Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 27 May 2026

TB2026.42

Title:	**Perinatal Quality Oversight Model Report (March data)**

Status:	**For Information**
History:	**Reported to:**
	Maternity Clinical Governance Committee 20 April 2026
	Trust Clinical Governance Committee 22 April 2026
	Maternity and Neonatal Governance and Operational Delivery Committee 23 April 2026
	SuWON Divisional Governance meeting 27 April 2026

Board Lead:	**Chief Nursing Officer**
Author:	**Milica Redfearn, Director of Midwifery**
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Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

1. This report provides assurance and oversight on maternity and neonatal services at Oxford University Hospitals NHS Foundation Trust, in line with the NHSE Perinatal Quality Oversight Model (PQOM).
2. Overall Position:
    - There have been no Maternity Outcomes Signal System (MOSS) alerts for Oxford University Hospitals up to 31 March 2026.
    - Birth activity increased significantly (16%), with associated pressure on staffing, induction flow, and neonatal capacity. Despite this, services maintained safe escalation, strong incident reporting, and high patient experience scores.
3. Safety & Compliance:
    - 295 maternity patient safety incidents reported, demonstrating high reporting culture: moderate harm incidents accounting for 31% (a 5% rise)
4. Workforce & Training:
    - Midwife-to-birth ratio improved to 1:24.22, reflecting the rise in births in March.
    - There was one occasion where the Delivery Suite coordinator was not supernumerary and two short periods where 1:1 care could not be provided due to high acuity; all episodes were brief with timely escalation and on-call staff responding promptly.
    - Strong midwifery recruitment pipeline; neonatal nursing recruitment progressing.
5. Experience & Feedback:
    - 96.5% of service users rated care as “good or very good” with a high 82% response rate.
6. National Programmes
    - The Trust has received confirmation from NHS Resolutions of successful completion of the Maternity (Prenatal) Incentive Scheme (MPIS) Year 7.
    - Year 8 of the MPIS was released on the 31 March 2026. It has been streamlined into six core areas (previously there were 10 safety actions). Year 8 focuses more on outcomes of the safety measure.
    - The MPIS lead is in the process of meeting with the key stakeholders in order to establish the new requirements and create a RAG rating for assurance purposes.

Recommendations

7. The Trust Board is asked to:

- Note and take assurance from the report, which highlights the stability of key metrics and compliance with the revised perinatal surveillance model.
- Continue to monitor and respond to patient feedback and complaints to drive service improvement and experience.
- Note the areas requiring continued oversight, particularly:
    - VTE electronic assessment performance
    - Postnatal readmissions
    - Complaints themes
    - High-risk maternity estates issues
    - Neonatal QIS training trajectory

Perinatal Quality Oversight Model Report (March data)

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 March 2026 and a summary of the key highlights are presented below.

Key Assurances – March 2026

3. Safety and Quality

3.1. There have been no Maternity Outcomes Signal System (MOSS) alerts for Oxford University Hospitals up to 31 March 2026.

3.2. Avoiding Term Admissions into Neonatal units (ATAIN) performance shows 36 (5.4%) term admissions to SCBU which is just under national target of 6%, an increase from the previous month. A neonatal thermoregulation quality improvement (QI) programme is underway to reduce avoidable term admissions.

3.3. Obstetric Anal Sphincter Injury (OASI) rate is at 3.81% which is above the national target of 3.29%.

3.4. Post-partum haemorrhage (PPH) ≥1.5L rate is at 4.7% which is above the national average of 3.41%.

3.5. A twice-weekly multidisciplinary incident review meetings has been introduced to undertake a rapid review of moderate harm and above incidents.

3.6. Six cases were reviewed using the perinatal mortality review tool (PMRT). The majority were graded A or B, indicating care was appropriate and in line with expected standards. One case was graded a C for the period prior to the diagnosis of the intrauterine death (IUD). This provided learning opportunities for earlier detection and escalation of concerns.

3.7. One case was referred to the Maternity and Neonatal Safety Investigations (MNSI).

4. Patient Experience

4.1. In maternity, Friends and Family Test (FFT) and 'Say-on-the-Day' feedback remains strongly positive at 96.5% good/very good, with a high 82% response rate (increase from 70% the previous month).

4.2. Emerging themes relate to communication, escalation and respect.

4.3. The neonatal team received 18 responses from families via 'Say-on-the-Day' devices (representing 20% of admissions) with overall experience rated 8.9/10.

5. Workforce

5.1. Midwife-to-birth ratio improved to 1:24.22, reflecting the rise in births in March and continued ability to provide 1:1 care in labour.

5.2. There was one occasion where the Delivery Suite coordinator was not supernumerary and two short periods where 1:1 care could not be provided due to high acuity; all episodes were brief with timely escalation and on-call staff responding promptly.

5.3. Midwifery workforce remains above the current BirthRate+ establishment due to SMART recruitment to backfill into Maternity leave (343.48 WTE staff in post).

5.4. Neonatal nursing recruitment remains active with 10 Band 5 nurses and 3 Band 6 nurses in pipeline.

5.5. Current compliance with the British Association of Perinatal Medicine (BAPM) standards for Qualified in Speciality (QIS) training is at 47%.

6. Compliance with National Programmes

6.1. The Trust has received confirmation from NHS Resolutions of successful completion of the Maternity (Perinatal) Incentive Scheme (MPIS) Year 7.

6.2. Year 8 of the MPIS was released on the 31 March 2026. It has been streamlined into six core areas (previously there were 10 safety actions). Year 8 focuses more on outcomes of the safety measure. The MPIS lead is in the process of meeting with the key stakeholders in order to establish the new requirements and create a RAG rating for assurance purposes.

7. Key Areas Requiring Board Attention

VTE Risk Assessment Performance (Special Cause Variation)

7.1. Completion of electronic VTE assessments fell to 82.4%, below the 95% Trust target.

7.2. Relaunched VTE Improvement Group with strengthened clinical leadership.

7.3. EPR changes due May 2026 to improve data capture.

7.4. Trust-wide audit scheduled for May/June.

Neonatal Deaths as rate per 1000 births (Special Cause Variation)

7.5. Six perinatal deaths occurred (1 intrauterine death (IUD), 5 neonatal), all with complex clinical backgrounds were reported in March.

7.6. All cases reflect high-risk pregnancies with significant fetal or maternal complications, with appropriate multidisciplinary management and palliative pathways followed where indicated.

7.7. All cases undergoing full PMRT review within required timeframes.

7.8. No immediate care concerns identified on initial review.

7.9. Thematic learning will be shared Trust-wide and escalated to Board.

Complaints (Special Cause Variation)

7.10. 20 complaints received, including three historic cases; themes include communication, escalation and respect.

7.11. Recruitment of a Patient Experience Lead is progressing.

Maternity Risk Register – High Scoring Risks

7.12. Current ≥15 risks include:

- Lack of psychologist within the maternal mental health service (MMHS) (Risk 3293).

- Impact of elective caesarean section (CS) demand on emergency capacity (Risk 2426) – data accuracy improvements requested.
- Maternity estates concerns (Risk 2221) – ageing infrastructure, lift failures, drainage, recovery space limitations.
- Drug room temperature breaches (Risk 3020) – cold-chain risks.
- Medical gases maintenance (Risk 3376, new risk) – Trust-wide regulator issues.
- Obstetrics and gynaecology medical residents staffing levels (3309). Risk increased to 16.

7.13. These risks are being actively managed with appropriate governance oversight.

8. Conclusion

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

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

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

9. Recommendations

9.1. The Trust Board is asked to:

- Note and take assurance from the report, which highlights the stability of key metrics and compliance with the revised perinatal surveillance model.
- Continue to monitor and respond to patient feedback and complaints to drive service improvement and experience.
- Note the areas requiring continued oversight, particularly:
    - VTE electronic assessment performance
    - Complaint’s themes
    - High-risk maternity estates issues
    - Neonatal QIS training trajectory

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Oversight Model Report and Dashboard

Reporting period: March 2026
Meeting date: April 2026

Presented to the Maternity Clinical Governance Committee

Authors:

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Oxford University Hospitals NHS Foundation Trust

Maternity Summary March 2026

Oxford University Hospitals NHS Foundation Trust

1.4% (prev. 1.1%)
Blood Loss >1500mls for CS

3.81% (prev. 2.17%)
3rd & 4th (SVD+OVD births only) degree tears

↑ 36 **Unplanned Term Admissions to NNU**
(5.6%)
≥ 37 weeks

↑**21 (3.33%)**
Freestanding MLU*

Horton 9
Chipping Norton 6
Wantage 3
Wallingford 3

↑ 574 **Delivery Suite**

↓25 (3.97%)
Spires

Excellence Reports
↑17

Friends and Family Test
96.5%
Good or Very Good Feedback
82% Response Rate

639 Babies Born to 630 Women
↑ 16%

↑ **42.9%**
Caesarean Sections (CS)
Elective CS –125 (19.8%)
Emergency CS – 145 (23%)

