Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 12 November 2025

TB2025.91

Title:	**Perinatal Quality Surveillance Report (September)**

Status:	**For Information**
History:	**Reported to MCGC 6th October 2025**

Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

1. This report provides assurance and oversight on maternity and neonatal services at Oxford University Hospitals NHS Foundation Trust, in line with the NHSE Perinatal Quality Surveillance Model (PQSM) and the newly republished Perinatal Quality Oversight Model (PQOM).
2. Key Areas of Focus

    - **Safety & Compliance:** All MNSI and PMRT reporting requirements have been met, with rapid reviews confirming no immediate care concerns in referred cases. Safety Action 2 is fully compliant following external verification and Safety Action 6 compliance measures have been achieved.
    - **Workforce & Training:** Fetal monitoring and newborn life support training compliance are above target for most staff groups. Attendance at PROMPT training is below target for consultant obstetric anaesthetists but expected to improve. 25 new preceptees are due to start between September and November.
    - **Quality Improvement:** The report demonstrates ongoing stability in perinatal surveillance metrics, with robust reviews ensuring accuracy. The Maternity Incentive Scheme Year 7 is progressing.
    - **Experience & Feedback:** There has been an increase in complaints, however the Friends and Family Test shows a high proportion of positive ratings.
    - **Operational Performance:** Maternity triage saw 36.8% of women within 15 minutes, with data accuracy improving significantly since the BSOTS project. No gaps were reported in the on-call medical workforce, and 100% consultant attendance at clinical incidents was achieved.

Recommendations

3. The Trust Board is asked to:

    - Note and take assurance from the report, which highlights the stability of key metrics and compliance with the revised perinatal surveillance model.
    - Continue to monitor and respond to patient feedback and complaints to drive service improvement and experience

Perinatal Quality Surveillance Report (September)

1. Purpose

1.1. The accompanying perinatal quality surveillance report is produced in alignment with the NHS England Perinatal Quality Surveillance Model, ensuring a comprehensive “ward-to-board” approach that supports two-way sharing of safety intelligence across multidisciplinary and multi-professional teams, including neonatal services.

1.2. This approach provides assurance that frontline insights are captured and escalated appropriately, enabling timely action and strategic oversight at Board level.

1.3. The accompanying perinatal quality surveillance report offers a structured view of key focus areas—Safety, Workforce, Quality Improvement, Maternity (Perinatal) Incentive Scheme, Experience, and Training—allowing the Board to monitor performance against national standards and local priorities.

2. Background

2.1. The Perinatal Quality Surveillance Model (PQSM) was published in December 2020. The model was refreshed and republished on the 26 August 2025 as the Perinatal Quality Oversight Model (PQOM).

2.2. The PQOM provides a structure with clear lines of accountability to address and escalate quality and safety risks at Trust, integrated care boards (ICB’s), region and national level.

2.3. The accompanying report presents key information and data up to the end of September 2025 and a summary of the key highlights are presented below.

3. Key Highlights – September 2025

3.1. All MNSI and PMRT reporting requirements met

3.2. Two cases reported to MNSI that met criteria

3.3. Four cases were reviewed through PMRT

Training Compliance

3.4. Compliance above target of 90%

3.5. Above target for midwives, nurses working in maternity, MSW’s, obstetric doctors for PROMPT training

3.6. Above target of 90% for newborn life support training

Maternity (Perinatal) Incentive Scheme Year 7

3.7. Safety Action 2 external verification received – safety action fully compliant.

3.8. Safety Action 6 – Quarter 1 Saving Babies Lives review undertaken by the LMNS – all compliance measures achieved.

3.9. 1:1 care in labour was provided consistently.

3.10. No gaps in the on call medical workforce on Delivery Suite.

3.11. 100% attendance by consultants at clinical incidents as per RCOG guidance.

MNSI referrals

3.12. 2 cases referred to MNSI. Rapid review undertaken and no immediate care concerns identified.

Perinatal Mortality Review (PMR) meeting

3.13. An external reviewer attended 3 out of the 4 PMR meetings

3.14. The MNVP lead attended 3 out of the 4 meetings

Maternity triage on the Maternity Assessment Unit (MAU)

3.15. 36.8% of women were seen within 15 mins. Since the start of the BSOTS project, data accuracy has improved to from 88.7% to 95.1%.

Midwifery Staffing

3.16. 25 newly registered midwives are due to start between September and November.

Training compliance

3.17. Attendance at PROMPT is below the target of 90% for consultant obstetric anaesthetists, however this should be above the target in November.

3.18. NLS certification for neonatal staff who attend neonatal resuscitations unsupervised, compliance is below the expected standard – training sessions are booked for November with the aim to be over 90% by the end of the reporting period.

Complaints/Patient Feedback

3.19. 24 complaints received which is an increase from previous months

3.20. 354 responses from friends and family test (FFT) received with 319 responses rating the service as ‘good’ or ‘very good’.

PMRT cases

3.21. Of the 4 cases reviewed – 1 case was graded as a D related to the care up until the delivery of the baby.

3.22. 1 case graded as a C due to missed referrals for safeguarding, glucose tolerance test and antenatal clinic.

4. Conclusion

4.1. The accompanying report provides a comprehensive monthly update and assurance regarding key maternity quality and safety metrics and ongoing activity. It underscores the Trusts commitment to transparency and continuous improvement, demonstrating progress towards meeting both local and national quality standards.

4.2. This report provides evidence of compliance with the revised perinatal surveillance model, highlighting key achievements and areas that require improvement. It is also intended to support maternity and neonatal services to collate evidence for the Maternity (Perinatal) Incentive Scheme.

5. Recommendations

5.1. The Trust Board is asked to:

- Note and take assurance from the report, which highlights the current position in relation to the stability of key metrics.
- Support ongoing improvement initiatives.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Surveillance Report

Presented at Maternity Clinical Governance Committee

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Date: October 2025

Data period: September 2025

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Maternity Summary - September 2025

Oxford University Hospitals NHS Foundation Trust

0.6% (prev. 0.9%)
Blood Loss >1500mls for CS
3.0% (prev. 4.5%)
3rd & 4th degree tears

↑**29** **Unplanned Term Admissions to NNU**
(4.8%)
≥ 37 weeks

↑**19** (3.01%)
Freestanding MLU*

Horton	8
Chipping Norton	5
Wantage	2
Wallingford	4

↓**558** **Delivery Suite**

↑37 (5%) **Spires**

Excellence Reports
16

↑**56%**
Friends Family Test

637 Babies Born
To
630 Women
(9.7% increase from August)

↑**37.1%**
Caesarean Sections (CS)
Elective CS –117 (18.6%)
Emergency CS – **117** (20.3%)

↓**27.5%**
Inductions of Labour

↓**10** (1.5%) **Home Births**

↑**674** **Scheduled Bookings**

100%
1:1 Care in Labour
1:23.5
Midwife to Birth Ratio

24 New Complaints

88.6%
Breastfeeding Initiation

*MLU – Midwifery Led Unit

Neonatal Summary - September 2025

NHS
Oxford University Hospitals
NHS Foundation Trust

Milk Bank

169L Breast Milk Pasteurised
16L Sold/ **£2.9k** Profit
11 Donors Recruited

39 Preterm Admissions (50%)

< 27 weeks – **9** (12%)
27-36 weeks – **30** (38%)

15 Excellence Reports

39 Term Admissions (50%)
≥ 37 weeks

100% Born in the right place*

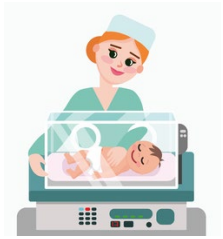
78 Admissions
September 2025

5%
Friends and Family Test

SONeT
SOUTHAMPTON OXFORD NEONATAL TRANSPORT

39 Total Transfers
8 Emergency Uplifts
31 Non-Urgent

1026 Care Days



Nursing Recruitment

4 Recruits
1 Leaver

Outreach Team

118 Home Visits
53 Babies Seen

9 Deaths

x6 - Extreme Prematurity ≤24/40
25/40 – NEC
26+2/40 – Septic Shock, NEC, PH
37/40 – Severe Resp. Acidosis

2
Neonatal Complaints

*Born in the right place (Level 3 NICU) – this applies to extreme preterm infants under 27 weeks, under 800g or under 28 weeks if multiple birth.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Scorecard (Exception Report and Dashboard)

Perinatal Quality Scorecard Summary

Overview

September was an exceptionally busy month for Maternity Services with a marked increase in both births and clinical acuity. A total of 630 mothers gave birth to 637 babies, and 674 scheduled antenatal bookings were completed. Caesarean sections accounted for 234 births, representing 37.1% of all deliveries. Midwifery-led settings supported 61 births (9.6%), including 32 on Spires, eight at Horton MLU, five at Chipping Norton, four at Wallingford, and two at Wantage. Activity and acuity remained consistently high throughout the month, reflecting sustained operational pressure and increased demand across the service.

On 15 September 2025, the Trust was announced as one of 14 trusts selected for inclusion in the National Maternity and Neonatal Independent Rapid Review, commissioned by NHS England. The Trust welcomes this opportunity for external scrutiny and learning and is fully committed to transparent and constructive participation in the review process. The Trust will fully engage with the investigation, share all relevant

Quality & Safety

Two hundred forty-nine maternity patient safety incidents were reported via Ulysses, which included 71 classified as moderate, with two downgraded after review. Moderate harm incidents related to postpartum haemorrhage (PPH) greater than 1.5 litres, obstetric anal sphincter injury (OASI), and unexpected admissions to the Special Care Baby Unit (SCBU). Appropriate learning responses were implemented in accordance with the Patient Safety Incident Response Framework (PSIRF) principles to ensure a considered and timely response. Immediate learning interventions were implemented on a case-by-case basis to address contributory factors and mitigate future risk, ensuring that learning was embedded promptly and effectively across relevant clinical teams.

During September, two maternity cases were referred to the Maternity and Newborn Safety Investigations (MNSI), both involving suspected Hypoxic-Ischaemic Encephalopathy (HIE). MNSI declined one case following parental feedback, as the family expressed high satisfaction with the care received and did not wish to proceed with an external investigation. The second case remains under review and is currently progressing through the MNSI triage process.

Outcomes

In September, 173 women underwent induction of labour (27.5%). The majority of births were unassisted vaginal deliveries (303 cases, 48.1%), with 100 assisted births (15.9%) using forceps or a Kiwi cup; the remainder were caesarean sections. There were 12 cases of obstetric anal sphincter injury (OASI), eight in unassisted vaginal births and four in assisted births—a reduction from the previous month, reflecting progress with the OASI Care Bundle and perineal protection strategies.

Postpartum haemorrhage (PPH) greater than 1.5 litres occurred in 15 cases, equating to 2.3% of total births. Of these, six cases were associated with unassisted vaginal births (1% of vaginal births), five with assisted vaginal births (0.79% of assisted births), and four with caesarean sections (1.7% of caesarean births).

There were 29 unexpected neonatal unit admissions among term babies. Sixteen of these babies were born by caesarean section, eight followed unassisted vaginal birth, and five were associated with assisted vaginal birth. These admissions are subject to review to identify any preventable factors and ensure timely escalation of care. Overall, the data demonstrates improvement in OASI rates and stability in PPH incidence. Neonatal admissions are being closely monitored, with targeted actions focusing on caesarean-related cases.

Experience

In September 2025, there were 24 complaints, up from 11 the previous month. Fifteen were from individuals of White British ethnicity, with the remainder spread across other ethnicities or not stated. Four complaints relate to care pre-dating 2024. The main themes were concerns about clinical treatment, communication, and appointment delays. The service received 354 Friends and Family Test responses (56% response rate), with 90% rating care as 'good' or 'very good'. The service is committed to listening and learning from every complaint as part of its drive for continuous improvement. All complaints are subject to systematic review, with themes such as clinical treatment, communication, and appointment delays analysed to identify underlying issues and inform service changes.

Work is underway to consult with patients and community groups on the Perinatal Improvement Programme, and an open engagement event is being scheduled for late November or early December. This will strengthen co-production and ensure service improvements reflect patient and community priorities.

The meeting with the Families Failed by OUH Maternity Services campaign group, scheduled for September, was cancelled at the request of the group's leaders. While this was disappointing for all involved, the group felt it necessary to cancel the face-to-face meeting owing to ongoing queries and the need to agree arrangements which fully reflect their needs. The Trust recognises the importance of creating an environment where everyone feels safe and supported to engage in dialogue. The Trust remains committed to agreeing appropriate arrangements so we can meet as soon as possible, as we are eager to meet with and support the families represented by the group. The Trust has been in frequent communication with campaign leaders.

Training

The 2025–2026 training year has commenced, featuring PROMPT, fetal monitoring training, the Maternity Update Day (OxMUD), and ongoing neonatal life support sessions. Rolling compliance remains above the 90% target for most staff groups, reflecting strong engagement with the programme. All maternity staff are allocated time during the training year to complete mandatory online modules, ensuring full compliance with both maternity-specific and general mandatory training within the rolling year.

Information Governance training compliance currently stands at 88.1%. Targeted efforts are underway to support staff who have not yet completed their training, with additional reinforcement through the appraisal process to achieve full compliance.

Patient Group Directive (PGD) compliance for all midwives employed at OUH is currently 80.29%. The practice education team has introduced focused initiatives to improve PGD compliance further, ensuring safe and effective practice across the service.

Workforce

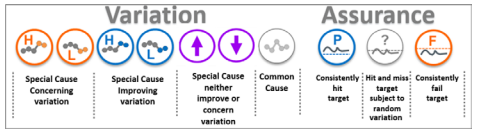
The midwife-to-birth ratio for September was 1:23.5. The service continues to implement a robust recruitment and retention plan, with 25 new Band 5 midwives expected to join between September and November. Daily staffing meetings ensure the service is safely staffed, enabling timely mitigations, staff movement between areas, and escalation when required.

There were no occasions in September when 1:1 care was not provided for women in established labour. There was one occasion when the Delivery Suite coordinator was not working in a supernumerary capacity at the start of the shift; this was for a short period and promptly addressed.

There were 57 women whose induction of labour was delayed by more than 24 hours, which represents an increase from the previous month. Work is underway to understand the causes of these delays and implement measures to reduce them. As part of the Perinatal Improvement Programme, the service is examining patient flow and progressing work to improve the induction of labour pathway.

