IUFD – Labour and induction - Full Clinical Guideline

Reference No.: UHDB/IP07:23/F10

Contents

1. Introduction

Fetal loss is a devastating event with enduring psychosocial consequences for parents, including anxiety and depression, guilt, complicated grief, social isolation, and relationship breakdown.

2. Purpose and outcomes

This guideline is to be followed in the event of the death of the fetus in the late second or third trimester, where induction of labour is required. This may be due to a spontaneous intra-uterine fetal death or following termination of pregnancy for fetal abnormality. Termination may have commenced with feticide using intra-cardiac potassium chloride if taking place beyond 21+6 weeks gestation for fetal abnormality.

3. Abbreviations and definitions

CTG - Cardiotocograph
GAU - Gynae Assessment Unit

IOL - Induction of labour
IUFD - Intrauterine fetal death
IV - Intravenous
PM - Post Mortem
PV - Per Vaginum

Miscarriage - Those infants born **<24 weeks** gestation known to have died in utero or born with no signs of life at all at birth, are regarded in legal terms as non-viable and therefore no registration or certification is required. However, in terms of the sensitive arrangements for the baby's body, parents' wishes should be respected and arrangements made deemed appropriate by them. Examination by Paediatrician/Obstetrician, should be requested if there is any suspicion of fetal abnormality.

Confirmed IUFD < 24 weeks gestation - Those infants that are **confirmed IUFD by ultrasound scan** at less than 24 weeks gestation but are born after 24 weeks do not require to be registered as stillborn. If there is any doubt the infant must be recorded as a stillbirth.

In the case of **feticide** by intra cardiac potassium chloride before 24 weeks gestation, IUFD will have been confirmed at the time of the feticide so would not be required to be registered as a stillbirth.

Stillborn – Those infants **>24 weeks** gestation known to have died in utero or who show no signs of life at birth, will be registered and certified as stillborn by the Obstetric staff, as is required by law, and the baby's body must subsequently be cremated or buried. The Obstetric staff or a suitably qualified midwife will discuss with parents post mortem examination and seek consent. The stillborn baby should be examined by an Obstetrician for any dysmorphic features and, if indicated, skin biopsy or placental tissue may be taken for karyotype with parental consent, unless a post-mortem examination is taking place

Live born – Those babies, **independent of gestation**, who are born showing signs of life, (e.g. any detectable heart rate, gasping etc.), even if born in very poor condition and resuscitation is not attempted, will be registered as a live birth with the agreement of the parents. A medical certificate of death will subsequently be issued by the attending Obstetrician / Paediatrician. It is then the Obstetrician's / Paediatrician's responsibility to discuss with parents post mortem examination, seek their consent and arrange subsequent counselling.

4. Diagnosis

When an intrauterine fetal death (IUFD) is suspected this **must** be confirmed by two-dimensional ultrasound at the earliest opportunity. If the diagnosis is suspected in the community setting then the mother should be referred to hospital for confirmation.

The optimal method will be a scan performed by trained sonographers. However, out of normal working hours a practitioner with appropriate training may use a portable ultrasound machine. The fetal chest should be imaged in the transverse so that a 4 chamber view can be identified.

Ultrasound features of IUFD are:
Absence of movement on direct visualisation of the fetal heart
Secondary features such as collapse of the skull with overlapping bones (Spalding's sign), hydrops, maceration and intrafetal gas.

If imaging is difficult in the presence of maternal obesity, abdominal scars or oligohydramnios colour flow Doppler of the fetal heart is useful to verify the absence of heart activity.

It is advisable to obtain a second opinion from a suitably trained person whenever possible although it is recognised that this may not always be possible in emergency situations.

Following the diagnosis and confirmation of an IUFD the parents must be given time to absorb and accept this news. Women and their partners need to be given accurate information about labour and birth. Any recommendations should take into account the woman's preferences as well as her medical condition and previous intrapartum history.

In the event of an intrauterine fetal death, offer support to help women and their partners and family cope with the emotional and physical consequences of the death. Offer them information about

specialist support.

On presentation, check full blood count (FBC), clotting screen and Kleihauer (irrespective of maternal blood group as this is to assess for fetomaternal haemorrhage). As there may have been fetomaternal haemorrhage, if the mother is Rhesus D negative an appropriate dose of Anti-D should be administered now. A further dose will need to be administered after delivery.