↑ **26.5%**
Inductions of Labour

↑ 10 **(1.59%) Home Births**

↑ **714 Scheduled Bookings**

99.7%
1:1 Care in Labour
1:24.21
Midwife to Birth Ratio

↑**92.83%**
Breastfeeding Initiation

20 New Complaints

*MLU – Midwifery-led Unit

Neonatal Summary

Oxford University Hospitals NHS Foundation Trust

Milk Bank

↑120L Breast Milk Pasteurised

36L Sold/ £6.5k Profit

19 Donors Recruited

44 Preterm Admissions

Admissions (48%)

< 27 weeks – 6 (7%)

27–36 weeks – 38 (41%)

↓18 Excellence Reports

48 Term Admissions (52%)

≥ 37 weeks

↑ 80% Born in the right place*

↓20% Say on the Day

↑3.3% Friends and Family Test

↑92 Admissions March 2026

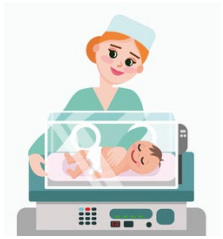
SONeT SOUTHAMPTON OXFORD NEONATAL TRANSPORT

↑ 34 Total Transfers

13 Emergency Uplifts

21 Non-Urgent

↑1079 Care Days



Nursing Recruitment

0 Recruits

1 Leaver

Outreach Team

↑ 94 Home Visits

38 Babies Seen

↑6 Deaths

x3 <24/40 – Extreme Prematurity

34+1/40 – Pulmonary Hypoplasia, PPHN

35+2/40 – Metastatic rhabdoid tumour

37/40 – Trisomy 18

1 MatNeo Complaint

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

Oxford University Hospitals
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Perinatal Quality Scorecard (Exception Report and Dashboard)

1. Perinatal Quality Scorecard Summary

Oxford University Hospitals NHS Foundation Trust

Overview

In March, a total of 630 mothers gave birth to 639 babies, and 714 scheduled antenatal bookings were completed. Caesarean sections accounted for 270 births, representing 42.9% of all deliveries. Midwifery led settings (freestanding and alongside midwifery led units, and homebirths) supported 56 births (9% of all birthing people). There have been no Maternity Outcome Signal System (M.O.S.S) alerts for OUH up to the 31 March 2026. All relevant staff have registered with the NHS applications required to access MOSS and receive notifications.

Quality & Safety

During March, 295 maternity patient safety incidents were reported, with 92 classified as moderate harm or above. The most common contributors to moderate harm were postpartum haemorrhage over 1.5L, obstetric anal sphincter injuries (OASI), and unexpected term admissions to Special Care Baby Unit (SCBU). All incidents were managed under PSIRF principles, with immediate learning actions implemented to reduce recurrence and strengthen safety practices.

There was one case referred to the Maternity and Neonatal Safety Investigations (MNSI).

Outcomes

In March most births were unassisted vaginal births (277 cases, 44%) with 90 births (14.3%) assisted with forceps or kiwi cup; the remainder, 270 (42.9%) were caesarean sections.
167 women were booked for an induction of labour (26.5%).

During March there were 14 reported cases of obstetric anal sphincter injury (OASI) - 3.81% which is above the published UK national rate of 3.29%. 9 occurred in unassisted vaginal birth, and 5 in assisted birth.

Postpartum haemorrhage (PPH) greater than 1.5 litres occurred in 30 cases (4.7%) which is an increase from the published UK national rate of 3.41% . Of these, 12 cases were associated with unassisted vaginal births, 9 with assisted vaginal births and 9 cases with caesarean birth.

36 unexpected term admissions were reported in March; this was an increase of 0.9% (10 cases).

Governance review confirmed that delays to induction of labour and/or triage, during the reporting period did not result in any poor safety outcomes for women or babies.

Experience

In March 2026, 20 complaints were received, of which three related to historic care. The main themes focused on communication, escalation and respect. Feedback indicated a need for clearer communication between staff, clearer updates when delays happen and timely debriefs alongside ensuring culturally sensitive and non-discriminatory interactions.
Overall, patient feedback remains positive across all areas within maternity with 96.5% of respondents rating their experience as good or very good. A total of 163 Friends and Family Test responses and 355 ‘Say on the Day’ responses were received, representing a strong 82% response rate compared to the number of births. Women are repeatedly praising staff for their kindness, professionalism, compassion and clear communication. Areas for improvement include equipment issues and waiting times for outpatient appointments.

Training

The 2025–2026 training year commenced in September, covering PROMPT, Fetal Monitoring, OxMUD and Neonatal Life Support (NLS). All maternity staff receive allocated time for mandatory e-learning, which supports the achievement of full compliance across the rolling year with most staff groups remaining above 90% compliance, demonstrating strong engagement with the mandatory training schedule.

Workforce

The midwife-to-birth ratio was 1:24.22, this is a significant increase from February reflecting the increased birth rate in March and reduced midwife availability. 2 incidents were reported of one-to-one care in labour not being maintained, with the Delivery Suite coordinator not remaining supernumerary on 1 occasion.

Our midwifery establishment has been realigned to the BirthRate+ benchmark of 332 WTE, supported by a SMART recruitment strategy to uplift the establishment to 355 WTE to cover predictable maternity leave. With 343.48 WTE now in post, we are seeing clear evidence of recruitment traction and improved workforce stability.

Indicator Overview – Maternity SPC Dashboard

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KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Mar 26	630	625			618	532	704
Babies Born	Mar 26	639	-			628	540	717
Scheduled Bookings	Mar 26	714	750			701	558	843
Inductions of labour (IOL)	Mar 26	167	-			152	108	196
Inductions of labour (IOL) as a % of mothers birthed	Mar 26	26.5%	-			24.6%	19.3%	29.9%
Spontaneous Vaginal Births SVD (including breech)	Mar 26	277	-			307	233	381
Spontaneous Vaginal Births SVD (including breech): a	Mar 26	44.0%	-			50.5%	43.4%	57.5%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Mar 26	90	-			86	55	117
Number of Instrumental births/Forces & Ventouse as	Mar 26	14.3%	-			13.9%	9.4%	18.3%
SVD + OVD Total	Mar 26	367	-			383	305	460

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Mar 26	270	-			222	179	265
Number of CS births as a % of mothers birthed	Mar 26	42.9%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Mar 26	145	-			130	95	165
Emergency CS births as a %	Mar 26	23.0%	-			20.5%	15.3%	25.7%
Number of Elective CS	Mar 26	125	-			102	62	143
Elective CS births as a %	Mar 26	19.8%	-			15.4%	11.0%	19.8%
Robson Group 1 c-section with no previous births a %	Mar 26	16.8%	-			14.0%	7.5%	20.5%
Robson Group 2 c-section with no previous births a %	Mar 26	62.2%	-			56.9%	45.8%	67.9%
Robson Group 5 c-section with 1+ previous births a %	Mar 26	80.2%	-			80.1%	63.2%	96.9%
Elective CS <39 weeks no clinical indication	Mar 26	0	0			0	-1	2

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Mar 26	109	109			109	109	109
Midwife:birth ratio	Mar 26	24.2	22.9			25.7	21.6	29.8
Maternal Postnatal Readmissions	Mar 26	15	-			9	-2	19
Readmission of babies	Mar 26	24	-			20	3	37
3rd/4th Degree Tears amongst mothers birthed	Mar 26	14	-			12	0	25
3rd/4th degree tears amongst mothers birthed as a %	Mar 26	3.8%	3.5%			3.0%	0.0%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Mar 26	9	-			8	-2	18
3rd/4th degree tears following unassisted Vaginal bir	Mar 26	2.5%	-			2.4%	-0.2%	5.0%
3rd/4th degree tears following an Instrumental vagin	Mar 26	5	-			3	-2	9
3rd/4th degree tears following an Instrumental vagin	Mar 26	5.6%	8.0%			4.2%	-2.4%	10.9%
PPH equal to or greater than 1.5L following an instrun	Mar 26	8	-			7	1	13
PPH equal to or greater than 1.5L following an instrun	Mar 26	1.3%	-			1.2%	0.1%	2.3%
PPH equal to or greater than 1.5L (Rate per 1,000)	Mar 26	46.0%	-			36.0%	20.0%	52.0%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Mar 26	12	-			11	0	22
PPH 1.5L or greater, vaginal (unassisted) births as a %	Mar 26	1.9%	2.4%			1.8%	0.1%	3.5%
PPH 1.5L or greater, caesarean births	Mar 26	9	-			7	-1	15
PPH 1.5L or greater, caesarean births as a % of mother	Mar 26	1.4%	4.3%			1.2%	-0.5%	2.9%
ICU/CCU Admissions	Mar 26	0	-			1	-1	2
% completed VTE admission	Mar 26	82.4%	95.0%			93.2%	88.5%	97.9%
Maternal Deaths: All	Mar 26	0	-			0	0	1
Early Maternal Deaths: Direct	Mar 26	0	-			0	0	0
Early Maternal Deaths: Indirect	Mar 26	0	-			0	0	0
Late Maternal Deaths: Direct	Mar 26	0	-			0	0	0
Late Maternal Deaths: Indirect	Mar 26	0	-			0	0	0

