety (HSSIB, 2025), with a specific focus on perinatal care.

Objectives

The objectives were to:

- Identify commonly reported EPR-related challenges affecting perinatal care and understand their effect on patient safety and healthcare professionals.
- Use this learning to develop practical improvement safety prompts to support safer EPR implementation, optimisation, and governance across maternity and neonatal services.

Methods

- A national thematic review was undertaken of 108 maternity and neonatal investigations from the Healthcare Safety Investigation Branch and the Maternity and Newborn Safety Investigations (MNSI) programme conducted in England between February 2020 and March 2025 that contained EPR-related findings or recommendations.
- Using an inductive thematic analysis methodology, investigation findings and recommendations were reviewed to synthesise themes for a national learning report. The review translated learning from safety investigations into actionable safety prompts for maternity and neonatal services, NHS trusts, integrated care systems, and EPR suppliers in the procurement, implementation, governance, and optimisation of EPR systems.

NATIONAL REVIEW



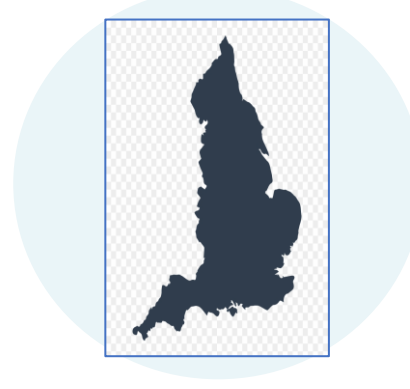
108
Investigations
reviewed



5 Years
(2020–2025)
of learning



6
Recurring
themes
identified



National
Learning
from England

● National thematic review of 108 HSIB/MNSI investigations between 2020 and 2025 ●

Conclusion

Maternity and neonatal services are becoming increasingly digital; ensuring EPR systems are safe, usable and interoperable is essential. Across all themes, digital governance emerged as a key enabler of safe EPR use, requiring clear accountability and end-user involvement. This review highlights recurrent themes and can inform safer implementation, optimisation and governance of EPR systems, including improving perinatal EPR standards in England.

References

Department of Health and Social Care (2025). Fit for the future: 10 Year Health Plan for England - Executive Summary [Online]. GOV.UK. Available at: <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary> [Accessed 17 July, 2026].

HSSIB (2025). Patient safety issues associated with electronic patient record (EPR) systems – a thematic review [Online]. HSSIB. Available at: <https://www.hssib.org.uk/patient-safety-investigations/electronic-patient-record-epr-systems-them30004305.30004305.atlc-review/investigation-report/#2-patient-safety-issues-summary>

Key findings



What did we find:

- Functionality:** EPR systems did not always support maternity and neonatal care requirements. This included limited integration of key information such as ultrasound results, compromising access to a complete clinical picture, inadequate decision-support tools that did not align with clinical guidance, and flawed capture or display of safety-critical information. This contributed to delays in risk recognition and escalation.
- Usability:** Staff and women experienced difficulties accessing, viewing and interpreting information within EPR systems. Key information could not be viewed simultaneously, such as writing notes at the same time as viewing cardiotocographs and care plans sometimes required extensive navigation to locate. This reduced situation awareness and patient engagement.
- Organisational factors:** Unreliable connectivity, insufficient hardware and workload pressures limited effective EPR use and timely documentation.
- Accessibility:** Limited interoperability between EPR systems restricted information sharing across trusts, specialties and community services, resulting in fragmented care records.
- Implementation:** Inconsistent training, incomplete migration of historical paper records, and delays in updating systems to reflect current guidance contributed to variation in practice and reduced confidence in system use.
- Benefits of EPR:** When designed and implemented well, EPR systems improved visibility of maternal risk factors, access to clinical information, structured documentation, automated safety prompts, and communication with women and families. These features supported safer decision-making, consistent record keeping and continuity of care.

To find out more about MNSI and our investigations, or to attend a webinar, please scan the QR code.



enquiries@mnsi.org.uk
www.mnsi.org.uk



Hearing Every Voice: Ambient Voice Technology in UK Obstetric Practice.

Service evaluation of clinician experience and service-user acceptability across obstetric practice

Dr Theo Johnson, ST7 Obstetrics & Gynaecology Trainee

Dr Rita Arya, Consultant Obstetrician & Gynaecologist,

Background

Both the Ockenden Review (2022) and the Kirkup Investigation into East Kent maternity services (2023) made the same uncomfortable finding: the NHS was not listening to women and their families

Ambient Voice Capture Technology (AVT) could be a solution, freeing clinicians to be present and draft clinical notes in real time.

AVT listens, transcribes and uses artificial intelligence (AI) to turn the transcript into structured notes for patient records.

Evidence is building quickly to support the use of AVT.

The largest trial run by Great Ormond Street looked at 17,000 encounters and found:

- Patient contact time rose
- Time was saved
- Fewer clinicians felt overwhelmed with their note taking burden.

Methodology

We ran an AVT service evaluation across fetal medicine, antenatal clinics, triage, intrapartum reviews, MDT meetings and bereavement debriefs.

We surveyed clinicians on

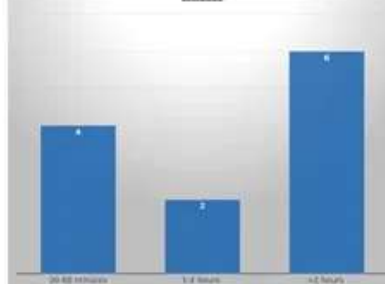
- documentation burden, out-of-hours work
- burnout, AVT familiarity, concerns
- preferred use cases
- interpreter use
- consent refusal.

We also informally gathered feedback from service users attending fetal medicine and pregnancy-loss consultations involving AVT.

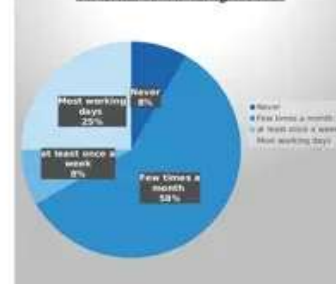
Findings

- 12 clinicians responded—6 consultants and 6 specialty trainees
- Burden of documentation is high – most spending 30-60 minutes and over half exceeding 2 hours of documentation time per shift.
- Staying late to finish documentation was common
- AVT mostly seen as a positive tool
- Despite most clinicians having never used AVT before, the majority saw it as a positive tool
- Despite AVT's positive impact there, areas of concern or requiring clarity were
 - Accuracy of AI generated texts or omissions particularly in fetal medicine and obstetric terminology
 - Medico-legal aspects
 - Privacy
 - Added burden of checking AI-generated notes.
- Patient feedback was reassuring in the fact no patient declined to have AVT used during their consult.

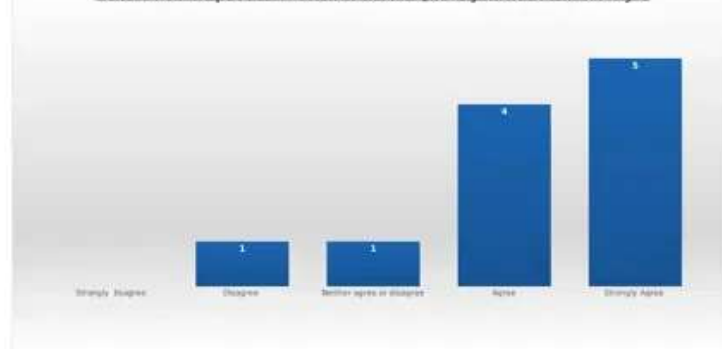
Time Spent on Documentation per shift.



Documentation being done outside of working hours.



Could AVT Improve Documentation Quality & Patient Safety?



Discussion

Clinicians were broadly positive: most believed AVT could improve documentation and safety, and no patient or family refused consent, even in emotionally difficult consultations.

NHS England requires that AVT tools

- Must keep data secure and use the minimum clinical data set
- Use is disclosed to patients
- Must be approved by local Information Governance departments
- Responsibility of the tool's compliance rests with the trust or clinician rather than the supplier

NHS England published a national registry of 19 approved AVT suppliers in January 2026 and has actively encouraged adoption. The NHS 10 Year Health Plan (July 2025) names AI scribes explicitly as a core tool for reducing administrative burden and releasing clinical time.

Every major national maternity inquiry has told the NHS to listen. AVT is a practical step toward that, and the workforce needs to engage and help shape its rollout to ensure it truly serves women and families.

By cutting screen time during maternity consultations NHS England views AVT as a way to put mothers back at the centre of care, provided clinicians verify the AI generated notes to maintain accuracy.

Using ambient voice technology, we are making better use of nonverbal skills.

References

1. Gokenden O. Independent Review of Maternity Services at The Streebory and Telford Hospital NHS Trust: Final Report. London: DHSC; March 2022.
2. Kirkup B. Independent Investigation of Maternity and Neonatal Services in East Kent. London: DHSC; March 2023.
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Maternity Disparities Consortium

Tackling maternity & neonatal inequalities through research and action

Working through nine regional hubs across all four UK nations, the NIHR Maternity Disparities Consortium brings together researchers, health and care professionals, communities and partners to develop, implement and evaluate practical interventions to reduce inequalities in maternal and neonatal health. Working with Core20PLUS communities, we are testing how evidence-based and co-produced approaches can be embedded into routine care and delivered equitably at scale.

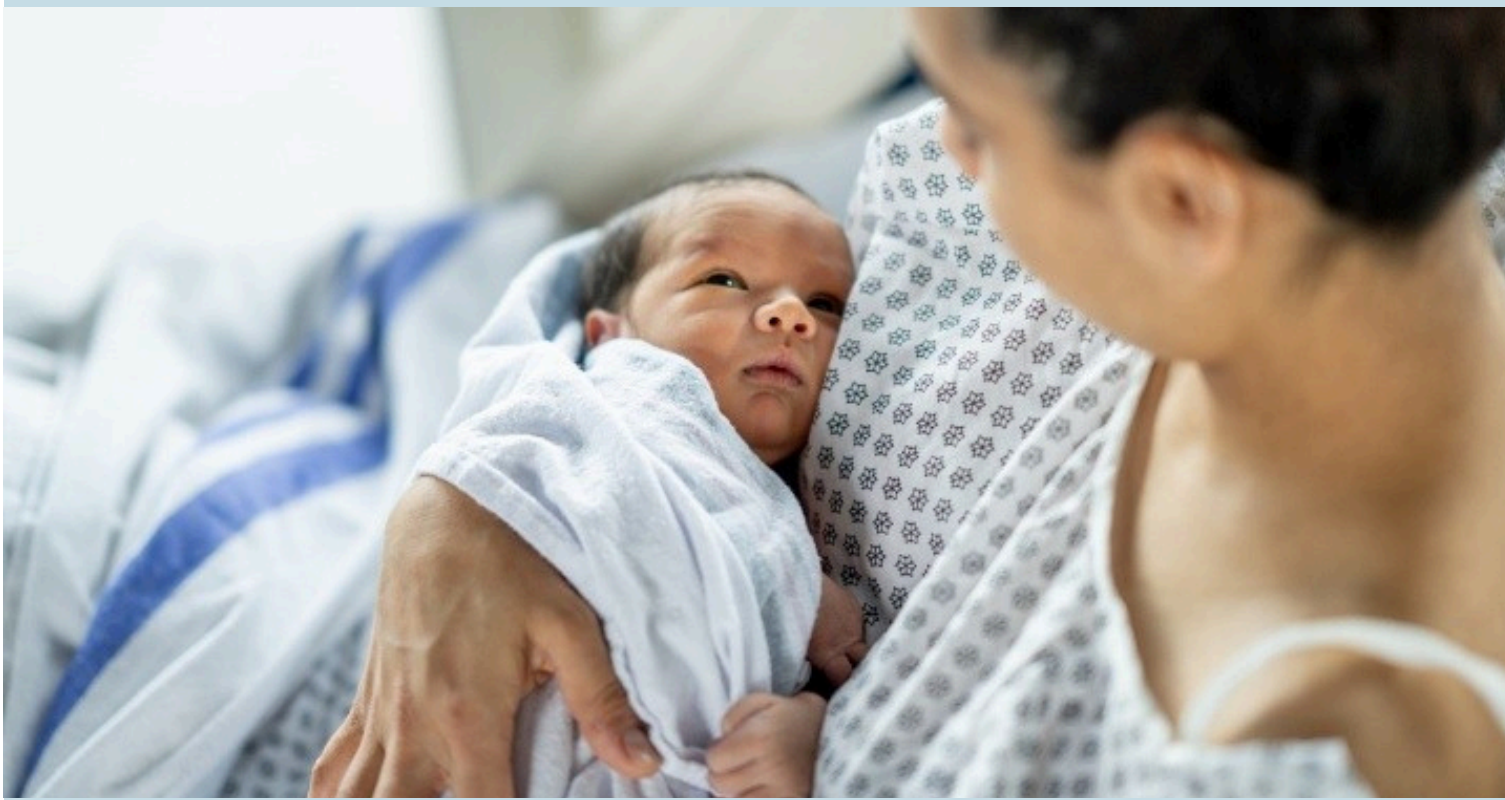
Our research adopts a life-course approach to maternity care, structured around three interconnected themes, two workstreams and two core-functions:

Preconception and interpregnancy health



Developing and implementing a systems-based blueprint for preconception and interpregnancy care to improve health before pregnancy and reduce the build-up of risk.

Pregnancy, birth, and early postnatal maternal health



Improving cardiometabolic health, perinatal mental health and psychosocial wellbeing, and postnatal recovery through equitable and better-connected care pathways.

Neonatal and longer-term child and family outcomes



Co-developing and testing enhanced neonatal and early-life hospital-to-home care for socially and clinically vulnerable babies and their families.

Access, communication and experience



Addressing access communication and experience in intervention design, delivery and evaluation.

Racism, discrimination and intersectionality



Addressing racism, discrimination and intersectionality in intervention design, delivery and evaluation.

Community engagement and co-production



Ensuring women, families, communities and VCSE organisations are equal partners in shaping, delivering and evaluating our research.

Digital, economics, data linkage, and analytics



Using data linkage and analytics, digital innovation and health economics to design, deliver and evaluate interventions and support scale-up.

Our Capacity Development Programme

We are delivering an innovative capacity development programme offering career development awards and opportunities embedded within the consortium's research areas to inspire and support the next generation of researchers working across clinical, practice and research sectors. Opportunities include:

Pre-Application Support

Embedded
Researchers

Transdisciplinary
Placements

Postdoctoral Fellowships

Methodology PhD
Studentships

Salaried Doctorates

Impact and Outcomes

The consortium has defined implementation outcomes and clear early success indicators, such as increased preconception folic acid uptake, greater continuity of care for women with physical and mental health conditions, and reduced inequalities in access and experience. The programme will also develop and evaluate innovative clinical and digital tools, including a standardised wound assessment tool to promote postpartum healing and prevent complications. Early measures include reach, uptake, fidelity, acceptability, and clinician adoption, alongside pilot implementation of enhanced maternity and neonatal care bundles. The consortium has been named in England's Women's Health Strategy, and findings will inform UK-wide scale-up and future national policy and guidance.

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Sign up/scan the QR code to receive updates, opportunities and news from the NIHR Maternity Disparities Consortium on our website at:
www.mdc.nihr.ac.uk



Interested in collaborating with the consortium or finding out more? We would love to hear from you at:
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Evaluation of the ONIRY device for better detection of Obstetric Anal Sphincter Injury

A Prospective Service Evaluation at Gloucestershire Hospitals NHS Foundation Trust

Sophie Carrick, Claire Winchester, Georgia Smith
Gloucestershire Hospitals NHS Foundation Trust

Introduction

- ✓ Obstetric anal sphincter injuries (OASI) are associated with significant physical and psychological morbidity.
- ✓ Prompt identification and appropriate management are essential to optimise outcomes.
- ✓ The ONIRY device is a novel AI-designed point-of-care impedance spectrometer used to assist in the detection of OASI at vaginal birth.
- ✓ Following higher than expected rates of OASI at our unit, we decided to trial the ONIRY device.

Objectives

- ✓ To evaluate the feasibility of implementation of the ONIRY device at our unit
- ✓ To look at diagnostic performance of the ONIRY device
- ✓ To review patient acceptability of the ONIRY device

Methods

Service Evaluation Design

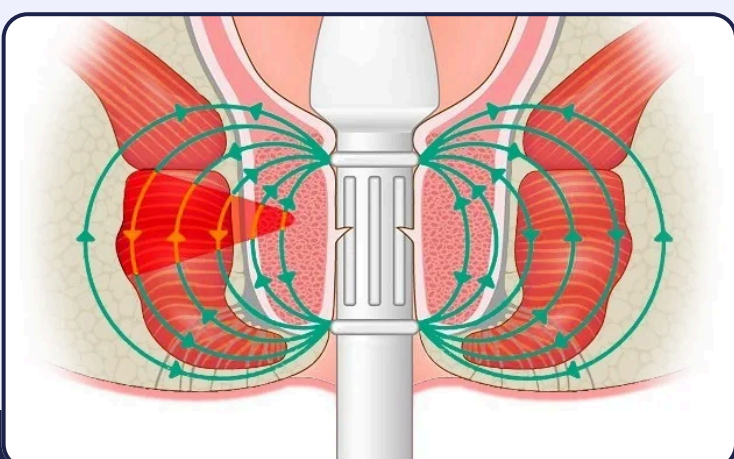
Prospective approach over a two month period between February and April 2026.

Participants

All women following vaginal births had ONIRY performed in addition to routine perineal assessment.

Results Pathway

- Results reported by the ONIRY device as 'PASS' (where spectrometer indicated no OASI had occurred) or 'REFER' (suggesting OASI)
- All patients with a 'REFER' outcome were subsequently assessed by an obstetrician
- Patient acceptability was assessed by self-reported pain using a 0-5 numerical scale



How does the ONIRY system work?

The ONIRY device is based on measuring the electrical impedance of tissue, using machine learning to help accurately distinguish between healthy and affected tissue of the perianal area.

