Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 29 July 2026

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Title:	**Perinatal Quality Oversight Model Report (June)**

Status:	**For Information**
History:	**Reported to:**
	Maternity Clinical Governance Committee 13 July 2026
	Perinatal Assurance Group (PAG) 21 July 2026
	SuWON Divisional Governance meeting 27 July 2026
Board Lead:	**Chief Nursing Officer / Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

- This report provides assurance and oversight of maternity and neonatal services at Oxford University Hospitals NHS Foundation Trust, in line with the NHS England Perinatal Quality Oversight Model (PQOM), presenting data to 30 June 2026.

Key Assurances

- No Maternity Outcomes Signal System (MOSS) alerts issued up to 30 June 2026.
- Safety: 231 incidents reported that 56 moderate or above, improved on last month despite higher operational demand. Robust review processes in place (PMRT, MNSI, twice-weekly MDT reviews). Overdue Ulysses reports reduced from 98 to 76, monitored weekly through the Maternity Clinical Governance Committee.
- Outcomes: Obstetric anal sphincter injury (OASI) rate below mean; Postpartum haemorrhage (PPH) >1.5L reduced; no harm identified in the cases reviewed relating to induction of labour (IOL) or triage delays.
- Experience: 87% positive Friends and Family Test (FFT) feedback, with women describing kind, compassionate and professional care. Improvement themes relate to waiting times, communication and the postnatal ward environment.
- Workforce and activity: 641 babies born; midwife-to-birth ratio 1:24.24; no breaches of 1:1 care in labour; stable establishment.
- Risks: Four maternity risks scoring ≥15 remain (medical gases, estates, drug room temperature, elective CS capacity). Mitigations active and monitored.

Areas Requiring Continued Focus

- Initial triage within 15 minutes: improved from 54.66% to 59.7% but remains below the required standard. All women are clinically prioritised on arrival using BSOTS. Further improvement is expected as changes to the estate, staffing, the CTG lounge and pathways are delivered.
- VTE assessment compliance: 85.2% against the 95% target. Ward-level reporting, weekly case review and a recovery trajectory (90% by end of July) are in place.
- Postnatal readmissions (special cause variation; infection identified as the leading driver and further IPC review, thematic review and Task and Finish Group oversight in progress).
- Maternal Care Bundle implementation (related to MEWS and digital dependencies requires Board oversight to ensure readiness for full implementation by March 2027).

Recommendations

The Trust Board is asked to:

- Consider the stability of key perinatal metrics and continued compliance with the revised perinatal surveillance model.
- Review and endorse the improvement actions in place for the areas of focus.

Perinatal Quality Oversight Model Report (June)

1. Purpose

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

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

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

2. Background

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

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

2.3. The accompanying report presents key information and data up to the end of June 2026 and a summary of the key highlights are presented below.

Key Assurances – June 2026

3. Safety and Quality

3.1. There have been no Maternity Outcomes Signal System (MOSS) alerts for Oxford University Hospitals up to 30 June 2026.

3.2. 231 maternity incidents reported: 56 moderate or above. Themes: post-partum haemorrhage (PPH) >1.5L, obstetric anal sphincter injury (OASI), bladder related incidents, unexpected term neonatal admissions, neonatal deaths and one intrauterine death.

3.3. One neonatal death was declared as a Patient Safety Incident Investigation (PSII), with a further review planned through the Perinatal Mortality Review (PMR) process.

3.4. All incidents managed within PSIRF with timely learning actions in place.

3.5. PMRT reviews: Five cases concluded, all graded A or B (safe and appropriate care).

3.6. 53 neonatal patient safety incidents were reported: 1 moderate or above. The moderate-harm incident related to a peripheral venous line (PVL) extravasation with necrotic lesion; rapid review identified no care concerns and Duty of Candour was completed.

3.7. Assurance: Robust review processes are in place, with external reviewers and representation from service user groups attending all PMRT meetings and multidisciplinary oversight embedded.

4. Areas of Focus

4.1. Test result endorsement compliance: Compliance with the timely endorsement of test results remains below target. Work to validate the data has improved our understanding of how activity is attributed and reported. However, the principal drivers of non-compliance are not yet fully understood. Until these are established, the Board can take only limited assurance that current improvement actions will deliver sustained improvement. A focused piece of diagnostic work is underway to identify the root causes, and a further update with a defined improvement trajectory will be brought to the Board.

4.2. Maternal postnatal readmissions: Infection was the leading cause of readmission for women following birth. No single source of infection has been identified. A multidisciplinary Task and Finish Group has been established and will complete avoidable harm reviews of readmissions related to postnatal hypertension and infection, followed by targeted quality improvement work informed by the findings. The group will also

develop and implement a multidisciplinary pathway for the management of breast engorgement and mastitis, supported by agreed audit measures, by October 2026. The issue has been recognised and a structured improvement programme with clear deliverables and timescales is in place. Progress will be measured through audit, and assurance on impact will follow once audit data is available.

4.3. VTE assessment compliance: Compliance with venous thromboembolism (VTE) risk assessment remains below the Trust target of 95%, reflecting both system and training challenges. Of the 90 assessments that did not meet the 14-hour standard, six were not completed and 84 were completed late. This distinction matters. The majority of patients were assessed, but not within the required timeframe. Enhanced operational oversight is now in place, including ward-level reporting, weekly compliance review, and individual case review of every breach. The Board can take assurance that each case is being reviewed for harm and that oversight arrangements are proportionate to the risk. Sustained recovery to the 95% standard will be monitored monthly.

4.4. Unexpected neonatal admissions: This indicator is reported as an exception because of a statistical signal on the SPC chart and identified gaps in assurance, not because the target has been breached. Performance remains below the Trust target of 4%, currently 3.4%, which is reassuring. Thermoregulation remains a contributory factor in a proportion of admissions. Environmental constraints and the absence of room thermometers in some areas currently limit full assurance. Actions in progress include implementation of the warm bundle, a review of transwarmer reliability, and alignment of pulse oximetry guidance with British Association of Perinatal Medicine (BAPM) requirements. The Board can take assurance that performance is within target and that the residual risks have been identified with specific actions to close them.

5. Operational Performance

5.1. There were 641 babies born to 631 women in June.

5.2. No closures of essential services (e.g. bereavement suite) occurred.

5.3. There were no unit closures and no suspension of homebirths.

5.4. Initial triage (seen within 15 minutes) in the Maternity Assessment Unit (MAU) improved from 54.66% to 59.7%.

5.5. Induction of labour (IOL): 129 IOLs booked and 109 inductions undertaken. Reduction in the number of delayed IOL’s > 24 to 1, attributed to Delivery Suite room capacity. This was recorded on Ulysses and reviewed, with no harm identified.

5.6. Assurance: Operational pressures are being actively managed with daily staffing huddles, escalation processes and targeted QI programmes (BSOTS, IOL).

6. Workforce

6.1. Maternity: The midwife to birth ratio was 1:24.24 and there were no breaches of 1:1 care in labour and no incidents where the delivery Suite co-ordinator was not supernumerary.

6.2. The establishment is aligned to BirthRate+ (332.45 wte) plus a 23 wte maternity leave uplift, giving a funded establishment of 355.45 wte. There were 344.28 wte in post in June.

6.3. There was high unavailability (36.88 wte) on average. This incorporates true vacancy, sickness, non-medical absences as well as supernumerary midwives. Midwifery Support Worker (MSW) vacancies remain high.

6.4. Neonatal nursing workforce data shows 3.53 WTE Band 5 vacancies, 1.98 WTE Band 6 vacancies and 9.36 WTE staff on maternity leave. Seventeen Band 5 nurses are in the recruitment pipeline, many due to join from September onwards.

6.5. Qualified in Specialty (QIS) compliance remains below the BAPM target of 70%, with compliance at 49% (same as previous month) at the end of June. The service has a trajectory to increase compliance, supported by structured training cohorts, divisional governance oversight and exploration of in-house QIS provision.

6.6. Assurance: Safe staffing standards for one-to-one care in labour and Delivery Suite co-ordinator supernumerary status were maintained in June. Recruitment pipelines are active, governance oversight is strong, and succession planning is embedded.

7. Training Compliance

7.1 Training compliance is broadly strong in several maternity domains, but key risks remain. PROMPT, fetal monitoring and neonatal life support (NLS) for midwives training are above 90% for most staff groups; however, neonatal nurses' NLS compliance is 81%, with a stated risk that this may not meet the >90% requirement by 1 August 2026. Additional training sessions have been scheduled by the resuscitation team to support achievement of the required compliance standard. Staff have been booked onto the training sessions and compliance is expected to be >90% by the 01 August.

8. Patient Experience

8.1. In maternity, Friends and Family Test (FFT) and 'Say on the Day' feedback remains positive at 87% good/very good, with a high 88% response rate compared to the monthly delivery rate.

8.2. Feedback highlighted kind, compassionate and professional staff, with women reporting that they felt safe, supported and reassured.

8.3. Improvement themes in maternity feedback included waiting times and delays, communication and timely updates, responsiveness to concerns, and ward environment, particularly heat and facilities on the postnatal ward. Sixteen new complaints were received in June, including three related to historic care in 2022, 2023 and 2025.

8.4. Neonatal patient experience feedback remains limited by low response rates. Two FFT responses were received in June, and 10 responses were received via Say on the Day devices, with overall experience rated 10/10.

8.5. One complaint was received in late June relating to a baby that required admission to Paediatric Critical Care Unit (PCCU) shortly after discharge home from Neonates. A neonatal response is currently being prepared, and any learning identified will be shared once the final investigation is complete.

8.6. Assurance: Feedback is consistently positive, with clear plans to improve response rates and address communication themes.

9. Risk Register (≥15)

9.1. Maternity: There are four high-scoring risks in maternity:

9.1.1 Medical gases compliance (16). A Trust-wide solution is in progress, with maternity included in the programme.

9.1.2 Maternity estates (16). This covers flooding, drainage, recovery space, and bathroom provision. Estates works are being progressed through the Perinatal Improvement Plan and divisional escalation routes.

9.1.3 Drug room temperature control (15). Funding has been secured and remedial work is due to commence in August 2026.

9.1.4 Elective caesarean capacity (15). Improvements to the electronic patient record are underway to strengthen scheduling, and a full capacity and demand review is planned for Quarter 2.

9.2. Neonates

9.2.1 Four risks in neonates carry high initial scores. With controls in place, three have a residual score of 12 and one has reduced to 8.

9.2.2 Incomplete transition to the electronic patient record (residual score 12). A lead informatics post is to be advertised to drive completion.

9.2.3 Environmental constraints (residual score 12). Estate work for the High Dependency Unit has been incorporated into the Perinatal Improvement Plan actions.

9.2.4 Availability of nitric oxide delivery equipment (NoxBox) (residual score 12). New devices have been provided to adult critical care areas, releasing older models for use in children's and neonatal services and improving availability.

9.2.5 Failure of SONeT/SORT neonatal transport services (residual score 8). The risk has reduced significantly following improvements in senior leadership and management at BEARS, which have delivered prompt repair and maintenance of the transport fleet. Approval for re-procurement remains outstanding and is being pursued; the risk will not be closed until this is resolved.

9.3. All eight risks have active mitigations with named actions and timescales. Escalation routes to Estates and Divisional Governance are in place and being used. The estates-related risks (maternity estates, drug room temperature, and neonatal environmental constraints) are dependent on capital works and will be monitored monthly until completion. The outstanding re-procurement approval for neonatal transport is the single action not yet within the division's control and has been escalated accordingly.

10. Maternity (Perinatal) Incentive Scheme (MPIS) and Maternal Care Bundle

10.1. MPIS Year 8 reporting covers the period 1 April 2026 to 30 November 2026. The report highlights that the amber rating reflects the early reporting period and timing of deliverables rather than current compliance concerns or risk.

10.2. The MPIS Safety Action B – training requires a minimum of ≥ 90% must be achieved for every required staff group at two points during the MPIS year (April to November 2026): 30 November (mandatory MPIS checkpoint), and one other Trust selected checkpoint, declared in advance through the Quality Governance Committee. There is a specific risk that neonatal nurses may not achieve Newborn Life Support compliance of ≥90% by 1 August 2026 which is the date agreed by the Maternity Clinical Governance Committee (MCGC). Staff have been booked onto the training sessions and compliance is expected to be >90% by the 01 August.

10.3. The Maternal Care Bundle (MCB) is due for full implementation by March 2027. The national (MCB) toolkit was published in June. The quarter 1 report

identifies progress across all five elements, but also highlights implementation risks, particularly Element 2 acute care / MEWS, where there is a risk that the wider Trust Oracle solution may not be ready by March 2027 due to dependency on national solution development and local EPR configuration.

10.4. Assurance: Progress against MPIS Year 8 and the Maternal Care Bundle is being actively monitored, with quarterly Board reporting requirements recognised. Board oversight should focus on neonatal NLS compliance, implementation of MEWS, digital dependencies and evidence of embedded implementation against national requirements.

11. Conclusion

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

11.2. All key metrics and exception reports are systematically reviewed through established governance processes.

12. Recommendations

The Trust Board is asked to:

- Consider the stability of key perinatal metrics and continued compliance with the revised perinatal surveillance model.
- Review and endorse the improvement actions in place for the areas of focus.
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Oxford University Hospitals
NHS Foundation Trust

PAG2026.22b

Perinatal Quality Oversight Model Report including Dashboard

Presented at Maternity Clinical Governance Committee

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Date: July 2026

Data period: 01/06/26 - 30/06/26 (June)

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CONTENTS

Maternity & Neonatal Summaries and successes –	3
Perinatal Quality Scorecard Summary	7
Indicator Summary (Maternity SPC Dashboard)	8
Perinatal Exception Report	10
Maternity and Neonatal Risk registers (top risks)	14
Perinatal Safety	16
Maternity Operational Activity	22
Maternity and Neonatal Workforce	24
Patient Experience	29
Quality Improvement •Triage (BSOTS) •Induction of Labour (IOL)	32
Maternity (Perinatal) Incentive Scheme and Maternal Care Bundle	37
Appendices Appendix 1: SPC Charts •Appendix 2: PMR Grading Categories •Appendix 3: Acronyms •Appendix 4: Ward to Board Structure	40

Maternity Summary
June2026

Oxford University Hospitals NHS Foundation Trust

↓0.8% (prev. 2%)
Blood Loss >1500mls for CS

↓1.83% (prev.3.56%)
3rd & 4th (SVD+OVD births only) degree tears

↓ 18 mins
(previous 19 mins)
Initial Triage in MAU

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

Friends & Family Test and Say on the Day:
87%
Very Good / Good feedback
Providing 88% response rate

New Complaints
= @16

↓Unplanned Term Admissions to NNU
22 (3.4%)
≥ 37 weeks

↓40.3%
Caesarean Sections 254 (CS)
Elective CS –121(19.2%)
Emergency CS –133 (21.1%)

25.4%
Inductions of Labour

↑21 (3.3%)
Freestanding MLU*
Horton 9
Chipping Norton 4
Wantage 2
Wallingford 6

↑21 (3.3%)
20 Home Births
1 Freebirth

Babies Born 641
To 631
Women Birthed

↑ 6.98%

↑542 Delivery Suite

47 (7.4%) Spires

↑Scheduled Bookings 626

Excellence Reports
↓15

100%
1:1 Care in Labour
1:24.24 Midwife to Birth Ratio

↓1(previous 18)
Induction of Labour (IOL)delayed >24hrs

↑92.16%
Breastfeeding Initiation

*MLU – Midwifery Led Unit

Neonatal Summary

Oxford University Hospitals NHS Foundation Trust

Milk Bank

↓**85L** Breast Milk Pasteurised

18L Sold/ **£3.2k** Profit

16 Donors Recruited

43 Preterm Admissions (59%)

< 27 weeks – **6** (8%)

27-36 weeks – **37** (51%)

19 Excellence Reports

30 Term Admissions (41%)

≥ 37 weeks

↑ **100%** Born in the right place*

16% Responses

100% Very Good

Friends and Family Test Say on The Day

↓**73**

Admissions

June 2026

SONeT

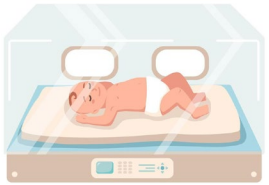
SOUTHAMPTON OXFORD NEONATAL TRANSPORT

↓**27** Total Transfers

10 Emergency Uplifts

17 Non-Urgent

↓**1069** Care Days



Nursing Recruitment

0 Starters

0 Leavers

Outreach Team

↓**119** Home Visits

49 Babies Seen

↑ **8** Deaths

19+3/ 40 - TOP

(x3) <24/40 – Extreme Prematurity

27^{+5}/40 – Ext Prematurity + Severe IUGR

30/40 – Pulmonary Hypoplasia

35^{+6}/40 – Tetralogy of Fallot

36^{+1}/40 – AKI, Pulm Hypoplasia

1

Complaint

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

Recent successes:

Oxford University Hospitals
NHS Foundation Trust

Celebrating 50 years of care: maternity screening specialist reaches milestone in her career

Annie Roberts- Antenatal and Newborn Screening Coordinator has recently celebrated five decades of service, supporting generations of families.

Over five decades, Annie has contributed to improvements in care both locally and nationally. One of her proudest achievements was supporting the implementation of screening for MCADD, a rare inherited metabolic condition, as part of the national rollout of newborn bloodspot screening in 2009. Her work was recognised with an invitation to the Houses of Parliament, where she attended a reception in the Members' Dining Room.

Huge thank you to Annie on behalf of Team Maternity for all that you have done and continue to do.

New video helps families prepare for postnatal stay

Team maternity have launched a new video to help families feel more informed about what to expect if they stay on the Postnatal Ward at the John Radcliffe Hospital's Women's Centre.

The video introduces 'family bays' on Level 5, where partners can stay overnight to support new parents and spend those first important days together as a family. The bays were introduced in response to feedback from patients and families, which showed strong interest in partners being able to remain overnight on the ward.

Created with input from staff and families, the video aims to provide clear, reassuring information for women and their loved ones ahead of coming into hospital.

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Perinatal Quality Scorecard (Exception Report and Dashboard)

1. Perinatal Quality Scorecard Summary

Oxford University Hospitals NHS Foundation Trust

Overview

In June, 631 women birthed 641 babies. 626 birthing people booked their pregnancies this month. The OUH has not received any Maternity Outcomes Signal System (MOSS) alerts. Rates of caesarean section have reduced by 3% since last month. There have been no exceptions escalated, or submission of a Ulysses report to highlight any closures of the Butterfly Suite. This means OUH have been able to provide bereavement care for all families that have required this service.

