

Report Title	Maternity and Neonatal 10 Point Plan Assurance
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Accountable Director	Executive Medical Director
Lead Board Committee	Quality Committee
Previous groups	N/A
Recommended action	Information
Purpose of the paper	The purpose of this paper is to brief the Board on the Trust's role in maternity and neonatal care, the findings of the independent investigation into maternity and neonatal services, and the Board's oversight of the actions being taken to strengthen the safety and quality of maternity and neonatal care.
Executive Summary	
The Independent National Maternity and Neonatal Investigation (AMOS) highlights persistent challenges in the safety and quality of maternity and neonatal care in England, including variation in care, workforce pressures, fragmented pathways, inequalities, and weaknesses in leadership, governance, listening and learning. The report reinforces the need for a strong safety culture, clear accountability and effective multidisciplinary and cross-system working. Ambulance services are a critical part of the maternity and neonatal pathway and may provide the first professional clinical assessment during a time-critical emergency. Although maternity and neonatal incidents account for less than 1% of overall ambulance workload, they can be high-acuity and require clinicians to rapidly assess and manage both mother and newborn, often in challenging environments. The ambulance service's role extends beyond transportation to include early recognition and escalation, clinical assessment, stabilisation, emergency treatment, appropriate destination decisions, pre-alert and communication with receiving services, safe transfer of care, and contribution to learning and improvement. The Independent National Maternity Investigation (AMOS) findings reinforce the need for robust ambulance clinical pathways, workforce competencies, equipment, governance and partnership arrangements to ensure safe, timely and equitable care. Board assurance should include the Trust's contribution to whole-system maternity and neonatal safety and evidence that learning from incidents and family experience drives improvement.	
Recommendation(s)	The Board is asked to note and support the role of Yorkshire Ambulance Service in strengthening maternity and neonatal safety, recognising the implications of national maternity reviews and investigations for pre-hospital care.

Link to Board Assurance Framework Risks (board and board assurance committees only)	3. Deliver quality for patients.
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Maternity and Neonatal 10 Point Plan Assurance

Maternity and Neonatal Safety: YAS Role and Response to National Review

1. INTRODUCTION & BACKGROUND

- 1.1 Maternity and neonatal services are under increasing scrutiny through independent reviews, national investigations and patient safety reports. The [Ockenden Review into maternity services at Nottingham University Hospitals NHS Trust](#) and the [Independent National Maternity and Neonatal Investigation](#) have highlighted persistent challenges in the safety, accessibility and delivery of maternity care. These reports demonstrate that maternity services are operating within a markedly different environment, with increasing complexity in both demand and the delivery of care. Maternal mortality remains a significant concern, highlighting the continued need to strengthen early recognition of deterioration, escalation and access to appropriate care.
- 1.2 The ambulance service can be the first point of contact for some women during pregnancy. Pressures on maternity services, including periods when homebirth services have been suspended, alongside findings from national maternity reviews regarding the safety and accessibility of maternity care, have influenced how some women access and engage with maternity providers. In turn, this has the potential to shift elements of maternity demand and clinical risk into the pre-hospital setting, placing ambulance services increasingly at the interface between women and maternity services.
- 1.3 This is particularly important for women for whom access to, engagement with or confidence in maternity services is limited. Nationally, ambulance services receive a disproportionate number of maternity-related calls from women from global majority communities and women living in areas of high socioeconomic deprivation, including those within IMD deciles 1 and 2. These patterns are particularly significant given the persistent inequalities in maternal outcomes.
- 1.4 The [MBRRACE-UK Saving Lives, Improving Mothers' Care 2025 report](#) highlights continuing inequalities in maternal mortality. The 2025 report identified that, in 2021–23, Black women in England had more than twice the risk of maternal death compared with White women, whilst Asian women also experienced an increased risk. Women living in the most deprived areas had almost twice the maternal mortality rate of women living in the least deprived areas.
- 1.5 The latest MBRRACE-UK data, published in September 2026, continues to demonstrate the importance of addressing maternal mortality and inequalities. The 2022–24 data show that the overall maternal death rate in the UK remains substantially higher than in 2009–11, with persistent inequalities in outcomes.
- 1.6 The ambulance service role within this pathway is further demonstrated by a secondary thematic analysis of maternal deaths investigated by the Maternity and Newborn Safety Investigations (MNSI), which found that ambulance services, nationally were involved at a crucial point in the woman's care pathway in 66% of cases. This highlights the significant role ambulance services can play in recognising deterioration, initiating timely clinical intervention and facilitating access to specialist maternity care. It also demonstrates the importance of ensuring that ambulance clinicians have the knowledge, skills and clinical pathways required to identify and respond appropriately to maternity-related deterioration.
- 1.7 The NHS England Maternal Care Bundle, and specifically Element 2: Pre-hospital and acute care, further reinforces the role of ambulance services within the maternity safety

pathway. Element 2 includes implementation of a common approach to recognising and managing maternal deterioration across care settings, standardised pre-alert communication between ambulance services and labour wards, and clear pathways for access to urgent obstetric and maternal medicine care. The national pre-hospital maternity decision tool incorporates the physiological parameters of the Maternal Early Warning Score (MEWS) to support ambulance clinicians in identifying women requiring timely acute assessment.