Indicator Summary – Maternity SPC Dashboard

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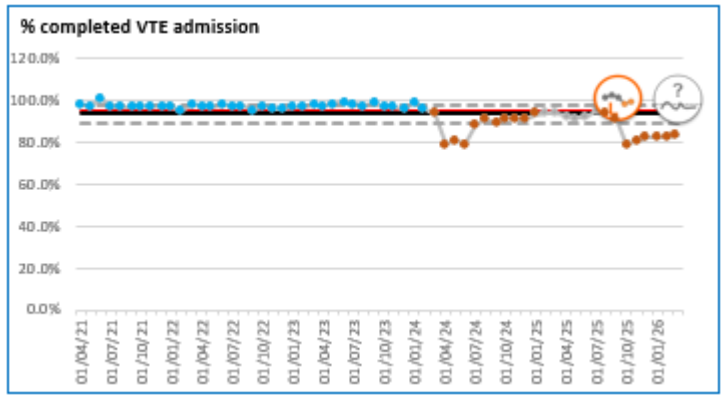
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Mar 26	3	-			5	-2	12
Puerperal Sepsis as a % of mothers birthed	Mar 26	0.5%	1.5%			0.8%	-0.3%	1.9%
Stillbirths (24+0/40 onwards; excludes TOPs)	Mar 26	1	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Mar 26	3	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Mar 26	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Mar 26	4	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Mar 26	3	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Mar 26	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Mar 26	6	3			2	-2	5
HIE	Mar 26	0	0			0	-1	1

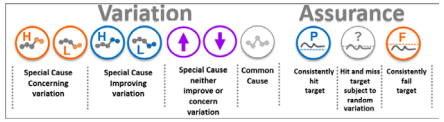
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Mar 26	11	-			9	0	18
Shoulder Dystocia as a % of babies born	Mar 26	1.7%	-			1.4%	0.0%	2.8%
Unexpected NNU admissions	Mar 26	34	-			25	8	42
Unexpected NNU admissions as a % of babies born	Mar 26	5.3%	4.0%			3.9%	1.2%	6.6%
Hospital Associated Thromboses	Mar 26	0	0			0	-1	1
Returns to Theatre	Mar 26	1	0			1	-2	5
Returns to Theatre as a % of caesarean section delive	Mar 26	0.4%	0.0%			0.7%	-0.9%	2.2%
Number of PSII	Mar 26	0	0			1	-2	4
Number of Complaints	Mar 26	20	-			10	-1	21
Born before arrival of midwife (BBA)	Mar 26	3	-			6	-2	14

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Feb 26	66.4%	85.0%			77.2%	65.8%	88.6%
Number Of Women Booked This Month Who Current	Mar 26	23	-			44	22	66
Percentage Of Women Booked This Month Who Curr	Mar 26	3.2%	-			6.3%	3.2%	9.4%
Number of Women Smoking at Delivery	Mar 26	16	-			31	13	48
Percentage of Women Smoking at Delivery	Mar 26	2.5%	8.0%			4.9%	2.1%	7.8%
Number of women with a live birth	Mar 26	628	-			604	501	708
Number of Woman with a live birth Initianing Breastf	Mar 26	583	-			528	386	670
Percentage of Women Initiating Breastfeeding	Mar 26	93%	80%			83%	75%	91%
Number of women booked by 10+0/40	Mar 26	489	-			428	244	611
Percentage of women booked by 10+0/40	Mar 26	68%	-			66%	56%	76%

Maternity Exception Report

Oxford University Hospitals NHS Foundation Trust



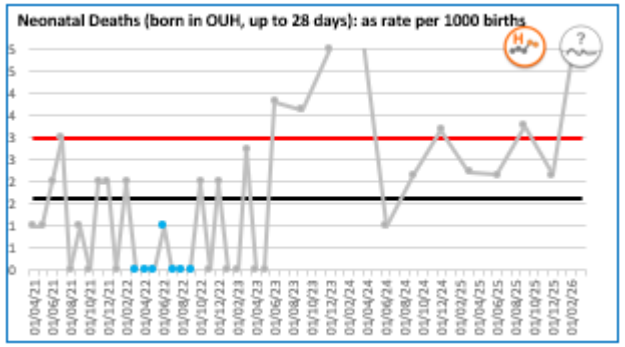


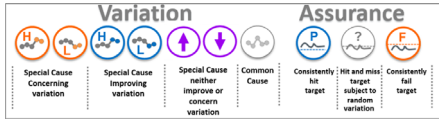
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating

Completion of VTE risk assessment on admission continues to shows limited improvement compared to the previous reporting period (82.4 this month compared to 82 last month) it still remains below the Trust target of 95%.
 	
A key barrier to reliable compliance reporting is the accuracy and consistency of data capture.
 	
There is not yet sufficient evidence of sustained shift above the target mean, to reflect the ongoing improvement efforts.
 	
n.b. This metric reflects completion of the electronic risk assessment within the required timeframe rather than failure to prescribe thromboprophylaxis.
	• **Visibility & Awareness Activities**
	  • VTE assessments featured in the February documentation roadshow.
	  • Displayed on the safety board for two weeks and incorporated into March safety huddles.
	  • Information shared in both handwritten format and via the Patient Safety Round Up (PSRU).
	  • The PSRU has highlighted VTE assessment six times in the last 12 months, meaning it has appeared on the safety board for six separate two-week cycles.
	• **Impact on Practice**
	  • Anecdotal feedback from ward areas indicates improved recording of VTE assessments in SBAR.
	  • Actual completion of VTE assessments shows limited improvement, signalling the need for continued focus.
	• **Monitoring & Quality Improvement Approach**
	  • The team will continue using the SPC chart for ongoing monitoring of VTE compliance.
	  • A QI methodology will be applied so that the impact of each QI initiative can be clearly seen on the SPC chart.
		• **Audit & Clinical Governance**
		  • As per PQOM requirements, an audit of LMWH prescribing is scheduled for May/June.
		  • This audit will be led by the Trust consultant haematologist and pharmacy lead to ensure patient safety.
		
		• **Future QI Structure & Leadership**
		  • A driver diagram to map out planned QI initiatives will be developed during April, supporting a more coherent, phased, and cyclical approach.
		  • The recent VTE meeting showed improved attendance and engagement, following the formalisation of TORs and membership, with the group now benefiting from strengthened clinical leadership and clearer direction.
		
		Maternity performance and audit results continue to be reviewed monthly through Clinical Governance Committee.
			N/A	N/A

Maternity Exception Report

Oxford University Hospitals NHS Foundation Trust





Neonatal Deaths (born in OUH, up to 28 days); as rate per 1000 births shows special cause variation (n=5)				
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**
• In March 2026, the service recorded one intrauterine death and five neonatal deaths, all linked to complex obstetric and clinical histories. • Cases included reduced fetal movements leading to an intrauterine death at 35+5, extreme prematurity with chorioamnionitis after in utero transfer, and a term infant with trisomy 18 and exomphalos receiving planned palliative care. • Further neonatal deaths involved a malignant facial tumour requiring comfort care, severe congenital anomalies with pulmonary hypoplasia, and a periviable birth at 23+2 following spontaneous membrane prolapse where the family chose comfort care. • These cases reflect high-risk pregnancies with significant fetal or maternal complications. Multidisciplinary management and palliative pathways were followed appropriately.	• All six cases are undergoing multidisciplinary Perinatal Mortality Review to provide structured scrutiny. • Reviews will consider the appropriateness of in utero transfers, adherence to escalation processes, the impact of staffing on delays to caesarean section, and infection management in PPROM and chorioamnionitis against local guidance.	• Perinatal Mortality Reviews will be completed within six months, with immediate learning identified and acted on promptly. • Additional internal neonatal morbidity and mortality reviews are pending and will be completed within two months. • Interim position: initial review has identified no immediate care concerns. • Follow-up actions: Thematic learning will be shared and embedded, with audit or deep-dive review commissioned if themes emerge.	N/A	N/A

Maternity Exception Report

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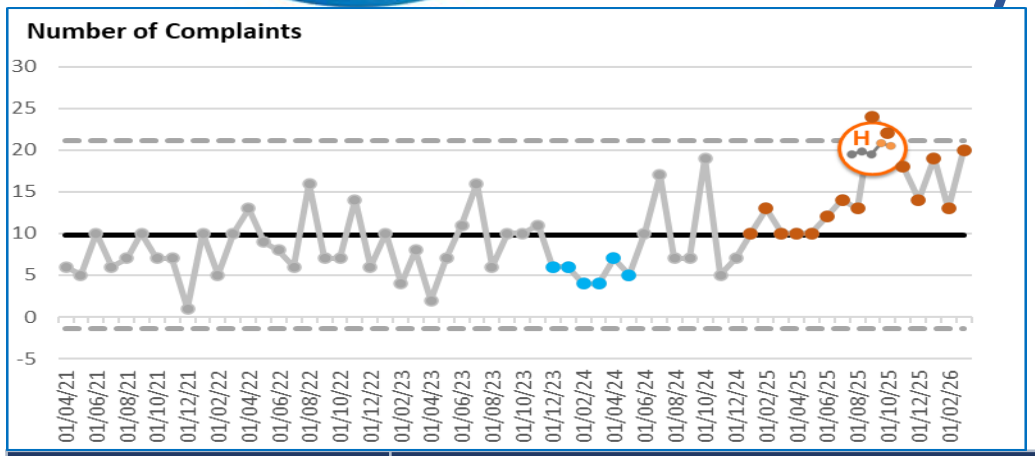