Quality & Safety	Outcomes	Experience	Training	Workforce
• 231 maternity patient safety incidents were reported in June; 56 were graded moderate or above. • Common moderate harms were postpartum haemorrhage over 1.5L, obstetric anal sphincter injuries, and unexpected term SCBU admissions. • All incidents were managed under PSIRF with immediate learning actions. • 1 case has been declared a PSII. • Postnatal readmissions remain an exception; an initial patient safety review found no systemic concerns. Avoidable harm review underway.	• 641 babies were born in June. • Births included 305 spontaneous vaginal births (48%), 78 instrumental births (12.4%), and 254 caesarean sections. • 7 cases of obstetric anal sphincter injury were reported (1.83%). • 14 postpartum haemorrhages over 1.5 litres were reported (2.2%), significantly lower than the previous month. • Governance review found no harm from induction delays, or delays in triage in Maternity Assessment Unit.	• 556 combined responses from FFT and Say on the Day were received. Overall response rate of 88%. • 87% rated care as very good or good. • Feedback highlighted Kind, compassionate and professional staff. Women felt safe, supported and reassured. Positive birth, antenatal and postnatal experiences. • Improvement themes included waiting times and delays. Communication and timely updates. Responsiveness to concerns. Ward environment, including heat and facilities. • 16 complaints received in June, including 3 historic complaints related to care received in 2022, 2023 and 2025	The 2025 to 2026 training year started in September and covers PROMPT, Fetal Monitoring, OxMUD, and Neonatal Life Support. • Mandatory e-learning time is allocated for all maternity staff. • Most staff groups remain above 90% compliance across the rolling year. • Training compliance continues to demonstrate strong engagement with the mandatory programme.	• The midwife-to-birth ration in June was 1:24.24 • No incidents were reported where one-to-one care in labour was not maintained or where the Delivery Suite Coordinator was not supernumerary. • The midwifery establishment has been aligned to the BirthRate+ benchmark of 332.45 WTE) with an additional 23 WTE uplift for maternity leave, giving a total establishment of 355.45 WTE. • Current Workforce: June midwifery workforce was 344.28WTE, leaving a vacancy of –11.17 WTE • Recruitment planning is now progressing for Autumn 2026 preceptees.

Indicator Overview Summary – Maternity SPC Dashboard

ER

ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Inductions of labour (IOL)	Jun 26	160	-			154	111	198
Inductions of labour (IOL) as a % of mothers birthed	Jun 26	25.4%	-			25.2%	19.7%	30.7%
Test Result Endorsement ER	May 26	65.8%	85.0%			78.7%	67.0%	90.5%
Number of PSII	Jun 26	1	0			0	0	0
Number of Complaints ER	Jun 26	16	-			11	0	22
Hospital Associated Thromboses	Jun 26	0	0			0	-1	1
Number Of Women Booked This Month Who Current	Jun 26	28	-			40	17	64
Percentage Of Women Booked This Month Who Curre	Jun 26	2.7%	-			5.8%	2.6%	9.0%
Number of Women Smoking at Delivery	Jun 26	17	-			28	11	46
Percentage of Women Smoking at Delivery	Jun 26	2.7%	8.0%			4.6%	1.7%	7.6%
Maternal Postnatal Readmissions ER	Jun 26	25	-			11	-2	23
Readmission of babies	Jun 26	32	-			20	2	39
% completed VTE admission ER	Jun 26	85.2%	95.0%			91.8%	86.6%	96.9%
Number of Woman with a live birth Initianing Breastf	Jun 26	576	-			530	394	667
Percentage of Women Initiating Breastfeeding	Jun 26	92%	80%			84%	76%	93%
Scheduled Bookings	Jun 26	626	625			695	551	838
Born before arrival of midwife (BBA)	Jun 26	10	-			6	-1	13
Number of women booked by 10+0/40	Jun 26	408	-			427	255	599
Percentage of women booked by 10+0/40	Jun 26	65%	-			66%	55%	76%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Jun 26	631	625			612	530	693
Babies Born	Jun 26	641	-			622	538	706
Spontaneous Vaginal Births SVD (including breech)	Jun 26	305	-			303	245	362
Spontaneous Vaginal Births SVD (including breech): a	Jun 26	48.3%	-			49.5%	42.3%	56.8%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Jun 26	78	-			84	50	117
Number of Instrumental births/Forces & Ventouse as	Jun 26	12.4%	-			13.7%	9.1%	18.2%
Caesarean Section (CS)	Jun 26	254	-			229	186	272
Number of CS births as a % of mothers birthed	Jun 26	40.3%	-			37.4%	31.5%	43.4%
Number of Emergency CS	Jun 26	133	-			132	96	168
Emergency CS births as a %	Jun 26	21.1%	-			21.1%	15.2%	27.1%
Number of Elective CS	Jun 26	121	-			103	61	145
Elective CS births as a %	Jun 26	19.2%	-			16.3%	11.5%	21.1%
Triage within 15 mins ER	Jun 26	59.8%	-			46.8%	35.9%	57.7%
MAU Attendances	Jun 26	1579	-			1336	1054	1618
MAU Data Accuracy (%)	Jun 26	98.6%	-			89.9%	83.9%	95.8%

What is the data telling us?

Exception Reporting highlighted for:

Test result endorsement - Summary and Actions Slide 10

Complaints –Incorporated into Slide 30

Maternal Postnatal readmissions - Summary and Actions Slide 11

% of completed **VTE assessments**. Summary and Actions Slide 12

Triage within 15 mins – Incorporated into Slide 33

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

Indicator Overview Summary – Maternity SPC Dashboard

ER

Variation Assurance

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Stillbirths (24+0/40 onwards; excludes TOPs)	Jun 26	0	-			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	Jun 26	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Jun 26	3	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jun 26	3	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Jun 26	0	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Jun 26	3	3			2	-2	6
Puerperal Sepsis	Jun 26	3	0			4	-2	11
Puerperal Sepsis as a % of mothers birthed	Jun 26	0.5%	1.5%			0.7%	-0.4%	1.7%
Unexpected NNU admissions	Jun 26	22	-			24	7	41
Unexpected NNU admissions as a % of babies born ER	Jun 26	3.4%	4.0%			3.3%	0.8%	5.8%
ICU/CCU Admissions	Jun 26	1	-			1	-1	3
SVD + OVD Total	Jun 26	383	-			380	304	457
Robson Group 1 c-section with no previous births a %	Jun 26	11.2%	-			14.3%	7.2%	21.3%
Robson Group 2 c-section with no previous births a %	Jun 26	58.9%	-			57.3%	45.6%	68.9%
Robson Group 5 c-section with 1+ previous births a %	Jun 26	89.0%	-			80.4%	62.5%	98.3%
Midwife:birth ratio	Jun 26	24.2	22.9			25.2	21.0	29.3
3rd/4th Degree Tears amongst mothers birthed	Jun 26	7	-			12	0	25
3rd/4th degree tears amongst mothers birthed as a %	Jun 26	1.8%	3.5%			3.1%	0.1%	6.1%
3rd/4th degree tears following unassisted Vaginal bir	Jun 26	6	-			8	-1	18
3rd/4th degree tears following unassisted Vaginal bir	Jun 26	1.6%	-			2.4%	0.0%	4.7%
3rd/4th degree tears following an Instrumental vagin	Jun 26	1	-			3	-2	9
3rd/4th degree tears following an Instrumental vagin	Jun 26	1.3%	8.0%			4.2%	-3.2%	11.6%
HIE	Jun 26	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH equal to or greater than 1.5L following an instrun	Jun 26	3	-			7	1	13
PPH equal to or greater than 1.5L following an instrun	Jun 26	0.5%	-			1.1%	0.0%	2.2%
PPH equal to or greater than 1.5L (Rate per 1,000)	Jun 26	22.2%	-			35.8%	18.6%	52.9%
PPH 1.5L or greater, vaginal births (unassisted)	Jun 26	6	-			11	1	22
PPH 1.5L or greater, vaginal (unassisted) births as a %	Jun 26	1.0%	2.4%			1.9%	0.3%	3.5%
PPH 1.5L or greater, caesarean births	Jun 26	5	-			7	-1	14
PPH 1.5L or greater, caesarean births as a % of mother	Jun 26	0.8%	4.3%			1.1%	-0.1%	2.4%
Maternal Deaths: All	Jun 26	0	-			0	0	1
Early Maternal Deaths: Direct	Jun 26	0	-			0	0	0
Early Maternal Deaths: Indirect	Jun 26	0	-			0	0	0
Late Maternal Deaths: Direct	Jun 26	0	-			0	0	0
Late Maternal Deaths: Indirect	Jun 26	0	-			0	0	0
Elective CS <39 weeks no clinical indication	Jun 26	0	0			0	-1	2
Shoulder Dystocia	Jun 26	12	-			9	-1	18
Shoulder Dystocia as a % of babies born	Jun 26	1.9%	-			1.4%	-0.1%	2.9%
Returns to Theatre	Jun 26	2	0			2	-2	5
Returns to Theatre as a % of caesarean section delive	Jun 26	0.8%	0.0%			0.7%	-1.0%	2.3%
Number of women with a live birth	Jun 26	625	-			604	504	704
IOL 0-6hours ER	Jun 26	75	-			47	27	67
IOL Delayed >24 hours (Red Flag SS)	Jun 26	1	-			29	-17	75
IOL Delayed 13-23 hours (Red Flag SS)	Jun 26	18	-			20	3	37
IOL Delayed 07-12 hours (Red Flag SS)	Jun 26	15	-			16	5	28

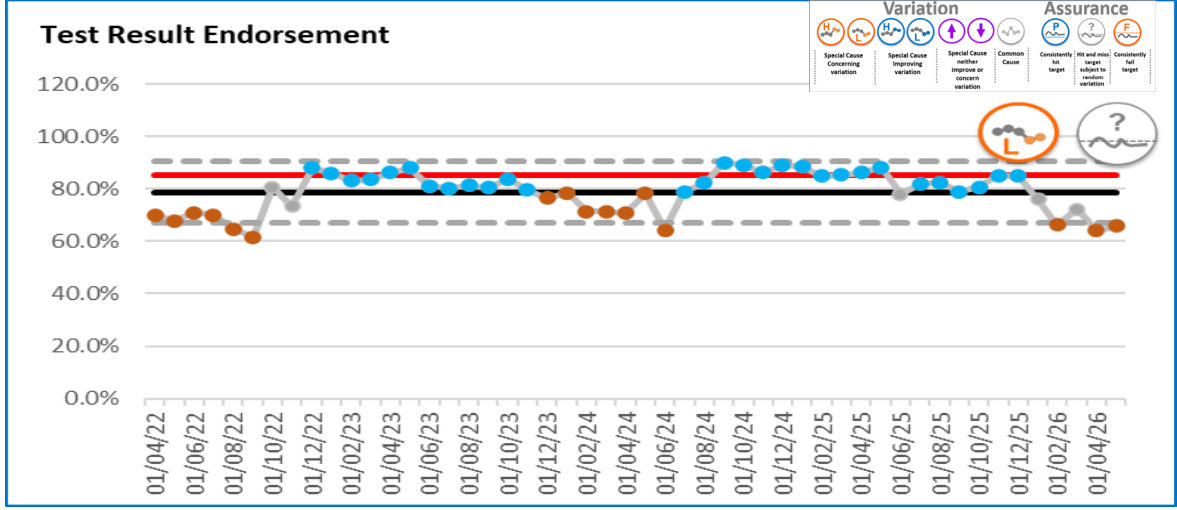
What is the data telling us?

Unexpected NNU admissions as a % of babies born Summary and Actions Slide 13
IOL 0-6hours –Incorporated into slide 36

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

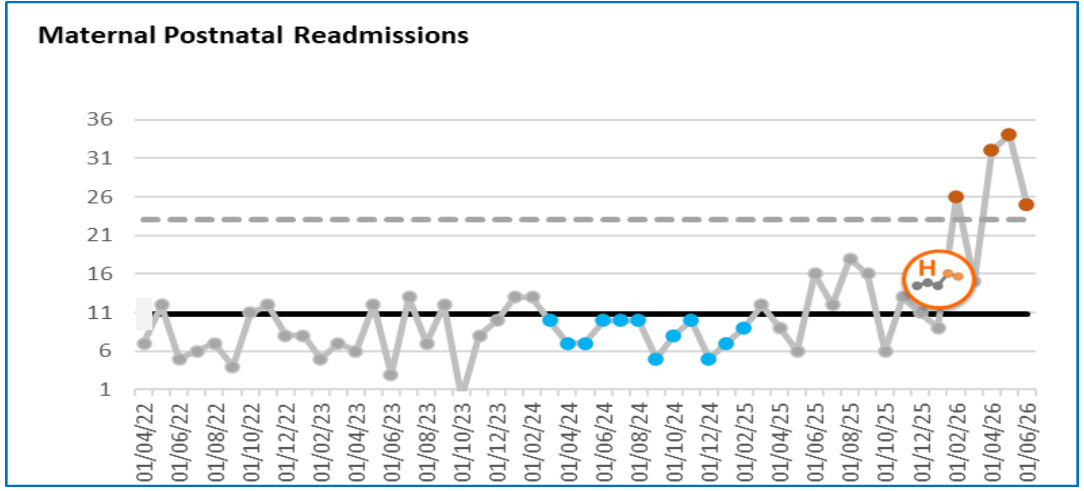
Maternity Exception Report - Test Result Endorsement

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



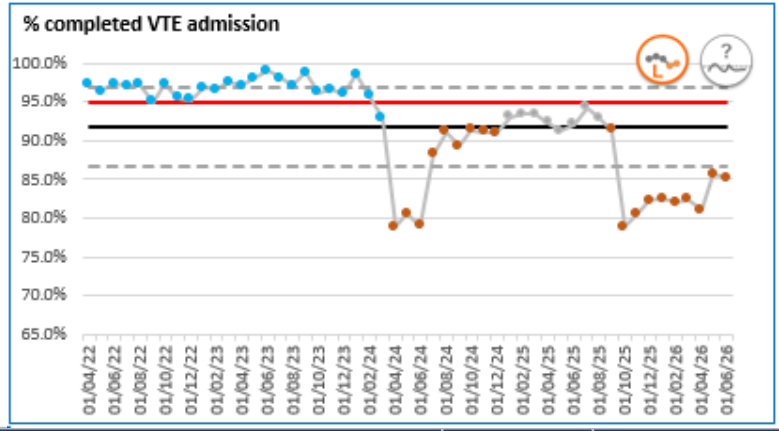
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Test Result Endorsement compliance remains below the Trust target of 85% as 65.8% in May, and continues to demonstrate variation around the control limit. During the reporting period, further data validation has been undertaken to better understand activity attribution within the reporting dataset. This has confirmed that specialty, and patient location fields are derived from different source systems and therefore records may appropriately appear within Maternity whilst being associated with non-maternity clinical locations. Whilst this provides increased confidence in the integrity of reported activity, work continues to fully understand the principal drivers of non-compliance across the maternity pathway. As a result, assurance regarding the effectiveness of improvement actions remains limited and performance continues to require close monitoring through the governance framework.	Key control measures include: •Completion of data validation exercise to improve understanding of activity attribution and reporting methodology. •Joint review with Digital and Information teams to identify key contributors to non-compliance and opportunities for targeted improvement. •Continued review of Test Result Endorsement performance through Maternity Governance Committee. •Ongoing engagement with relevant corporate teams regarding training compliance performance and monitoring arrangements. •Development of a targeted improvement plan informed by findings from data validation and pathway analysis. Control effectiveness is monitored through: • Governance review of error trends and data completeness • Training completion tracking and escalation of non-compliance	• SOP revision, re-issue and training video completed – **May 2026** ✓ • Data quality validation exercise – **June 2026** ✓ (ahead of schedule) • Analysis of key causes of non-compliance and performance variation – **July-August 2026** • Refined improvement plan presented through governance structure – **August 2026** • Training compliance review and update from responsible corporate team – **September 2026** (amended)	N/A	Satisfactory

Maternity Exception Report - Postnatal Readmissions (Maternal)



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
There is moderate assurance that rising postnatal readmissions are being actively managed through surveillance, thematic review and governance oversight. Infection remains the leading driver of readmissions into June. On initial review there is no single driver for infection, a review with the Infection Prevention and Control team is scheduled. The impact on women and families includes unplanned readmission, delayed recovery, disruption to breastfeeding and wider family support. Review of potential avoidable harm is being progressed.	**Key control measures include:** • Task and finish group to ensure ongoing review, accountability and governance • Focussed QI review of hypertension related admissions • Development of mastitis/engorgement MDT pathway • Standardised safety netting information package • Review of digital systems and any risks **Control effectiveness is monitored through:** • Task and finish attendance • Routine monitoring of postnatal readmissions through governance structures • Project specific controls will be determined based on findings of reviews	**Completed (June 2026)** Establish a multidisciplinary Task and Finish Group, meeting fortnightly to oversee delivery of the improvement programme. **By September 2026** Implement a standardised postnatal safety-netting information package and commence monthly audit of compliance. **By October 2026** Complete targeted quality improvement and avoidable harm reviews of postnatal hypertension and infection-related readmissions and develop and implement a multidisciplinary engorgement and mastitis management pathway, supported by agreed audit measures. **By November 2026** Complete a review of documentation risks across BadgerNet and Cerner systems, with an associated digital action plan. **Ongoing** Maintain monthly monitoring of postnatal readmissions through maternity governance with oversight provided by the multidisciplinary Task and Finish Group and findings of the reviews reported to Trust Board.	N/A	Satisfactory