Results & Discussion

Use of ONIRY

Number of Births

A total of 476 vaginal births occurred during the trial period. **261 (54.8%)** were assessed using ONIRY.

Device Reliability

Cable failure and system error messages prevented complete assessment of all vaginal births.

Pain Scores

Pain scores were recorded in 62 women (23.7%) and indicated low levels of discomfort, with less than 10% giving higher pain scores of 3, 4 or 5, suggesting good patient acceptability.

Results

ONIRY Device Results

243 (93.1%) received a 'PASS' result and 18 (6.9%) a 'REFER' result.

OASI Incidence

There were 13 cases of confirmed OASI, however only six had ONIRY performed due to device issues in the other seven.

- In patients receiving a 'PASS' result, **98.8%** represented a true negative with no clinically apparent OASI.
- In those receiving a 'REFER' result, only **16.7%** had confirmed OASI.
- Diagnostic performance demonstrated specificity of **94.1%** and sensitivity of **50%**.

Discussion

- Device reliability significantly impacted the proportion of included patients and therefore internal validity of this data.
- ONIRY demonstrated high specificity and a high negative predictive value, but limited sensitivity, particularly for detection of lower-grade (3a) OASI.
- This, coupled with low positive predictive value, suggests its use alone cannot entirely replace skilled clinical examination.

Conclusion

- ✓ The ONIRY device is a useful diagnostic adjunct that is well accepted by patients
- ✓ Addressing technical limitations, alongside evaluation in larger cohorts, will be essential to determine a more accurate reflection of diagnostic capability and its future utility in clinical practice to improve patient care.

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- ✓ Roper et al. (2022). Under-classified obstetric anal sphincter injuries. *International Urogynaecology Journal*
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Implementing ONIRY for Improved OASI Detection

A Feasibility and Staff Acceptability Study in a UK District General Maternity Unit

Claire Winchester
Specialist Midwife
for Perineal Care

Dr Georgia Smith
Obstetric Lead for
Perineal Care

Dr Joe Atley
Obstetrics & Gynaecology
Registrar



Obstetric anal sphincter injuries (OASI) are associated with significant long-term morbidity.

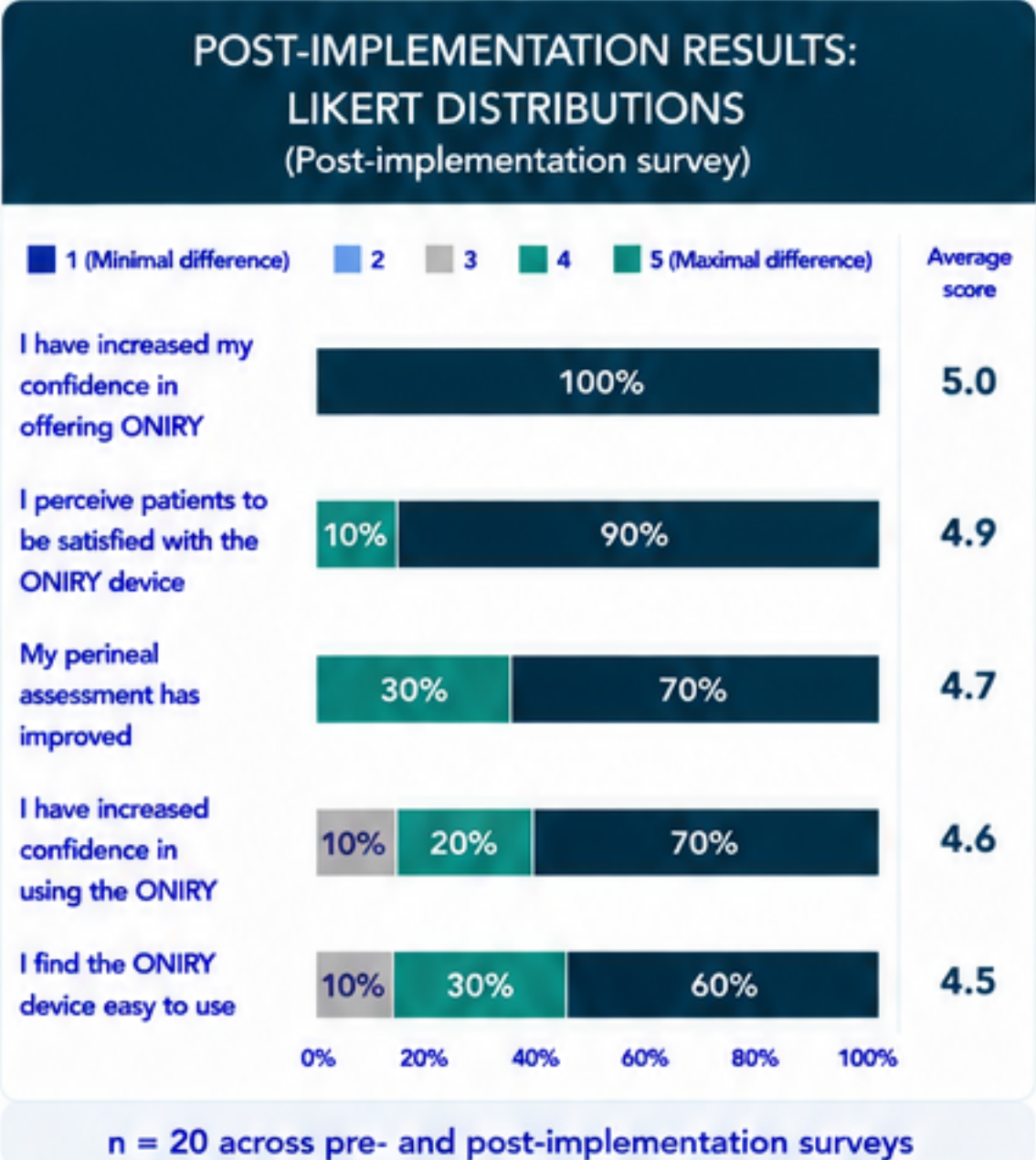
In 2025, Gloucestershire Hospitals NHS Foundation Trust was identified as a national outlier for OASI incidences, driving a focus on improvement.

OUR STUDY: FROM PLANNING TO PRACTICE



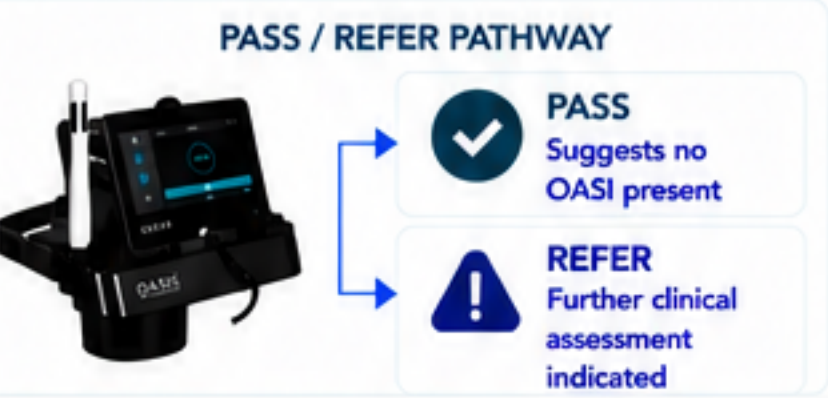
STAFF SURVEY RESULTS: BEFORE IMPLEMENTATION	
(Pre-implementation survey)	
Willing to perform ONIRY	100%
Believed ONIRY would improve care	100%
Comfortable offering ONIRY	100%
Supported departmental adoption	100%
Preferred face-to-face training	100%
Anticipated additional assessment time 5–10 min	90%
No concerns about consent/privacy	100%
Anticipated most women would accept ONIRY	100%

All responses are percentages of staff respondents.



- ### HOW ONIRY SUPPORTS CLINICAL PRACTICE
- Improves confidence in assessing perineal trauma
 - Provides reassurance for women and families
 - Enhances clinical decision-making at the point of care
 - Easy to integrate into busy maternity workflows

KEY FINDINGS AT A GLANCE – POST-IMPLEMENTATION SURVEY ONLY



WHAT STAFF SAID...

“ It gives us objective data to support our clinical judgement and discuss with women. ”

“ Easy to use and fits well into routine practice. ”

“ Reassuring for women to know we are using the best available technology. ”

(Thematic feedback from post-implementation survey)

- ### IMPLEMENTATION CHALLENGES
- (Identified by staff)
- Single device in circulation – occasionally harder to locate
 - Theatre availability can be limited
 - Device/lead robustness and technique-related false REFER results during early implementation

How accurate are our growth scans?

A clinician-led quality improvement project providing the first objective assessment of fetal growth scan accuracy and clinician variation, to drive safer maternity care.

Dr Emily Fraser-Mackenzie^{1,2} Midwife Sonographer and Founder · **Jo Lee¹** Consultant Midwife Sonographer and Lead Clinician for the AST
Wendy Randall¹ Director of Midwifery · **Dr Peter Fraser-Mackenzie²** Founder and Senior Data Scientist
¹ Hampshire Hospitals NHS Foundation Trust · ² Decision Data Ltd · emily@decisiondata.org.uk

1 INSIGHT Background

In 2023 we began examining the accuracy of third-trimester growth scans in our Trust. Estimated fetal weight (EFW) influences surveillance and decisions around timing of birth, while national guidance emphasises the identification and management of SGA and FGR.^{1,2} However, EFW is subject to recognised random and systematic error.^{3,4}

We wanted to answer a simple question: how accurate were our growth scans?

We found this surprisingly difficult. National measures appropriately focus on detection and management of SGA/FGR, but do not directly quantify EFW accuracy or systematic

bias. Image-based audit assesses scan quality, but is resource-intensive and difficult to scale across a service.⁵

As we introduced changes intended to improve scanning practice, a further problem emerged: we had no robust way of knowing whether accuracy had actually improved. Small-sample audit can have wide uncertainty, making genuine change difficult to distinguish from normal variation.⁶

This reframed the problem. If we could not measure accuracy reliably, how could we improve it?

That question became the starting point for the Antenatal Sonography Toolkit.

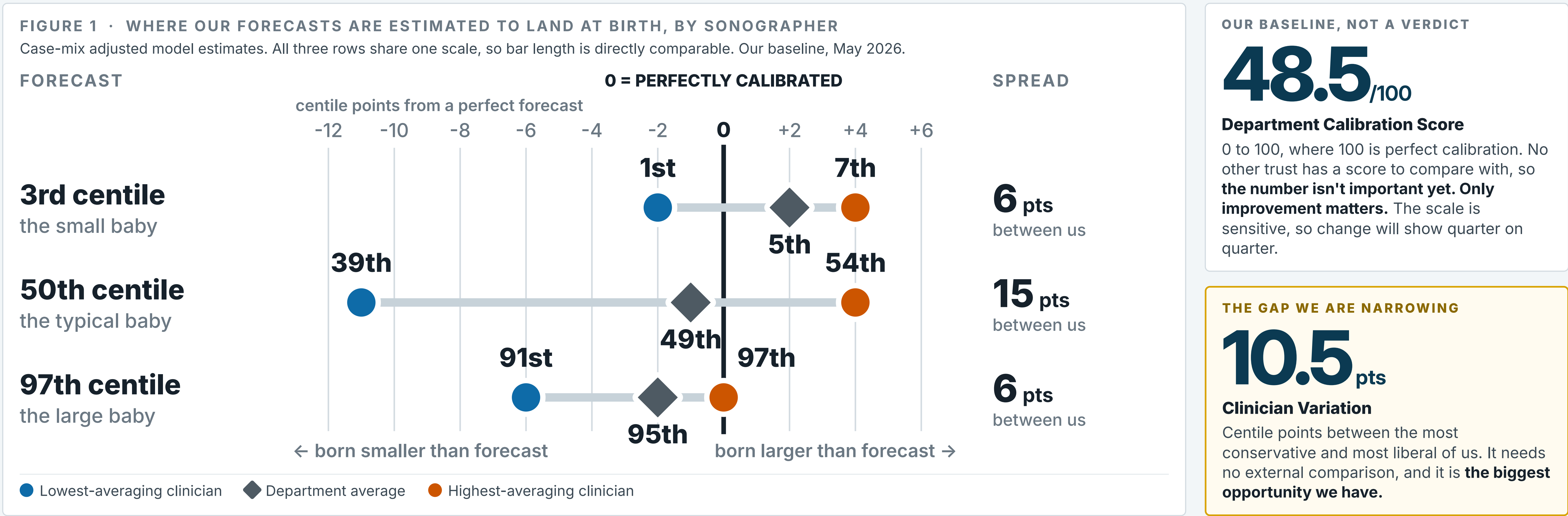
2 IMPLEMENTATION The toolkit we built

- **Clinician-led, developed with a senior data scientist.** Sonographers and a data scientist built the method together, so it reflects how growth scans are performed in practice.
- **Anonymised, routinely collected maternity data.** AST compares fetal growth-scan forecasts with actual birthweight outcomes.
- **Hadlock standard** used to model growth curves and calculate scan centiles, giving a consistent basis for analysis.
- **Case-mix adjusted.** Clinicians scan different patient populations, so simple comparison of scan estimates with birthweight can be misleading. **Bayesian hierarchical modelling**, developed from 42,672 historical scans, adjusts for relevant maternal, fetal and scan-related factors and pools information across clinicians, so estimates stay reliable where individual numbers and rare events are small.
- **The result:** departmental and individual calibration assessed more fairly, and variation in practice monitored over time.

The AST is designed to be developmental, not punitive. It engages clinicians with their own data to encourage reflection and support improvement.

3 What we found

Our department is broadly well calibrated. Between us as individuals, it is not. The model estimates that a 3rd centile forecast made by one of us would, on average, be born on the 1st centile. The same forecast from a colleague would, on average, be born on the 7th.



4 IMPACT What AST has enabled

A whole-service view of performance

All eligible third-trimester growth scans in the dataset can be assessed, rather than relying on a small audit sample.

A low-burden, repeatable process

Quarterly analysis requires around 30 minutes of lead-clinician time, with anonymisation and encryption completed within the clinician's browser.

Variation made visible

Baseline analysis identified substantial variation in calibration, with individual scores ranging from 7.9 to 83.4, that had not been apparent through existing audit processes.

Measurement embedded within governance

Quarterly reporting creates a baseline and allows changes in practice to be monitored over time.

Personalised feedback with a learning focus

Every participating sonographer and consultant receives case-mix adjusted feedback designed to support reflection and targeted improvement.

Designed to be transferable

Because AST uses routinely collected maternity data, the approach is intended to be applicable across different NHS maternity services.

5 What we test next

- **Primary question**
Does individualised, non-punitive feedback reduce clinician variation from our 10.5-centile-point baseline over 12 months?
- **We will also evaluate**
Whether clinicians find the feedback useful, whether seeing their own data supports changes in practice, and whether AST can detect meaningful change at team level.
- **Our longer-term aim**
For every maternity service to be able to understand, monitor and report the calibration of its own growth scanning.

What we cannot yet claim

- The measure is internally consistent and case-mix adjusted. We **cannot** yet show it predicts outcomes, or that improving the score improves safety. The next twelve months test that.
- Single site. A local baseline, not a benchmark. No external NHS comparator exists.

Would you like this for your service?

Join our waiting list.



decisiondata.org.uk/toolkits/antenatal-sonography

Four NHS maternity services will receive a free Accuracy Snapshot in 2027.

No obligation. Developed with Decision Data.

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The NHS Fife logo, featuring the letters 'NHS' in a large, bold, white sans-serif font, with a white stylized wave or swoosh underneath, and the word 'Fife' in a smaller, white sans-serif font below the swoosh.

Victoria Hospital, NHS Fife, Kirkcaldy

births in 2025

PPH 1.5 L and over, per 1,000 births in 2025 — from 48.2 in 2023

STEP-2 activation

of major obstetric haemorrhage over 2 L now managed with ROTEM

PROMPT attendance, 2023–2025

NHS Fife is a maternity unit with approximately 2,700 births (2024/2025) annually serving a population with marked socioeconomic inequalities.

Following an increase in major postpartum haemorrhage (PPH) rates in 2020, a multidisciplinary quality improvement programme was established to address PPH and also reduce the overall incidence.