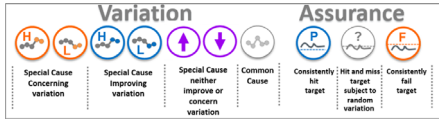

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issues and identification of any gaps in assurance	Risk Register score	Data quality rating
Number of complaints shows special cause variation.	In March, the service received 20 complaints, including three relating to care delivered more than 12 months ago. The key themes identified were communication, escalation and respect. Although complaint numbers remain high, the data now shows the beginning of a downward trend. Targeted improvement work continues through the Perinatal Improvement Programme and the Engagement and Involvement Strategy, including direct engagement with service users from under-represented communities and responsive, trauma-informed, face-to-face complaint meetings to ensure families feel heard and supported. To strengthen this work, a new Patient Experience Lead role has been created and actions from the five-year thematic review are being aligned with current workstreams to ensure a coherent approach. In addition, the service is focused on improving complaint response times, with enhanced oversight and process changes aimed at consistently achieving the 25-day response target and reducing delays in providing timely, meaningful responses to families.	Several targeted initiatives continue to be implemented in direct response to patient feedback, reinforcing our commitment to a responsive and learning-focused service. Infographics in the Maternity Assessment Unit to improve transparency around average wait times and enhance patient experience have received positive feedback. Communication skills, trauma-informed approaches and active bystander training form part of this year's mandatory training week, ensuring staff are equipped with the competencies that patients and families value most. These initiatives sit alongside ongoing work to address persistent concerns, with a clear focus on ensuring improvements are both meaningful and sustained. Progress is routinely monitored and triangulated with themes identified through recent complaints, real-time feedback and the five-year thematic review. This triangulation is supporting current improvement workstreams and informing where further strengthening is required. Assurance is maintained through monthly reporting to relevant governance committees, enabling oversight, timely escalation, and sustained service and organisational learning.	N/A	N/A

Maternity Risk Register - March 2026 (Risks Currently Rated 15 or Greater)

Oxford University Hospitals NHS Foundation Trust

Title	Description	Initial Rating	Current Rating	Target Rating
Lack of psychologist within the MMHS (3293)	Lack of psychologist within the MMHS team has meant that any referrals of pregnant women with secondary tokophobia will not be able to be acted upon. This could mean that women with secondary tokophobia may not be seen in a timely manner. The MMHS team along with the trauma midwife and mental health team are aware and attempting to mitigate. All staff members working within maternity are aware that this has occurred and that the trauma midwife, mental health and MMHS should be contacted.	16	16	4
Replacement and maintenance of cylinders and regulators for Medical Gases (3376)	Noncompliance with safe storage of maintenance and storage of medical gases policies and regulations. Cause: Following review, it has emerged there is an issue with the maintenance and replacement of medical gas cylinders and regulators. Replacing regulators solely within maternity does not provide a solution as they are returned to a central team who replace them with trust wide cylinders with inappropriate regulators.	16	16	4
Maternity Estates Risks (2221)	Ageing estate – frequent lift unreliability. Insufficient recovery area for post-operative patients and subsequent impact on patient flow. Frequent flooding and drainage issues. Lack of individual bathrooms on delivery suite for intrapartum care impact on privacy and dignity. Actions include business cases for improvements. Project has been completed to improve ventilation.	20	16	8
Obstetrics and gynaecology Medical residents Staffing levels 3309	There is a risk that obstetric medical staffing levels may become insufficient to safely meet clinical demand during periods of high activity, increased acuity, or multiple simultaneous emergencies. Current rota gaps, vacancies, or delays in recruitment might limit overnight resident staffing and increase reliance on consultants providing cover from home, which could reduce the team's ability to respond rapidly to emergent obstetric or gynaecological events. Any further staffing pressures across anaesthetics, midwifery and neonatal combined with pressures to obstetrics medical staffing rosters, may cumulatively weaken resilience of the service and might impact bed capacity, timeliness of admissions and discharges, and consultants' ability to complete non core activities, increasing vulnerability if staffing falls below planned levels.	12	16	4
Level 5 Maternity drug room temperature 3020	Lack of air conditioning leads to frequent breaches of cold chain policy with drug fridges breeching temperature which leads to medicine wastage. This has an impact on the safe storage and effectiveness of medicines.	15	15	5
Impact of increased demand for Elective Caesarean birth on emergency pathways (2426)	There is increased demand for elective CS birth which impacts on capacity of urgent work. Currently there is frequent spillover to the emergency theatre to accommodate demand. This impacts on staff deployment and resource allocation on delivery suite. This risk was discussed 10/03/26 at Risk Committee. The Service Manager has reviewed the data collection processes and requested changes in EPR to capture this data more accurately. Currently no change to score.	20	15	5

Oxford University Hospitals
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Perinatal Safety

Perinatal Safety – Maternity Incidents

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

•**Incident reporting overview:** 295 patient safety reports were submitted in March, with moderate harm incidents accounting for 31% (a 5% rise). These included 14 third-degree tears, 30 PPHs, returns to theatre, bladder complications, and two deaths (one IUD and one neonatal death receiving comfort care).

•**Neonatal safety and term admissions:** 36 unexpected term admissions were recorded in March). A governance paper has been submitted outlining the review of increased SCBU admissions and the QI actions underway to improve neonatal thermoregulation and reduce avoidable term admissions.

•**External assurance:** No Maternity Outcome Signal System (M.O.S.S.) alerts have been issued for OUH up to 31 March 2026, providing assurance regarding outcome monitoring.

Strengths

- The increased number of Ulysses submitted demonstrates a strong reporting culture, supported by monthly trend analysis and escalation processes to ensure learning is captured and timey learning occurs.
- Overdue Ulysses are actively monitored with 41 being overdue at the end of the reporting period (compared to 68 last month). There is a clear recovery plan in place that includes targeted working with specific departments and weekly communication to incident leads. Additionally, oversight is managed through the Maternity Clinical Governance Committee (MCGC).
- Responsive 'Learning of the week' communication is delivered through varying forums and embedded in safety huddles and team briefings. Compliance with required actions is monitored via feedback loops to confirm dissemination and impact.
- Additionally, spot check audits are undertaken where appropriate to ensure safety actions are being consistently undertaken.

Focus

•**Thematic learning and improvement:** Governance reviews (including incident investigations and documentation audits) have identified themes around escalation of pain, pain management, and recognition of the deteriorating patient. These are being addressed through a coordinated thematic review, with shared learning scheduled for the Intrapartum Shared Learning meeting and alignment with the Trust's QI priorities on early recognition and management of maternal deterioration.

•**Strengthened incident oversight:** A new twice-weekly multidisciplinary review group (Tuesdays and Fridays) has replaced the previous incident meeting structure, providing a more consistent, timely, and structured review process for all moderate incidents.

•**Integration with Trust-wide improvement work:** Findings from the thematic review and MDT incident processes directly inform the Trust's wider quality improvement programme, ensuring maternity learning is embedded and supports system-level improvements in safety and clinical response.

Future

- To address health inequalities, the service are consistently reviewing the ethnicity of users affected by moderate harm incidents.
- This data collection inform thematic analysis and targeted interventions to address disproportionate outcomes should they occur.

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

Oxford University Hospitals

Each stillbirth and neonatal death continues to be reviewed using the national Perinatal Mortality Review Tool (PMRT), PSIRF-aligned review, and MNSI referral where criteria are met. All neonatal deaths are also reviewed by the Neonatal Operational Delivery Network and the Child Death Overview Panel (CDOP).

PMRT Reporting and Learning

- All cases that met the criteria in March 2026 were reported to MBRRACE, in line with national requirements.
- Six multidisciplinary case reviews were completed during March.
- PMRT meetings are held weekly, and an external reviewer was invited to every meeting, in line with MPIS requirements. All five 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

During March, one case was referred to MNSI. This involved a term vaginal birth (primiparous, midwifery led care) following which the baby was noted postnatally to have unusual movements. The baby was admitted to SCBU and subsequently diagnosed with central hypotonia.

In addition, the service received the final MNSI report for case MI-046794. The report has been shared with the clinical team, and an MDT meeting will be convened to develop an action plan in response to the recommendations. The recommendations pertain to reviewing guidance on induction of labour for women who present with reduced fetal movements and the supervision of students undertaking clinical practice.

Learning from Maternity PMRT Reviews

Six cases were concluded in March. The majority were graded A or B, indicating care was appropriate and in line with expected standards. One case was graded C for the period prior to the diagnosis of an IUD. This provided learning opportunities for earlier recognition and escalation of concerns.