5. Timing of induction

Assessment of maternal wellbeing should be carried out. If there is any evidence of sepsis, pre-eclampsia, placental abruption, ruptured membranes or laboratory evidence of DIC women should be strongly advised to take immediate steps towards delivery.

In the absence of maternal compromise, it is reasonable to delay delivery if the mother wishes. A short delay (less than 48 hours) may also give optimal chance of success with the method of induction of labour. Women should be given the following advice:

- A short delay is unlikely to be associated with any physical harm, but with a more prolonged delay the development of severe medical complications is more likely, and anxiety is likely to be greater.
- If expectant management is prolonged the appearance of the baby may deteriorate, and the value of any post-mortem may be reduced.
- Testing for DIC twice weekly should be undertaken if labour is delayed for more than 48hours.
- All mothers should be given a 24 hour contact number if they are managed as an outpatient for any time between diagnosis and delivery

6. Consent

Valid consent paperwork for medical termination of pregnancy must have been obtained. This is for fetal abnormality and would have been completed by fetal medicine consultant

7. Mode of delivery

Vaginal birth is the recommended mode of delivery for most women, and can be achieved within 24 hours of induction of labour for about 90% of women. The benefits of vaginal delivery include a shorter stay in hospital and quicker physical recovery time.

In the event of an intrauterine fetal death, if the woman appears to be physically well, her membranes are intact and there is no evidence of infection or bleeding, discuss the options for birth (expectant management, induction of labour or caesarean birth) and respect the woman's decision.

In the event of an intrauterine fetal death, if there is evidence of ruptured membranes, infection or bleeding, offer immediate induction of labour or caesarean birth.

If a woman with an intrauterine fetal death chooses an induced labour, follow the recommendations on monitoring of uterine contractions (preferably using manual assessment) and provide one-to-one midwifery care of the woman during labour and birth.

Caesarean section (CS) may occasionally be indicated by maternal condition; if there is no time to allow for induction and vaginal birth, or if vaginal birth itself would carry significant risk to the mother (e.g. multiple previous CS or major degree of placenta praevia.)

If a woman requests a CS because she wishes to avoid giving birth vaginally to a dead baby, it is important that a careful and sensitive discussion, including the implications of CS for future pregnancies, takes place involving the woman and her partner, the obstetric consultant and an experienced midwife.

Discuss methods of induction with a woman who has had intrauterine fetal death and a previous caesarean birth, so that she can make an informed decision about the most appropriate choice. This should cover the following:

- induction of labour can lead to a risk of uterine rupture

- the suitability of mechanical methods of induction, including the risk of infection
- the marketing authorisations for dinoprostone and misoprostol contraindicate their use for inducing labour in women with a uterine scar, because they increase the risk of uterine rupture
- the risks and consequences of caesarean birth, including both short- and long -term morbidity.

8. Medication used for induction of labour

RCOG states that a combination of mifepristone and a prostaglandin preparation should usually be recommended as the first-line intervention for induction of labour.

Mifepristone (progesterone receptor blocker) increases the sensitivity to misoprostol and should be administered 36-48 hours prior to Misoprostol.

Increasing dosage of Misoprostol increases the likelihood of successful delivery but also increases the incidence of side-effects, which include pyrexia, nausea and vomiting and diarrhoea. The incidence of uterine rupture is low (0.2%), but is increased in the presence of a uterine scar (eg following previous Caesarean section) to around 4%.

The sensitivity to Misoprostol increases with gestation and with fetal demise. Hence, in the third trimester, progressively **lower doses** of Misoprostol should be used. Trials utilising mifepristone prior to Misoprostol have demonstrated the shortest Misoprostol-to-delivery times.

Mifepristone: 200mg orally

This drug must only be administered in hospital and patients should be observed when taking this medication. Contraindications include:

- uncontrolled or severe asthma
- chronic adrenal failure
- acute porphyria

Cautions:

- asthma
- risk factors for cardiovascular disease; prosthetic heart valves or endocarditis
- haemorrhagic disorders.

Termination may have commenced with feticide using intra-cardiac potassium chloride if taking place beyond 20 weeks gestation. If feticide with intracardiac potassium chloride is being performed, Mifepristone will be administered following confirmation of fetal asystole.

Prior to going home, staff should ensure that the woman has contact numbers for the unit which will enable her to obtain appropriate advice at any time over the next 48 hours.

