Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Oversight Model Board Report (including Dashboard)

Presented at Maternity Clinical Governance Committee

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Presented by the Perinatal Leadership Team

Date: September 2026

Data period: 01/08/26 - 31/08/26 (August Data)

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Executive Summary

Oxford University Hospitals NHS

Board assurance statement: The Board can be assured that perinatal safety systems are in place and outcome measures remain stable. Partial assurance is provided regarding VTE risk assessment and test result endorsement compliance, where further work is required to demonstrate sustained improvement.

Actions required from Board:

- ☐ Decision / approval
- ☐ Support / escalation
- ☑ Assurance only

Activity

- 592 women birthed 598 babies in August
- 595 maternity bookings received

What is going well:

- No maternal deaths, Never Events or new MNSI referrals; training compliance above 90% for PROMPT, fetal monitoring and NLS; 92.5% positive patient feedback; no care issues identified in PPH or OASI reviews.

Quality & Safety

- 286 maternity incidents reported; 53 moderate harm or above
- 60 neonatal incidents reported; 2 moderate harm or above
- Common harms: PPH, OASI and unexpected term SCBU admissions
- All incidents managed under PSIRF
- OUH received 1 Maternity Outcomes Signal System (MOSS) alert in August, response submitted within agreed timeframe
- There have been no exceptions escalated, or submission of a Ulysses report to highlight any closures of the Butterfly Suite. This means OUH was able to provide bereavement care for all families that have required this service.
- The Maternity and Obstetric team responded promptly to the rise in overdue Ulysses, reducing the backlog from a peak of 98 to 38 cases (61%) between 10 and 26 August 2026.

What is of concern:

- Test result endorsement and VTE compliance remain below target
- Several mandatory training modules remain below 90%. including IPC Level 2, information governance, moving and handling, resuscitation and safeguarding children Level 3.
- Inability to reduce estates related risk due to delay in estates work related processes.

Clinical Outcomes

- 45.3% spontaneous vaginal births
- 15.0% instrumental births
- 39.7% caesarean births
- PPH >1.5L: 4.05%
- Governance review found no harm from induction delays, or delays in triage in Maternity Assessment Unit.

Emerging/continuing risks:

- MAU environment and patient visibility
- Ongoing estates
- Medicines storage risks.

Experience

- 448 feedback responses received in Maternity
- 75% response rate
- 92.5% rated care good or very good
- Positive feedback on staff compassion and professionalism
- 9 complaints were received in Maternity, all relating to care within the last 12 months. No new neonatal complaints were received.

Improving trends and trends that need attention:

- Improving: MAU triage, safeguarding compliance and patient experience. Stable: most SPC indicators and complaints.
- Focus: induction delays >24hrs increased from 8 to 14.

Workforce & Service Delivery

- The midwifery establishment has been aligned to the current approved BirthRate Plus benchmark of 332.45 WTE with an additional 23 WTE uplift for known maternity leave, giving a total establishment of 355.45 WTE.
- Combined all unavailability = -43.38 WTE Inc Maternity leave
- The service is currently progressing through the Birthrate Plus cycle with the business case to support under development.
- There were no incidents where 1:1 care in labour was not provided. There were no incidents where the Delivery Suite Coordinator was not supernumerary.

Key system actions underway:

- Sustain VTE improvement plan and progress estates mitigations, including Level 5 drug room air conditioning and MAU visibility improvements

Executive Summary Performance Overview

Oxford University Hospitals NHS

Not achieving target	Not achieving target	Not achieving target	Summary
Special cause variation - deterioration	**Special cause variation - deterioration**	**Special cause variation - deterioration**	**Special cause variation - deterioration**
• Test Result Endorsement • % completed VTE admission	• IOL 0-6hours • Triage within 15 mins		Discussed further in Maternity Exception Report slides, and Perinatal Improvement Programme slides.
Common cause variation	**Common cause variation**	**Common cause variation**	**Common cause variation**
• Scheduled bookings • Born before arrival of midwife (BBA) • Number of women booked by 10+0/40 • Percentage of women booked by 10+0/40 • Number of PSII • Number of complaints • Mothers birthed • Babies born • Spontaneous vaginal births SVD (including breech) • Forceps and ventouse/instrumental deliveries (OVD) • Forceps and ventouse/instrumental deliveries (OVD): as a percentage • Number of Emergency CS • Emergency CS births as a % • Number of Elective CS • Elective CS births as a % • Number of women with a live birth • Maternal Postnatal Readmissions	• SVD + OVD Total • Robson Group 1 c-section with no previous birth as a % • Robson Group 5 c-section with 1+ previous birth as a % • 3rd/4th degree tears amongst mothers birthed • 3rd/4th degree tears amongst mothers birthed as a % • 3rd/4th degree tears following an instrumental vaginal birth • 3rd/4th degree tears following an instrumental vaginal birth as a % • PPH equal to or greater than 1.5L following an instrumental • PPH equal to or greater than 1.5L following an instrumental as a % • PPH equal to or greater than 1.5L (Rate per 1,000) • PPH 1.5L or greater, vaginal births (unassisted) • PPH 1.5L or greater, vaginal births (unassisted) as a % • PPH 1.5L or greater, caesarean births • Late maternal Deaths: Direct • Late Maternal Deaths: Indirect • IOL Delayed 13-23 hours (Red Flag SS)	• IOL Delayed 07-12 Hours (Red Flag SS) • Stillbirths (24+0/40 onwards; excludes TOPs) • Neonatal deaths (born in OUH, up to 28 days) All • Neonatal deaths (born in OUH, up to 28 days) Early • Neonatal deaths (born in OUH, up to 28 days) Late • Neonatal deaths (born in OUH, up to 28 days) As rate • Puerperal Sepsis • Puerperal Sepsis as a % of mothers birthed • Unexpected NNU admissions • Unexpected NNU admissions as a % of babies born • ICU/CCU Admissions • Elective CS <39 weeks no clinical indication • Shoulder Dystocia • Shoulder Dystocia as a % of babies • Returns to theatre • Returns to theatre as a % of caesarean section deliveries • Number of women with a live birth initiating breastfeeding • Readmission of babies	No missed targets. Continue to be monitored through Governance, overseen by Maternity Clinical Governance Committee.
Special cause variation - improving	**Special cause variation - improving**	**Special cause variation - improving**	**Special cause variation - improving**
• Hospital Associated Thrombosis • Midwife: birth ratio • 3rd/4th degree tears following unassisted vaginal birth • 3rd/4th degree tears following unassisted vaginal birth as a percentage • HIE	• Maternal Deaths: All • Early Maternal Deaths: Direct • Early Maternal Deaths: Indirect • Late fetal losses (delivered 22+0 to 23+6/40; excludes TOPs) • MAU Data Accuracy • IOL Delayed >24 hours (Red Flag SS)	• Percentage of women initiating breastfeeding • Number of Women Booked This Month Who Currently Smoke • Percentage of Women Booked This Month Who Currently Smoke • Number of Women Smoking at Delivery • Percentage of Women Smoking at Delivery	
Other*	**Other***	**Other***	
• Inductions of labour (IOL) • Inductions of Labour (IOL) as a % of mothers birthed • Spontaneous vaginal births SVD (including breech)	• Robson Group 2 c-section with no previous birth as a % • MAU attendances • Caesarean Section (CS) • Number of CS births as a % of mothers birthed	• PPH equal to or greater, caesarean births as a % • Percentage of Women Smoking at Delivery	
*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*	*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*	*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*	

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Oxford University Hospitals NHS Foundation Trust

Maternity Summary
August 2026

NHS
Oxford University Hospitals
NHS Foundation Trust

=2.2%
Blood Loss >1500mls for CS

3rd & 4th (SVD+OVD births only) degree tears
↓0.8%

↓ 17 (2.87 %)
Freestanding MLU*

Horton 6
Chipping Norton 5
Wantage 3
Wallingford 3

Excellence Reports

↓13

↑14(previous 8)
Induction of Labour (IOL)delayed >24hrs

↑ 64.7%
(previous 59.76%)
Initial 15 min Triage in MAU

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

↑ Unplanned Term Admissions to NNU
22 (3.7%)
≥ 37 weeks

↓ 543 Delivery Suite

24 ↓(4.05%) Spires

598 Babies Born To 592 Women

↓5.53%

Friends & Family Test and Say on the Day:
↑92.5%
Very Good / Good feedback Providing
↑75% response rate

100%
1:1 Care in Labour

↓ 39.7%
Caesarean Sections 235 (CS)
Elective CS –107 (18.1%)
Emergency CS –128 (21.6%)

↓595 Scheduled Bookings

New Complaints
= 9

↑31.8 %
Inductions of Labour

↓ 8 (1.35%)
Home Births

↓89.95 %
Breastfeeding Initiation

*MLU – Midwifery Led Unit

Neonatal Summary
August 2026

Oxford University Hospitals
NHS Foundation Trust

Milk Bank

161.6L Breast Milk Pasteurised

25 L Sold / £4.5 Profit

15 Donors Recruited

31 Preterm Admissions (48%)

< 27 weeks – **4** (13%)

27–36 weeks – 27 (87%)

2

17 Excellence Reports

33 Term Admissions

(52%)

≥ 37 weeks

100% Born in the right place*

64 Admissions

August 2026

FFT – 0 responses
(technical issue)
Say on The Day
100% positive

SONeT
SOUTHAMPTON OXFORD NEONATAL TRANSPORT

35 Total Transfers

12 Emergency Uplifts

23 Non-Urgent

1,125 Care Days

Nursing Recruitment

1 Starter
1 Leaver

Outreach Team

84 Home Visits

33 Babies Seen

4 Deaths

24+6/40 IVH +Pulmonary Haemorrhage

32+4/40 NEC

37/40 Congenital Diaphragmatic hernia

25+2/40 Pulmonary Haemorrhage

0 Complaints

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

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Recent Successes:

Fetal Growth Surveillance:

In August, the service successfully implemented a revised fetal growth scan pathway in line with NHS England's *Saving Babies' Lives Care Bundle*. The new pathway went live on 10 August and was delivered through strong multidisciplinary collaboration across fetal medicine, obstetrics and operational teams, supporting improved and standardised surveillance of fetal growth in pregnancy aligning local practice with the national pathway and supports the earlier identification and management of babies at risk of growth restriction.

The Trust have also commissioned an independent review of the fetal growth scanning pathway to provide additional assurance regarding compliance with national guidance and best practice.

Neonatal Excellence:

During August, the Oxford Newborn Care Unit was rated 'Outstanding' in six of the eight domains assessed by the National Neonatal Audit Programme (NNAP). This reflects consistently high standards of care for newborn infants and families, strong compliance with national quality standards, and effective collaboration across neonatal and maternity services. The result provides external assurance on the quality and safety of OUH neonatal care and demonstrates continued progress in outcomes for some of the Trust's most vulnerable patients.

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Perinatal Quality Exception Report and Risk Registers

Indicator Overview Summary – Maternity SPC Dashboard

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Inductions of labour (IOL)	Aug 26	188	-			156	112	199
Inductions of labour (IOL) as a % of mothers birthed	Aug 26	31.8%	-			25.4%	19.8%	31.0%
Scheduled Bookings	Aug 26	595	625			693	544	843
Born before arrival of midwife (BBA)	Aug 26	6	-			6	-1	13
Number of women booked by 10+0/40	Aug 26	398	-			428	252	603
Percentage of women booked by 10+0/40	Aug 26	67%	-			66%	55%	76%
Test Result Endorsement	Jul 26	66.8%	85.0%			78.2%	66.7%	89.7%
Number of PSII	Aug 26	0	0			0	0	0
Number of Complaints	Aug 26	9	-			11	0	22
Hospital Associated Thromboses	Aug 26	0	0			0	-1	1
Mothers Birthed	Aug 26	592	625			612	531	692
Babies Born	Aug 26	598	-			622	539	704
Spontaneous Vaginal Births SVD (including breech)	Aug 26	268	-			303	244	361
Spontaneous Vaginal Births SVD (including breech): as a	Aug 26	45.3%	-			49.5%	42.2%	56.7%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Aug 26	89	-			83	50	117
Number of Instrumental births/Forces & Ventouse as a	Aug 26	15.0%	-			13.6%	9.0%	18.3%
Caesarean Section (CS)	Aug 26	235	-			230	187	273
Number of CS births as a % of mothers birthed	Aug 26	39.7%	-			37.6%	31.7%	43.4%
Number of Emergency CS	Aug 26	128	-			132	96	168
Emergency CS births as a %	Aug 26	21.6%	-			21.2%	15.3%	27.1%
Number of Elective CS	Aug 26	107	-			103	63	144
Elective CS births as a %	Aug 26	18.1%	-			16.4%	11.7%	21.0%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SVD + OVD Total	Aug 26	357	-			379	305	453
Robson Group 1 c-section with no previous births a %	Aug 26	16.2%	-			14.3%	7.3%	21.4%
Robson Group 2 c-section with no previous births a %	Aug 26	63.7%	-			57.5%	46.0%	68.9%
Robson Group 5 c-section with 1+ previous births a %	Aug 26	82.7%	-			80.4%	62.4%	98.4%
Midwife:birth ratio	Aug 26	22.8	22.9			25.1	21.0	29.2
3rd/4th Degree Tears amongst mothers birthed	Aug 26	3	-			12	0	24
3rd/4th degree tears amongst mothers birthed as a %	Aug 26	0.8%	3.5%			3.0%	0.1%	6.0%
3rd/4th degree tears following unassisted Vaginal birth	Aug 26	2	-			8	-1	17
3rd/4th degree tears following unassisted Vaginal birth	Aug 26	0.6%	-			2.2%	0.0%	4.5%
3rd/4th degree tears following an Instrumental vaginal	Aug 26	1	-			3	-2	9
3rd/4th degree tears following an Instrumental vaginal	Aug 26	1.1%	8.0%			4.1%	-3.2%	11.3%
HIE	Aug 26	0	0			0	-1	1

What is the data telling us?

Exception Reporting highlighted for:
Test result endorsement - Summary and Actions Slide 11

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

Indicator Overview Summary – Maternity SPC Dashboard

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH equal to or greater than 1.5L following an instrume	Aug 26	6	-			6	0	13
PPH equal to or greater than 1.5L following an instrume	Aug 26	1.0%	-			1.1%	0.0%	2.2%
PPH equal to or greater than 1.5L (Rate per 1,000)	Aug 26	40.5%	-			35.9%	18.3%	53.6%
PPH 1.5L or greater, vaginal births (unassisted)	Aug 26	5	-			11	1	22
PPH 1.5L or greater, vaginal (unassisted) births as a % of	Aug 26	0.8%	2.4%			1.8%	0.3%	3.4%
PPH 1.5L or greater, caesarean births	Aug 26	13	-			7	-1	14
PPH 1.5L or greater, caesarean births as a % of mothers b	Aug 26	2.2%	4.3%			1.2%	-0.1%	2.5%
Maternal Deaths: All	Aug 26	0	-			0	0	1
Early Maternal Deaths: Direct	Aug 26	0	-			0	0	0
Early Maternal Deaths: Indirect	Aug 26	0	-			0	0	0
Late Maternal Deaths: Direct	Aug 26	0	-			0	0	0
Late Maternal Deaths: Indirect	Aug 26	0	-			0	0	0
Stillbirths (24+0/40 onwards; excludes TOPs)	Aug 26	2	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Jun 26	2	0			4	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Aug 26	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Aug 26	3	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Aug 26	2	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Aug 26	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Jun 26	3	3			2	-2	6
Puerperal Sepsis	Aug 26	1	0			4	-2	10
Puerperal Sepsis as a % of mothers birthed	Aug 26	0.2%	1.5%			0.7%	-0.4%	1.7%
Unexpected NNU admissions	Aug 26	22	-			24	7	41
Unexpected NNU admissions as a % of babies born	Aug 26	3.7%	4.0%			3.3%	0.8%	5.8%
ICU/CCU Admissions	Aug 26	0	-			1	-1	3

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Elective CS <39 weeks no clinical indication	Aug 26	0	0			0	-1	2
Shoulder Dystocia	Aug 26	12	-			9	-1	18
Shoulder Dystocia as a % of babies born	Aug 26	2.0%	-			1.4%	0.0%	2.9%
Returns to Theatre	Aug 26	0	0			1	-2	5
Returns to Theatre as a % of caesarean section deliverie	Aug 26	0.0%	0.0%			0.6%	-1.0%	2.3%
Number of women with a live birth	Aug 26	587	-			604	507	701
IOL 0-6hours	Aug 26	57	-			49	28	70
IOL Delayed >24 hours (Red Flag SS)	Aug 26	14	-			28	-16	71
IOL Delayed 13-23 hours (Red Flag SS)	Aug 26	19	-			20	4	36
IOL Delayed 07-12 hours (Red Flag SS)	Aug 26	27	-			18	4	32
Triage within 15 mins	Aug 26	64.7%	-			47.8%	37.1%	58.5%
MAU Attendances	Aug 26	1661	-			1355	1085	1626
MAU Data Accuracy (%)	Aug 26	97.3%	-			90.3%	84.6%	96.0%
Maternal Postnatal Readmissions	Aug 26	23	-			19	1	37
Readmission of babies	Aug 26	38	-			25	-3	53
% completed VTE admission	Aug 26	88.7%	95.0%			91.6%	86.4%	96.7%
Number of Woman with a live birth Initianing Breastfee	Aug 26	528	-			532	400	663
Percentage of Women Initiating Breastfeeding	Aug 26	90%	80%			85%	76%	93%
Number Of Women Booked This Month Who Currently S	Aug 26	28	-			40	17	63
Percentage Of Women Booked This Month Who Current	Aug 26	4.7%	-			5.8%	2.4%	9.1%
Number of Women Smoking at Delivery	Aug 26	13	-			28	10	45
Percentage of Women Smoking at Delivery	Aug 26	2.2%	8.0%			4.5%	1.6%	7.5%

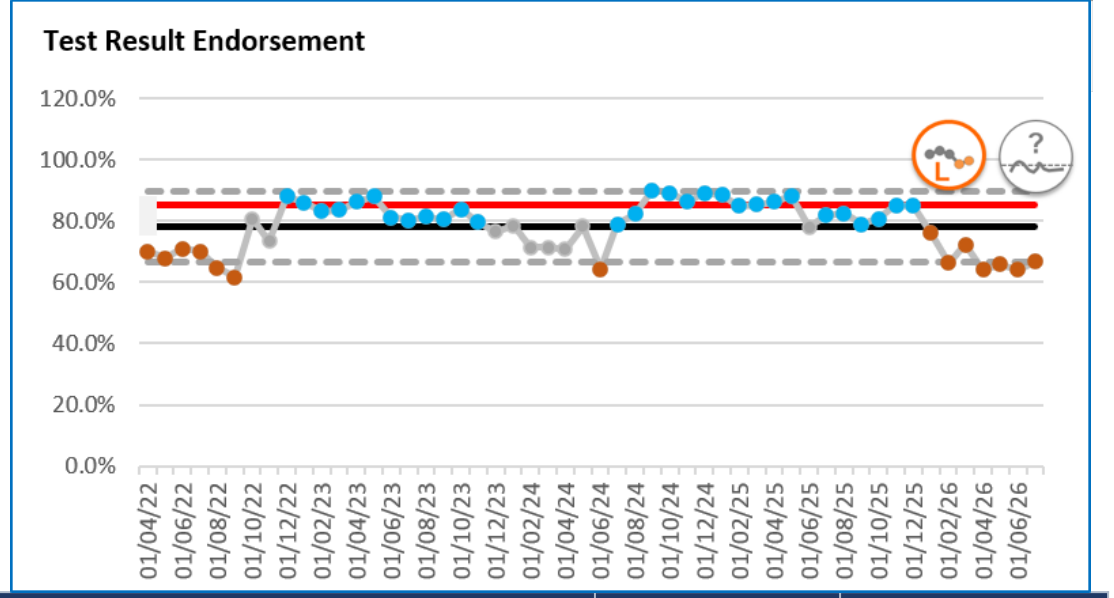
What is the data telling us?

IOL 0-6hours – Incorporated into Slide 34
Triage within 15 mins – Incorporated into Slide 32
% of completed **VTE assessments**. Summary and Actions Slide 12

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

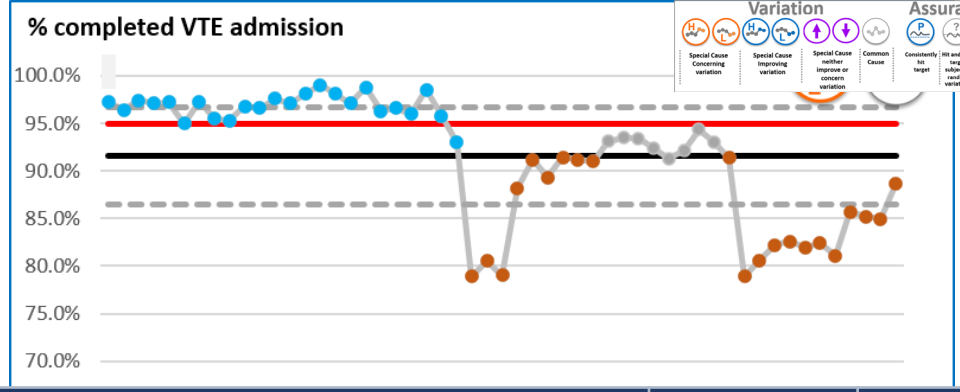
Maternity Exception Report - Test Result Endorsement

(note data is retrospective for this KPI, therefore latest figure is July)



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
Test Result Endorsement compliance remains below the Trust target of 85% as at 66.8% in July (retrospective data). Confidence in the reported data has improved following validation activity; however, further assurance is required to fully understand the causes of variation and support sustained improvement.	Key control measures include: •Completion of the data validation exercise. •Joint review with Digital and Information teams to identify key contributors to non-compliance. •Continued review of Test Result Endorsement performance through the Maternity Governance Committee. **•Identification of an Obstetric Clinical Lead has been escalated to the Medical Clinical Director, who is reviewing consultant job planning to establish sustainable clinical leadership for this programme. A detailed improvement plan will be finalised once leadership arrangements are confirmed.**	•SOP revision, re-issue and training video completed – **May 2026** ✓ •Data quality validation exercise – **June 2026** ✓ (ahead of schedule) •Identify lead obstetric consultant – **August 2026 – remains pending escalated to Clinical Director, dependent on Medical Clinical Director job planning review.** **•Following confirmation of clinical leadership, a detailed improvement plan with agreed milestones and performance trajectory will be developed and presented through the Governance structure.** **•Progress will continue to be monitored through the Maternity Governance Committee, with ongoing escalation to the Medical Clinical Director until clinical leadership is in place**	Draft risk for consideration at Maternity Risk Committee 11/09/26	Satisfactory – subject to greater review once obstetric lead identified

Maternity Exception Report - %VTE Risk Assessment Completed



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
1. August compliance improved to 88% (up from 85% in July) but remains below the Trust target of 95% within 14 hours of admission **2. Review of missed assessments identified no actual patient harm**. However, missed VTE assessments present a potential risk of delayed thromboprophylaxis and preventable VTE events where risk factors are not identified and acted upon promptly. 3. Key themes identified: • Staff uncertainty regarding the ongoing purpose of VTE assessment following changes to TED stocking guidance. • Transfer of women between clinical areas creating ambiguity regarding responsibility for assessment completion. • Missed assessments following obstetric review where medical ownership and accountability were unclear. • Inconsistent understanding that a VTE assessment remains mandatory regardless of whether thromboprophylaxis is ultimately prescribed. 4. Current safety-netting processes are predominantly midwifery-led. Greater obstetric leadership and accountability are required as medical staff are responsible for prescribing prophylaxis.	**Actions** 1) Continued inclusion of VTE assessment in ward safety rounds and prospective audits. 2) Targeted communication reinforcing that VTE assessment is required irrespective of expected prophylaxis prescribing. 3) Escalation to Obstetric Leadership regarding accountability for VTE assessment completion and prescribing decisions. 4) Weekly dissemination of compliance reports and thematic learning to ward managers. 5) Request for change with Pharmacy Informatics for implementation. Escalated to DCMO due to delay. Requested increased score on risk register 6) Fortnightly compliance reports continue to be reviewed at ward, governance and leadership meetings.	**Evidence of improvement** Weekly patient-level reviews are now undertaken by ward managers and the Midwifery Leadership Team to identify missed assessments and ensure women are reviewed retrospectively where required. This process has strengthened assurance by enabling rapid identification of non-compliance, review of prescribing requirements and capture of learning. Compliance has improved from 85% to 88%, although sustained improvement is not yet demonstrated and performance remains below trajectory. **Remaining assurance gap** A formal midwifery fail-safe process is in place; however, no equivalent obstetric review mechanism currently exists. Agreement of an obstetric-led assurance process is required to provide shared accountability for assessment completion and prophylaxis prescribing. **Monitoring** Weekly review against trajectory. Monthly review through Maternity Clinical Governance Committee. Themes and learning monitored through governance meetings, safety huddles and leadership forums.	Moderate Risk due to be reviewed at September risk committee and risk increase proposed.	Satisfactory

Maternity Risk Register- August 2026 (risk scoring 15 or greater prior to control)

Oxford University Hospitals NHS
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Title	Opened	Description	Initial	Current	Target	Key Progress Notes
Replacement and maintenance of cylinders and regulators for Medical Gases (3376)	11/03/26	Non-compliance with the safe storage and regulation of medical gases has been identified, linked to the trust-wide replacement of cylinders and regulators following return from the maternity unit. Local replacement alone has not provided a sustainable solution.	16	16	4	This risk has been escalated to estates and the central medical gases team to agree a trust-wide, standardised and compliant solution. Immediate risks to safety have been minimised through appropriate local mitigations as reported through Governance previously. A Trust wide response is required to mitigate this risk in its entirety and for the long term, hence why initial and current risk scores remain the same. **Target dates therefore sit with Chief Pharmacist and overseen by the Medical Gases Committee and is outside the control of Maternity Services**. Risk will continue to be reviewed on the Committee action log.
Maternity Estates Risks (2221)	26/03/26 (amalgamation of estates risks)	Overarching risk reflecting ageing and insufficient estate across Women's centre. This includes: •Insufficient recovery area for post-operative patients and subsequent impact on patient flow, •Recurring flooding and persistent drainage problems within the building – potential impact on operational efficiency, •The absence of individual bathrooms in the Delivery Suite raises issues regarding patient privacy and dignity	20	16	8	Actions include need for continuous efforts to identify sources of funding needed to improve future improvements, and collaboration with estates, to ensure systems are actively monitored. Completion of improvements to date (such as Entonox project in DS completed summer 2025) are reflected within this risk . The risk also includes updates on ongoing work within Women's centre: - Wider ventilation project in the Women's centre- started in August 2026, with work in Delivery Suite currently scheduled between December 2026 and February 2027 - Fire Safety Survey- completed June 2026. Report shared with the Trust at the start of July 2026, with recommendations currently being transferred into a detailed works plan.
Level 5 Maternity drug room temperature 3020	14/07/25	Lack of air conditioning leads to frequent breaches of cold chain policy with drug fridges breaching temperature which leads to medicine wastage. This has an impact on the safe storage and effectiveness of medicines.	15	15	5	Contractors have started works in August to begin air conditioning installation. Drug room and fridge temperatures continue to be monitored as per policy and breaches reported. Pharmacist has oversight of the breaches and actions undertaken. No change to risk grading as mitigations currently not in place sufficiently enough, however with the estates plans this is on track. **Asbestos work completed August. Installation of air conditioning planned for September, Directorate Manager overseeing.**
Impact of increased demand for Elective Caesarean birth on emergency pathways (2426)	22/12/25	The rising demand for elective caesarean section (CS) births is placing significant strain on the capacity for urgent procedures. To manage this increased volume, elective cases are frequently moved to the emergency theatre, which disrupts staff allocation and resource management	20	15	5	Recognising these challenges, the Service has evaluated current data collection methods and as of 11/06/2026 implemented changes to the EPR system to improve data accuracy. With EPR solution now in place, allowing to capture categories of any sections going through theatres, request has been placed for data from 11/06 up to end of July, to allow the initial assessment. This data will be reported in September's Risk Committee 11/9/26.

