Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.74c**

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| **Title:** | **Perinatal Quality Surveillance Summary Report – June and July 2025** |

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| **Status:** | **For Discussion** |
| **History:** | **Maternity Clinical Governance Committee (MCGC) 11/08/2025, Maternity and Neonatal Governance Operational Delivery Committee 28/08/2025** |

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| **Board Lead:** | **Chief Nursing Officer** |
| **Author:** | **Milica Redfearn, Director of Midwifery**<br>**Sharon Andrews, Head of Midwifery**<br>**Claire Litchfield, Maternity Clinical Governance Lead**<br>**Joana Dias, Perinatal Clinical Governance Lead**<br>**Nadine Purdy, Neonatal Matron**<br>**Niamh Kelly, Maternity Safety, Risk and Compliance Lead**<br>**Chantal Percy, PMR and ATAIN Midwife** |
| **Confidential:** | **No** |
| **Key Purpose:** | Assurance |

## Executive Summary

1. This report summarises perinatal quality surveillance at Oxford University Hospitals for June and July 2025, following Ockenden report recommendations and MPIS Year 7 safety actions.
2. **Perinatal Deaths Review:** The report summarises 7 perinatal deaths that were reviewed in June and July; using the Perinatal Mortality Review Tool (PMRT).
3. **Patient Safety Incidents:** In maternity there were 48 moderate and above harm incidents reported in June 2025 and 58 in July 2025.
4. **Avoiding Term Admissions:** Unplanned neonatal unit admissions were 3.4% in June and July, below the 6% national target. Most admissions and discharge diagnoses were due to neonatal respiratory distress.
5. **Training compliance:** Over 90% of midwives, neonatal/paediatric consultants, junior neonatal doctors attending births, ANNPs, and Neonatal Nurses are compliant with newborn life support training.
6. **Delivery Suite Care:** There were no occasions in June or July when 1:1 care in labour was not provided. There was one occasion when the Delivery Suite coordinator was not supernumerary for a brief period at the start of the shift.
7. **Maternity and Perinatal Incentive Scheme (MPIS):** The reporting period for MPIS Year 7 runs from 2 April – 30 November 2025. All safety actions are being worked towards, with regular meetings established with key stakeholders.
8. **Service Users' Feedback**: In June, the service received 66 Friends and Family Test (FFT) responses (11% of our delivery rate). Of the responses received, 87.5% rated the service as good or very good, while 13.5% provided neutral, poor, or very poor ratings. In July 2025, the maternity service collected 287 FFT responses, covering 47% of monthly deliveries. Approval ratings were strong: 78% for antenatal care, and 82% for both intrapartum and postnatal inpatient services. Staff kindness and compassion stood out as main strengths. Areas for improvement include communication, high ward temperatures, and long antenatal clinic wait times. Action plans are being developed to address these issues, ensuring ongoing quality improvement and patient-centered care.
9. The installation of “Say on the Day” devices in the Maternity Ultrasound Scan (USS) Departments, as well as their recent deployment in both the Postnatal Ward and Neonatal services, demonstrates the ongoing commitment to fostering responsive and transparent feedback channels for patients and staff. Collaborative efforts with the Patient Experience Team are actively underway to further enhance participation rates, ensuring that all service areas benefit from a culture of continuous improvement and open communication.
10. **Staff Feedback:** On 30 July 2025, the Safety Champions Walk-around covered both the Transitional Care Unit (Level 5) and the Neonatal Unit. Senior leadership

continued weekly safety walkabouts following the Trust Care Assurance framework. Staff can still rate their shift experiences via “Say on the Day” devices, now overseen by the PMA/Wellbeing lead for Maternity, with updates given at the August Maternity Clinical Governance Committee.

11. The annual staff survey results were shared with matrons, and Growing Stronger Together sessions in June led to co-produced action plans. In 2024, 50.78% of staff would recommend the organisation as a workplace (down from 51.18%), while 74.61% would trust its care for friends or relatives (up from 72.51%). The GMC survey for O&G (July 30, 2025) showed the service exceeded the national average in Educational Governance and unit induction.

## Recommendations

12. The Trust Board is asked to:

- Receive and note the contents of the Perinatal Quality Surveillance Model Report.

## Contents

# Perinatal Quality Surveillance Summary Report – June and July 2025

## 1. Purpose

1.1. The report provides an overview of the perinatal quality surveillance at Oxford University Hospitals, based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 7 safety actions.