A delay is required to optimise the effect of Mifepristone. This is ideally 36 to 48 hours. During this time the woman may be at home, but should be advised to attend if any bleeding or pain. The women needs to be given information on where to attend and how to contact this department.

Misoprostol

Note oral administration (swallowing) of misoprostol has lower efficacy and so oral administration should only be used if the pregnancy is < 7 weeks gestation and if vaginal, sublingual or buccal routes of administration of misoprostol are unacceptable to the woman

The patient should be made aware that administration by sublingual (sl) or buccal route is associated with higher likelihood of headache. Misoprostol tablets administered buccally or sublingually may take approximately 20 minutes to dissolve, may not dissolve fully and are associated with an unpleasant taste in the mouth.

Side effects include fever, nausea, vomiting, abdominal cramping and diarrhoea.

Dosing schedule for Mifepristone and Misoprostol for unscarred uterus

Drugs	Gestation 20 - 26+6 weeks	Gestation 27 weeks or more
Mifepristone	200mg	200mg
After 36-48 hours Misoprostol	200mcg PV/ SL/ buccal every 4 hours for a maximum of 6 doses	50mcg PO every 4 hours for maximum of 6 doses. (Two 25mcg to be given)

The above regimen would be expected to achieve delivery within 24 hours of commencing Misoprostol in 97% of cases.

9. Induction of labour in scarred uterus

The presence of a previous Caesarean section scar significantly increases the risk of uterine rupture, but there is no good trial evidence to identify any one best method of induction in this situation. Women with a uterine scar requiring induction of labour for IUFD should therefore be counselled about the risk of uterine rupture and the appropriate regimen for the gestation to be commenced with caution.

During the labour, close observation for the following signs of possible scar dehiscence should be maintained: Abdominal **pain persisting between contractions** or sudden onset of **breakthrough pain** with regional anaesthesia; vaginal **bleeding**; signs of developing **tachycardia or hypotension** in the woman; sudden **loss of contractions**; **change in fetal lie** or presentation; **disengagement** of the presenting part.

Senior medical review should be sought if scar dehiscence is suspected, a laparotomy and hysterotomy or Caesarean section may be required.

- Prior to induction a discussion about the benefits and risks of induction should be undertaken by a consultant obstetrician.
- Women with a single lower segment scar should be advised that, in general, induction of labour with prostaglandin is safe but not without risk.
- Women with 2 previous scars should be advised that in general the absolute risk of induction of labour with prostaglandin is only a little higher than with a single previous LSCS
- Women with more than 2 LSCS scars or longitudinal scars should be advised that the safety of induction of labour is unknown.
- Mechanical methods of induction might increase the risk of ascending infection in the presence of IUFD.
- VBAC is not ordinarily recommended for women with three previous caesarean sections, previous uterine rupture or upper segment incisions
- Women should be offered a combination of Mifepristone 200mg orally, followed 36-48 hours later by Misoprostol orally *at a reduced dose*.

Dosing Schedule for Mifepristone and Misoprostol for scarred uterus

Drugs	Gestation 20 - 26+6 weeks	Gestation 27 weeks or more
Mifepristone	200mg	200mg
After 36-48 hours Misoprostol	100mcg PO every 4 hours for maximum of 6 doses (Four 25mcg tablets to be given)	25mcg PO every 4 hours for maximum of 6 doses

10. Unsuccessful induction

If the woman remains undelivered after the full course of Misoprostol, a full obstetric review should be undertaken and further management decided by the consultant obstetrician.

Possible options include:

- IV syntocinon, (see Induction of labour guidelines), which must not be commenced for at least 4 hours after the last dose of Misoprostol
- Repeat the dosage regimine of Misoprostol 12hours after the last dose

11. Monitoring in labour

Women with regular painful contraction/ in labour should have regular observations undertaken and a partogram used as advised in the "Guideline for the management of normal labour". Vaginal examination should be offered 4 hourly, or where there is concern about progress or in response to the mother's wishes.

Women undergoing VBAC with an IUFD should be closely monitored for features of scar rupture – as fetal bradycardia is the most common indicator and does not apply here, staff must be vigilant for other signs such as maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse. Any concern about potential scar dehiscence or rupture should prompt an urgent medical review. **If progress in labour is slow and oxytocin augmentation is considered, this must be discussed with and sanctioned by the obstetric consultant.**

12. Multiple pregnancy

Where two or more fetuses require delivery after they have died, a plan for intrapartum care should be formulated by the Consultant Obstetrician overseeing their delivery. In many cases, the use of Mifepristone and Misoprostol as detailed above will be appropriate, but doses appropriate to the gestational size of the uterus should be used. If there is a delay in delivery of second twin, contact the on call registrar.