Maternity Exception Report - VTE Risk Assessment

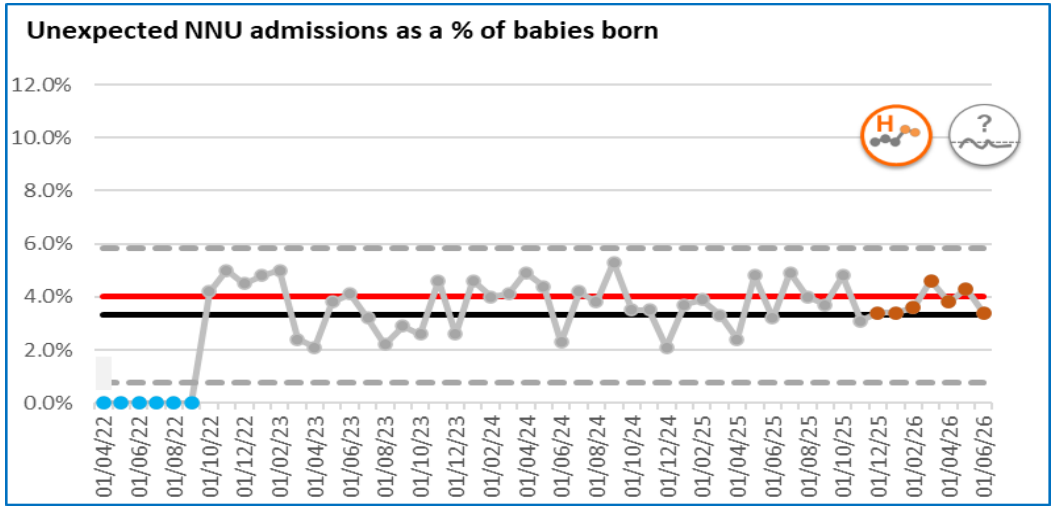


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating

Current performance remains below the Trust standard (June: 85.2%; target ≥95%). Of the 90 assessments not achieving the 14-hour standard, six were not completed (all women discharged within 24 hours) and 84 were completed outside the required timeframe. Whilst overall compliance remains largely unchanged from May, enhanced controls have now been implemented to strengthen oversight, identify missed assessments and support sustained improvement.	**Enhanced operational oversight**
	• Ward managers now have access to ward compliance reports since beginning of July.
	• Weekly compliance review introduced at Midwifery Leadership Team meeting from 6 July with agreed recovery actions for areas below trajectory.
	• Fortnightly compliance reports continue to be reviewed at ward, governance and leadership meetings.
	Patient safety and case review
	• Individual women without a completed VTE assessment are now, as of July, identifiable through reporting functionality.
	• Weekly spot-checks and case reviews commencing from July to:
	  • confirm assessment completion
	  • determine whether thromboprophylaxis was indicated or delayed
	  • identify actual or potential patient harm
	  • identify recurring system issues.
	Data quality
	• Cerner reporting correction due 13 July.
	Standardisation and sustainability
	• Admission checklist continues on Level 6 with evaluation for wider implementation.
	• Monthly review through local Governance
	• Roles of resident and consultant obstetricians clarified.
	• Improvement trajectory:
	  • July ≥90%
	  • August ≥92%
	  • September ≥95%
		Assurance and monitoring:
		Weekly
		• Ward compliance reviewed against trajectory.
		• Areas below target required to present recovery actions.
		• Spot-check findings reviewed by Deputy Head of Midwifery.
		Monthly
		• Progress reviewed through Maternity Clinical Governance Committee.
		• Themes and learning shared via governance meetings, safety huddles and leadership forums.
		Patient safety:
		For each missed assessment:
		• confirmation assessment completed
		• thromboprophylaxis reviewed
		• actual/potential harm assessed
		• learning captured where appropriate
			N/A	Satisfactory

Maternity Exception Report - Unexpected NN admissions as a %

This performance indicator is reporting as an exception due to SPC chart signal and assurance gaps. It is not a target breach.



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
Unexpected NNU admissions remain below the 4% performance threshold. However, this is reported as an exception due to an SPC signal indicating special cause variation above the performance mean. Thermoregulation remains a contributory factor in a proportion of cases. Delivery of the warm bundle is progressing but is not yet fully embedded because of environmental constraints, including the absence of room thermometers. Assurance that performance can be sustained will be strengthened further through confirmation of sustained compliance with MPIS pulse oximetry requirements and alignment with updated BAPM recommendations.	• Continuation of the **thermoregulation QI project**, previously presented at governance, with focus on improving compliance with the "warm bundle." • Engagement with operational and budget leads to **secure provision of room thermometers** to support reliable environmental temperature monitoring and embed best practice. • Escalation of **transwarmer performance concerns** to neonatal leadership; ongoing monitoring of incidents with consideration of supplier review or alternative equipment if required. • Maintenance of **pulse oximetry screening as standard practice** within maternity services in line with local guidelines. • Neonatal team undertaking **review of local guidance against BAPM standards**, with planned audit to map current practice, identify gaps, and ensure full MIS compliance.	**Short term (by September 2026):** • Initiate audit planning for pulse oximetry compliance against BAPM standards – specific requirement is to update the local guidance and ensure auditable standards are in alignment with BAPM and audit cycle in accordance with MPIS requirements. **Meeting on 6th July confirmed neonatal lead, with maternity and assurance stakeholders** • Alignment of local guideline with BAPM framework b**y August 2026** **Medium term (by December 2026):** • Full implementation and embedding of thermoregulation warm bundle. **Improvement and implementation group will commence by end July 2026.** • Completion of pulse oximetry audit plan with reporting through governance structures. **Gaps:** • Environmental monitoring limitations (room temperature) currently impact full assurance. • Audit data required to confirm alignment with BAPM guidance and MIS requirements.	N/A	Satisfactory

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

Title	Opened	Description	Initial	Current	Target	Key Progress Notes (*These risks will be reviewed 14/07/26*)
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. In the interim, mitigating controls are in place, including enhanced local checks, clear escalation routes for non-compliant equipment and increased oversight within maternity governance arrangements. This ensures immediate risks to safety are minimised while longer-term actions are implemented. The corporate aspects of this were due to be discussed 12/06/26, however the meeting was re-scheduled for the **10/07/26** with any actions brought back to maternity as appropriate.
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 Womens' centre: - Wider ventilation project in the Women's centre- due to start in **Q3 2026**, with work in Delivery Suite currently scheduled between 23.12. 2026- 18.02.2027 - Fire Safety Survey- completed June 2026. Report shared with the Trust at the start of July 2026, with recommendations currently being reviewed.
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	Funding and Purchase Order (PO) numbers confirmed. Contractors starting 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.
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 within the Delivery Suite.	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. Now these enhancements are in place, updated data will be shared between the intrapartum team and service governance, enabling greater local oversight and informed decision-making moving forward. Capacity and demand data collection is **planned for Q2**. Maternity (Perinatal) Incentive Scheme lead and obstetric lead to look at risk definition to ensure captures and monitors in alignment with National requirements.

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

Oxford University Hospitals NHS Foundation Trust

No	Title	Description	Initial Rating	Current Rating	Target Rating	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 advertised, with interviews scheduled to take place in July.
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	Housekeeper post has been advertised, with interviews scheduled to take place in July. Once recruited and established, Band 2 and 3 vacancies will also be advertised. HDU estate work now incorporated in Perinatal Improvement Plan actions.
3065	Availability of NoxBox Machines for nitric delivery	Challenges in locating an available and working NoxBox Machine in the trust when required for a critically unwell patient	20	12	8	New nitric oxide machines are now available in Adult Critical Care areas, increasing the availability of older models for use in Children's and Neonates.
3121	Failure of SONeT/SORT transport services	Ambulances are nearly 5-years old and there is an increasing number of faults occurring as a result potential for breakdown. Delayed maintenance and repairs; Gaps on driver rota / staffing levels with lack of information to the clinical team; Drivers new to contract, no orientation, familiarisation with geographical area, equipment, speciality of team, unique neonatal and paediatric equipment; Lack of engagement from the ambulance management team to resolve issues in a timely fashion.	15	8	4	There has been a change in senior leadership and management at BEARS, which has significantly reduced the risk through prompt repair and maintenance, as well as improved financial stability for the company. However, there is still no agreed approval to proceed with re-procurement. We are awaiting the outcome of Trust commissioning discussions.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Safety

Perinatal Safety - Maternity Incidents

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

There were 231 patient safety incidents reported in June, 56 of which were moderate and above (24%). This is an improvement from last month (26.6%) despite higher operational demand. A breakdown of the moderate harm incidents includes 8 obstetric anal sphincter injuries (1 reported retrospectively from May), 14 postpartum haemorrhages (PPH), 2 return to theatre, 2 bladder stretches, 2 bladder injury during caesarean section, 1 intrauterine deaths and 24 term admissions to the neonatal unit (2 reported retrospectively from May 22 reported in June). 1 cord gas<6.9, 2 neonatal deaths.

PSII declaration: One neonatal death was reported 30/05/26. Baby delivered by emergency caesarean section following maternal presentation with bleeding and fetal bradycardia. Baby was admitted to SCBU and died at 6 hours of age. Rapid Review completed and PMR scheduled which will inform investigation.

So what: incident volume and acuity remain significant, indicating sustained clinical risk and the need for continued scrutiny of themes, timeliness of review and delivery of learning. External assurance remains supportive, with no Maternity Outcome Signal System (M.O.S.S.) alerts issued for OUH thus far. A drill alert will be run in line with the Maternity and Perinatal Incentive Scheme year 8, with findings reported through maternity and neonatal governance.

Strengths

Overdue Ulysses are actively monitored, with 76 overdue at the end of the reporting period. A clear recovery plan is in place, and this has reduced from 98 last month. This will continue to be monitored weekly with oversight from Maternity Clinical Governance Committee (MCGC).

Responsive 'Learning of the week' communication is embedded through safety huddles, team briefings and feedback loops to confirm dissemination and impact.

So what: this provides reasonable assurance that known risks are being actively managed, with governance oversight and mechanisms in place to support timely learning and recovery.

Focus

Twice-weekly multidisciplinary review meetings are being held after the incident meeting to support timely review, shared learning and prompt action.

Trust Governance requested a review of Urinary Retention cases and for this to be included in the PQOM moving forwards for oversight and assurance.

So what: Continued twice-weekly multidisciplinary incident review meetings support faster review of moderate harm and above incidents, enabling timely learning, shared decision-making and earlier implementation of actions to reduce repeat harm.

Enhanced oversight of urinary retention through PQOM will strengthen governance of this identified risk, support trend monitoring and provide assurance that improvement actions are being implemented and sustained.

Future

Work and assurance will be strengthened through triangulation across feedback from women and families, complaints, incidents, workforce insight and equality data. This intelligence will be systematically reviewed and translated into targeted improvement actions, including explicit consideration of health inequalities and the experience of under-represented and at-risk groups.

Identified themes will remain aligned to agreed improvement programmes with clear ownership, actions and timescales. Progress will continue to be monitored through maternity governance and quality assurance arrangements so that implementation, impact and embedded learning can be evidenced.

So what: this will strengthen confidence that improvement activity is evidence-led, equitable and capable of demonstrating whether actions are achieving sustained

Bladder Care Incident Review: Urinary Retention April-June 2026 Slide 1/2

Oxford University Hospitals NHS Foundation Trust

Incident number and short description	Area	Guideline followed	Barrier identified	Action
457063 Bladder injury at ELCS	DS	✓	None	No further action
456719 Failed TWOC	L5	✓	None	No further action
458298 Failed TWOC	L5	✕	Staffing, equipment	Ward stock review; reinforce fluid balance documentation (owner/date pending)
458457 Urinary retention	DS	✕	Documentation, staffing	TWOC diary updated; fluid balance compliance work (owner/date pending)
459548 Failed TWOC	L5	✕	Documentation	Fluid balance compliance work (owner/date pending)
460323 Failed TWOC	L5	✓	None	No further action
462252 Failed TWOC	L5	✓	None	No further action
458484 Urinary retention	DS	✕	Documentation, staffing	Fluid balance compliance work (owner/date pending)
460287 Multiple failed TWOCs	L5	✕	Documentation, knowledge	Reminder on bladder scanner use; fluid balance work (owner/date pending)
461656 Declined catheter	DS	✓	None	No further action
461045 Failed TWOC	L5	✓	None	No further action
461030 Bladder injury ELCS	DS	✓	None	No further action
463588 Ongoing investigation	L5	✓*	Under investigation	Actions pending
463591 Ongoing investigation	L5	✓*	Under investigation	Actions pending
463773 Early catheter removal	DS	✕	Staffing, knowledge	Actions to support L2 staff during escalation (owner/date pending)
465950 Failed TWOC	L5	✓	None	No further action
466728 Retention after declined catheter	DS	✓	None	No further action

- A review of all reported bladder care incidents has been completed against the local care guidelines. The majority of incidents related to urinary retention following routine Trial Without Catheter (TWOC), with management in most cases compliant with the guideline.
- Where deviations from the guideline were identified, these primarily related to:
  - incomplete fluid balance documentation
  - delays associated with workload or patient transfers
  - inconsistent use of bladder scanning
  - equipment availability.
- June urinary retention incidents (n=2) were reviewed, and both were managed in accordance with the guideline with no additional actions identified.

Bladder Care Incident Review: Improvement Plan Slide 2/2

Improvement area	Action	Lead	Target date	Status
Data quality	Review and standardise Ulysses bladder incident categorisation to improve data quality and enable meaningful trend analysis/SPC reporting.	Patient Safety Midwife & Maternity Quality Assurance and Improvement Coordinator	30 September 2026	In progress
SPC monitoring	Develop monthly SPC chart for bladder incidents once data quality review is complete.	Patient Safety Midwife & Maternity Quality Assurance and Improvement Coordinator	30 September 2026	Planned
Documentation/Education	Reinforce completion of fluid balance charts and bladder care documentation through ward safety huddles.	Ward Managers	31 August 2026	Pending confirmation
Learning	Continue monthly review of all bladder incidents through Maternity Governance and monitor actions to completion.	Maternity Patient Safety Team	Ongoing	Ongoing

Data quality note: SPC charts are not included within this month's PQOM. Review has identified variation in Ulysses incident categorisation, preventing reliable trend analysis. Standardisation of incident coding is the first improvement action and will enable routine SPC reporting once completed.

Further assurance regarding bladder care will be provided through a programme of documentation audits, review of compliance with bladder assessment and monitoring standards and oversight through the MCGC. Findings from incidents, complaints, patient feedback and case note reviews will be triangulated to identify any recurring themes. Compliance data and learning outcomes will be reported regularly to the Divisional and Trust Governance Committee, with targeted actions implemented where gaps are identified. A re-audit will be undertaken to provide assurance that improvements have been embedded into clinical practice and are resulting in safer, more consistent bladder care.

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

Oxford University Hospitals NHS Foundation Trust

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

PMRT Reporting and Learning

- All cases that met the criteria in June were reported to MBRRACE, in line with national requirements.
- 5 multidisciplinary case reviews were completed during June, and a joint review meeting between maternity and neonates was conducted providing an overview of all NND cases reviewed in quarter 1.
- PMRT meetings are held weekly on a Monday afternoon. An external reviewer was invited to every meeting, in line with MPIS requirements.
- All meetings were attended by an external reviewer and had representation from service user groups.
- Families are involved through the process and invited to provide feedback and ask questions.

MNSI Reporting and Learning

The trust received 1 report for factual accuracy in June.

There were no cases referred to MNSI in June.

Learning from Maternity PMRT Reviews

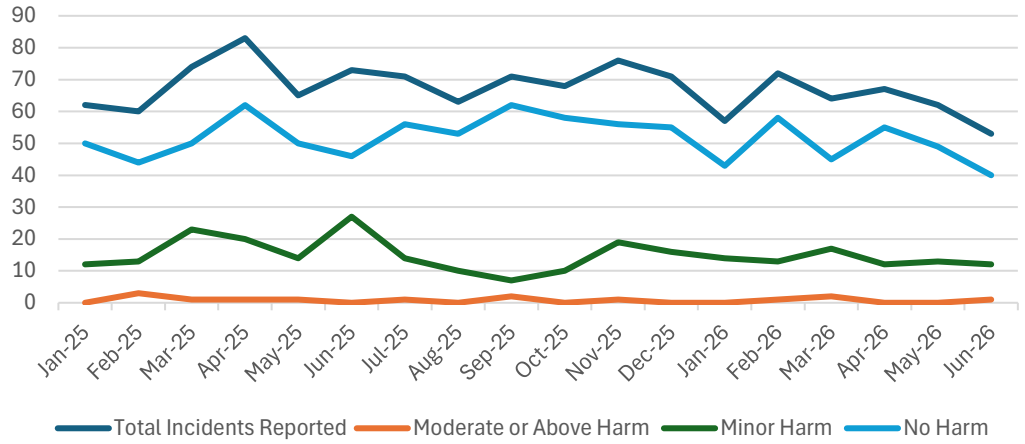
Five cases were concluded in June. All cases were graded either A or B, meaning care was safe and appropriate. For four cases there were no care concerns identified by the reviewing panel and parental feedback was addressed. There were no cases graded C or D.

	Summary	Key Learning and Actions
1	A baby with an antenatal diagnosis congenital anomaly. Baby was born at 34+ weeks gestation due to maternal discomfort. Baby sadly passed away on day 3.	Parents provided positive feedback about their care. The review panel highlighted delays in enquiring about domestic violence because the partner was present at most community midwife visits. The booking trust has taken learning from the case to redistribute to their team.
2	At 25+6 weeks, a mother attended the maternity assessment unit with symptoms of chorioamnionitis and preterm prolonged rupture of membrane. Her babies were delivered by emergency caesarean section at 26 weeks. Sadly, one baby died during the neonatal period.	Care was deemed to be appropriate and in line with relevant guidelines, no actions were made as a result of the meeting.
3	A mother attended MAU at 22 weeks gestation with ruptured membranes. An intrauterine death was diagnosed shortly after admission; chorioamnionitis was the cause of death	A plan was made for a further SEIPS analysis of events in view of a delayed diagnosis of chorioamnionitis
4	A baby who was born at 23+ weeks gestation following a diagnosis of chorioamnionitis on amniocentesis. The neonatal team provided counselling to the parents, who opted for comfort care.	From parental feedback it was highlighted that there was a delay in provision of analgesia for baby whilst receiving comfort care. An action was made to pursue a standardised SOP or plan for neonates to be involved with cases where parents have opted for comfort care to provide an individualised plan.
5	A baby that was born at 25 weeks gestation due to maternal chorioamnionitis.	The review panel felt that measuring HbA1c at booking would have enabled the booking Trust to provide appropriate counselling and offer earlier termination of pregnancy, given the elevated HbA1c identified later in pregnancy

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. The PMRT meetings are attended by peer colleagues from other Trusts and service user representatives to agree grading and any necessary next steps.