1.2. The report covers the data from June and July 2025.The Trust is required to provide a PQSM report to the Berkshire West, Oxfordshire, Buckinghamshire (BOB) local maternity and neonatal services (LMNS) for perinatal quality oversight.

1.3. The monthly data on which this paper is based is presented within the maternity quality report at the Maternity Clinical Governance Committee (MCGC) meetings.

1.4. Provide an overview of compliance in relation to MPIS Year 7.

## 2. Perinatal Deaths

2.1. The table below summarises the total number of deaths by type and gestation reported through maternity services.

2.2. There were 2 perinatal deaths in June and 6 in July 2025.

| Month | | Jun ’25 | Jul ‘25 |
|---|---|---|---|
| **Total Number of Deaths** | | **2** | **6** |
| Type of Mortality | Antepartum Stillbirths | 0 | 1 |
| | Intrapartum Stillbirths | 0 | 1 |
| | Neonatal Deaths | 2 | 4 |
| Gestational Age | <24 weeks | 0 | 2 |
| | 24-27 weeks | 1 | 2 |
| | 28 - 31 weeks | 1 | 0 |
| | 32 - 36 weeks | 0 | 2 |
| | 37-41 weeks | 0 | 0 |
| | ≥ 42 weeks | 0 | 0 |
| Number of Cases reviewed using PMRT | | 4 | 3 |
| External Panel Member | Occasions present | 3 | 3 |

**Findings from Perinatal Deaths Reviews**

2.3. During the month of June, 4 cases were reviewed using the Perinatal Mortality Review Tool (PMRT) and 3 cases was reviewed in July (see table 1). The care is graded using A, B, C and D categories during the review process, two grades are given, one for care up to the point of diagnosis of

death, and one for care following the diagnosis of death. Definition of categories attached as appendix 1.

2.4. Two of the cases 6 and 7 were graded A/A as there were no issues identified with the care.

2.5. Case 1 B grade identified that IUD care set bloods were not taken on admission. A reminder has gone out to staff and newly developed bereavement training includes this.

2.6. Case 2 B grade identified that an interpreter was not always offered. There was also an issue that privacy was not always protected when using interpreters. Feedback has been provided to the interpreting service providers, and a weekly meeting has been taking place so incidents can be raised and responded to in a timely fashion. It was also identified that cabergoline was not given due to confusion over contraindications, this has since been clarified and information shared with staff. An audit of interpreting services for maternity is also planned.

2.7. Case 3 was graded a C and learning identified includes a consistent approach in the provision of information on reduced fetal movement given at scan. This is being addressed through a review of specific patient information, focusing on both accessibility and availability.

2.8. Case 4 was graded a C due to delay in delivery with an abnormal CTG. This case has been referred to MNSI and the report is awaited. Learning around timely escalation of abnormal CTGs to expedite delivery has been disseminated to individual staff and the case will be discussed at intrapartum shared learning.

2.9. Case 5 was graded a B as CO monitoring was not completed at every scheduled appointment – the service user was an ex-smoker and the monitoring is in line with the saving babies lives care bundle v3.2

| Ulysses No: or MBRRACE Ref. | Case | IUD - Grading of care of the mother and baby up to the point that the baby was confirmed as having died | Grading of care of the mother following the death of her baby |
|---|---|---|---|
| Case 1 | P0 booked at SMH. 23 week PROM, IUD, SVD. | B | B |
| Case 2 | P0. T18. 40+1 IUD | B | B |
| Case 3 | P0 31+1 RFM IUD | C | A |

| | | | |
|---|---|---|---|
| Case 4 | P1 38+0 spont lab, abnormal CTG, EMCS, NND on day 1. | C | B |
| Case 5 | P0 CLC, attended CMW at 28+4 IUD confirmed | B | A |
| Case 6 | P0. PROM and cord prolapse at 23+3. IUD | A | A |
| Case 7 | P1 MLC SVD, attended A+E at 3weeks with SVT, NND | A | A |

*Table 1: Reviews in June and July 2025*

## 3. MNSI Referrals

3.1. There were no referrals to MNSI during June or July 2025.

## 4. Patient Safety

4.1. In maternity there were 48 moderate and above harm incidents reported in June 2025 and 58 in July 2025.

4.2. The Trust adopted a standardised approach from October 2021, automatically grading Postpartum Haemorrhage (PPH) of more than 1.5 litres and Obstetric Anal Sphincter Injury (OASI) incidents as moderate harm to ensure thorough investigation and learning. Of the PPH cases 2 were graded as C where learning was identified for the team around timeliness of escalation, all others were graded A or B. Of the OASI cases, 2 were graded C with learning for teams around decision timing for episiotomy and the consistent use of the PEACHES approach to second stage.