In the event of an early demise of one fetus, this may result in a fetus papyraceous being seen at the time of the birth of the other twin, see appendix A Fetal Papyraceous

13. Pain relief in labour

- Women should be offered an opportunity to meet with an obstetric anaesthetist.
- Assessment for disseminated intravascular coagulation (DIC) and sepsis should be undertaken before administering regional anaesthesia.
- Blood should be sent for FBC, coagulation screen, and LFTs.
- Although the incidence of coagulopathy is very low if fetal demise has happened within 2 weeks of presentation, risk is more in the presence of abruption, uterine rupture or pre-eclampsia.
- Analgesia – all the usual modalities should be available, including regional analgesia. Various options available are:
    - Entonox
    - Parental opioids, either by IM route or PCA. Diamorphine and Morphine are preferred over Pethidine as they have greater analgesic qualities and longer duration of action. Morphine PCA can be used according to protocol (the on call ODP should be able to help with setting this up). Paracetamol can be used to supplement opioids.
    - Regional Analgesia. If no evidence of coagulopathy or sepsis, epidural catheter can be inserted and connected to PCEA pump. Routine observations must be recorded as per PCEA protocol.
    - In the rare instances where Caesarean Section is indicated (eg. abruption with massive bleed, risk to maternal life necessitating CS), General Anaesthesia would be most likely required. The on-call Consultant Anaesthetist should be informed and made aware of the situation.

14. Antibiotic use

- Routine antibiotic prophylaxis should not be used

- Women with sepsis should be treated with intravenous broad-spectrum antibiotic therapy click here for Obstetric Infections Microbiology guideline
- Intrapartum antibiotic prophylaxis for women colonised with group B Streptococcus is **not** indicated

15. Retained placenta

If expulsion of the fetus is not followed by complete delivery of the placenta, additional action may be required. Refer to the guidelines 'Care for Women in Labour' L2– see retained placenta.

16. Gender determination of miscarried or terminated fetus

Determination of the gender of the miscarried or terminated fetus is not always straightforward and parents should be made aware of the difficulties in determining the gender of the fetus and that mistakes can be made when determining the gender of a very immature infant.

It is not always possible to confirm the gender of the fetus below 24 weeks and if this is the case a 2nd opinion must be sought.

If, however, the parents are insistent on gaining an opinion of the gender of their baby, a senior paediatrician should be involved to discuss this further. The midwife responsible for caring for the woman should inform the labour ward midwife coordinator of the situation.

If a post mortem is to be held, or chromosome analysis to be performed, the parents can be informed that a clearer definition of the infants' gender may be available later.

17. Documentation of initial examination of the baby following intra-uterine fetal death

- Description of the condition of the baby may help estimate the time of intrauterine death, thus helping clarify the events around this time, particularly if a post-mortem (PM) has been declined. This can be carried out by the midwife/obstetrician or paediatrician if present, and documented in the medical records.
- In the event of a stillbirth, describe the baby's condition at birth and document in the medical records. Do not try to estimate the timing of death as other factors may effect the state of deterioration e.g. length of time of ruptured membranes; infection.
- Record the baby's weight.
- Document any unusual features or anomalies. If any are present or suspected ask the paediatric registrar to look at the baby, particularly if a PM has been declined. Consider medical photographs; X-rays; placental examination – with maternal consent.

17.1. Descriptions to be used

Superficial separation of skin

- Can the epidermis be easily separated from the dermis by applying oblique stress?
- Is there loss of dermis/epidermis with exposure of a red, shiny moist dermal surface, particularly noticeable over bony prominences?

Fluid filled bullae

- Are there fluid filled 'lumps' (between dermis & epidermis)?

Complete disruption of skin

- Has the fetal epidermis lost its integrity completely, exposing underlying structures?
- Skin oedema
- Is there subcutaneous oedema, if so state where it is present?
- Longstanding IUFD may occasionally mimic hydrops fetalis

Amniotic Fluid

Please clearly document the colour, amount and any odour of the amniotic fluid.
Please ensure the stillbirth checklist has been completed.