To reduce the rate of postpartum haemorrhage rates by 30% by 2026

- Quality improvement methodology involving multidisciplinary teams
- Establish baseline
- Assess risk factors
- Plan intervention
- Staff support and education

- PPH Focus Group established beginning of 2022
- Multidisciplinary team: obstetricians, anaesthetists, midwives
- Deep dive and identification of risk factors
- Data collected for 2023 to establish the baseline
- Run chart analysis of monthly rates against the 2023 median

AIM Reduce the incidence of PPH by 30% within Victoria Maternity Unit by 2026	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
	Effective risk assessment	Standardised PPH risk assessment. Effective communication of risk between teams	PPH risk assessment antenatal, during labour, in theatre and following birth · High risk women identified at all handovers, ward rounds and safety briefings Watchers Board · Deep dive case review
	Early recognition and response	Quantitative measurement of all blood loss. Early recognition of deterioration. Early escalation	Phase 2 — Stop and Check team communication and situational awareness tool · Weigh and measure all blood loss · Use MEWS and SBAR · Activate MOH protocol at 1500 mL · Use instrumental delivery checklist
	Reliable and evidence based care processes	Optimising antenatal haemoglobin. Management of 3rd stage of labour. Management of PPH	PRAMS (PRegnancy Anaemia Management Scotland) 2023 · ROTEM 2023 · PPH management guidelines · PPH management checklist · Tranexamic acid — scoring Red · Report all PPH incidents on Datix · Use learning from excellence (GREATix)
	Motivated and engaged staff. Optimal birth environment	Skilled and competent teams. Dedicated obstetric theatre(s)	PROMPT and PPH drills · Involve staff in generating and testing ideas · Display data and provide feedback

PPH risk assessment chart

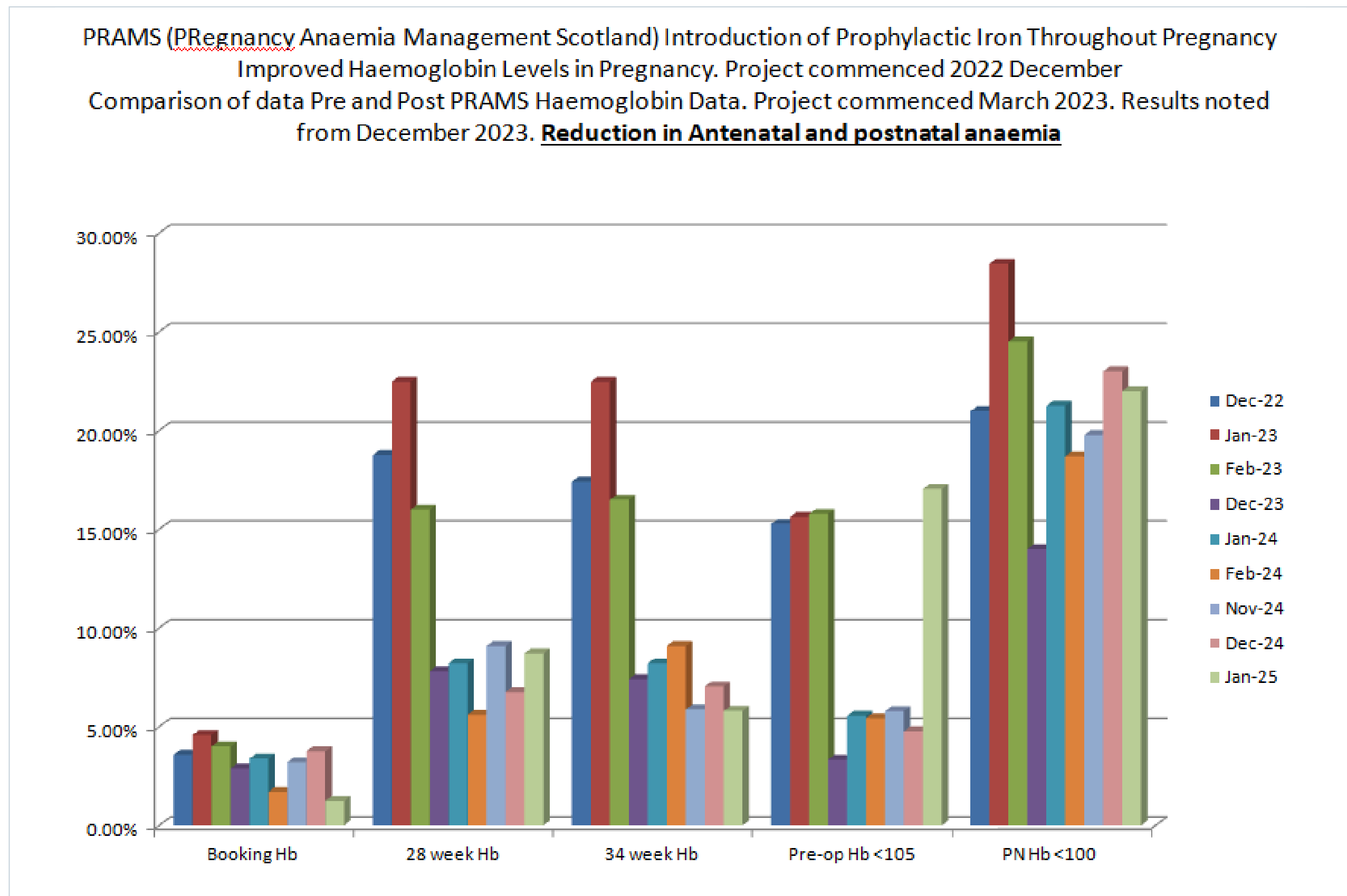
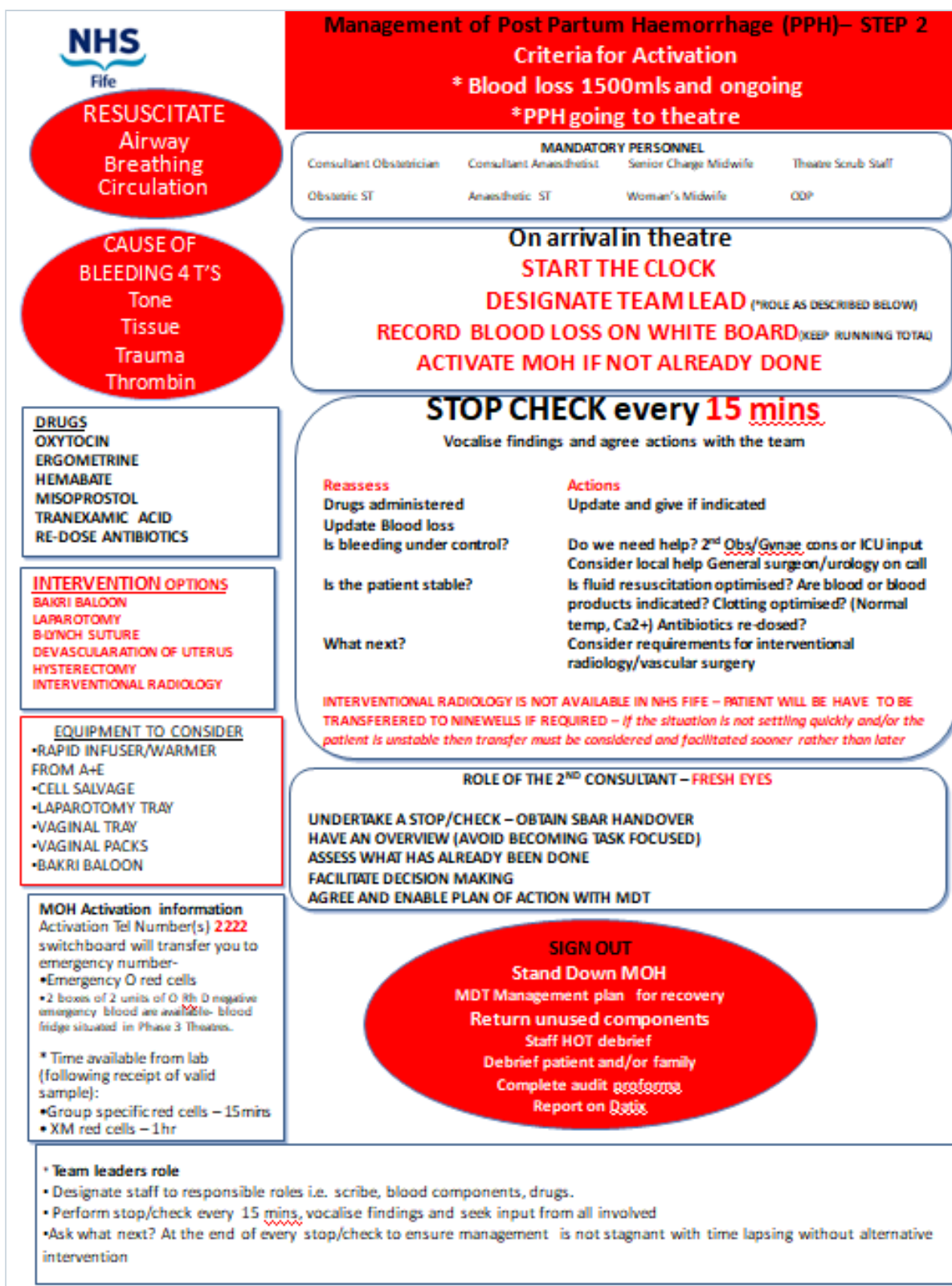
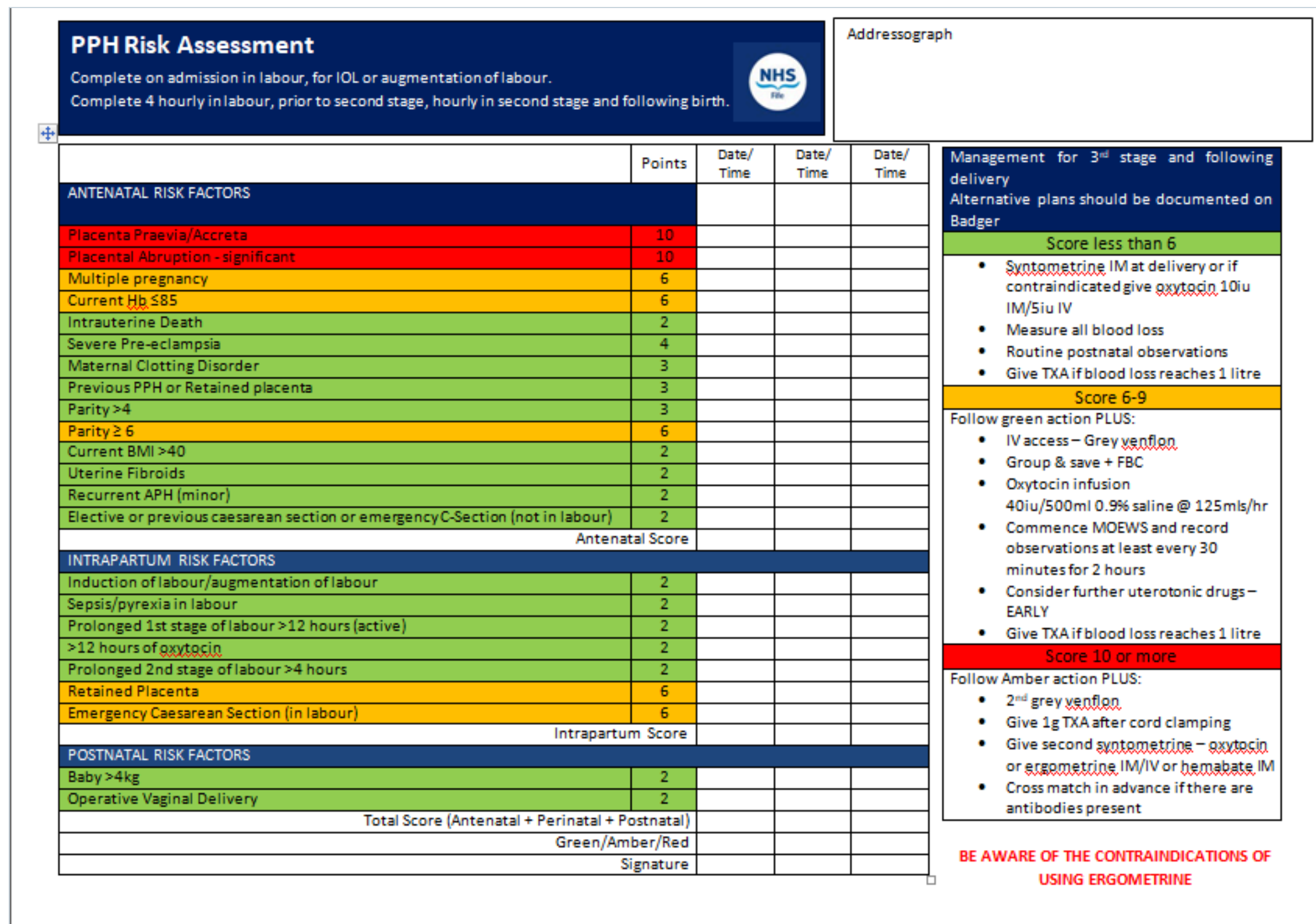
Scored on admission, in labour, in the II stage and in theatre, with a points score driving green, amber or red actions for the third stage.

STEP-2 – activated at 1500 mL

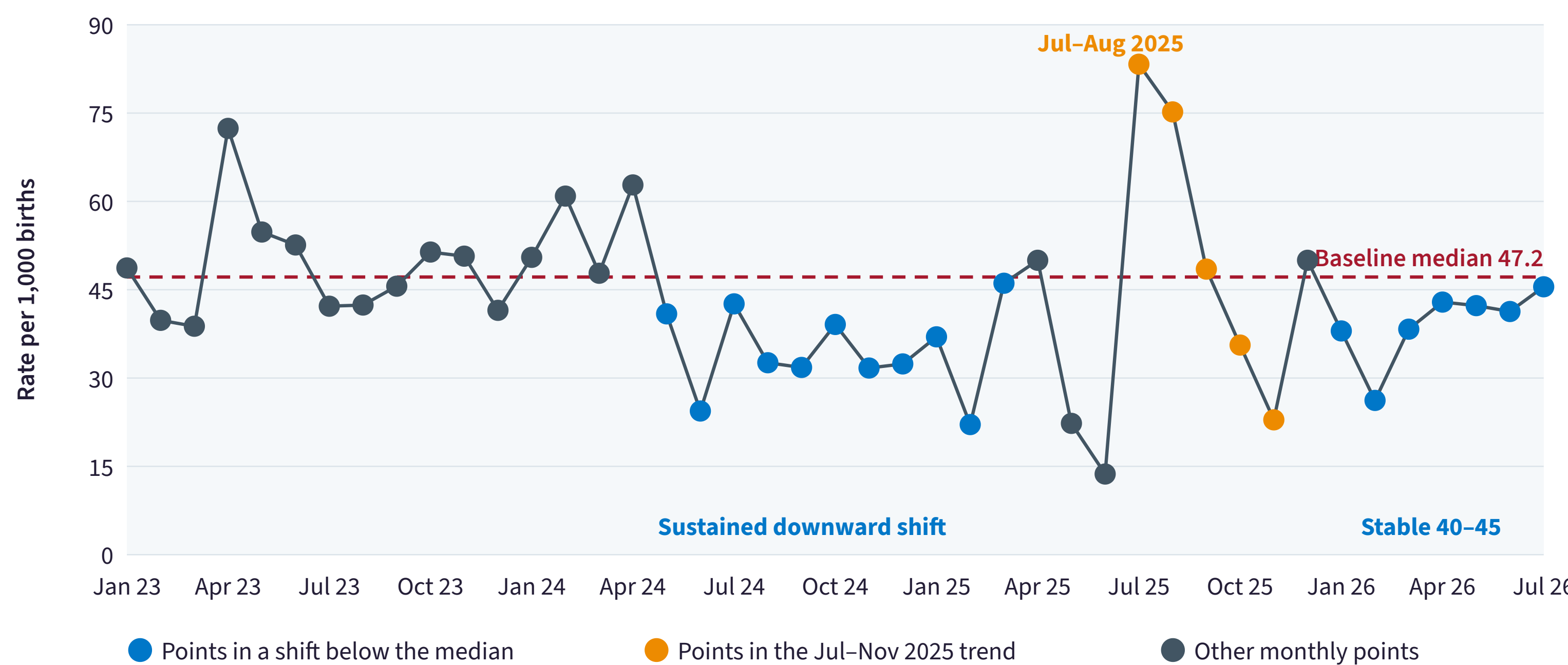
Co-ordinated by the senior charge midwife. A structured stop-check every 15 minutes, with defined roles, drugs, intervention options and a formal stand-down.

PRAMS – PRegnancy Anaemia Management Scotland. Haemoglobin before and after prophylactic iron

Introduction of prophylactic iron throughout pregnancy improved haemoglobin levels in pregnancy. Project commenced March 2023; results noted from December 2023. Reduction in antenatal and postnatal anaemia.



Rate of postpartum haemorrhage over 1.5 L, 1 January 2023 – 30 July 2026



Run chart analysis demonstrated a sustained downward shift in PPH rates following implementation of the improvement bundle.

ROTEM point of care testing in theatres

- Introduced in May 2023; now used in 75% of major obstetric haemorrhage over 2 L
- Statistically significant reduction in cases requiring red cell transfusion, 88.5% to 68.9%, and fresh frozen plasma, 21.2% to 6.5%
- Fibrinogen replacement, with either cryoprecipitate or fibrinogen concentrate, more than doubled with ROTEM guided treatment

Results

Measure	2023	2025
Total births	2,733	2,666
PPH 1 L and over	398 (145.6)	369 (138.4)
PPH 1.5 L and over	132 (48.2)	114 (42.7)
PPH 2.5 L and over	16 (5.85)	24 (9)

Counts, with rate per 1,000 births in brackets.

- Risk assessment tool completed for all major PPH
- STEP-2 activation: 100%
- Utilisation of ROTEM: now used in 75% of major obstetric haemorrhage
- PROMPT attendance: 85%, 2023–2025

Analysis of 2025 data

- There is evidence of a temporary improvement during late 2024 and early 2025
- Improvement was interrupted by very high rates in Jul–Aug 2025. This was reviewed and reasons clearly understood and addressed. This has skewed the data
- Further downward trend seen from September 2025 — 10 data points
- Current performance (2026) appears relatively stable at around 40–45 per 1,000 births

Conclusions

- Reliable processes in place, although no significant reduction in PPH rates. This is also partly affected due to increase in operative delivery observed over the last 4–5 years along with significant change in other demographic factors
- Management of PPH is however well embedded in practice, with good leadership and reliable teamwork

Going forward

- Use of MABL: maximum allowable blood loss
- Use of carbetocin
- Continuous audit processes in place

ACKNOWLEDGEMENTS

We thank our entire team members and our multidisciplinary team who contributed to the PPH Focus Group including Dr Jennifer Allison, Dr Jennifer Boyd, Ms Aileen Lawrie, Ms Pamela G Galloway, Ms Pamela Higgins, Ms Keva Smith.

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National scale-up of PROMPT Wales and its impact on maternity safety culture

Sophie Renwick, Jane Storey, Sarah Hookes, Sarah Morris, Erik Lenguerrand, Tim Draycott, Christy Burden and the PROMPT Wales National Implementation Team
Birmingham • 16 September 2026

Why does effective scaling of interventions in maternity matter?

- **Reduce unwarranted variation:** National maternity inquiries have highlighted persistent variation in the quality and safety of care, demonstrating the need to reliably implement evidence-based interventions across services.
- **Improve equity and outcomes:** Variation in maternity care can contribute to inequitable outcomes; effective scale-up can help ensure that women and babies benefit from evidence-based, safety-focused care regardless of where they receive maternity services.
- **Move from evidence to system-wide impact:** Evidence-based interventions can have limited impact if implementation is inconsistent.

