- all recommendations the Trust has received from HSIB regarding maternity incidents that occurred within the Trust.
- which month and year each recommendation was received, and which month and year the incident each relates to occurred.
- the implementation plans attached to each recommendation showing completed actions (including when they were completed) and any outstanding actions.

Recommendation	Month/Year received	Month/Year of incident	Completed/Out standing
1. The Trust should ensure that a full breastfeeding assessment is undertaken prior to discharge and ensure that the ward handover includes the status and / or outcome of the assessment. 2. The Trust should ensure all maternity midwives and midwifery support workers undertake annual breastfeeding training and receive face to face assessment of breastfeeding skills in line with Baby Friendly Initiative Standards recommendations / assessments. 3. The Trust should ensure there is a maternity discharge policy which includes a clear discharge process covering both in-hours and out-of-hours and incorporates the community midwifery referral process. 4. The Trust should ensure there is a central triage system 24/7 to respond to calls for community concerns. 5. The Trust should ensure there are appropriate staffing levels on the postnatal ward to care for all mothers and babies. 6. The Trust should ensure there is adequate access to computer terminals for all relevant staff enabling full documentation of electronic records.	09/2019	01/2019	1. Complete 2. complete 3. complete 4. complete 5. complete 6. complete

1. The Trust should ensure it has a reliable system in place so that mothers attending the hospital antenatal clinic are seen at the correct time and by an appropriately experienced clinician. 2. The Trust should review the care pathway for all mothers who book following a caesarean section to ensure that risks and benefits are discussed and documented. 3. The Trust should ensure that any mother having had a previous caesarean section has an agreed management plan documented regarding the birth of her baby. The discussion for this plan should be consultant-led. 4. The Trust should ensure that the emergency cascade bleep system is activated in the event of an obstetric emergency. 5. The Trust should ensure that the Trust guideline and electronic categorisation of the CTG during labour are consistent. 6. The Trust should ensure that a fresh eyes review of a CTG during labour includes a documented assessment of the CTG.	03/2020	03/2019	1. Complete 2. Complete 3. Complete 4. Complete 5. Complete 6. Complete
1. The Trust to ensure mothers are encouraged to be in a semi-recumbent position when holding their baby and are informed of the risks of bed-sharing with their baby when they are excessively tired.	10/2020	12/2019	completed

1. The Trust to ensure all members of the clinical team working in maternity understand the risks of confirmation bias and the key principles of maintaining situation awareness to ensure the safe management of complex clinical situations. 2. The Trust to ensure that there is a clear escalation process to the obstetric team when a CTG is difficult to interpret, leading to an obstetric review with a clear management plan, agreed with the mother, being documented. 3. The Trust to ensure that where If multiple tasks occur at once, a member of the team maintains the role of someone having a 'helicopter view' at all times.	04/2021	12/2020	1. Complete 2. Complete 3. Complete
1. The Trust to ensure that intermittent auscultation is carried out in line with national guidance ensuring early consideration is given to monitoring a baby's heart rate using cardiotocograph when intermittent auscultation is not possible. 2. The Trust to ensure that guidance and training supports staff in recognising the need for immediate transfer of mothers from the birthing pool in emergency situations.	05/2021	12/2020	1. Complete 2. Complete
1. The Trust to ensure that mothers with cumulative risk factors have an obstetric led individualised discussion about their risks, including the timing and mode for birth 2. The Trust to ensure mothers with complex medical factors have obstetric led risk assessment and an individualised plan for IOL, in conjunction with the multidisciplinary team 3. Trust to ensure staff are supported with clear guidance to support managing IOL services including triggers to support robust escalation when delays occur for any reason	08/2021	02/2021	1. Complete 2. Complete 3. Complete

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1. The Trust to ensure mothers with complex medical factors have obstetric led risk assessment and an individualised plan for induction of labour, in conjunction with the multidisciplinary team. 2. The Trust to ensure staff are supported with clear guidance to support managing induction of labour services including triggers to support robust escalation when delays occur for any reason. 3. The Trust to support staff to interpret a cardiotocograph in line with current national guidance (National Institute for health and Care Excellence, 2014).	10/2021	05/2021	1. Complete 2. Complete 3. Complete
1. The Trust to ensure the staffing model enables the labour ward coordinator to remain supernumerary at all times. 2. The Trust to ensure that junior staff and newly qualified clinicians have a personalised support plan in place to consolidate their skills and confidence. 3. The Trust to ensure that there is escalation to the obstetric team when there are concerns regarding a CTG. An obstetric review with a clear management	09/2021	05/2021	1.Complete 2. Complete 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete

plan, agreed with the mother should be documented, ensuring that there is oversight of the full clinical picture. 4. The Trust to ensure staff are supported to categorise a CTG, in real time, and in line with current national guidance (National Institute for Health and Care Excellence, 2014, updated 2017). The local policy and training programmes should reflect these changes. 5. The Trust to ensure that staff are supported to make clinical assessments in real time, and that these assessments are documented contemporaneously. 6. The Trust to ensure essential equipment that may be required during a birth is immediately available in the labour rooms. 7. The Trust to ensure all members of the clinical team working in maternity understand the risks of expectation bias and the key principles of maintaining situation awareness to ensure the safe management of complex clinical situations.			
1. The Trust to ensure staff are supported to resolve different clinical opinions when interpreting a CTG.	07/2022	01/2022	1.Outstanding
1. The Trust to implement a system to ensure that placental histology is requested in line with national guidance, and that results are checked in a timely manner.	09/2022	01/2022	1.Outstanding
The Trust to ensure a structured neurological assessment takes place and is documented when hypoxic ischaemic encephalopathy is suspected.	11/2022	05/2022	1.Complete
1. The Trust to ensure mothers with high risk factors for early onset fetal growth restriction receive low dose aspirin and ongoing surveillance in line with national guidance.	11/2022	06/2022	1.Ongoing