Indicator Summary – Maternity SPC Dashboard

ER



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Sep 25	630	625			620	538	703
Babies Born	Sep 25	637	-			630	546	714
Scheduled Bookings	Sep 25	674	750			702	552	852
Inductions of labour (IOL)	Sep 25	173	-			152	107	196
Inductions of labour (IOL) as a % of mothers birthed	Sep 25	27.5%	-			24.5%	18.8%	30.1%
Spontaneous Vaginal Births SVD (including breech)	Sep 25	303	-			310	235	385
Spontaneous Vaginal Births SVD (including breech): a	Sep 25	48.1%	-			50.9%	43.6%	58.2%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Sep 25	100	-			87	56	118
Number of Instrumental births/Forces & Ventouse as	Sep 25	15.9%	-			14.0%	9.5%	18.4%
SVD + OVD Total	Sep 25	403	-			389	314	464

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Sep 25	234	-			219	177	261
Number of CS births as a % of mothers birthed	Sep 25	37.1%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Sep 25	117	-			127	96	158
Emergency CS births as a %	Sep 25	18.6%	-			20.2%	15.2%	25.3%
Number of Elective CS	Sep 25	117	-			100	59	141
Elective CS births as a %	Sep 25	18.6%	-			15.1%	10.8%	19.3%
Robson Group 1 c-section with no previous births a %	Sep 25	17.8%	-			13.5%	7.0%	20.1%
Robson Group 2 c-section with no previous births a %	Sep 25	54.8%	-			56.1%	44.6%	67.7%
Robson Group 5 c-section with 1+ previous births a %	Sep 25	79.5%	-			79.7%	62.7%	96.8%
Elective CS <39 weeks no clinical indication	Sep 25	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Sep 25	109	109			109	109	109
Midwife:birth ratio	Sep 25	23.5	22.9			25.9	22.0	29.8
Maternal Postnatal Readmissions	Sep 25	16	-			8	-1	18
Readmission of babies	Sep 25	32	-			19	4	35
3rd/4th Degree Tears amongst mothers birthed	Sep 25	12	-			12	-1	25
3rd/4th degree tears amongst mothers birthed as a %	Sep 25	3.0%	3.5%			3.0%	-0.1%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Sep 25	8	-			8	-2	18
3rd/4th degree tears following unassisted Vaginal bir	Sep 25	2.0%	-			2.4%	-0.1%	4.9%
3rd/4th degree tears following an Instrumental vagin	Sep 25	4	-			4	-2	9
3rd/4th degree tears following an Instrumental vagin	Sep 25	4.0%	8.0%			4.4%	-3.2%	12.0%
PPH equal to or greater than 1.5L following an instrun	Sep 25	5	-			7	0	13
PPH equal to or greater than 1.5L following an instrun	Sep 25	0.8%	-			1.1%	0.0%	2.2%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Sep 25	6	-			12	0	23
PPH 1.5L or greater, vaginal (unassisted) births as a %	Sep 25	1.0%	2.4%			1.9%	0.2%	3.7%
PPH 1.5L or greater, caesarean births	Sep 25	4	-			7	-2	15
PPH 1.5L or greater, caesarean births as a % of mother	Sep 25	0.6%	4.3%			1.2%	-0.6%	2.9%
ICU/CCU Admissions	Sep 25	0	-			1	-1	2
% completed VTE admission	Sep 25	91.4%	95.0%			94.5%	90.1%	98.9%
Maternal Deaths: All	Sep 25	0	-			0	0	1
Early Maternal Deaths: Direct	Sep 25	0	-			0	0	0
Early Maternal Deaths: Indirect	Sep 25	0	-			0	0	0
Late Maternal Deaths: Direct	Sep 25	0	-			0	0	0
Late Maternal Deaths: Indirect	Sep 25	0	-			0	0	0

Indicator Summary – Maternity SPC Dashboard

ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Aug 25	4	-			5	-2	13
Puerperal Sepsis as a % of mothers birthed	Aug 25	0.7%	1.5%			0.8%	-0.3%	2.0%
Stillbirths (24+0/40 onwards; excludes TOPs)	Sep 25	3	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Sep 25	3	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Sep 25	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Sep 25	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Sep 25	0	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Sep 25	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Sep 25	3	3			2	-2	5
HIE ER	Sep 25	2	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Aug 25	82.4%	85.0%			76.9%	#N/A	#N/A
Number Of Women Booked This Month Who Current	Sep 25	25	-			42	21	64
Percentage Of Women Booked This Month Who Curre	Sep 25	3.7%	-			6.1%	2.8%	9.3%
Number of Women Smoking at Delivery	Sep 25	29	-			32	15	48
Percentage of Women Smoking at Delivery	Sep 25	4.6%	8.0%			5.1%	2.4%	7.8%
Number of women with a live birth	Sep 25	627	-			606	507	704
Number of Woman with a live birth Initianing Breastf	Sep 25	556	-			523	379	667
Percentage of Women Initiating Breastfeeding	Sep 25	89%	80%			82%	74%	91%
Number of women booked by 10+0/40	Sep 25	399	-			419	227	610
Percentage of women booked by 10+0/40 ER	Sep 25	59%	-			66%	57%	75%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Sep 25	12	-			9	0	17
Shoulder Dystocia as a % of babies born	Sep 25	1.9%	-			1.4%	0.1%	2.7%
Unexpected NNU admissions	Sep 25	29	-			25	8	42
Unexpected NNU admissions as a % of babies born	Sep 25	4.6%	4.0%			3.9%	1.2%	6.6%
Hospital Associated Thromboses	Sep 25	0	0			0	-1	1
Returns to Theatre	Sep 25	2	0			1	-2	5
Returns to Theatre as a % of caesarean section delive	Sep 25	0.9%	0.0%			0.6%	-0.9%	2.2%
Number of PSII	Sep 25	0	0			1	-2	4
Number of Complaints	Sep 25	24	-			9	-2	20
Born before arrival of midwife (BBA)	Sep 25	5	-			6	-2	14

What is the data telling us?

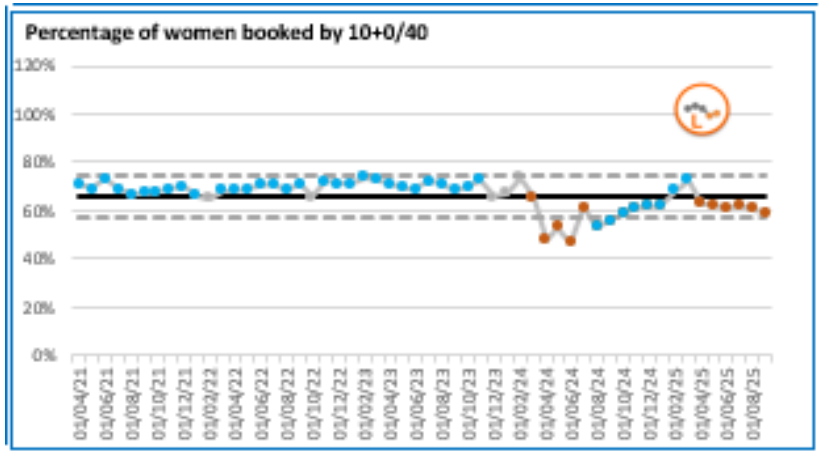
Exception Reporting highlighted for HIE and Percentage of Women booked by 10+4/40. Summary and Actions Slide 11

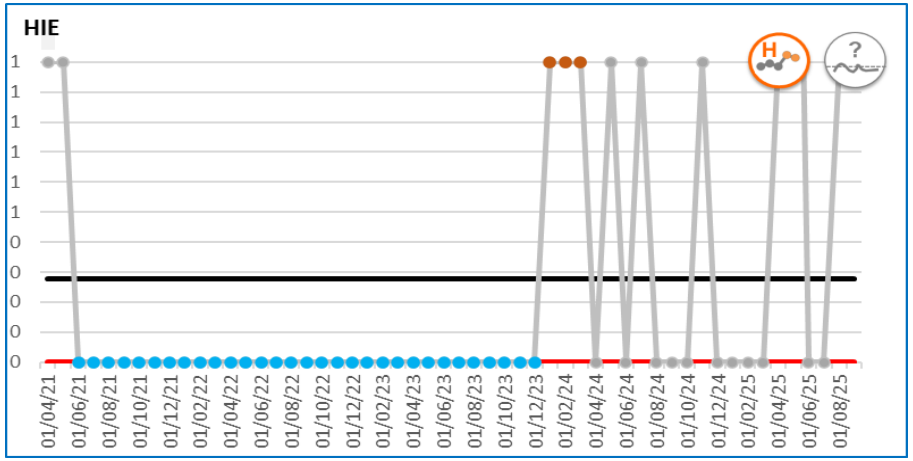
Exception Reporting highlighted VTE and Complaints. Summary and Complaints Slide 12

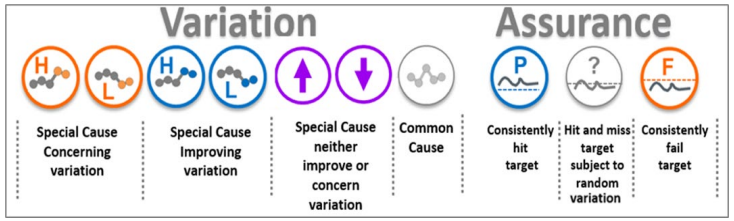
All other Key Performance Metrics range within common cause variation with no significant change.

Perinatal Exception Report

Oxford University Hospitals NHS Foundation Trust



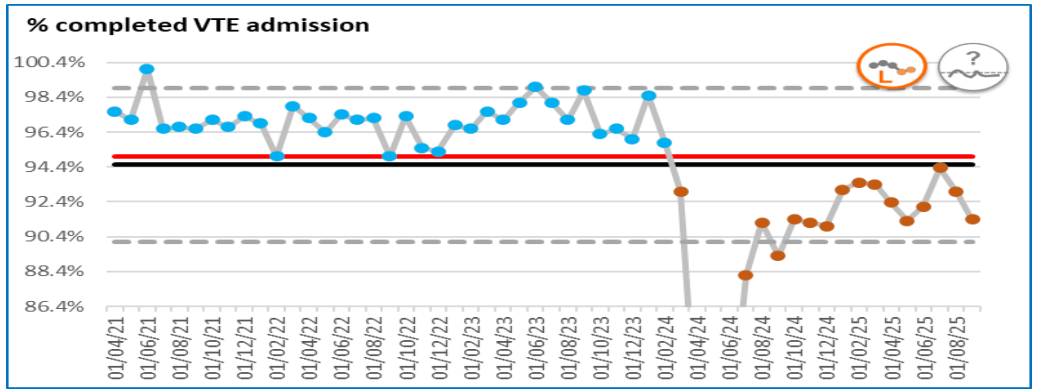


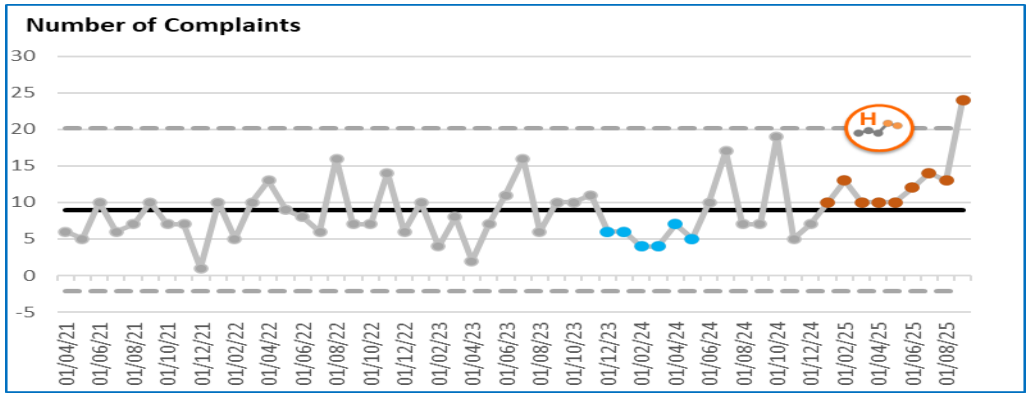


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Percentage of women booked by 10+/40 shows a special cause variation.	Limited booking slots and estate constraints have potentially created confusion around the booking process. Proposed solutions include backup staff cover, clearer communications for users and staff, and expanding clinic capacity with additional or out-of-hours bookings.	Community Matron to report exceptions into November Maternity Clinical Governance Committee (MCGC)	N/A	N/A
HIE shows a special cause variation.	Two-term infants were identified as having suspected hypoxic-ischaemic encephalopathy (HIE). One infant, who collapsed shortly after a straightforward vaginal delivery, required therapeutic cooling for 72 hours and was later diagnosed with moderate HIE based on MRI results. A rapid review of the case confirmed that no concerns were raised regarding the care provided. The second infant underwent therapeutic cooling following an emergency caesarean section due to a sudden drop-in heart rate. An MRI conducted on day 10 showed normal results, and, similarly, the rapid review found no concerns with the care received. Both cases were managed in accordance with national guidelines, and prompt escalation and treatment were administered appropriately.	Both cases appropriately referred to MNSI for investigation. Immediate learning responses undertaken in rapid reviews by local team with no care concerns identified.	N/A	N/A

Perinatal Exception Report

Oxford University Hospitals NHS Foundation Trust





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission shows a special cause concerning variation	There has been a slight decrease in compliance by 1% on the previous month. A multidisciplinary VTE task and finish group has been established. This group will oversee improvement work with the objective of achieving 100% compliance of timely and accurate VTE assessment. Current focus is as follows: • Guideline has been reviewed and requires ratification from maternity Document Review Group (DRG). To optimise VTE compliance and accuracy amendments are required to Cerner EPR which has been escalated to IM&T. • Communication to all maternity staff that all VTE risk assessments must be completed in CERNER. • Ongoing additional audit	Continuous audit of VTE assessment completion. Progress and monitoring of any action plans will be reported monthly at MCGC	N/A	N/A
Number of complaints	The service continues to respond promptly to complaints, engaging directly with complainants and involving both rapid responders and the maternity patient safety partner to ensure compassionate, service user-centred responses. In September 2025, there were 24 complaints—mainly relating to clinical care, communication, and appointment delays—with all concerns thoroughly reviewed and addressed through the Triangulation and Learning Committee (TALC) to drive tangible improvements. To further enhance responsiveness, the Trust is recruiting an additional role dedicated to supporting face-to-face resolution of complaints and facilitating meetings with families, ensuring that concerns are addressed in a timely and empathetic manner.	Monthly complaint themes reviewed through subsequent TALC meeting and reported up to MCGC A thematic review of all complaints is currently underway	N/A	N/A

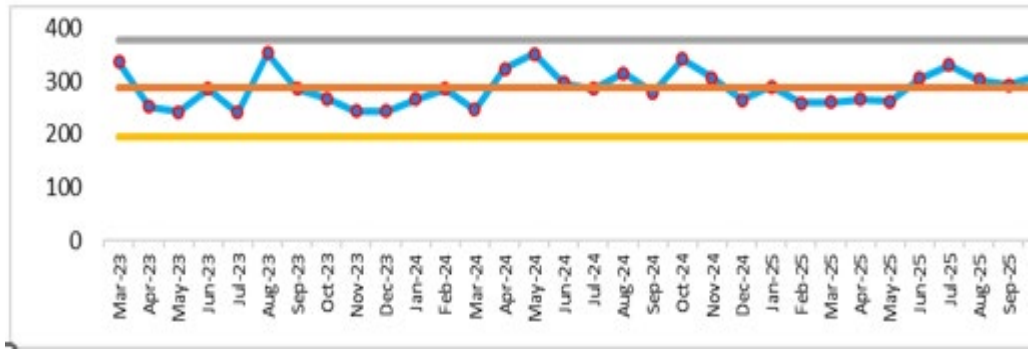
Oxford University Hospitals
NHS Foundation Trust

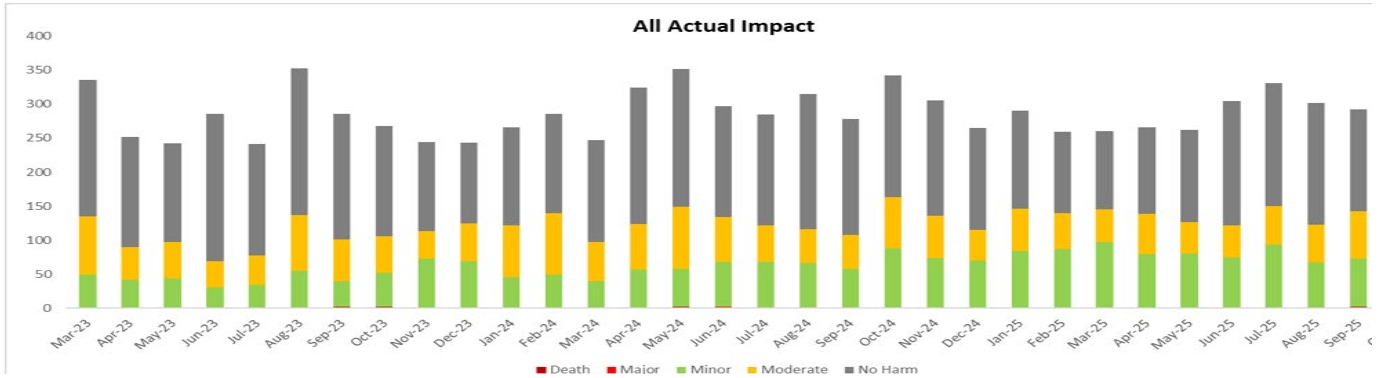
Perinatal Safety

Perinatal Safety - Maternity Incidents

Oxford University Hospitals NHS Foundation Trust

Total Incidents Reported





SUMMARY

Summary of Data

- In September 2025, a total of 249 patient safety reports were submitted via Ulysses. Of these, 71 were reported as moderate harm; two were subsequently downgraded.
- Moderate harm incidents accounted for 27% of all patient safety incidents, representing a slight increase of 3% compared to the previous month.
- Among the 69 moderate harm incidents, the following causes were recorded: five bladder stretches (over one litre), 12 third-degree tears, 15 postpartum haemorrhages, two return to theatre, and 29 unplanned term admissions to SCBU.
- The two return-to-theatre cases in were reviewed and there were no concerns regarding care identified.