Effective scaling provides the **governance, support, resources and quality assurance** needed to translate proven interventions into sustained improvements across whole healthcare systems..

What is PRACTical Obstetric Multi-Professional Training (PROMPT)?

PROMPT is an evidence-based, multi-professional maternity safety programme using interactive drills and workshops. When implemented authentically improvements in clinical outcomes for mothers and babies have been published.

MULTI-PROFESSIONAL	Midwives • Obstetricians • Anaesthetists • Wider maternity team
IN-SITU	Training in the clinical environment using local equipment and systems
ANNUAL	Maternity staff trained regularly to maintain readiness
TEAMWORK + HUMAN FACTORS	Teamwork and human factors training embedded – communication, teamwork, situational awareness, leadership

PROMPT has been implemented internationally however it has not always achieved improvements in outcomes across all settings, which may be due to the challenges with scaling up a complex intervention

AIMS

- To measure safety attitudes in all the maternity units undertaking PROMPT Wales training, and analyse if implementing this training had a meaningful impact on these outcomes.
- To compare outcomes across health boards and professional groups.

What made PROMPT Wales different?

PROMPT Wales followed a structured affiliation scaling model informed by the IHI Framework for Going to Full Scale.

01 | National infrastructure

Governance • standards • accountability • Welsh Government sponsorship

02 | Implementation support

Context assessment • local planning • faculty development • coaching

03 | Quality & learning

Monitoring • quality assurance • feedback • networking • shared learning

The difference: moving from “*help it happen*” to “**make it happen**” through structured, longitudinal implementation support.

Process measures

12/12

obstetric-led units implemented

>90%

eligible staff trained within 15 months

326

local facilitators trained

HIGH FIDELITY

100% core elements
93% courses observed

The scaling methods reduced the variation in adoption, reach, timescale and authenticity of implementation between units, previously identified as a challenge in large-scale PROMPT implementation projects.

Safety culture evaluation design

Validated Labour & Delivery Sexton Safety Attitudes Questionnaire (SAQ) assesses safety culture across six domains

2018 baseline SAQ → 2018–20 national implementation → 2020 post-implementation SAQ → 2022 follow-up

663 RESPONSES
354 pre • 309 post
64% midwives • 14.6% obstetricians • 13.3% anaesthetists
6.5% allied health professionals • 0.8% managers

Main area of work: 55.5% delivery suite • 19.6% antenatal/postnatal • 13.3% community

Methods & statistical analysis

- 57-item UK Labour & Delivery SAQ; six domains converted to 0–100 climate scores.
- Descriptive analysis: frequencies/percentages, plus mean (SD) SAQ scores pre/post nationally and by Health Board.
- Multinomial logistic regression stratified by Health Board and adjusted for job role, main area of work and length of time working in the hospital.

Ethics & data collection

HCRW classified the project as a service evaluation exempt from formal ethical approval; written approval was obtained from Heads of Midwifery and R&D departments across all 7 Health Boards.
Anonymous secure online survey; paper copies added post-implementation to improve uptake.

Results

Change in mean 100-point scores per SAQ domain on a national level comparing pre-implementation of PROMPT Wales and post-implementation periods.

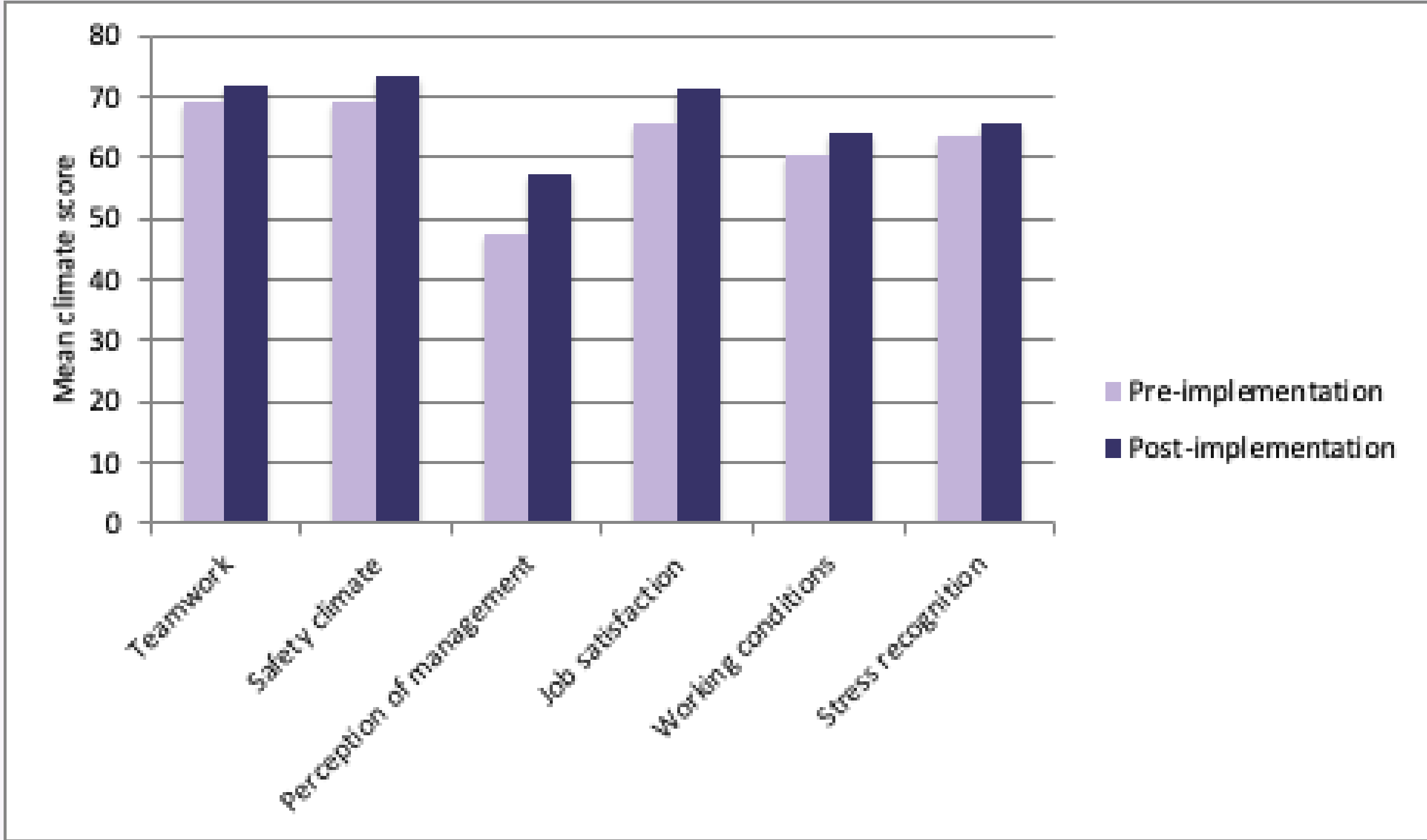


Chart: Change in mean 100-point SAQ scores nationally, pre- vs post-PROMPT Wales.

What changed?

Mean SAQ scores improved across all six domains.

MULTINOMIAL LOGISTIC REGRESSION Outcomes were not significantly affected by job role, main area of work or length of time working in the unit.

5 / 6

domains improved significantly

MOST SIGNIFICANT IMPROVEMENT

Perception of management

Primary multinomial model

Odds of a more positive SAQ score after PROMPT Wales

Teamwork climate	1.86	<0.001
Safety climate	1.90	<0.001
Job satisfaction	2.24	<0.001
Perception of management	2.95	<0.001
Working conditions	1.51	0.011
Stress recognition	1.21	0.202

DID IT LAST?

2022 SAQ

A further survey (n=185) found mean climate scores across all six domains remained above baseline, suggesting that improvements were maintained beyond the initial implementation period.

Strengths and Weaknesses

- National, multi-professional implementation across all 12 obstetric-led units
- Large pre/post sample with representation across professional groups
- PROMPT Wales showed a greater improvement in safety attitudes measured by the SAQ than a similar large-scale PROMPT scaling project in Australia
- Pre/post cross-sectional design; individual respondents were not matched
- The SAQ is a one-dimensional measure of safety culture and cannot replace in-depth qualitative and quantitative research; however, it provides a validated, standardised measure to assess and compare changes in staff perceptions of safety culture at scale
- Response represented approximately 13–15% of eligible staff

KEY MESSAGES

FROM INSIGHT → IMPLEMENTATION

This national scaling project led to successful implementation of PROMPT across all health boards in NHS Wales, with >90% of all eligible midwives, obstetricians and anaesthetists trained between Jan 2019–March 2020.
Improvements in safety culture were demonstrated nationally as measured by a validated questionnaire
Implementation success was driven by a deliberate and structured scaling approach, with an implementation team providing longitudinal support, monitoring and networking for maternity units, accountability with national standards and sponsorship by Welsh Government.

To achieve safer care at scale, we need to purposively design the implementation infrastructure around evidence-based interventions — not just the intervention itself.

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Audit of Antenatal Knowledge and Experience of Assisted Vaginal Birth

Dr. Shazia Liaqat, Dr. Vishnu Padmanabhan
University Hospitals of North Midlands , NHS trust

University Hospitals
of North Midlands
NHS Trust

The best joined-up care for all



Background

Assisted vaginal birth (AVB) using forceps or suction cup is a key component of intrapartum care. Women often give the impression of unfamiliarity about assisted births & having information on this for the first time when offered in labour. **It is also commonly observed that women who have assisted birth in previous pregnancy identify their experience to be traumatic & request a planned caesarean section.**

National guidance (NICE NG192) emphasises the need for antenatal counselling, clear intrapartum communication, and shared decision-making.

The Physical Birth Injuries (PBI) survey undertaken by **the Australasian Birth Trauma Association (ABTA)**, Birth Trauma Association (BTA) and Make Birth Better (MBB) in May 2022 **recommend development of national standards around consumer antenatal education content and curriculum.**

The MASIC Foundation carried out an online survey in November 2022, exploring women's experiences of having a vaginal birth assisted by instruments (Forceps or Ventouse). 78% of the respondents felt they did not have enough information to make an informed decision about having an instrumental birth and the type of instrument used. 57% of respondents were not aware of factors which mean some women are more likely to need an assisted vaginal birth. These factors include having a first baby, the baby becoming distressed, having an epidural for pain relief, the baby being too big for the mother's pelvis and being unable to push the baby out. The majority of the respondents (73%) were not made aware antenatally that instrumental deliveries are associated with an increased risk of maternal injury.

Patient feedback nationally suggests inconsistent antenatal information and variable experience of involvement in decision-making.

Interviews with community midwifery antenatal education teams at UHNM confirmed a lack of discussion around assisted births during antenatal classes or at 36 weeks appointment to avoid creating anxiety among pregnant women.

We were keen to explore antenatal education & women's experience around assisted birth at UHNM. We believed this would identify the gaps in practices & help us improve women 's knowledge about assisted births to be better prepared when indicated in labour.

Aim, Objectives & Method

Aim

To evaluate the adequacy of antenatal information, intrapartum counselling, and shared decision-making for women undergoing assisted vaginal birth, and to identify opportunities to strengthen antenatal education and reduce through standardised information provision and improved psychological follow-up.

Objectives

To determine:

- Proportion offered antenatal classes
- Whether assisted birth was discussed antenatally
- Source and clarity of information
- Whether risks/benefits were explained in labour
- Whether women felt involved in decision-making
- Willingness for assisted birth in future pregnancies
- Themes from free text feedback

Methodology

Sample: 60 women who had assisted vaginal birth over a 6month period from July to Dec 2025 had questionnaire handed out post birth .13 responses were obtained by sharing questionnaire online in Feb 2026 through Maternity and Neonatal voices partnership (MNVP) to women who have had assisted birth at UHNM in the last 2 years