Perinatal Safety - Neonatal Incidents

Oxford University Hospitals NHS Foundation Trust



Summary of Data

- In June, 53 patient safety incidents were reported via Ulysses; 13 resulted in harm: 12 minor and one moderate. The moderate-harm incident related to PVL extravasation with necrotic lesion in the context of severe oedema, clinical fragility and difficult IV access. A rapid review identified no care concerns, and Duty of Candour was completed with the parents.
- The most common causes of minor harm incidents were medication-related issues, medical device incidents, and communication or documentation concerns.
- Trend data over the past 12 months demonstrates sustained incident reporting within the Neonatal Unit, predominantly driven by no harm events. This pattern is indicative of a positive safety culture, with staff supported and encouraged to report incidents to facilitate early risk identification and continuous quality improvement.

Strengths

- Incident reporting within neonates remains consistent, reflecting a strong culture of openness and learning. Currently, there are eight overdue incidents, which are being actively managed. The continuous low number of outstanding cases, supported by monthly governance reviews and clear escalation processes, provides assurance that issues are addressed promptly and effectively.
- Neonates continue to rank as the second-highest reporters of excellence within the Children's Directorate, reflecting a strong culture of learning and recognition of good practice.
- In addition, representation at local, directorate, and divisional governance meetings continues to improve, supporting stronger engagement and alignment with organisational priorities.

Focus

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

Future

- Ongoing governance awareness and education within the neonatal team, supported by targeted teaching sessions and integration into team development activities. This will strengthen understanding of governance processes and accountability across all staff groups and will continue to be a focus over the coming months.

Oxford University Hospitals
NHS Foundation Trust

Maternity Operational Activity

Maternity Operational Activity

Oxford University Hospitals NHS Foundation Trust

Summary

Summary of Data (e.g. total births, community births, transfers, on call utilisation, IOLs, MAU attendances, closures)

- 631 people birthed 641 babies in June.
- In June, 41 births took place in community setting; 21 in our freestanding midwifery-led units and 19 at home. In addition, 1 freebirth took place. This represents 6.4% of all births for the month.
- 11 women and birthing people were transferred from community birth setting to the obstetric unit – 4 within intrapartum care; appropriately indicated by maternal observations, analgesia requirements, and meconium-stained liquor - 7 within postnatal care; appropriately indicated by postpartum haemorrhage, and neonatal observations.
- There were no closures of the obstetric led unit in June. There were no temporary suspensions of community or homebirths.
- There were 1579 MAU admissions - an increase of 85 from May
- The percentage of women seen within 15 minutes for initial triage has risen from 54.66% to 59.7% a 5% improvement on last month, which was itself a 4% improvement on the month before an improvement of approximately 10% over the 3 months.

Strengths

- Based on the data in Re: Safe Staffing/Red Flags and staff moving June 2026, total on-call hours increased to 217 hours in June after a reduction to 148 hours in May.
- This was driven primarily by use of hospital on-call hours, which rose from 140.75 hours in April to 158.75 hours in June.
- Community on-call hours showed an overall reduction across the quarter, decreasing from 103.25 hours in April to 58.25 hours in June, with a particularly marked reduction in May and June. Overall, the data suggests reduced reliance on community escalation support compared with April, while hospital-based on-call utilisation increased in June in response to operational demand.
- There is evidence of improving operational performance and patient flow despite ongoing service pressures, with appropriate governance and monitoring arrangements in place to support sustained improvement.

Focus

- The service continues to maintain robust oversight of workforce capacity through daily review of vacancies, sickness, and staff unavailability, triangulated against NHSP data, patient acuity, and predicted demand. OPEL status and staffing fill rates are reviewed each day to support proactive operational management and service stability.
- Performance improved during June, with no requirement for additional LSCS lists and only one induction of labour delayed beyond 24 hours, attributable to delivery suite room capacity. Early improvements have been observed following implementation of the revised RAG scoring system and changes to induction medication pathways, supporting safer patient flow and reducing delays.

Future

- Development of a CTG lounge and a separate initial triage room is underway in MAU, with both expected to be operational by the end of July.
- Two car parking spaces have been identified to support the wellbeing of staff parking closer to the JR when needing to work 10.00--22.30. This will launch 13th July.
- Assurance is provided that delivery of the 15-minute triage KPI is under active governance oversight and is being monitored through routine performance reporting. The expected trajectory is for sustained compliance by the end of Quarter 2, subject to completion of the agreed enabling actions: estate and equipment works commenced, additional rooms opened, CTG and call-bell systems functioning, and secure doors replaced. Progress against these actions will continue to be tracked by the triage quality improvement group, with Committee assurance provided once the improvements are embedded and performance is consistently maintained.

Workforce -Maternity

SUMMARY

Summary of Data (current ratio, coordinator supernumerary, establishments, whole time equivalent (WTE), support workers, consultant)

- **Midwife-to-birth ratio** was 1:24.24 for June reflecting a stable birth / staffing model / fill rates. Increase in June due to 44 more births.
- **Safe Staffing Incidents**: No reported incidents of 1:1 care not being provided in labour or the Delivery Suite coordinator not remaining supernumerary
- **Workforce establishment:** Midwifery establishment aligned to BirthRate+ (332.45 WTE) with an additional 23 WTE uplift for maternity leave, giving a total establishment of 355.45 WTE.
- **Current Workforce:** June midwifery workforce was 344.28WTE, leaving a vacancy of –11.17 WTE
- **Total unavailability** remains high at –36.88 WTE on average throughout June. This incorporates true vacancy, sickness and non-medical absences as well as supernumerary midwives. Mental health is still the highest cause of absences.
- Maternity Support Worker Vacancies remain high at –13.5 WTE, with high unavailability of –24.77 WTE. Mental health and surgery were the highest causes of absences.
- There was an increase in service wide use of on-call hours which correlates with a 100% fill rates, reduction of birth and stable improved unavailability. Increase use of NHSP to increase MAU staffing model.

Strengths

- Maintaining workforce establishment figures through new starters and a reduction in leavers Q4 (3 leavers) of 25-26. (14 Midwife leaves Q1)
- Succession planning with preceptee autumn recruitment including a wait list to replace leavers in a timely manner
- 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
- Increase of the hospital on call pool from 2 to 3 each night effective from the 13th of July roster
- Any short notice gaps in the roster are mitigated through tactical staff redeployment and NHSP with shifts proactively released to maintain safe staffing levels
- 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.
- 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.

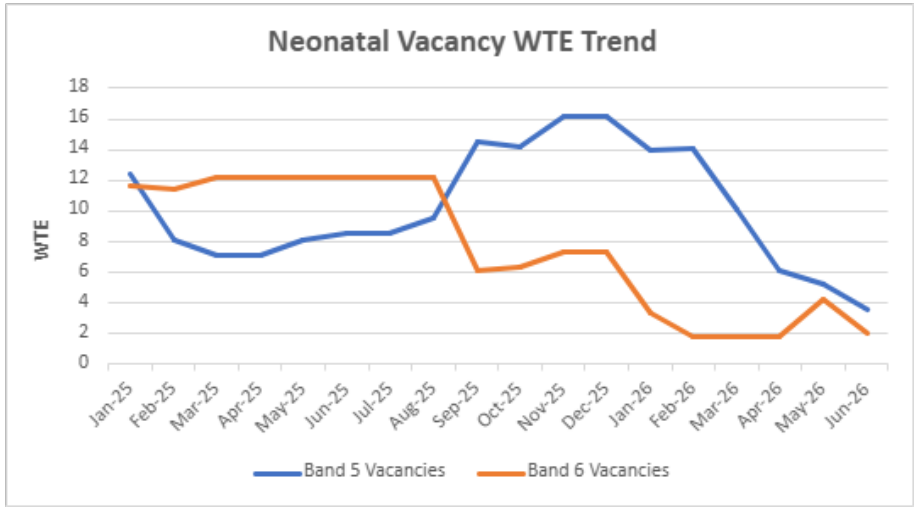
Focus

- Preceptee recruitment ready for autumn 2026 16 OBU students offered Band 5 posts, 4 on waiting list.
- Birthrate plus establishment review final report was received 30th June
- Increase MSW recruitment efforts to close gap on vacancies
- Roll out of 24/7 maternity bleep holder role will commence from the 13th July roster. The baton role is embedded within the band 7 Specialist and Matron job descriptions with a rolling educational programme supported by the outpatient matron and the trust emergency planning officer. This role will support with the continuous and consistent provision of 1:1 care in labour, monitor and enable patient flow, improve the facilitation of elective work and support the supernumerary status of Delivery Suite (DS) coordinator.
- MSW recruitment for Band 2/3 rotational post in progress

Future

- Workforce development: Succession planning strengthened through short courses and apprenticeship pathways to build leadership capability and future workforce resilience. 5 Short course candidates to start Sept 2026
- Midwifery recruitment: Targeted recruitment continues, with successful candidates allocated to high-maternity-leave areas (total maternity leave 24.47WTE a reduction of 1.98 WTE from May.) and wait-lists used to support pressure points.
- Resident doctors- Currently 1.00 wte registrar vacancy, start date in July. Two more resident doctors due to leave in the Autumn- recruitment process started.
- Consultants within the service are currently job planned . Job planning compliance rate at start of July 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 (scheduled for Autumn 2026).
- Currently there is one consultant vacancy at shortlisting stage. Another consultant is due to leave end of July- recruitment processes have been started for that post.
- Second SHO will be added to the overnight rota, starting from August 2026.
- Option of moving to a 3 tier roster for resident doctors is being explored, with business cases being drafted.

Workforce – Neonatal Nursing Workforce



Summary of Data

- In June, there were 3.53 WTE Band 5 and 1.98 WTE Band 6 vacancies in Neonates. Additionally, there are 9.36 WTE staff on maternity leave. This reflects a positive improvement, however, mitigation strategies remain in place, including regular staffing reviews and cross-divisional critical care redeployment, to ensure patient safety and service continuity are maintained at all times.
- Progress against recruitment targets and temporary staffing usage is monitored through and reviewed through divisional governance.

Strengths

- Currently, seventeen Band 5 nurses are in the recruitment pipeline and awaiting start dates. Many of these candidates are newly qualified and will be joining from September 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. Existing Band 2 staff will pilot the revised induction and pathway ahead of wider implementation.

Future

- The rolling recruitment programme for Band 5 and Band 6 nurses is ongoing.
- The Band 6 educator post is going through trac approval for advert.
- Two further Band 7 opportunities are currently being advertised.

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%	49%	67%	77%	87%
				Correct as of 8th July 2026	Prospective Data		

Summary of Data

- Current compliance with British Association of Perinatal Medicine (BAPM) standards for Qualified in Specialty (QIS) training is 49%, but the service continues to actively address these gaps and there is a clear trajectory in place for improvement, supported by a structured action plan.
- Please note that monthly fluctuations in compliance are a natural consequence of active staff recruitment and retention cycles within the unit. At the end of June, the total nursing workforce was 166, of whom 82 (49%) 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.
- In addition, significant progress has been made in increasing the number of staff undertaking QIS training which has increased from 8 to 17 staff across two cohorts - 7 nurses commenced training in September, and a further 10 in February 2026.
- This upward trajectory demonstrates a strong commitment to workforce development.
- Approval granted to externally advertise for band 6 and 7 posts will support our ability to meet our QIS trajectory

Focus

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

Future

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

Perinatal Training

Oxford University Hospitals NHS Foundation Trust

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

Summary of Data

- Patient Group Directive (PGD) compliance is 77.86% - Reminder email sent out to managers on the 3/7/26 to chase individuals.
- Oliver McGowan Part 1 is 83.4%. Part 2 face to face (FTF) – line managers will liaise with roster co-ordinators to book staff onto the course. A target of 25% by the end of quarter 3 in each of the individual clinical areas has been set with plans to monitor by the Deputy HoM.
- Neonatal nurses' neonatal life support (NLS) training is currently at 81% and there is a risk that they may not be above the 90% compliance for MPIS by the 01 August 2026.

Strengths

- Fetal monitoring compliance >90% for all relevant groups.
- Newborn life support (NLS) training >90% for midwives
- Training compliance continues to improve and remains on trajectory to achieve the required compliance standard by the end of July for anaesthetic staff, supported by targeted training sessions and active monitoring of attendance.

Focus

- Final consultant anaesthetist booked to attend in July which should take compliance over 90% in this category.
- Moving and Handling training compliance: 78% - dates planned monthly, and staff reminded to complete the e-learning as well as attending practical sessions. Sessions including fire evacuation chair and pool evacuation training.
- Safeguarding training – A targeted approach is being used to meet the compliance level. An additional maternity specific session is planned for 16/07/26 and is available to book on My Learning Hub.
- Neonatal nursing staff have been booked onto the additional NLS training sessions and compliance is expected to be >90% by the 01 August.

Future

•A rolling monthly training and compliance schedule is embedded across maternity and neonatal services to support sustained compliance above the 90% target for PROMPT, fetal monitoring and Newborn Life Support (NLS) across all staff groups.

•Ward managers continue to work closely with the Perinatal Training Team to coordinate targeted skills-and-drills sessions, ensuring training delivery is responsive to local risks, team needs and service pressures.

•Maternity staff are allocated protected training time within their training week to complete mandatory e-learning, aligned to operational requirements and monitored through local and divisional governance arrangements.

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	^83%
Core Skill – Information Governance and Data Security	^87.4%
Core Skill - Moving and Handling Level 2	^78.1%
Core Skill – Resuscitation Level 1	^89.1%
Core Skill - Resuscitation Level 2, 3 OR 4	^88%
Core Skill – Safeguarding Adults Level 3	^89.8%
Core Skill - Safeguarding Children Level 3	^86.9%

Core Skills Modules below target	Neonatal Unit
Core Skill – Moving and Handling Level 2	↓84%
Core Skill – Safeguarding Children Level 2	↓81%

PROMPT	Midwives	95%
	Nurses working in maternity	100%
	MSW's	97%
	Consultant Obstetricians	100%
	Trainees ST1-7	100%
	Obstetric anaesthetic consultants	88%
	All other anaesthetic doctors who contribute to obstetric rosters	96%
Fetal Monitoring	Midwives	95%
	Consultant Obstetricians	100%
	Trainees ST 1-7	100%
Newborn Life Support	Midwives	92.5%
	Neonatal/Paediatric: Consultants Junior neonatal Dr's (who attend births) ANNP's	 100% 92% 100%
	Neonatal Nurses	81%

Oxford University Hospitals
NHS Foundation Trust

Perinatal Improvement Programme

Patient Experience

Theme 2

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 (122 responses) and Say on the Day (434 responses) demonstrates consistently high levels of satisfaction across OUH maternity services. This combined number provides a 88% response rate compared to our delivery rate for June.
- Overall feedback was predominantly positive, with many women and families praising the kindness, compassion, professionalism and friendliness of staff across community and hospital maternity services. Horton MLU, Florence Park Midwives, Chipping Norton and Level 1 Outpatients received particularly positive comments, with service users describing staff as supportive, attentive, informative and caring. Several comments highlighted individual staff members and teams who made women feel at ease and well supported during their care.
- The main areas of concern related to environment, waiting times and communication. A significant theme from the Level 5 Postnatal Ward was the impact of hot weather, with multiple comments describing uncomfortable temperatures, lack of fans and concerns about the ward environment for both patients and staff. Waiting times were also raised in MAU and outpatient services, particularly delays in medical review and clinic appointments. Despite these concerns, positive feedback about staff compassion and care remained a consistent theme throughout the month.
- 16 new complaints were received in June with 1 subsequently withdrawn and 3 related to historic care received 2025, 2023 and 2022. This is equals to the number received in May and a reduction to the number received in April.
- Overall, historic complaints centre on labour, birth, immediate postnatal care and the need for follow up or de-brief. In comparison, the current themes suggest a pattern of communication, access and responsiveness issues across the maternity pathway with feedback on difficulties obtaining advice, receiving clear explanations and feeling listened to or taken seriously. While concerns about delays, pain relief, escalation and postnatal support remain present in both historic and current data, current themes indicate that key area for improvement is not only clinical response itself but also consistency, compassion and clarity of communication that surrounds care planning , follow up and escalation.

Strengths

- Consistently compassionate and caring staff, with numerous comments highlighting kindness, friendliness, professionalism and supportive care across both hospital and community services.
- Strong patient experience in community settings, particularly at Horton MLU, Florence Park Midwives and Chipping Norton, where women reported positive, timely and personalised care.
- Staff who provide reassurance and emotional support, with patients describing teams as attentive, informative and helping them feel at ease during their maternity journey.
- Positive recognition of individual staff members, demonstrating the impact of compassionate interactions and high-quality personalised care.
- Good appointment experience in several areas, with feedback referencing appointments running on time and efficient service delivery.
- Strong teamwork and engagement, reflected in repeated comments describing services as excellent, helpful, attentive and supportive.
- High levels of satisfaction despite service pressures, with many respondents stating there was little or nothing that could be improved about their care experience.

Focus

- Improve environment on MAU with CTG lounge and dedicated initial triage room. This will improve 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.
- A continued focus on community engagement is being maintained through attendance at community events and outreach activities, enabling the service to hear directly from local communities, gather feedback from seldom-heard groups and use these insights to inform service improvement and enhance patient experience

Future

- Review and update visitor access to level 2 to reduce risk of tailgating through delivery suite and observation area – Ongoing (once Ward clerk desk is relocated within MAU we can commence new flow of visitors) Deadline end Q2
- A project is commencing with Trust support to review the potential amalgamation of the Day Assessment Unit and Maternity Assessment Unit, enabling unified managerial oversight and a clear escalation pathway; this remains a longer-term priority alongside current focus on triage and IOL – Deep dive review of DAU guideline is ongoing and links to BSOTS and reduced fetal movements guideline renewal. Deadline DRG Aug 26
- Order Fans for each bedside within level 5 and level 6 – Cleaning schedule has been implemented for compliance with infection control. Deadline end July 26.

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

Oxford University Hospitals NHS Foundation Trust

Summary of Data

- A revised approach to the Friends and Family Test (FFT) was implemented within Neonates in May 2025, providing a structured method for capturing patient experience. In June 2026, two FFT responses were received, representing a decrease compared with May, but remaining in line with response volumes from previous months.
- Overall response rates remain low. A series of targeted actions have been implemented to strengthen the collection of Service User Feedback. This has included repurposing "Say on the Day" devices to support real-time feedback from families and service users, and improving the visibility of FFT materials through updated posters displayed across key areas of the unit. Further work has included weekly feedback walk rounds, supported by the administrative team where capacity allows and where appropriate, and engagement with OMNVP to benchmark local practice against network and national approaches to improving feedback uptake. Planned next steps include embedding the FFT feedback form within the Neonatal Padlet and both admission and discharge packs to improve accessibility and increase opportunities for families and service users to provide feedback.
- One complaint was received in late June relating to a baby that required admission to Paediatric Critical Care Unit (PCCU) shortly after discharge home from Neonates. A neonatal response is currently being prepared, and any learning identified will be shared once the final investigation is complete.