The Maternal Care Bundle is available here:

[NHS England – The Maternal Care Bundle](#)

- 1.8 The ambulance service is therefore an integral component of the wider maternity safety system. As the first healthcare professional contact for some women, ambulance clinicians are well positioned to recognise deterioration, initiate early intervention and facilitate access to specialist care. Strengthening the interface between ambulance and maternity services is therefore important to ensuring that women receive timely, equitable and safe care across the whole maternity pathway.
- 1.9 Whilst the independent reviews and national investigations are primarily focused on maternity provider organisations, their findings have important implications for ambulance services and the wider maternity and neonatal system. YAS therefore needs to be aware of the recommendations and consider how they may affect the ambulance service, particularly in relation to pre-hospital clinical pathways, workforce competencies, triage, escalation and communication, conveyance and destination decision-making, and partnership working with maternity and neonatal providers.
- 1.10 However, there is no requirement for ambulance services to complete or report against the 10-point plan in the same way as maternity provider organisations, or to submit an audit of triage against the plan by 25 September 2026. The expectation is that YAS considers the implications of the 10-point plan for its service, including how it would be affected by implementation of the actions by maternity providers, and that this is appropriately considered and recorded through YAS governance and assurance processes. YAS will also be engaged in regional discussions arising from feedback received from maternity providers and invited to participate in relevant assurance visits and quarterly quality and safety meetings. This provides an opportunity for YAS to contribute to the wider system response and ensure that national learning is reflected in pre-hospital care.

2. TRIAGE

- 2.1 Effective triage is a critical component of maternity and neonatal safety and begins at the point a woman or family first seeks help. For ambulance services, this extends from the initial telephone assessment and clinical triage of a 999/111 call, through ambulance dispatch, to further clinical review and assessment once an ambulance response is initiated. Robust ambulance triage systems are essential to ensure that women with potentially serious or time-critical maternity or neonatal presentations are identified early, receive an appropriate level of response and are escalated when their clinical presentation or circumstances indicate increased risk.
- 2.2 YAS uses NHS Pathways as the clinical assessment and triage system for calls received through the Emergency Operations Centre (EOC). This provides a structured approach to identifying the presenting problem and determining the appropriate

response from the point of contact. However, maternity presentations can be complex, and additional information or changes in the woman's condition may become apparent following the initial assessment. It is therefore important that ambulance triage is supported by mechanisms that enable calls to be clinically reviewed and re-assessed where concerns are identified.

- 2.3 YAS Clinical Navigators in the EOC provide an additional level of clinical oversight and are able to contact women to undertake further assessment, re-triage the presentation and escalate the response where necessary. This is particularly important for maternity presentations, where seemingly non-specific symptoms may represent early signs of significant maternal deterioration or an obstetric emergency.
- 2.4 In addition, Specialist Paramedics working on the Critical Care Desk within YAS undertake clinical review of calls and can identify presentations that may represent a maternity or neonatal emergency. This provides an additional opportunity for clinically concerning calls to be identified and appropriate escalation considered at an early stage.
- 2.5 Once an ambulance is dispatched, the national pre-hospital maternity decision tool provides an important clinical assessment, triage and escalation tool for ambulance clinicians. The tool is available within the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and incorporates the physiological parameters of the national Maternal Early Warning Score (MEWS). These parameters are specifically designed to take account of the physiological changes associated with pregnancy and the postnatal period and provide an appropriate framework for identifying maternal deterioration.
- 2.6 The use of the pre-hospital maternity decision tool is an important component of Element 2: Pre-hospital and acute care of the [NHS England Maternal Care Bundle](#). Element 2 supports a common approach to the recognition and management of maternal deterioration across care settings and expects ambulance clinicians to use the national pre-hospital maternity decision tool when assessing pregnant, suspected pregnant and recently pregnant women. Consistent use of the tool therefore supports clinical decision-making and provides a clear link between assessment, recognition of deterioration, escalation and destination.
- 2.7 YAS is about to undertake an audit of the use of the national pre-hospital maternity decision tool to understand current levels of utilisation and identify opportunities for improvement. For sustained improvement and greater reliability, the decision tool also needs to be incorporated into the YAS electronic patient record (EPR). There has been a delay in progressing this work, and this remains an important patient safety and improvement opportunity.
- 2.8 Experience from neighbouring ambulance services has demonstrated the value of embedding the decision tool within electronic clinical records, supporting clinicians to assess women against the specific physiological parameters appropriate to pregnancy and the postnatal period. Incorporating the tool into the YAS EPR would provide a prompt at the point of assessment, support more consistent application and documentation, and enable improved monitoring and assurance of its use.
- 2.9 Without consistent use of the national decision tool, there is a risk that women may be assessed using generic adult physiological parameters rather than those specifically designed to reflect the physiological changes associated with pregnancy and the postnatal period. This creates a potential patient safety risk, as early signs of maternal deterioration may not be recognised or escalated as promptly as they should be.