Neonatal Risk Register- August 2026 (risk scoring 15 or greater prior to control)

Oxford University Hospitals NHS Foundation Trust

No	Title	Description	Initial	Current	Target	Key Progress Notes
618	Incomplete Transition to Electronic Patient Record (EPR) System in the Neonatal Unit	The Neonatal Unit remains one of the few areas within the Trust that has not migrated to a full Electronic Patient Record (EPR). While Maternity Services use BadgerNet EPR, the Neonatal Unit relies on a hybrid model consisting of CERNER for electronic prescribing and paper-based documentation for all other clinical records.	16	12	4	A Band 7 Clinical Nursing Informatics Lead post has been advertised within Neonates to support further EPR rollout and ongoing system management. The post has been filled, subject to HR checks and confirmation of a start date.
1928	Environmental constraints on the Neonatal Unit impacting safety, IPC compliance and service quality	Due to the Neonatal Unit being located within the old estate, which is not designed for current activity and acuity levels, there is a significant lack of space for babies, families, and staff, particularly within the HDU and LDU areas. There is no appropriate sluice provision for proper management of liquid clinical waste and limited storage space. These constraints contribute to increased clutter, reduced workflow efficiency, and challenges in maintaining effective infection prevention and control (IPC) standards.	16	12	4	A housekeeper post has been advertised, with interviews scheduled for August. Once the post is filled and the appointee is established, Band 2 and 3 vacancies will also be advertised. HDU estate work is now included in Perinatal Assurance Group actions.
3060	Loss of Neonatal Psychology Capacity Due to Unfilled Key Posts	Recruitment restrictions have prevented the appointment of two key psychology posts within the Neonatal Psychology Service, reducing staffing capacity to 23% of recommended levels. As a result, the service is unable to provide its previous level of support to neonatal families and staff. This increases the risk of unmet psychological need, deterioration in staff wellbeing, increased patient and family complaints, higher demand on external services, reputational harm to the Trust, and non-compliance with national maternity and neonatal standards.	16	12	4	Work is ongoing to prioritise workload, maintain the most effective service possible and develop long-term solutions for the workforce model.
3121	Failure of SONeT/SORT trans port services	Ambulances are nearly five years old, and the increasing number of faults creates a risk of breakdown. Contributing factors include delayed maintenance and repairs; gaps in the driver rota and staffing levels, with limited information provided to the clinical team; drivers new to the contract who lack orientation and familiarity with the area, equipment and specialist neonatal and paediatric requirements; and limited engagement from the ambulance management team to resolve issues promptly.	15	8	4	A change in senior leadership and management at BEARS has significantly reduced the risk through prompt repairs and maintenance and improved the company's financial stability. However, approval to proceed with re-procurement has not yet been agreed; the outcome of Trust commissioning discussions is awaited.

Neonatal Risk Register- August 2026 (risk scoring 15 or greater prior to control)

Oxford University Hospitals NHS Foundation Trust

No	Title	Description	Initial	Current	Target	Key Progress Notes
2172	Failure to maintain medicines guidelines, monographs and staff training in neonatal unit.	There is a risk that key aspects of medicines safety—including governance processes, guideline development, monograph updates and staff training—may be compromised or delayed. This could lead to inconsistent practice, reduced compliance with safety standards and potential medication-related harm. It may also prevent the review of high-risk, vulnerable patients on some days and the consistent provision of bespoke parenteral nutrition.	15	12	4	Extensive work is under way across the neonatal service, pharmacy and the division to develop the libraries and safeguards; progress is good.
2935	Limitations of facial recognition system	The current facial-recognition system for parents of babies in the neonatal unit may allow staff to enter using facial recognition instead of Trust swipe access. Managers cannot audit access logs, and a photograph could potentially be used in place of a person's face, creating a risk of unauthorised access to the neonatal unit.	16	12	4	An improved process for adding and removing parents, carers and service users has been implemented, alongside increased awareness and improved staffing at the unit's entry and exit points.

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Perinatal Safety

Perinatal Safety - Reported maternity incidents and thematic learning from investigations

Reviewed incidents from SPEN, PMRT/ MNSI/ MOSS/ PSIRF findings / National reports

Incident type	Incident	What learning has been identified	Family view / DoC	External Reviewer	Grading of care up to birth/ diagnosis of IUD	Grading of care following the death of baby
PMR PMR PMR PMR	NND 26+1 NND 23+2 NND 23+4 IUD 35+1	Holistic risk assessments, inclusive of wider clinical picture, social factors, to be reviewed alongside fetal monitoring, to ensure plans of care are comprehensive. Learning about documentation has been identified for sharing with the neonatal team. Means of identifying placentas required to ensure opportunities for histopathology aren't missed.	Feedback received Feedback requested x2 Feedback received Feedback requested x 2	Yes Yes No Yes	C B B B	B A B A
Assurance: All families were given multiple opportunities to provide feedback for the reviewing team to consider. Follow up has been arranged with a consultant obstetrician to discuss findings. Maternity (Perinatal) Incentive Scheme (MPIS) requires that at least 60% of PMRT meetings are attended by peer colleagues from other Trusts and service user representatives to agree grading and any necessary next steps. 75% of meetings this month were attended by an external reviewer.						

Learning From incidents Summary of learning and actions. Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals.

Type of review	Theme	Outcome / Learning /Actions/ Improvements	What support do you need from executive board
MNSI	Reduced fetal movements	Guideline in the process of being updated to offer induction after 38+6 weeks when presenting with reduced fetal movements. Needs to be in alignment with DAU admission criteria, DAU service review currently underway, sits within wider MAU Perinatal Improvement Programme work.	N/A
2L Rapid review	Escalation	Learning shared about escalation to senior staff for support and to have a 2nd midwife during instrumentals in the room, to help support and escalate when needed.	
PMR	Holistic assessment	Fetal wellbeing training 2026/27 inclusive of the theme of holistic assessment when considering appropriate ongoing management and escalation of cases	
PMR	Histopathology	All placentas to be labelled, communication has been distributed amongst staff within the intrapartum area.	

MNSI: There were no referrals to MNSI in August. The trust received the final report for MI-053123, the action plan is currently being drafted.

Overdue Ulysses: The Maternity and Obstetric team responded in a timely manner to the increase in overdue incidents, with cases reducing from a peak of 98 on 10 August 2026 to 38 by 26 August 2026, a reduction of 60 incidents (61%) over a 16-day period. This demonstrates the effectiveness of the actions taken to address the backlog and this performance has been sustained into September.

Maternity Incentive Scheme (MIS) Year 8 Safety Action C - Quarter 1 2026/27
A Quarterly Report on Investigation Learning and the Service User

Oxford University Hospitals NHS Foundation Trust

Top Injury By Volume:		Top Injury By Value:
Brain Damage	16	Brain Damage
Fatality	10	Cerebral Palsy
Unnecessary Pain	9	Stillborn
Psychiatric/Psychological Dmge	7	Wrongful Birth
Stillborn	7	Erb's Palsy

Top Cause By Volume:		Top Cause by Value:
Fail / Delay Treatment	22	Fail / Delay Treatment
Failure/Delay Diagnosis	15	Fail To Monitor 1st Stg Labour
Not Specified	5	Fail To Make Resp To Abnrm FHR
Fail To Make Resp To Abnrm FHR	5	Fail To Warn-Informed Consent
Inappropriate Treatment	4	Failure To Perform Operation

Complaints Q1 26/27
Communication and information
Shared decision-making / feeling listened to
Delays and responsiveness
Postnatal follow-up and continuity of care
Staff interactions

Incidents Q1 26/27
Recognition and escalation of concerns
Fetal monitoring
Documentation quality
Communication
Shared decision-making

Triangulation Analysis Themes Q1 26/27
Communication and Information Sharing
Shared Decision-Making
Fetal Monitoring
Recognition and Escalation of Concerns
Documentation Quality
Postnatal Pathways
Workforce and Staffing Pressures

Improvement Area	Baseline Position	Quarter 1 Position	Direction of Travel
Maternity Triage Performance	April average assessment time: 21 minutes	June average assessment time: 18 minutes	Improving
Induction of Labour Delays >24 Hours	18 women delayed in April	1 woman delayed in June	Significant improvement
Patient Experience (FFT)	83% positive feedback in April	94% positive feedback in May and 87% in June	Sustained positive performance
PPH (>1500ml) at vaginal delivery	Q4 2025/26 baseline	Reduction observed during Quarter 1	Improving
Obstetric Anal Sphincter Injury (OASI)	Previous quarterly baseline	Reduced to 1.83% in June	Improving
Community Birth Service Availability	Community service maintained	No community birth service closures	Sustained
PMRT Compliance	National standards compliance	100% compliance achieved	Sustained
Parent Engagement in PMRT	National requirement	100% compliance with offer achieved	Sustained

Improvement Theme	Current Status	RAG
Shared Decision-Making (BRAIN)	Programme underway, impact being monitored through complaints, feedback and audits	In progress
Communication & Patient Experience	Patient Experience and Engagement Lead recruited to. Improvement work planned, awaiting measurable outcomes	In progress
Deteriorating Patient QI Project	QI project progressing, impact being assessed through audits and incidents	In progress
Documentation Quality	Audit and improvement programme ongoing	In progress
Postnatal Readmissions	Improvement work underway, outcome measures not yet confirmed	In progress
VTE Compliance	Recovery programme in progress, monitored monthly	In progress
Birth Reflections	Service improvement work ongoing	In progress
Martha's Rule	Implementation in progress	In progress

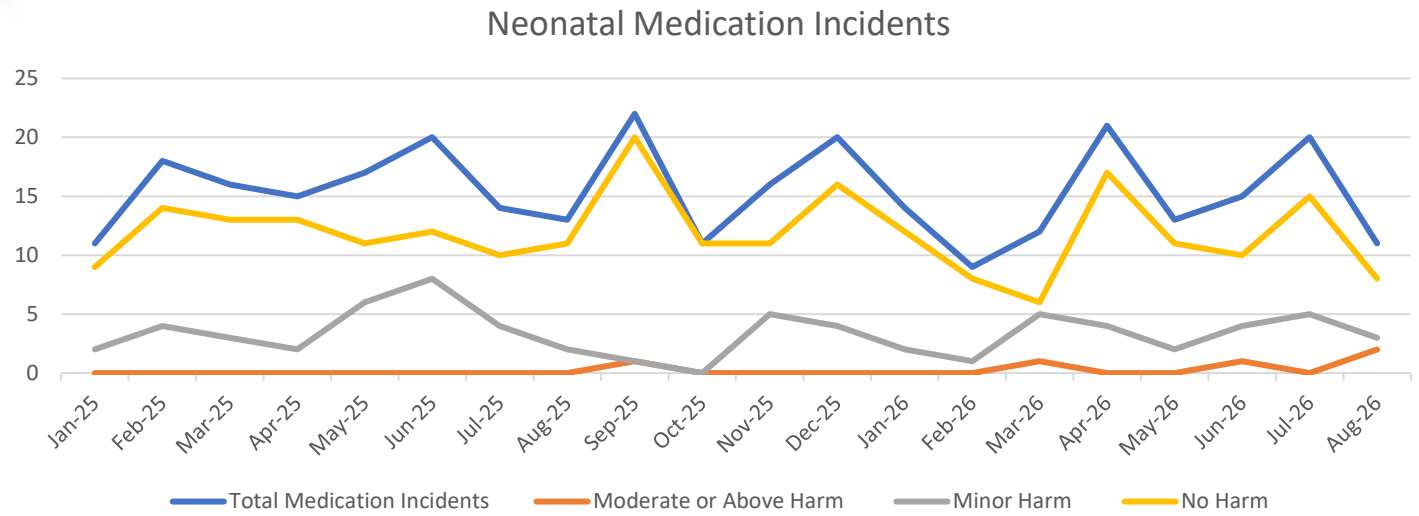
Quarter 1 Summary of Community Births

Number community births	Number of home births / BBA	Number birthing at home against medical advice	Number transferred into acute unit	Number of transfers with a delay	Number MLU closures
107	49	3 in April, 4 in May, 6 in June	Intrapartum 25, Postnatal 21	2 reported on Ulysses (461664, 459670). No patient harm.	0

Learning and action taken from incident reviews, complaints, and audits	Action	Progress on actions / impact
Documentation Standards Source: Incident review. Learning: Retrospective entries were not always being documented with the correct timings. Entries were not always attributed to the individual making the record.	• Ensure retrospective documentation clearly states the time of the event and the time of entry. • Ensure staff select their own name when documenting.	Learning circulated through Community Newsletter and incident feedback process.
VTE Risk Assessment Compliance Source: Incident review / audit findings. Learning: Mandatory VTE assessments are not consistently completed at: Booking, 28 weeks, Intrapartum admission	• Reinforce compliance with maternity VTE requirements. • Monitor through record review and audit.	Included as a key learning point for all community teams.
Surrogacy Case Review Source: Case review Learning: Several communication gaps were identified between Community Midwives and Health Visitors. Health Visitors do not routinely review booking forms before issuing initial postnatal information. Surrogacy guideline contains limited HV guidance and is difficult to navigate. Missed HV meetings resulted in missed opportunities for information sharing.	• Midwives to use local trackers to flag cases for HV discussion. • Reinforce attendance at HV liaison meetings. • Ensure feeding plans and ongoing concerns are communicated on discharge. • Consider review of surrogacy guidance/checklists.	Key learning shared with teams. Clear expectation established regarding information sharing with Health Visitors.
Interpreter Incident Source: Ulysses incident review. Learning: Pre-booked interpreters only remain available for approximately 10 minutes after appointment start time. Delays were not escalated to Absolute Interpreting. Trust support line had not been contacted in accordance with guidance.	• Notify provider immediately if running late. • Contact support line as soon as interpreting difficulties arise. • Ensure staff are familiar with current interpreting process.	Reminder circulated to all Community Midwifery teams
Confidentiality Complaint Source: Complaint. Learning: Confidential information was reportedly discussed/shared outside an appropriate healthcare setting.	• Reinforce confidentiality requirements. • Maintain professional boundaries when discussing patient information.	Included within community complaints learning.
Home Birth Kit Audit Findings Source: Equipment audit/check process. Learning: Equipment was being marked as "missing" when replacement items were immediately available.	• Update equipment details at the time of replacement. • Only record items as missing when replacement cannot occur immediately.	Clarified instructions issued to staff.
Delayed Response to Service User Source: Complaint Learning: Recognising there was missed communication and the use of email as a mechanism for hearing service user voice	• Increase monitoring of email accounts • Learning circulated by matron	Nil further issues re communication
Engorgement/Mastitis Misinformation Source: Complaint Learning: Outdated advice was given	• Use updated guidance • Share evidence based information	Matron has circulated guidance through newsletter and team huddles

Perinatal Safety - Neonatal Incidents

Oxford University Hospitals NHS Foundation Trust



Summary of Data

- In August, 60 patient safety incidents were reported via Ulysses; 20 resulted in harm: 18 minor and 2 moderate.
- The most common causes of minor harm were medication-related issues, medical device incidents, and communication or documentation concerns.
- Over the past 12 months, incident reporting in the Neonatal Unit has remained consistent and has been predominantly driven by no-harm events. This indicates a positive safety culture in which staff are encouraged and supported to report incidents, enabling early risk identification and continuous improvement.

Strengths

•Incident reporting in Neonates remains consistent, reflecting a strong culture of openness and learning. Two incidents are overdue and are being actively managed. The low number of outstanding cases, monthly governance reviews and clear escalation processes provide assurance that issues are addressed promptly.

•The neonatal service continues to rank second for excellence reports within the Children's Directorate, reflecting a strong culture of learning and recognition of good practice.

•Representation at local, directorate and divisional governance meetings continues to improve, strengthening engagement and alignment with organisational priorities.

Focus

•Governance education and training for the neonatal team are being strengthened through planned sessions during nursing team days and the doctors' induction programme. The sessions will reinforce governance, risk management and accountability across all staff groups.

•The service continues to strengthen its partnership with the Maternity and Neonatal Safety Improvement Programme (MatNeo), supporting consistent application of shared learning and best practice.

•The new doctors' induction will focus on medicines and PowerPlans to reduce medication incidents.

Future

•Over the coming months, targeted teaching and team development will continue to strengthen governance awareness and accountability across the neonatal team.

Oxford University Hospitals
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Perinatal Improvement Programmes
Maternity and Neonatal Workforce

Theme 1 - Staff Experience

Maternity Workforce and Operational Activity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- 592 people birthed 598 babies
- 4.22% community birth rate (17 MLU and 8 Home) with a further 10 transfers (all reviewed) and no themes or concerns identified
- No closures or suspensions affected JR or community

OPEL shift status = 21 Green 10 Amber 0 red – All appropriately risk assessment and escalated

Red flags

0 incidents of 1:1 care not being provided in labour.

0 incidents of the Delivery Suite coordinator not remaining supernumerary.

Workforce establishment:

Midwifery establishment aligned to Birth Rate+ (332.45 WTE) with an additional agreed 23 WTE uplift for maternity leave, giving a total establishment of **355.45 WTE**.

- RM in post **336.27WTE**
- vacancy of -**19.18 WTE** (against 355.45)
- Total unavailability RM -**43.38 WTE.**
- Mental health is the highest cause of absence; **9** people. This is an increase by 2 from July

Maternity Support Worker establishment

- Vacancies –12.73 WTE, with high unavailability of –22.21WTE. MSK and related absences were the highest cause (all appropriately reviewed and supported)

On call management

36 midwives were called into the John Radcliffe as part of the escalation process. 25 were midwives from the hospital on-call rota covering 169.25 hours. 11 were community midwives covering 62 hours as part of the escalation pathway.

The total number is similar to July.

Strengths

- New starters – (Midwives) 1.2 WTE.
- Succession planning with preceptee autumn recruitment and ongoing recruitment with 24.72 WTE offers/confirmed starts for Sept-Nov and 31 band 5/6 interviews planned in September.
- As part of the Perinatal Improvement Programme, the staff experience workstream enhances staff wellbeing, care, and retention through ongoing leadership development, comprehensive support services (including counselling and resilience activities), regular reflective forums like Schwartz Rounds, and mandatory Active Bystander Training to promote an inclusive and supportive workplace.
- Implementation of the 24/7 bleep holder role
- 3 on call RM each night effective from the 13th of July roster
- Safe staffing is dynamically risk assessed and supported across the service by real-time oversight by a community day co-ordinator, the 1570 maternity bleep holder, a 24/7 manager on-call alongside area leads. There is 7/7 daily staffing meetings for community and Monday to Friday staffing meetings for acute to review and update staffing versus acuity requirements.
- Daily triangulation of staffing levels, patient acuity, activity, NHSP utilisation, vacancies and sickness provides assurance that staffing decisions remain responsive to clinical demand. Escalation arrangements, including on-call provision and OPEL review processes, continue to support safe service delivery despite ongoing workforce pressures.
- MediRota for Medical staffing is reviewed regularly by directorate team with the aim to achieve compliance with the six-week leave policy and maintaining oversight of session planning and rota integrity.

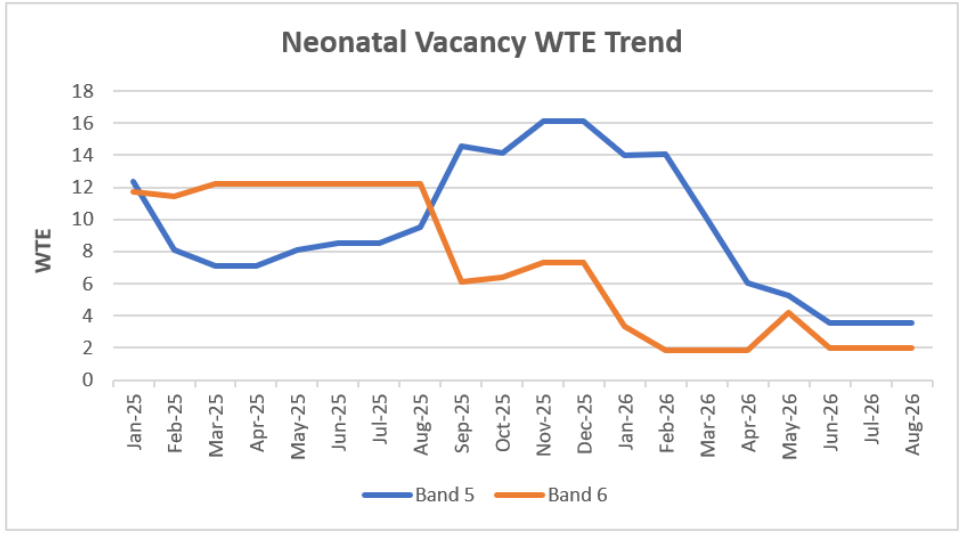
Operational Focus

- Leavers RM 6.84 WTE
- Starters RM 1.2 WTE
- 19 Brookes students offered Band 5 posts, 0 on waiting list.
- Further interviews booked for September
- Birthrate plus establishment review final report
- MSW recruitment -4 New starters for September.

Future

- Succession planning strengthened through short courses, 4 starting in September and apprenticeship pathways, 2 starting in January 2027, subject to interview.
- Resident doctors- 2.00 WTE registrar are due to leave in the autumn. Recruitment at shortlisting stage.
- Consultants job plan compliance rate in August was 90.9%, with 3 outstanding job plans (one of them being University contract). As per Trust's directive, the directorate team is currently exploring the concept of departmental job planning planned for Autumn 2026.
- 3 consultant vacancies- 2 as a result of colleagues leaving the service, and 1 new consultant post funded via TME to support with USS pathway changes. Interviews for 2 planned for September.
- Second SHO have been added to the overnight rota from August 2026.
- Option of moving to a 3 tier roster for resident doctors is being explored, with business cases going through the approval channels.

Workforce – Neonatal Nursing Workforce



Summary of Data

•In August, Neonates had 3.53 WTE Band 5 vacancies, 1.98 WTE Band 6 vacancies and 8.4 WTE staff on maternity leave. This is an improvement; however, mitigation remains in place—including regular staffing reviews and cross-divisional critical care redeployment—to maintain patient safety and service continuity.

•Progress against recruitment targets and temporary staffing use is monitored and reviewed through divisional governance.

Strengths

•Sixteen Band 5 nurses are in the recruitment pipeline and awaiting start dates. Many are newly qualified and will join from September 2026 onwards.

Focus

•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.

•The non-registered workforce has undergone a service review involving updated job descriptions, improved induction and clearer career progression pathways.

Future

•The rolling recruitment programme for Band 5 and Band 6 nurses is ongoing.

•The addition of 16 new Band 5 nurses will reduce the percentage of staff who are QIS-compliant.

•Interviews for the Band 6 educator post have been completed; a start date is awaited.

•Two further Band 7 roles have been filled by internal candidates, who are completing HR checks and awaiting start dates.

•Interviews for a senior housekeeper were unsuccessful; the post will be re-advertised.

•Continue work to progress the Band 2/3 workforce.

Workforce – Specialist Training (Neonatal)

Oxford University Hospitals NHS Foundation Trust

Qualified in Speciality (QIS) Training - Target 70%	2023	2024	2025	2026	2027	2028	2029
Compliance	42%	46%	48%	48%	67%	77%	87%
				Correct as of 10th Sept 2026	Prospective Data		

Summary of Data

•Current compliance with British Association of Perinatal Medicine (BAPM) standards for Qualified in Specialty (QIS) training is 48%. The service is addressing the gap through a structured action plan and has a clear improvement trajectory.

•Monthly fluctuations in compliance reflect active staff recruitment and retention cycles within the unit. At the end of August, the total nursing workforce was 166, of whom 80 (48%) were Qualified in Specialty.

•The current action plan relies on developing staff internally through training. Looking ahead, this approach will be complemented by efforts to recruit external candidates who are already qualified in the specialty. However, recruitment remains challenging, as suitably qualified candidates are rare and competition is high.

Strengths

•The neonatal service was fully compliant with MPIS Safety Action 4 for 2025, supported by a clear and structured action plan, which is monitored through divisional governance.

•The number of staff undertaking QIS training has increased from 8 to 17 across two cohorts, demonstrating a strong commitment to workforce development. Places have been secured for 7 nurses in September 2026.

•Approval to advertise Band 6 and 7 posts externally will support delivery of the QIS trajectory.

•In August 2026, the TV&W Neonatal ODN confirmed that recurrent NHSE funding had been allocated for QIS course fees. Funding will be provided through ETAP (Education Training Activity Plan) for both Foundation and Specialist-level courses.

Focus

•QIS training is being delivered through the agreed action plan to improve compliance with BAPM standards. Actions include prioritising staff according to service need, securing CPD funding for external provision and increasing mentor capacity.

•The Neonatal Education and Workforce Group monitors progress and reports to divisional governance. Training cohorts are phased to minimise operational impact while meeting compliance targets.

•Together, these measures provide assurance that the Trust is addressing current gaps and has a structured route to full compliance.

Future

•The neonatal service aims to achieve 70% QIS compliance in line with BAPM standards through its structured action plan.

•To accelerate progress, the service is exploring in-house QIS training to reduce reliance on external providers, improve cost efficiency, increase scheduling flexibility and better integrate training with clinical practice.

•The suitability of the current two-cohort programme will be reviewed to ensure it meets operational needs and maximises training capacity.

•The Neonatal Education and Workforce Group will continue to monitor compliance and training delivery and report to divisional governance.

Staffing Vacancy Rates

Oxford University Hospitals NHS Foundation Trust

Staff group	SIP WTE	Vacancy rate (%)	July Fill rate (%)
Midwifery Inpatient Est 166.33 WTE	163.21	3.12	100%
Community Midwifery Est = 94.2 WTE	88.26	5.94	(%) -
Management Specialist MWs Est = 71.92wte	65.56	6.36	N/A
Maternity Support Workers	88.84	12.62	99.40
Obstetric Consultants*	23.39	7.7	N/A
Obstetric resident doctors*	45.06	8.05	N/A
Neonatal Nurses Est: 162.72wte	132.97	20	96.5
Neonatal Clinical Support Staff Est: 32.45wte	15.55	52.1	84
ANNP	2	0	N/A
Neonatal Consultants	13.3	1.75	N/A

*Obstetrics medical staffing figures for July 2026. August data not available at the time when this report was written
Anaesthetic staff will be reported on next month as data not available. The anaesthetic team ensure maternity services are covered every day and night.

Midwifery Staffing - Area-level figures are reported against the 332.45 WTE BirthRate Plus establishment. The overall vacancy of 19.18 WTE additionally includes 3.76 WTE of the 23 WTE maternity-leave uplift that was unallocated in August.