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.
- In June, 10 responses were received from families via Say on the Day devices (representing 14% of admissions), with overall experience rated 10/10.
- Positive responses are seen through both feedback platforms. Recognition of supportive staff, kindness and compassion is expressed throughout.
- Comments are consistently positive with examples such as "*Brilliant care*" *and "Amazing staff, nothing is too much trouble and always greeted with a smile. Made to feel welcome and so do our children. We will very calm and feel our baby is in safe hands."*

Focus

- While feedback received to date has consistently highlighted exceptional care and professionalism within the neonatal service, the current response rate for formal patient experience remains below expectations. To address this, a clear improvement plan has been implemented alongside the Patient Experience Team.
- Staff have been briefed to actively encourage completion of FFT at key touchpoints, including admission, discharge, and during longer inpatient stays.
- Engagement will be further strengthened through targeted communication campaigns and digital options to ensure inclusivity and representation from diverse communities.
- Response rates and feedback themes will be monitored monthly through divisional governance.

Future

- The neonatal service is committed to increasing FFT and 'Say on the Day' response rates to ensure a more representative view of service user experience and to capture constructive suggestions for improvement.
- Staff engagement remains central to this plan, with training and reminders embedded into daily huddles to encourage families to provide feedback at key touchpoints such as admission, discharge, and during longer inpatient stays.
- Progress will be monitored through monthly governance reviews, with a 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.

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Perinatal Improvement Programme

Quality Improvement

Theme 3 –Safety

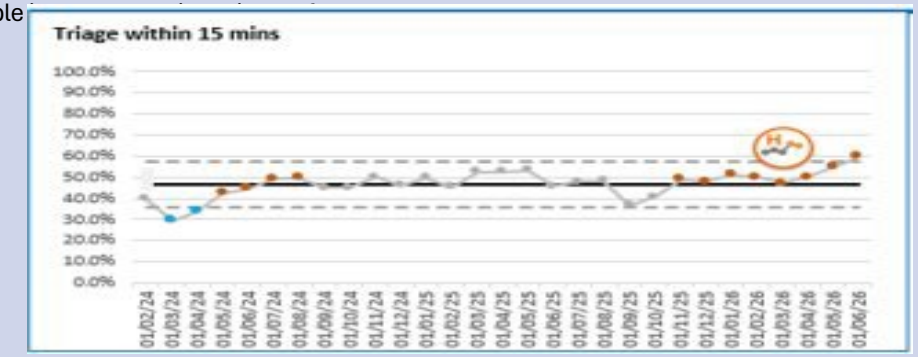
Focus Quality Improvements: Triage (BSOTs) Perinatal Improvement Programme – Safety (1)

NHS Oxford University Hospitals

TRIAGE QUALITY IMPROVEMENT: SUMMARY

Summary of data

- Performance remains below the required standard for safe and effective care; however, there has been a modest improvement in the proportion of women receiving an initial triage assessment within 15 minutes. This month it is at 59.7% a 5% improvement on last month, which was itself a 4% improvement on the month before. . Improvement initiatives are in place and beginning to show early impact, but further acceleration is required to achieve sustained compliance. Focus remains on embedding existing interventions, strengthening operational oversight, and ensuring timely feedback and accountability mechanisms to support measurable and sustainable



Strengths

- Sustained performance under unprecedented demand: Maternity Assessment Unit managed its highest ever monthly activity (1,579 attendances) and highest single-day volume (76 attendances), while maintaining strong performance in ongoing midwifery care, with Green pathway compliance consistently close to 100%.
- Improving timeliness of initial assessment: Initial triage performance has improved for the third consecutive month, increasing by approximately 10% over the past three months. The number of women waiting over one hour for initial triage reduced from 54 to 35, demonstrating progress despite increasing demand.
- Positive improvement in ongoing care standards: Ongoing medical review performance has strengthened, with Green pathway compliance remaining above 90% for three consecutive months and a notable improvement in Yellow pathway performance from a three-month average of 46% to 56%, indicating early impact from improvement initiatives.

Focus

•Complete a detailed review of the 10am-22.30 shift impact once staffing data becomes available, to understand its contribution to the recent improvement in initial triage performance and identify opportunities for optimisation.
•Sustain and embed current improvement initiatives that have delivered a 10% improvement in initial triage performance over the last three months, ensuring consistency across all shifts and days of the week.
•Align workforce deployment to demand patterns, particularly during periods of highest activity, given the record monthly attendance and highest-ever single-day volume experienced this month.
•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.
•Review attendance patterns for suspected labour presentations, which remain the largest reason for attendance (16% of cases), to identify opportunities for pathway optimisation and appropriate redirection where clinically suitable.
•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.

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.
•Undertake detailed reviews of patients experiencing waits over one hour, identifying themes and implementing targeted actions to address avoidable delays.
•Strengthen real-time operational oversight and escalation processes, enabling earlier intervention when performance deteriorates.
•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 and reducing extended waits by the end of quarter 2 (Q2).
•On track for full compliance of KPI initial triage < 15mins by the end of Q2
•A business case is being developed by the Clinical Director to establish Registrar presence on every MAU shift, strengthening medical staffing and enabling timely clinical escalation.

Maternity Assessment Unit (MAU)

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Month:	June	Year:	2026
Attendances:	1579	Calls:	1676

Initial Triage

Data Accuracy	98.6%
Seen within 15mins	59.8%

Feedback

'Midwife called Kathryn was so helpful, calm and reassuring. I went in with a fall and was very concerned, she was able to provide amazing care as well as be a genuine human being. She even came to check in on me when she saw my name on labour ward. She's a great asset to the team and gives MAU and the maternity department a good reputation.' - 07/06/2026

Quietest Day

Sun 21st
38

Busiest Day

Thurs 4th
76

Midwifery Care

Data Accuracy	97.7%
Seen within 4 hours	100%
Seen within 1 hour	87.5%
Seen within 15mins	71.2%

Medical Care

Data Accuracy	78.7%
Seen within 4 hours	97.6%
Seen within 1 hour	61.4%
Seen within 15mins	40.0%
Total cases reviewed	788

Perinatal Improvement Programme

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

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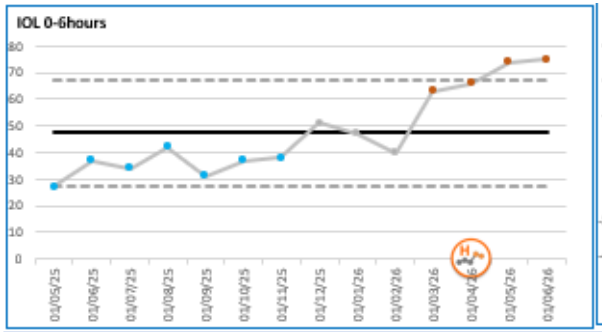

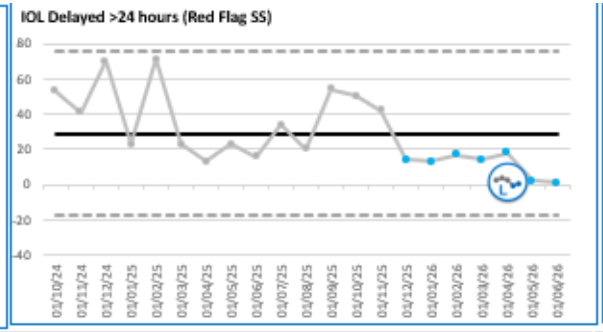

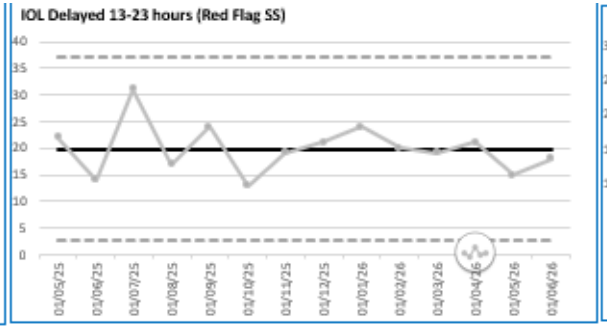

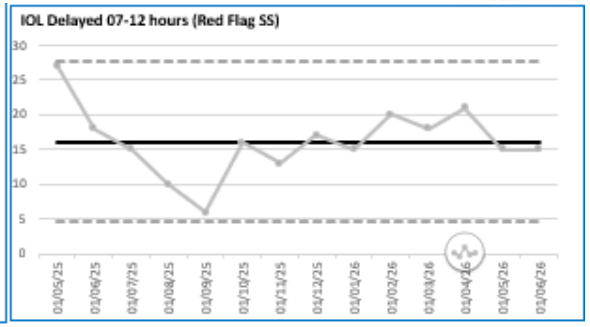

Summary of Data

- 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.

Strengths

- One red flag delay of over 24 hours was reported in June. This was recorded on Ulysses and reviewed, with no harm identified. The delay related to Delivery Suite room capacity at the point transfer was required. Assurance is provided that mitigating actions are underway, including improved room utilisation and revised flow so elective caesarean patients do not wait on Delivery Suite pre-operatively, releasing three rooms to support timely transfers.

Focus

- Performance has improved, with transfers to Delivery Suite within 0–6 hours increasing by a further 2% compared with May.
- Longer transfer-time categories have reduced as more women are transferred within the 0–6 hour standard.
- 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

- A survey has been launched to gather feedback on the induction of labour pathway, including the new RAG scoring system, methods of induction, and patient experience in relation to booking, waiting times, and communication.
- Current feedback is positive, with all individuals who have responded stating they would be happy to have an IOL in a future pregnancy.
- Enhance communication at the time of induction booking to ensure women receive clear information about the induction process, expected timelines, and potential delays.
- 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.
- The monthly induction of labour (IOL) audit remains ongoing, with a comprehensive summary of findings due at the end of Quarter 2. Triangulation of audit outcomes with service-user survey feedback will provide a more robust understanding of the induction pathway, helping to validate findings and identify targeted opportunities for further quality improvement and service development.

Focus Quality Improvements: IOL Perinatal Improvement Programme – Safety (3)

Oxford University Hospitals NHS Foundation Trust

Month:	June	Year:	2026	Booked induction:	129	Actual induction:	109

Feedback

No feedback specifically mentioned inductions this month

Quietest Day

Mon 8th

1

Busiest Day

Weds 10th

8

Transfer to delivery suite

0-6 hours	75
7-12 hours	15
13-18 hours	14
19-23 hours	4
24+ hours	1

Nullipara	55
Primip	32
Multip	22

Method of delivery

ELCS	1
EMCS	32
Forceps	18
SVD	51
VBB	0
Ventouse	7

Perinatal Improvement Programme

116676

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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 through internal governance processes this month and will be submitted to trust board in July. • Requirement of report is biannual thus next report will cover Q1/2 data • Addition of operational capacity monitoring, including elective Caesarean activity via SitRep – working group in progress to develop new requirements.
B - Training		• As reported in June, the internally declared checkpoint was changed to **1st August 2026** with oversight and agreement from MCGC **–** this will be detailed in next months PQOM**.** • 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 • **There is a risk that neonatal nurses may not achieve the NLS target compliance of ≥90% by the 01 August 2026**.
C – Learning from Reviews and Investigations		• Quarterly thematic report due from Quarter 1 onwards • Changes made to routine reports and trackers to meets 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. • ICB assurance step removed as ICBs no longer hold a formal oversight role. • Quarterly update for MCB Quarterly update for MCB due in July – see slide 39 • Significant progress with pulse oximetry requirement – guideline changes due for DRG 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 drill to be completed • 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.

Maternal Care Bundle Implementation Quarter 1 Update

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Under the Maternity (Perinatal) Incentive Scheme (MPIS) Year 8, Trusts are required to report progress against the implementation of the Maternal Care Bundle (MCB) quarterly to trust board. The aim is for the bundle to be fully implemented by March 2027. The national MCB toolkit was published in June 2026. The leads for each element are updating their actions and progress into the toolkit. Internal audits of the mandated performance indicators will occur once the required processes are embedded which will be monitored via the MCB toolkit.

Summary of Elements

Element 1 VTE – Work in progress with acute care to agree early pregnancy pathway, and digital teams to include self-assessment into first contact midwifery referral form.

Element 2 Acute Care – Ongoing work planning rollout of MEWS. Significant multidisciplinary team (MDT) involvement required in order for element to be successfully implemented.

Element 3 Epilepsy - Job planning and clinic set ups required in order to comply with requirements.

Element 4 Maternal Mental Health- Guideline changes in progress with plan in place for completion. Challenges presented surrounding self assessment element of Whooley questions at required time frames.

Element 5 Obstetric Haemorrhage – Ongoing work with MDT to include reporting changes**.** Action plan developed to meet all requirements by March 27.

Strengths

Element 1 - Required changes already included with current VTE guideline

Element 2 – Working group set up in maternity to monitor implementation of MEWS

Element 3 – Monthly MDT discussions already well-established process in maternal medicine network, as well as out of area referrals.

Element 4 – 97% women had Whooley and general anxiety disorder (GAD) questions asked at booking in Quarter 1 2026, however this is not via self .

Element 5 – Twice weekly rapid review cases already set up and in place, positive feedback received.

Focus

Element 1 - VTE risk assessment tool on EPR in process of being updated – due by 13 July

Element 2 – Unable to implement roll out in maternity until October 2026 due to availability of practice development team. **There is a risk that implementing MEWS on Oracle (wider Trust) will not be ready for March 2027 due to dependency on Oracle development of the national solution and subsequent local EPR configuration requirements.** This will be added to the maternity risk register and with escalation to the corporate risk register.

Element 3 – Work on job planning for specialist support.

Element 4 – Work required on how Whooley questions will be self-administered and digital requirements. Required audits will be set up once process in place.

Element 5 – Obstetric support required surrounding proposed action plan for changes.

Future

Element 1 – Ongoing work with ICB to develop requirements with acute care and GP prescribing low molecular weight heparin (LMWH)

Element 2 – Required maternity document updates in relation to MEWS are due to go to the Document Review Group (DRG) in August. Further work required in relation to the implementation of MEWS outside maternity settings with the RAID committee as may not have a digital solution by March 2027. Ongoing work with ambulance service to review and standardise the pre-alert communication system between the ambulance service and the Delivery Suite and to ensure there is adequate signage to Delivery Suite.

Element 3- New required clinic having soft launch mid July. New consultant within epilepsy team due to start in November.

Element 4 – Updated Perinatal Mental Health guideline due to go to DRG in August 2026.

Element 5 – Guideline required to be reviewed and updated. Monthly MDT PPH review required.

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Appendices

Appendix 1: SPC Charts

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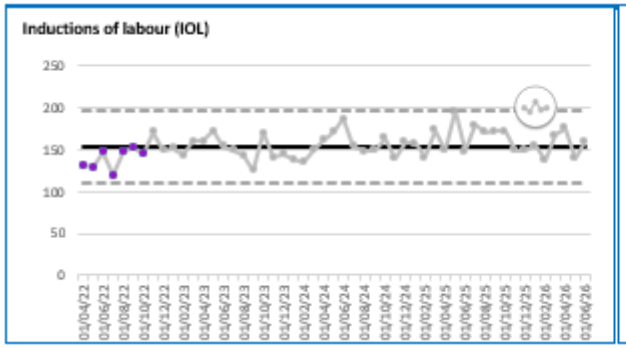