Strengths

- High number of Ulysses submitted demonstrates a strong reporting culture, supported by monthly trend analysis and escalation processes to ensure learning is captured and acted upon.
- The 77 Ulysses overdue for review are actively monitored, with a clear recovery plan in place and oversight through divisional governance.
- Learning of the Week is embedded in safety huddles and team briefings, with compliance monitored via audit and feedback loops to confirm dissemination and impact.
- Moderate Harm incidents remain within national averages for the categories.

Focus

- Timely review of Ulysses
- Consistent use of interpreters
- Timely transfer from the Spires to Delivery Suite
- Bladder Care
- Follow the PEACHES care bundle to prevent obstetric anal sphincter injuries (OASI)

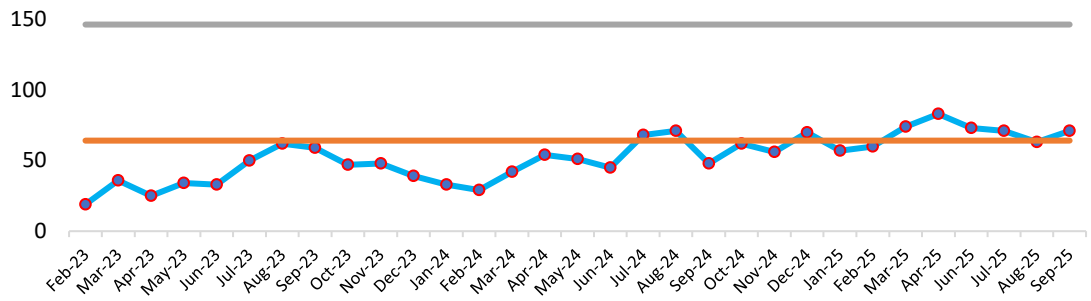
Future

- To address health inequalities, the service will review the ethnicity of users affected by moderate harm over an extended period.
- This longer-term analysis will give a clearer picture than monthly data, helping to identify any disproportionate trends.
- Results will be reported to the Maternity Clinical Governance Committee, and any key findings will inform improvement plans.

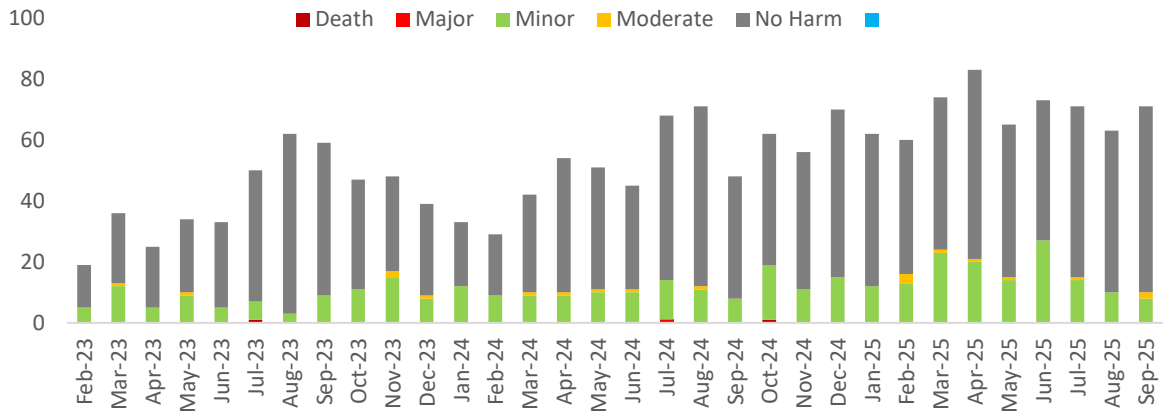
Perinatal Safety - Neonatal Incidents

Oxford University Hospitals NHS Foundation Trust

Total Incidents Reported



Incidents by Impact



Summary of Data

- In September, 77 patient safety incidents were reported via Ulysses, including one classified as moderate harm. This incident related to fingertip ischaemia.
- A full investigation was undertaken, and no concerns regarding the care were identified. The skin damage was considered likely to be associated with a vascular issue rather than a pressure injury. Duty of Candour requirements were completed in line with policy.

Strengths

- Incident reporting within the neonatal team remains consistent, and there are currently no overdue incidents, providing assurance that issues are being managed promptly and effectively. This is supported by monthly governance reviews and escalation processes to ensure timely resolution.
- Neonates continue to rank as the second-highest reporters of excellence within the Children's Directorate, reflecting a strong culture of learning and recognition of good practice.
- In addition, representation at local, directorate, and divisional governance meetings has improved, supporting stronger engagement and alignment with organisational priorities.

Focus

- Education and training on governance within the neonatal team are being enhanced through planned teaching sessions incorporated into nursing team days and the induction programme for doctors. These sessions aim to embed a strong understanding of governance processes, risk management, and accountability across all staff groups.
- The service continues to strengthen its partnership with the Maternity and Neonatal Safety Improvement Programme (MatNeo), ensuring shared learning and best practice are consistently applied. This collaborative approach supports continuous improvement.

Future

- Governance awareness and education within the neonatal team have improved significantly, supported by targeted teaching sessions and integration into team development activities. This has strengthened understanding of governance processes and accountability across all staff groups and will be a focus over the next three months.

Perinatal Safety - Perinatal Mortality Review Tool (PMRT) and Maternal and Neonatal Safety Investigations (MNSI)

Each individual stillbirth and neonatal death continue to be reviewed using the national perinatal mortality review tool (PMRT), PSIRF aligned review and MNSI referral where referral criteria are met. All neonatal deaths are also reviewed by the Neonatal Operational Delivery Network and by the Child Death Overview Panel (CDOP).

PMRT Reporting and Learning

- In September 2025, four qualifying PMRT cases were reported to MBRRACE.
- An external reviewer attended three of the four PMRT meetings, which is fully compliant with MPIS standards.
- In addition, the Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP) lead participated in three of the four meetings, ensuring strong service user representation and supporting transparency and learning.

MNSI Reporting and Learning

MNSI undertakes investigations where specific criteria are met, including early neonatal deaths, intrapartum stillbirths, severe brain injury (hypoxic-ischaemic encephalopathy – HIE) in term babies following labour, and maternal deaths in England.

- In September, two cases were appropriately referred, in line with national requirements (see exceptions reporting on slide 8).

- The service also received one draft report (MI-041518) for factual accuracy review, which was completed and returned by the deadline.

Learning from PMRT Reviews

1. Case 1 28+5 Day 1 Neonatal Death (NND) was graded D up to the time of birth due to a delay in escalation and management of an abnormal CTG. The care following birth was graded A. Immediate learning points identified include issues with CTG monitoring and documentation. There were delays in assessing spontaneous rupture of membranes (SROM) in pre-term women, alongside concerns regarding pain management. Additionally, delayed escalation of care was noted, particularly in progressing patients from the Maternity Assessment Unit to Delivery Suite. A quality improvement project has been launched to address CTG management and reinforce the importance of timely escalation, supported by ongoing assessment of CTG equipment. Updated pain management guidelines have been co-produced with service users to improve practice and responsiveness to patient needs. In addition, an immediate safety alert has been issued to all staff. These actions are being monitored through the Maternity Clinical Governance Committee to ensure implementation and sustained improvement.

2. Case 2 35+5 Intrauterine Death (IUD) was graded C due to missed referrals for safeguarding (SG), glucose tolerance test (GTT) and antenatal clinic (ANC). The care following the birth was graded B as no partogram was completed.

3. Case 3 23+3 Day 0 was graded B due to the carbon monoxide (CO) monitoring not being completed at booking. During the review meeting, the care and management of chorioamnionitis was exemplary, excellence reports have been completed for those involved. The care following birth was graded a B due to the bereavement care being provided on L6.

4. Case 4 23+5 was graded a B due to a slight delay in recognition and management of chorioamnionitis, which would not have made a difference to the outcome, however, there is a new educational staff poster being produced about chorioamnionitis. The care following the birth was graded a B due to the bereavement care being provided on Level 6.

*Note that the bereavement suite is now staffed 24/7 enabling postnatal bereavement care to be consistently provided in the right place for families.

Oxford University Hospitals
NHS Foundation Trust

Maternity Operational Activity

Maternity Operational Activity

Summary

Summary of Data

- In September, births increased by 9.7% to 637, with 4.5% of these occurring in community settings. Safe staffing was maintained through daily reviews and redeployment, including specialist midwives, to support increased activity and acuity, thereby ensuring continuity of care.
- Mutual aid was requested on four occasions, with two transfers accepted to Stoke Mandeville Hospital for induction of labour, demonstrating proactive escalation and collaboration to maintain patient safety.
- There were 54 delays in induction of labour exceeding 24 hours, with 30 delayed for more than six hours and 27 for more than 12 hours. Work is underway through the Perinatal Improvement Programme to address patient flow and improve the induction pathway.
- There was an increase in the number of caesarean births, however there were fewer emergency caesareans, with elective caesarean births increasing by 4.2% compared with previous months.
- MAU managed 1496 attendances. 36.8% of women were seen within 15 mins (Data accuracy is 95.1%.).

Strengths

- On-call community midwives attended the JR unit responsively to support escalation, demonstrating flexibility and commitment to maintaining safe staffing levels.
- Specialist midwives and Ward Managers also provided timely support to operational colleagues during periods of escalation, ensuring continuity of care and effective risk management.
- One-to-one care in labour was consistently achieved, in line with national standards, and compliance is monitored through the maternity dashboard and reported at the maternity clinical governance committee.
- Antenatal risk assessments were completed in 99.2% of cases, providing assurance that risk identification and mitigation processes are robust.
- Additionally, place of birth suitability was recorded at 85.9%, and improvement actions are being tracked through maternity clinical governance committee to ensure ongoing progress.

Focus

- The service will continue to closely monitor staffing, patient flow, and capacity through daily staffing meetings, ensuring timely escalation and proactive management of risk.
- A quality improvement programme is underway to align triage processes with the BSOTS framework, targeting a 15-minute triage time and timely midwifery and medical reviews; progress is tracked through the Perinatal Improvement Programme and performance audits.
- A quality improvement programme is addressing induction of labour (IOL) processes and patient experience, with improvement actions monitored through the Perinatal Improvement Programme.

Future

- The service will continue to maintain safe staffing levels across both acute and community sites through daily monitoring and escalation processes, ensuring continuity of care and patient safety.
- Actions are in place to improve patient flow and continuity within inpatient areas, supported by real-time oversight at daily staffing meetings.
- A Birthrate+ review has been commissioned and will commence before the end of December 2025, providing an independent assessment of workforce requirements to inform future planning.
- From January 2026, a 24-hour bleep holder role will be rolled out to strengthen operational oversight and escalation management.

Oxford University Hospitals
NHS Foundation Trust

Maternity and Neonatal Workforce

Workforce -Maternity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- The current midwife-to-birth ratio stands at 1:23.5, which is monitored against Birthrate+ standards to ensure safe staffing levels.
- On one occasion, the Delivery Suite coordinator was not supernumerary at the start of a shift; this was for a short period and mitigated through escalation and senior oversight, providing assurance that patient safety was maintained.
- The service in September has a vacancy of 7.12 WTE midwives/obstetric nurses and 9.06 maternity support workers, and recruitment plans are in place.
- Consultant engagement remains strong, with 100% attendance at clinical incidents in line with RCOG guidance, ensuring senior clinical oversight and learning from events.
- Sickness absence rates are stable at 4.4% (rolling 12 months), and trends are monitored monthly with targeted wellbeing interventions where required.

Strengths

- There are currently no gaps in the on-call medical workforce on the Delivery Suite, providing assurance that senior clinical cover is consistently maintained in line with national standards.
- Workforce resilience is further supported by the planned introduction of 25 newly registered midwives between September and November, which will enhance staffing capacity and continuity of care.
- In addition, ongoing leadership development opportunities are being delivered to strengthen capability and succession planning, ensuring that operational and clinical leadership remains robust.

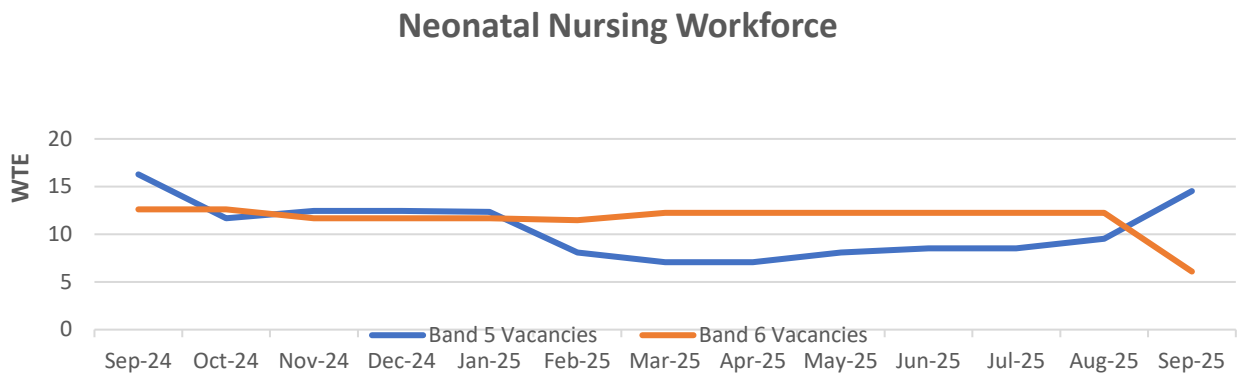
Focus

- All unfilled shifts are proactively released to NHSP to ensure safe staffing levels and continuity of care. Where necessary, staff are redeployed from non-clinical roles to work clinically, supported by real-time oversight at daily staffing meetings.
- Active recruitment for Band 5 and Band 6 midwives is ongoing, including proactive over recruitment beyond the staffing establishment to cover maternity leave.
- Return-to-work interviews are being completed within agreed timeframes, providing assurance that staff wellbeing and compliance with policy are maintained. Continued awareness and promotion of staff wellbeing interventions are in place, supported by the Trust's wellbeing programme and monitored through uptake data.
- In addition, staff are being encouraged to complete the annual staff survey, which commenced in September, to ensure feedback informs improvement actions.

