

Description

Fresh Eyes on CTG Reviews: Time to Reflect and Rethink?

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Summary

Hourly “fresh eyes” cardiotocography (CTG) reviews were introduced to improve intrapartum fetal surveillance, but there is little evidence that they reduce adverse outcomes. While the practice remains part of *Saving Babies’ Lives Care Bundle Version 3*, it is no longer a reportable audit outcome for NHS Trusts, reflecting uncertainty about its value. This blog explores the limited evidence base, professional perceptions of “fresh eyes” as potentially burdensome or “policing” and asks whether the practice should continue. Readers are invited to contribute their views via a short survey to help shape discussion about meaningful, evidence-based maternity safety practices.

“Fresh eyes” CTG reviews were introduced with the best of intentions, but are they really improving safety, or are they another layer of practice without clear evidence? As midwives and obstetricians, it’s time to pause, reflect, and ask: do they truly work?”

My Experience Introducing “Fresh Eyes”

In September 2016, I began a secondment as a Sign up to Safety Lead for Maternity. One of my key projects was the introduction of “fresh eyes” cardiotocography (CTG) reviews. The aim was clear: to reduce neonatal adverse outcomes, particularly unnecessary admissions to the neonatal unit.

On paper, the idea seemed straightforward. An hourly, independent review of the CTG by another midwife or doctor would, it was hoped, improve detection of abnormalities and reduce missed opportunities for escalation. By the end of the project, compliance with the “fresh eyes” process had been achieved across the service (90% target for all women who received CTG monitoring during labour). And yet, the data told a different story. There was no meaningful reduction in neonatal unit admissions.

The Rationale: What the Literature Says

Some of the rationale for introducing “fresh eyes” reviews comes from earlier work suggesting benefits to shared interpretation. Fitzpatrick and Holt described how two people working together as a “buddy” system could enhance the accuracy of CTG interpretation, supporting each other and creating opportunities for learning.[1] Similarly, Donnelly and Hamilton highlighted how fatigue, familiarity and limited knowledge can all contribute to misinterpretation, issues that a second reviewer might help mitigate.[2] While these points are valuable, what remains uncertain is whether hourly “fresh eyes” checks, as mandated in policy, genuinely improve outcomes for mothers and babies.

Experiences from Practice

What struck me during the project was how midwives described the practice. Some felt it was “policing” rather than supporting their judgement. Others worried it added to workload without clear benefit. And when I searched for evidence, I found little to underpin the practice as an effective intervention.

Policy Context: Saving Babies’ Lives Care Bundle V3

More recently, Saving Babies’ Lives Care Bundle Version 3 continues to include hourly “fresh eyes” reviews as part of intrapartum surveillance.[3] However, it is telling that while the practice remains in the bundle, it is no longer a reportable audit outcome for NHS Trusts, suggesting a recognition of its limited evidence base and impact.

This change was confirmed at the launch of the Maternity Incentive Scheme (MIS) Year 7,[4] facilitated by NHS Resolution on 28th April 2025. Importantly, “fresh eyes” CTG reviews were not included as an audit/process indicator for Saving Babies’ Lives compliance. Instead, the revised process indicators now focus on:

- staff training in CTG interpretation, intermittent auscultation, human factors, and situational awareness;
- mandatory annual competency assessment;
- appointment of fetal monitoring leads.

Outcome indicators have also been sharpened to capture intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are contributory factors (see MIS Year 7 guidance). This shift reflects a move away from compliance with a checklist towards measuring what truly impacts safety outcomes.

Time to Reconsider?

This raises an important question: should “fresh eyes” remain part of our national care bundle? Or is it time to reconsider and focus on what we *do* know makes a difference, such as ongoing multidisciplinary training in CTG interpretation, situational awareness, and timely escalation?

Join the Conversation

I’d love to hear from NHS colleagues across the UK, midwives, student midwives, and obstetricians alike. What has your experience of “fresh eyes” reviews been? Do they reassure you, add value, or do they sometimes feel like a tick-box exercise?

Take the short survey here:

https://forms.office.com/e/pX6xzAWSVX

Your insights will remain anonymous, and the findings will be shared in a follow-up blog to continue this important conversation. NHS sign-in will be required to validate professional participation, and completion of the survey will be taken as consent for your responses to be used in this way. The survey will remain open until Friday 31st October 2025.

Because ultimately, maternity safety isn’t just about doing more, it’s about doing what works.

References

1. Fitzpatrick T, Holt L. A ‘buddy’ approach to CTG. *Midwives*. 2008;11(5):40-41.
2. Donnelly L, Hamilton L. A ‘fresh eyes approach’. *Midwives*. 2012;15(5):44-45.
3. NHS England. *Saving Babies’ Lives Version Three: A care bundle for reducing perinatal mortality*. 2023. Available from: https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00614-Saving-babies-lives-version-three-a-care-bundle-for-reducing-perinatal-mortality.pdf
4. NHS Resolution. *Maternity (Perinatal) Incentive Scheme Year 7: Conditions and Guidance*. London: NHS Resolution; 2025. Available from: https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf

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