Case 1: Intrauterine death diagnosed at 32+4 following a diagnosis of pre-eclampsia. Care was graded C up to the point of diagnosis, due to concerns regarding the timing of fetal heart rate assessment and escalation of this, including incomplete MEOWS documentation.

Case 2: Intrauterine death at 24+6 following admission with reduced fetal movements. Care prior to diagnosis was graded B, with an identified opportunity for earlier referral to perinatal mental health services at booking. Care following diagnosis was graded A..

Case 3: Intrauterine transfer at 24+0 with vaginal bleeding and threatened preterm labour. An intrapartum intrauterine death was diagnosed. Care was graded A prior to diagnosis and B thereafter, due to incomplete completion of the partogram in labour.

Case 4: Neonatal death (NND) at 26+1 on day 2 of life following induction of labour for chorioamnionitis. Care was graded a B due to the delay in medical review on MAU on initial presentation. Care was graded A following the death of the baby.

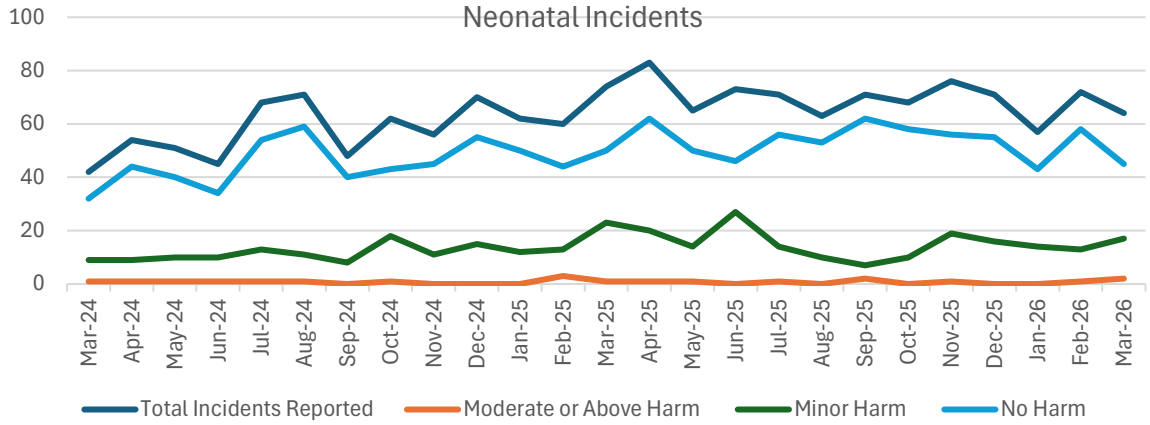
Case 5: Neonatal death at 23+6 following intrauterine transfer in preterm labour. Care prior to birth was graded B due to incomplete MEOWS documentation, and B postnatally due to the absence of obstetric review prior to discharge.

Case 6: Neonatal death following birth at 38+6 with antenatal diagnosis of congenital heart disease. Care was graded A throughout.

•Key Learning and Actions

- **Documentation/Completion of partogram:** A review of notes has found partograms are not consistently completed for bereavement cases. In response to this a Bereavement "At A Glance" learning has been disseminated to all staff.
- **Surveillance for deteriorating patients:** There is a continued need to strengthen the monitoring and timely escalation of deteriorating patients on the wards, with a particular focus on improving compliance with MEOWS. A dedicated quality improvement project is now being developed to address these gaps and support more consistent, proactive clinical oversight.
- All cases were reviewed through established governance processes.
- Learning has been identified and translated into actions.
- Feedback has been shared with relevant teams to support ongoing improvements

Perinatal Safety - Neonatal Incidents



Summary of Data

- In March, 64 patient safety incidents were reported via Ulysses. Of these, 19 resulted in harm - 17 minor and 2 moderate. The two moderate-harm incidents were peripheral venous line (PVL) extravasations with necrotic lesions. Both occurred in the same baby in the context of severe oedema, clinical fragility, and difficult IV access. Two rapid reviews were completed; immediate learning was shared with the team, and a Duty of Candour (DoC) letter was issued to the parents.
- The most common causes of minor harm incidents were medication issues, skin integrity concerns and specimen related incidents.
- Trend data over the past two years demonstrates an overall increase in incident reporting within the Neonatal Unit, largely driven by no harm events. Incidents resulting in harm remain low and stable, typically fewer than 20 per month. This pattern is consistent with a positive safety culture, where staff are supported and encouraged to report incidents to enable early risk identification and continuous improvement.

Strengths

- Incident reporting within neonates remains consistently high, reflecting a strong culture of openness and learning. Currently, there are four 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 has improved, supporting stronger engagement and alignment with organisational priorities.

Focus

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

Future

- 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 be a focus over the next few months.

Oxford University Hospitals
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Maternity Operational Activity

Summary

Summary of Data

- 630 people birthed their babies in March. This represents an 16% increase in the birth rate from the previous month.
- In March, 31 births took place in community settings. 21 in our freestanding midwifery-led units and 10 at home. This represents 5% of all births for the month.
- 8 women and birthing people were transferred from community birth setting to the obstetric unit - 4 for delay in labour, 2 for postnatal complications and 2 with reason classified as 'other'. All 8 transfers were reviewed and confirmed as aligned to established escalation pathways, appropriate and timely. This provides assurance that safety-critical decision-making and risk management processes are functioning effectively.
- In March, on-call utilisation increased to 315.25 hours with 167 hours from hospital on call and 148.25 hours from community on call roster. This increase of 131 hours comparative to February can be attributed to the current focused improvement drive to reduce delays in induction of labour improving patient and staff safety and experience.

Strengths

- On call community midwives attended the JR unit responsively to support in escalation, demonstrating flexibility and commitment to maintaining safe staffing levels.
- Specialist midwives and Ward Managers also provided timely support to operational colleagues during periods of escalation, ensuring continuity of care and effective risk management.
- Antenatal risk assessments were completed in 98% of cases, providing assurance that risk identification and mitigation processes are robust.
- Additionally, place of birth suitability was recorded as compliant at 85% as per national Ockenden requirements

Focus

- The service will continue to closely monitor staffing, patient flow, and capacity through daily staffing meetings, ensuring timely escalation and proactive management of risk.
- A daily staffing huddle has been embedded for the community service to align the oversight achieved with acute.
- A quality improvement programme continues to fully align triage processes with the BSOTS framework, targeting a 15-minute triage time and timely midwifery and medical reviews; progress is tracked through the Perinatal Improvement Programme and performance audits.
- A quality improvement programme to reduce delays to induction of labour is also continuing with March seeing the launch of a new RAG rating system. Although it is early days, since the launch on 23rd March, to the end of the reporting period, there has only been 1 delay greater than 24 hours.

Future

- The service is currently undertaking a full Birthrate Plus Safe Staffing Review with a formal report anticipated by the end of Q1 2026/27.
- The service will continue to monitor safe staffing levels across both acute and community sites through daily monitoring and escalation processes, assuring dynamic risk assessment and patient safety.
- Training is ongoing for the delivery of a 24-hour bleep holder role that will strengthen operational oversight and escalation management. A stepped approach to launching the role is planned from May 2026/27
- Collaborative summer mitigation planning will commence in April 2026

Oxford University Hospitals
NHS Foundation Trust

Maternity and Neonatal Workforce

Workforce – Maternity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- **Midwife-to-birth ratio:** Current ratio is 1:24.22, reflecting the rise in births in March and continued ability to support safe 1:1 care in labour.
- **Safe staffing incidents:** One occasion where the Delivery Suite coordinator was not supernumerary and two short periods where 1:1 care could not be provided due to high acuity; all episodes were brief with timely escalation and on-call staff responding promptly.
- **Workforce establishment:** Midwifery establishment aligned to BirthRate+ (332.06 WTE) with an additional 23 WTE uplift for maternity leave, giving a total establishment of 355.06 WTE.
- **Current workforce position:** March midwifery workforce was 343.48 WTE, with an unavailability of 26.93 WTE, equating to a 10.87% true vacancy rate. Maternity Support Worker vacancies stand at 10.65 WTE.
- **Consultant assurance:** 100% consultant attendance at clinical incidents in line with RCOG guidance.
- **On-call utilisation:** Increased use of hospital and community on-calls correlates with higher birth activity and midwifery unavailability, though sickness levels showed a slight improvement in March.

Strengths

- Ongoing pro-active recruitment to meet Birthrate+ establishment
- 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.
- Proactive pastoral and wellbeing support continues for all staff cohorts, including internationally trained staff, with uptake monitored and feedback informing improvement actions.
- Only 5% shifts in March had less than 85% staffing.
- 24/7 bleep service to be implemented through a stepped approach from May 2026 covering 3 nights a week initially.