Future

- A recruitment plan is in place to address Registrar vacancies, with progress monitored through maternity clinical governance committee.
- MediRota is now reviewed monthly by roster teams, ensuring compliance with the six-week leave policy and maintaining oversight of session planning and rota integrity.
- An updated BirthRate Plus review has been commissioned and will commence in December 2025, providing an independent assessment of workforce requirements to inform future planning and resource allocation.
- Innovative succession planning and development opportunities are being implemented, including short courses and apprenticeship programmes, to build leadership capability and future workforce resilience.
- In addition, proactive pastoral and wellbeing support continues for all staff cohorts, including internationally trained staff, with uptake monitored and feedback informing improvement actions.

Workforce – Neonatal Nursing Workforce



Summary of Data

- In September there were 6 WTE Band 6 and 12 WTE Band 5 vacancies in Neonates. Additionally, there are 9 WTE staff are on maternity leave, and mitigation plans are in place, including active recruitment campaigns and redeployment strategies, to ensure service continuity.
- Progress against recruitment targets and temporary staffing usage is monitored through and reviewed through divisional governance.
- NHSP and agency use has reduced overall, although it remains variable depending on unit acuity, demonstrating proactive workforce management to maintain safe staffing levels.

Strengths

- 8 Band 5 Neonatal Nurses have been recruited and are scheduled to commence in October 2025, which will help address current workforce gaps and improve staffing resilience.
- Recruitment efforts have also been expanded to include newly qualified nurses, ensuring a sustainable pipeline of talent.
- Neonates is complaint with MPIS Safety Action 4 for 2025, supported by a clear action plan and regular progress reviews through the divisional governance structure.

Focus

- The rolling recruitment programme for Band 5 and Band 6 nurses is set to recommence, pending authorisation of vacancies on TRAC, ensuring a proactive approach to addressing workforce gaps.
- Development programmes for Band 6 and Band 7 staff are being implemented to build leadership capability and support career progression, contributing to workforce stability and retention.
- The Unit Ethos continues to be embedded across teams, reinforcing a culture of safety, collaboration, and excellence.

Future

- Recruitment efforts include a specific focus on Band 4 roles and the expansion of apprenticeship programmes to build a sustainable workforce pipeline and support career progression.

Workforce – Neonatal Nursing Workforce

Oxford University Hospitals NHS Foundation Trust

Summary of Data

- Sickness absence rates were 10.4% in September and remain broadly in line with wider divisional trends, indicating no disproportionate impact on this service compared to other areas.
- The most common reasons for absence have been flu-like symptoms and pregnancy-related disorders, which are being monitored closely to identify patterns and inform targeted interventions.
- Return-to-work interviews are completed within agreed timeframes, and wellbeing support is actively promoted to staff, including access to occupational health and flu vaccination programmes.
- Absence data is reviewed monthly at divisional governance meetings, and any emerging risks are escalated providing assurance that sickness absence is being managed proactively within a robust governance framework.

Strengths

- Enhanced measures have been implemented to improve sickness management and staff wellbeing. Increased monitoring of return-to-work interviews ensures compliance with policy and timely identification of any underlying issues impacting attendance.
- Additional HR-led drop-in sessions have been introduced to support senior teams in applying sickness management procedures consistently and effectively.
- These actions are monitored through workforce dashboards and reviewed at divisional governance meetings, providing assurance that sickness management is proactive, supportive, and aligned with best practice standards.

Focus

- Timely and effective return-to-work interviews will continue to be prioritised in line with the Trust's sickness management procedure, ensuring compliance and consistency across all teams.
- Enhanced monitoring will be maintained through workforce dashboards, with regular audits and HR oversight to provide assurance that interviews are completed promptly and any underlying issues are addressed.
- Additional support measures, including HR-led drop-in sessions and wellbeing interventions, will remain in place to strengthen staff engagement and reduce recurrent sickness absence.
- These actions will be reviewed at divisional governance meetings to ensure accountability and alignment with workforce resilience objectives.

Future

- Return-to-work interviews are consistently completed and in full alignment with the Trust's sickness management procedure.
- Compliance is monitored through workforce dashboards and reviewed at divisional governance meetings to ensure timely intervention and adherence to policy.
- This process supports early identification of any underlying issues, enables appropriate wellbeing measures, and reduces the risk of recurrent absence.

Workforce – Specialist Training (Neonatal)

Oxford University Hospitals NHS Foundation Trust

Qualified in Speciality (QIS) Training	Target	2023	2024	2025	2026	2027	2028	2029
Compliance	**70%**	42%	46%	51%	59%	68%	77%	86%
					Prospective Data			

Summary of Data

- Current compliance with BAPM standards for Qualified in Specialty (QIS) training is 51% and there is a clear trajectory in place for improvement supported by a structured action plan.
- The current action plan is reliant on training staff internally and looking ahead, the trajectory will be broadened to recruit external candidates who are already qualified in the speciality. However, this approach remains difficult as such candidates are rare, making recruitment highly competitive and challenging.
- A recruitment plan is in place, which includes open days designed to attract potential candidates and showcase the opportunities available within the service. These initiatives aim to engage a wider pool of applicants and support the long-term sustainability of the neonatal nursing workforce.

Strengths

- The neonatal service is fully compliant with MPIS Safety Action 4 for 2025, supported by a clear and structured action plan (see Appendix 7), which is monitored through divisional governance.
- In addition, significant progress has been made in increasing the number of staff undertaking QIS training which has increased from 8 to 15 staff across two cohorts—7 nurses commenced training in September, and a further 8 are scheduled to start in February 2026.
- This upward trajectory demonstrates a strong commitment to workforce development.

Focus

- QIS training is being delivered in line with the agreed action plan to improve compliance with BAPM standards. The plan includes prioritising staff for training based on service need, securing CPD funding for external provision, and increasing mentor capacity to support trainees.
- Progress is monitored through the Neonatal Education and Workforce Group and reported to divisional governance, ensuring transparency and accountability. Phased scheduling of training cohorts is in place to minimise operational impact while meeting compliance targets.
- These measures provide assurance that the Trust is actively addressing current gaps and implementing a structured approach to achieve full compliance within a robust governance framework.

Future

- The neonatal service has set a clear trajectory to achieve 70% QIS compliance in line with BAPM standards, supported by a structured action plan.
- To accelerate progress, in-house QIS training provision is being explored, reducing reliance on external providers and improving cost efficiency. This approach also enhances flexibility in scheduling and supports better integration with clinical practice.
- The suitability of the current two-cohort programme will be reviewed to ensure it meets operational needs and maximises training capacity.
- Progress against compliance targets and training delivery is monitored through the Neonatal Education and Workforce Group and reported to divisional governance, providing assurance that workforce capability and quality standards are being actively managed within a robust governance framework.

Workforce – Neonatal Medical Workforce

Oxford University Hospitals NHS Foundation Trust

Non-resident consultant service with the largest overseas Medical Training Initiative (MTI) programme for resident doctor recruitment

- Consultants - 11WTE (includes 3 Locum)
- Resident doctor's workforce established 39 WTE (following BS in 2025)
    1. Current gaps – 2 WTE
    2. 18 WTE deanery
    3. 19 MTI trainees – resident medical doctors
    4. 2 ANNPs

Summary of Data

- The neonatal service is fully compliant with the British Association of Perinatal Medicine (BAPM) national standards for medical staffing, as required by the Maternity and Perinatal Incentive Scheme (MPIS) for 2023 and 2024.
- In 2024, the Board approved a medical staffing business case that included the recruitment of six WTE medical registrars to ensure safe nighttime cover and the introduction of consultant presence on the neonatal unit for 12 hours over weekends.
- These measures have been successfully implemented, and the service is now established for 39 WTE medical doctors, meeting all requirements for registrar and consultant cover.
- The neonatal service currently has a vacancy of 2 WTE, active recruitment plans are in place, and risks are mitigated through rota management and escalation processes.

Strengths

- The budget for 39 WTE medical rota positions for the resident medical doctor workforce has been confirmed, ensuring financial stability and alignment with the approved business case.
- Recruitment activity is progressing as planned, with clear milestones in place to achieve full establishment by March 2026.

Focus

- The service will convert locum consultant posts into substantive positions to improve workforce stability, continuity of care, and long-term resilience. Recruitment plans are in place, and progress will be monitored through divisional governance.
- We will ensure full compliance with MPIS requirements for safe staffing this year.

Future

- Fully compliant with BAPM and MPIS standards for safe staffing.

Perinatal Training

Oxford University Hospitals NHS Foundation Trust

Maternity (Perinatal) Year 7 Safety Action 8 requires 90% compliance across relevant staff groups is required for PROMPT (obstetric emergencies), fetal monitoring and Basic Newborn Life Support (NLS). The training year runs from September to July and is in line with the Core Competency Framework. New material for all training days is reviewed/changed every September (start of the training year) to ensure nationally mandated topics are covered.

Data

- Collected on a monthly basis
- Training compliance for consultant obstetric anaesthetists is below the target of 90%. However, this will be greater than 90% following the next PROMPT date scheduled for the 17/10/25

Positive

- Fetal monitoring compliance >90% for all relevant groups (apart from consultant anaesthetists).
- Training weeks in Maternity that include PROMPT, fetal monitoring training, OxMUD and Neonatal Life Support restarted in September 2025.
- Training compliance for newborn life support (NLS) is above the target of 90% for all neonatal staff groups.

Focus

- Attendance of anaesthetic staff at PROMPT – small number of staff
- Training weeks restarted in September
- Moving and Handling dates planned monthly, and staff reminded to complete the e-learning as well as attending the practical.

Future

- To be above the 90% target for all staff groups for Prompt, Fetal Monitoring and NLS
- To continue working with ward managers to organise skills and drills dates
- Staff in Maternity are given time to undertake their e-learning as part of their training week.

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	81.6%
Core Skill - Information Governance and Data Security	88.1%
Core Skill - Moving and Handling Level 2	74.5%
Core Skill - Resuscitation Level 1	84%

Core Skills Modules below target	Neonatal Unit
Core Skill - Information Governance and Data Security	89%
Core Skill - Safeguarding Adults Level 1	87%
Core Skill - Safeguarding Children Level 2	79%

PROMPT	Midwives	98%
	Nurses working in maternity	100%
	MSW's	98%
	Consultant Obstetricians	100%
	Trainees ST1-7	100%
	Obstetric anaesthetic consultants	**89%**
	All anaesthetic doctors who contribute to obstetric rosters	100%
Fetal Monitoring	Midwives	98%
	Consultant Obstetricians	96%
	Trainees ST 1-7	Reg 98% SHO 100%
Newborn Life Support	Midwives	98%
	Neonatal/Paediatric: Consultants Junior neonatal Dr's (who attend births) ANNP's	 100% 91% 100%
	Neonatal Nurses	94%

Oxford University Hospitals
NHS Foundation Trust

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Oxford University Hospitals NHS Foundation Trust

Safety Action	RAG	Comment
1: Use of Perinatal Mortality Review Tool		On track to meet increased requirements for completed reviews and external reviewer attendance.
2: Submitting data to the Maternity Services Data Set		CNST scorecard validation received – compliant in both metrics.
3: Transitional Care and Avoiding Term Admissions to Neonatal Unit		Transitional Care Unit (TCU) requirements met ATAIN QI project has been registered. Presented to Safety champions on 9th October and LMNS on 12th November.
4. Clinical workforce planning		Progress on the neonatal nursing action plan to be submitted to Trust Board (see appendix 7). Neonatal medical workforce is compliant with BAPM standards. A 3-month audit has been undertaken, and it demonstrates 100% compliance with consultant attendance in person to clinical situations listed in the RCOG workforce document.
5. Midwifery workforce planning		BirthRate plus review scheduled for November. This will evidence requirements of a systematic evidence-based process to calculate midwifery staffing establishment. Current BR+ review still within necessary time frame to meet compliance requirements. Bi-annual reports to Trust Board. Will require action plan for supernumerary status of Delivery Suite coordinator and 1:1 care in labour reported.
6. Saving Babies Lives Care Bundle		Q4 and Q1 reports reviewed by LMNS and have met compliance standards. New compliance measures set inline with Q1 results and SBL v3.2. Quarter 2 review is scheduled with the LMNS for the end of November.
7. Listening to women, parents and families		MNVP lead now embedded as quorate member in most necessary meetings. Awaiting updated Terms of Reference for the meetings.
8. Multidisciplinary training		Newborn Life Support (NLS) certification for neonatal staff who attend neonatal resuscitations unsupervised compliance is below expected standard – training sessions are booked for November with the aim to be over 90% by the end of the reporting period.
9. Trust Board Oversight on Safety and Quality Issues		No anticipated concerns
10. MNSI and Early Notification Scheme reporting		No anticipated concerns

Oxford University Hospitals
NHS Foundation Trust

Patient Experience

Patient Experience – Maternity FFT, Complaints, Concerns & Compliments

Oxford University Hospitals NHS Foundation Trust

Feedback is gathered from friends and family test (FFT) ,complaints, quarterly survey by Oxford Maternity & Neonatal Voices Partnership (OMNVP) concerns raised through PALS and compliments received. This information feeds into the Triangulation and Learning Committee (T.A.L.C).

Summary

Summary of Data

- In September, the Friends and Family Test (FFT) generated 354 responses (a 56% response rate), of which 90% rated the service as 'good' or 'very good,' providing assurance of high satisfaction levels.
- 24 new complaints were received, with 15 from individuals of White British ethnicity and the remainder distributed across other ethnic groups. Three complaints relate to care pre-dating 2024, and one was from a local MP requesting further information.
- Themes identified include clinical treatment concerns, communication issues, and appointment delays. All complaints are logged, investigated, and monitored through divisional governance, with learning shared via safety huddles and quality meetings. Equality data is reviewed to ensure no disproportionate representation and to inform improvement actions.

Strengths

- Awareness among staff and service users to complete the Friends and Family Test (FFT) has increased, supported by additional 'Say on the Day' devices to make feedback more accessible.
- Over 85% of FFT responses remain positive, with specific recognition of key service features such as the accessibility of the immunisation hub, infant feeding support, 24-hour visiting on the postnatal ward, and staff being consistently helpful and kind.
- Additional resource has been invested to ensure more opportunities for complaint resolution meetings to be offered promptly, improving responsiveness and patient confidence in the complaints process. Funding is in place for this additional post, and recruitment is currently in progress.

Focus

- Continue to collect and triangulate themes from complaints, FFT, patient safety incidents, and patient experience data.
- Postnatal improvements will include enhanced discharge processes, improved accessibility to pain relief, strengthened infant feeding support, and better visitor facilities. Progress will be monitored through TALC providing assurance of measurable impact.
- Review referral and access to postnatal trauma pathways, including birth reflections, to ensure timely psychological support and equitable access. This will be tracked through Maternity Clinical Governance Committee.
- Implement a new infant feeding structure and refreshed strategy informed by feedback from MNVP and FFT.

Future

- Increase feedback from a broader range of ethnic and cultural backgrounds through enhanced engagement with service users representing diverse communities. This will include targeted outreach, collaboration with community groups, and monitoring of demographic data to ensure inclusivity.
- Review, analyse, and action the full results of the annual CQC Maternity Survey, co-creating solutions with the OMNVP. Actions will be prioritised based on identified themes and tracked through improvement plans, with quarterly updates to Maternity Clinical governance Committee.
- Monitor and evaluate improvement actions to assure sustainability and improved patient experience. This will include outcome audits, patient feedback analysis, and governance oversight to ensure that changes deliver measurable benefits and remain embedded in practice.