Data source: Patient survey through structured questionnaire

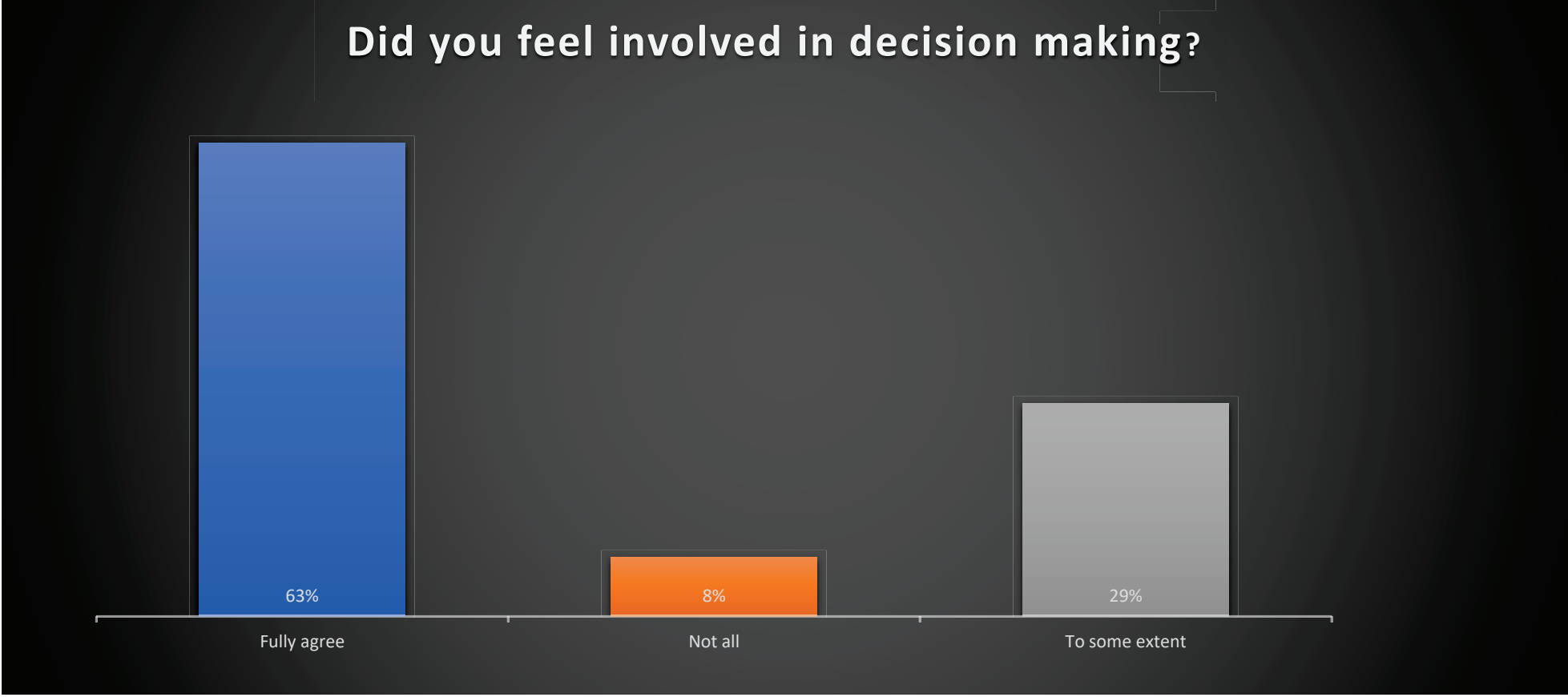
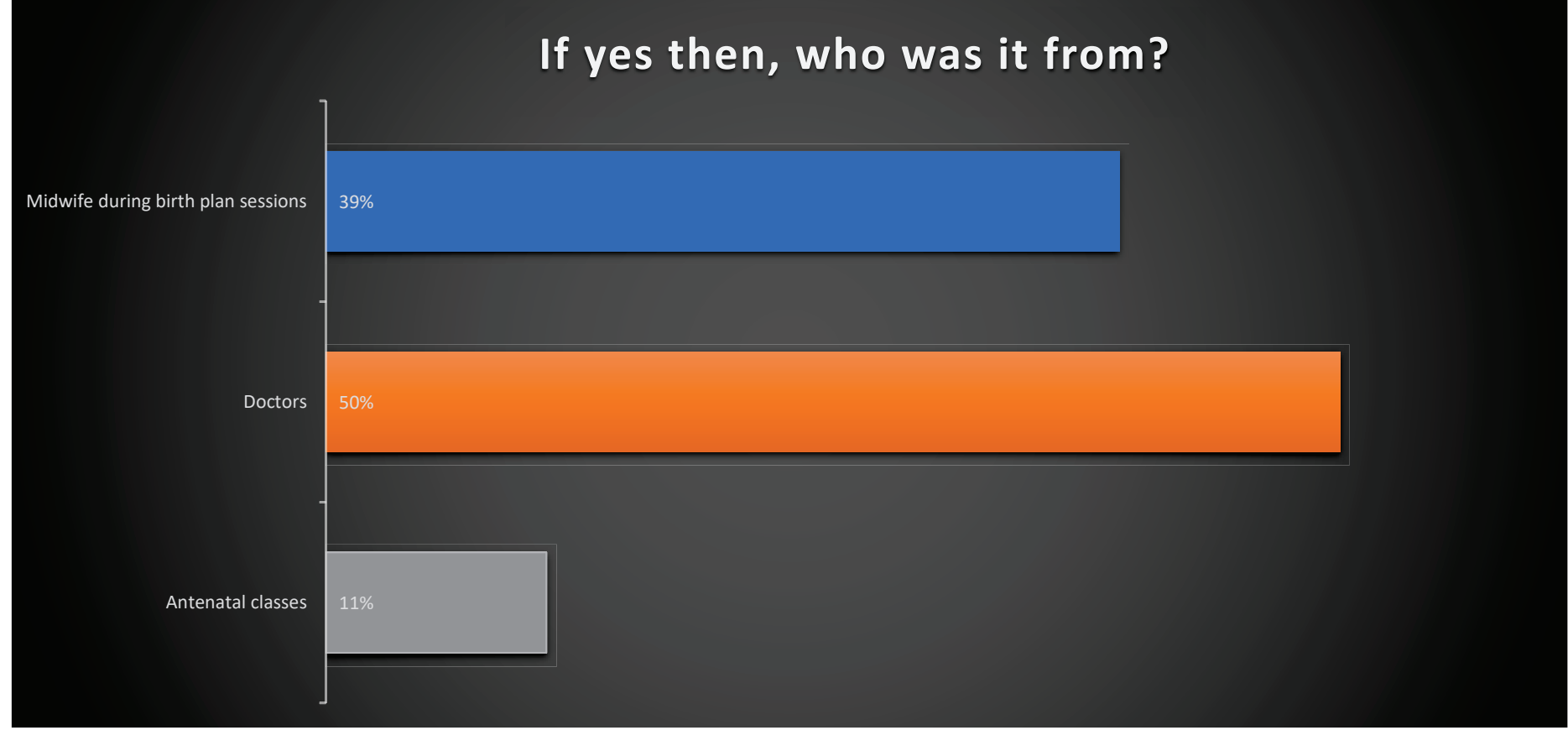
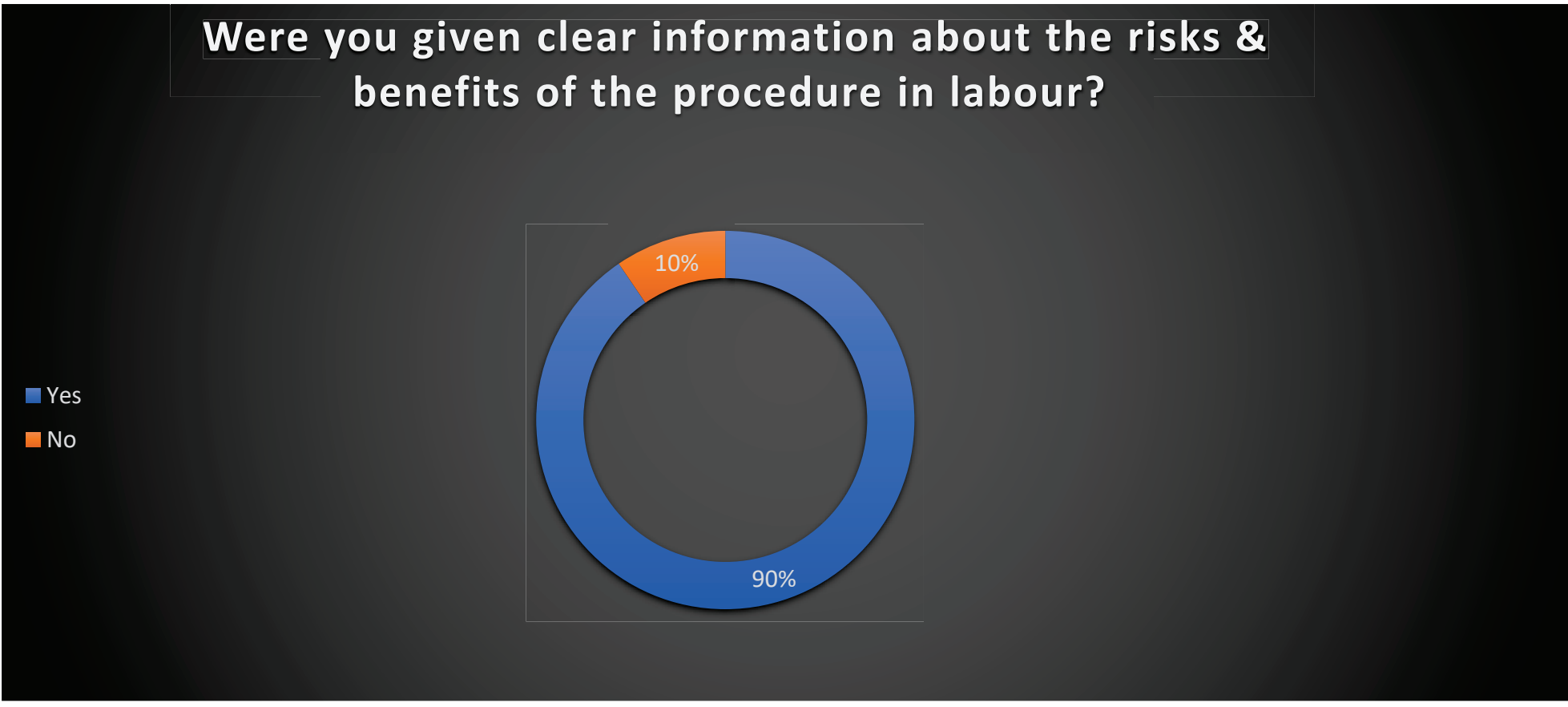
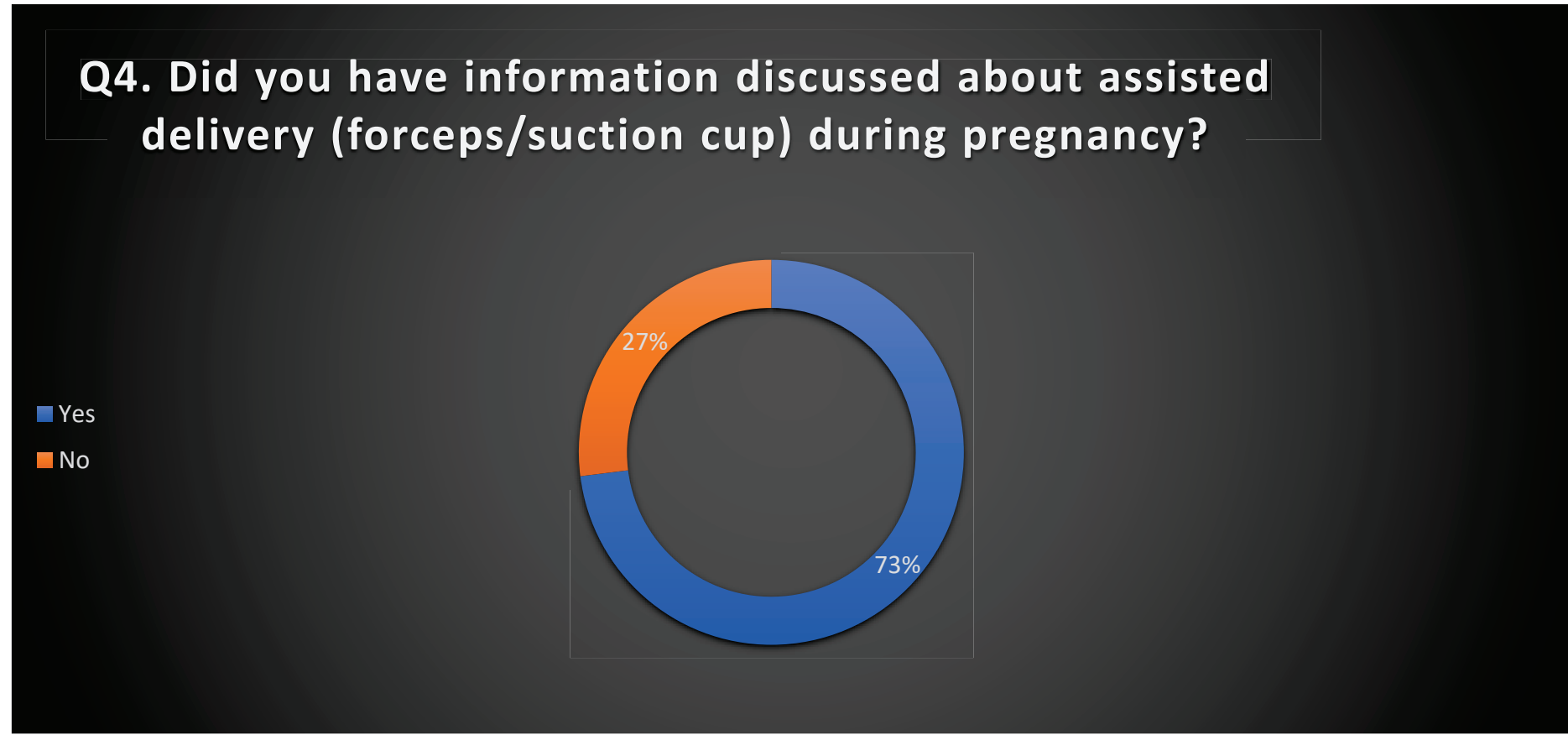
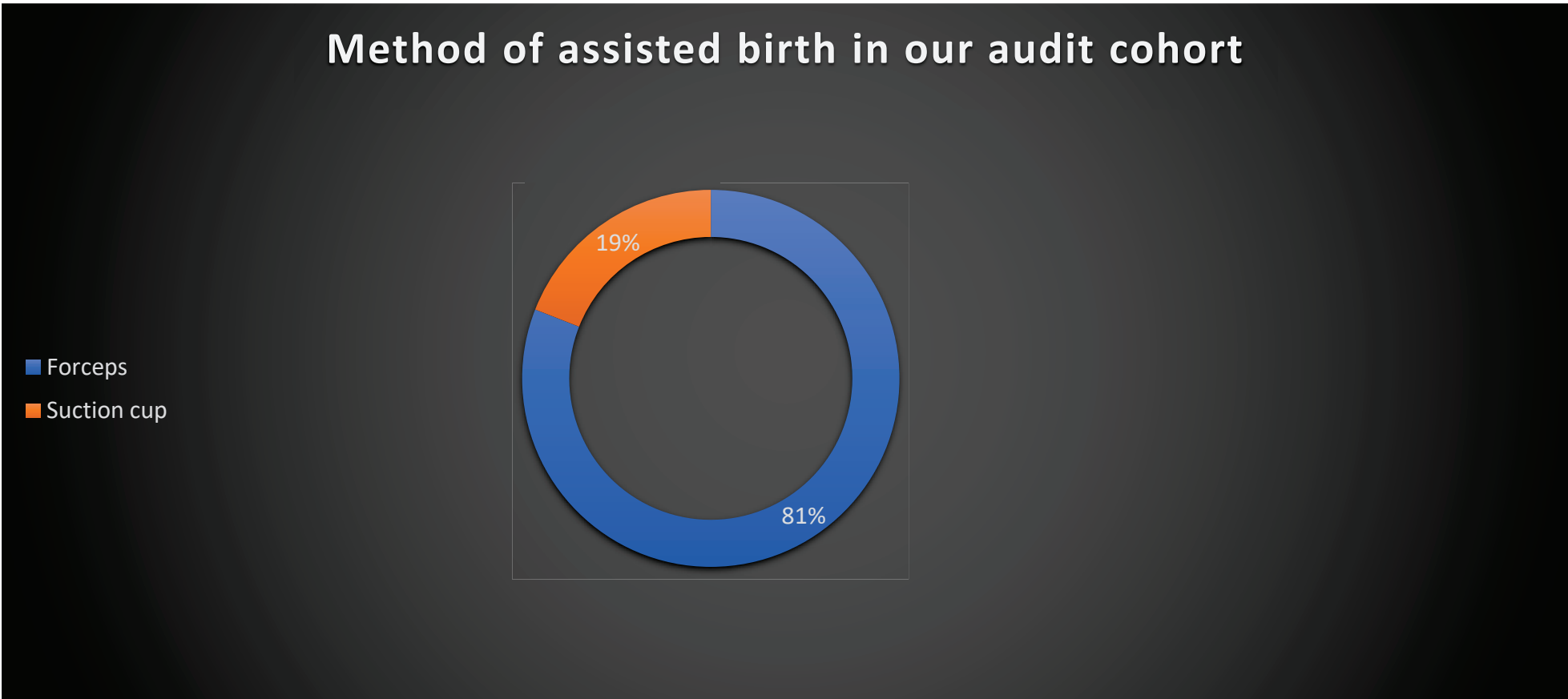
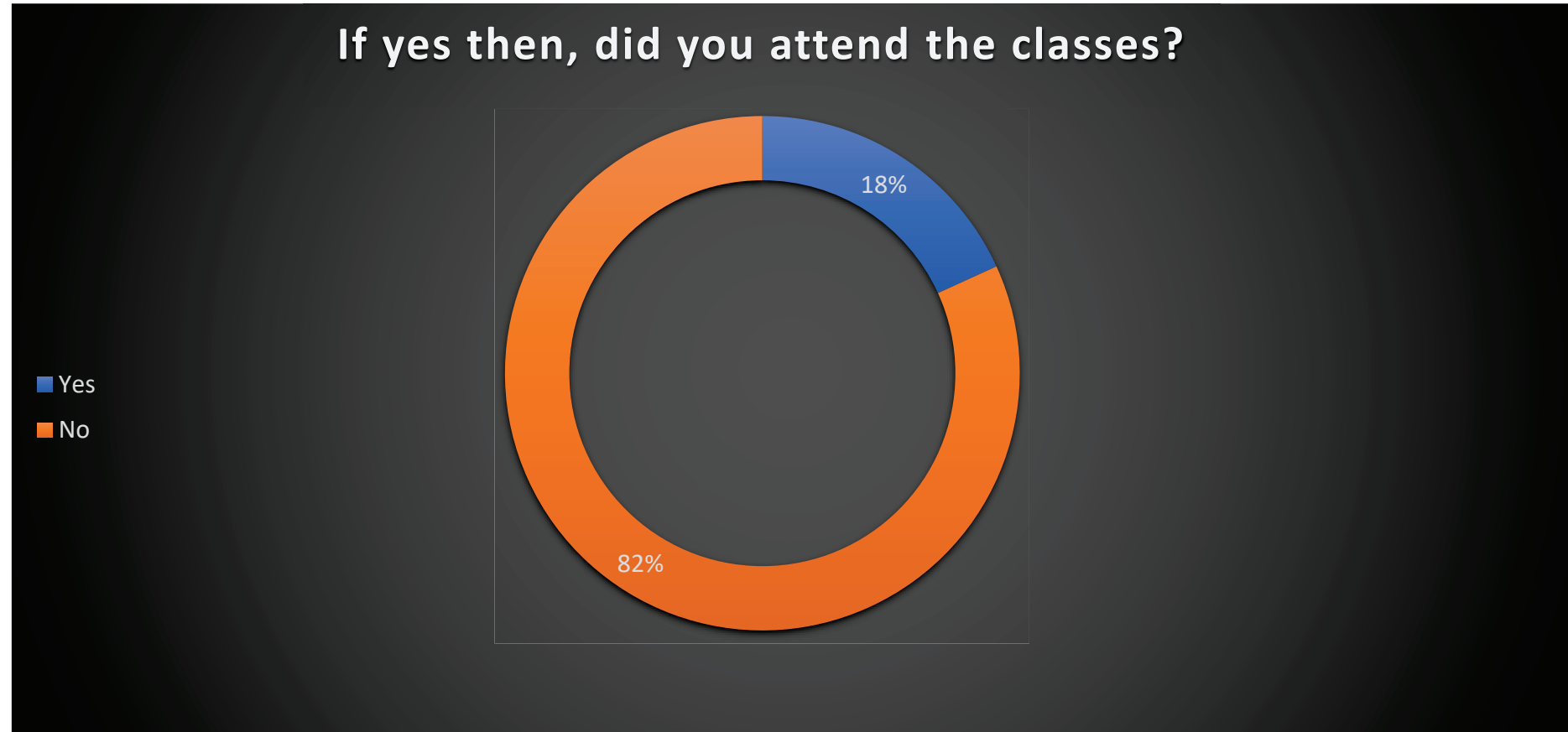
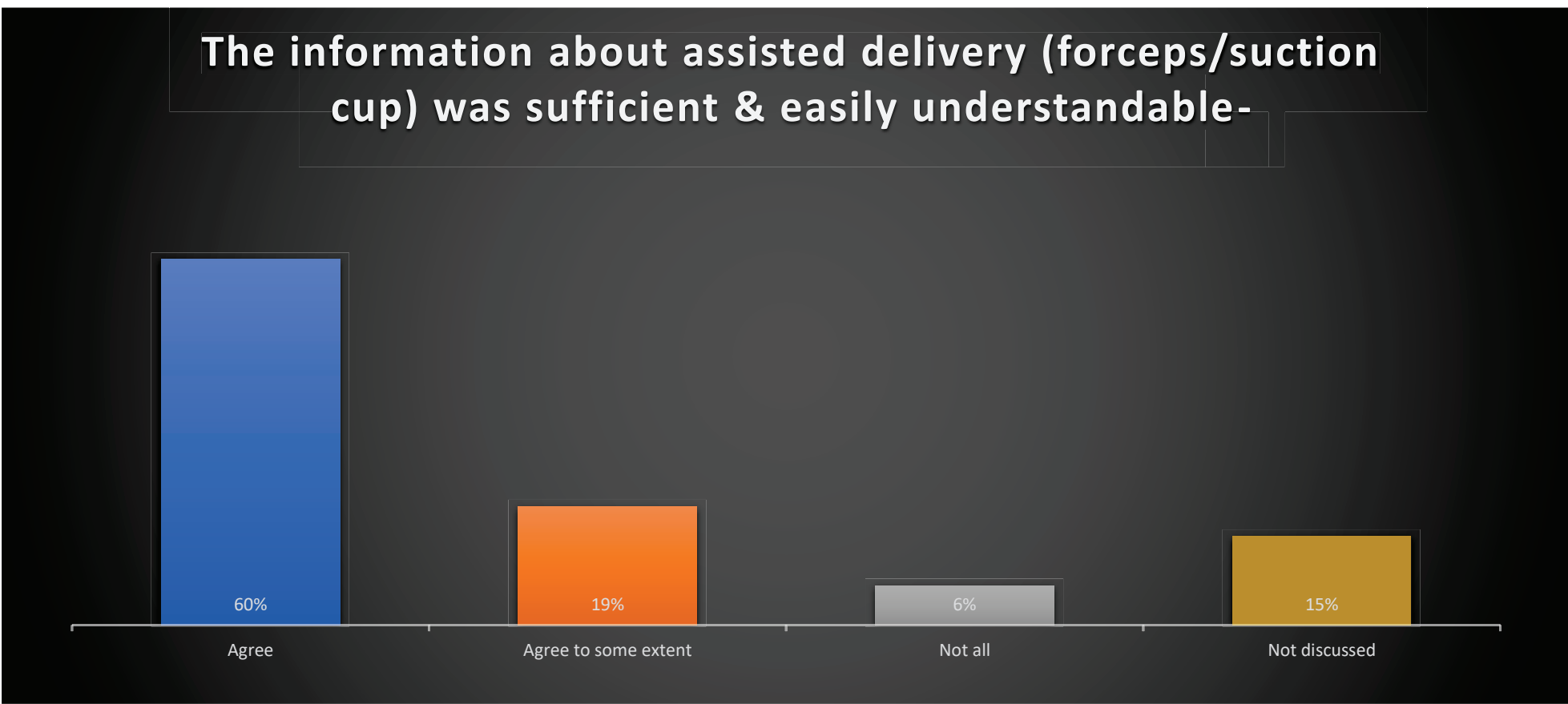
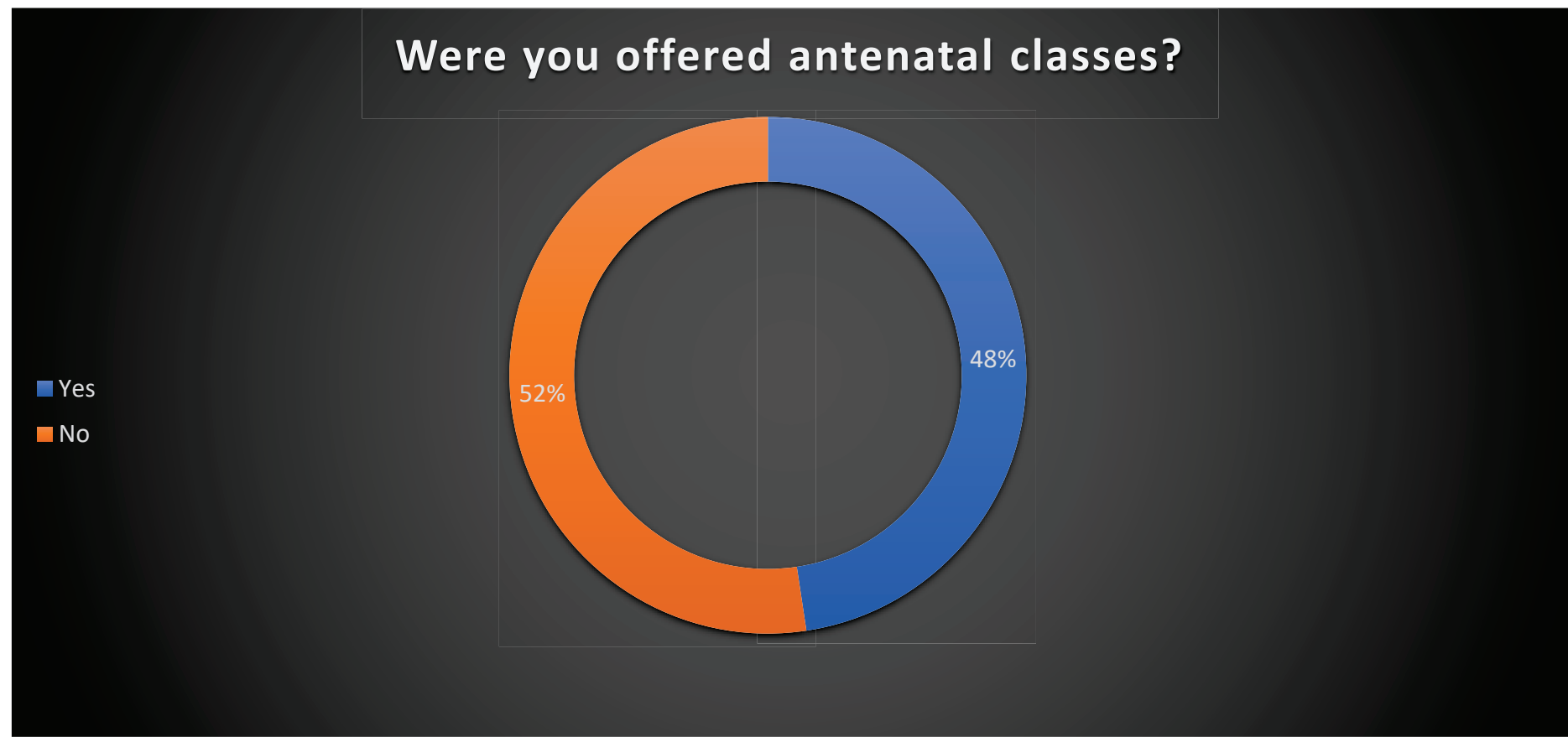
Audit type: Local retrospective audit