Risks	Mitigations	Escalations
Midwifery: During August we held a known vacancy to support the newly qualified midwives who start in September.	Mitigating actions are in place, including enhanced workforce oversight, careful deployment of existing resources (summer mitigations' and active monitoring of staffing levels to maintain safe staffing and service delivery).	Daily, weekly and monthly review of staffing deficits. Real-time management of NHSP release in line with real-time acuity review and response mechanisms. Summer mitigations is a proactive management of office staff being moved to clinical shifts to reduce the clinical deficit.
Midwifery: Unavailability = 43.38 WTE (Inc of Mat leave 19.24 WTE, Sickness 23.14 wte,1 supernumerary)	Mitigating actions are in place, including enhanced workforce oversight, implementation of agreed summer mitigations, and active monitoring of staffing levels. These measures provide assurance that workforce capacity is being managed proactively to maintain safe staffing and service delivery throughout this transitional period. The additional uplift of 23WTE to cover permanent maternity leave is not currently allocated to individual areas within the overall establishment. In August, the maternity leave was 19.24 WTE, 3.76WTE lower than the agreed uplift leaving a discrepancy.	Daily triangulation of staffing levels, patient acuity, activity, NHSP utilisation, vacancies and sickness provides assurance that staffing decisions remain responsive to clinical demand. Escalation arrangements, including on-call provision and OPEL review processes, continue to support safe service delivery despite ongoing workforce pressures.
Midwifery: Leavers Maintaining workforce establishment figures through new starters and a reduction in leavers Q4 (3 leavers) of 25-26. (24.74 Midwife leaves April – August. With a further predicted 12.88 WTE leavers September-November)	Implemented exit interviews. Number 1 reason – Relocation Flexible working committee implemented for operational transparency and fairness utilising trust policy to guide decisions.	Daily workforce oversight, incorporating staffing levels, patient acuity, activity, NHSP utilisation, vacancy rates and sickness absence, provides assurance that resources are aligned to clinical demand. Escalation and operational review processes, including on-call arrangements and OPEL monitoring, support proactive risk management and the continued delivery of safe care in the context of sustained workforce pressures.
NNU unregistered staff vacancy and fill rate	Mitigating actions include implementing the new job description (JD) and training plan to improve recruitment and retention, alongside staffing reviews at least twice daily to support safe, high-quality care.	Work closely with the divisional Human Resources (HR) team and Recruitment and Retention (R&R) lead, and monitor and mitigate staffing through divisional and cross-divisional Critical Care staffing meetings and the Trust staffing meeting.

Perinatal Training

Oxford University Hospitals NHS Foundation Trust

Maternity (Perinatal) Year 8 Safety Action B 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 October to July and is in line with the Core Competency Framework. New material for all training days is reviewed/changed for the start of the training year to ensure nationally mandated topics are covered.

Summary of Data

- Moving and handling Level 2 decreased to 88.6% in August. Oliver McGowan training compliance is as follows:
  - Part 1: 85.7%
  - Part 2: 26% of maternity staff have attended in-person training.
- PGD training compliance is 77%.

Strengths

- Training compliance exceeded 90% for PROMPT, Fetal Monitoring and neonatal life support by 1 August 2026, meeting the midpoint assessment requirement for Year 8 of the Maternity (Perinatal) Incentive Scheme.
- Safeguarding level 3 training adults and children increased in August with adult training above 90%.
- By the end of Quarter 3, 25% of staff are required to have completed Oliver McGowan Part 2 training – maternity staff are currently at 26%.

Focus

- SPC charts have been introduced to monitor compliance with PROMPT, Fetal Monitoring training and NLS.
- From Sept 2026, the Practice Development (PD) team will deliver monthly Moving and Handling updates for maternity staff.
- Preceptees and internationally educated midwives (IEM) are having bespoke safeguarding level 3 children training offered to them.

Future

- The next training year will commence in October 2026.
- . Maternity services are on a trajectory to achieve this.
- Skills and drills sessions remain paused due to summer mitigation arrangements and redeployment of the Practice Development team. Staff are expected to return to Practice Development roles on 14 September 2026. The next session is planned for 7 October 2026 in Wantage and will cover anaphylaxis and maternal collapse.
- The PROMPT faculty preparation day is scheduled for 1 October 2026.
- First cohort of NQM's start in trust on 14 September 2026 - focus on orientation and training in 1st 4 weeks with support from PD team and clinical areas.

Training Compliance 26-27

KPI	Latest month	Measure	Target	Variation	Assurance
PROMPT Midwives	Aug 26	98.0%	90.0%	H	P
PROMPT MSW's	Aug 26	100.0%	90.0%		
PROMPT Nurses	Aug 26	100.0%	90.0%	H	
PROMPT Obstetric Consultants	Aug 26	100.0%	90.0%		
PROMPT Obstetric Registrars	Aug 26	96.0%	90.0%		P
PROMPT Obstetric SHO	Aug 26	100.0%	90.0%	H	P
PROMPT Anaesthetic Consultants	Aug 26	93.0%	90.0%	H	
PROMPT Anaesthetic Registrars	Aug 26	100.0%	90.0%		P
Fetal Monitoring - Midwives	Aug 26	98.0%	90.0%	H	P
Fetal Monitoring - Obstetric Consultants	Aug 26	92.0%	90.0%	L	P
Fetal Monitoring - Obstetric Trainees ST1-7	Aug 26	97.0%	90.0%		P
Newborn Life Support (NLS) - Midwives	Aug 26	96.0%	90.0%		
NLS - Neonatal Nurses	Aug 26	90.4%	90.0%		
NLS - Neonatal SHO and registrars	Aug 26	100.0%	90.0%	H	
NLS- Neonatal Consultant	Aug 26	91.6%	90.0%		
NLS - ANNP	Aug 26	100.0%	90.0%		P

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	↓84.6%
Core Skill – Information Governance and Data Security	↓87.1%
Core Skill - Moving and Handling Level 2	↓88.6%
Core Skill – Resuscitation Level 1	^89.2%
Core Skill - Resuscitation Level 2, 3 OR 4	^88.7%
Core Skill – Safeguarding Adults Level 3	↑91.8%
Core Skill - Safeguarding Children Level 3	↑88.1%

Oxford University Hospitals
NHS Foundation Trust

Perinatal Improvement Programme

Patient Experience

Theme 2- Patient Experience

Patient Experience and Engagement – 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

- Feedback from both Friends and Family Test (72 responses) and Say on the Day (376 responses) demonstrates consistently high levels of satisfaction across OUH maternity services. This combined number provides a 75% response rate compared to our delivery rate for August.
- Overall feedback remains overwhelmingly positive, with service users consistently praising the compassion, professionalism and responsiveness of maternity staff. The main opportunities for improvement relate to communication, management of waiting times, and environmental concerns particularly relating to temperature control across multiple maternity facilities. There were also concerns relating to access to parking facilities.
- 9 complaints were received in August, all concerning care received within the last year.
- Complaint analysis suggests a strong recurring theme around patients and families not feeling listened to, believed, or adequately informed by the MDT, particularly when raising concerns about increasing pain, mental health needs, or postnatal care.

Strengths

- Feedback demonstrated service users feeling listened to, well-informed, reassured and supported, with several individuals receiving specific recognition for exceptional care.
- Care at Wantage MLU was described as incredibly positive with a relaxing environment
- Staff repeatedly described as supportive and knowledgeable, as well as friendly and approachable
- Improvement in care from previous experiences noted
- Several accounts of service users noting clear explanations and information given

Focus

- A focus from learning from complaints on improving compassionate communication, timely response to postnatal inpatient care needs, and to improve the reliability of information/documentation across maternity pathways.
- Continuous development of MAU focusing on the environment, CTG lounge and improvement towards the BSOTS 15 minute target.
- Continue to closely monitor changes to the IOL pathway, with regular QI meetings providing real-time oversight and enabling prompt escalation where required. As well as monitoring of patient feedback.

Future

- The service will continue to strengthen engagement with women, families and community groups to ensure that lived experience informs service planning, quality improvement and the delivery of equitable, personalised maternity care.
- Addition of monitoring of deprivation index in relation to complaint analysis to gain better understanding of demographic population
- Integration of perinatal experience and engagement lead into existing works streams as development of future workstreams
- OMNVP 15 steps walk around planned for 15th September

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

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Summary of Data

•No new complaints were received in August.

•No Friends and Family Test (FFT) responses were received because a technical fault prevented their retrieval.

•In August, 16 responses were received from families through Say on the Day devices; overall experience was rated 10/10.

•Overall response rates remain low. Targeted actions have been implemented to strengthen the collection of service-user feedback.

Strengths

•There is increased awareness among staff and families regarding the Friends and Family Test (FFT) and "Say on the Day" devices, supported by proactive engagement and improved accessibility.

•Feedback through Say on the Day is consistently positive, highlighting supportive staff, kindness and compassion.

•Comments are consistently positive with examples such as "*Amazing staff, very kind even when very, very busy. Very grateful for such wonderful care.*" and "*The Neonatal team have been great – patient staff very well looked after during a very emotional stage in our lives*".

Focus

- As at the end of August 2026, FFT had been added to admission and discharge packs to improve accessibility and increase opportunities for feedback. The next step is to include the FFT form in the baby's Red Book at discharge; this was delayed by QR-code issues.
- The August QR-code issue has been resolved, enabling full implementation of the response-rate improvement plan.
- Although feedback highlights exceptional care and professionalism in the neonatal service, the formal patient-experience response rate remains below expectations. An improvement plan is in place with the Patient Experience Team and Perinatal Engagement Lead.
- Staff have been asked to encourage FFT completion at key touchpoints, including admission, discharge and longer inpatient stays.
- Targeted communication campaigns and digital options will further strengthen engagement and improve inclusivity and representation from diverse communities.
- Response rates and feedback themes are triangulated with complaints and reviewed monthly through divisional governance.

Future

•The neonatal service aims to increase FFT and 'Say on the Day' response rates, providing a more representative view of service-user experience and capturing constructive suggestions for improvement.

•Staff engagement remains central to the plan, supported by training and reminders in daily huddles.

•An OMNVP 15 Steps visit is planned for October 2026.

•Monthly governance reviews will monitor progress against the measurable target to increase neonatal feedback response rates over the next few 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.

•The newly appointed Perinatal Engagement Lead will hold monthly meetings in line with the FFT response-rate action plan.

Insights from service users and Maternity & Neonatal Voices Partnership Co-production inc. Quarterly EDI Update

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Perinatal Experience and engagement lead commenced in role on 10th August 2026. Plan to strengthen ongoing collaboration with OMNVP and community projects.

Ongoing projects – community engagement project supported by external agencies, BSOTs MAU improvement workstream, OMNVP 15 steps planned for September, Martha's rule implementation, service user feedback from USS pathway changes

A QI project is underway with the Governance Lead to strengthen service user involvement in patient safety incident investigations, in line with AMOS recommendations. The current phase involves process mapping of the existing investigation pathway to identify opportunities to embed meaningful service user voice and co-production, with subsequent implementation of an improved governance process to support learning and person-centred care.

MPIS Safety Action D (EDI) – Quarterly Governance Update – Quarter 1

Overall RAG: AMBER with clear plan to move to GREEN

Achievements (D1 & D2)

- Strong evidence of communication equity initiatives
- Interpreter access, translated information and reasonable adjustments established
- Community outreach, OMNVP, FFT, PALS and listening events capturing service user voice
- Governance route agreed through quarterly MCGC reporting

Key Gaps / Next Steps

- Demonstrate impact through audits, outcome measures and QI methodology
- Launch consent audits and interpreter monitoring
- Develop quarterly dashboard and MCGC report
- Strengthen theme analysis, action tracking and feedback loop closure

Governance Summary

Current position reflects good progress and accurate identification of gaps. Assurance regarding improving communication, reducing inequalities and improving experience, remains limited until monitoring, measurable outcomes and governance reporting are embedded. Support from DOM, EDI leads and multidisciplinary teams is in place to achieve compliance.

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Perinatal Improvement Programme

Quality Improvement

Theme 3 –Safety

Focus Quality Improvements: Triage (BSOTs) Perinatal Improvement Programme – Safety (1)

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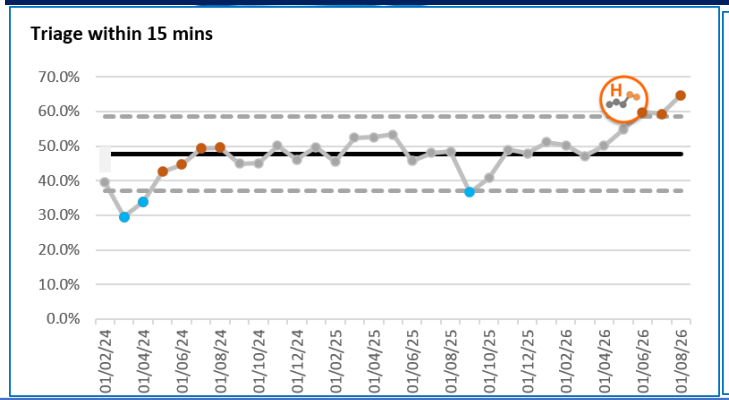

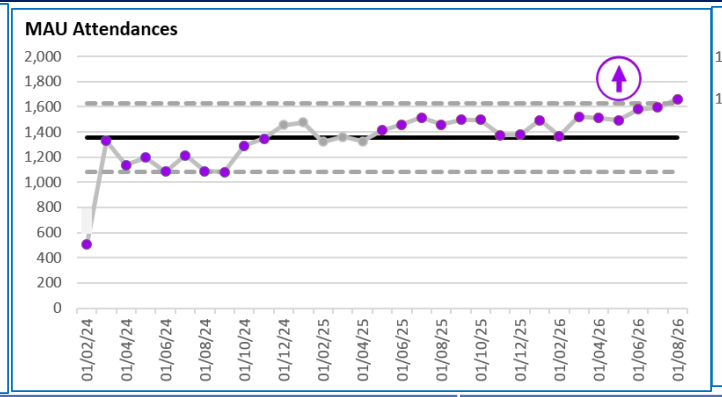

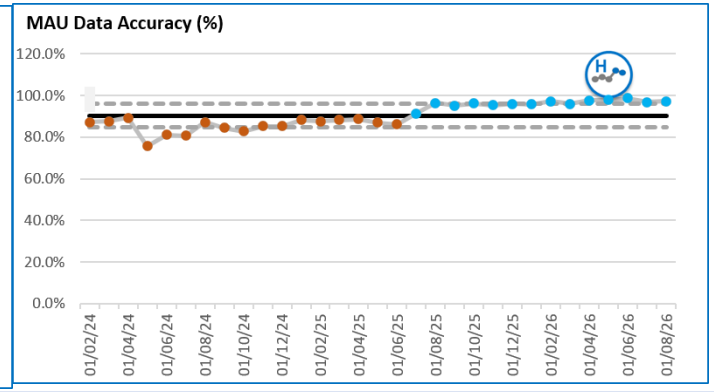

TRIAGE QUALITY IMPROVEMENT: SUMMARY

- Performance remains below the required standard for safe and effective care; however, there has been an improvement in the proportion of women receiving an initial triage assessment within 15 minutes. This month it is at 64.7% a 5% improvement on last month. Improvement initiatives are in place and beginning to show early impact, further improvements relating to the physical space are due to come on stream in September.
- For the last three weeks of August, the Initial Triage compliancy has reached 72.3%
- Review and evidencing for the National Maternity Benchmarking tool

Exception for August

Strengths

- Sustained performance under unprecedented demand: Maternity Assessment Unit managed its highest ever monthly activity (1,661 attendances) and highest single-day volume (79 attendances), while maintaining strong performance in ongoing midwifery care, with Green pathway compliance consistently close to 100%.
- Initial Triage compliance improved by 5% - monthly compliance for initial triage now at 64.7%
- Ongoing Midwifery Care stable at 99% Green, 90% Yellow, 77% Orange
- Ongoing Medical Care stable and improving, 93% Green, 53% Yellow, 61% Orange (averaged of both urgent/non urgent)
- Enhanced monitoring and investigation in place, reporting 3 times per week.

Focus

•Sustain and embed current improvement initiatives that are continuing to provide improvement in initial triage performance, ensuring consistency across all shifts and days of the week.
•Continue to strengthen streamlining and escalation processes, ensuring women are rapidly prioritised according to acuity and directed to the most appropriate care pathway.
•Focus on reducing unwarranted variation in ongoing medical review times, particularly within the Orange pathways, to minimise delays that may contribute to patient flow pressures.
•Progression of automated monitoring and reporting processes.
•Maintain enhanced monitoring and monthly performance reviews, using real-time data and feedback loops to track progress, identify barriers promptly, and ensure improvements are sustained.
•Structured analysis of impact of third registrar to performance, shift and day comparatives to be conducted in the same manner as previously completed for midwifery staff.

Future

•Take operational ownership of the CTG Lounge, creating additional capacity within triage and improving patient flow through the assessment pathway.
•Protect triage staffing by reducing movement of staff from MAU, ensuring consistent workforce availability to support timely initial assessment and ongoing care. Receiving sign off within the budget to have the new staffing model as substantive.
•Strengthen real-time operational oversight and escalation processes, enabling earlier intervention when performance deteriorates. Ulysses to be completed when a breach of initial triage has occurred.
•Continue to optimise streaming and patient flow pathways, ensuring women are assessed by the right clinician at the right time.
•Maintain monthly performance reviews and quality improvement cycles, focusing on sustained improvement in 15-minute initial triage compliance of over 85% and reducing extended waits by the end of quarter 2 (Q2).
•On track for full compliance of KPI initial triage 85% < 15mins by the end of Q2
•Patient Visible Wait times solution

Focus Quality Improvements: Triage (BSOTs) Perinatal Improvement Programme – Safety (1)

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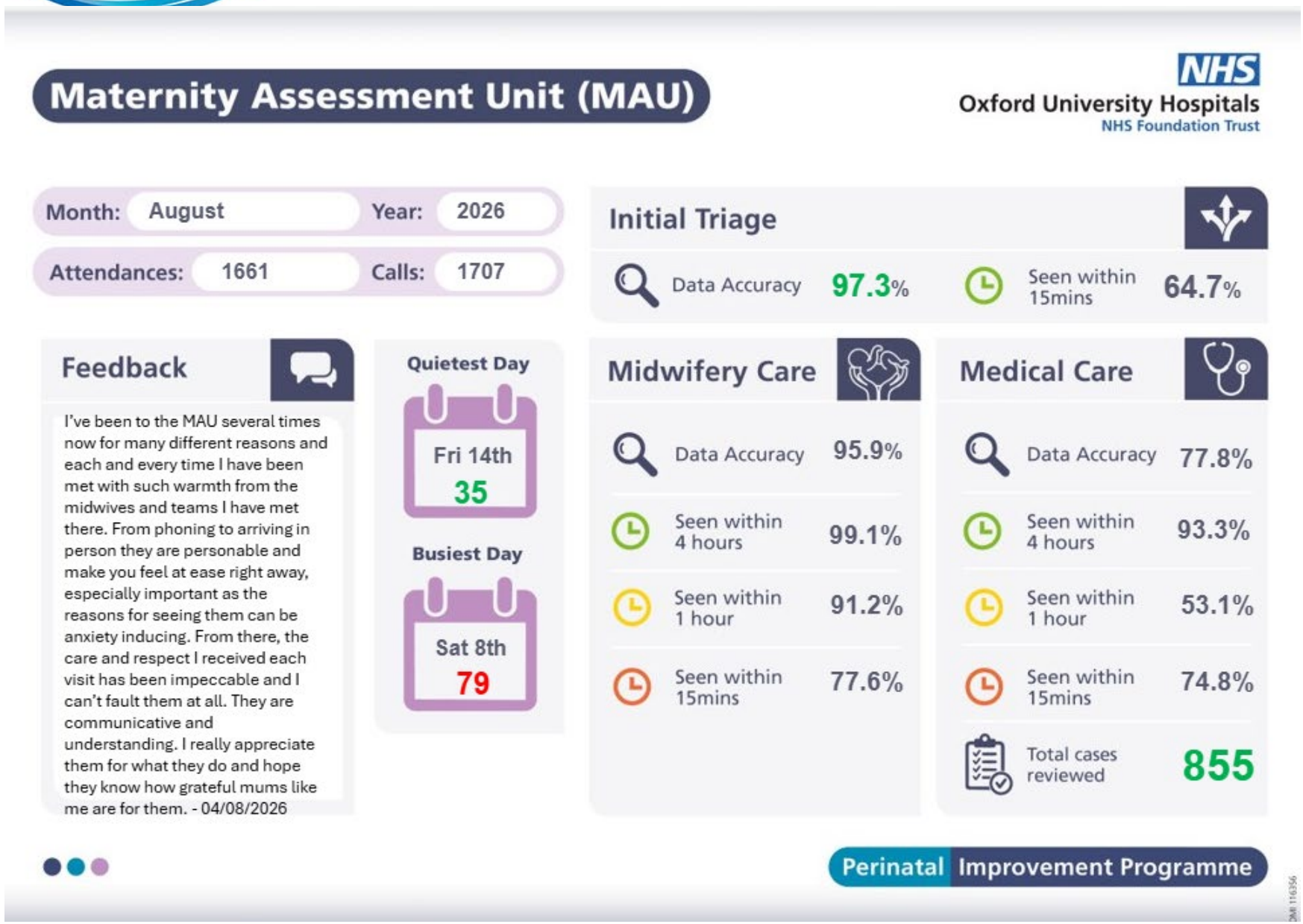
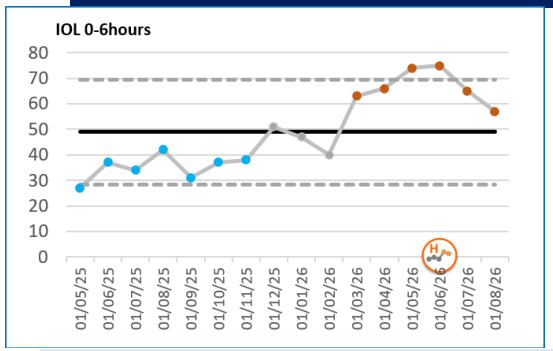
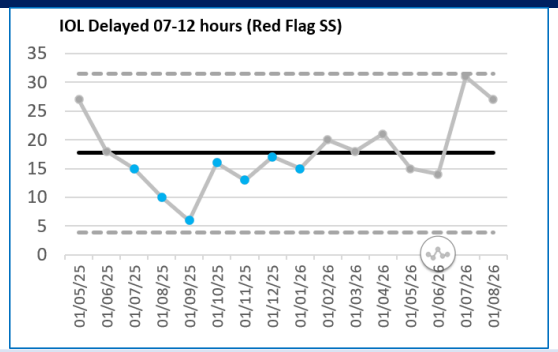
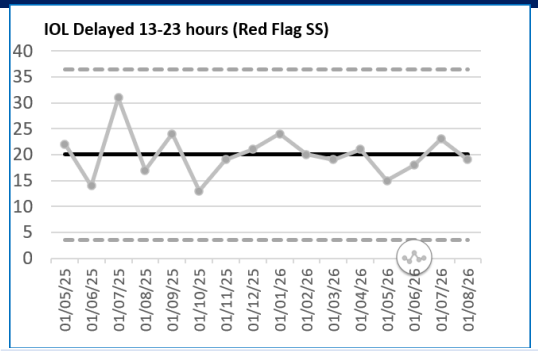
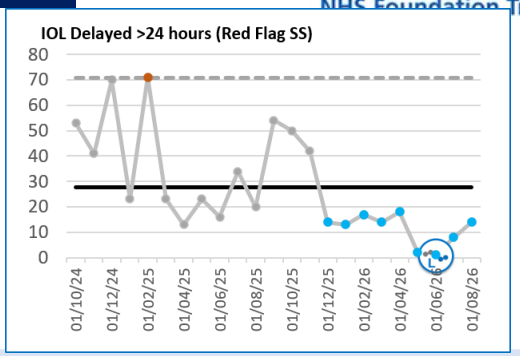


Focus Quality Improvements: IOL Perinatal Improvement Programme – Safety (1)









Summary of Data

- The IOL quality improvement programme provides assurance that induction of labour delays are being actively managed, with improved oversight, communication and patient information supporting safety, experience and flow for women, birthing people and neonates.
- The data is also providing an opportunity to review the impact of different methods of induction and the impact on delay.
- We have 14 cases of delayed IOL waiting over 24 hours – This has been due to lack of rooms on delivery suite.

Strengths

- Increase in use of Misoprostol with over 50% of cases using this.
- Only a single 3rd degree tear occurred
- Despite capacity challenges, average and longest wait times remains stable with no significant flex

Focus

- Performance has seen a 5% fall reduction in volumes delays less than 6 hours, this has been isolated to a period of 4 days at the end of the month, due to capacity, which impacted the monthly averages.
- Assurance is provided through continued monitoring of transfer-time data and reasons for delay, with the objective of achieving 100% transfer within 6 hours once ready for Delivery Suite.
- A business plan is being developed to support the long-term use of Misoprostol and sustain improvements in induction flow

Future

- All inductions of labour delayed beyond 24 hours continue to be reviewed via Ulysses platform / audit to identify learning opportunities and support ongoing service improvement.
- Automated reporting under development with data analytics team, to provide enhanced oversight and remove single points of failure from reporting pathways.
- Discuss moving the outpatients work away from delivery suite (the elective LSCS patients currently use 3 rooms on DS while waiting for their time slot). Working group has been commenced to find alternative space. We require support from the MDT to achieve this.