Embedding the tool within the EPR would therefore provide an important safety prompt and help reduce variation in clinical assessment.

- 2.10 Taken together, NHS Pathways at the point of call, Clinical Navigator review and re-triage, Specialist Paramedic clinical oversight and the national pre-hospital maternity decision tool provide multiple opportunities to identify and respond to risk throughout the ambulance pathway. Further integration of the national decision tool into the YAS EPR will support a more reliable and measurable approach to maternity triage and escalation.
- 2.11 This approach supports the wider national direction of travel set out through the Amos Investigation, the NHS England National Maternity Triage Specification and Element 2 of the Maternal Care Bundle, recognising that safe maternity care depends on effective identification of risk and timely escalation across the whole pathway, including the ambulance service. YAS is therefore an important system partner in the early identification, triage, escalation and safe onward referral of women and babies requiring urgent or specialist care.

3. CLINICAL RESPONSE

- 3.1 Maternity and newborn care accounts for less than 1% of overall ambulance activity; however, these incidents are relatively infrequent, often high acuity and time critical. Ambulance clinicians may be required to assess and manage two patients simultaneously in challenging pre-hospital environments.
- 3.2 The low frequency of these incidents presents a particular challenge for YAS in maintaining clinical exposure, experience and confidence across the wider workforce. In response, the Trust is developing a more targeted approach to the deployment and development of its specialist Critical Care Teams (CCTs), recognising the importance of maintaining capability in this low-frequency, high-risk area of practice.
- 3.3 A key component is the increased deployment of CCTs to maternity and neonatal incidents. This will provide additional clinical support to frontline crews while increasing specialist clinicians' exposure to maternity and neonatal presentations. The approach is intended to strengthen recognition of normal physiological processes and early identification of deterioration, enabling timely intervention and escalation.
- 3.4 CCTs are being supported through targeted obstetric and neonatal emergency training, including enhanced assessment and management of key emergencies, use of additional medications and interventions, and recognition of the need for urgent specialist maternity or neonatal care. This will enhance the Trust's ability to stabilise patients prior to transfer to the appropriate obstetric or neonatal unit.
- 3.5 From October, changes to the Trust's clinical response model will provide CCTs with greater flexibility to operate across geographical boundaries. This, alongside a revised dispatch model, will support the deployment of the right clinical resource to the right patient at the right time. The automatic dispatch of CCTs to all Category 1 maternity and neonatal incidents will provide early access to enhanced clinical expertise for the highest-acuity presentations.
- 3.6 Collectively, these measures provide a more targeted approach to maintaining specialist capability in maternity and neonatal emergencies, supporting earlier recognition of deterioration, enhanced clinical intervention and appropriate escalation.