4.3. In Neonates there were no moderate harm incidents reported in June 2025 and 1 in July 2025. This involved a line being inadvertently inserted in an artery rather than a vein leading to reduced perfusion and necrosis on an infant's right foot. This incident remains under review, but new guidance has since been produced re Peripheral Arterial Lines and key aspects to avoid, reduce and promptly identify arterial cannulation.

4.4. Avoiding Term Admissions to the Neonatal Unit (ATAIN): Unplanned admissions to the neonatal unit were 3.4% and 3.4% in both June and July remaining below the national target of 6%. The primary reason for admission and diagnosis on discharge is respiratory distress in the neonate.

4.5. The Quality Improvement Red Hat project commenced on 27 January 2025 and concluded on 30 April 2025. A proposal was presented to maternity clinical governance regarding the continuation of the project, focusing on improving adherence to the timing and frequency of observations.

## 5. Maternity Mandatory Training Attendance

5.1. Current compliance at the end of July 2025 for attendance at PROMPT is as follows: for midwives (98%), nurses (100%), MSW (98%) and Obstetricians (all grades) (100%), obstetric anaesthetists (94%).

5.2. Attendance at Fetal monitoring training compliance is as follows: for midwives (98%), Consultant Obstetricians (96%), Registrars (98%), FY 1-2 (100%).

5.3. Attendance at Newborn Life Support for midwives is 98%.

5.4. At the end of July 2025, training compliance for newborn life support is above the target of 90% for neonatal/paediatric consultants, junior neonatal doctors (who attend births), ANNP's and Neonatal Nurses.

## 6. Minimum Staffing

6.1. There were no occasions in June or July when 1:1 care in labour was not provided for women and birthing people in established labour. There was one occasion when the Delivery Suite Co-ordinator was not working in a supernumerary capacity for a brief period at handover.

6.2. The midwife to birth ratio was 1:23.68 in June and 1:25.51 in July 2025.

6.3. In June hours 261.5 hours were provided by on-call Midwifery staff and in July 219.25 hours were provided. This is an increase on previous months.

6.4. The neonatal team is progressing towards BAPM workforce compliance. After the Trust Management Executive approved the business plan to increase staffing on 28 November, two locum consultants were appointed. The service will provide 12-hour weekend resident cover from 01 July 2025. Six additional registrars have been recruited—three have started to support night cover, with three more beginning by summer's end.

6.5. Eight Band 5 Nurses are due to start in September 2025. A full review of establishment and budget is underway. The focus remains on fully supporting to Qualify in Speciality (QIS).

6.6. Prospective consultant hours on Delivery Suite are 109hrs per week. The Trust monitors compliance with regards to consultant attendance for clinical situations listed in the RCOG workforce document 'roles and responsibilities of the consultant providing acute clinical care in obstetrics and gynaecology,' via exception reporting. No episodes have been reported where a consultant did not attend in person in June or July.

## 7. Maternity (Perinatal) Incentive Scheme (MPIS)

7.1. Year 7 of the Maternity and Perinatal Incentive Scheme (MPIS) was published on the 02 April 2025.

7.2. Monthly meetings occur with all key stakeholders and plans are in place to meet requirements in line with necessary time frames. Potential areas of concern arise from the following safety actions:

7.2.1. Safety Action 4: An action plan is in place to meet the neonatal workforce requirements, and this is anticipated to be compliant by September. Risk identified surrounding compliance with Neonatal Nursing workforce in alignment with BAPM nursing standards.

7.2.2. Safety Action 7: The Maternity and Neonatal Voices Partnership (MNVP) lead to be a quorate member of trust governance, quality and safety meetings at speciality/divisional/directorate level. The post was appointed to in June 2025, and onboarding is currently in progress.

## 8. Service Users Feedback

8.1. The service has implemented a Triangulation and Learning Committee (TALC) which includes complaints, service user feedback, safety themes, legal/claims, patient experience and operational representation. The aim of the group is to triangulate feedback data from the multiple sources and develop and execute actions to address themes in a timely and systematic way. The group meets monthly.