Focus Quality Improvements: IOL Perinatal Improvement Programme – Safety (1)

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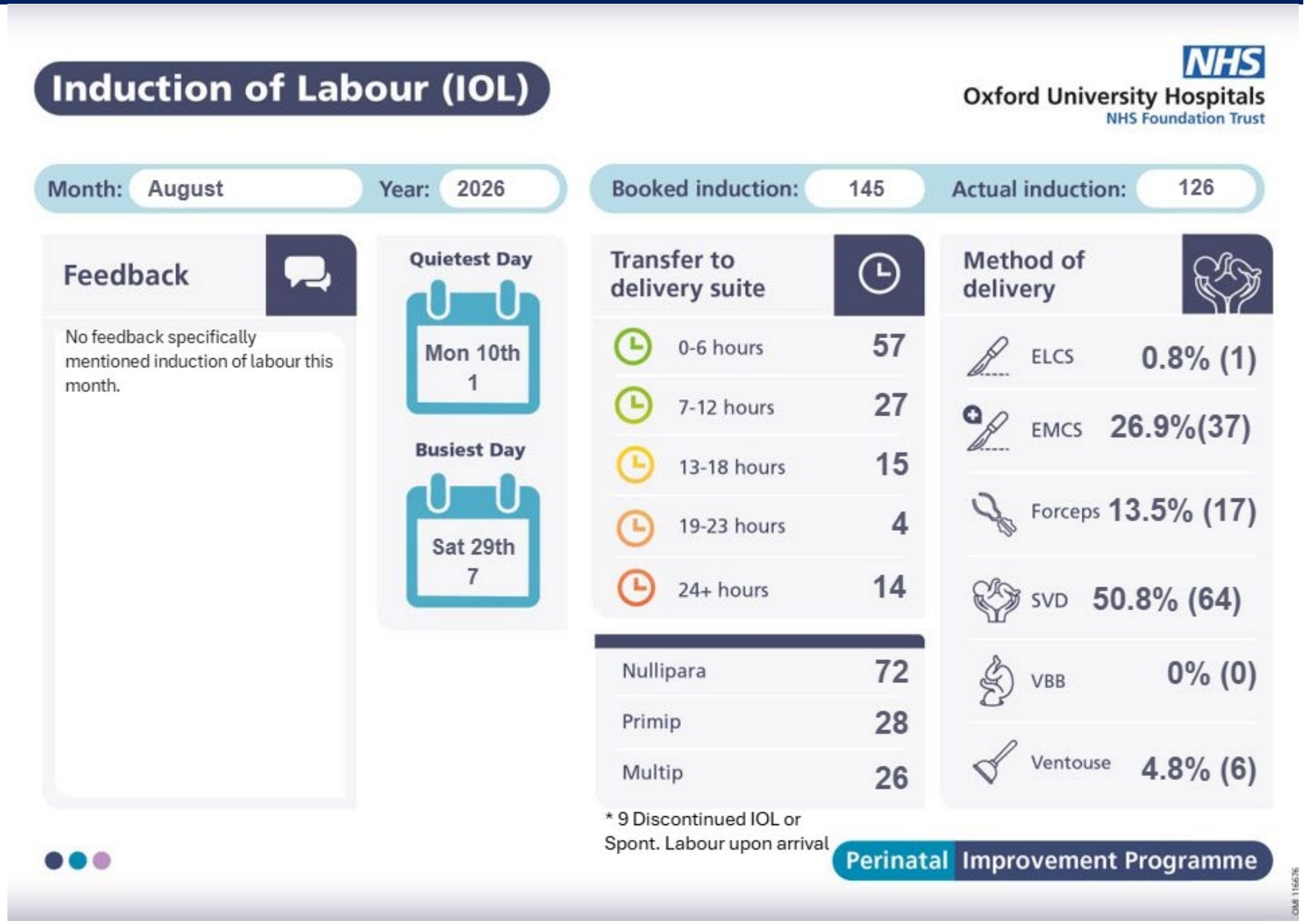

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National Updates and Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Year 8 : reporting period 1st April 2026 – 30th November 2026

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Oxford University Hospitals NHS Foundation Trust

Safety Action	RAG*	Summary of actions and current status
A – Workforce and Capacity		• Combined perinatal staffing report covering Q3/4 data has been reported to Trust Board on the 29 July 2026. • Requirement of report is biannual thus next report will cover Q1/2 data and will be due to go to Trust Board in November. • Addition of operational capacity monitoring, including elective Caesarean activity via SitRep – working group in progress to develop new requirements.
B - Training		• Training compliance is above 90% for PROMPT, Fetal Monitoring and neonatal life support by the 01 August 2026 which is the mid-point assessment for the Maternity (Perinatal) Incentive Scheme, Year 8. Quarter 1. • SPC charts now in place to assist with monitoring compliance percentages, with quarterly updates being detailed. • Work required for development of Newborn Life Support Training Needs Analysis which covers perinatal service • Plan for community scenario to be included from September 2026 training year
C – Learning from Reviews and Investigations		• Quarterly thematic report due from Quarter 1 onwards. This was reported to MCGC and PAG in August and IAC in September. • Changes made to routine reports and trackers to meet new requirements • No anticipated concerns
D – Service User Voice and Equity		• Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments. • Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care. • Work required on assurance of equity requirements
E – Care Bundles		• Safety Action includes Saving Babies Lives (SBLv3.2), Maternal Care Bundle (MCB) and neonatal pulse oximetry. • Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence. Quarter 1 included on slide 38 • ICB assurance step removed as ICBs no longer hold a formal oversight role. • Quarterly update for MCB – Q1 reported last month. • Pulse oximetry – guideline updated and approved in August.
F – Board Oversight, Governance, Culture and Leadership		• Clearer expectations for Board-level assurance and use of safety intelligence. • Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs - MOSS alert received. Safety checklist completed and returned to region and ICB (see slide 39) • Board Safety Champion meetings with MNVP involvement. • Live Perinatal Culture Improvement Plan required, with quarterly Board review.

*The amber rating reflects the early reporting period and timing of deliverables, not concerns regarding compliance or risk.

Saving Babies Lives v3.2 (Quarter 1)

Oxford University Hospitals NHS Foundation Trust

	Compliance / progress / action
El 1: Smoking in pregnancy	All elements are above the ICB target with the exception of one element below the national standard. This is in relation to the percentage of women where there is a recorded CO measurement at the 36 week appointment. An action plan is in place to improve compliance.
El 2: Fetal growth	All elements are above the LMNS target apart from one - % of pregnancies where an SGA fetus is antenatally detected. Updates to growth scan pathways in August so they fully align with Saving Babies Lives version 3.2.
El 3: Reduced fetal movement	Achieving over target compliance in 2 out of 2 measures. **Compliance improved** in relation to 3.2 3b - Proportion of women who attend with recurrent RFM who had an ultrasound scan by the next working day to assess fetal growth improved with the action plan that was implemented following the quarter 4 audit.
El 4: Fetal monitoring	Achieving over target compliance in 2 out of 2 measures.
El 5: Pre-term births	Compliance is above target in 9 of 11 measures. Performance has fallen for two measures: the percentage of babies born before 34 weeks whose first admission temperature is 36.5–37.5°C and measured within one hour of birth, and the percentage who receive their own mother's milk within the first 2 days of life. The neonatal consultant has reviewed the findings. **Receipt of mother's milk within 2 days of life – this is a reporting issue linked to outstanding records and missing data. The neonatal team is addressing delays in receiving notes by requesting that all notes remain in the neonatal unit for one month after discharge. All April–June data are being reviewed. Staff have been reminded about the lower performance and the need to record information accurately in the correct place.** **Normothermia – the neonatal team is reviewing out-of-range temperatures to determine how many were unavoidable and identify common themes. Staff have been asked to record temperature 3 times: at the end of stabilisation, before leaving DS, and on arrival in the neonatal unit. Data are now reviewed prospectively each week. Staff have been reminded about the lower performance and the need for vigilance with temperature-control measures.**
El 6: Diabetes in pregnancy	Achieving compliance in 2 out of 2 measures. Drop in compliance for Quarter 4 noted but not thought to be significant by relevant teams or due to any notable factor. Will be closely monitored.

Maternity Outcomes Signal System (M.O.S.S)

Oxford University Hospitals NHS Foundation Trust

A level 1 MOSS signal relating to the John Radcliffe Hospital, Oxford University Hospitals (OUH), was generated on 27 August 2026. Team members registered to receive notifications were sent the alert. A meeting took place on the first working day to confirm responsibility for completing the critical safety checklist and timeframes to send to the Trust Board Executives, the region and ICB, after which a live copy was provided to the key stakeholders. The checklist was completed by the perinatal leadership team and shared with Trust Board executives, the ICB and region as per the national Standard Operating Procedure (SOP) within the agreed 8 working days.

A review of the six recent perinatal deaths identified no common causative factor, no recurring safety issue and no immediate system-wide safety concern. All cases have undergone, or are undergoing, formal review through PMR and MNSI processes where applicable. The review concluded that known safety risks are already identified, have mitigation plans in place and are progressing through established governance arrangements.

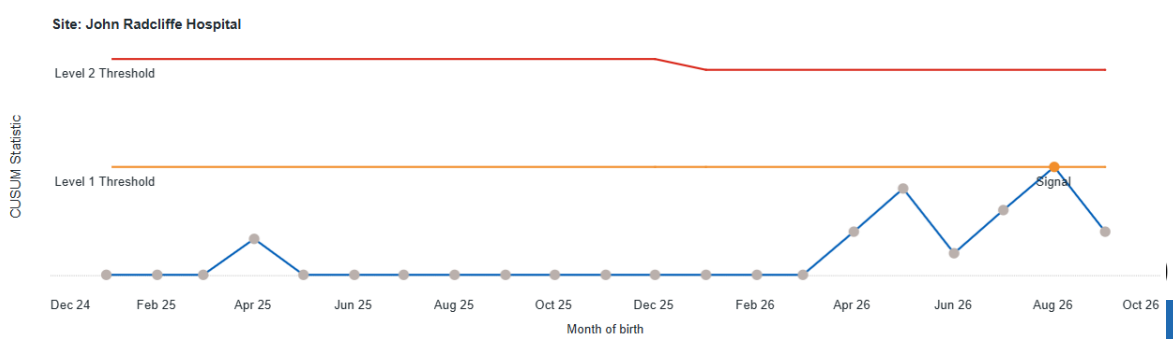
Key Areas Providing Assurance

- No immediate common theme identified across recent deaths.
- Daily MDT safety huddles, structured SBAR handovers and multidisciplinary escalation processes are embedded.
- Training compliance exceeds the 90% standard for CTG, PROMPT and neonatal resuscitation training.
- At the time of completing the form, there were no reported incidents where one-to-one care in labour was not maintained or where the Delivery Suite Coordinator was not supernumerary.
- Category 1 caesarean section performance remains strong over the past 3 months (average 93.9% achieved within 30 minutes).

Principal Risks Requiring Continued Oversight

- Maternity Assessment Unit (MAU) Triage
  - On average 61.2% of women assessed within 15 minutes against national expectation over the past 3 months.
  - Improvement trajectory evident (57.9% to >72%), but performance remains below standard.
- Category 2 Caesarean Section Timeliness
  - Compliance with delivery within 75 minutes is 63.3% over the past three months.
  - Further validation and analysis underway to understand causes of delay and identify additional actions.
- Culture, Communication and Staff Experience
  - Staff continue to report concerns regarding visibility of leadership, responsiveness to concerns, staffing pressures and communication.
  - Service users, MNVP and complaints data consistently identify communication and involvement in care planning as key improvement themes.
- Workforce and Capacity Risks
  - Obstetric staffing remains a recognised risk, particularly resident doctor capacity, MAU cover and out-of-hours resilience, although no direct impact on safety was identified during the review period

The Trust Board is asked to note the Green/Amber MOSS outcome and acknowledge that no new system wide safety issue has been identified.



Maternity and Neonatal Safety Champions feedback (quarterly)

Oxford University Hospitals NHS Foundation Trust

Feedback raised by staff	Action
• Staffing pressures were highlighted, particularly linked to summer nursing shortages in NNU and the impact on workload and continuity. • Teams reported strong overall experience, peer support and confidence in clinical skills. • IT challenges were repeatedly raised, including limited computer access and delays caused by system performance. Staff emphasised that IT issues directly affect efficiency and safety. • Positive feedback was given about new starters and students, who were described as enthusiastic, well-supported, and contributing meaningfully to the team. • Students reported good learning experiences, feeling welcomed and well-supervised. • They valued exposure to neonatal and transitional care environments and felt their confidence was growing.	• Review IT access and reliability across Level 5. • Escalate staffing pressures through safe-staffing governance routes. • Continue visible leadership presence to maintain psychological safety and open dialogue. • Share feedback with matrons and multidisciplinary leads to support targeted improvements.
Feedback raised by service users	**Additional safety champions intelligence**
• Families described staff as kind, present, and reassuring, particularly during periods of uncertainty. • They appreciated clear communication and continuity of care. • Some families noted delays linked to staffing or IT access, reinforcing the themes raised by staff.	**Key Themes Identified** • Staffing pressures impacting pace and workload. • Strong clinical experience across teams, with good support for students. • IT barriers affecting documentation, flow, and staff efficiency. • Positive family experience, with clear appreciation of staff compassion and communication.

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Appendices

Appendix 1: SPC Charts

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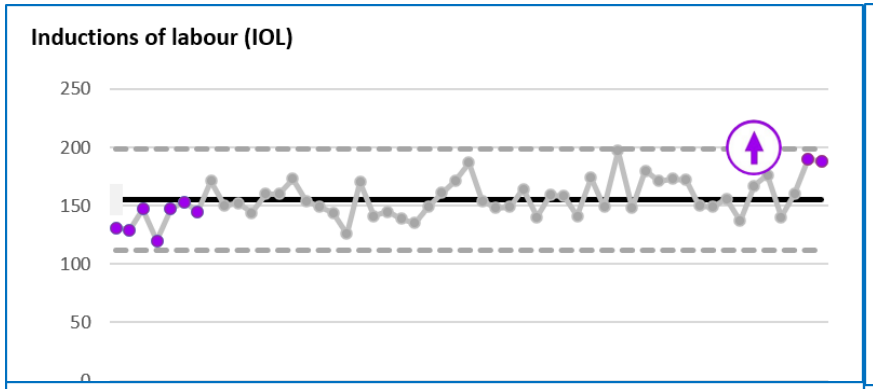

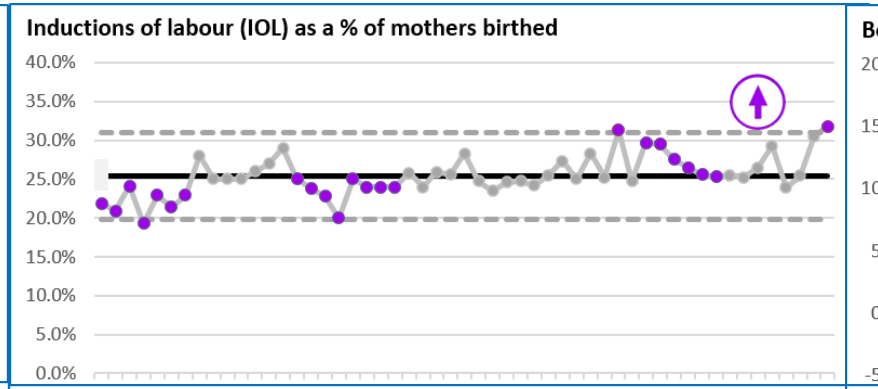

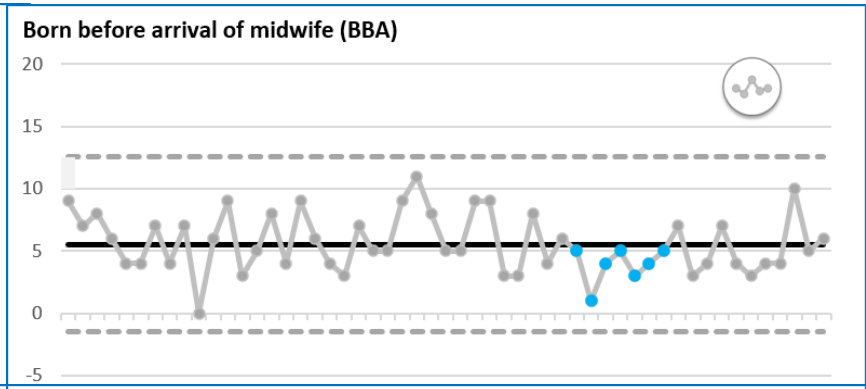

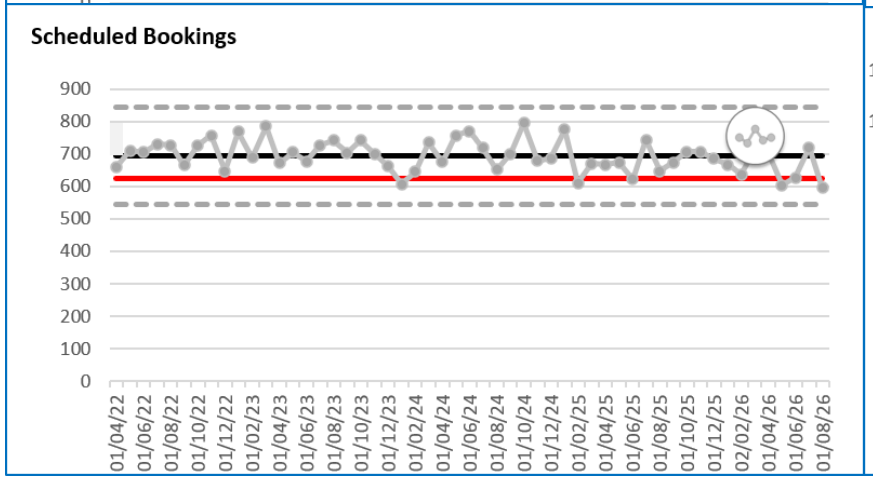

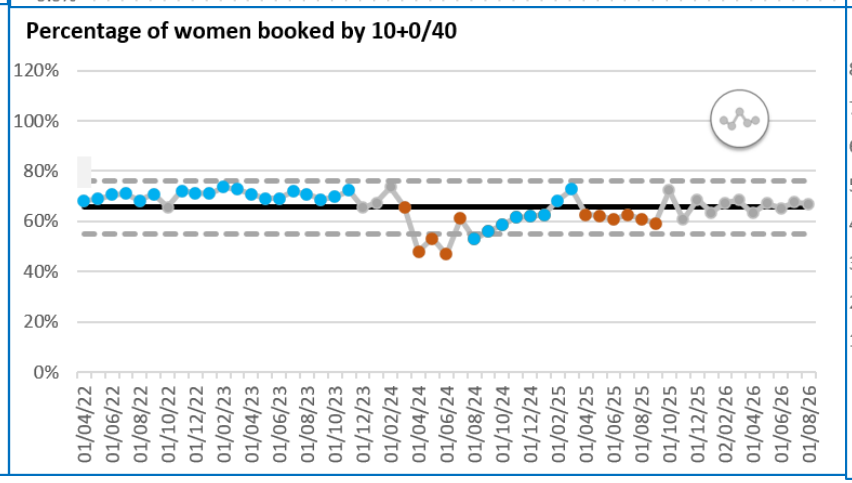

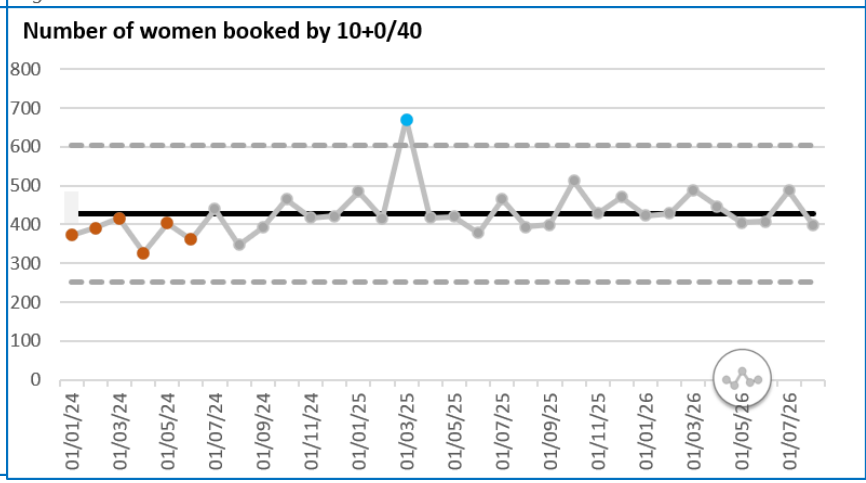

Appendix 1: SPC Charts

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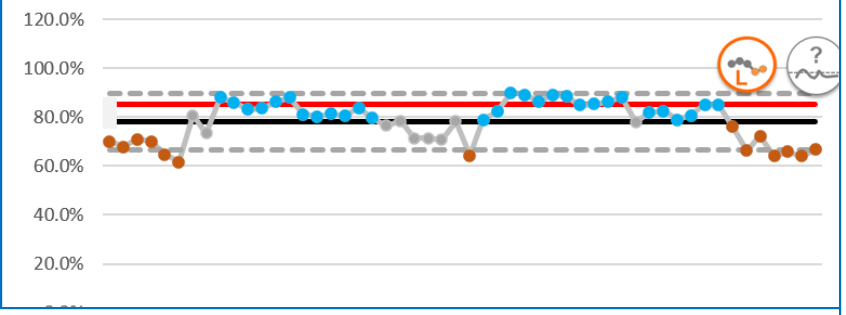
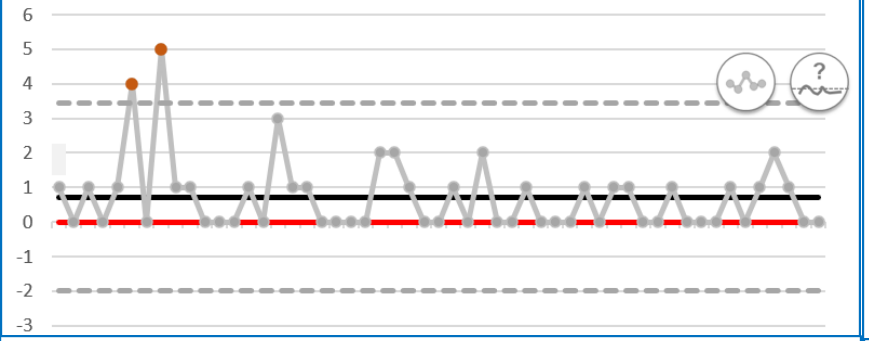
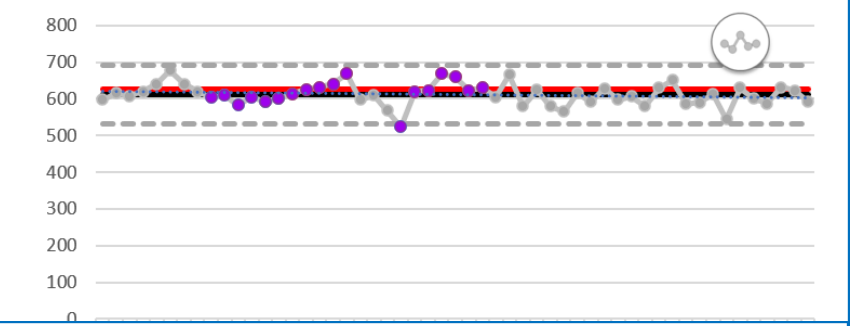
Test Result Endorsement



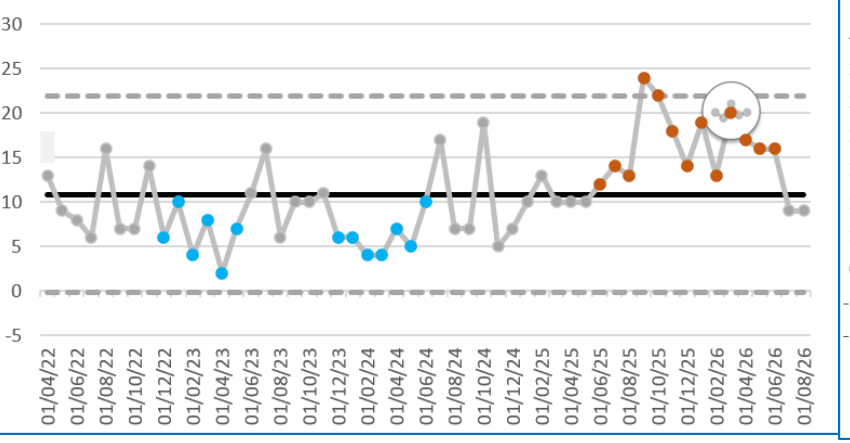
Number of PSII



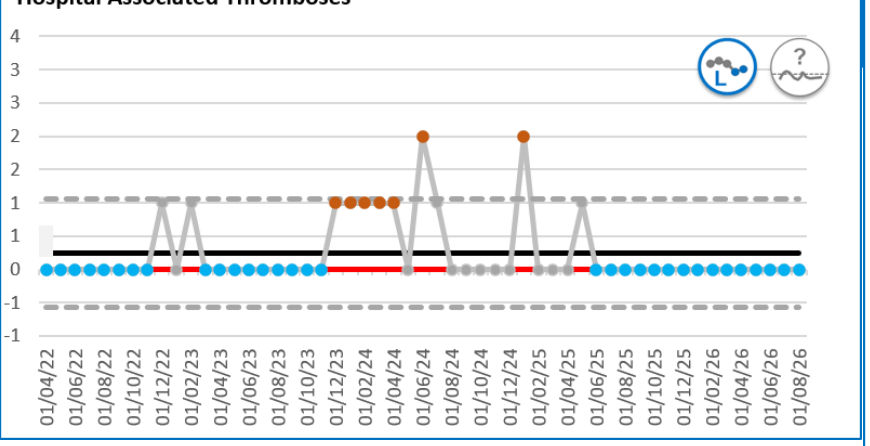
Mothers Birthed



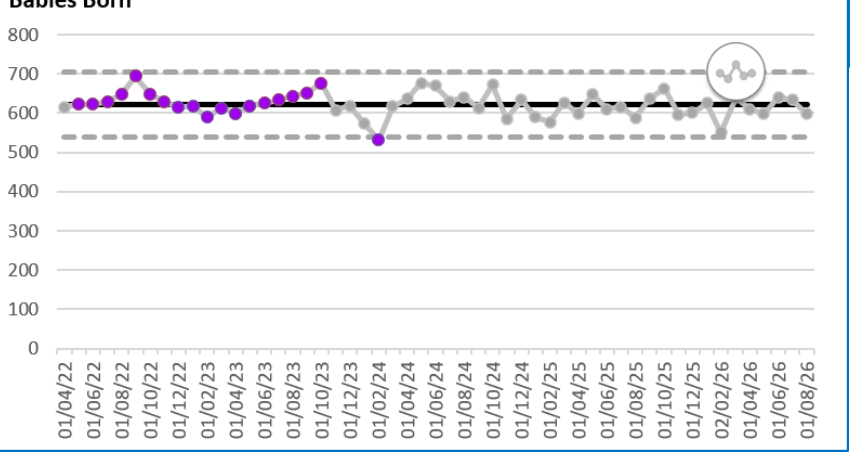
Number of Complaints



Hospital Associated Thromboses



Babies Born



Appendix 1: SPC Charts

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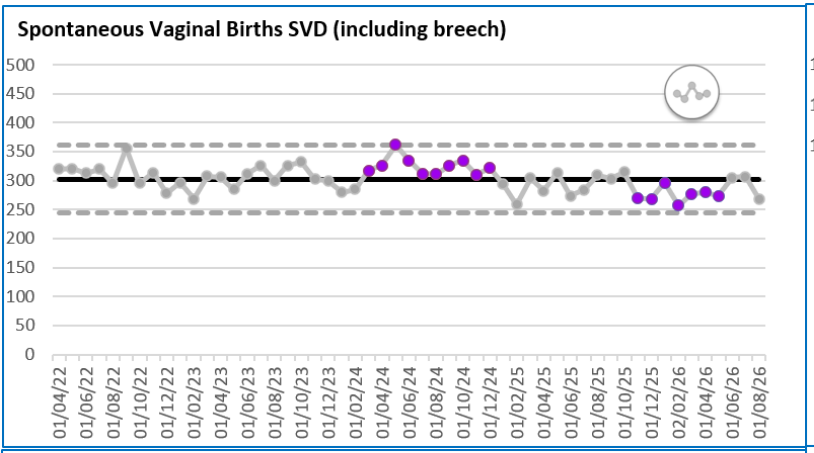