4. **ESCALATION.**

- 4.1 Effective escalation between ambulance services and maternity and neonatal providers is fundamental to ensuring that women and babies receive timely, appropriate and safe care. Ambulance clinicians are often required to make clinical and destination decisions in the pre-hospital environment, where access to specialist maternity and neonatal advice may be critical. This is particularly important when presentations are complex or deteriorating, and where transfers are being undertaken as time-critical emergencies.
- 4.2 Ambulance clinicians working on the road can access clinical advice and support through Remote Patient Care and the Critical Care Desk within the Emergency Operations Centre (EOC). These mechanisms provide an additional layer of clinical support, enabling clinicians to seek advice regarding assessment, management, escalation and destination where required. Effective escalation also depends on direct and timely access to specialist maternity and neonatal services.
- 4.3 YAS has worked with maternity providers to implement a pre-alert telephone process across maternity units in Yorkshire, providing ambulance clinicians with a direct access point to maternity services. This enables early communication of the woman's clinical presentation and facilitates preparation by the receiving maternity team, supporting more effective handover and access to appropriate care. This work aligns directly with Element 2: Pre-hospital and acute care of the NHS England Maternal Care Bundle, which promotes standardised pre-alert communication between ambulance services and maternity units.
- 4.4 This approach also reflects learning from national maternity investigations and reviews. The Ockenden Review identified repeated failures in the recognition and escalation of clinical concerns, including failures to escalate deteriorating women to the appropriate level and weaknesses in multidisciplinary communication and collaboration. More recently, the Independent National Maternity and Neonatal Investigation led by Baroness Amos has highlighted continuing system-wide challenges relating to increasing demand and complexity, delays in care, information-sharing, inequalities and variation in leadership and governance. Clear ambulance-to-maternity escalation routes therefore provide an important practical response to this wider learning.
- 4.5 Work is ongoing with maternity units to improve signage and wayfinding at hospital sites, recognising that clear and consistent routes of access are essential when ambulance clinicians are conveying women requiring urgent maternity assessment. This is particularly important when women or babies are being conveyed as time-critical emergencies, where avoidable delays in reaching the appropriate clinical environment may have significant consequences.
- 4.6 Further work is also being undertaken with maternity providers to establish a more standardised approach to which presentations are accepted directly into maternity services, with a particular focus on the early postnatal period. Greater consistency across providers and geographical areas will support ambulance clinicians in making appropriate destination decisions, reduce variation in pathways and improve the likelihood that women and babies reach the right place for care first time.
- 4.7 Continued development of the interface between YAS, maternity and neonatal services will support more consistent escalation and destination decision-making and ensure that specialist advice can be accessed at the earliest appropriate point.

5. JOINT INVESTIGATION AND SHARED LEARNING

- 5.1 YAS is continuing to develop opportunities to strengthen learning from maternity and neonatal incidents, both internally and in partnership with maternity services. This aligns with the recommendations of the Independent National Maternity and Neonatal Investigation, which emphasises the importance of joint investigation and shared learning across organisational boundaries. As maternity and neonatal care is delivered across multiple services, understanding the contribution of each part of the pathway is essential when reviewing incidents and outcomes.
- 5.2 YAS is working with maternity providers to strengthen participation in mortality reviews and the Perinatal Mortality Review Tool (PMRT) where appropriate. This provides an opportunity to consider the contribution of pre-hospital care alongside the wider maternity and neonatal pathway and identify areas where improvements may be required.
- 5.3 YAS participates in Maternity and Newborn Safety Investigations (MNSI) where the ambulance service has been involved in the care pathway. This provides an opportunity to understand the circumstances surrounding significant incidents and identify learning that may have implications for ambulance practice or the wider system. YAS is developing processes to ensure that relevant safety prompts, recommendations and learning from MNSI investigations are appropriately considered and translated into clinical practice, education, pathways and system working.
- 5.4 This learning is also considered through the YAS Patient Safety Incident Response Framework (PSIRF). PSIRF provides the organisational framework for responding to patient safety incidents and identifying proportionate actions to improve care. Bringing together learning from PSIRF, MNSI investigations, maternity mortality reviews, PMRT and joint incident reviews will support YAS to identify recurring issues and determine whether changes are required to clinical practice, education, pathways, documentation or system interfaces.
- 5.5 The aim is to ensure that learning results in measurable and sustained improvement, with recommendations and safety prompts translated into practice and monitored through appropriate governance arrangements.

6 TRAINING AND EDUCATION

- 6.1 Training and education are important components of maternity and neonatal safety, ensuring that ambulance clinicians have the knowledge, skills and confidence to recognise and manage emergencies. National maternity reviews have highlighted the importance of multiprofessional training, particularly where care involves multiple organisations and clinical teams.
- 6.2 YAS is developing multiprofessional training with local maternity providers, with an ambition to increase opportunities for clinicians from ambulance and maternity services to train together. The forthcoming national homebirth review is awaited to provide clarity on the future direction of travel and the expectations for ambulance and maternity services in relation to homebirth and associated emergency care. Current multiprofessional training is supported in part through non-recurrent funding, which limits the ability to establish a sustainable long-term model. The outcome of the national review will therefore be important in informing future workforce, training and funding requirements.