FFT Data	Count of Ethnicity
Asian / Asian British	1
Asian or Asian British - Any other Asian background	3
Asian or Asian British - Bangladeshi	4
Asian or Asian British - Indian	12
Asian or Asian British - Pakistani	12
Black or Black British - African	8
Black or Black British - Caribbean	2
Mixed - Any other mixed background	10
Mixed - White and Asian	5
Mixed - White and Black African	6
Mixed - White and Black Caribbean	3
Other ethnic group	2
Other Ethnic Groups - Any other ethnic group	4
Other Ethnic Groups - Chinese	5
Prefer not to say	12
White	11
White - Any other white background	14
White - British	168
White - Irish	8
(blank)	
Grand Total	**290**

Patient Experience and Engagement – Neonatal FFT, Complaints, Concerns & Compliments

Oxford University Hospitals NHS Foundation Trust

Summary of Data

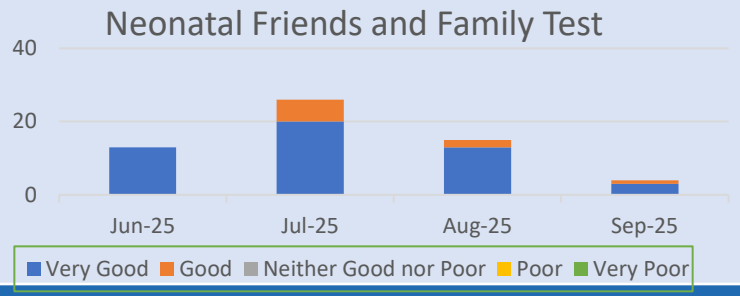
- A revised approach to the Friends and Family Test (FFT) was successfully launched in Neonates in May 2025, providing a structured mechanism for capturing patient experience. In September, four responses were received (representing 5% of admissions), all rating their experience as 'good' or 'very good.'
- While the response rate remains low and has decreased since July—primarily due to reduced face-to-face collection by the Patient Experience Team—mitigation measures are in place. These include repurposing 'Say on the Day' devices in August 2025 to capture real-time feedback, which has yielded positive written comments.
- Two complaints were received in September, both relating to care in HDU and communication between teams and families. Each complaint is logged, investigated, and reviewed through divisional governance, with learning shared at safety huddles and incorporated into improvement plans.

Strengths

- There is increased awareness among staff and families regarding the Friends and Family Test (FFT), supported by proactive engagement and improved accessibility.
- Comments consistently highlight exceptional care, kindness, and professionalism, with examples such as "exceptional, kind and caring staff" and "never a situation you want to find yourself in, but we feel safe here."

Focus

- While responses to date have been positive, the current response rate remains low, with September recording only 5% of admissions. To address this, a clear improvement plan has been implemented.
- Additional 'Say on the Day' devices have been deployed to increase accessibility and convenience for families, and staff have been briefed to actively encourage completion of FFT at key touchpoints, including admission, discharge, and during longer inpatient stays.
- Engagement will be further strengthened through targeted communication campaigns and digital options to ensure inclusivity and representation from diverse communities.
- Response rates and feedback themes will be monitored monthly through divisional governance.



Future

- The neonatal service is committed to increasing Friends and Family Test (FFT) and 'Say on the Day' response rates to ensure a more representative view of patient experience and to capture constructive suggestions for improvement. To achieve this, additional devices have been deployed in high-traffic areas to make feedback collection more accessible and convenient.
- Staff engagement remains central to this plan, with training and reminders embedded into daily huddles to encourage families to provide feedback at key touchpoints such as admission, discharge, and during longer inpatient stays.
- Targeted outreach will focus on engaging families from diverse backgrounds through translated materials and culturally appropriate communication, supported by volunteers and patient experience champions during visiting hours.
- Progress will be monitored through monthly governance reviews, with a measurable target to increase neonatal FFT response rates by 50% over the next six months.
- Feedback themes will be triangulated with complaints and patient safety data to identify improvement opportunities, and written comments will be analysed to inform service development.

Maternity & Neonatal Safety Champions Walkaround

Oxford University Hospitals NHS Foundation Trust

Date: 26th September 2025

Visited Areas: Delivery Suite and Neonatal Unit

Summary of Findings: The walkaround highlighted excellent patient feedback, particularly within the Neonatal Unit (NNU), and confirmed a strong culture of support and responsiveness on the Delivery Suite. The proactive handling of equipment concerns and the integration of safety messages into routine huddles demonstrate a clear commitment to continuous improvement and patient safety. These findings provide assurance that the service is embedding a positive safety culture, supported by visible leadership and effective communication.

- In the NNU, three mothers whose babies had been receiving care for several weeks following premature labour expressed deep appreciation for the compassion and professionalism of the maternity and neonatal teams. Their feedback highlighted excellent communication and transparency, which contributed significantly to trust and confidence in the service. One mother shared how reassured she felt throughout her baby's stay, noting that she was consistently kept informed about her baby's condition and the care being provided. This level of communication and transparency was clearly valued and contributed significantly to her sense of trust and confidence in the team.

- On the Delivery Suite, staff were observed working under operational pressure yet reported feeling well supported by colleagues and leadership. The atmosphere reflected teamwork and resilience, with a strong commitment to maintaining safe and effective care.

- A concern regarding equipment availability was raised and immediately escalated to the Matron, resulting in prompt resolution. In addition, a safety message on timely reporting of faulty equipment was developed and disseminated and incorporated into safety huddles to reinforce awareness and encourage proactive action.

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Quality Improvement

Quality Improvements: Triage (BSOTs) and Induction of Labour (IOL)

Oxford University Hospitals NHS Foundation Trust

TRIAGE QUALITY IMPROVEMENT: SUMMARY

The triage quality improvement programme was established to address delays in timely access to triage. By implementing the Birmingham Symptom-specific Obstetric Triage System (BSOTS), the service aims to deliver safer, timelier, and effective risk assessments for women and birthing people. Progress is monitored through compliance audits, performance dashboards, and governance reporting, with clear escalation processes for any deviations. Training for staff is embedded to maintain competency, and patient feedback is actively sought to evaluate impact.

Focus

- Consistent reduction of triage wait times to ≤ 15 minutes in line with BSOTS recommendations
- Improved midwifery and medical review times in line with BSOTS recommendations
- MAU midwifery rotation now increased from 6 to 12 months
- 24/7 Triage midwife recruitment progressing
- Triage data reported weekly, accuracy now 95.1%
- Guideline update in progress
- Clinical Director to progress plans for optimal medical MAU staffing cover.
- Development of patient information Infographics
- Reconfiguration of current estate

Future

- BOB LMNS Mamas Triage line externally sited
- Education triage competency package review including E-learning package for telephone triage competencies
- Ongoing call analysis from monitored and recorded calls
- Explore the feasibility of air conditioning in clinical rooms

- **Progress monitored and reported through MCGC**

IOL QUALITY IMPROVEMENT: SUMMARY

The IOL quality improvement initiative was launched to address delays affecting service users and to ensure the safety and satisfaction of women, birthing people, and neonates during the induction of labour process. The project also aimed to provide clear communication and accessible information for both patients and staff, while enhancing service user experience and performance related to wait times.

Focus

- Accurate data collection
- Alignment to Southeast Principles for IOL – reporting delays at 6 hours, 12 hours and 24 hours
- Fire break Friday introduced
- Clinic alignment to avoid bottlenecks following high risk clinics
- Continued dynamic daily risk assessment to inform prioritisation and planning
- Review of scheduling
- Improved communication throughout IOL patient pathway – proactive and responsive from MDT

Future

- Consider alternative induction methods, including outpatient options
- Review of service user education throughout the pathway
- Provide education and training for healthcare providers involved in the induction of labour
- Consider midwifery led post-dates clinic

- **Progress monitored and reported through MCGC**

Progress on the Horton CQC and the Antenatal and Newborn Screening Assurance Action Plan

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Horton CQC Action Plan

- There are no overdue 'Must Do' or 'Should Do' actions.
- The Maternity Services, in collaboration with the Trust Assurance Team and Corporate Nursing, have continued to meet monthly as part of the Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan. The group last held a meeting on the 29 September 2025.

Antenatal and Newborn Screening(ANNB) Action Plan

- Quarter 1 key performance indicators were reported to MCGC:
- ST2: There was a slight decrease to 63.8% in timeliness of antenatal screening during quarter 1. There is continued work with the community lead and EDI midwife to identify barriers to early booking and any service needs.
- ST3: completion of FOQ is at 97.8% - monitoring and feedback continues and there were no trends identified.
- NB2: avoidable repeats 3.1%. Data provided by the screening laboratory 0.4% improvement. There is an action plan in progress to reduce the number of avoidable repeats.
- Work continues to embed practice and sustain the improvements from the changes made following the ANNB Assurance visit in April 2024.
- The Trust Assurance Team met with the Maternity team in September to monitor and evaluate the progress of the effectiveness of the action plan. The group last met on the 29 September 2025.
- Progress against the ANNB action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports. It is also discussed at the Antenatal and Newborn Quarterly Board meetings. The quarterly ANNB is planned for October 2025.

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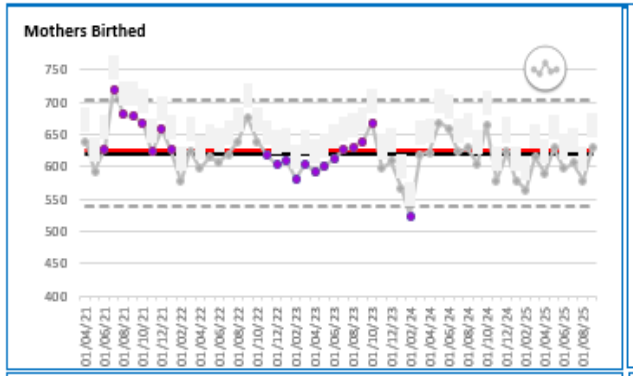
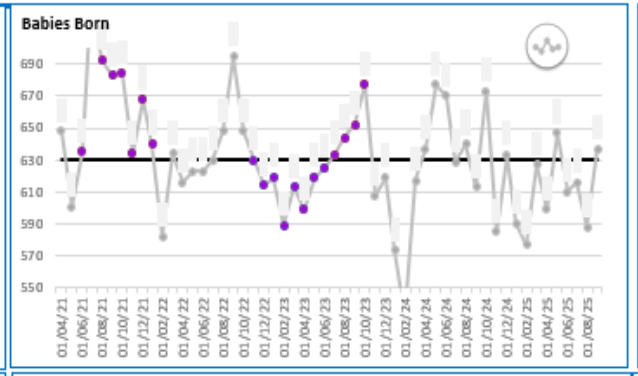
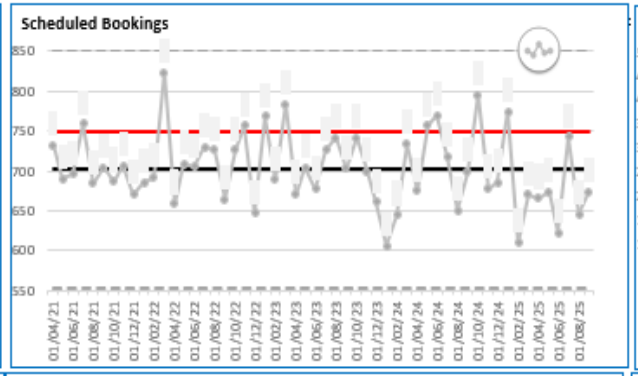
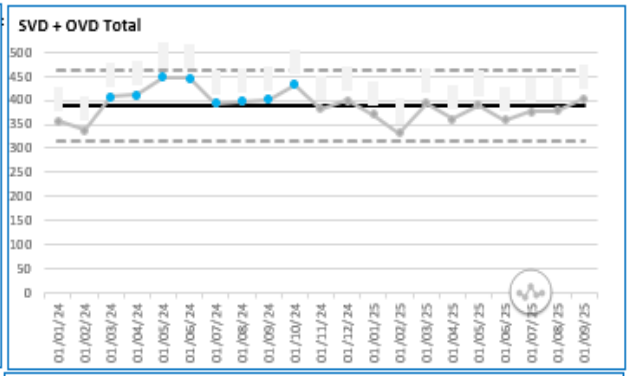
Appendices