18. Rhesus negative women

Click here for full guidelines Anti-D Administration in Pregnancy

19. Lactation suppression

Following termination of pregnancy or intrauterine death after 14 weeks gestation, many women may commence lactation. This may be a distressing experience following pregnancy loss, so the option of lactation suppression must be discussed.
Some women may experience lactation at even earlier gestations following pregnancy loss, so consideration must be given to offering suppression any time after 14 weeks gestation. Some women will not wish suppression of lactation and should be offered support to relieve the potential discomfort of engorgement if it should occur.

If pharmacological lactation suppression is given, **a single oral dose of Cabergoline 1mg post-delivery is the optimal treatment**, with fewer side effects and less rebound lactation.

20. Caring for parents post delivery

- Support is available from the Bereavement Specialist Midwife.
- Please refer to the Fetal Loss checklists within the Fetal Loss folder for specific details on care post delivery.
- Consideration must be given to the parents' wishes as to how long they wish the baby to be with them. In all cases the baby must be kept as cool as possible. This is especially important if post mortem is being considered.
- Place of transfer should be according to mother's preference. The woman may wish to go home, stay on Labour ward, be cared for on the postnatal ward or transfer to the gynaecology ward.

21. Request for post mortem

Obtaining consent should be the responsibility of a member of the team suitably trained in obtaining consent. Parental understanding of the post mortem process should be that their consent, if given, is informed. Good practice recommends that consent for examination is obtained for all fetuses, both pre and post 24 week's gestation.

Post mortems on fetuses and babies may:-

- provide confirmation of clinical diagnoses
- provide a cause or causes of death
- identify structural abnormalities, some of which may be minor but important for genetic counselling
- provide an estimate of time of death (in intra-uterine deaths)
- identify the presence of chronic intra-uterine disease
- give information on complications of treatment and are a form of medical audit

It is important to remember that, even after the most careful and detailed examination, a specific cause of death is not always found. This is especially true of fetuses and stillbirths. Nevertheless this information is still of value in counselling parents.

Before discussion with parents, the professional should ensure they know:-

- why the post mortem is necessary
- where and by whom the examination will be performed
- the possible outcomes and when results might be available

N.B The post mortem request form must be completed FULLY.

It is recommended that the placenta is sent for histology. The appropriate consent form must be completed.

If the baby is undergoing a post-mortem the consent form covers both baby & placenta. Only the Notice of Death form to go with the baby to the mortuary. All other appropriate bereavement documentation to be hand delivered the Bereavement Services, RDH.

At QHB: PM consent forms and clinical information would accompany the baby to the mortuary as per the PM SOP.

If a family consent to a PM or a PM is required by the coroners, it is highly recommended that the baby is transferred to the mortuary within 72 hours of being born, to ensure a high quality, accurate PM examination and prevent deterioration of the baby.

22. Certification

Legally, a medical certificate of stillbirth should be issued in all cases of stillbirth from 24+0 weeks gestation by a doctor or midwife who has either delivered the baby or thoroughly examined the baby afterwards. If there is any uncertainty of cause of death, clarity should be sought from a senior clinician. The direct cause, antecedent causes and other significant conditions that are recorded on the stillbirth certificate should be recorded in the mother's notes

23. Documentation

- Documentation and checklists are all now on NET-i
- Commence appropriate checklists available in the black guideline folder in the resource room on labour ward / postnatal ward.
- All procedures must be documented in the medical records and dated & signed
- In the event of losses under 24 weeks gestation the details are to be entered in the top of the LW delivery record book; in the case of losses 24 weeks and over or any neonatal death (any gestation) the details need to be entered in the body of the LW delivery record book. In addition the details need to be entered on the maternity clinical system and included in the maternity hand held records. Please put a 'tear drop' sticker on the alert card with the consent of the parents.

24. Risk management

A clinical incident form should be completed for all cases of intrauterine fetal death. All cases will be discussed at the monthly Stillbirth Review Group, and presented at the Perinatal Mortality Meeting. If risk issues are identified further investigation using NPSA investigation and root cause analysis may be undertaken.

25. Monitoring compliance and effectiveness

Monitoring requirement	To ensure compliance with guideline
Monitoring method	Retrospective case note review
Report prepared by	Named individual undertaking audit
Monitoring report sent to:	Labour Ward Forum
Frequency of report	3 yearly

26. References

RCOG Green-top Guideline No.55 Late Intrauterine Fetal Death and Stillbirth October 2010

BJOG 2002; 109:443-447. Enkin M et al in A Guide to Effective Care in Pregnancy and Childbirth. 2nd Edition, Oxford University Press, 1995. p373.