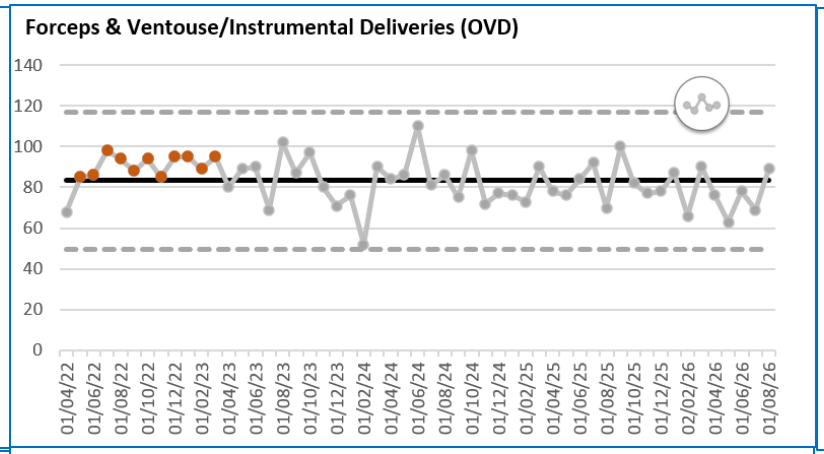

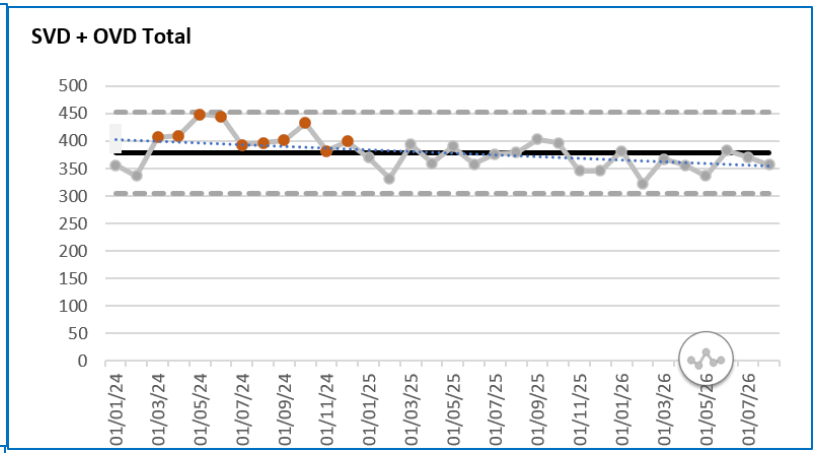

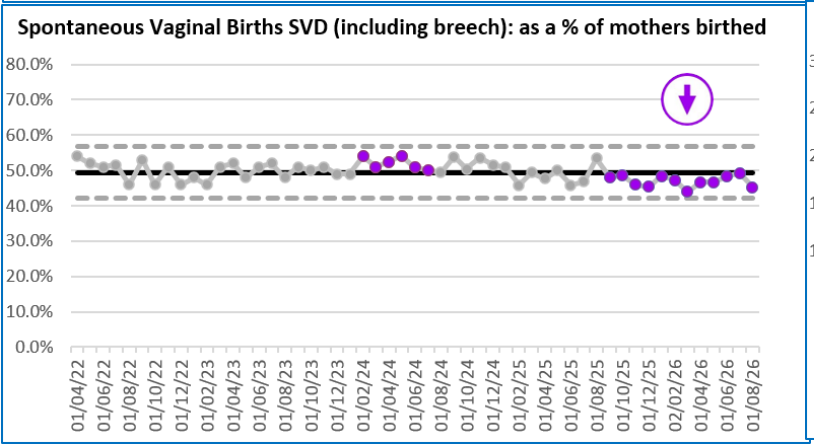

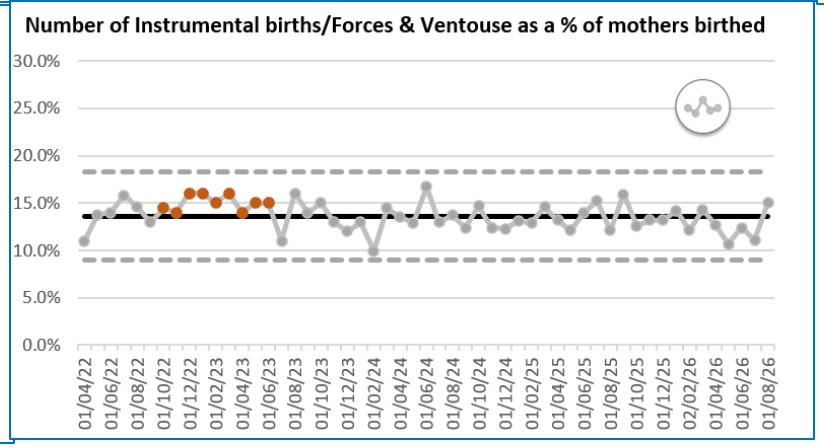

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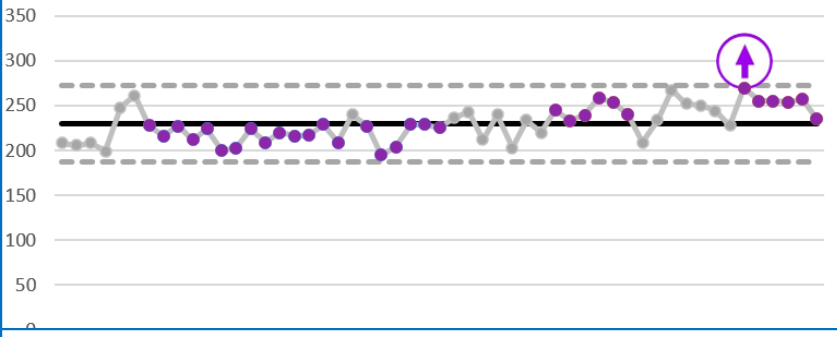
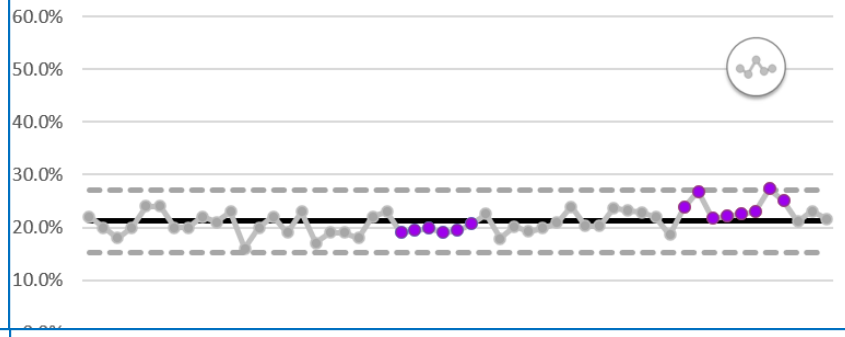
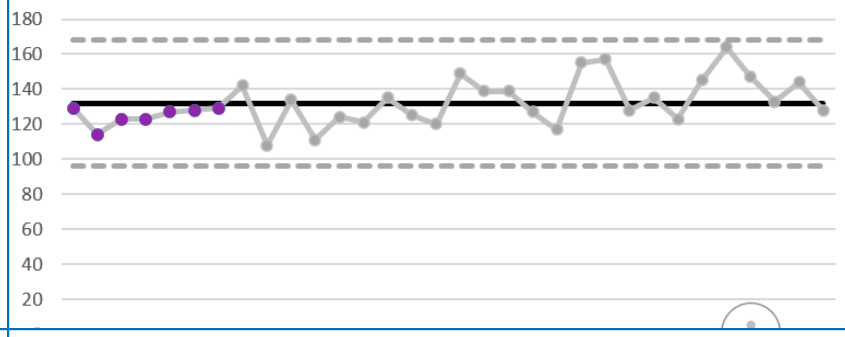
Caesarean Section (CS)



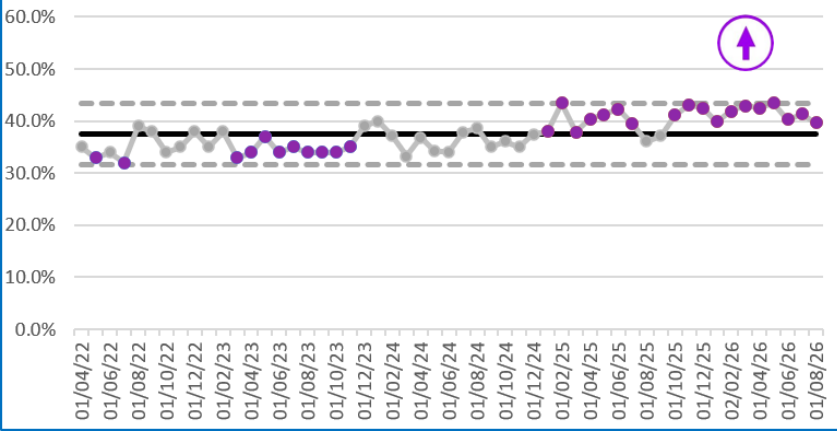
Emergency CS births as a %



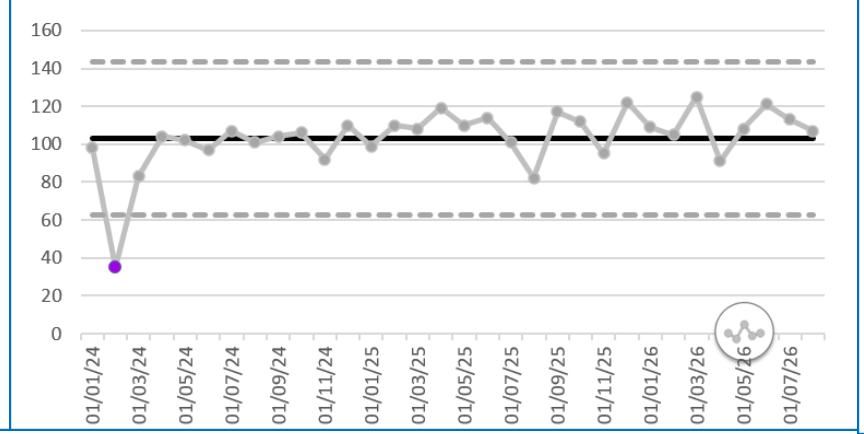
Number of Emergency CS



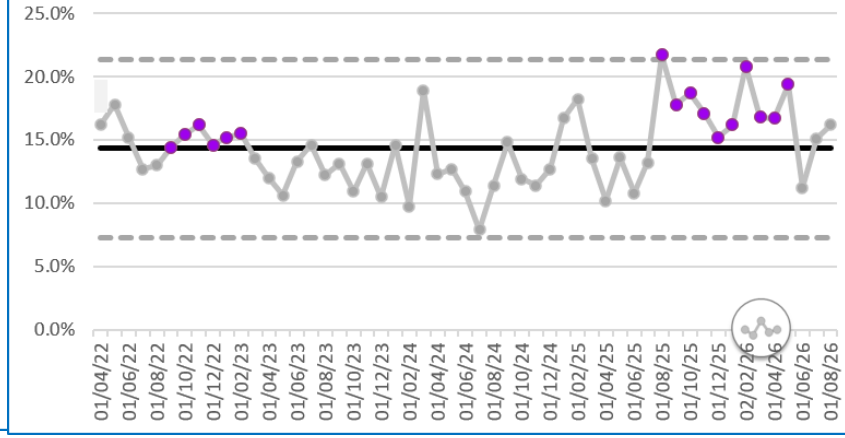
Number of CS births as a % of mothers birthed



Number of Elective CS



Robson Group 1 c-section with no previous births a %



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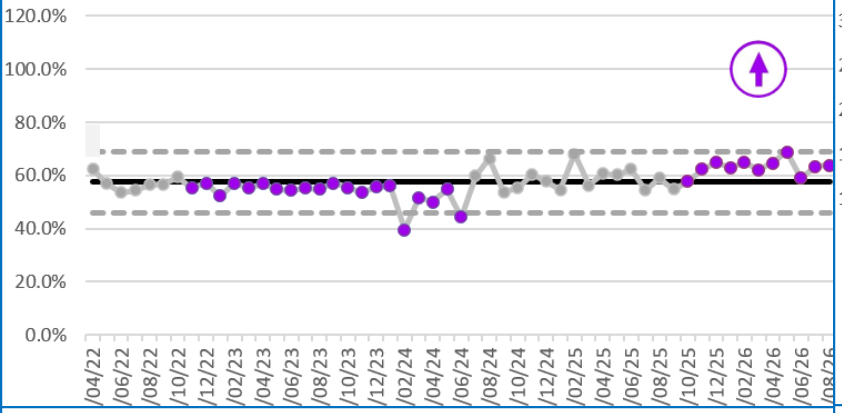
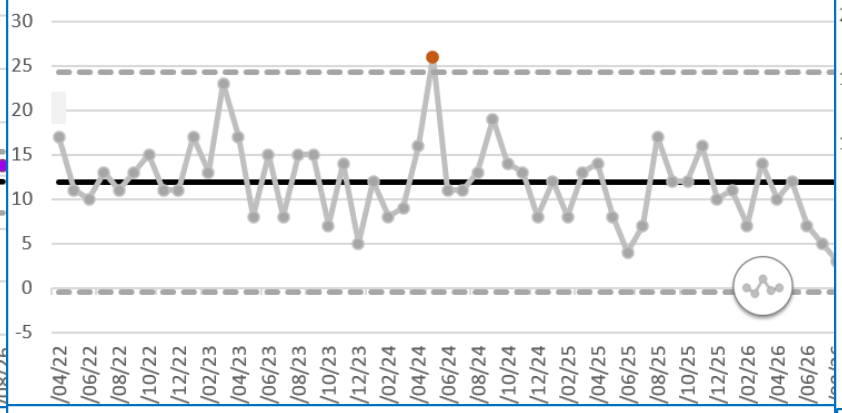
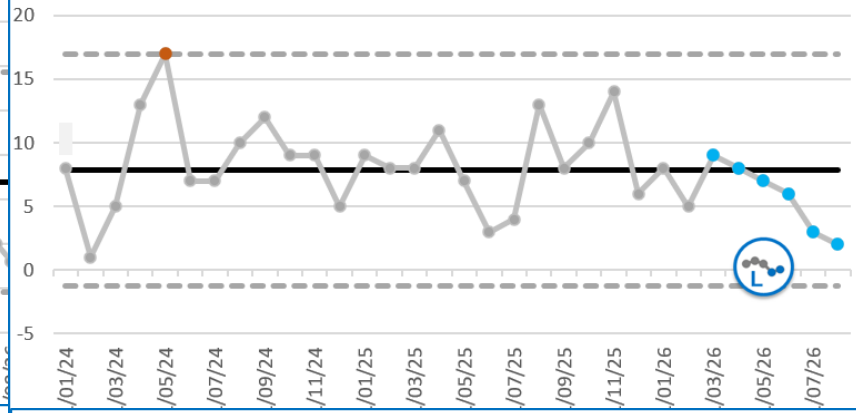
Robson Group 2 c-section with no previous births a %



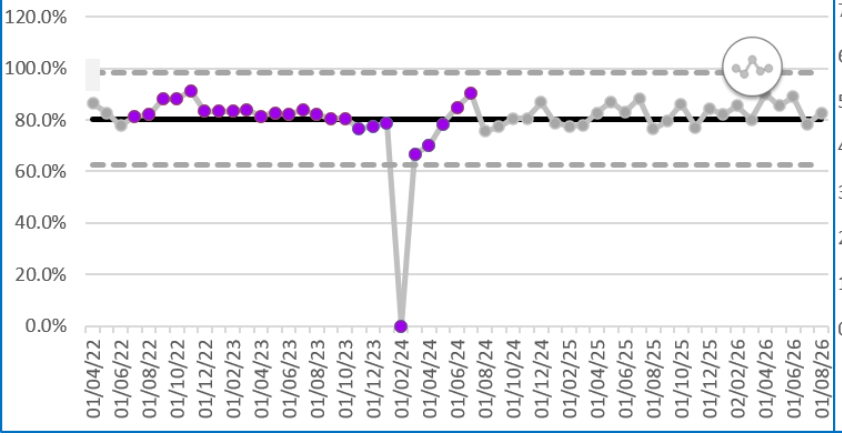
3rd/4th Degree Tears amongst mothers birthed



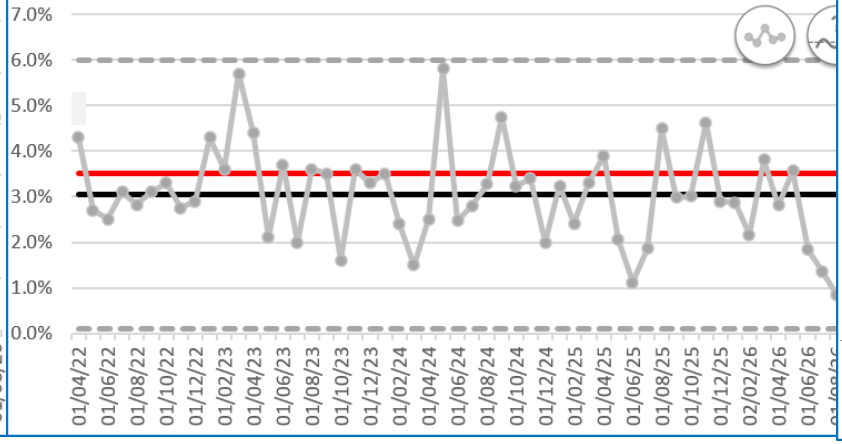
3rd/4th degree tears following unassisted Vaginal birth (SVD)



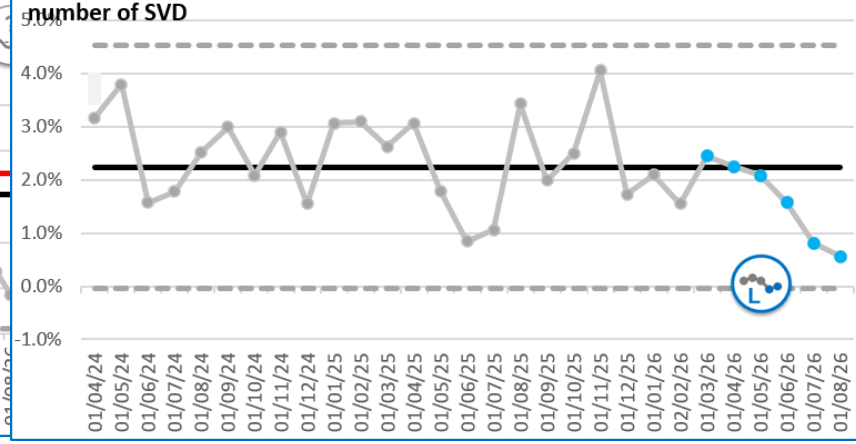
Robson Group 5 c-section with 1+ previous births a %



3rd/4th degree tears amongst mothers birthed as a %



3rd/4th degree tears following unassisted Vaginal birth (SVD) as a % of total number of SVD



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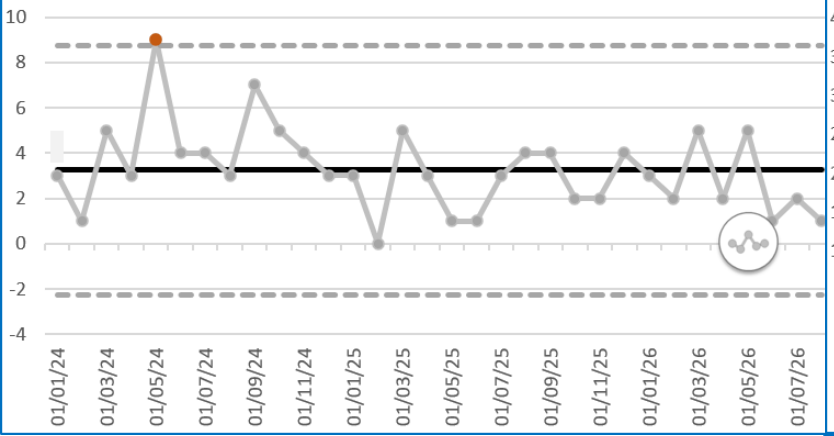
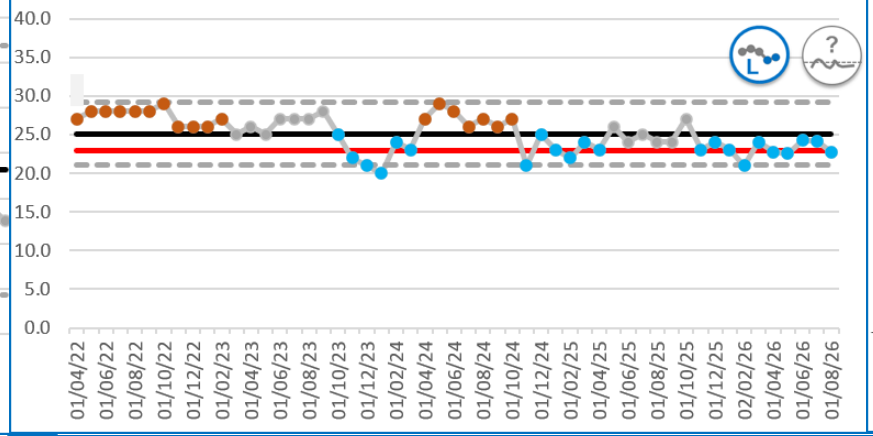
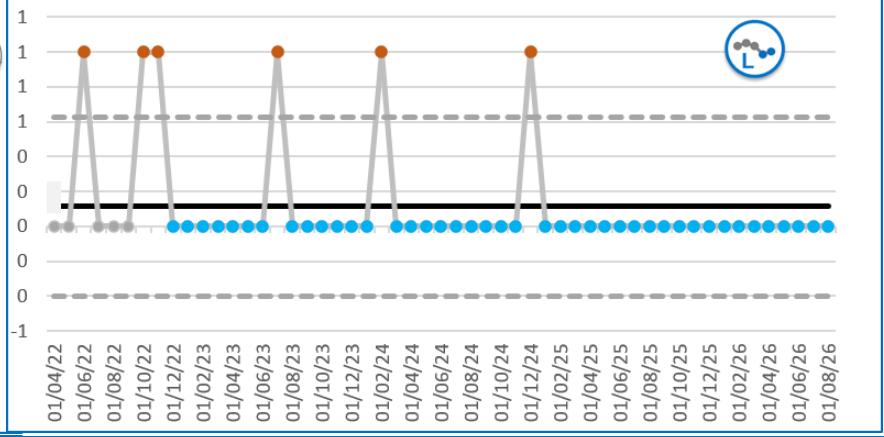
3rd/4th degree tears following an Instrumental vaginal birth (OVD)



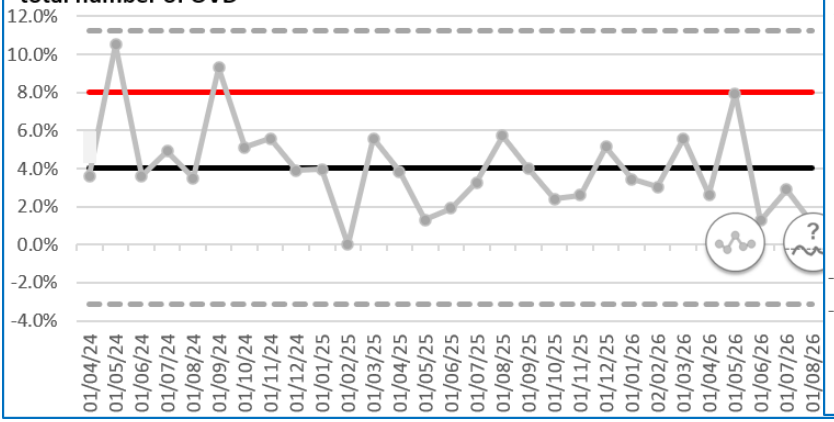
Midwife:birth ratio



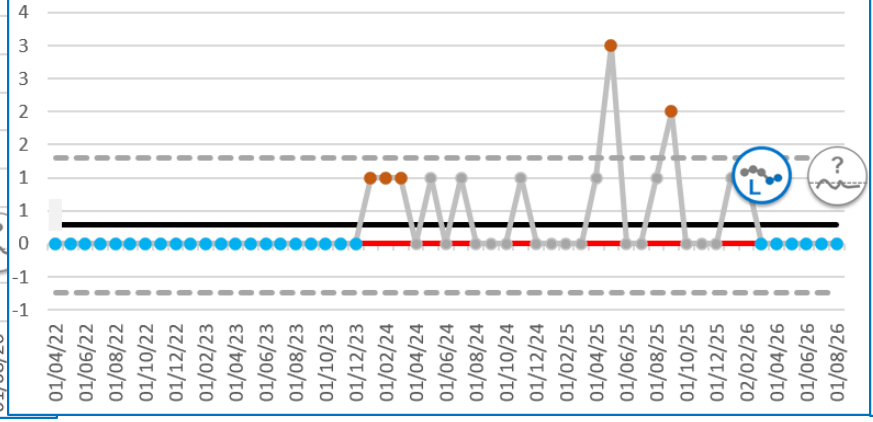
Maternal Deaths: All



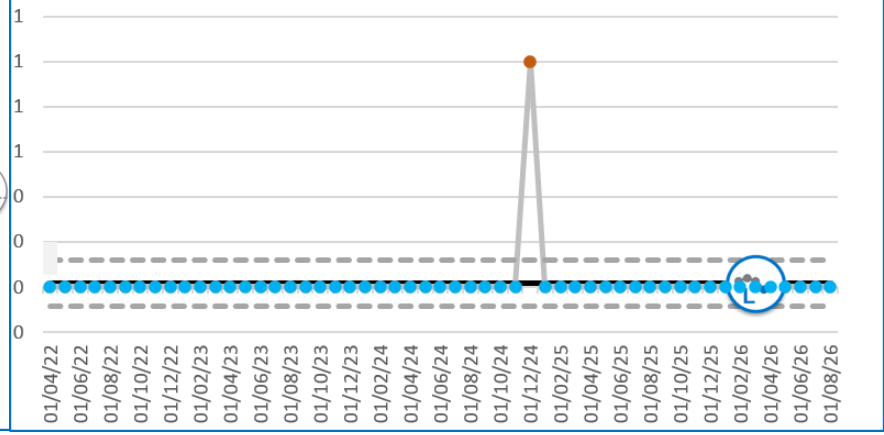
3rd/4th degree tears following an Instrumental vaginal birth (OVD) as a % of total number of OVD