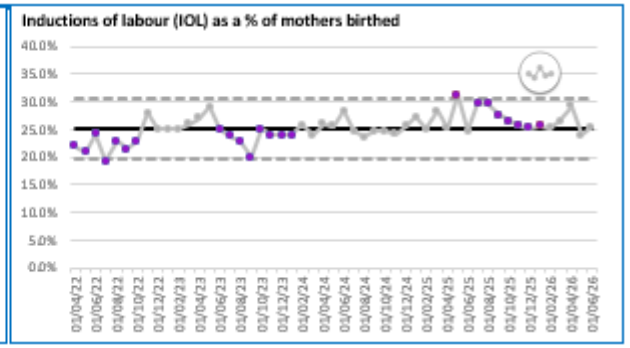

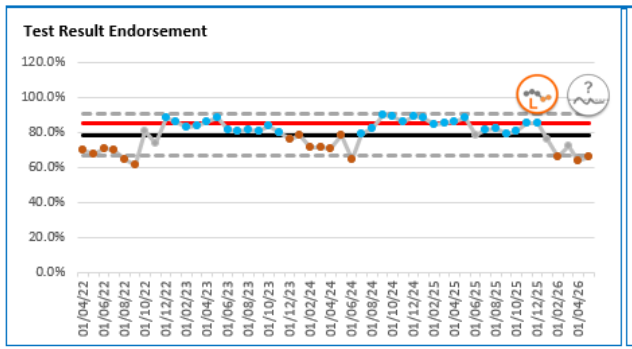

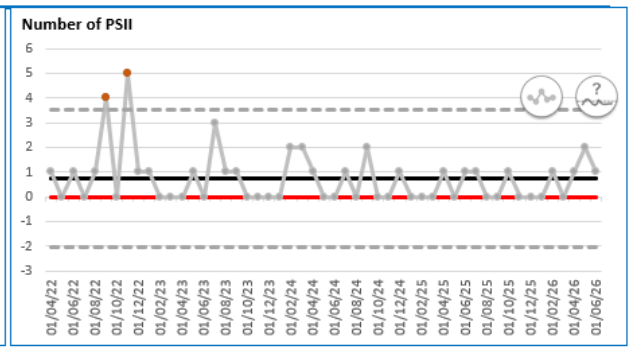

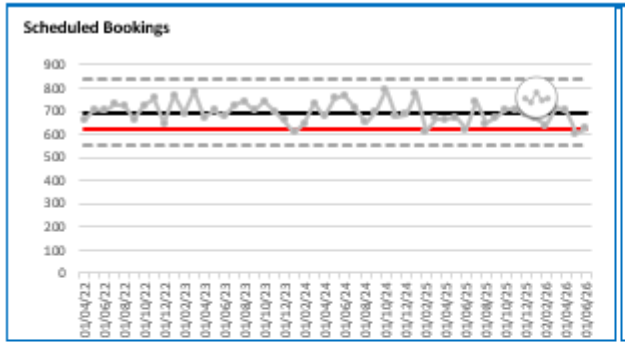

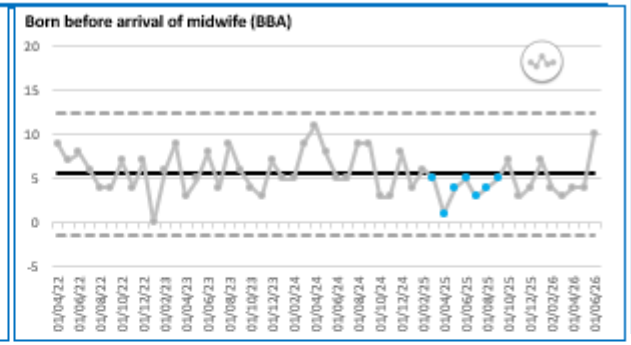

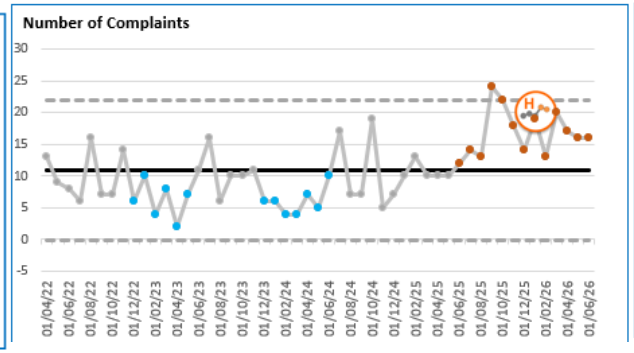

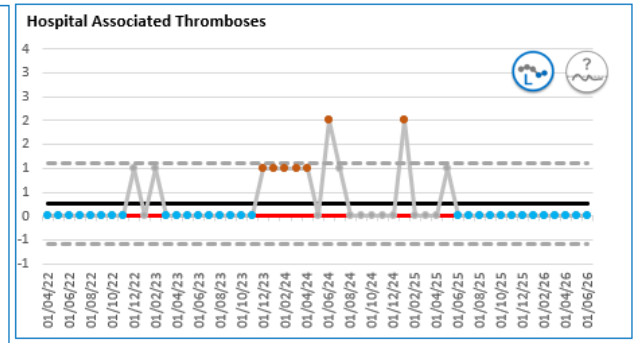

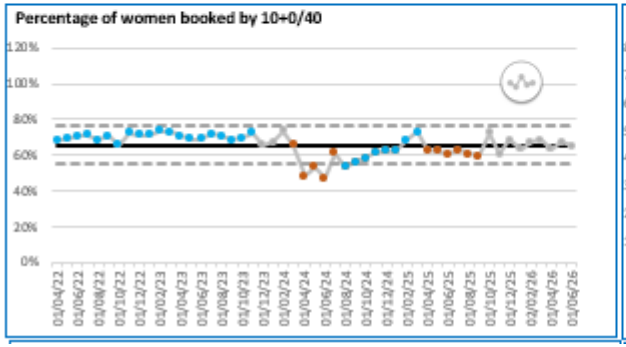

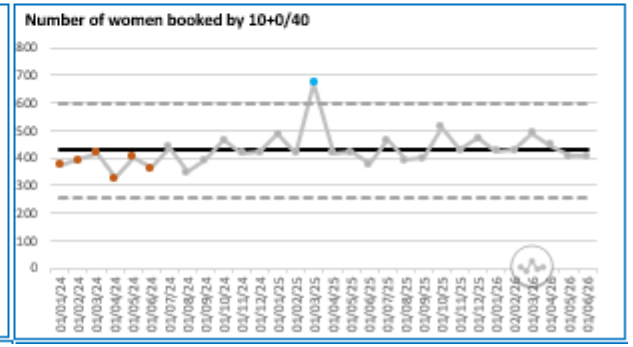

Appendix 1: SPC Charts

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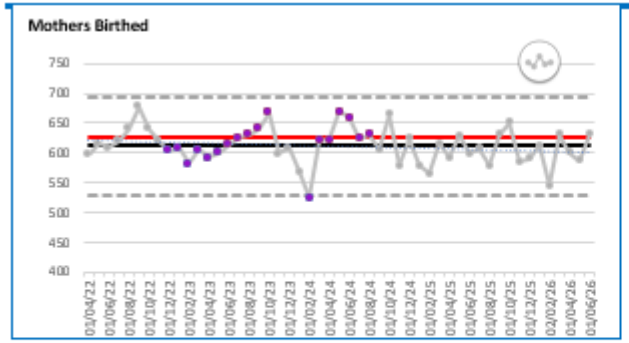

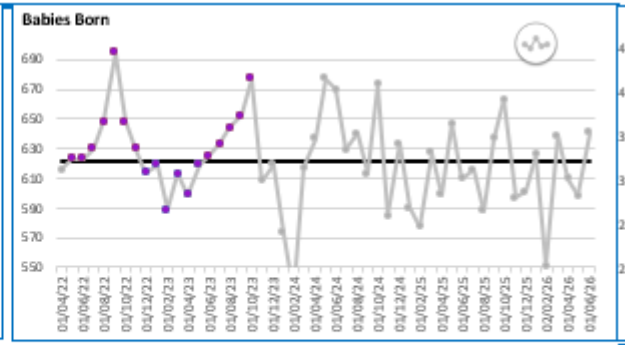

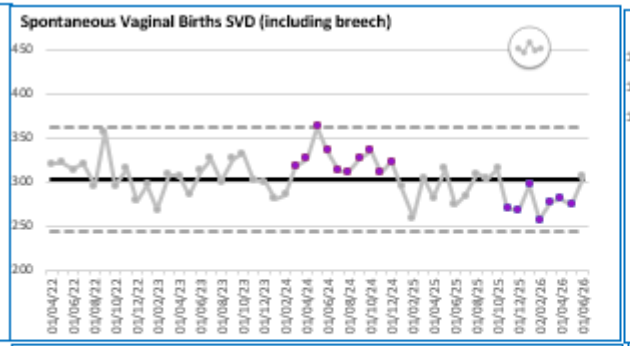

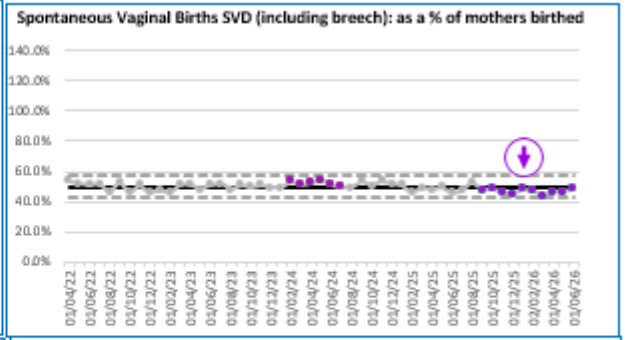

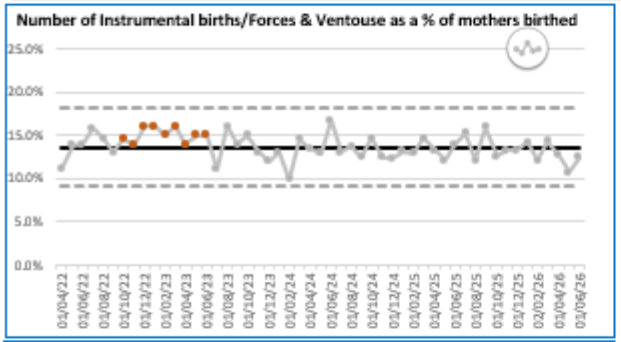

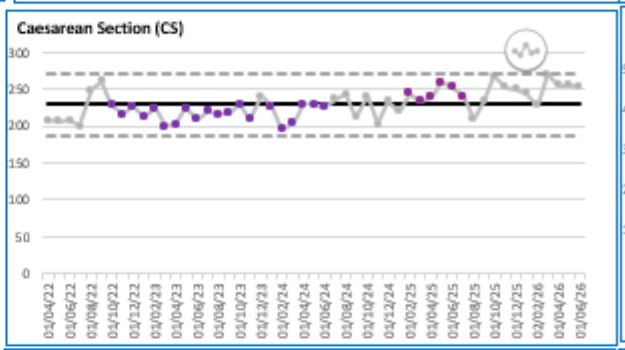

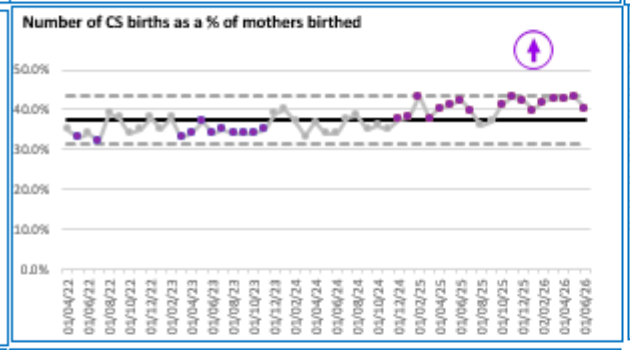

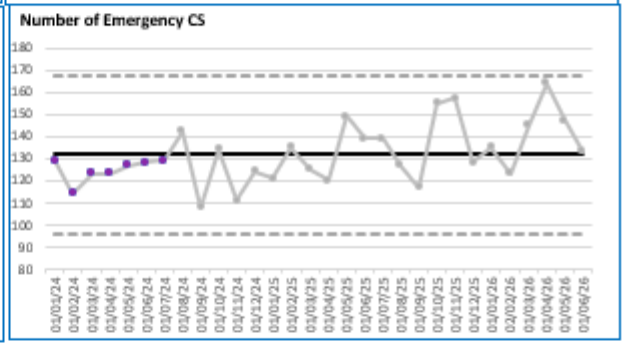

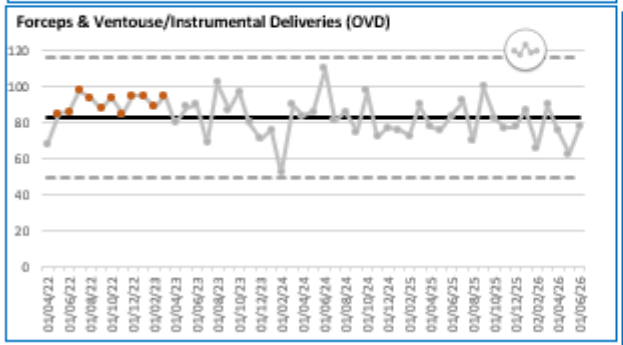

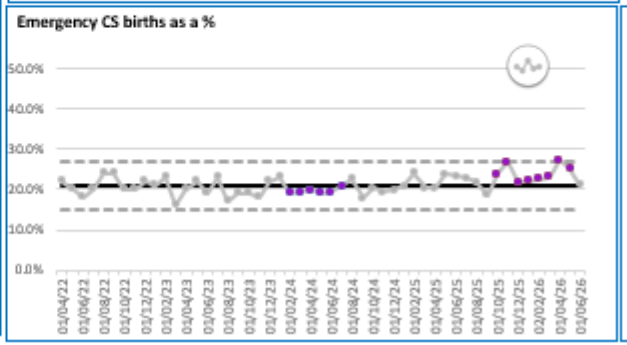

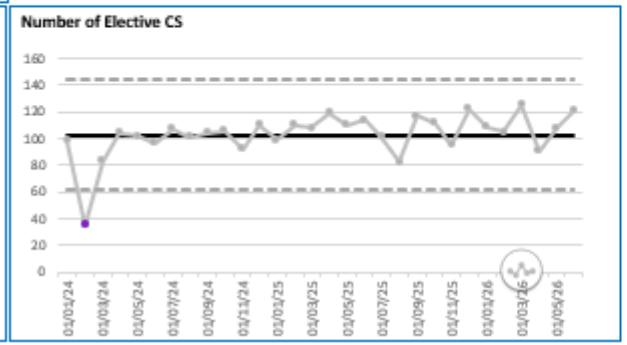

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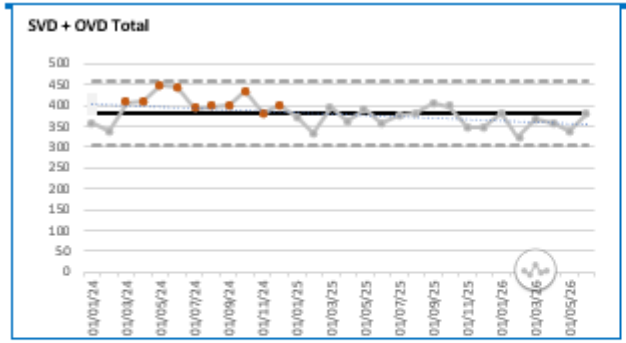