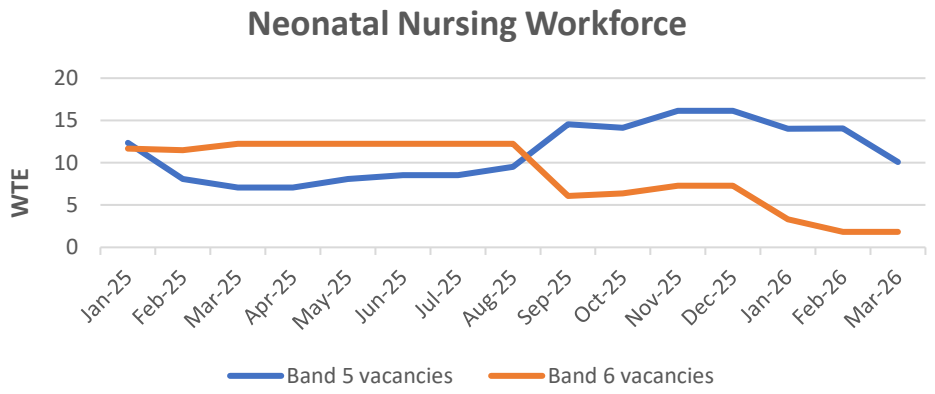
Focus

- 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 by real-time oversight by the bleep holder, manager on-call and ward managers and at daily staffing meetings Monday - Friday.
- Birthrate plus establishment review final report anticipated during Q1 2026/27
- Continuous and consistent provision of 1:1 care in labour and supernumerary status of Delivery Suite (DS) coordinators remains a focus with a targeted communication and education programme now in place.
- There was an increase in sickness absence during Q4 has led to overdue return-to-work interviews. The legacy midwife, supported by HR, is providing support to matrons and ward managers to manage this aligned to Trust policy to assure staff wellbeing is maintained.
- Staff experience workstream focused on consistent support of staff wellbeing, care and retention (Part of Perinatal Improvement Programme)
- Focused reducing violence and aggression quality improvement to support staff affected by racially motivated behaviour incidents

Future

- **Medical staffing gaps:** Recruitment underway for 5.0 WTE middle-grade vacancies; two appointees start in April and June, with remaining start dates pending HR checks. An unexpected 1.0 WTE GP trainee gap (Feb–May 2026) is being mitigated.
- **Rota and cover arrangements:** Current middle-grade gaps escalated to the Division and Trust, with mitigation through Patchwork-filled shifts and consultant step-down where required. MediRota now reviewed monthly to support six-week leave compliance and rota integrity.
- **Governance and workforce planning:** Medical staffing escalation SOP in development and shared in draft. One consultant retires end of June, with replacement process underway. All consultants have up-to-date job plans, and departmental job-planning models are being explored.
- **Workforce development:** Succession planning strengthened through short courses and apprenticeship pathways to build leadership capability and future workforce resilience.
- **Midwifery recruitment:** Targeted recruitment continues, with successful candidates allocated to high-maternity-leave areas and wait-lists used to support pressure points.

Workforce – Neonatal Nursing Workforce



Summary of Data

- In March, there were 1.83 WTE Band 6 and 10.07 WTE Band 5 vacancies in Neonates. Additionally, there are 9 WTE staff on maternity leave. Despite these challenges, mitigation strategies are in place, including regular staffing reviews and cross-divisional critical care redeployment, ensuring that 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, ten Band 5 nurses are in the recruitment pipeline and awaiting start dates, with Band 5 rolling advert ongoing. In addition, three Band 6 nurses are in the pipeline.
- Further interviews are planned within the Children's Directorate for April 2026 to support the recruitment of newly qualified nurses.

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 and are now being progressed as an exception during the financial controls.
- Recent external Band 7 advertisements have resulted in 3WTE posts filled.

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%	47%	72%	84%	96%
				Correct as of 1st April 2026	Prospective Data		

Summary of Data

- Current compliance with BAPM standards for Qualified in Specialty (QIS) training is 47%, 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.
- The current action plan is reliant on training staff internally and looking ahead, the trajectory will be broadened to recruit external candidates who are already qualified in the speciality. However, this approach remains difficult as such candidates are rare, making recruitment highly competitive and challenging and was delayed by Trust processes delaying external adverts.

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 for PROMPT (obstetric emergencies), fetal monitoring, and Basic Newborn Life Support (NLS). The training year runs from September to July, aligned to the Core Competency Framework.

Summary of Data

- The data is collected on a monthly basis
- Patient Group Directive (PGD) compliance is 76%
- Oliver McGowan Part 1 is 82.3%. 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.

Strengths

- Fetal monitoring compliance >90% for all relevant groups.
- Newborn life support training >90% for midwives and 88% for neonatal nurses.

Focus

- Attendance of anaesthetic consultants at PROMPT in March is <90% . Consultants requiring attendance are all booked on.
- Moving and Handling training compliance: 82% - dates planned monthly, and staff reminded to complete the e-learning as well as attending practical sessions.
- Safeguarding training – A targeted approach is being used to meet the compliance level. An additional maternity specific session is planned for 05/05/26 and is available to book on My Learning Hub.

Future

- To be above the 90% target for all staff groups for PROMPT, Fetal Monitoring and NLS – the rolling monthly schedule provides the opportunity to achieve this.
- To continue working with ward managers to organise tactical skills and drills sessions across the service
- Maternity staff are allocated protected time to undertake their e-learning as part of their training week, this is aligned to operational service need and delivery.
- NEWTT2 chart roll out May 5th, TTT to be delivered by PDT

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	↓82.3%
Core Skill - Information Governance and Data Security	↓88.9%
Core Skill - Moving and Handling Level 2	↔82%
Core Skill – Resuscitation Level 1	↓88%
Core Skill - Resuscitation Level 2, 3 OR 4	↓84.8%
Core Skill - Safeguarding Children Level 3	↓85%

Core Skills Modules below target	Neonatal Unit
Core Skill - Information Governance and Data Security	↓84%
Core Skill - Safeguarding Children Level 2	↓81%

PROMPT	Midwives	91%
	Nurses working in maternity	90%
	MSW's	100%
	Consultant Obstetricians	96%
	Trainees ST1-7	100%
	Obstetric anaesthetic consultants	81%
	All other anaesthetic doctors who contribute to obstetric rosters	100%
Fetal Monitoring	Midwives	92%
	Consultant Obstetricians	96%
	Trainees ST 1-7	100%
Newborn Life Support	Midwives	91%
	Neonatal/Paediatric: Consultants Junior neonatal Dr's (who attend births) ANNP's	 100% 92% 100%
	Neonatal Nurses	88%

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Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

The Trust has received confirmation from NHS Resolutions of successful completion of MPIS Year 7. MPIS Year 8 was released on 31 March 2026. This year introduces significant changes to the structure of the scheme and its associated safety actions. The MPIS lead will meet with key stakeholders in the coming weeks and attend a national webinar led by NHS Resolutions on 23 April 2026 to obtain further information on these changes. Following the release of the latest MPIS, the RAG rating for this year has not yet commenced.

Safety Action	Summary of Key Changes
A – Workforce and Capacity	• Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action. • Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags. • Addition of operational capacity monitoring, including elective Caesarean activity via SitRep. • Continues funded midwifery establishment (BirthRate+) and introduces funded neonatal establishment requirements. • Addition of a combined staffing report including medical and neonatal workforce
B - Training	• Strengthens training and assurance with two compliance checkpoints across MPIS year. • In-situ simulation now required in both hospital and community settings. • Anaesthetic training requirement reduced to a half-day to support attendance. • Impacted Fetal Head (IFH) scenarios must be included by year end to align with Avoiding Brain Injury in Childbirth (ABC) preparation.
C – Learning from Reviews and Investigations	• Strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement. • PMRT external review threshold increased to 60%. • Addition of Quarterly Board-level thematic reports. • Greater focus on learning → action → impact.
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. • Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps.
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. • Trusts required to develop a MCB implementation plan with quarterly Board oversight.
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. • Bimonthly Board Safety Champion meetings with MNVP involvement. • Live Perinatal Culture Improvement Plan required, with quarterly Board review.

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Patient Experience

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

Oxford University Hospitals NHS Foundation Trust

Feedback is gathered from the Friends and Family Test (FFT), complaints, the quarterly survey by Oxford Maternity & Neonatal Voices Partnership (OMNVP), concerns raised through PALS, and compliments received. This information is reported to the Triangulation and Learning Committee (T.A.L.C.).

Summary

Summary of Data

- March 2026 utilised the 2 available platforms from service users: The Friends and Family Test (FFT) and 'Say on the Day' devices.
- 163 responses were received from FFT and 355 from 'Say on the Day' devices, this combined feedback rated the service 96.5% Very good or good with increase in response rate from 70 % to 82% this month when compared to delivery rate.
- 20 complaints were received. 3 related to care delivered >12 months ago - 2 from 2024 and 1 from 2023). 3 key themes were identified this month centred on communication, escalation and respect.

Top three themes

- Postnatal ward feedback is similarly positive, with numerous references to supportive staff and excellent breastfeeding guidance.
- Equipment issues
- Lengthy waiting times for outpatient appointments (DAU and /MAU)

Strengths

The March FFT feedback reflects consistently high levels of satisfaction across antenatal, birth and postnatal services, with patients repeatedly praising staff for their kindness, professionalism, compassion and clear communication. Many comments highlight the value of continuity of midwifery care, personalised support, and the reassuring presence of clinical teams during complex or emotionally difficult experiences.