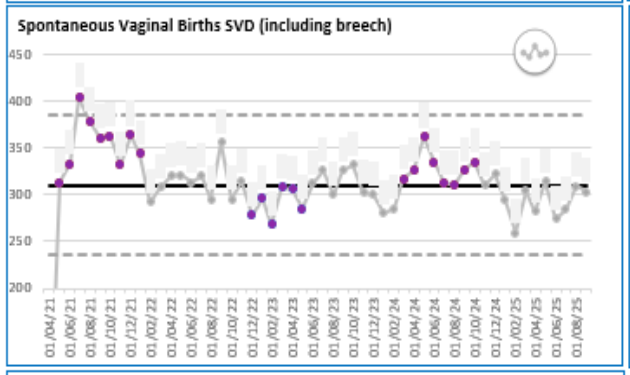
Appendix 1: SPC Charts

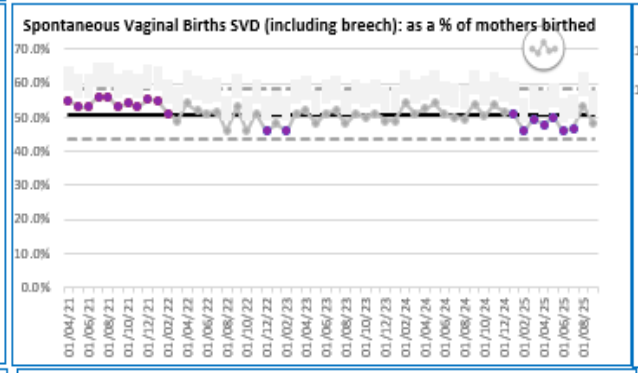


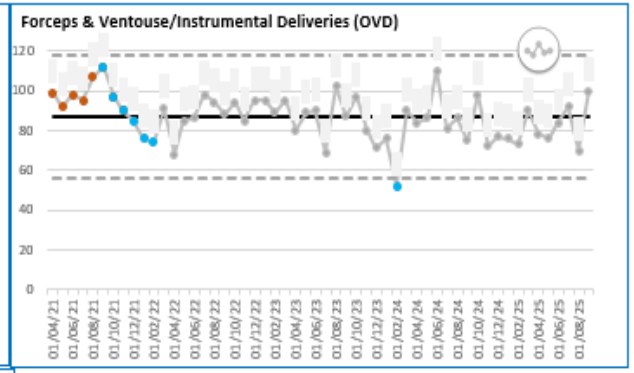


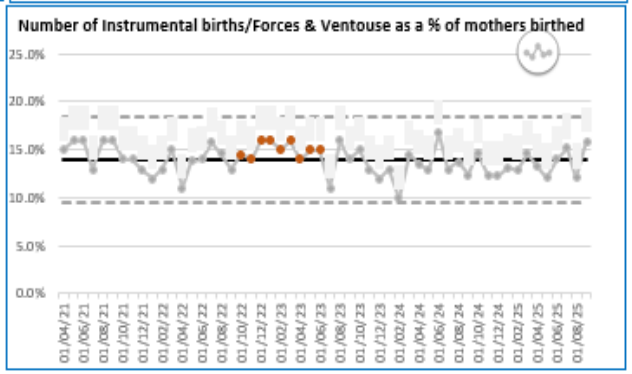


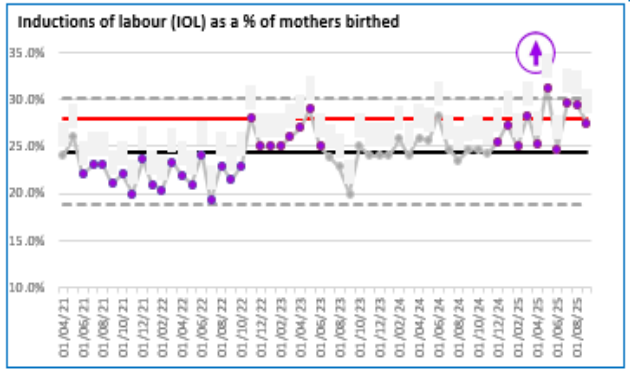


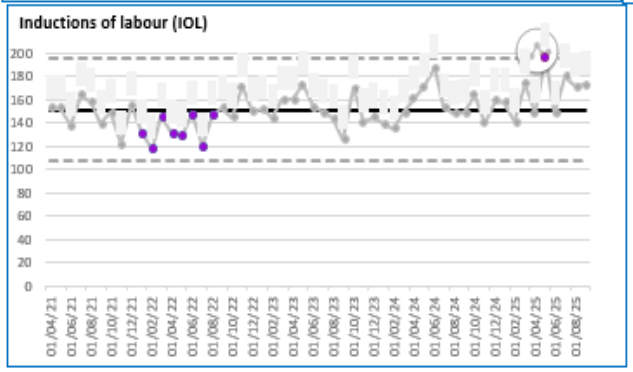


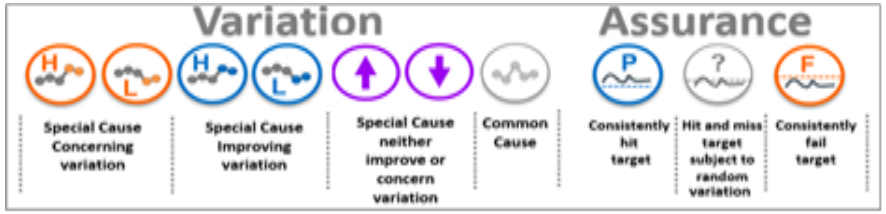




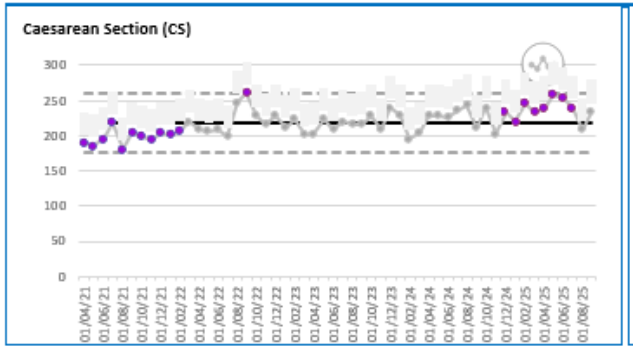


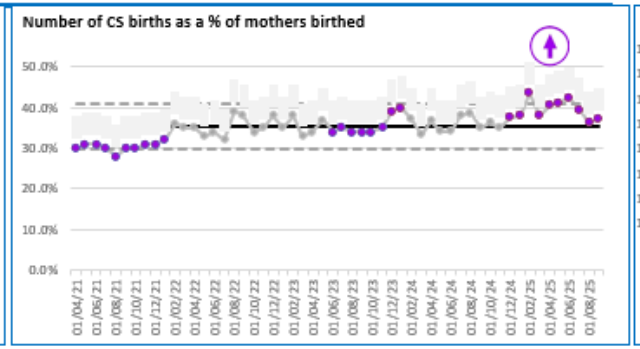


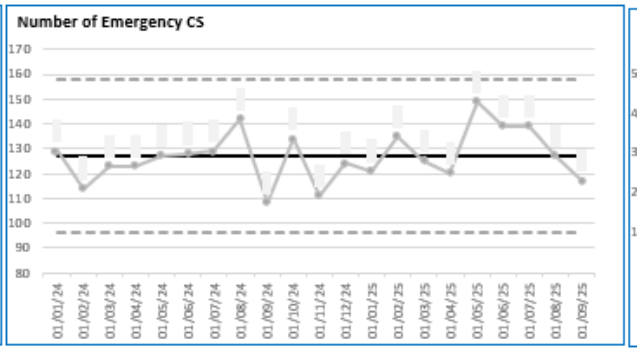


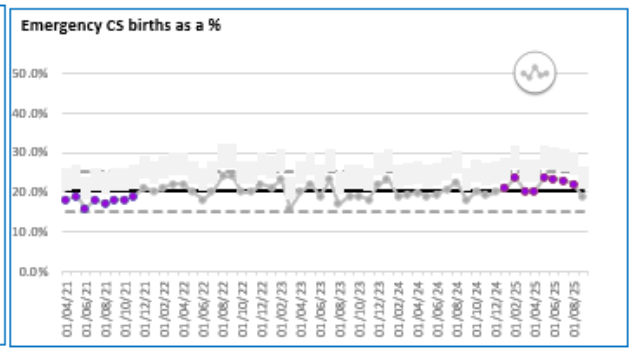


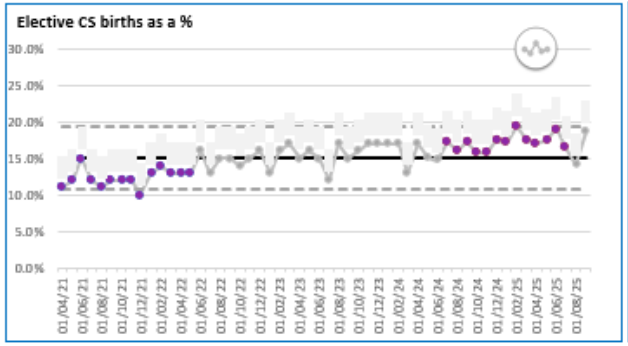
Appendix 1: SPC Charts

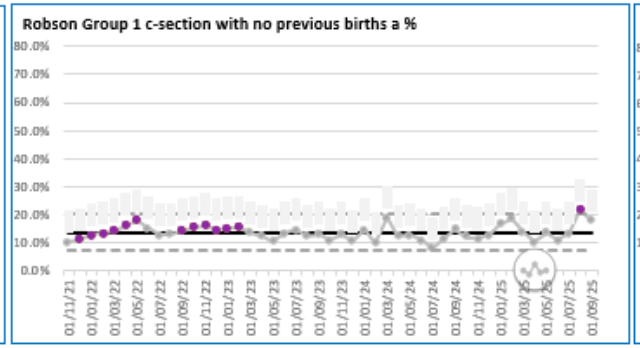


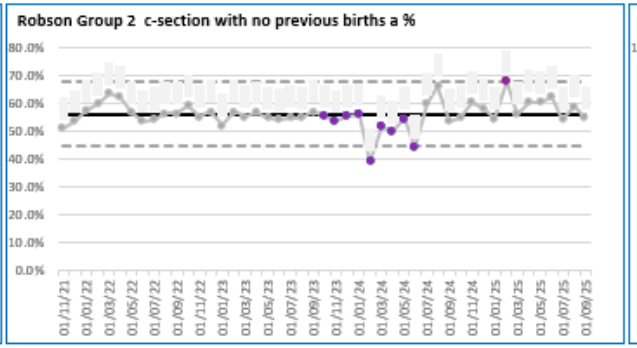


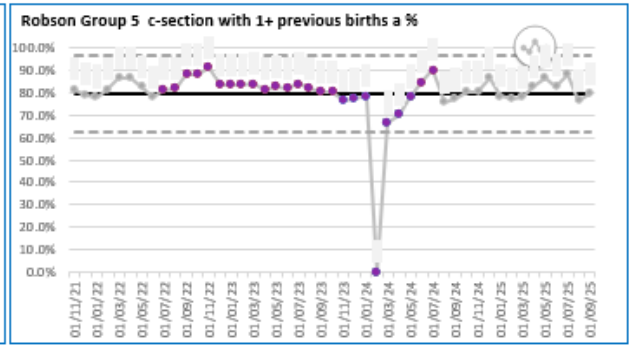


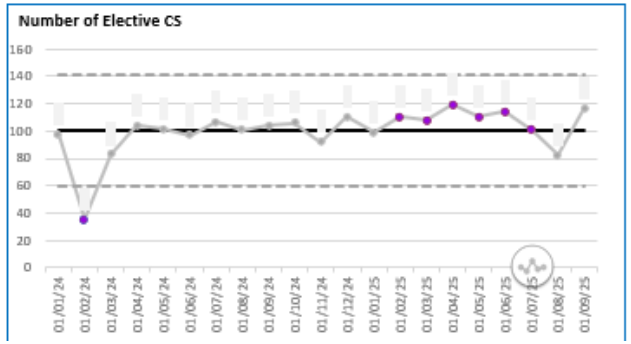


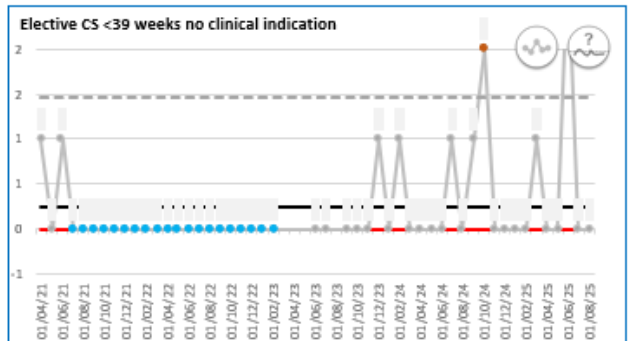


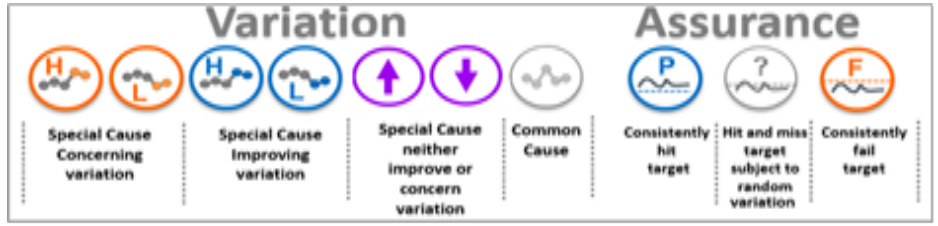












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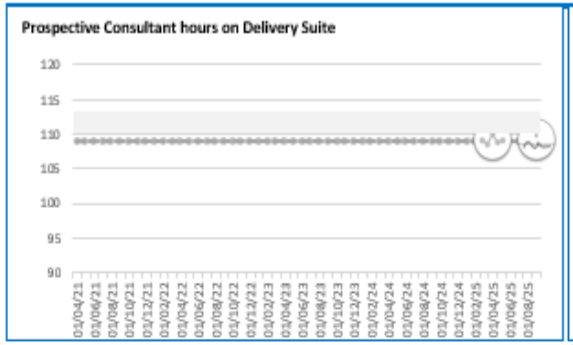
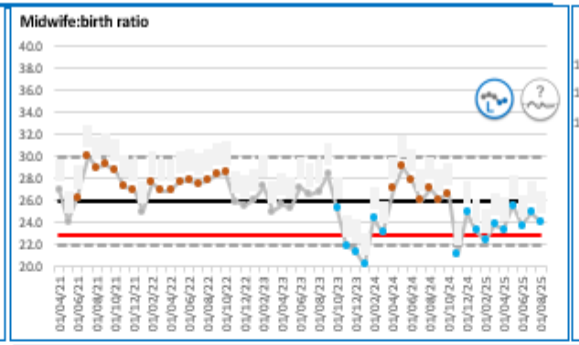
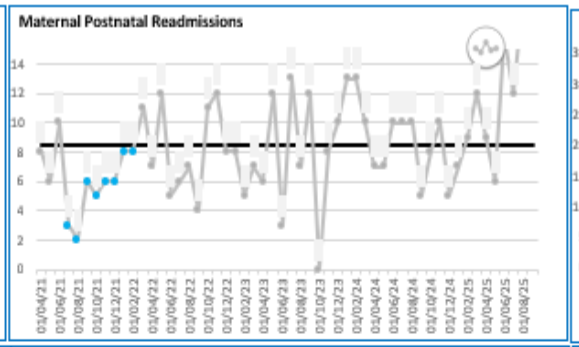
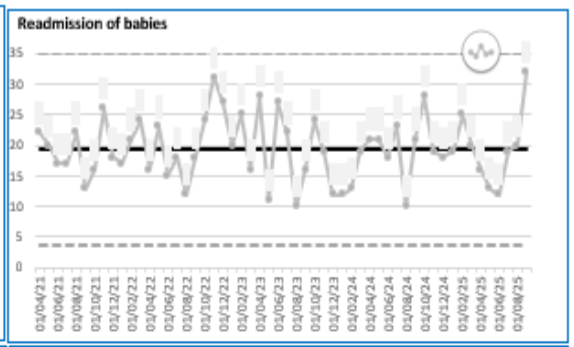
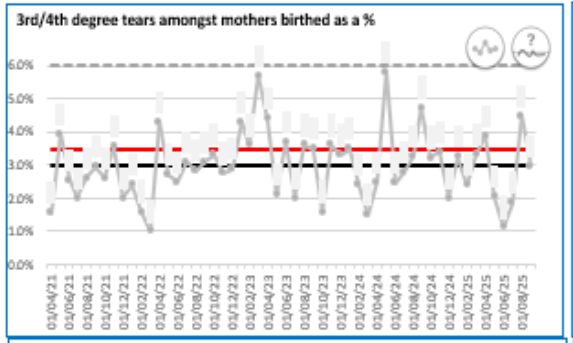
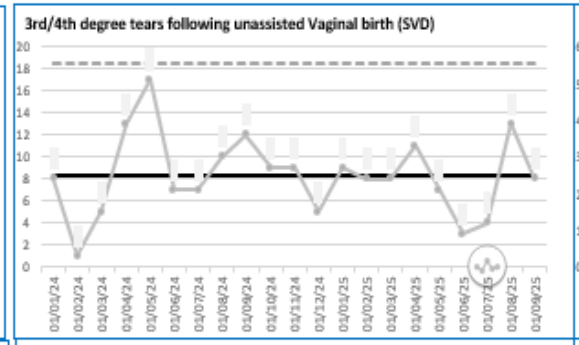