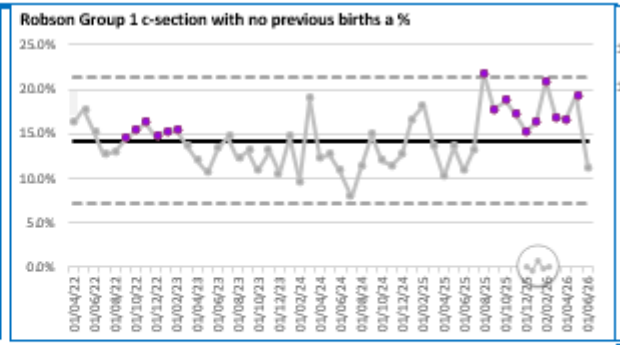

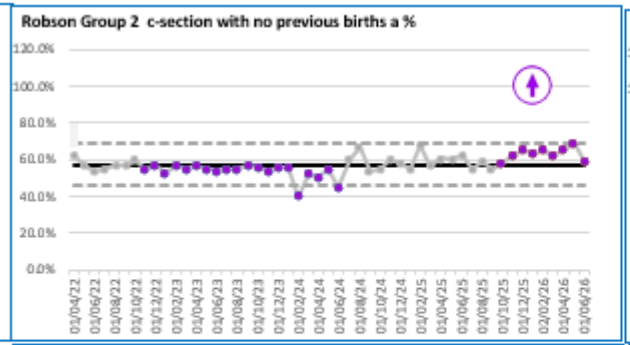

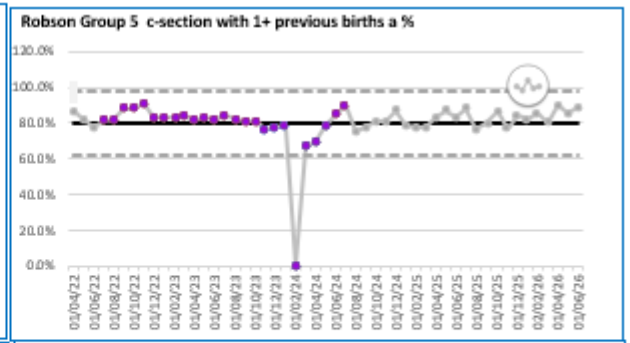

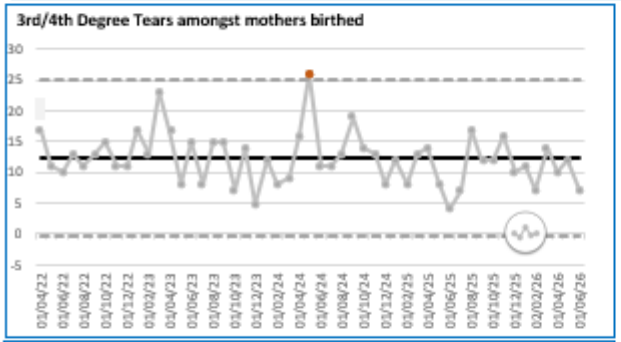

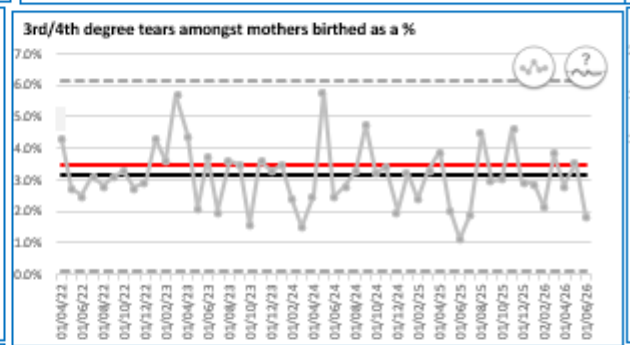

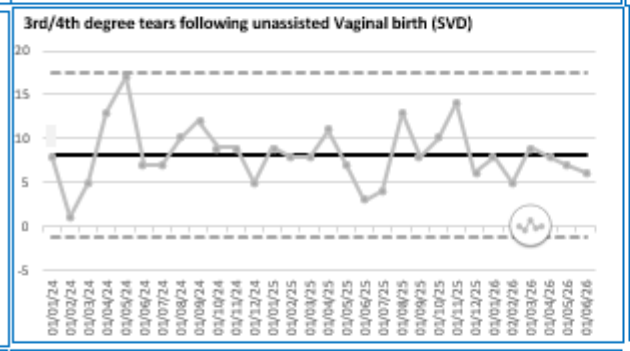

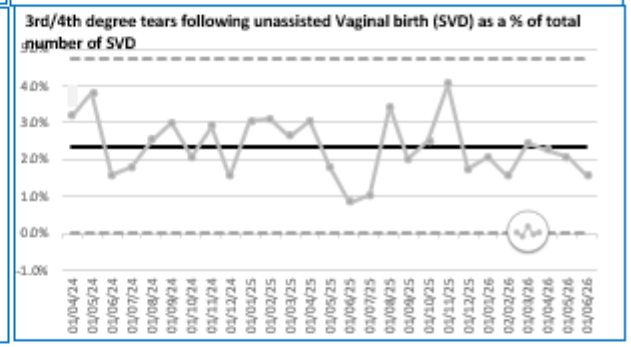

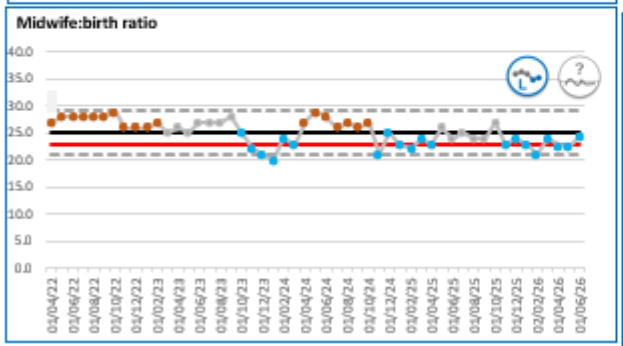

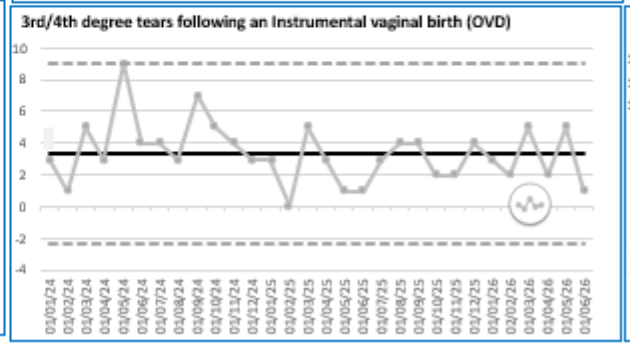

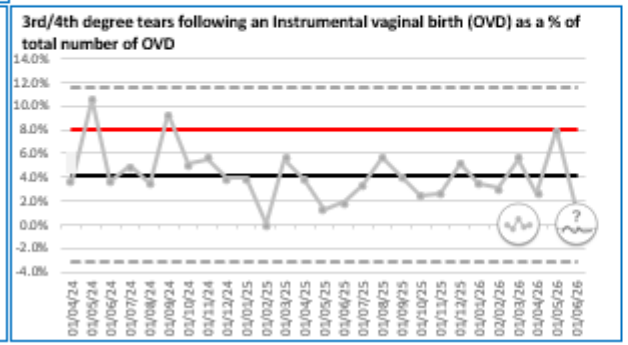

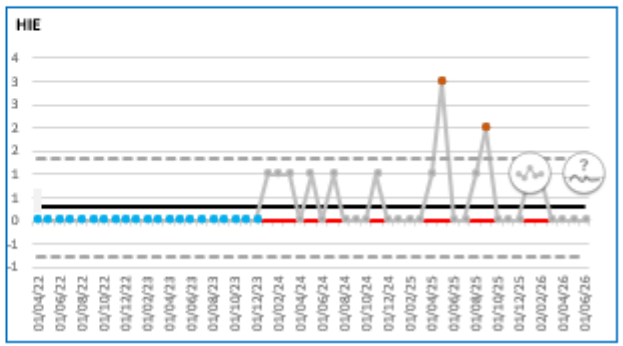

Appendix 1: SPC Charts

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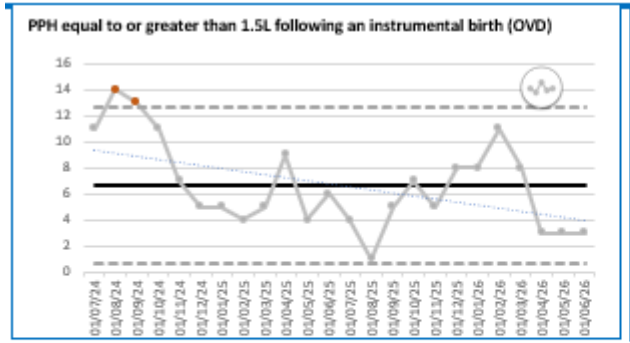

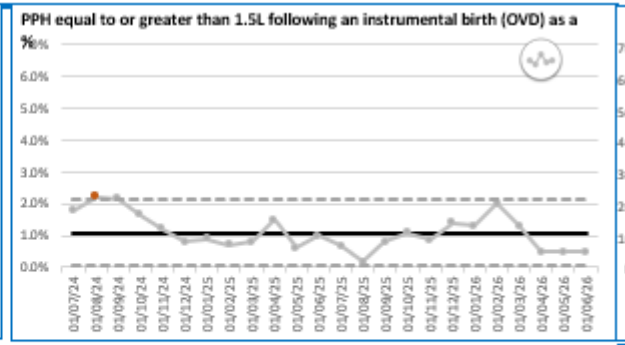

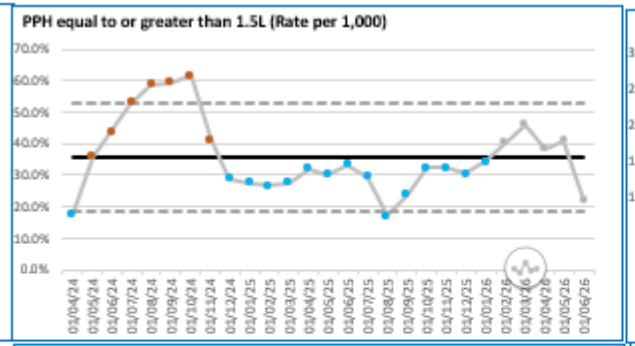

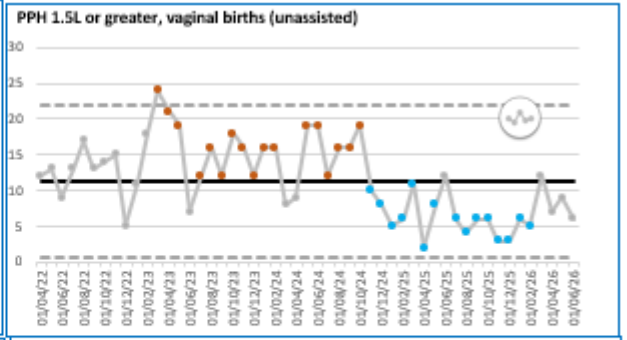

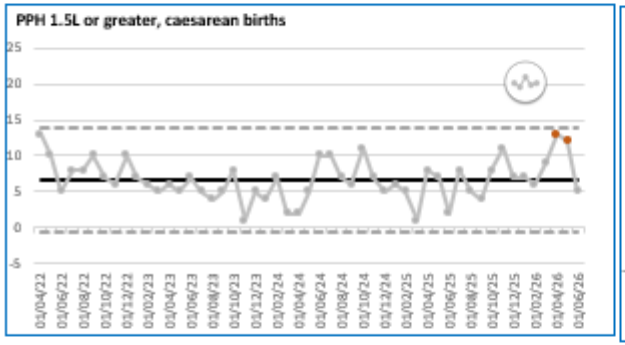

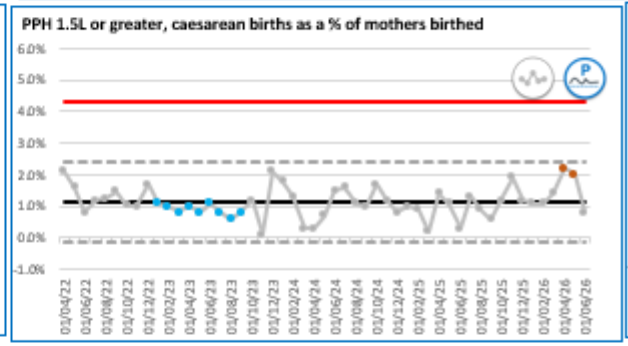

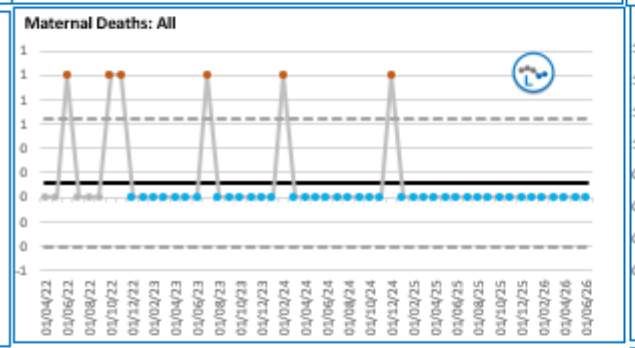

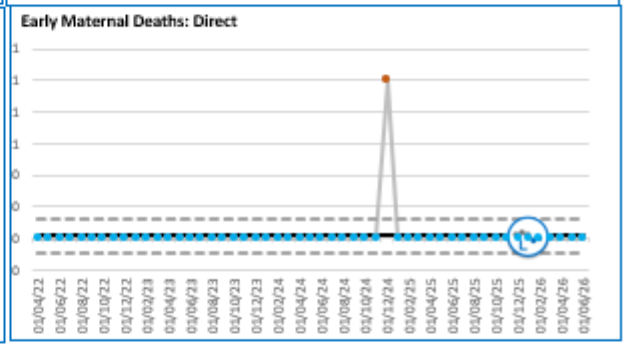

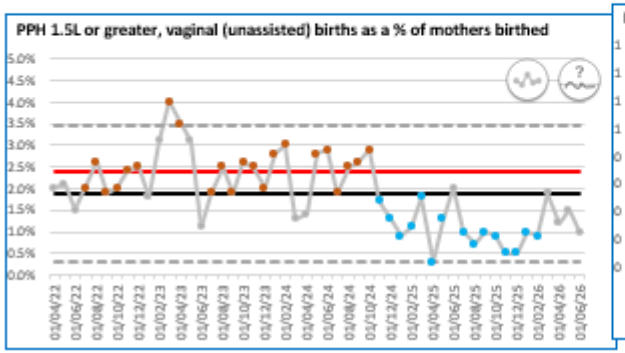

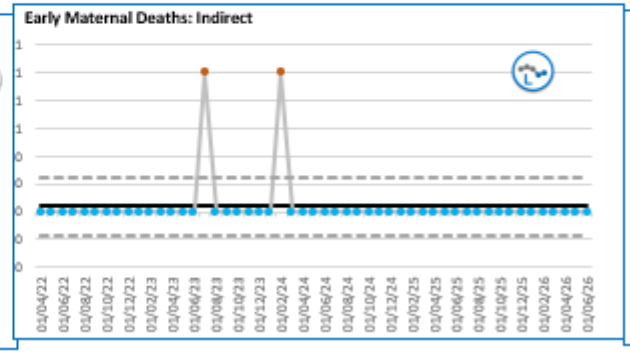

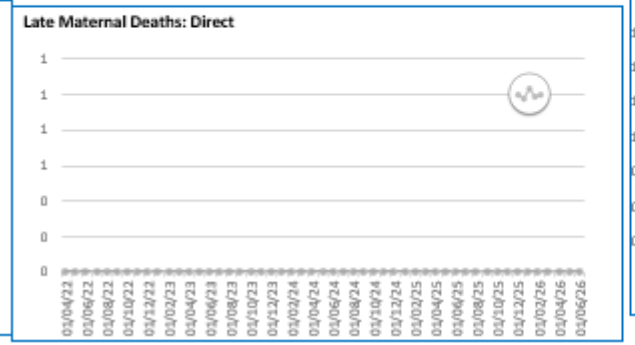

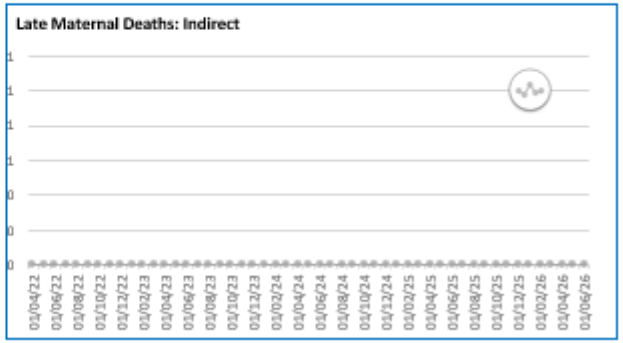

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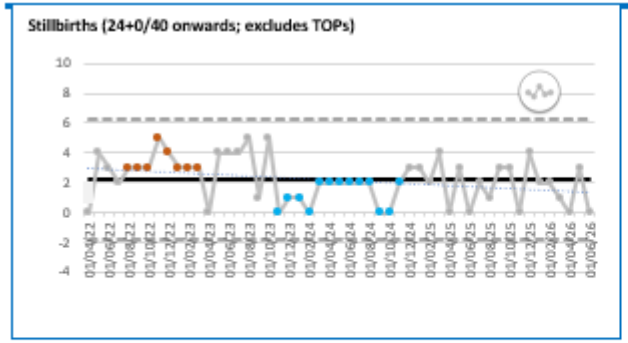

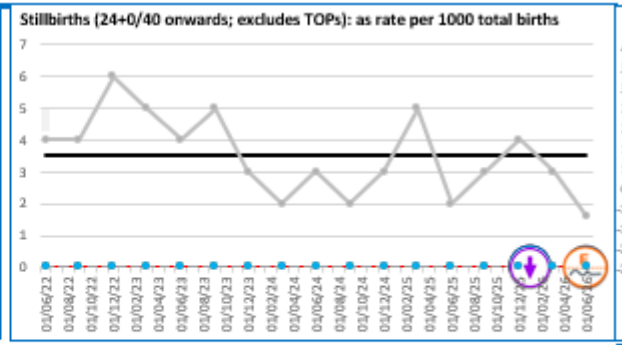

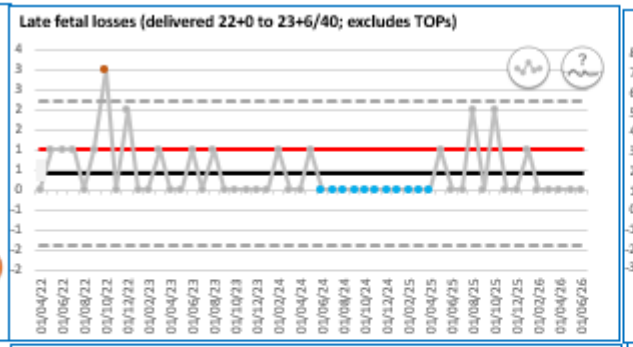

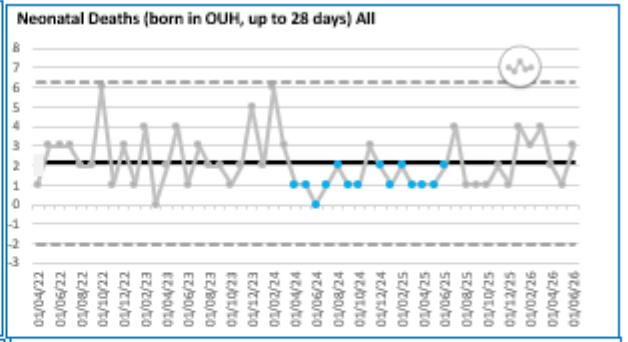

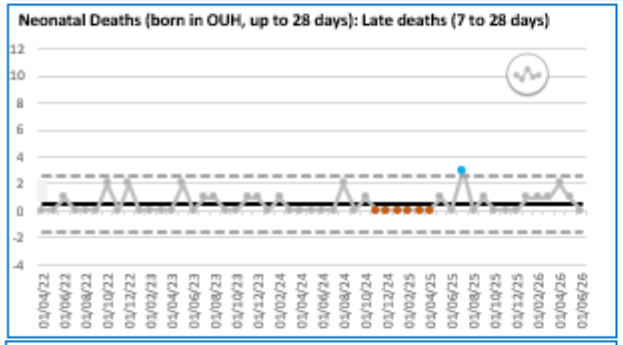

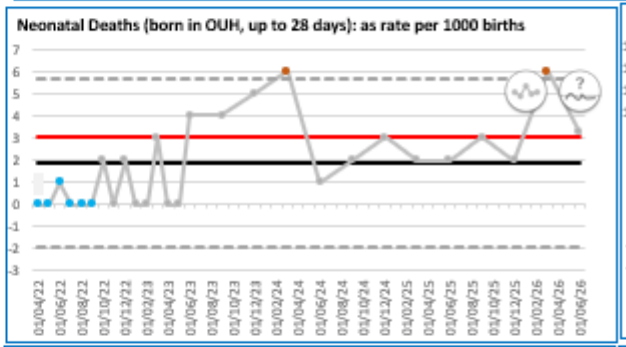

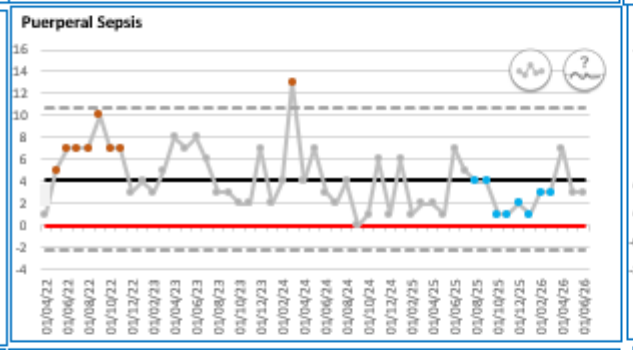

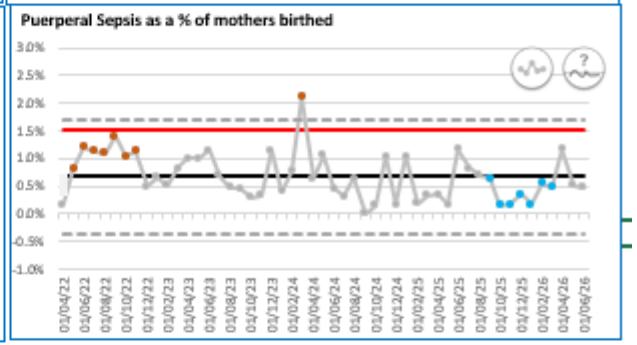

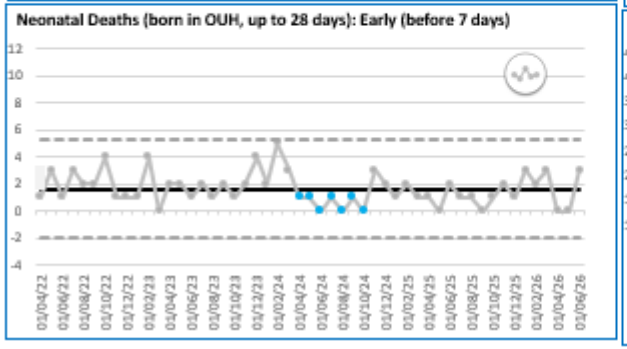

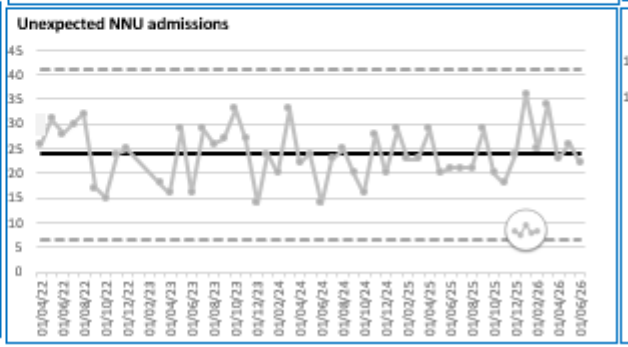

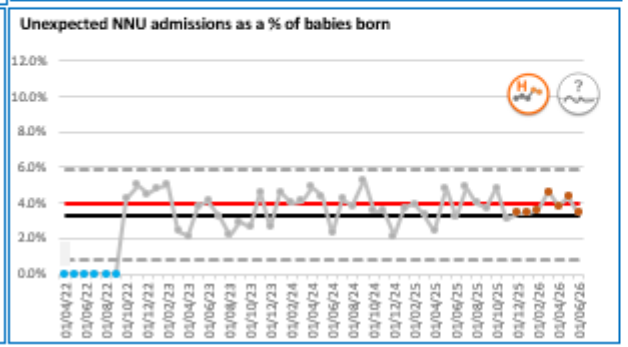

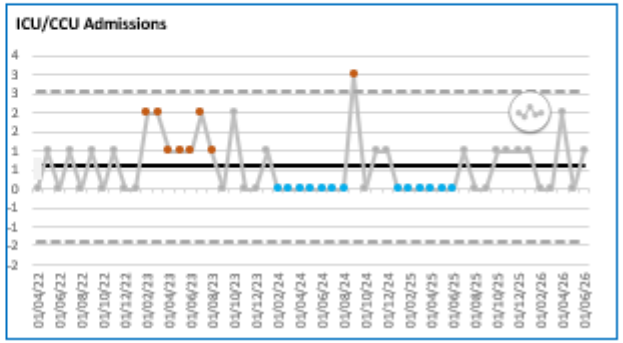

Appendix 1: SPC Charts

Oxford University Hospitals
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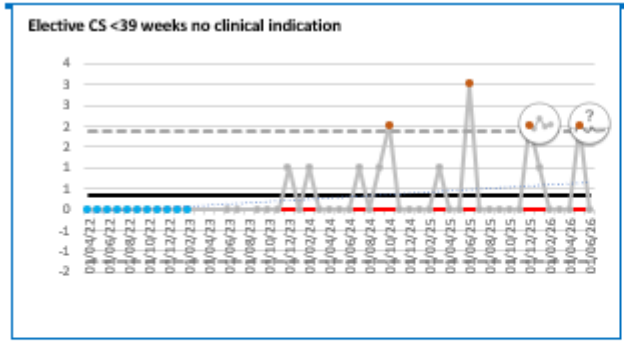