HIE



Early Maternal Deaths: Direct



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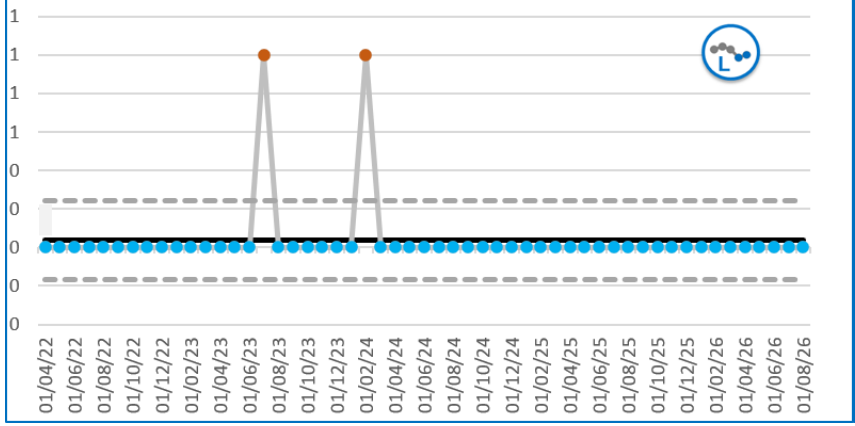
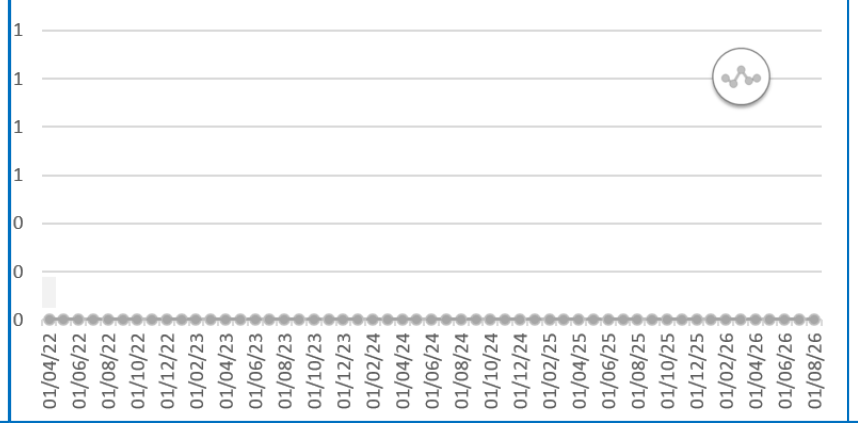
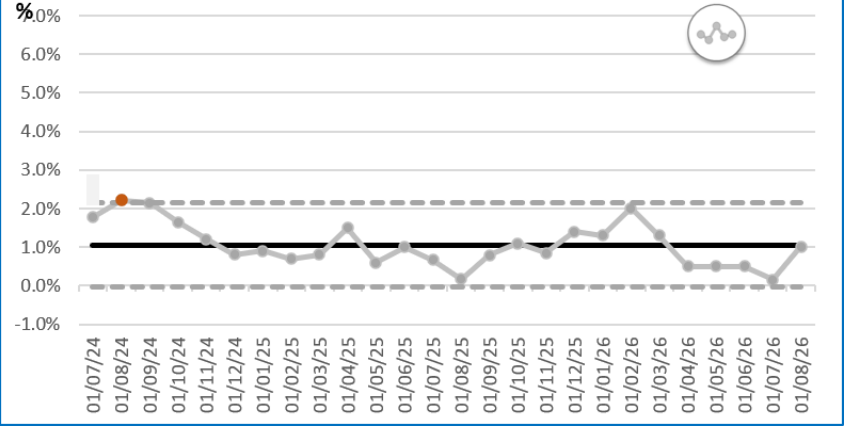
Early Maternal Deaths: Indirect



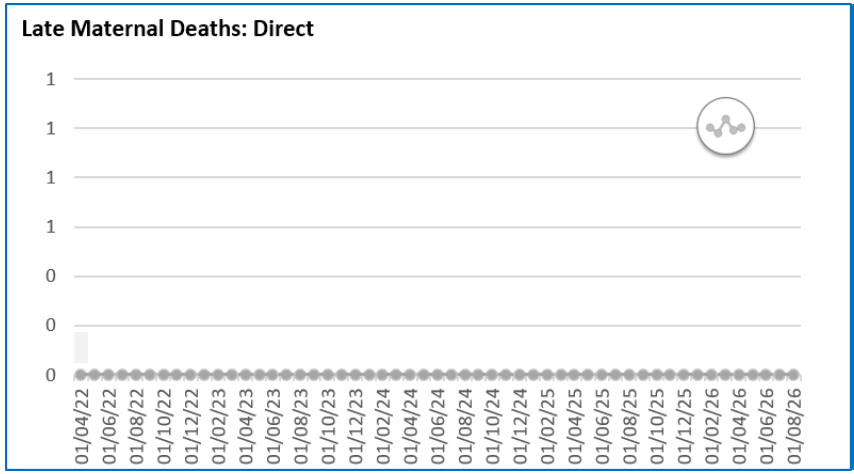
Late Maternal Deaths: Indirect



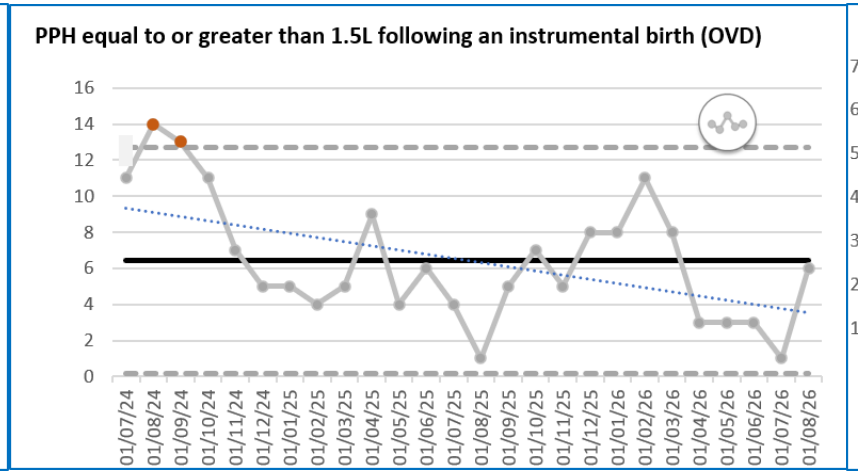
PPH equal to or greater than 1.5L following an instrumental birth (OVD) as a %



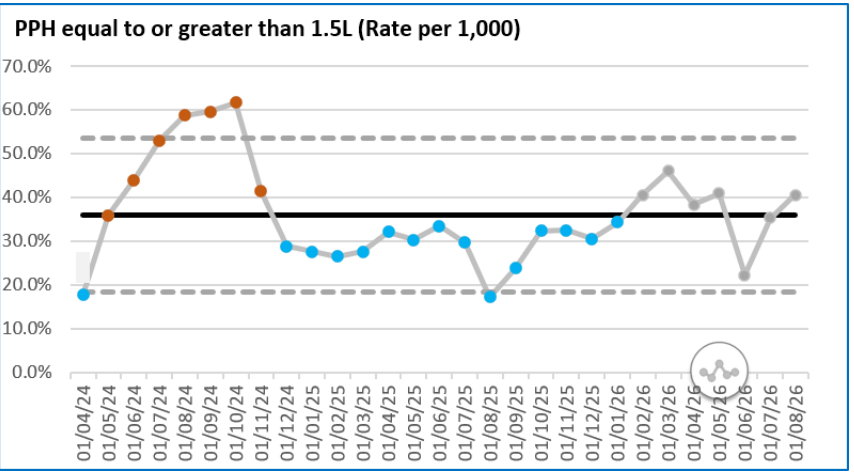
Late Maternal Deaths: Direct



PPH equal to or greater than 1.5L following an instrumental birth (OVD)



PPH equal to or greater than 1.5L (Rate per 1,000)



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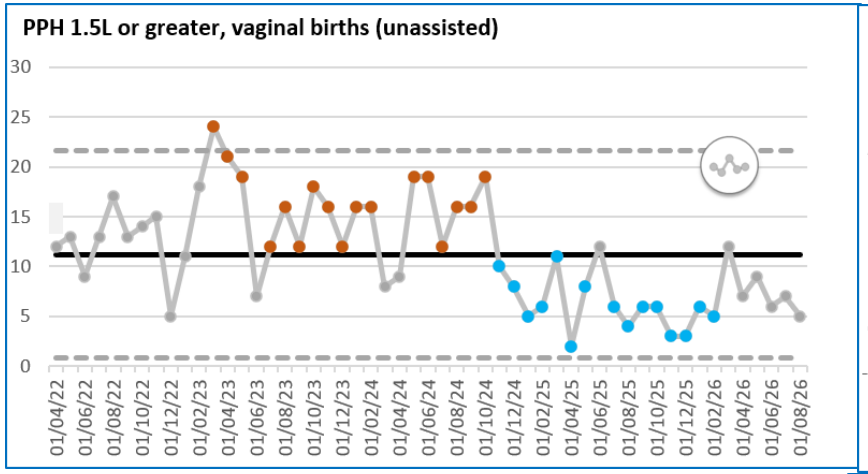

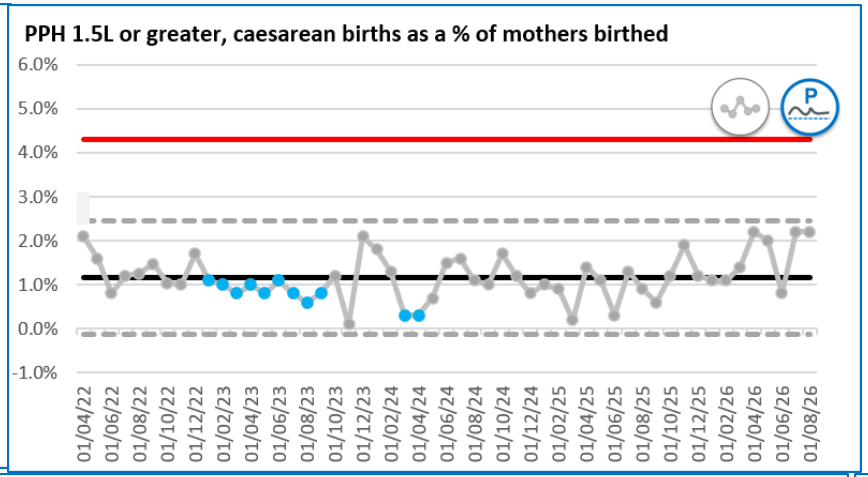

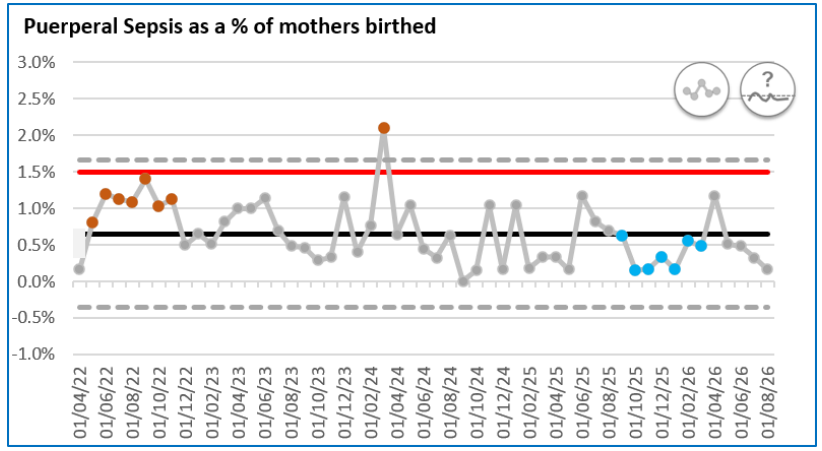

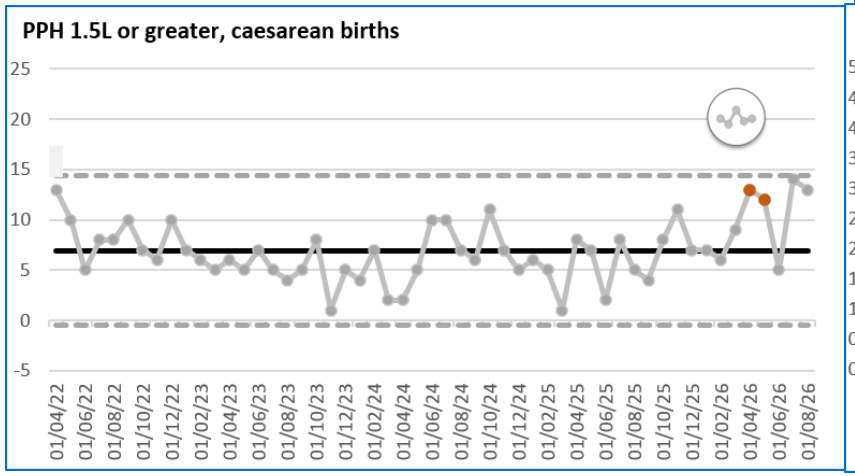

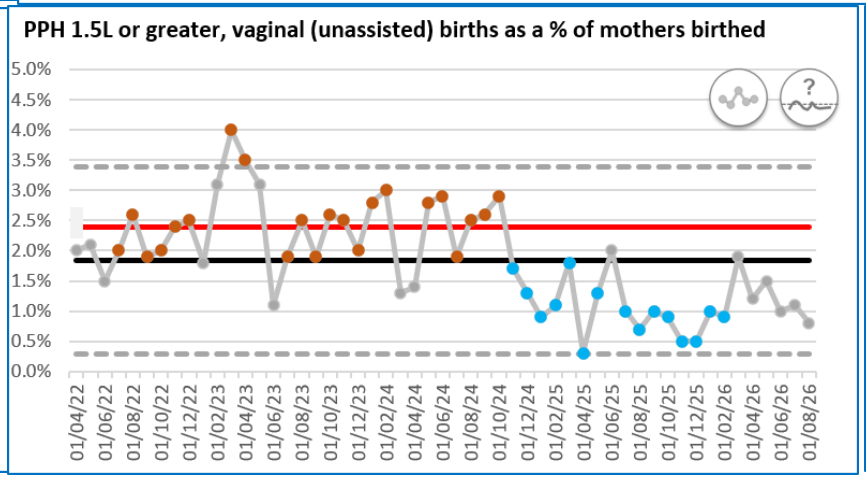

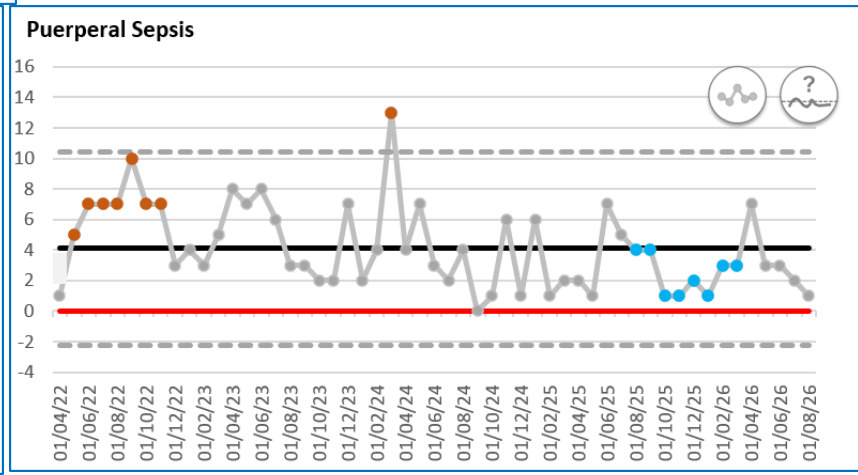

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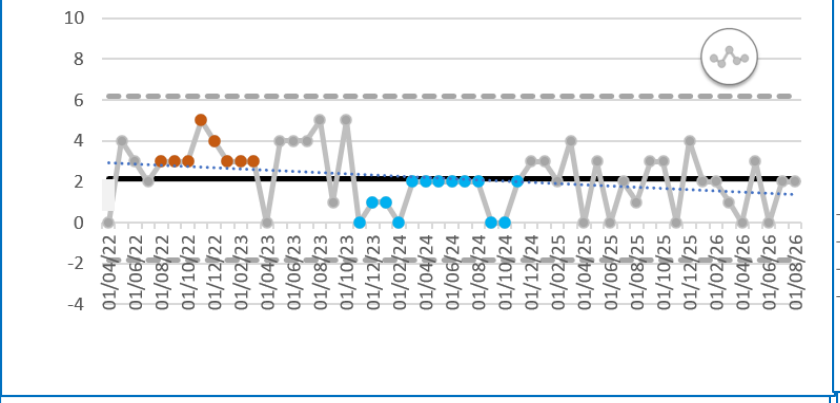
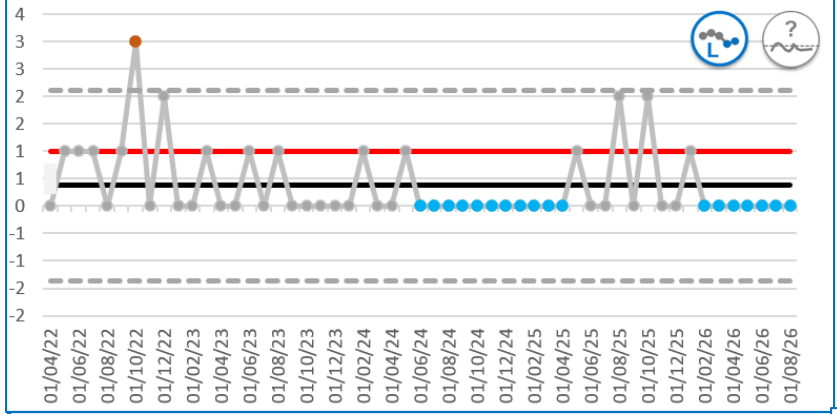
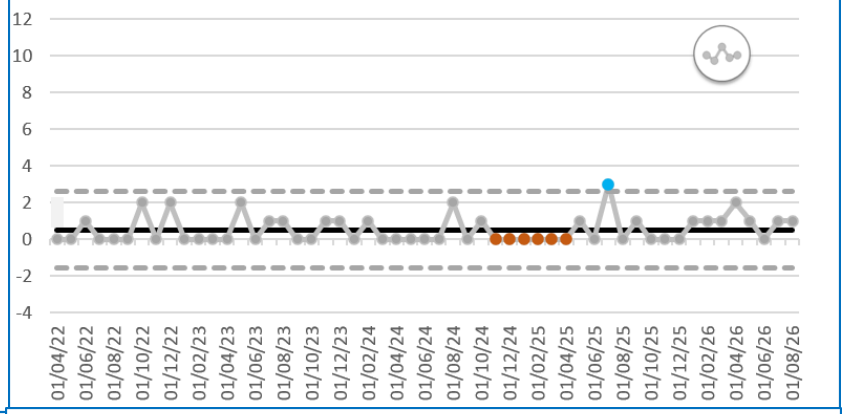
Stillbirths (24+0/40 onwards; excludes TOPs)



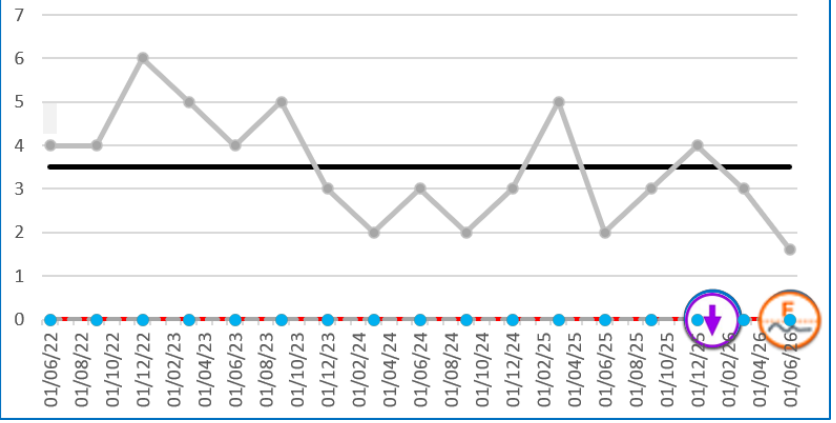
Late fetal losses (delivered 22+0 to 23+6/40; excludes TOPs)



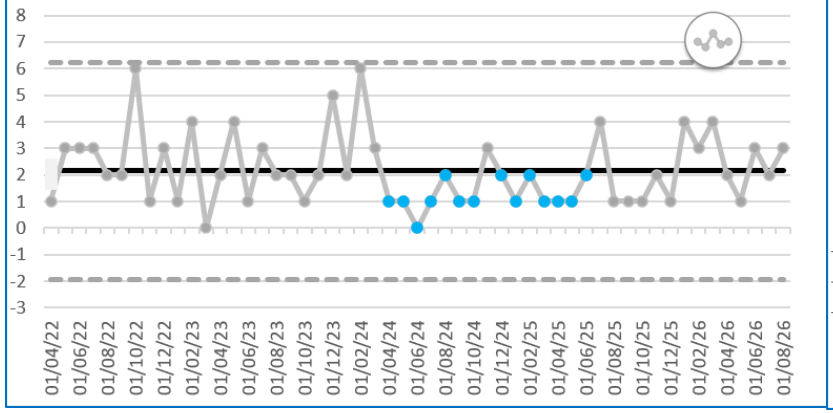
Neonatal Deaths (born in OUH, up to 28 days): Late deaths (7 to 28 days)



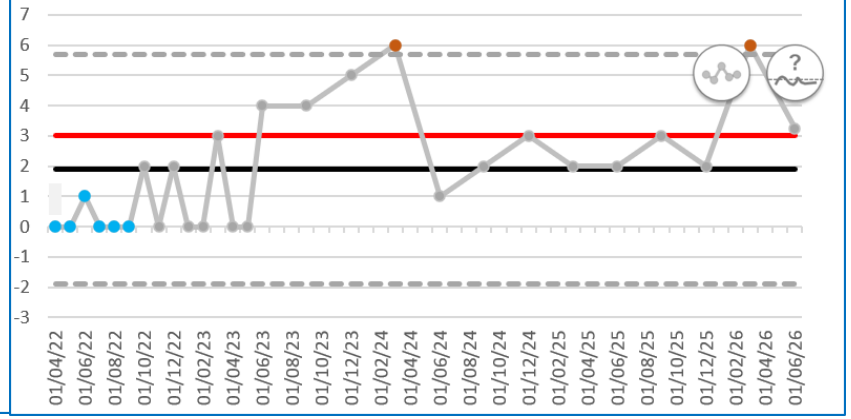
Stillbirths (24+0/40 onwards; excludes TOPs): as rate per 1000 total births



Neonatal Deaths (born in OUH, up to 28 days) All



Neonatal Deaths (born in OUH, up to 28 days): as rate per 1000 births



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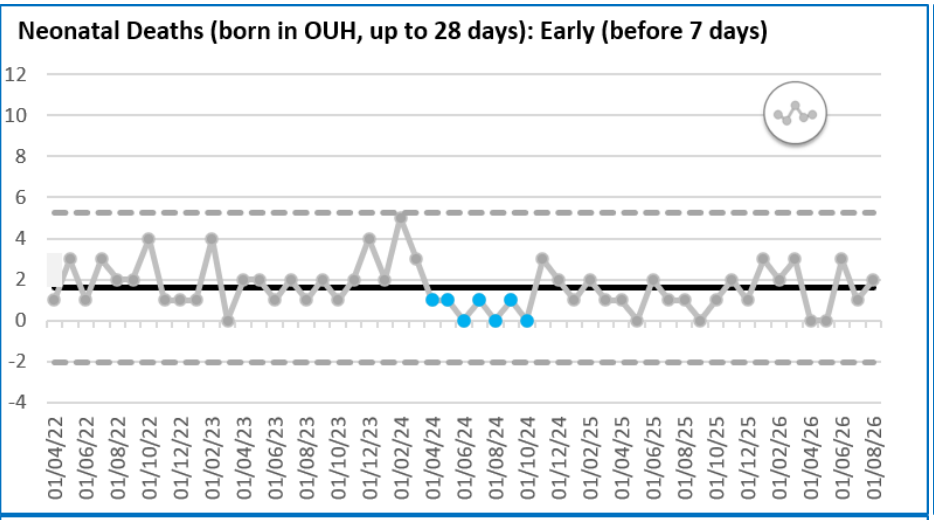

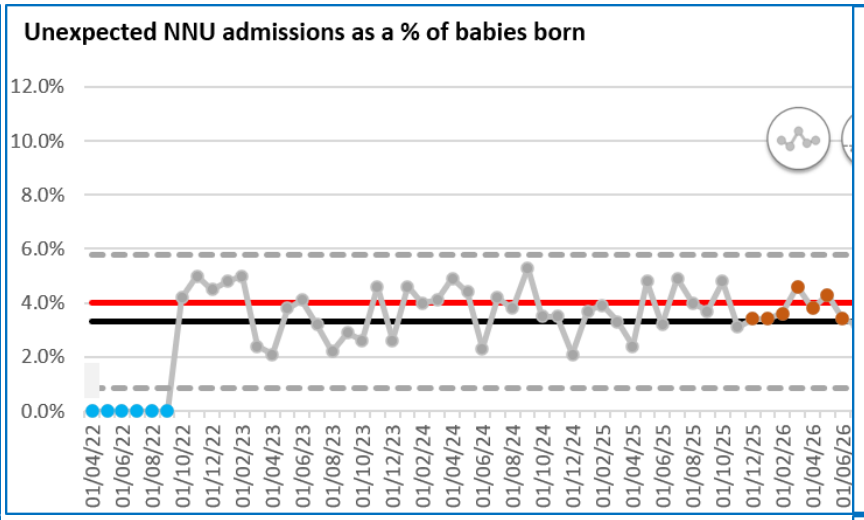

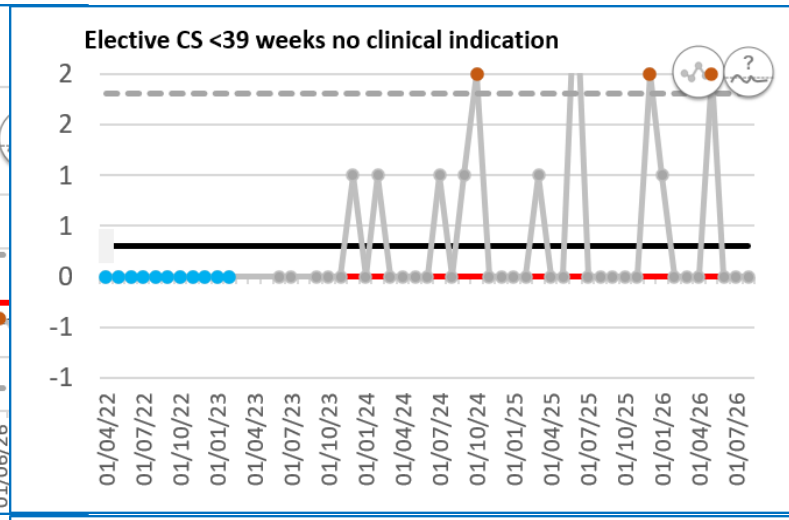

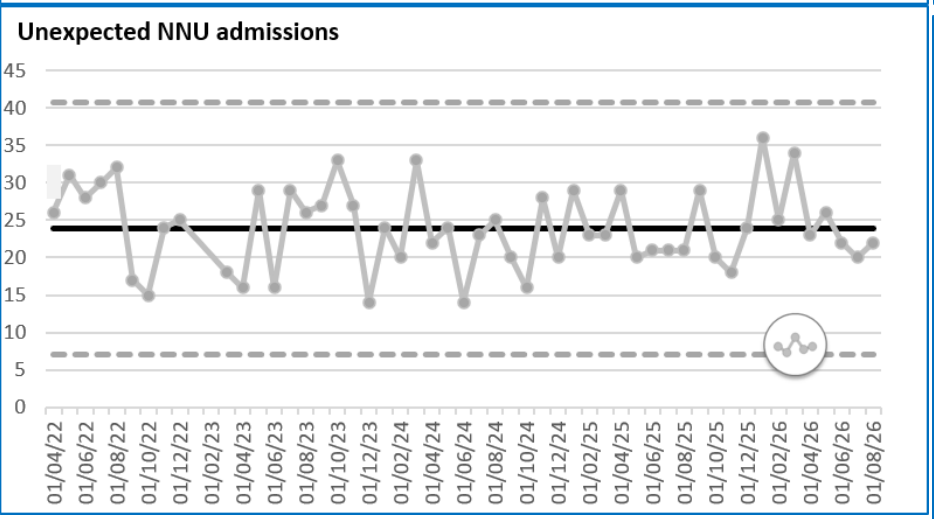

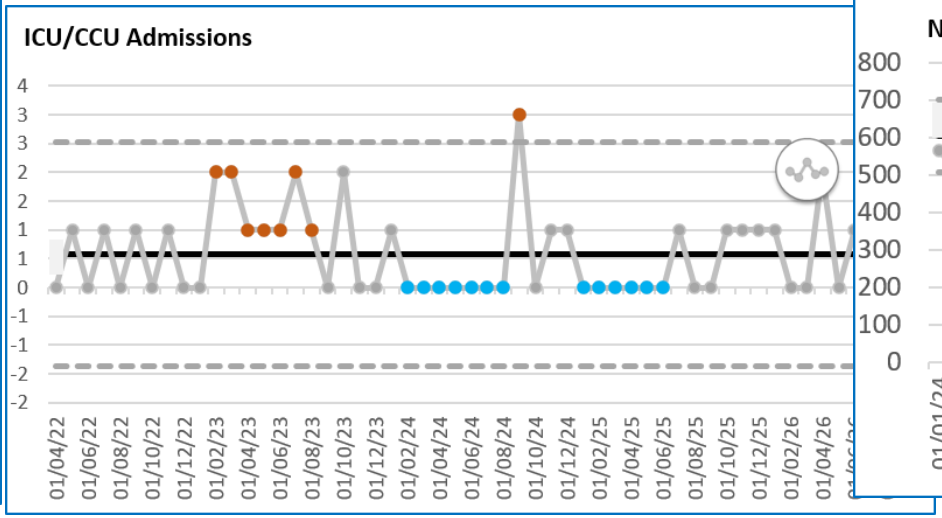

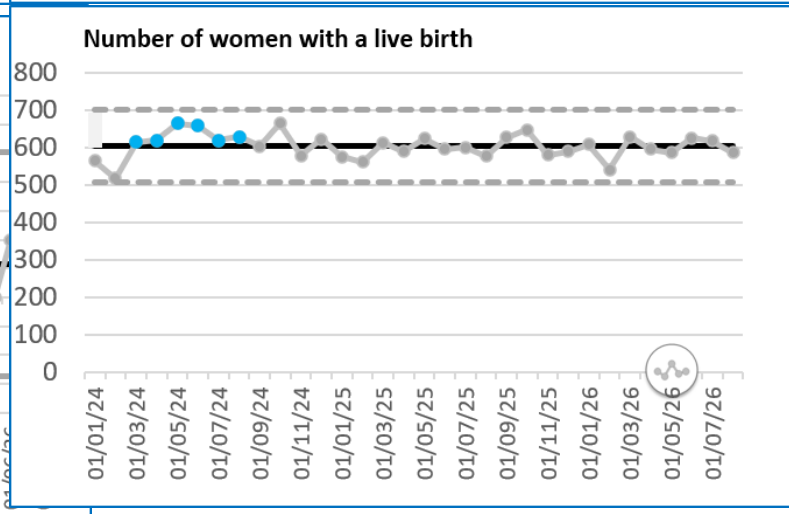

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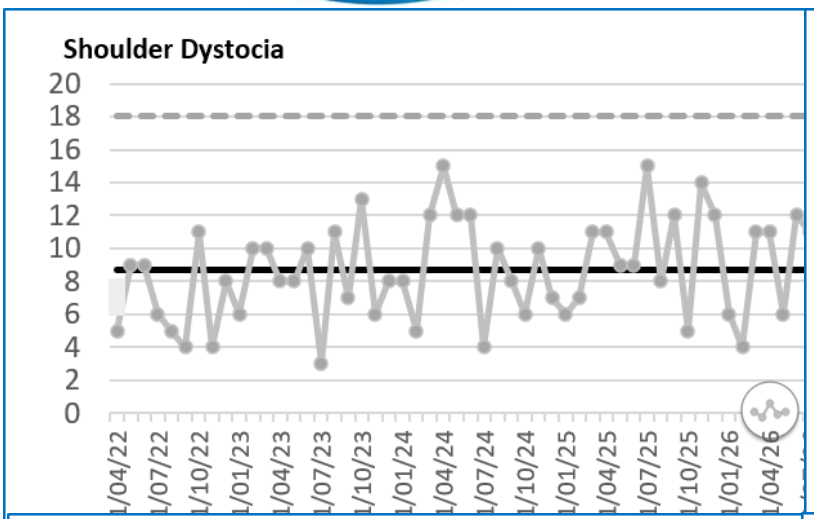