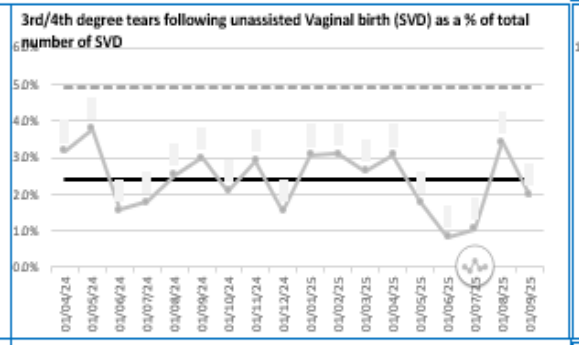


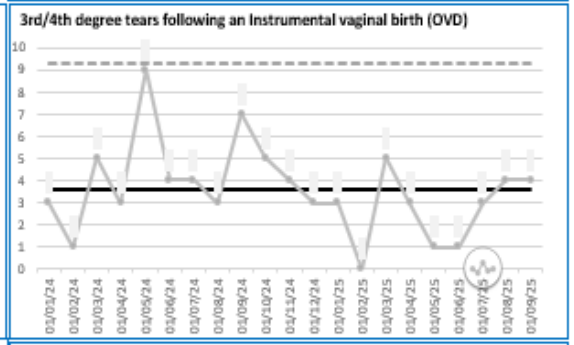


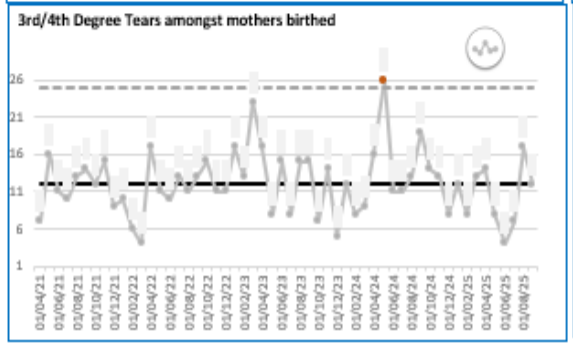


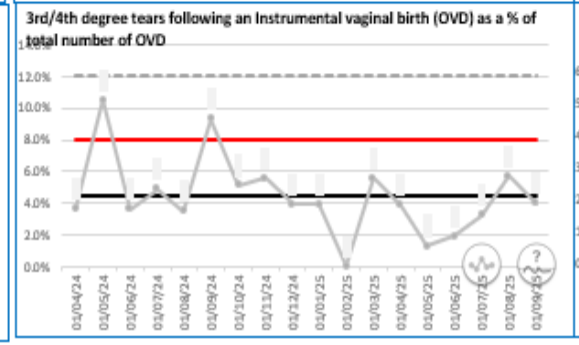


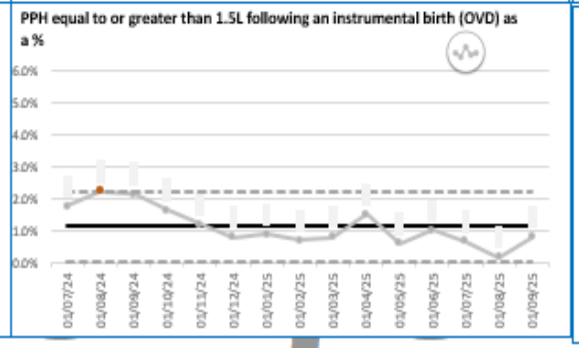


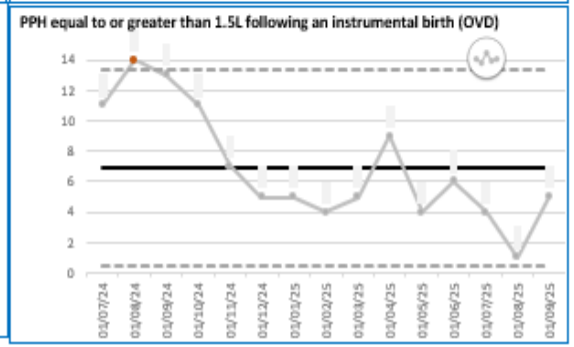






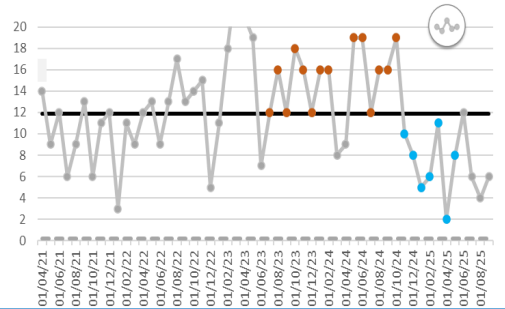




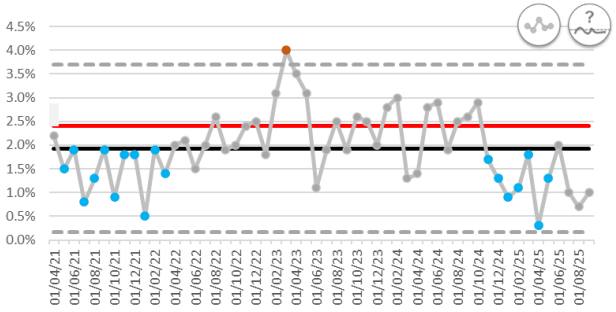


Appendix 1: SPC Charts

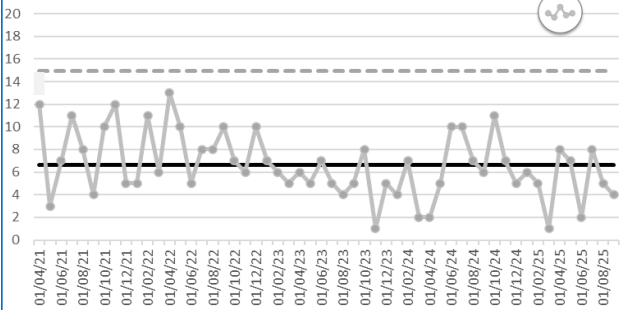
PPH 1.5L or greater, vaginal births (unassisted)



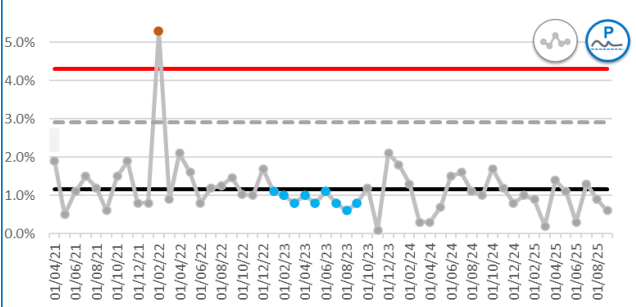
PPH 1.5L or greater, vaginal (unassisted) births as a % of mothers birthed



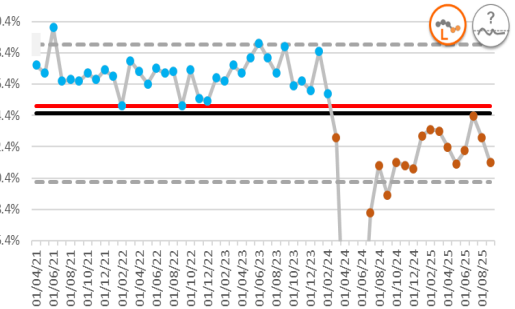
PPH 1.5L or greater, caesarean births



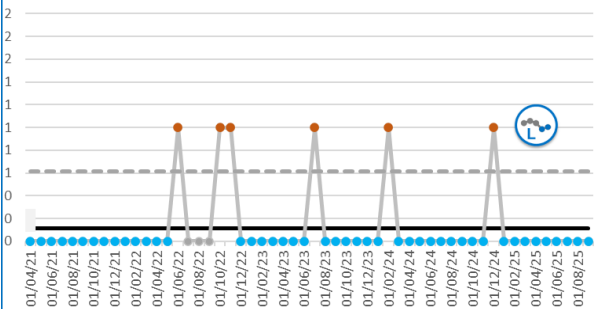
PPH 1.5L or greater, caesarean births as a % of mothers birthed



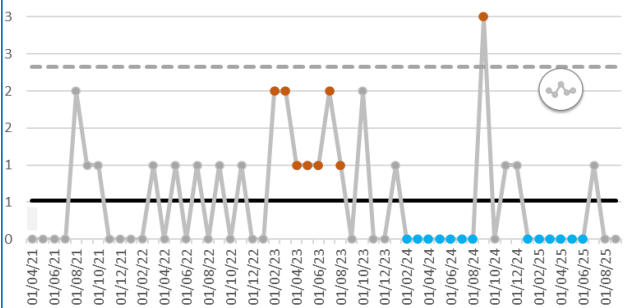
% completed VTE admission



Maternal Deaths: All



ICU/CCU Admissions



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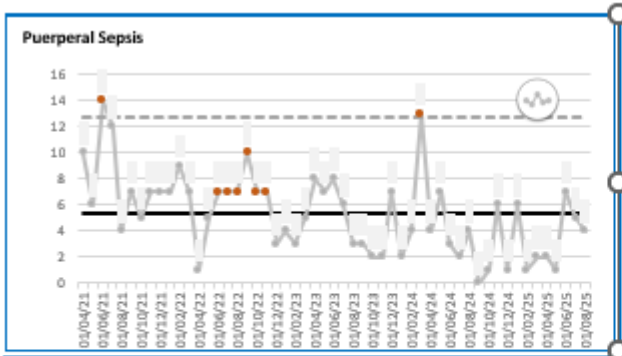
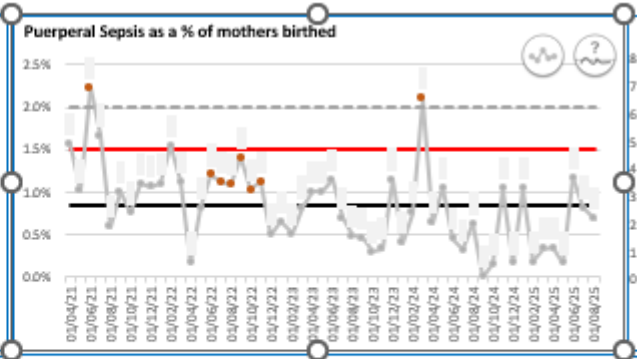
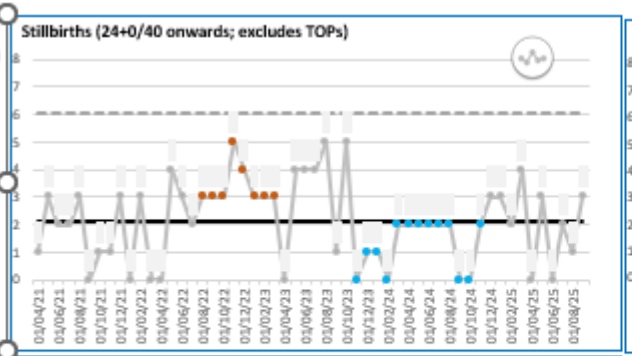
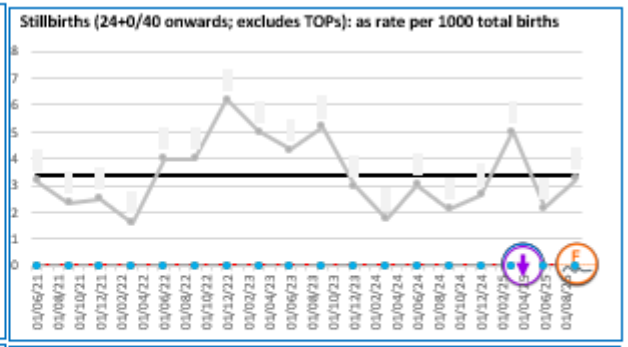
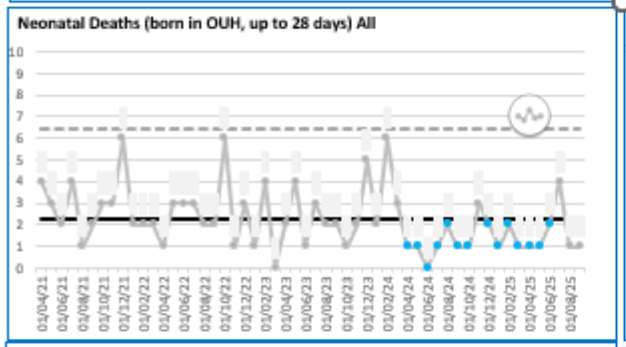
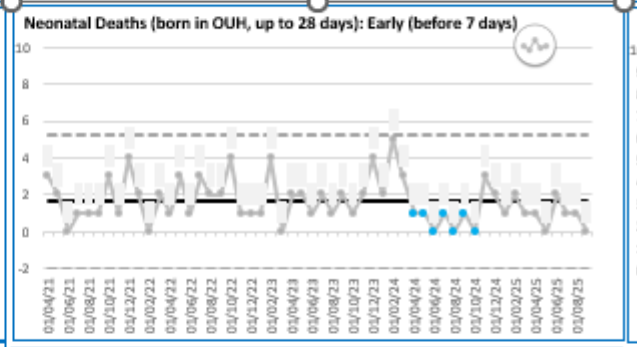