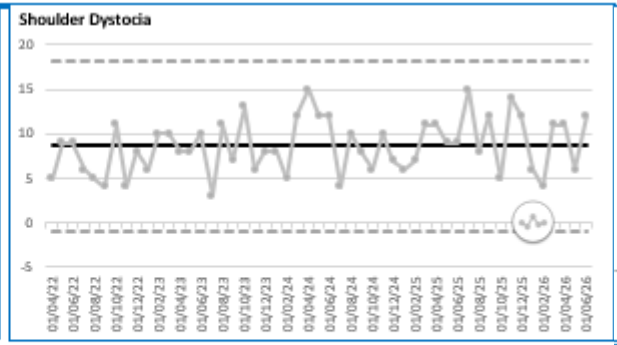

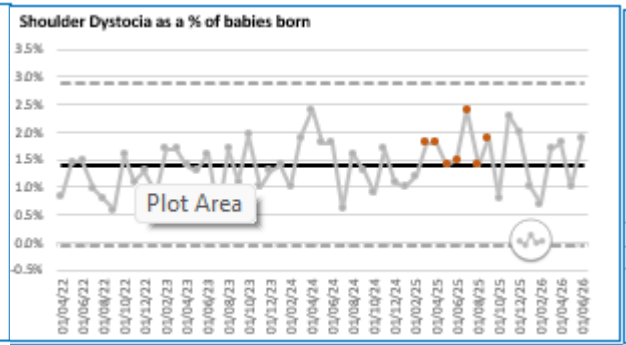

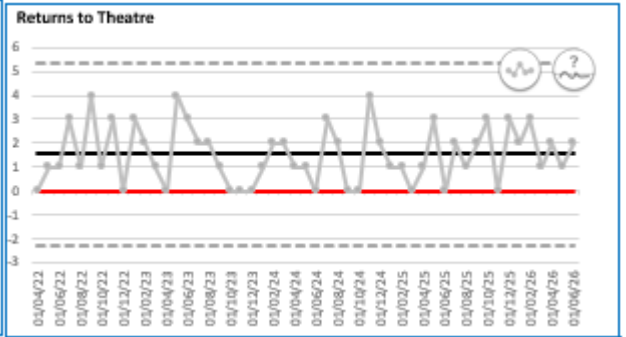

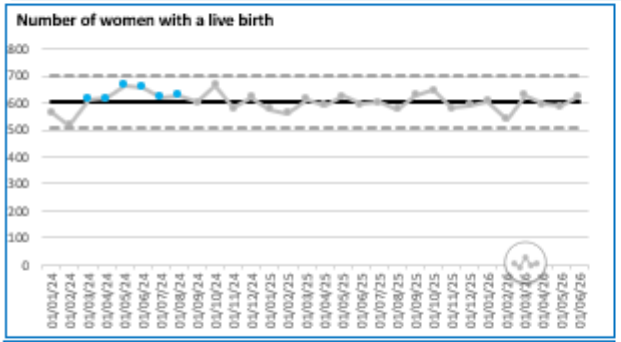

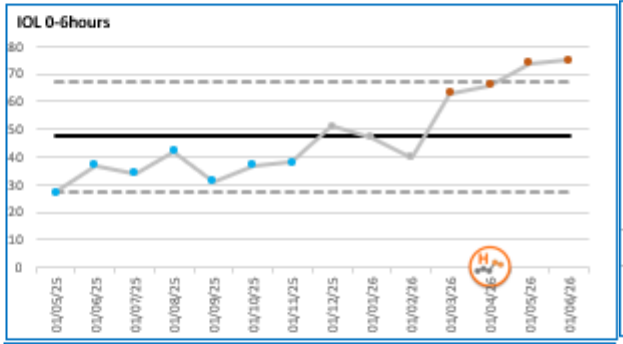

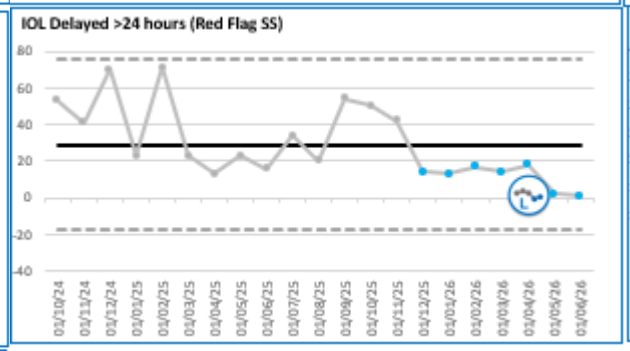

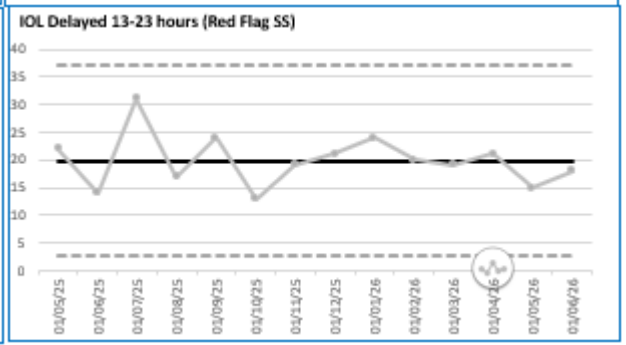

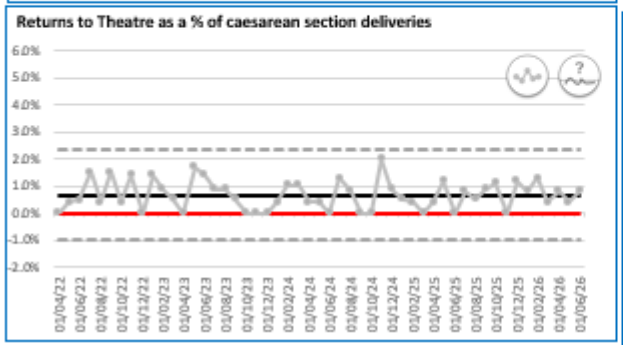

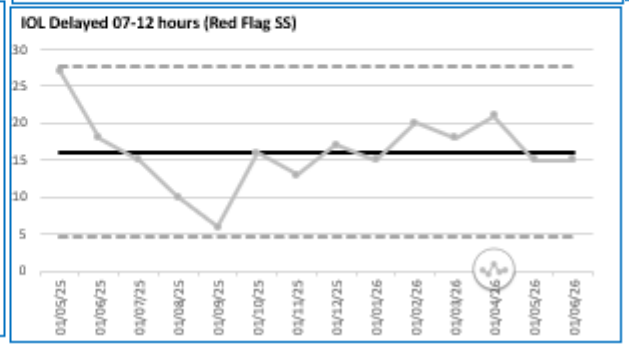

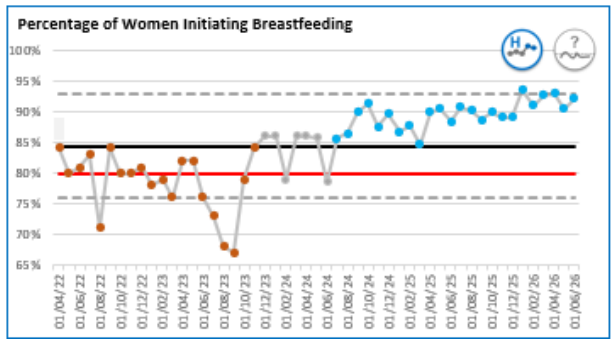

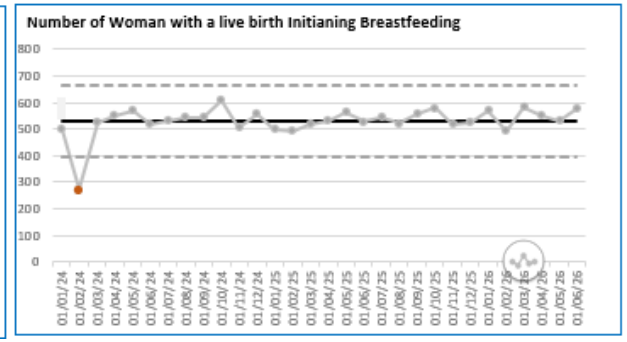

Appendix 1: SPC Charts

Oxford University Hospitals
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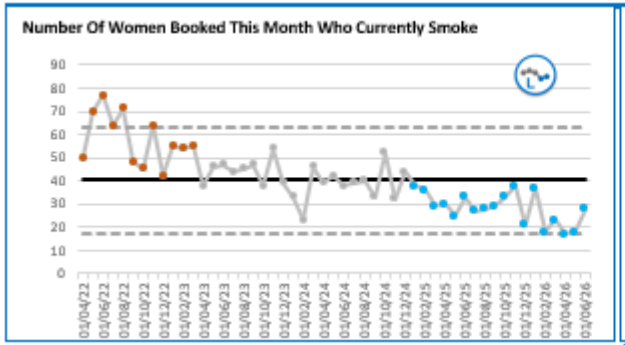

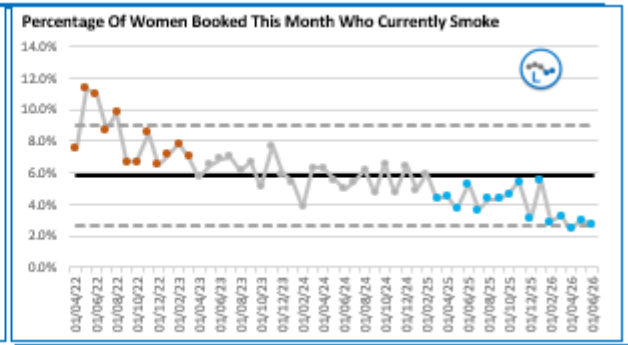

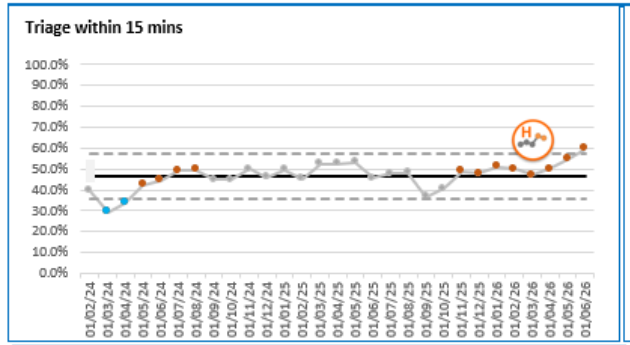

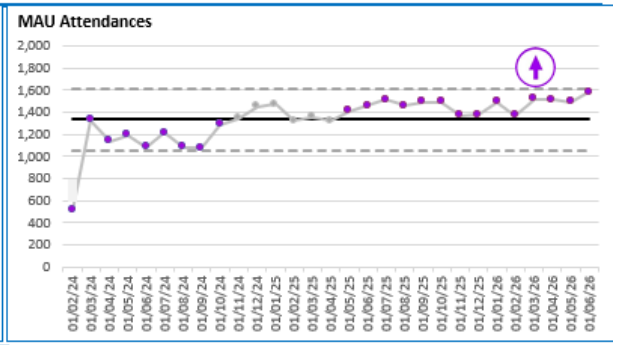

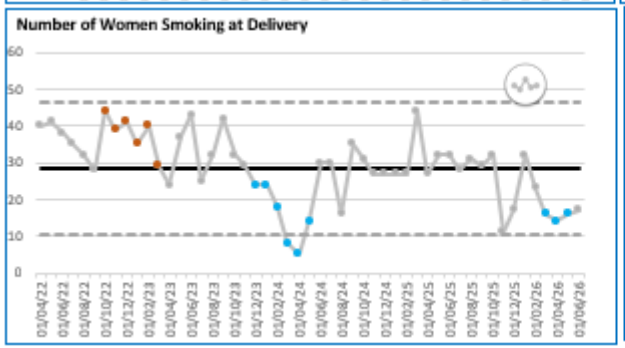

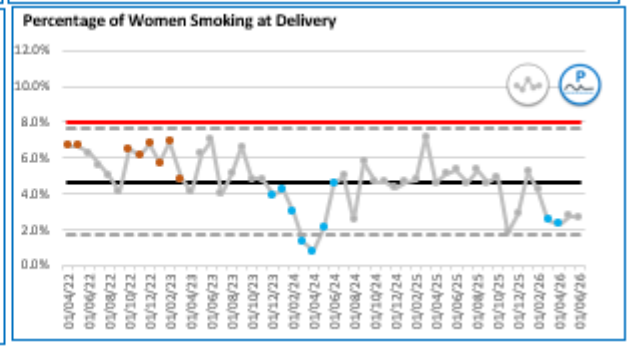

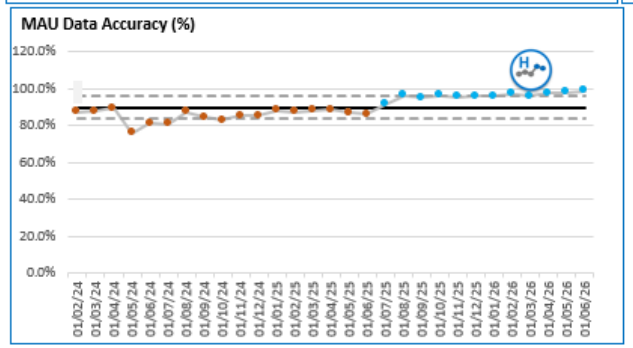

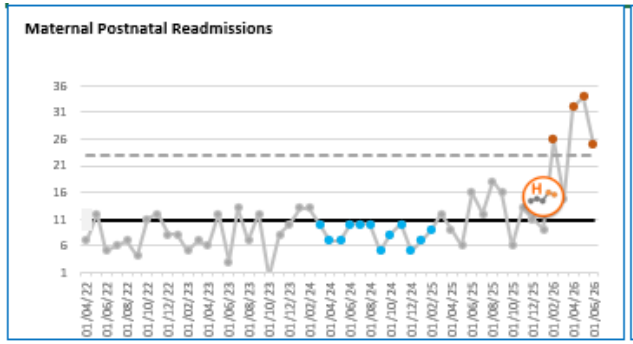

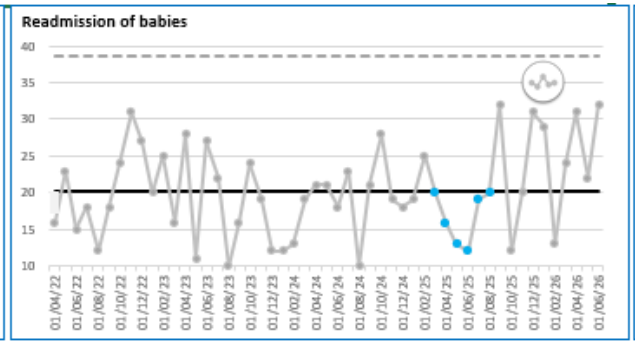

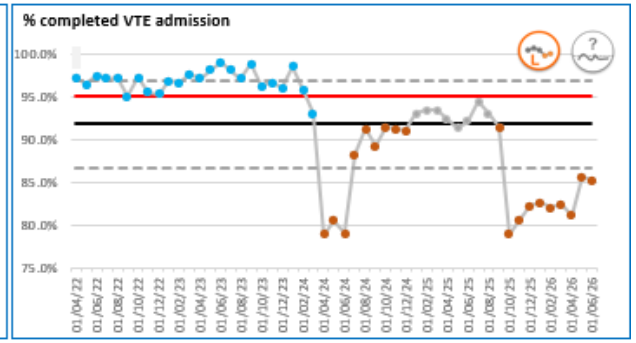

Appendix 2: Categories used for grading of care for perinatal mortality reviews (PMR)

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

Appendix 3: Acronyms

Oxford University Hospitals NHS Foundation Trust

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

Appendix 4: Ward to Board

Oxford University Hospitals NHS Foundation Trust