Design: Quantitative + qualitative thematic analysis

Data collection: Structured questionnaire

Data analysis: Descriptive statistics

Results



Women's perspectives

Positive themes

Clear communication
Supportive staff
Good coordination
Feeling prioritised and safe
Example- 'Amazing quality of care. Very satisfied.'

Negative themes

Lack of antenatal education
"More information to be given at midwife appointments... not relying on people to self-educate."
Traumatic experience
"I found forceps delivery to be very traumatic..."
Lack of involvement in decisions
"I was never involved in that decision."
Inconsistent communication
"Mixed opinions from different consultants."
Poor intrapartum support
"I received very little and poor support during labour."

Recommendations

- Introduce a standardised antenatal information package on assisted birth (leaflet + digital video) to be shared through My pregnancy notes & on antenatal classes.
- Ensure midwives discuss assisted birth during the 36-week birth plan appointment.
- Perinatal mental health team to keep a database for PTSD associated with assisted births & birth choices team to keep a database of women requesting planned CS after assisted births for audit & service improvement for women.

Conclusion

This audit demonstrates significant gaps in antenatal counselling regarding assisted vaginal birth, with only half of women reporting that the topic was discussed. Intrapartum communication was generally good, but a notable minority felt excluded from decision-making, and several reported traumatic experiences.

There is a clear need for structured antenatal education, consistent messaging, and enhanced shared decision-making

References

NICE NG192 (2021) Intrapartum Care
RCOG Green top Guideline 26 (2011) Operative Vaginal Delivery
Trust Consent Policy (2024)

Transforming Maternity Triage:

Improving Flow, Experience and
Timely Assessment in a High-Volume
Maternity Service



BACKGROUND



Maternity triage services nationally are experiencing **increasing demand, workforce pressures** and challenges in meeting **timely assessment standards**.



BHRUT's maternity triage service manages approximately **70 women per day** within one of the largest maternity services in London.



AIM

To improve patient flow, reduce delays and enhance patient experience within maternity triage.



METHODS

A multidisciplinary improvement programme was implemented focusing on:



Workforce redesign and enhanced leadership presence



Additional assessment capacity



Improved patient streaming processes



Enhanced operational oversight



Daily flow management



Improved escalation processes



Continuous monitoring of triage performance indicators



Patient experience improvements, including refreshments and environmental enhancements



RESULTS



The service demonstrated a **reduction in breach rates** despite increasing demand.



Operational flow improved and women experienced more **timely assessment and review**.



Patient feedback highlighted **positive improvements** in experience and communication.



Outpatient induction pathways also contributed to **reducing inpatient demand**.

The service demonstrated a reduction in breach rates despite increasing demand. Operational flow improved and women experienced more timely assessment and review. Patient feedback highlighted positive improvements in experience and communication.



~25%

of women now supported through **outpatient induction processes**



CONCLUSION

Improving maternity triage performance requires a whole-system approach that combines operational leadership, workforce optimisation, patient experience initiatives, and robust performance monitoring. The programme demonstrates how large maternity services can improve flow and reduce delays whilst maintaining quality and safety.



Reducing Health Inequalities Through a Multi-Ethnic Empowerment Programme:

Improving Access, Communication and Personalised Care Across the Maternity Pathway



Accessible care



Culturally responsive



Improved experience



Reduced inequalities



BACKGROUND



BHRUT serves one of the most ethnically diverse populations in England, with approximately half of women accessing maternity services speaking English as an additional language. Language barriers, health literacy challenges and digital exclusion contribute to inequalities in access, experience and outcomes.

“When I can understand, I feel more confident and involved in my care.”

– Service user



AIM

To improve communication, engagement and personalised care for women from diverse ethnic backgrounds throughout pregnancy, birth and the postnatal period.



METHODS

A Multi-Ethnic Empowerment Programme was developed to address barriers to access and engagement. Key interventions included:



Recruitment and deployment of bilingual support workers



Enhanced culturally sensitive care pathways



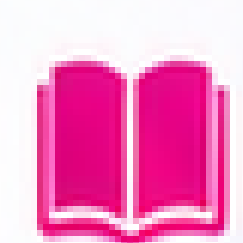
Support throughout the maternity journey from booking to postnatal care



Community engagement initiatives



Translation and interpretation support



Development of multilingual educational resources



Exploration of innovative technologies including Pocketalk translation solutions



Partnership working with local communities and voluntary sector organisations



RESULTS

- ✓ Improved access to information.
- ✓ Stronger communication between women and healthcare professionals.
- ✓ Enhanced personalised care delivery.
- ✓ Women reported increased confidence navigating maternity services and improved understanding of their care.
- ✓ Staff reported greater confidence supporting women with complex language needs.

“I felt respected, heard and supported in my language. It made a big difference.”

– Service user



CONCLUSION

Addressing communication barriers requires more than interpretation services alone. Embedding culturally competent support throughout the maternity journey can improve patient experience, reduce inequalities and strengthen personalised care. This model demonstrates a practical approach to advancing equity within maternity services.

*Different languages
Same hopes
Brighter tomorrows*



Safe care



Kind care



Excellent care



Inclusive care



Redesigning a Homebirth Service:

Balancing Women's Choice, Workforce Sustainability and Patient Safety in a Large Urban Maternity Service



"Supporting women to give birth where they feel safe, informed and empowered."



Women's choice



Workforce sustainability



Patient safety



Stronger together



BACKGROUND



Maintaining a safe and sustainable homebirth service presents significant challenges for maternity providers nationally. Workforce shortages, staff fatigue, service suspensions and concerns regarding resilience have resulted in many organisations reducing or restricting homebirth provision. At BHRUT, we recognised the need to redesign our homebirth model to improve sustainability whilst preserving women's access to personalised birth choices.

"Homebirth gave me the calm, respectful and empowering experience I wanted, with a team who listened and supported me."

- Service user



AIM

To develop a clinically safe, workforce sustainable and resilient homebirth service through engagement, consultation and workforce redesign.



METHODS

A comprehensive service review was undertaken involving community midwives, operational leaders, obstetric colleagues, HR and staff side representatives.

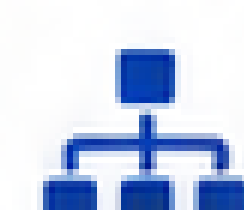
Workforce data, service activity, escalation incidents, staff feedback and on call arrangements were reviewed. The redesign included:



Extensive staff consultation and engagement



Introduction of a revised three midwives on call model



Clear escalation and business continuity arrangements



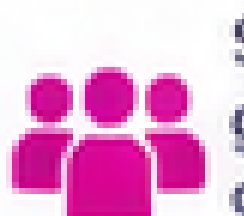
Improved compensatory rest processes



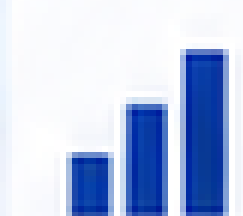
Integration off community and hospital working



Six monthly community specific emergency skills and drills programme



Strengthened governance through a dedicated Homebirth Steering Group



Ongoing workforce and safety monitoring



RESULTS

- Improved service resilience and reduced the risk of service suspension.
- Women maintained access to homebirth.
- Staff reported improved confidence, wellbeing and sustainability.
- Strengthened integration between community and hospital teams, supporting maintenance of intrapartum skills.
- Improved governance oversight through regular monitoring of workforce, activity, safety metrics and service availability.



"A safe, supported and empowering birth at home. Exactly what we hoped for."

- Service user

Safe
Personalised
Respectful
Together



CONCLUSION

A collaborative workforce redesign approach enabled the development of a sustainable homebirth service that balances women's choice with workforce wellbeing and patient safety. This model demonstrates how large maternity providers can maintain homebirth provision through robust governance, workforce planning and staff engagement and may provide a transferable framework for other NHS maternity services.

Supporting choice
Strengthening communities
Building brighter futures



Safe care



Kind care



Excellent care



Inclusive care



We care, We respect,
We are inclusive.



Wye Valley Trust Maternity



PPH >1500mls and the impact on breastfeeding rates through the implementation of Amber Feed Charts to aid risk assessment and care planning.

Audit Overview

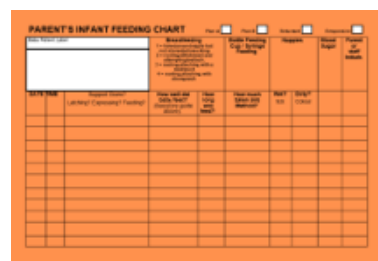
Following service user feedback, an audit was undertaken for the period December 2024 - May 2025 June looking at the impact of PPH rates on breastfeeding rates at 3 key points, birth, discharge from hospital and discharge to health visitors. This was repeated for the period June 2025 -December 2025, to measure the impact of the implementation of Amber feed charts to support initial risk assessment and identification of the potential need for extra feeding support following a PPH.

Data

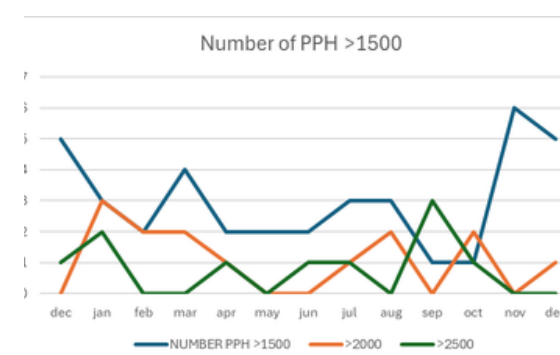
- During the period December 2024- May 2025 there were 29 PPH >1500mls
- 17 PPH >1500ml but <2000mls
- 8 PPH >2000mls but <2500mls
- 4 PPH >2500mls.
- During the period June- December 2025 there were 33 PPH >1500mls
- 19 PPH >1500ml but <2000mls
- 6 PPH >2000mls but <2500mls
- 6 PPH >2500mls.
- (2 births sadly resulted in NND and were therefore excluded from the data.)

Objectives

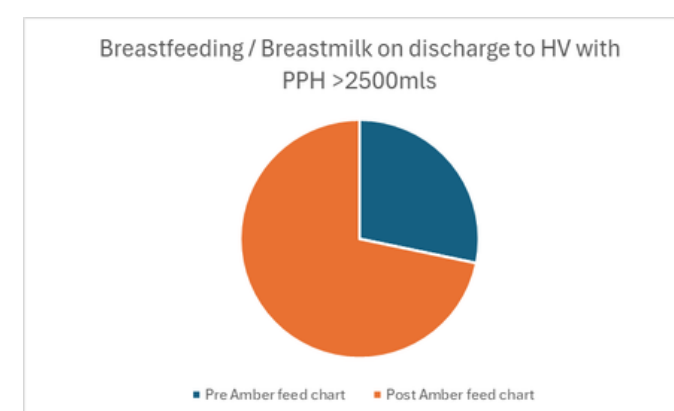
- To measure the impact of use of the Amber feed chart to identify the need for additional feeding support following a PPH >1500mls to increase breastfeeding rates within this cohort.
- To audit feeding outcomes following implementation of the Amber feeding charts at 3 key points, first feed, at time from discharge from hospital and at time of discharge to health visitor - usually day 10-14 after birth (where data available) .



Key Highlights and recommendations.

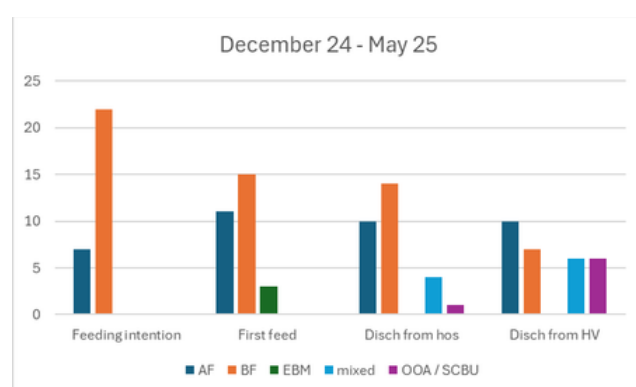


It can be seen that the number of PPH >2000mls have significantly reduced following the implementation of the OBS WVT PPH risk assessment tool.



Following implementation of the Amber Feed Charts in the PPH >2500mls cohort - 17% had a first feed of breastfeed or EBM (of which 67% intended on breastfeeding). - However on discharge to health visitor 66% were giving breastmilk after receiving feeding support which is a significant increase from 25% prior to implementation of the Amber Feed charts to aid the identification of the need for additional feeding support.

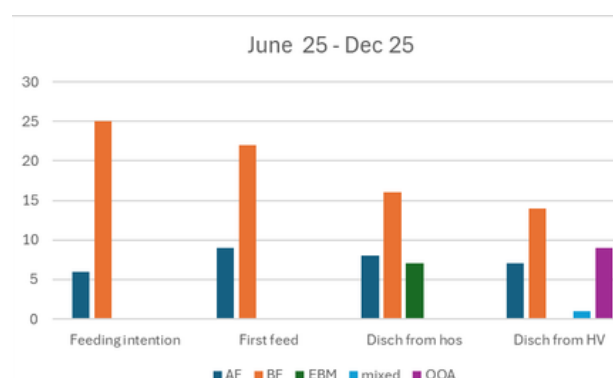
Findings



After the implementation of Amber feed charts in June 2025 it was noted that there was an overall increase in breastfeeding feeding, most noticeably with the first feed .