- 6.3 There is also an opportunity to increase the use of in-situ simulation with maternity partners. Training together in the environments in which clinicians provide care allows teams to test both clinical skills and practical interfaces between services, including triage, escalation, communication, pre-alert, access and transfer processes. This can identify barriers that may not be apparent through classroom-based training. There is strong appetite from YAS and maternity partners to develop this further; however, the training burden and release of staff from operational duties will need to be considered within the wider YAS training plan.
- 6.4 To further strengthen this provision, YAS has developed a paper for NHS England seeking additional funding to appoint Practice Development Midwives on secondment across each of the three ICB areas. The proposed roles would support and enhance in-house training for ambulance clinicians in obstetric emergencies and neonatal care, providing specialist maternity expertise closer to operational teams. The Practice Development Midwives would also work alongside YAS Academy staff to increase their maternity and neonatal knowledge and capability, supporting the development of sustainable in-house education.
- 6.5 Taken together, multiprofessional education, in-situ simulation, established RCUK training and specialist Practice Development Midwife support provide an opportunity to strengthen maternity and neonatal education across YAS. Further development will need to take account of the national homebirth review, available funding and the capacity required to release operational staff for training.

7. FINANCIAL IMPLICATIONS

- 7.1 The work described in this paper has immediate and longer-term financial implications for YAS. Proposed improvements, including integration of the national pre-hospital maternity decision tool into the EPR, multiprofessional training, in-situ simulation and strengthening system interfaces, will require investment in digital development, workforce capacity and staff release for education.
- 7.2 Current multiprofessional training is supported in part through non-recurrent funding, limiting the ability to establish a sustainable long-term model. The proposed Practice Development Midwife secondments across the three ICB areas provide an opportunity to strengthen YAS capability through targeted additional investment and support the development of sustainable in-house education.
- 7.3 There is also potential for improved triage, earlier recognition of deterioration, appropriate escalation and destination decision-making to reduce avoidable harm and the associated financial consequences of serious incidents.

8. EQUALITY IMPLICATIONS

- 8.1 There are significant equality considerations within maternity and neonatal care. National evidence demonstrates that the risk of maternal death is higher for Black and Asian women and for women living in areas of greater deprivation. The latest MBRRACE-UK data continues to demonstrate persistent inequalities in maternal mortality.

- 8.2 YAS data also indicates disproportionate maternity-related ambulance activity among Global Majority women and women living in the most deprived areas.
- 8.3 Ambulance services may become an important point of access for women who experience barriers to accessing maternity services or who are unable to access maternity triage directly. Strengthening triage, escalation, referral and access pathways therefore provides an opportunity to reduce variation in access and care and support more equitable outcomes for women and babies. The latest MBRRACE-UK report is available here:

[MBRRACE-UK – Saving Lives, Improving Mothers’ Care 2026](#)

- 8.4 The 2025 report, which provides the maternal mortality data referenced in earlier sections of this paper, is available here: [MBRRACE-UK – Saving Lives, Improving Mothers’ Care 2025](#)

9. QUALITY IMPLICATIONS

- 9.1 The quality and patient safety implications are significant. National maternity reviews and investigations continue to identify themes relating to delayed recognition and escalation of deterioration, communication, access to appropriate care, variation in practice, workforce capability and organisational interfaces.
- 9.2 For YAS, these themes are directly relevant to pre-hospital assessment, triage, clinical decision-making, escalation, conveyance and destination.
- 9.3 Consistent use and electronic integration of the national pre-hospital maternity decision tool, strengthened communication and pre-alert arrangements, clearer access and referral pathways, joint investigation and shared learning, and enhanced multiprofessional education all provide opportunities to improve reliability and reduce variation.
- 9.4 Collectively, these measures will support YAS to respond to national learning and strengthen the quality and safety of care provided to women and babies.

10. RECOMMENDATION

- 10.1 The Board is asked to note and support the role of Yorkshire Ambulance Service in strengthening maternity and neonatal safety, recognising the implications of national maternity reviews and investigations for pre-hospital care.
- 10.2 The Board is asked to support the continued development of the YAS maternity and neonatal safety programme, including:
- strengthening ambulance triage, clinical assessment, escalation and destination decision-making, including consistent use and electronic integration of the national pre-hospital maternity decision tool;
 - continuing to develop clinical response capability, multiprofessional education and in-situ simulation with maternity and neonatal providers;
 - strengthening ambulance-to-maternity communication, pre-alert, access and referral pathways across Yorkshire;

- developing joint investigation and shared learning with maternity and neonatal providers, including through MNSI, PMRT and YAS PSIRF arrangements; and
- working with NHS England, ICBs and maternity providers to understand and respond to the implications of national maternity safety requirements for ambulance services.

10.3 Progress against these areas should be monitored through existing YAS governance and assurance arrangements, with significant risks, barriers and opportunities escalated to the Board as appropriate.