8.2. In June, the service had 66 responses (11% delivery rate), with 87.5% rated good or very good and 13.5% neutral or negative. Feedback reflected booking ethnicities: 33% non-white, 66% white. Positive themes were communication and care, including 100% positive birth feedback—an improvement over previous month. Negative themes involved delayed communication from medical staff and between units. Actions, such as a mind-map visual aid and bedside handovers, are underway to improve these issues.

8.3. In July, the maternity service recorded 287 responses to the patient experience survey, representing 47% of the month's deliveries. Antenatal areas achieved a 78% positive approval rating, intrapartum care 82%, and postnatal inpatient services 82%. Key positive feedback highlighted staff kindness and compassion, while areas for improvement included communication and high temperatures on the wards. Negative feedback for antenatal clinics related primarily to waiting times and the temperature of waiting areas.

8.4. The ‘Say on the Day’ devices stationed in the Maternity Ultrasound Departments confirmed 268 responses over July and have achieved a 9.6/10 score for the John Radcliffe and a 7.5/10 score for the Horton. Positive themes include efficiency and kindness of staff; less positive comments were around estates and car parking.

8.5. The Newborn Care Unit is working collaboratively with the Thames Valley and Wessex Neonatal Network to implement a Neonatal Family Experience Feedback Survey. The FFT has now been setup within neonates. In June, the service received 13 responses from the Friends and family test (FFT) and 28 responses in July. All feedback has been 100% positive, and the team is working closely with the Patient Experience Team to increase uptake by including text message reminders and Say-on-the-day devices on the unit.

## 9. Feedback from Staff Engagement Sessions and the Safety Champions

9.1. A safety champion walkaround was conducted on 30 July. The visit included both the postnatal ward and the neonatal unit. A summary of their findings is provided below:

9.2. Neonatal Unit (NNU): During the visit to the Neonatal Unit (NNU), they had the opportunity to speak with a woman who had experienced a full maternity journey within the hospital, having been cared for on the antenatal ward, delivery suite, and postnatal ward, with her baby currently receiving care in the NNU. She described her experience as overwhelmingly positive, stating that she felt consistently well cared for and fully informed at every stage of her journey. She expressed appreciation for the clear communication from staff and the continuity of care she received, which helped her feel reassured and confident in the care being provided to both her and her baby. A nurse in the NNU described a supportive, team-oriented culture and reported feeling happy and fulfilled in their role.

9.3. Postnatal Ward: On the postnatal ward, a second-year student midwife nearing the end of her placement described her experiences. She reported gaining significant learning opportunities during her time on the ward and identified support provided by both the team and her assessor. She noted that the environment facilitated confidence building and clinical skill development. Additionally, she observed that staff were approachable and that the team actively included students in teaching and ward activities.

9.4. Transitional Care Unit (TCU): A woman who received care throughout her pregnancy and delivery in several units, including the TCU, described her experience as excellent. She praised the staff for their kindness and

attentiveness, appreciated being well-informed about her and her baby's care, and felt involved in decisions. Her feedback highlighted strong patient-centred care.

## 10. Staff Survey

10.1. From the 2024 staff survey, 50.78% would recommend the organisation as a place to work compared to 51.18% the previous year. 74.61% would be happy with the standard of care provided by the organisation if a friend or relative needed treatment which is a slight improvement from the previous year of 72.51%.

10.2. The feedback has been shared with the areas and staff have reviewed the results and identified areas of improvement and subsequently developed action plans.

10.3. Maternity services have compiled a “You said, we listened” report in response to the annual staff survey and action plans are underway to address areas of concern.

10.4. The Schwarz round programme will continue in September following a pause for summer, supported by the service’s clinical psychologist.

## 11. GMC survey

11.1. The service has received the results of the GMC survey for obstetrics & gynaecology (O&G) on the 30 July 2025. The service was above the national average for Educational Governance and for induction to the unit.

11.2. The service did not flag as an outlier within other parameters.

## 12. Conclusion

12.1. The report outlines the implementation of the Perinatal Quality Surveillance Model (PQSM) in alignment with the Ockenden report's recommendations and the Year 7 safety actions of the Maternity Perinatal Incentive Scheme (MPIS).

12.2. It details the number and types of perinatal deaths documented within the Trust, followed by a summary of the reviews conducted via the Perinatal Mortality Review Tool (PMRT).