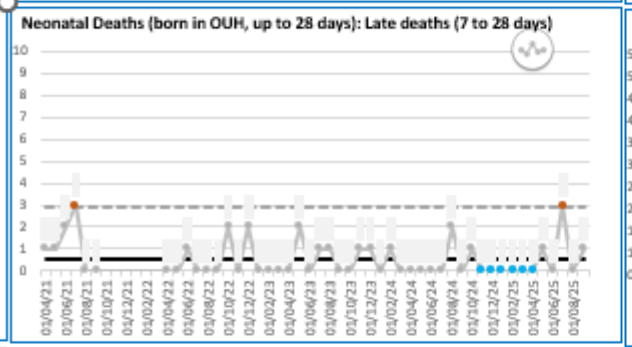


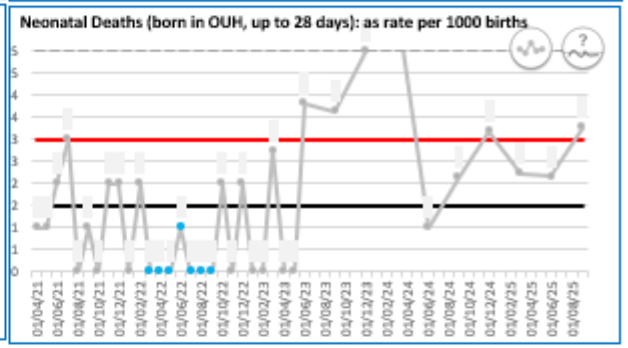


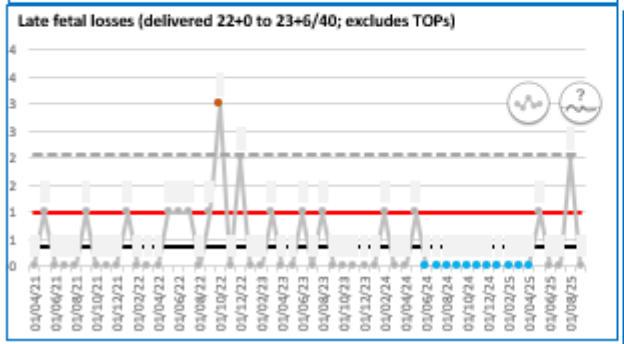


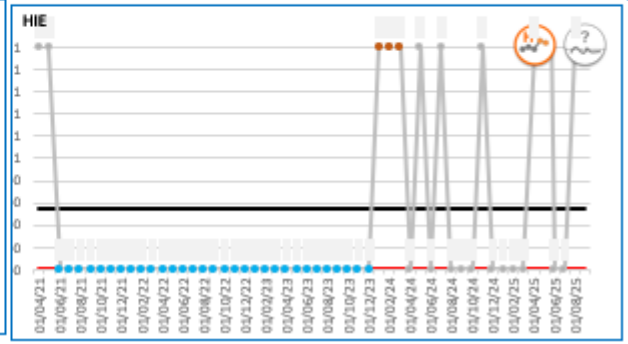




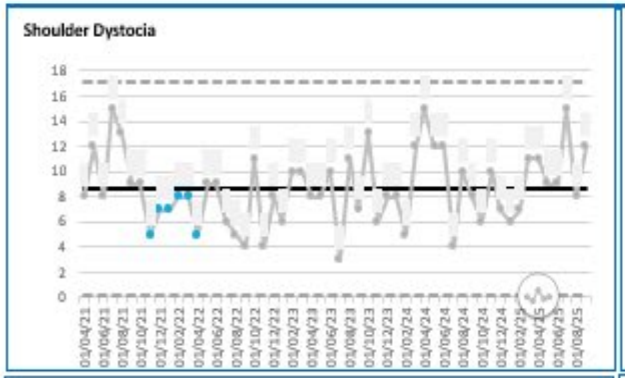


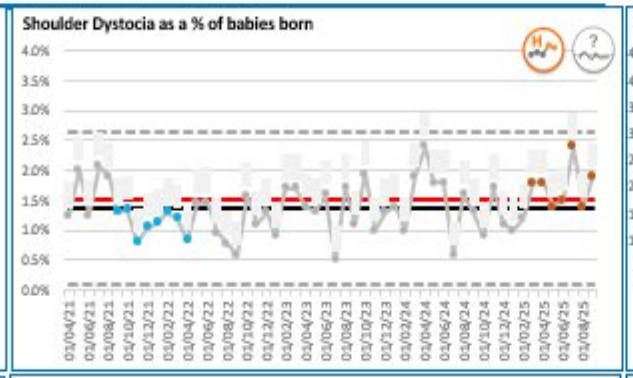


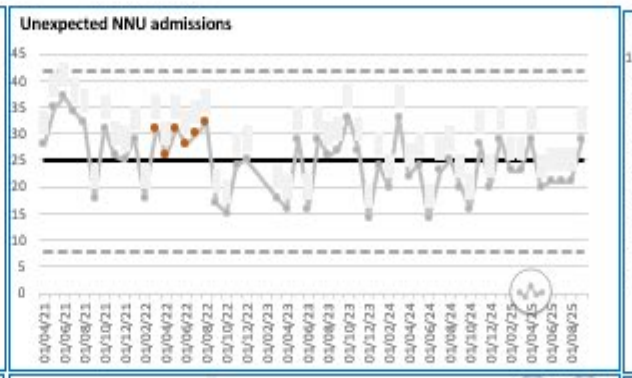


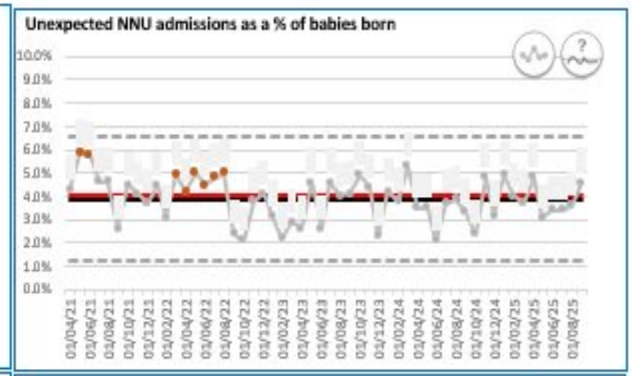


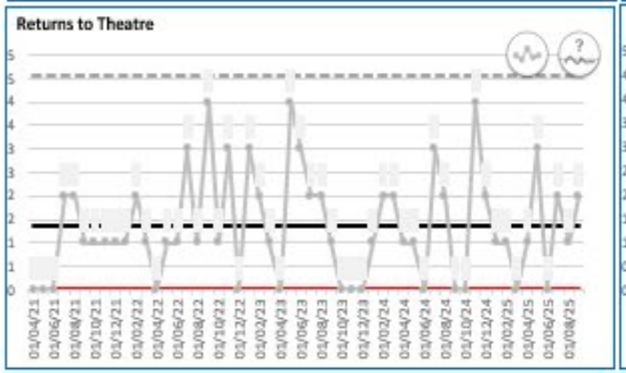
Appendix 1: SPC Charts

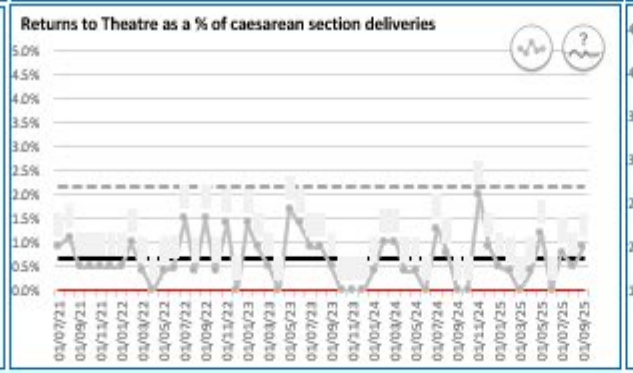


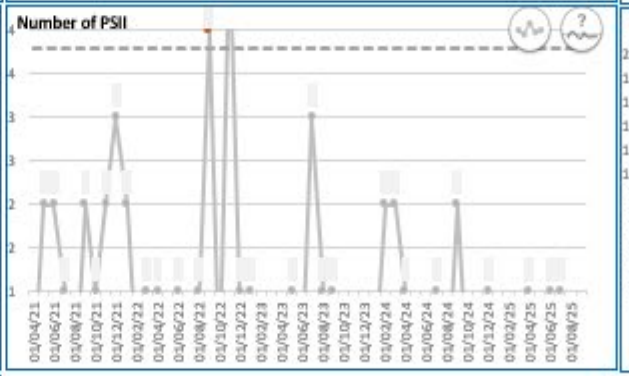


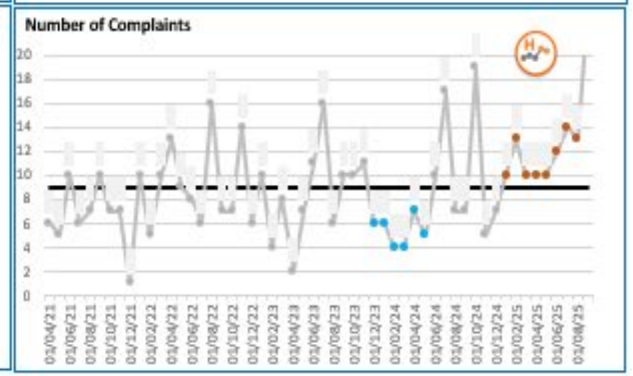


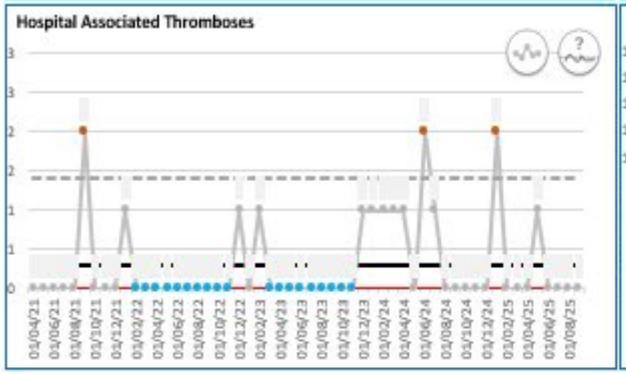


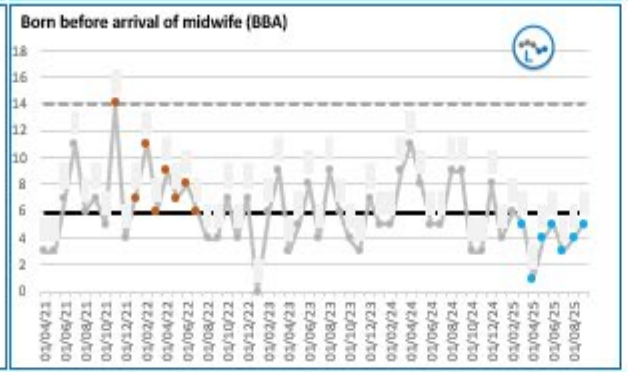




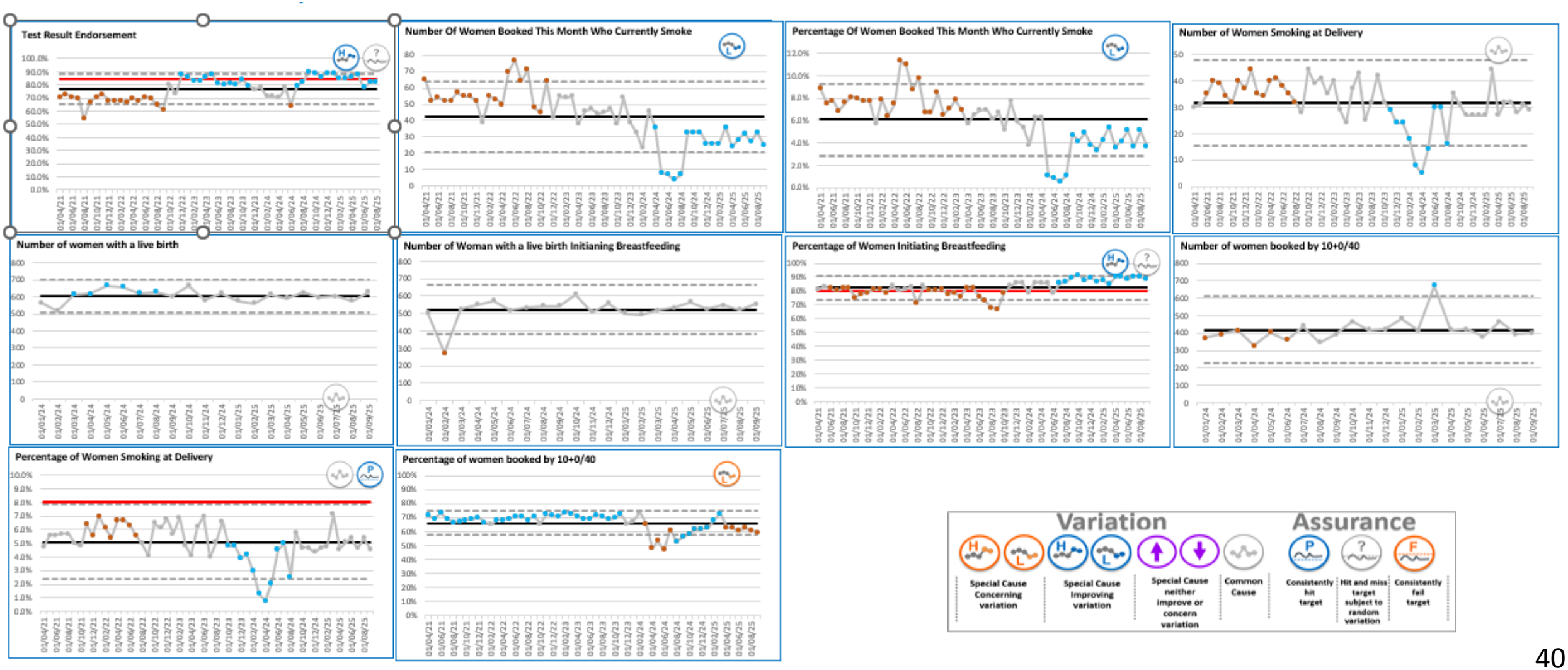








Appendix 1: SPC Charts



Appendix 2: Categories used for grading of care for perinatal mortality reviews (PMR)

- A – The review group concluded that there were no issues with care identified.
- B – The review group identified care issues which they considered would have made no difference to the outcome.
- C – The review group identified care issues which they considered may have made a difference to the outcome.
- D – The review group identified care issues which they considered were likely to have made a difference to the outcome.

Appendix 3: Acronyms

Oxford University Hospitals NHS Foundation Trust

Name	Definition
ATAIN	Avoiding Term Admission into Neonatal Units. National programme to support the reduction of harm leading to an avoidable admission to neonatal unis for babies born at or above 37 weeks.
BFI	Baby Friendly Initiative. This is a global programme launched by UNICEF and WHO to support and promote breastfeeding.
HIE	Hypoxic ischaemic encephalopathy. HIE is a type of brain injury caused by a lack of oxygen to the brain. The severity of injury is graded 1-3 with 1 being mild and 3 being the most severe, included definition of grades.
LMNS	Local Maternity and Neonatal System: The goal of an LMNS is to implement national plans to make care safer, more equitable, and more personalised for women, babies, and families.
MPIS	Maternity (Perinatal) Incentive Scheme: This is a financial incentive scheme designed to enhance maternity safety within NHS Trusts. It supports maternity and perinatal care by driving compliance against ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths and brain injuries.
MNSI	Maternity and Neonatal Safety Investigations: The MNSI programme is part of the national strategy to improve maternity safety across the NHS in England. The programme was established in 2018 as part of the Healthcare Safety Investigation Branch (HSIB) and is now hosted by the Care Quality Commission (CQC).
MCGC	Maternity Clinical Governance Committee
PMRT	Perinatal Mortality Review Tool. This is a national tool which was developed to standardise perinatal mortality reviews across the NHS.
PPH	Post partum haemorrhage: The dashboard captures PPH of 1500mls and above
1:1 Care in Labour	When a woman/birthing person in labour is cared for by a midwife who is not providing care for any other woman (does not have to be the same midwife continuously). One to once care should be provided to all women/birthing people in labour.
SBLCBv3.2	Saving Babies Lives Care Bundle version 3.2
QIP	Quality Improvement Project

Appendix 4: Neonatal Nursing Action Plan

Oxford University Hospitals NHS Foundation Trust

Funding

- 2021 – Neonatal Unit (NNU) had business case approved by the Trust Management Executive (TME). This was a 5-year phased plan to bring nursing staffing on NNU in line with the national BAPM guidance.
- 2023 – NNU received full funding for the business plan for the extra 36.8 wte (whole time equivalent) and therefore meeting the requirements of safety action 4 of the Maternity (Perinatal) Incentive Scheme.
- 2025 - Increase in budget has seen an increase in nursing vacancies. recruited 6 band 5 wte and 6 band 6 wte since April.
- 5 wte band 5 newly qualified nurses due to start in the coming months.

	Additional WTE Budget	Total Budget
2020		161.03
2021	13.7	174.73
2022	7.2	181.93
2023	15.6	197.53
2024	0	197.53
2025	0	197.53

- BAPM states that each unit must work on staffing levels based on ratios within each area of the unit. The table below details how this has improved since the increased budget.

	BAPM Standard		OUH ratios 2021		OUH ratios 2023	
Areas	Nurses	Babies	Nurses	Babies	Nurses	Babies
ICU	1	1	1	2	1	1
HDU	1	2	1	3	1	2
LDU	1	4	1	4	1	4

Neonatal Nurse Education

- BAPM standards also include a requirement that 70% of the neonatal unit's staff have attained a Quality in Specialty (QIS) Course.
- Current compliance is at 51% (n-85) nurses. The service plans to train 11-15 nurses every year and as a result will be compliant with the BAPM standards in 2028.
- The NNU have been working with the Thames Valley and Wessex (TV&N) Neonatal operational delivery network (ODN) who run the QIS course and have introduced a second cohort per year to increase the opportunities for places on the course.

Qualified in Speciality (QIS) Training	Target	2023	2024	2025	2026	2027	2028	2029
Compliance	70%	42%	46%	51%	59%	68%	77%	86%
					Prospective Data			

Action Plan

1. Continue with External adverts for Band 5 and Band 6 nurses – matron and deputy matron.
2. Unit recruitment onboarding programme continues with education team support – recruitment and education lead band 7.
3. Continue to work closely with universities and their students while on placement on the unit.
4. Attending local and national recruitment events – Divisional recruitment and retention lead.
5. Embedding Unit Ethos work to address unit culture and improve wellbeing and retention of current staff – matron, deputy matron and clinical lead.
6. Collaborative working across OUH critical care areas for recruitment strategies, focusing on Band 6 vacancies as this is hard to recruit to - matron, deputy matron.
7. Engaging with teams to explore scope of alternative Band 4 roles in Neonatal unit as well as providing staff with other routes into nursing – matron and deputy matron.
8. Review the two intakes per year Cohort QIS course – Education Lead.

Monitoring and Compliance

This action plan is monitored via the Neonatal Clinical Governance Committee (NCGC). The staffing vacancies and QIS data are reported to the TV&W ODN network quarterly.

Conclusion

Neonatal nursing workforce is compliant with the BAPM standard for nursing recruitment; however, an action plan is in place as detailed above to ensure compliance with qualified in speciality (QIS).