Birth feedback frequently commends midwives, theatre teams and anaesthetists for creating calm, safe environments, with several patients describing their care as "incredible", "astonishing", or "phenomenal" *"Every single member of staff worked with dedication, professionalism, deep care and unbelievable patience."*.

Focus

- MAU – Perinatal Improvement Project on going - triangulating waiting times with outcomes. Business case to increase clinical rooms and obstetric and midwifery staffing
- Working group to agree on and provide a business case for new CTG machines for acute. 20 new machines required.
- Actively monitor equipment and order appropriately

Future

- MAU: Continue to work with the trust to gain access to additional clinical rooms within the MAU corridor (currently being used by the university). This will improve initial triage time and reduce waiting times. Increase amount of CTG monitors to match the number of clinical rooms – this will enable a faster review and therefore decrease wait time for review.
- Induction of labour RAG prioritisation introduced. PDSA cycle ongoing. Initial findings - review use of acute delivery rooms and review staffing model for delivery suite through the birth rate plus

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 March, three FFT responses were received, representing a slight increase compared to the previous month.
- While overall response rates remain low, mitigating actions are in place, including the repurposing of 'Say on the Day' devices to capture real-time feedback, which has generated positive written comments. A strengthened engagement plan was introduced in February with administrative team support; however, delivery has been impacted by high sickness levels.
- One joint MatNeo complaint was received in March relating to a delayed Jaundice Clinic appointment. A neonatal response has been submitted, and learning will be shared following completion of the final investigation.

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 March, 18 responses were received from families via Say on the Day devices (representing 20% of admissions), with overall experience rated 8.9/10.
- Positive responses are seen through both feedback platforms. Recognition of supportive staff and kindness and compassion is expressed throughout.
- Comments are consistently positive with examples such as "*Great support and compassion from team"* and "*I was very impressed with the care me and my son received. All team was amazing. They not only took care of my son but they also made sure I am feeling good and I understand what is going on and what's a plan to approach."*

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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Quality Improvement

Quality Improvement Focus: Triage (BSOTs)

Oxford University Hospitals NHS Foundation Trust

TRIAGE QUALITY IMPROVEMENT: SUMMARY

The triage quality improvement initiative was established in response to identified issues in the provision of timely access to triage. By implementing the Birmingham Symptom-specific Obstetric Triage System (BSOTS), the aim is to deliver safer, timelier, and effective risk assessments for women and birthing people, ensuring a standardised approach that aligns with CQC expectations and supports high-quality, consistent care across the maternity service.

Focus

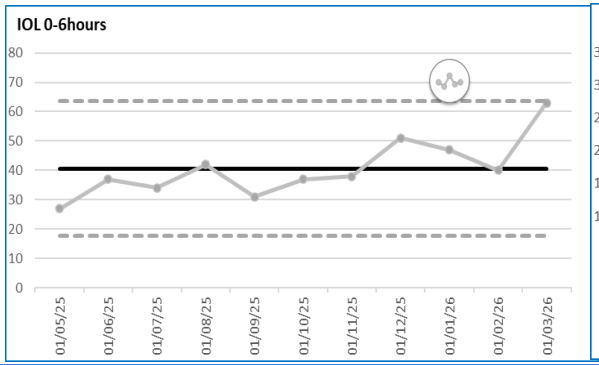
- Reconfiguration of 2 x clinical rooms in MAU entrance by end Q4 2025/26 (Dependant on university relocation) this is ongoing and being led by maternity operational service manager.
- Additional CTG machines quote as been uploaded to support MAU rooms to support flow and reduce waiting times by end of March 2026
- BadgerNet iPad project ongoing with hardware procured and software updates in progress - to launch by end March 2026.
- 'Perfect Week' implemented during March, significant improvement noted around initial triage time, from 50% triaged in 15 minutes to 75%, although further improvement required with time to medical review. Full feedback report to be provided by end April 2026
- Trajectory for increased medical staffing should align to delivery of dedicated medical presence in MAU
- Visit undertaken to Liverpool Maternity Service to observe benchmark MAU/Triage service, feedback report and recommendations to be received by end April 2026

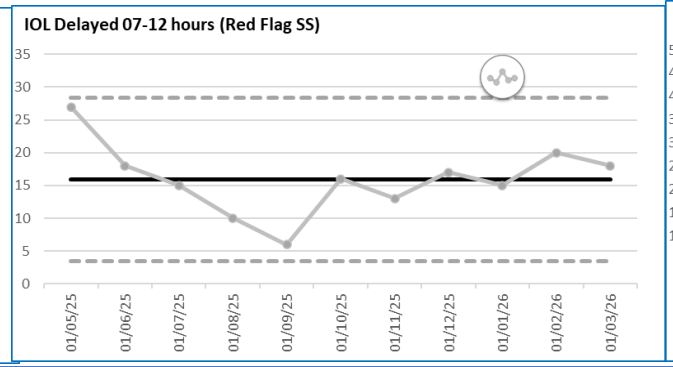
Future

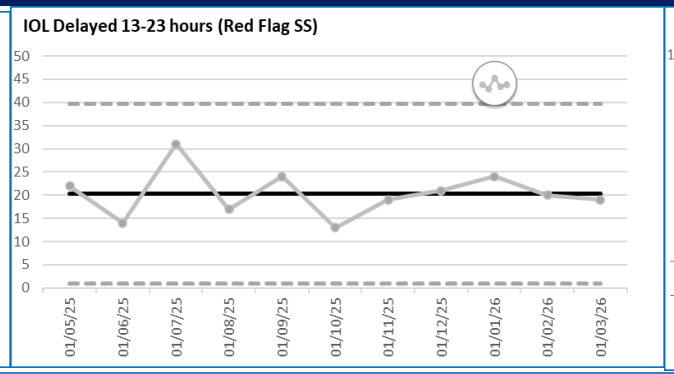
- Ongoing work with BOB LMNS Mamas Triage line externally sited (ICB led)
- Telephone e-learning package to be completed by all triage midwives. New rotation to area (23/3/26) with completion deadline of 30/4/26.
- Explore the feasibility of air conditioning in clinical rooms
- Birthrate Plus assessment and CNO establishment reviews to inform MAU staffing model
- Progress scoping exercise for MAU and DAU merger
- Progress monitored and reported through MCGC

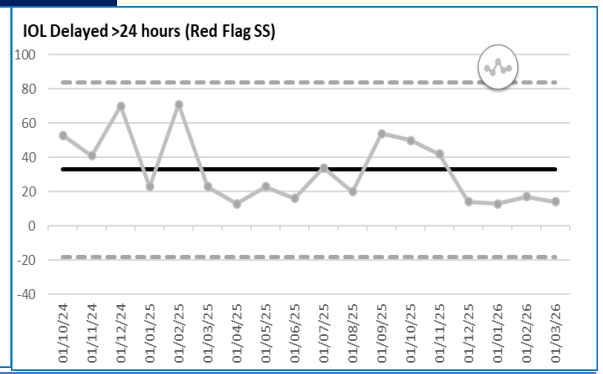
Focus Quality Improvements: Induction of Labour (IOL)

Oxford University Hospitals NHS Foundation Trust









IOL QUALITY IMPROVEMENT: SUMMARY

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

Focus

- The RAG-rated Induction of Labour (IOL) system was implemented on 23 March, providing clearer prioritisation and oversight of delays.
- Since implementation, there has been only one delay >24 hours, involving a green (post-dates) IOL with a 32-hour wait due to documented acuity and staffing pressures.
- A total of 13 red-rated IOLs have been undertaken; two exceeded the 6-hour transfer target, with delays of 9 hours and 7.5 hours linked to Delivery Suite bed capacity and staffing.
- All amber-rated IOLs met the 12-hour transfer standard, demonstrating improved flow for moderate-risk cases.
- Emerging themes highlight capacity and staffing constraints on Delivery Suite as the primary cause of delay for high-risk (red) transfers.
- Continued monitoring of RAG performance will support safer prioritisation, improved escalation, and targeted workforce planning across the IOL pathway

Future

- Move to misoprostol may be moved forward due to national patient safety alert outlining stock issues with current Prostin method – plan to be developed by end April 2026.
- Service user and staff education review: Questionnaire collaboratively designed and findings reviewed to inform updates in information provision by end of Q1 2026/27
- Provision of education and training for healthcare providers involved in the induction of labour – developed following review during Q2 2026/27
- Consider midwifery led post-dates clinic with proposal by end of Q1 2026/27

- Progress monitored and reported through MCGC

EDI: Collecting and Using Local Data to Address Inequalities – Staff and Service User

Oxford University Hospitals NHS Foundation Trust

Mar 2026 Updates:	Activity	Total Encounters
Translated Antenatal classes	Languages: Tetum, English, Arabic	3 + Annual Flo's conference
Digital Inclusion support	Free preloaded Sim cards	5
	Donated mobile phones	0
EDI Working group	Monthly	0
Staff consultations-adhoc	Enquiries	5
	Concerns	2
Clinical & Non clinical Staff: Active Bystander Training	Complete attendance	54
	Partial attendance	0
Health inequalities projects	Access to Screening Audit	Repeat data set will be available in May 2026. Screening access: Bookings beyond 14+1 weeks were audited, results shared, and poster dissemination is complete. SOP ongoing
	Patient Information videos	4 transcripts completed and voiced in March. Initial animation pending from OMI. Video resources will be voiced in Tetum with English subtitles. Created by OMI.
	Tackling Bias amongst Staff	The QI project is live on Ulysses QI 10530, with a deadline of March 2026. Now included in the Perinatal Improvement Programme (workforce stream) for further follow-up.
Community engagement monthly (pregnant & new mothers)	AFIuk	0
	East Oxford Stay & Play	0
Total		**69**

Quality improvement work remains focused on reducing racially motivated incidents against staff, supported by the wider Trust and aligned with best practice through the Violence and Aggression Reduction Committee. To strengthen this workstream further, action cards will be introduced across all service areas in April to support staff at the point of escalation of poor behaviour, including administrative and clinical teams managing challenging interactions by telephone.