Keeling JW. Fetal and Neonatal Pathology. 2nd Ed Chapter 7 pp 183-185
Cunningham F G et al (1997) Williams Obstetrics 20th Edition p 180

Fetus Papyraceous

In the event of a multiple pregnancy where one or more babies have died earlier in the pregnancy there may be a fetus papyraceous or recognisable remains of the deceased baby. Parents need to be prepared for this and may wish to be involved in the sensitive management of this situation. This will need to be documented in the woman's obstetric notes.

The fetus papyraceous may be attached to the placenta or membranes.

- If it is possible to easily separate the fetus papyraceous from the placenta it can be managed separately. If fetus papyraceous is within the membranes it can be removed with that portion of membrane and findings documented in the obstetric notes.
- If it is not possible to separate, then the placenta should be sent to histopathology for the pathologist to confirm fetal tissue and arrange sensitive cremation.

Ensure this is documented on the histopathology clinical details form and placental histology consent form. Inform the parents.

A description of the fetus papyraceous needs to be documented in the woman's obstetric notes. If not being sent to histopathology the tissue will need 2 identification labels and be placed in an angel pocket, sensitively wrapped in a blanket before being put into a body bag for transport to the mortuary after the parents have left the ward.

If the fetus papyraceous is managed on the labour ward, ensure funeral choices have been discussed with the parents. Offer the option to the parents to speak to the hospital chaplain and/or the bereavement midwife. Complete the funeral arrangement form.

If the fetal loss is under 24 week gestation the appropriate paperwork needs to be completed and taken to bereavement services along with the green copy of the funeral arrangement form.

Parents should be offered the option of a memento certificate to recognise their baby.

If the parents do not want to be involved at all then the appropriate documentation needs to be completed and the fetus papyraceous will have a hospital arranged cremation.

Site Specific Operational Guidance

RDH

1. In-Patient Care
   Up to 20 weeks gestation, the most appropriate place for administration of Misoprostol to take place would be on the gynaecology ward. Beyond 20 weeks, administration of Misoprostol should take place on labour ward wherever possible.

2. Caring for Parents Post Delivery
   Place of transfer should be according to mother's preference. The woman may wish to go home, stay on Labour ward, be cared for on the postnatal ward 314 or transfer to the gynaecology ward 209 .

QHB

1. Gynaecology ward for under 16 weeks and snowdrop suite or room 7 LW beyond 16 weeks

Documentation Control

Reference Number: UHDB/IP/07:23/F10	**Version:** **UHDB 1**		**Status: FINAL**	
	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	4	May 2015	Maternity Guidelines Group - Sue Rucklidge, Bereavement Specialist MW	Updated in line with revised IOL guidelines (I1) & Early Pregnancy Loss Guidelines (M1)
	Burton Trust prior to merged document:			
WC/OG/95	2	April 2018	Dr Wendy Oakley – Obstetric Consultant	Routine review – no changes
WC/OG/96	3	April 2018	Dr Wendy Oakley – Obstetric Consultant	Routine review – no changes
Version control for UHDB merged document:				
UHDB	1	March 2021	Miss S Chaudhry - O&G Consultant (RDH) Dr Thangavelu – O&G Consultant (QHB)	Review / merge
	2	Jan 2023	Miss S Chaudhry - O&G Consultant (RDH) Abigail Glenn - Specialist Midwife for Bereavement	Changes with Misoprostol
	2.1	Nov 2023	Joanna Harrison-Engwell - Lead Senior Midwife for Guidelines, Audit & Quality Improvement	Additions made to ensure full compliance with Baseline assessment Tool
Intended Recipients:				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;				
To be read in conjunction with:				
Keywords:				
Consultation with:	Midwifery & Medical Staff			
Business Unit sign off:	02/05/2023: Maternity Guidelines Group: Miss S Rajendran – Chair 24/112023: V2.1 19/06/2023: Maternity Governance Group – Mr R Deveraj 04 /12/2023: V2.1			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/06/2023 V2.1: 19/12/2023				
Implementation date:	V2.1 28/12/2023			
Review Date:	July 2026			
Key Contact:	Joanna Harrison-Engwell			