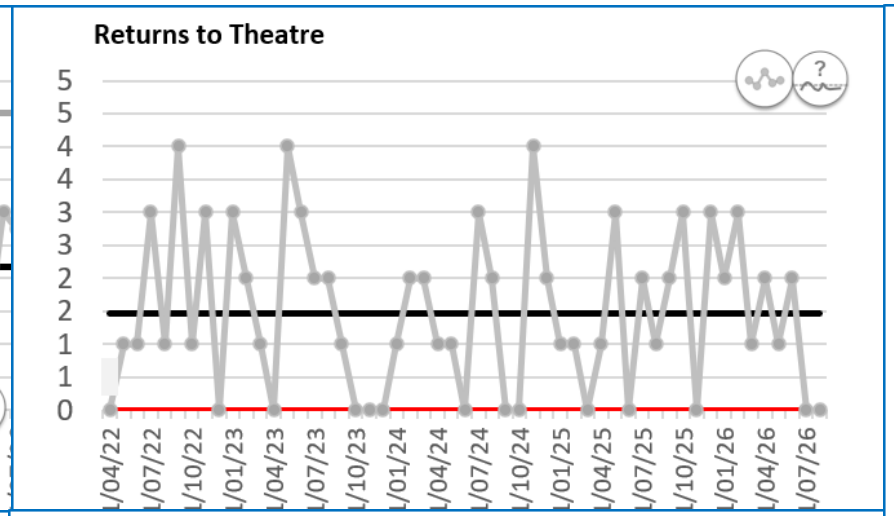

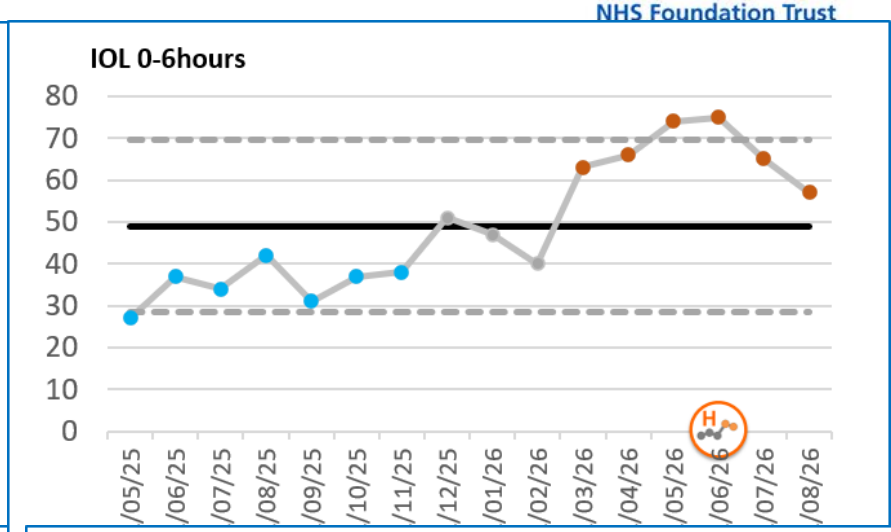

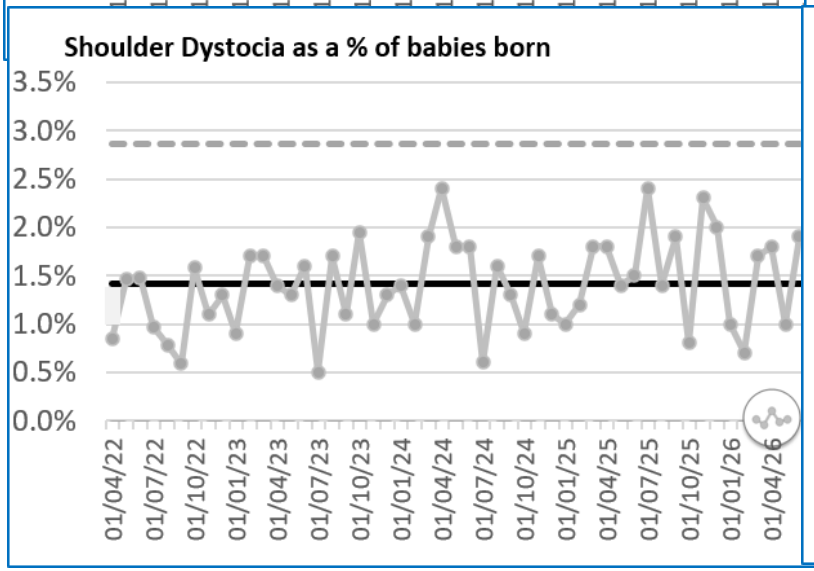

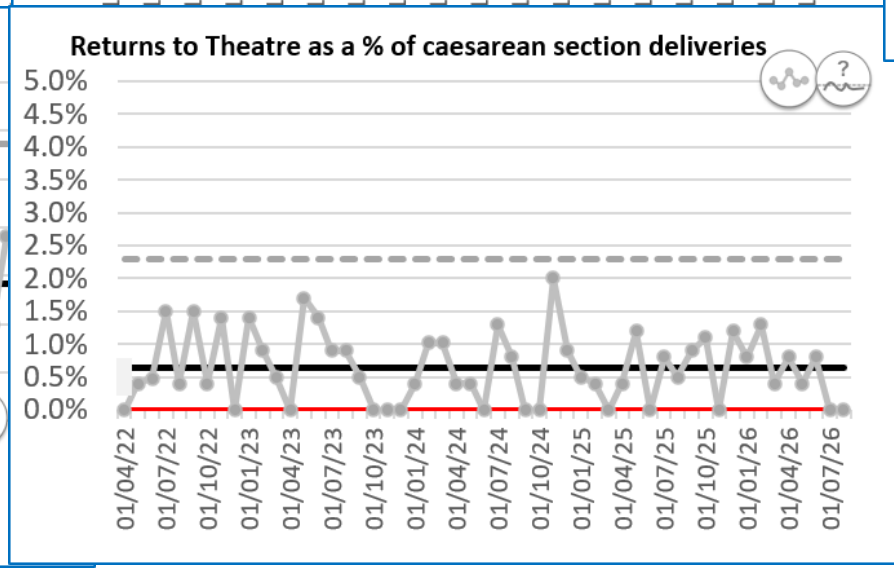

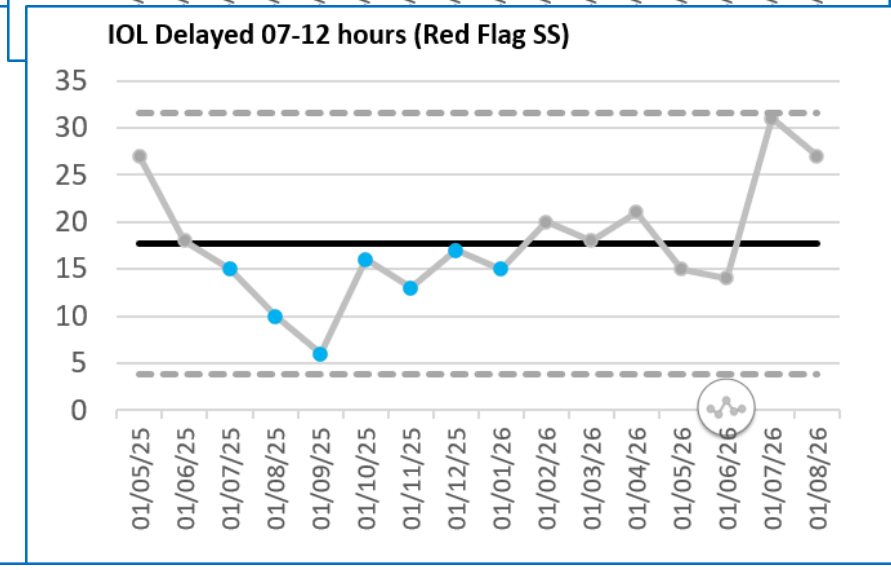

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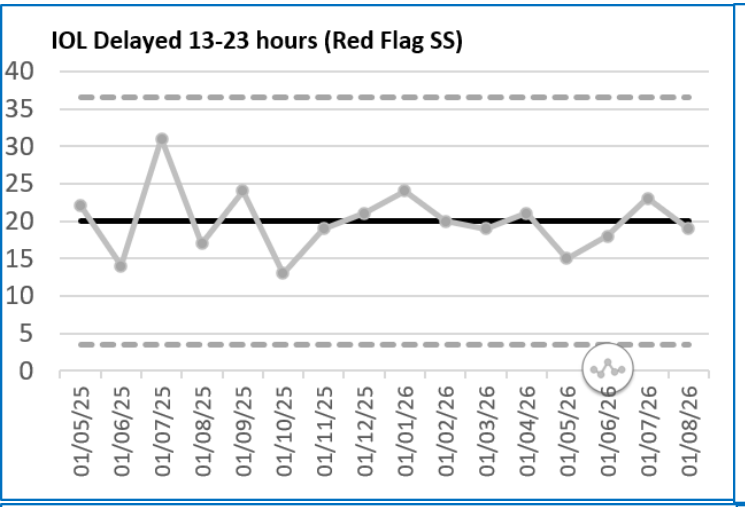

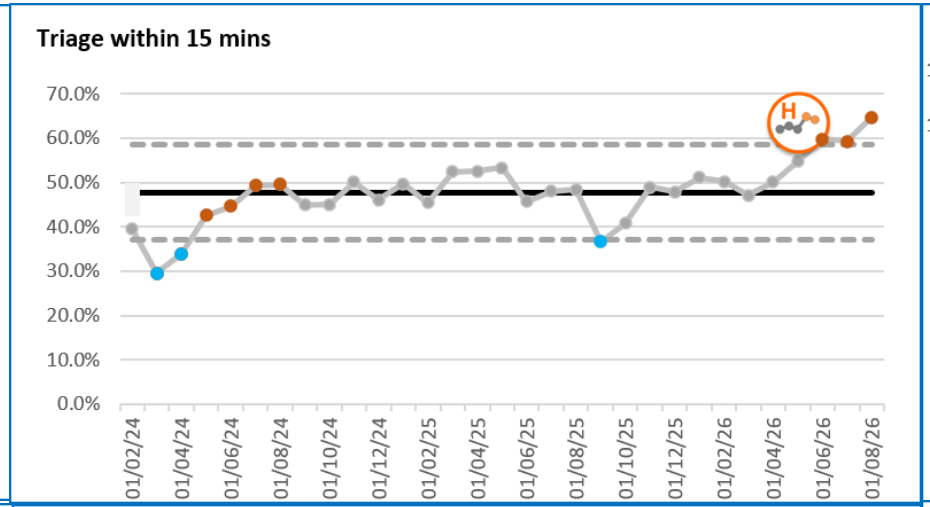

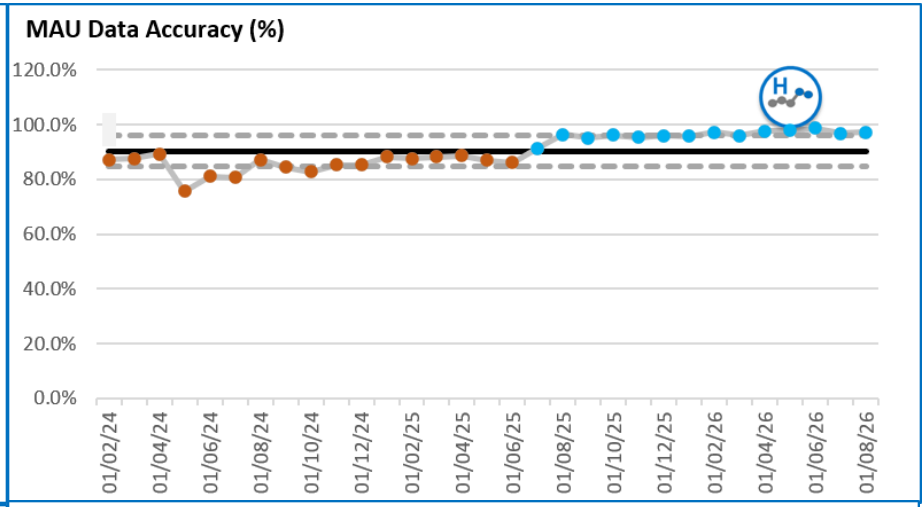

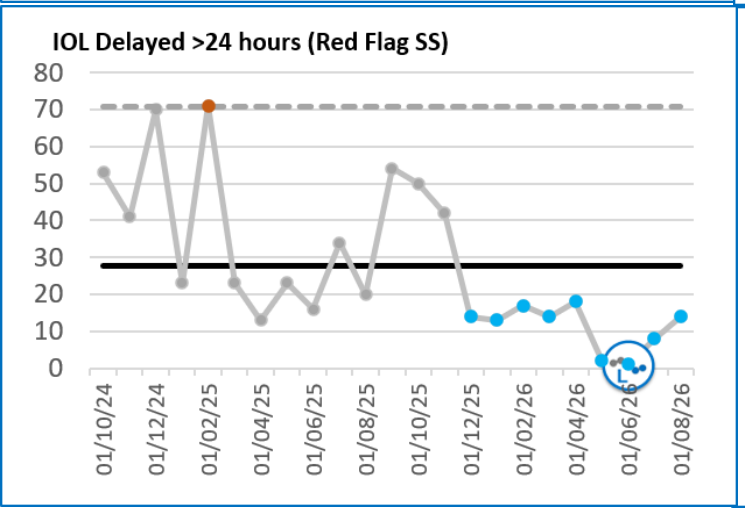

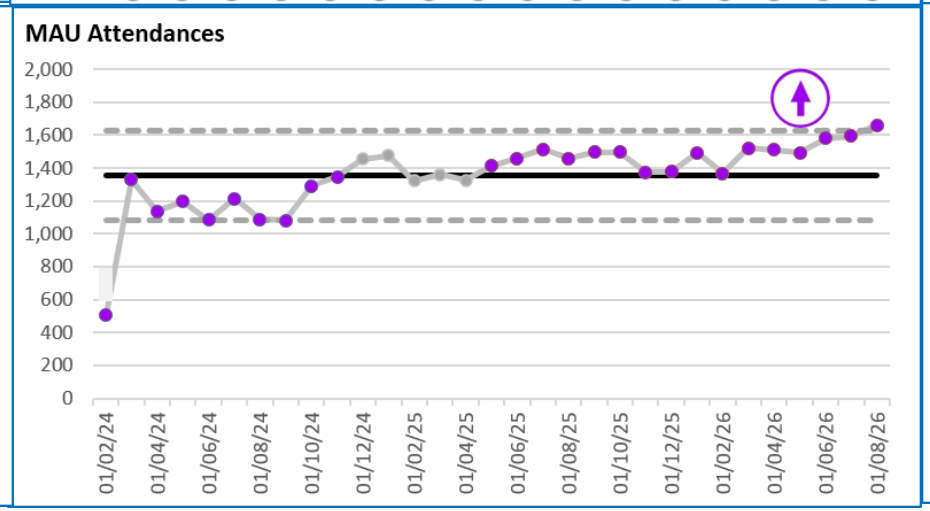

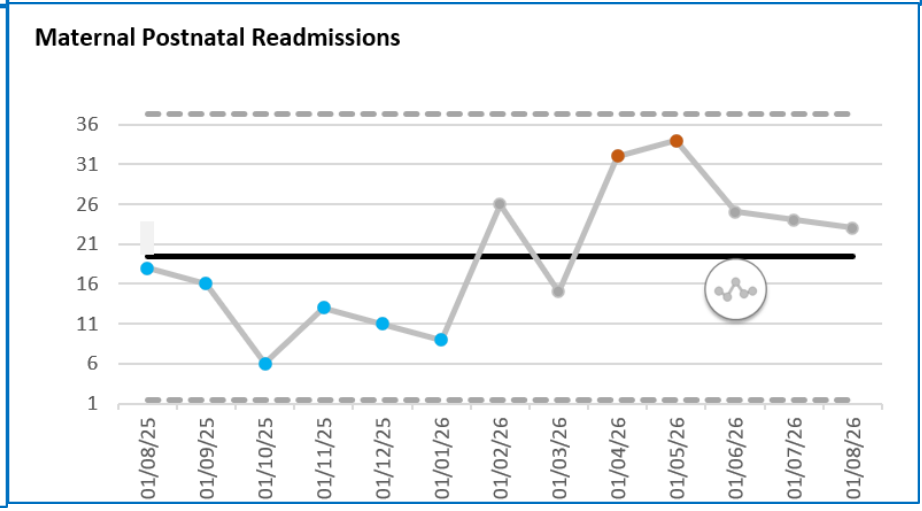

Appendix 1: SPC Charts

Oxford University Hospitals
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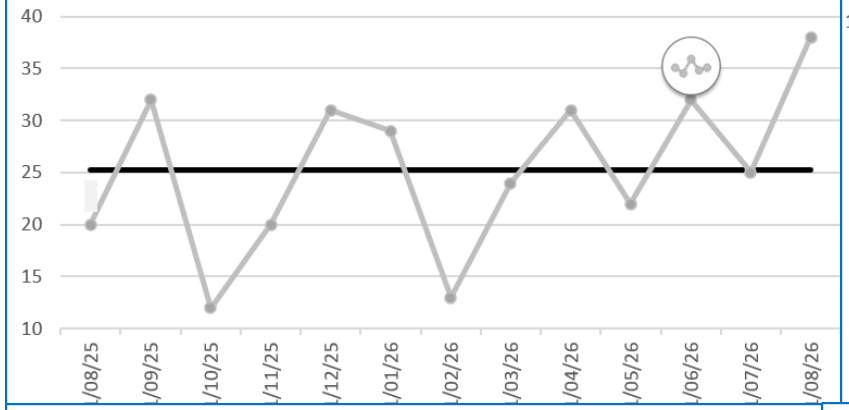
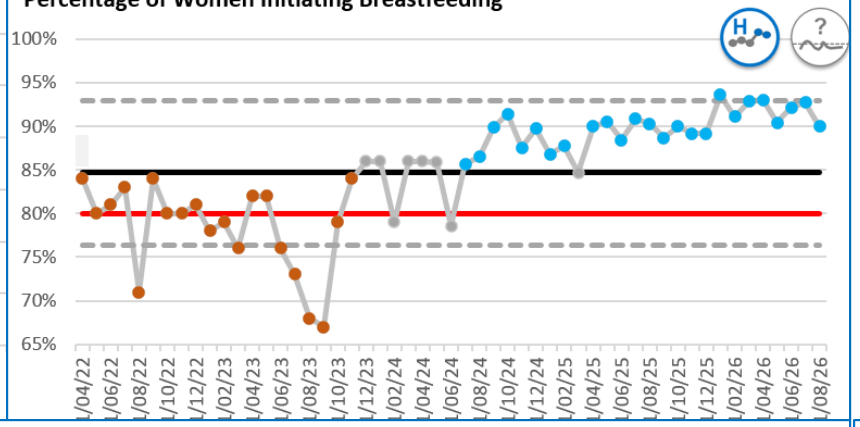
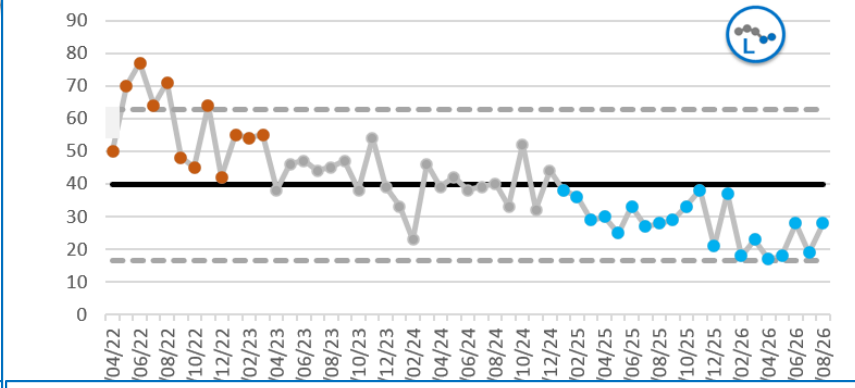
Readmission of babies



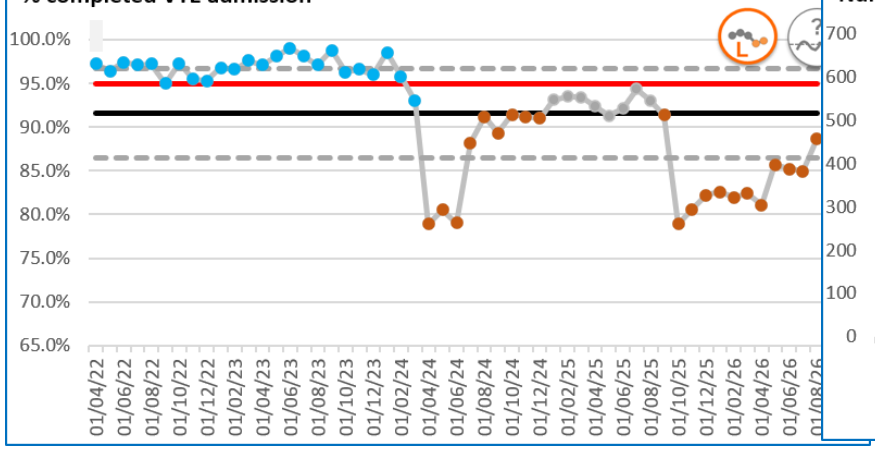
Percentage of Women Initiating Breastfeeding



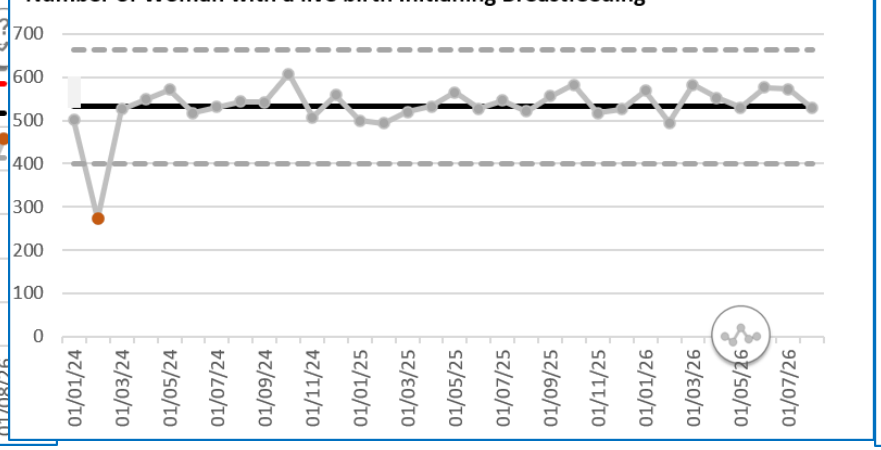
Number Of Women Booked This Month Who Currently Smoke