12.3. The report also summarises prominent themes and actions derived from these reviews and incidents.

12.4. Additionally, the report indicates the percentage of term admissions to the Neonatal Unit (NNU).

## 13. Recommendations

13.1. The Trust Board is asked to:

- Receive and note the contents of the Perinatal Quality Surveillance Model Report.

**Appendix 1: 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 2: Maternity (Perinatal) Incentive Scheme Overview

| Safety Action | Description | RAG rating | Comment |
|---|---|---|---|
| 1  | Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard | | Q4 PMRT report was sent to board in May.<br>MNVP to be added to ToR once necessary training completed.<br>On track to meet increased requirements for completed reviews and external reviewer attendance. |
| 2  | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | | No issues identified<br>July is MSDS reporting month. Internal data checks demonstrate compliance with both metrics. |
| 3  | Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies? | | TCU requirements met<br>Plan to launch new Qi project to be registered by September. |
| 4  | Can you demonstrate an effective system of clinical workforce planning to the required standard? | | Required audit currently in place for RCOG compliance.<br>Neonatal medical workforce on risk register and is on track with the previous action plan to recruit trainees by September 2025.<br>Concerns escalated with compliance of neonatal nursing workforce due to changes to establishment. Eight Band 5 Nurses are due to start in September 2025. A full review of establishment and budget is underway. The focus remains on supporting to Qualify in Speciality (QIS). |
| 5  | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | | Birth Rate plus (BR+) review scheduled for the end of the calendar year. This will certify requirements of a systematic evidence-based process to calculate midwifery staffing establishment. Current BR+ review still within necessary time frame to meet compliance requirements. Bi-annual reports to Trust Board. Supernumerary status of Delivery Suite coordinator and 1:1 care in labour reported as part of the Maternity |

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|---|---|---|---|
| | | | Performance Dashboard and the Perinatal Quality Surveillance Model (PQSM) report. |
| 6  | Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | | Q4 data waiting finalisation by LMNS.<br>Updated v3.2 Saving babies lives audits in place from Q1. |
| 7  | Listen to women, parents and families using maternity and neonatal services and coproduce services with users. | | MNVP lead recruited in June. Risk remains whilst training and onboarding in progress – LMNS aware of concerns surrounding compliance with this element. |
| 8  | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training? | | Current training year finished in July. New training year begins in September. All standards on track to be met. |
| 9  | Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues? | | No anticipated concerns |
| 10.  | Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025 | | No anticipated concerns |

**Appendix 3: ATAIN Action Log**

# ATAIN action plan, Quarter 1 25-26

**Action Owners: ATAIN Midwife and Neonatal Consultant**

| No. | Recommendation | Action | Evidence | Responsibility | Deadline | Progress Update |
|---|---|---|---|---|---|---|
| **Patient Safety Incident Response Framework** | | | | | | |
| **1** | Compassionate Engagement | Creation of survey to ask parents/carers of babies who are unexpectedly admitted to the neonatal unit | Copy of survey/Copy of agenda | Perinatal Risk Coordinator/OMNVP/ EDI Midwives | 30th June 2025 | **Ongoing.** For MNVP input |
| **2** | Actions from MNSI case regarding care of low risk newborn | Update the Immediate care of the newborn guideline | | Consultant Midwife | 31st Dec 2025 | **Ongoing** |
| **Common Discharge Diagnosis** | | | | | | |
| **3** | **TTN** | Explore the resource needs for the high flow oxygen at the mother's bedside project | Resource planning, equipment/staffing needs | Consultant Neonatologist | 31st July 2025 | For neonatal consultant to explore |
| | Explore the training needs for the high flow oxygen at the mother's bedside project | | Copy of Training Plan | | 31st July 2025 | For neonatal consultant to explore |
| | | **QI Projects** | | | | |
| **4** | **Red Hat QI Project** | Register QI project by 1/9/24 in line with MPIS. | QI Log | Perinatal Risk Coordinator | 31/05/25 | Project registered and red hats received. Launched 27 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | January 2025, this was presented at MCGC on the 14th of July. Plan to relaunch with audit in 6 months to review timings of NEWS. |
| **5** | **Plan for new QI project with CTG focus** | Not yet been designed | QI log | ATAIN midwife and Fetal monitoring team | 01/09/2025 | Not yet started |