PPH >1500mls - 84% had a first feed as a breastfeed or EBM - (previously 45%)

PPH >2000mls - 50% had a first feed as a breastfeed or EBM (previously 13%)



As part of the QI project learning, was disseminated to staff for the need to consider the clinical situation in PPH cases, ensuring that the PPH be managed appropriately, however that it was also of great benefit to risk assess the baby to ascertain if there is a clinical need to supplement / offer formula in the first instance (i.e. an 'at risk' baby). The use of the risk assessment and Amber Feed charts therefore aids informed clinical decision making that a healthy well term infant may benefit from waiting for a first breast / EBM feed rather than a formula feed if the situation does not allow for hand expression whilst in theatre. Supplementation with formula milk without clinical indication can impact on establishing breastfeeding, a reduction in breastmilk supply, reduction in mothers confidence in breastfeeding and can cause issues such as increasing risk of allergies, thus in turn, reducing longer term breastfeeding rates.

Conclusion

The implementation of the Amber feed charts , as a direct result of listening to our service users, can be seen to have a positive effect in identifying mothers and babies that may require additional feeding support following a PPH. These include a shorter hospital stay, and an increase in initiation of breastfeeding, an increase in breastfeeding rates on discharge from the hospital and also on discharge to health visitors. Therefore having not only an increase in service user satisfaction of achieving their feeding goals but also wider positive benefits of helping to reduce health inequalities along with a positive financial benefit for the Trust.

Increases in longer term breastfeeding rates could save the NHS over £11 million to £100 million annually in treatment costs and GP consultations as a result of the known evidence based health benefits of breastfeeding.

Testament to the ongoing work to support breastfeeding within the Wye Valley NHS Trust maternity is further acknowledged by the recent achievement of being awarded the prestigious UNICEF Baby Friendly Initiative (BFI)Gold Award (February 2026)

Creating a Culture of Respectful Escalation: Implementing a “Pause for Review” in Obstetric Emergencies



Bethan Percival, ST7 O&G¹ · Jessica Thomas, Lead PMA/Labour Ward Sister¹ · Divya Nambiar, Consultant Obstetrician & Gynaecologist¹

¹Buckinghamshire NHS Foundation Trust

NATIONAL MATERNITY SAFETY CONFERENCE 2026



AIMS AND OBJECTIVES

Independent maternity investigations and Maternity and Newborn Safety Investigations (MNSI) recommendations repeatedly identify delayed escalation, poor communication, and dismissive responses to challenge as contributors to avoidable harm.¹⁻³ Following a neonatal injury during a complex assisted vaginal birth, our maternity service was tasked with introducing an interruption system to create a clear “pause and review” moment during obstetric emergencies when concerns are raised.

This quality improvement project aimed to co-design and implement a standardised escalation process using shared safety-critical language, a structured “Pause for Review” intervention, and an agreed respectful response to challenge. The objectives were to improve psychological safety, reduce hierarchy-related barriers, standardise escalation behaviours, and support timely senior review during emergencies to improve maternity safety.



METHODS

Using a multidisciplinary QI approach and PDSA methodology, the project engaged midwives, obstetricians, anaesthetists, theatre staff and maternity voices representatives. Baseline work included a multidisciplinary focus group involving 22 participants and a wider staff survey exploring “work as done” around escalation and speaking up.

Key themes identified included fear of speaking up, inconsistent responses to concern, hierarchy, incivility, and lack of a standard escalation process. Staff strongly supported introducing a structured pause mechanism that was non-confrontational and safe to use in front of women and families.

The intervention evolved from “Safety Pause” to the patient-centred phrase “Pause for Review”. A graded escalation model was developed:

- Gentle prompt: “Can we pause for a moment?”
- Explicit concern: “I have a concern — can we pause and review?”
- Formal escalation: “I’m calling a Pause for Review.”

A standardised response protocol was embedded:

- Acknowledge immediately
- Pause and create brief reflective space
- Structured review of concern and options
- Agree and close the loop on the ongoing plan.

The intervention has been incorporated into visual prompts for labour ward, WHO theatre time-out, PROMPT simulation training and labour ward handovers.



IMPACT AND OUTCOME DATA

Baseline findings demonstrated significant cultural and communication challenges:

- Survey respondents described escalation as challenging in some situations.
- Psychological safety and hierarchy emerged as dominant barriers across all staff groups.
- Staff identified a need for simple, standardised escalation language and clearer behavioural expectations.

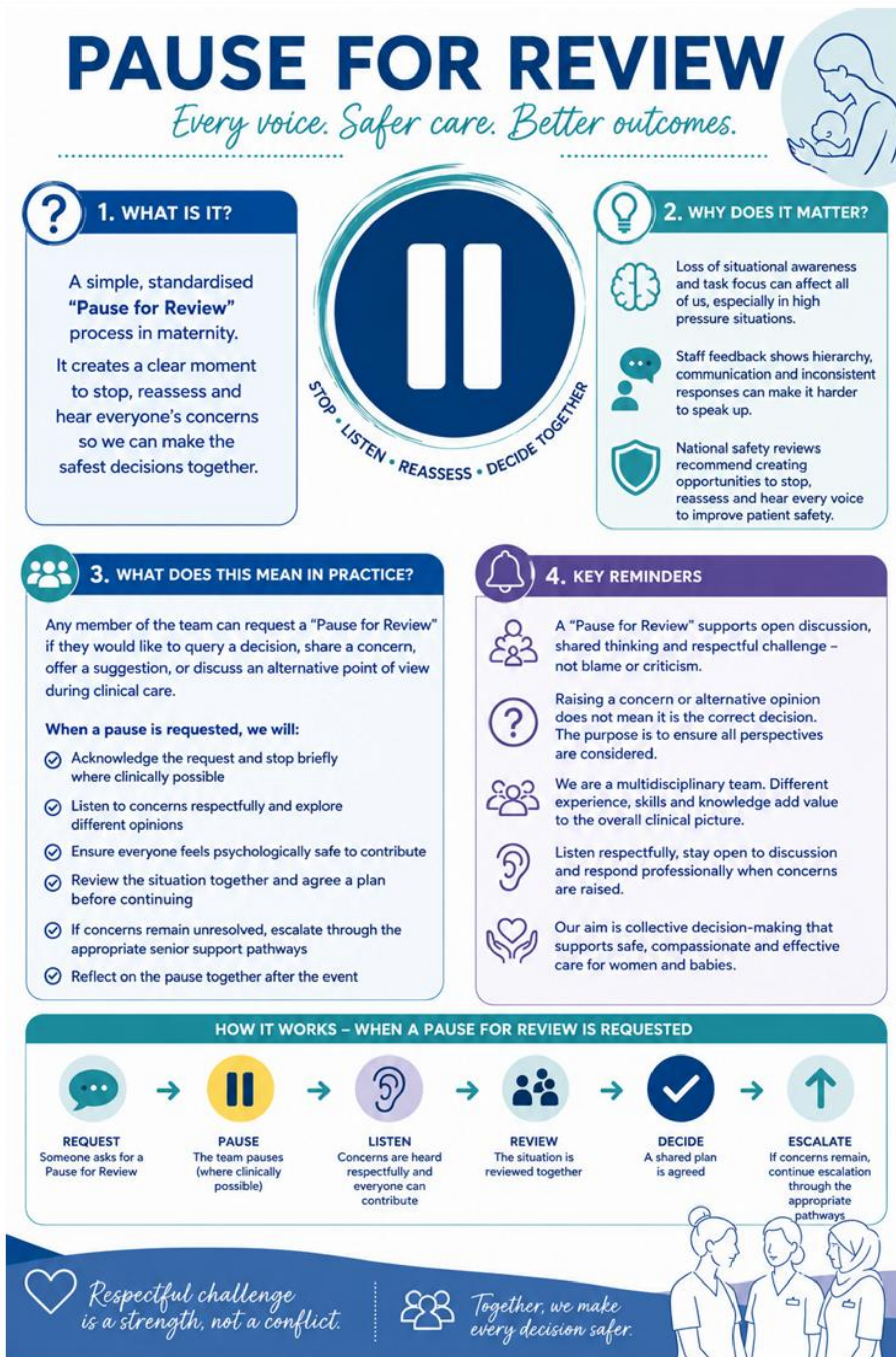
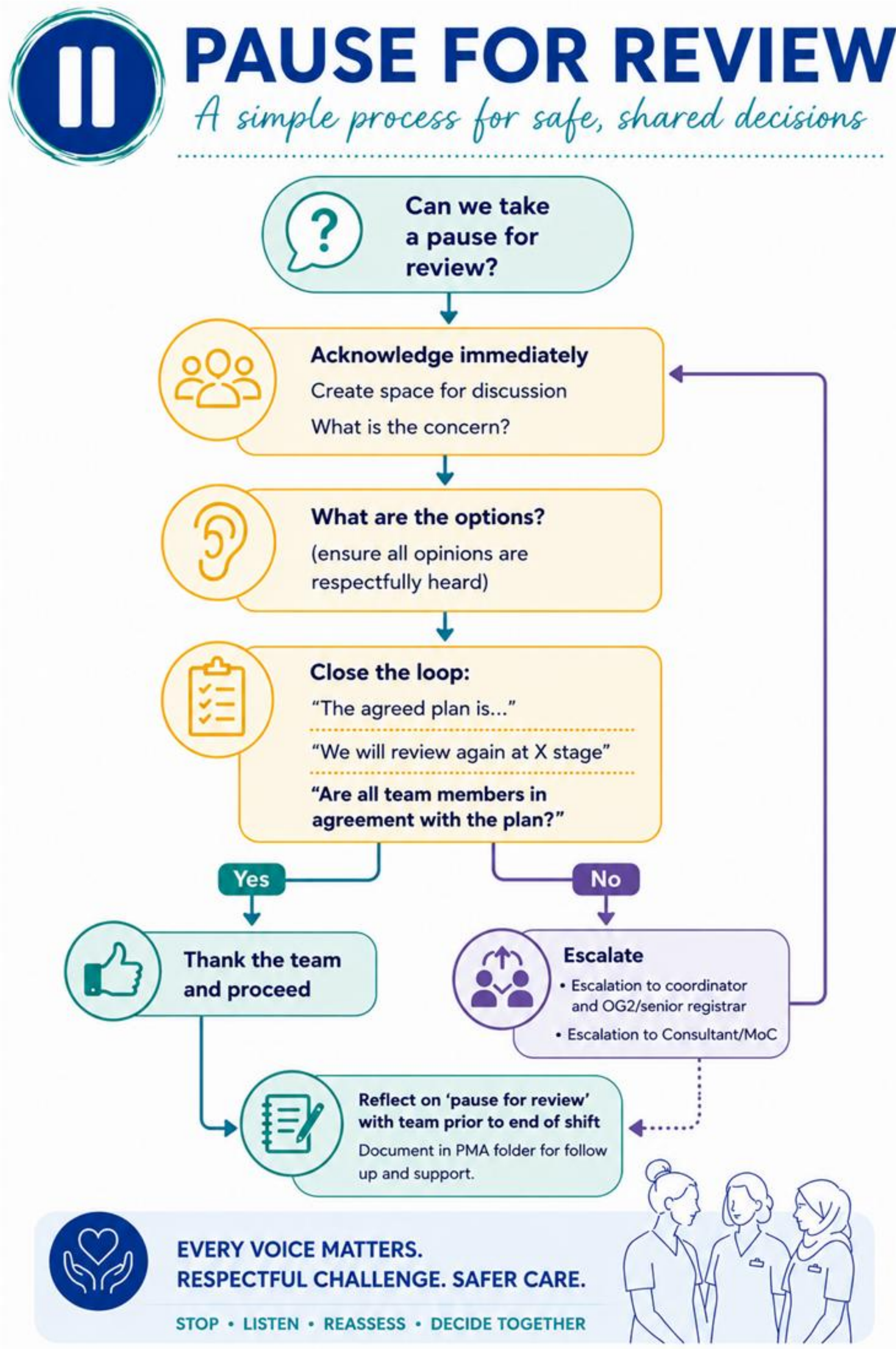
Early implementation outcomes include:

- Multidisciplinary agreement on standardised escalation language
- Integration planning into theatre safety processes and PROMPT simulation
- Increased engagement in discussions regarding civility, respectful challenge and escalation culture.

Prospective measures include frequency of “Pause for Review” use collected through labour ward morning safety huddles, feedback from staff gathered through PMA follow-up discussions and debriefs with those involved, staff confidence in escalating concerns, and qualitative measures of team culture, civility and psychological safety.



THE INTERVENTION



CONCLUSION

This project translates national safety recommendations and frontline staff experience into a practical, implementable intervention aimed at improving safety and culture in obstetric emergencies. By moving from insight, into embedded behavioural and system change, the project demonstrates how respectful escalation, psychological safety and standardised communication can be operationalised within maternity care.

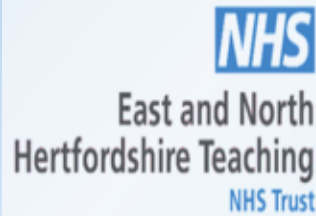


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1. Ockenden D. Final report of the Ockenden review: maternity services at Shrewsbury and Telford Hospital NHS Trust. HC 1219. London: DHSC; 2022.
2. Kirkup B. Reading the signals: maternity and neonatal services in East Kent – report of the independent investigation. HC 681. London: DHSC; 2022.
3. Maternity and Newborn Safety Investigations. Annual publication of MNSI safety recommendations 2024/25. London: MNSI; 2025.

Perinatal Optimisation Working Group (POWG) – a Continuous Quality Improvement (QI) Project following implementation of a Multidisciplinary Team (MDT) at a Local Neonatal Unit

Mitra, N; Amos, N; Thorpe, D; Wooldridge, R.
Department of Neonatology and Department of Obstetrics and Gynaecology, Lister Hospital, East and North Hertfordshire Teaching NHS Trust, UK.



Background

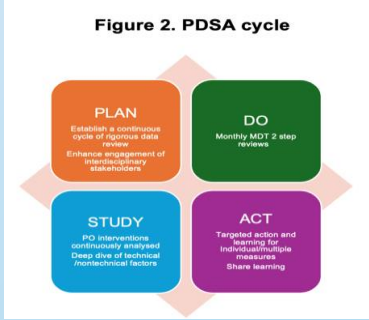
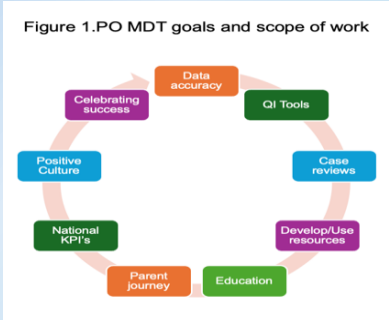
The ‘Perinatal Optimisation (PO) Care Pathway’ is the process of reliably delivering evidence-based interventions in the antenatal, intrapartum and neonatal periods to improve preterm outcomes₁. However, there is wide variation in practice amongst operational delivery networks (ODN’s)₂. Reliable delivery of PO measures is dependent on a “strong team working culture, high quality communication habits and pursuit of common goals within perinatal teams”₃.

Aim

To improve delivery of PO interventions in the antenatal, perinatal and postnatal periods for preterm births < 34 weeks’ gestation through MDT working at a district general hospital with a local neonatal unit.

Methods

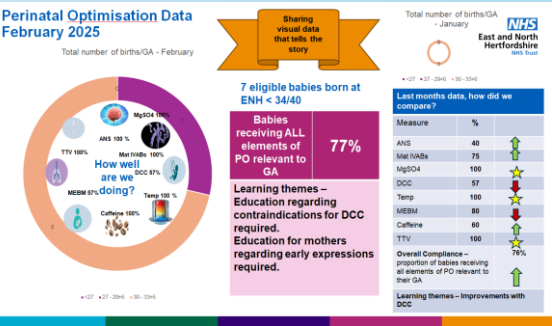
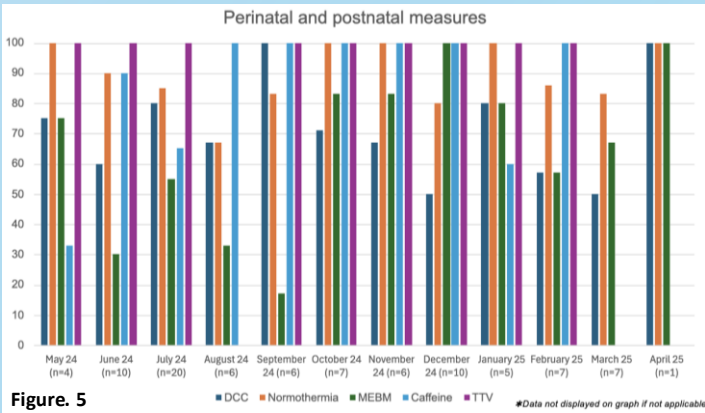
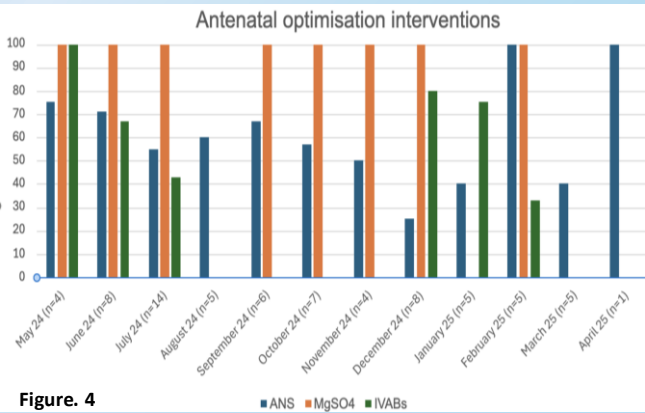
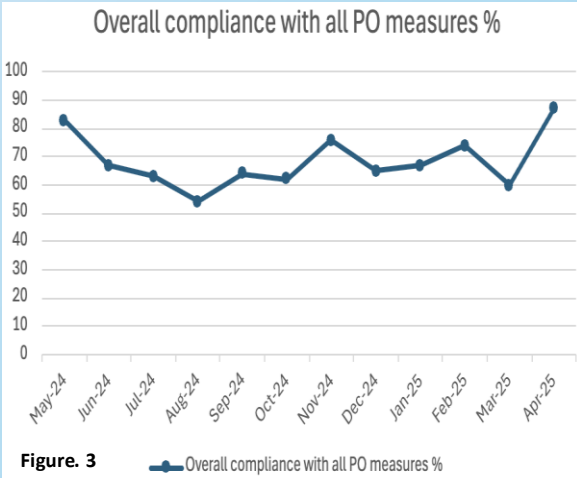
An MDT comprising of an obstetrician, preterm-birth midwife, neonatal nurse-practitioner, and a neonatologist used QI tools to align goals with national performance metrics commencing in April 2024. They embarked on a PDSA plan to improve PO pathway.