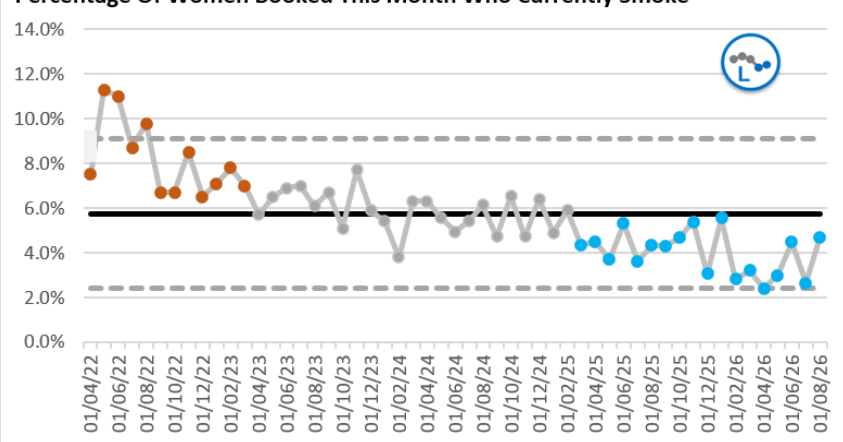
% completed VTE admission



Number of Woman with a live birth Initianing Breastfeeding



Percentage Of Women Booked This Month Who Currently Smoke



Appendix 1: SPC Charts

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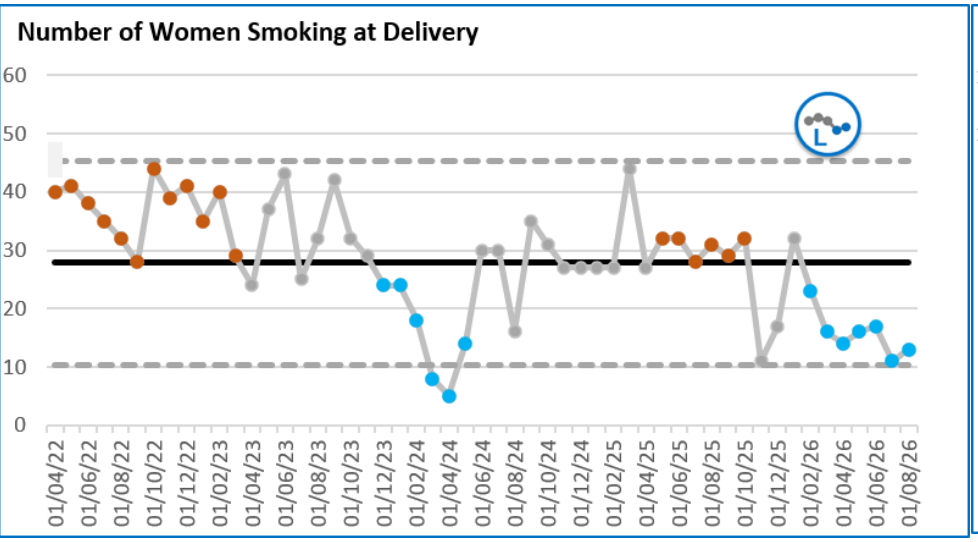

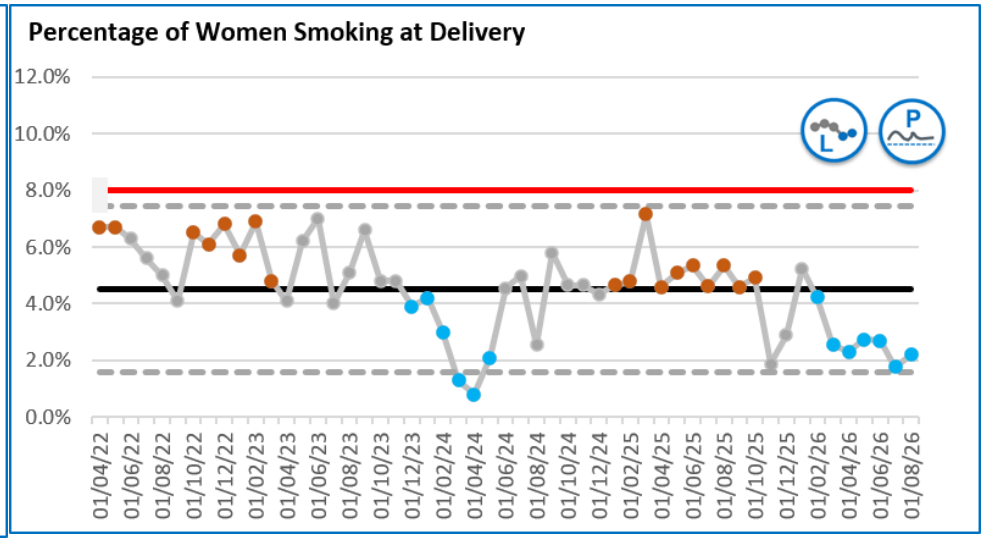

Appendix 1: SPC Charts

(Training)

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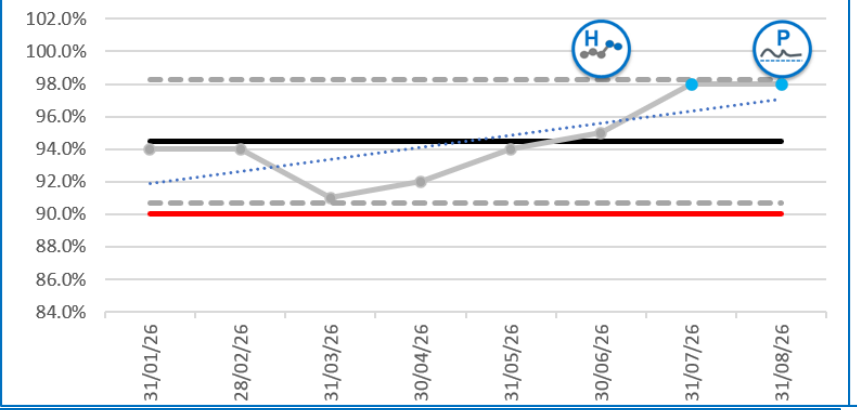
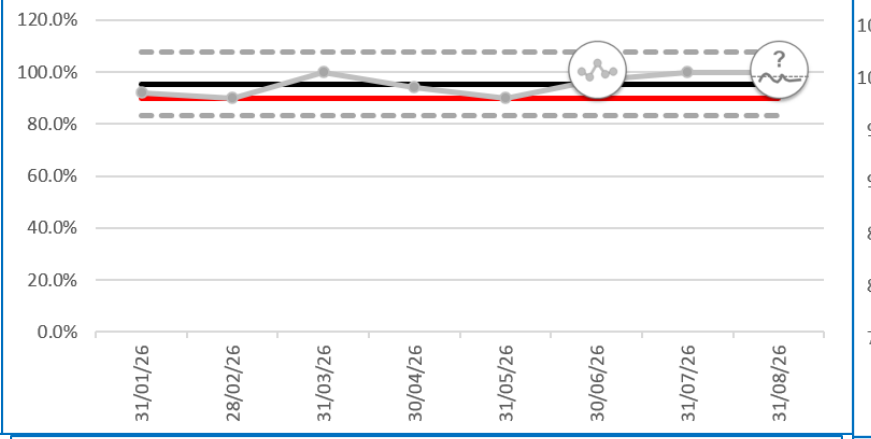


PROMPT MSW's



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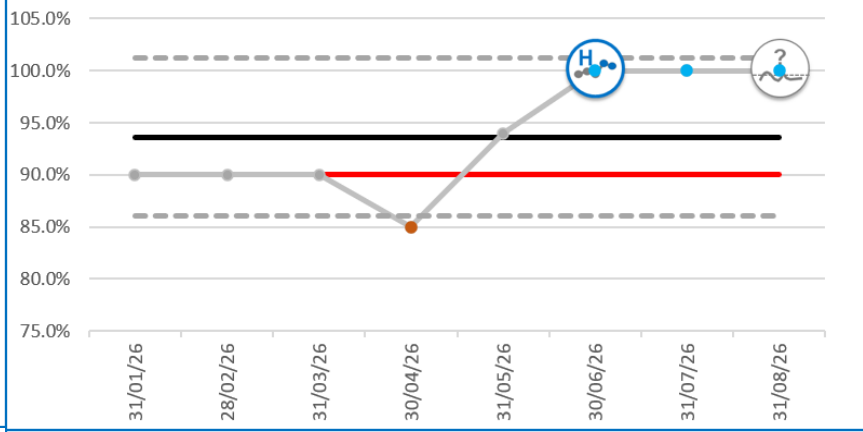
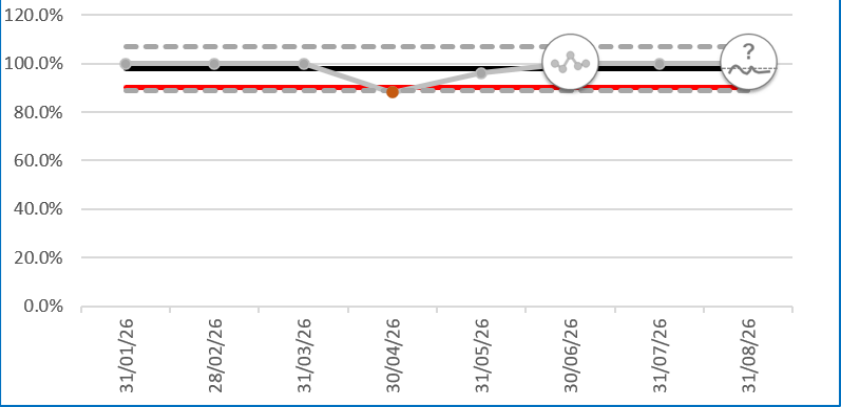
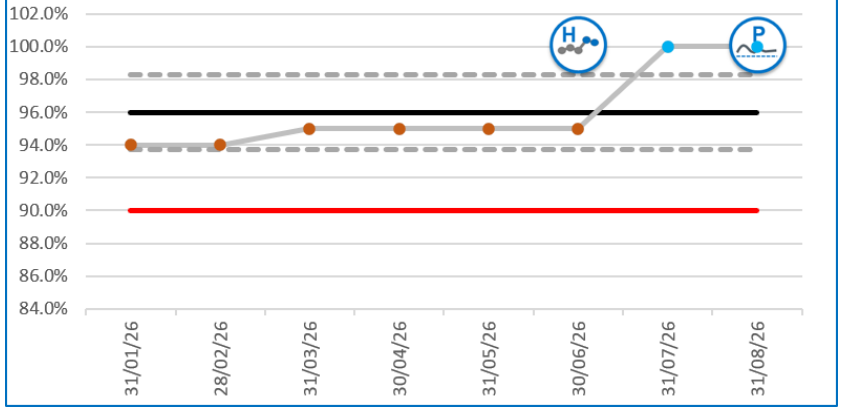


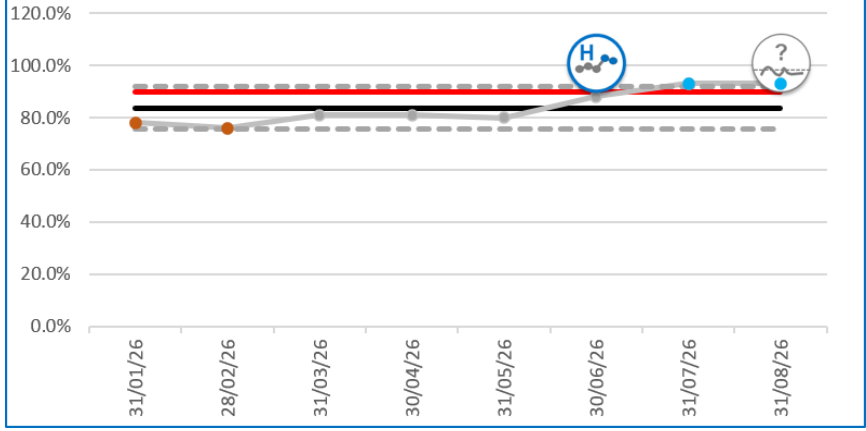
PROMPT Obstetric Consultants



PROMPT Obstetric SHO



PROMPT Anaesthetic Consultants



Appendix 1: SPC Charts

(Training)

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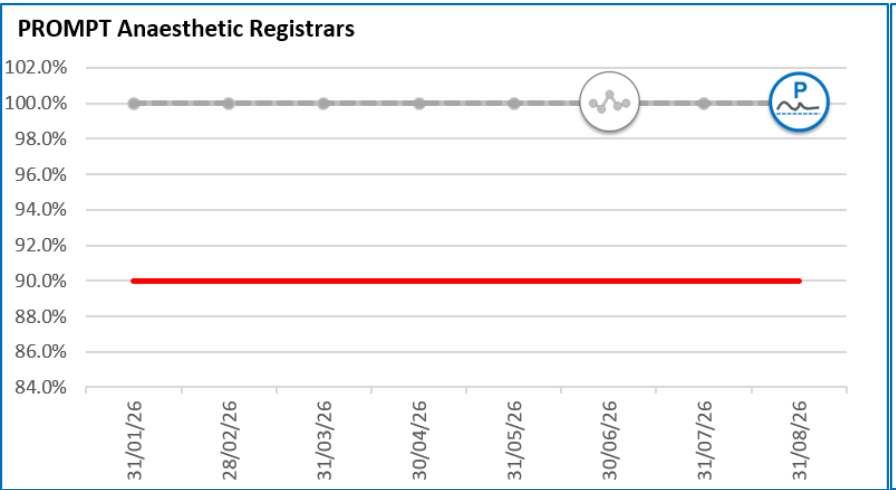
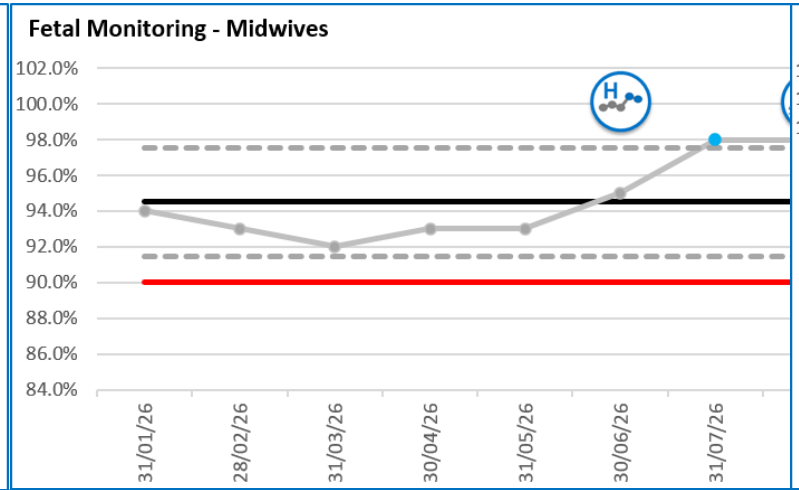
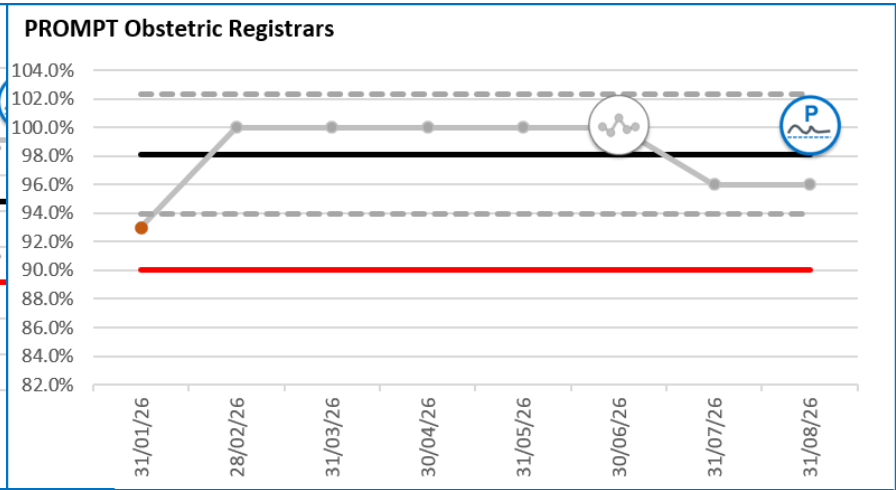
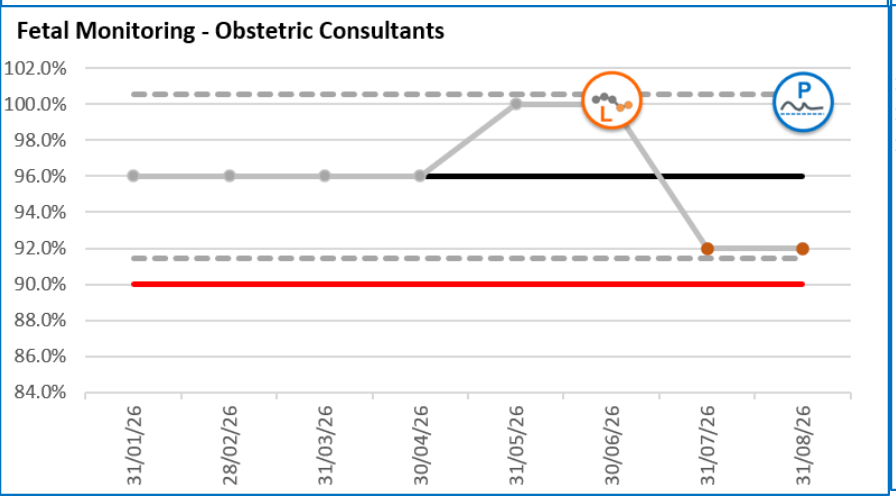
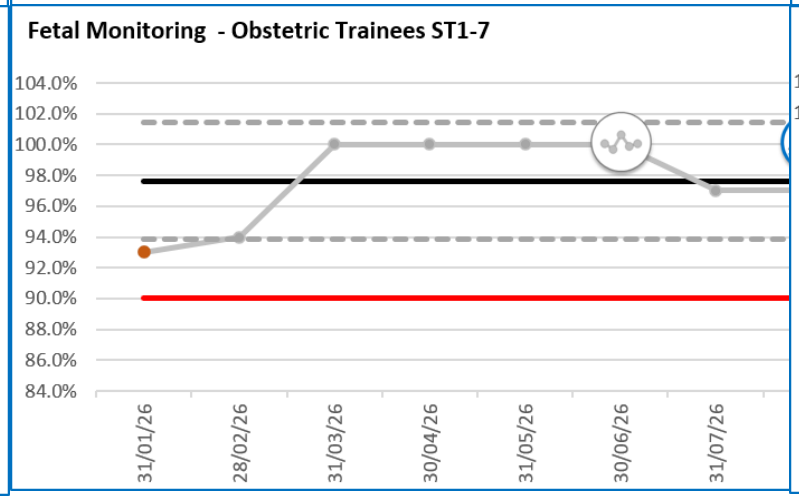
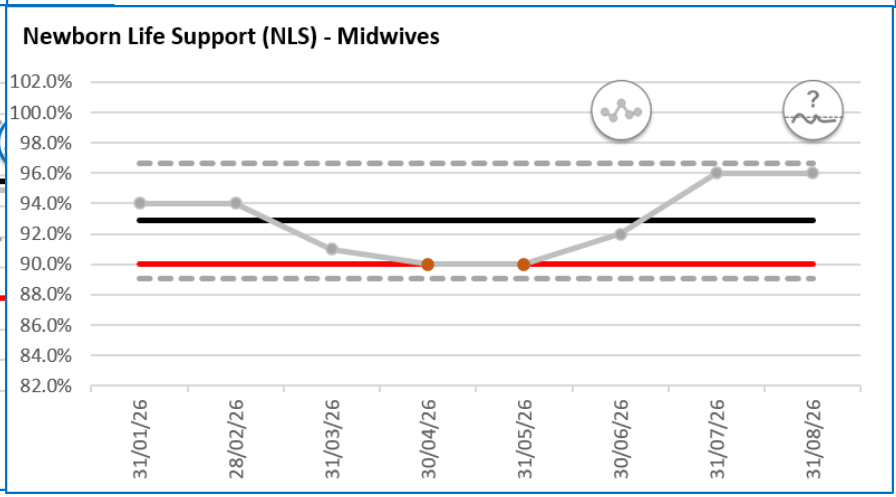








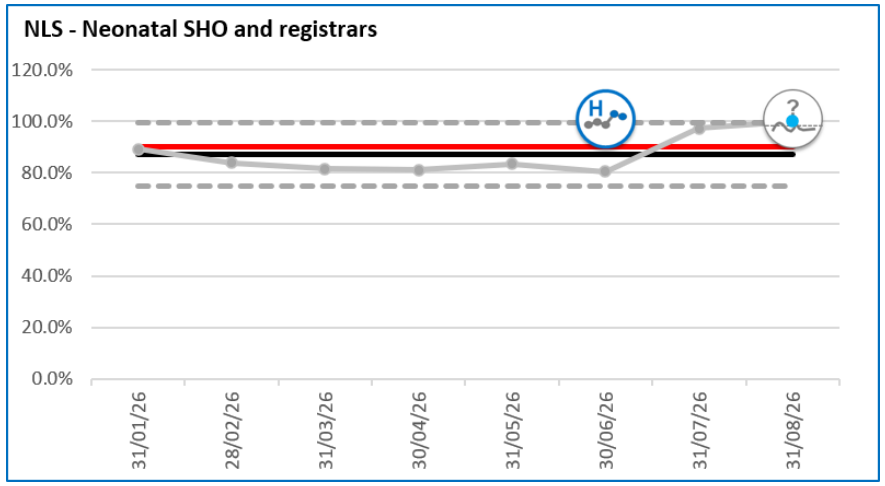


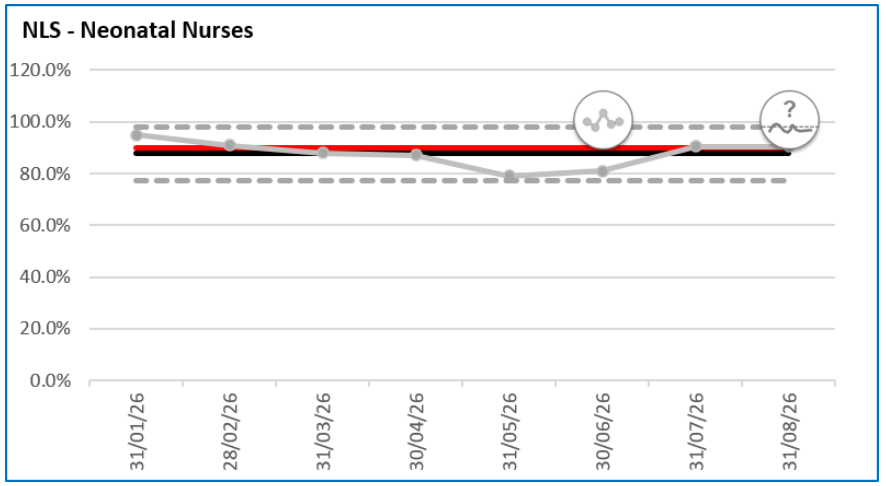


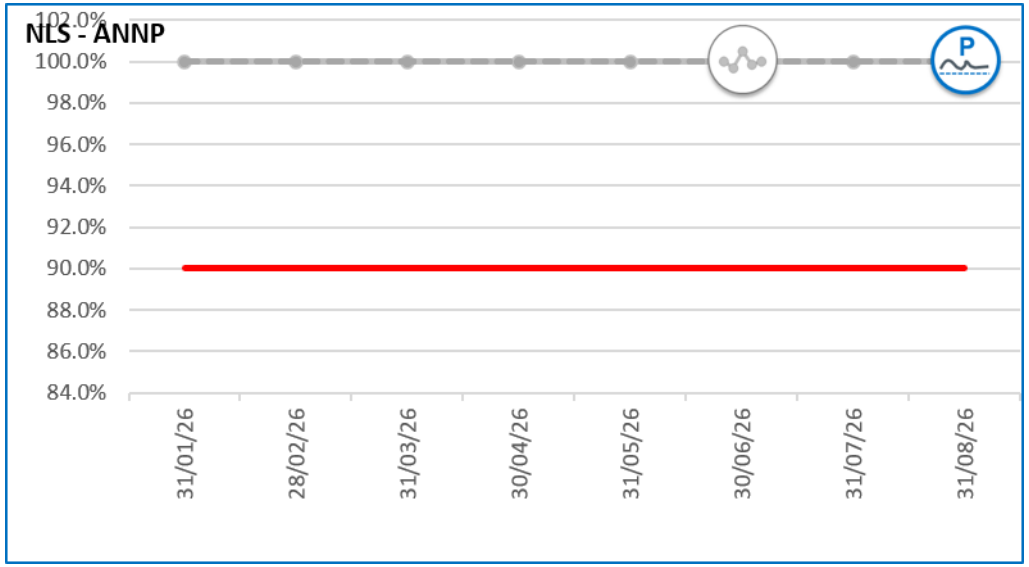
Appendix 1: SPC Charts

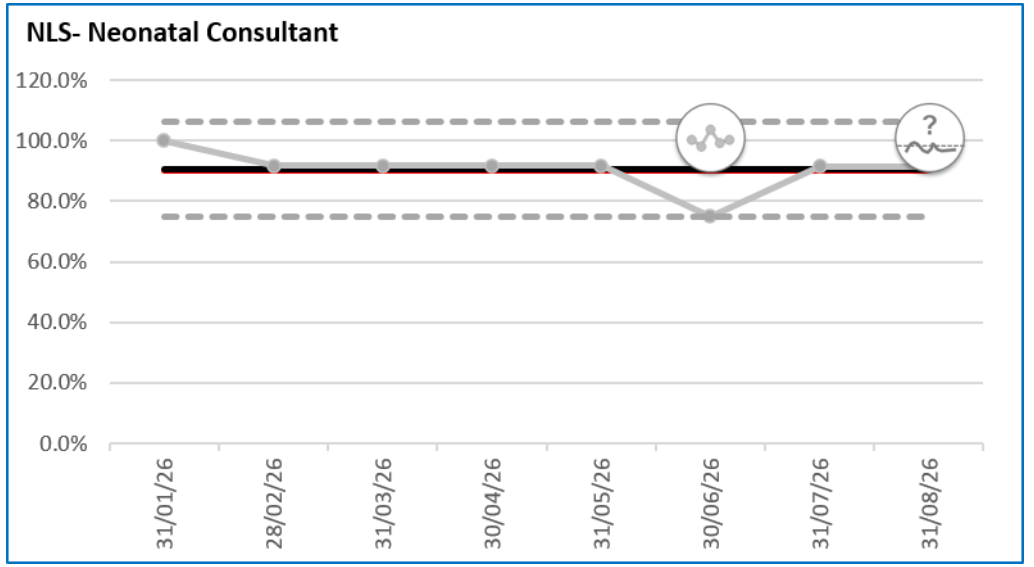
(Training)

Oxford University Hospitals NHS Foundation Trust









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 units 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. Severity is graded from 1 to 3, with grade 1 mild and grade 3 the most severe.
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. Established in 2018 as part of the Healthcare Safety Investigation Branch (HSIB), it is now hosted by the Care Quality Commission (CQC). MNSI undertakes investigations when specified criteria are met, including early neonatal deaths, intrapartum stillbirths, severe brain injury (hypoxic-ischaemic encephalopathy—HIE) in babies born at term following labour in England, and maternal deaths in England.
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	Postpartum haemorrhage: the dashboard captures PPH of 1,500 mL and above.
1:1 Care in Labour	When a woman or birthing person in labour is cared for by a midwife who is not providing care to anyone else; the same midwife does not need to provide continuous care. One-to-one care should be provided to all women and birthing people in labour.
SBLCBv3.2	Saving Babies Lives Care Bundle version 3.2
QIP	Quality Improvement Project

Appendix 4: Ward to Board

Oxford University Hospitals NHS Foundation Trust