Key Results

During this study period (May 2024 to April 2025), 72 eligible mothers and 89 babies < 34 weeks’ gestation were identified:

- The average compliance in 2nd half of the year was 71.5% as compared to 65.5% in the 1st half (Figure 3).
- 97% compliance was achieved for “Right place of birth”. Individual/multiple measures were targeted for improvement. For example, in the first half of the study period, the average compliance of normothermia was 56.7%, and for the 2nd half was 91.5%.
- We shared monthly statistics with staff (Figures 4-5); validated the data for regional/national dashboards.
- We disseminated learning monthly (example shown in Figure 6).
- We held MDT study days including parent delivered talks and conducted in-house training to foster improvement (Figures 7-8).
- We launched the use of perinatal passports.
- We collaborated with other projects/team members such as “Golden Drops”, Safety Champions and strived to foster a positive culture.



Conclusion

We established a PO-MDT and through a cycle of ongoing continuous QI, targeted PO measures resulting in improved engagement and compliance.

References

1. BAPM. Perinatal Optimisation pathway. Resources to help improve preterm outcomes. <https://www.bapm.org/pages/perinatal-optimisation-pathway>
2. Alessandra Gaver Williams, Sam Tukey, Hayley McElin, Nahin Mericles, Sally Hedge, Sarah Bates, Karen Luyt - Perinatal excellence to reduce injury in preterm birth (PERIPrem) through quality improvement: BMJ Open Quality 2022; 11:e001906.
3. BAPM Building Successful Perinatal Optimisation Teams. A Toolkit to support delivery of the Perinatal Optimisation Pathway. BAPM 2023 <https://www.bapm.org/resources/building-successful-perinatal-optimisation-teams>

Supporting Safer Maternity and Neonatal Care: Use of MBRRACE-UK resources

GL Page, LK Smith and BN Manktelow on behalf of MBRRACE-UK

Background

- MBRRACE-UK undertakes national surveillance and in-depth confidential enquiries into perinatal deaths and maternal mortality and morbidity to improve outcomes in the UK.
- MBRRACE-UK provides a range of resources, with aims of supporting improvements in maternity and neonatal care by sharing morbidity and mortality data and making national recommendations.

Aim

- MBRRACE-UK seeks to understand the impact of its work and how its resources are used to support positive change.
- An ongoing survey is gathering feedback from healthcare professionals to identify opportunities for improvement, understand the limitations of current resources, and maximise their impact.

Share your feedback



Key MBRRACE-UK resources

Perinatal

Perinatal Mortality Review Tool (PMRT)

A tool for mandatory, systematic review of stillbirths and neonatal deaths

Annual reports for trusts and health boards

Confidential, individualised perinatal mortality reports for all NHS trusts and health boards

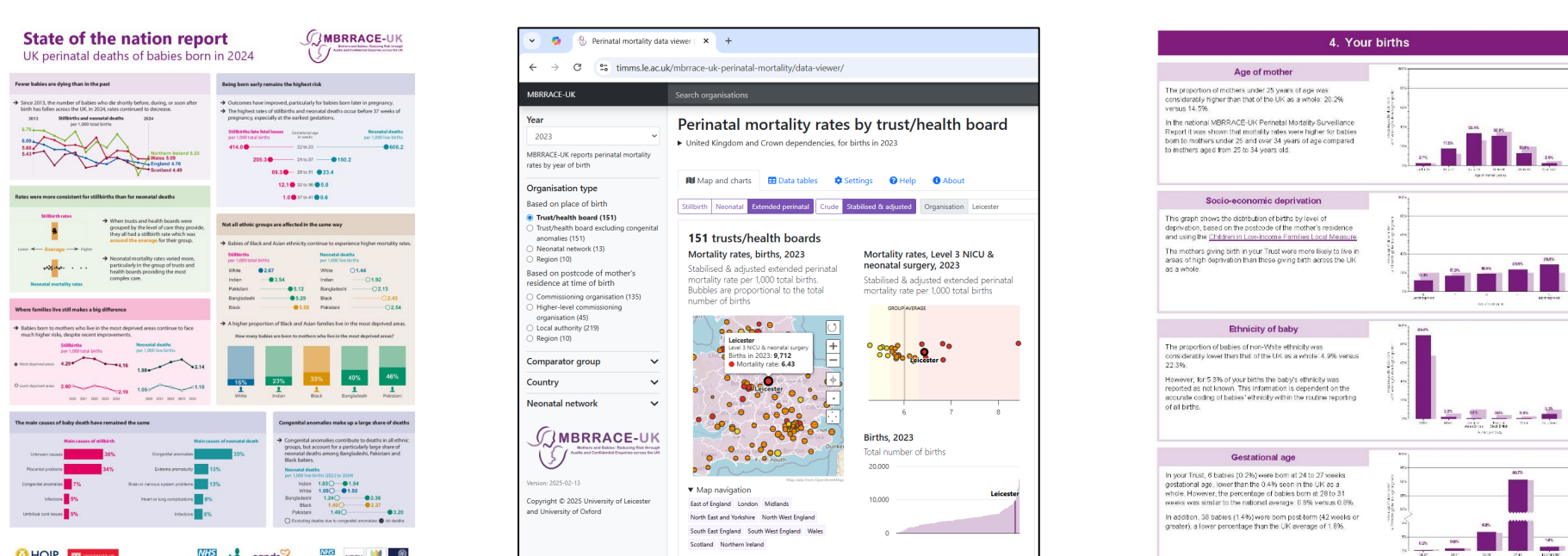
Perinatal mortality data viewer

Comparison of perinatal mortality rates across organisations in the UK

Real-Time Data Monitoring (RTDM) tool

A tool for monitoring and identifying trends in perinatal mortality in real-time

Signs of Life Guidance: UK clinical guidance on the determination of signs of life in babies born before 24 weeks gestation (including training videos)



Both

State of the Nation surveillance reports

Annual reports detailing maternal morbidity and mortality and perinatal mortality rates for the UK

Infographics

Supporting reports through simple and clear imagery and plain language

Confidential enquiries

Detailed, expert review of clinical care using anonymised medical notes

Annual conferences

Key findings from the annual Saving Lives, Improving Mothers Care report

Key findings from surveillance and PMRT annual reports, stakeholder responses, good practice examples and the experiences of bereaved parents

Free CPD training course

Lessons from the previous years' MBRRACE-UK Perinatal Report, the Perinatal Mortality Review Tool annual report and Saving Lives, Improving Mother's Care report

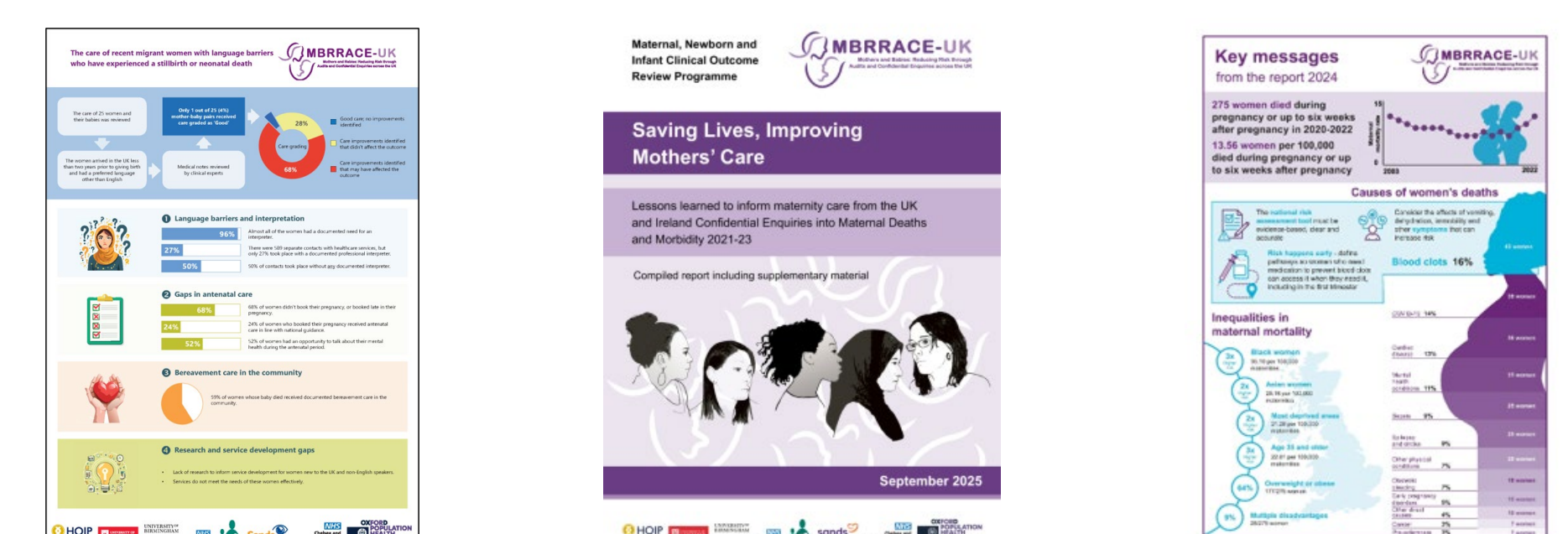
Maternal

Saving Lives, Improving Mother's Care report

Includes surveillance, epidemiology and confidential enquiries into maternal mortality and morbidity-

Data briefs

High level maternal mortality data published online ahead of the Saving Lives, Improving Mothers Care report to improve the timeliness of data availability



Access to all MBRRACE-UK Resources

Supporting quality improvements to provide safe and empathetic care

Governance and mortality review processes

- PMRT resources and best practice documents have been used to **benchmark** our current processes and lay out areas where the process can be improved. ~ Midwife
- There has been increased **robustness** in the mortality review process. ~ Midwife
- PMRT review and learnings helped **improve outcomes**. ~ Neonatal Consultant
- PMRT line of questions highlighted improvements we needed to make. ~ Midwife

Clinical pathway and guideline development

- Pregnant women now **automatically have MEWS** when attending the emergency department. ~ Obstetrician
- The PMRT is used to determine if changes are needed to guidelines/ways of working. **SMART goals** are always used. ~ Midwife
- Improvement has been made to guidelines regarding **post partum haemorrhage management**. ~ Obstetrician
- Women whose first language is not English must now be seen **face to face** when they call triage. ~ Midwife

Training and education

- The **vignettes** and recommendations are really useful for teaching and remembering **why** we do things and what the **pit falls** are. ~ Obstetrician
- **Data dashboards** are useful in training and education. ~ Midwife
- MBRRACE resources have been used for the infographics on our **maternal medicine information boards** on the ante/postnatal wards. ~ Midwife
- Resources have been used for university lessons **training future midwives**. ~ Midwife

Bereavement and family centred care

- We have implemented the role of **Family Liaison Officer** for all PMRT patients to have an independent point of contact throughout the review process to improve their experiences. ~ Midwife
- Our bereavement team is now available **7 days a week** for both staff and families. ~ Midwife
- Improvement in **planning for future pregnancies**. ~ Midwife
- The PMRT provides an opportunity to **hear feedback from families** about their care experience. ~ Midwife

Using data for quality improvement and safety

- Enabled **GAP analysis** of services and **mapping** our position against **best practice** and national figures. ~ Midwife
- The maternal mortality report highlighted VTE was major cause of maternal death, this led to **improved VTE risk assessment** rates. ~ Obstetrician
- Updates to operational policy and protocols with other teams e.g. **improved working between perinatal MH and CAMHS/Addictions services**. ~ Psychiatrist
- Data regarding ethnicity and social deprivation was used to **compare local findings**. This fed into the **equity and equality working group**. ~ Midwife



VTE Assessment in Maternity Patients in Outlier Wards: A QI Audit

AUTHORS & INSTITUTION

 **Dr Mitovieya Faith Roman**
Supervised by Dr Bee Chen
Barnsley District General Hospital

INTRODUCTION

Venous thromboembolism (VTE) is the leading cause of maternal mortality. Pregnancy increases VTE risk fivefold, rising to 30–60 times higher in the postpartum period compared to non-pregnant women [1]. Consequently, maternity patients require specialised risk assessment distinct from general adult tools.

The Thromboembolic Risk Assessment Form (TRAF) is a nationally recognised, evidence-based tool recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) for assessing VTE risk in pregnant and postpartum women [2]. Its use in non-maternity (outlier) wards is essential to ensure appropriate prophylaxis and dosing.

OBJECTIVES

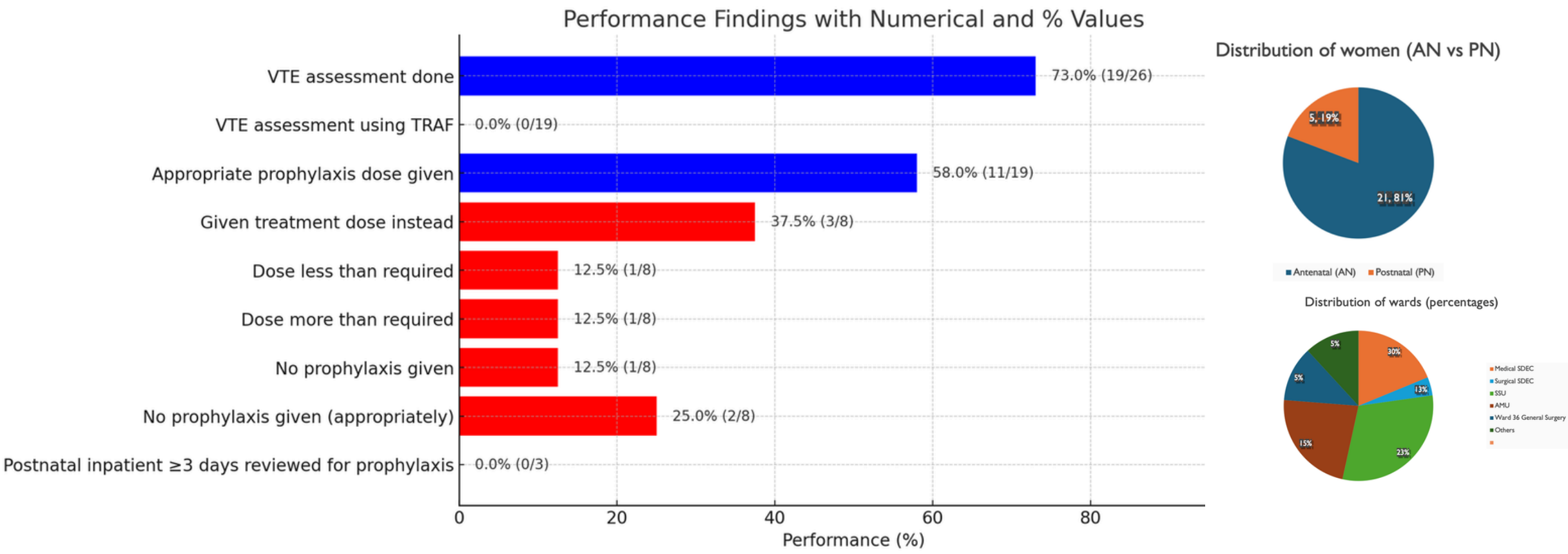
- To assess compliance with maternity-specific VTE risk assessment guidelines in non-maternity wards.
- Assess use of TRAF
- Evaluate appropriateness of prophylaxis dosing
- Identify areas for improvement

METHODOLOGY

- A retrospective audit was conducted on pregnant or postpartum women (≤6 weeks) admitted to non-maternity wards between 1 June and 30 September 2024.
- Exclusions included admissions to maternity/gynaecology wards and short stays (<6 hours or ED observation units).
- From an initial sample of 40 patients, 26 met the inclusion criteria.

RESULT

- Of the women audited, 73% had a VTE assessment done, but 0% had been assessed using the TRAF scoring system.
- All women who were admitted for longer than 14 hours had a VTE risk assessment recorded.
- 0% of postnatal women had a reassessment for VTE risk.
- Most people who received appropriate prophylaxis doses had a prescription using the Electronic Prescribing and Medicines Administration (EPMA) protocol 50–99kg/100–149kg (vs 50–90kg/91–130kg).



CONCLUSION

TRAF was not utilised in any outlier ward. Instead, maternity patients were assessed using general adult VTE tools, resulting in inconsistent and occasionally inappropriate prophylaxis, posing a patient safety risk.

Contributing factors included limited awareness of TRAF and variation in clinical systems for assessment and prescribing across departments.

ACTIONS IMPLEMENTED

- TRAF proforma uploaded to the Trust intranet for wider access
- Prompt for TRAF assessment included in CareFlow clinical notes.
- The RCOG-based prescription protocol was integrated into the generic adult prescribing software.
- A “TRAF How-to-Use” road-map poster was developed for education.
- Staff education was delivered via thrombosis meetings, doctors’ induction, and teaching sessions, with midwife educator input to improve awareness among adult nursing staff.
- Awareness was enhanced through patient safety bulletins.

NEXT STEPS

- Re-audit planned for December 2026 to assess improvement in compliance and patient safety.

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