As evidenced by the targeted interventions above, the service continues to reduce workplace inequalities actively by prioritising Equity, Diversity, and Inclusion. The service also uses feedback from women and birthing families to minimise disadvantages experienced by different groups accessing maternity care and, wherever possible, remove those disadvantages.

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National Updates

Three Year Single Delivery Plan Progress

Oxford University Hospitals NHS Foundation Trust

We continue to report against the Single Delivery Plan figures in the illustration, which are from 2025. This is to evidence that the work towards the negative outliers is ongoing. However, there has been an update this month to the preterm birth rate, as shown. Control of this data sits with the National Team.

Positive Outliers:

- Sickness rate data in the Single Delivery Plan is from October 2025 and is therefore highlighted in the illustration as a positive outlier. The sickness rate is monitored monthly and reported as part of this report. The current sickness rate is 5.94%, as referenced in the workforce update.

Negative Outliers:

- The results of the 2025 Maternity CQC survey were received in December. The service has met with the MNVP to co-produce an action plan. This will be taken to the Triangulation and Learning Committee (TALC). However, monthly FFT and 'say on the day' device feedback demonstrate consistent improvement in service user experience, with 80–85% of respondents rating their experience as good or very good.
- Strategy development to achieve baby-friendly initiatives (BFI) accreditation will commence in Quarter 1, 2026/27. The infant feeding lead is undertaking audits as part of the preparation for BFI accreditation. However, as Oxford is currently under national investigation, the maternity statement from the national BFI team outlines that the service will not currently be able to undergo a stage 3 assessment.
- The stillbirth data for 2024 (data from 2023), was published on 12 March. This showed the stillbirth rate as 3.47 per 1000 total births, which is in line with the national average rate for a tertiary-level service.
- Preterm birth rate – Further information is required from the national team in relation to distinguishing between iatrogenic and spontaneous preterm birth and the significance of what this figure represents.

Ongoing projects

- The new national MEWS is available in BadgerNet from 24 March 2026. The guidelines are currently being updated in maternity and will go through the governance processes in May 2026.
- NEWTT2 is due to go live on 05 May 2026.

Maternity and Neonatal Three Year Delivery Plan Oversight Tool - Outlier summary

This sheet shows, for each ICB and Trust, how many measure results are demonstrating better outcomes / progress or needing further suppo

Select organisation (table): Oxford University Hospitals NHS Foundation Trust

MBRRACE-UK metrics: Better outcomes – Poorer outcomes

All other metrics: More positive – Improvement / support needed

Oxford University Hospitals NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	41	5	1
Listening to and working with women and families with compassion	12	3	
Growing, retaining and supporting our workforce	13		1
Developing and sustaining a culture of safety, learning and support	13		
Standards and structures that underpin safer, more personalised, and more equitable care	3	2	

T1g:Adequacy of information or explanations during postnatal hospital care	53.0%
T1ni:Baby Friendly Accreditation - Maternity	0.0%
T1nii:Baby Friendly Accreditation - Neonatal	0.0%
T2ii:Midwife Sickness Absence Rate	3.9%
T4aiii:Stillbirth Rate (Stabilised) (MBRRACE)	3.6
T4eii:Preterm Birth Rate (MSDS)	9.2%

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Appendices

Appendix 1: Maternity Governance – Ward to Board

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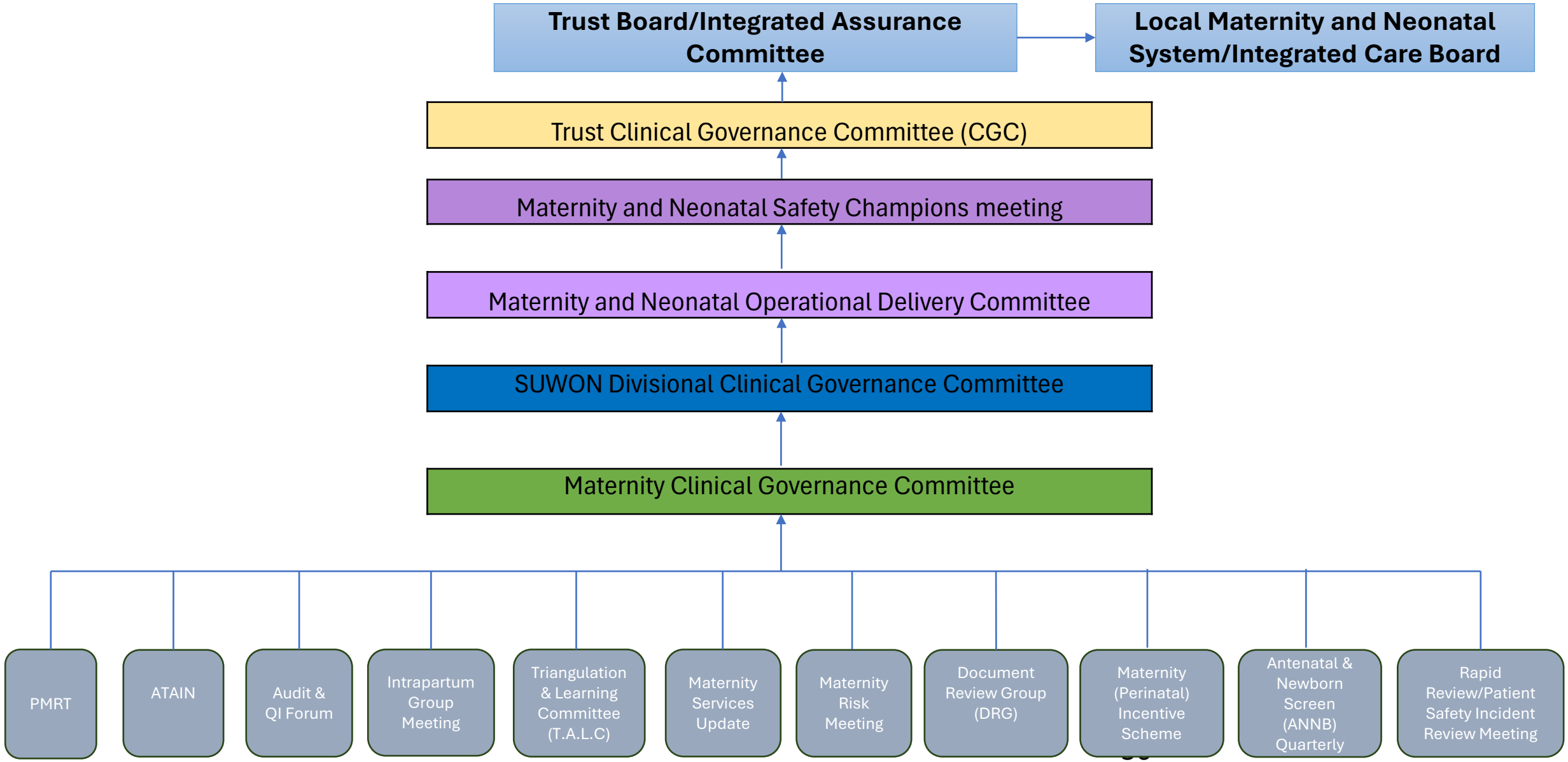

Appendix 2: SPC Charts

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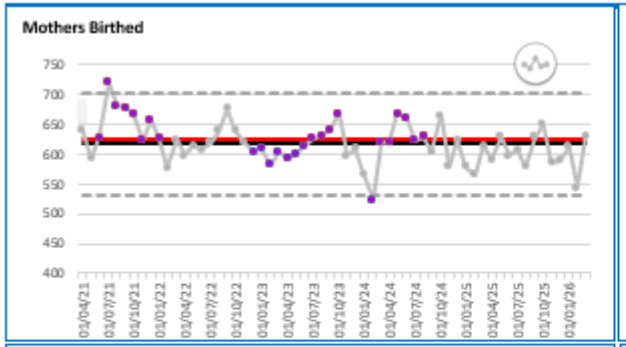

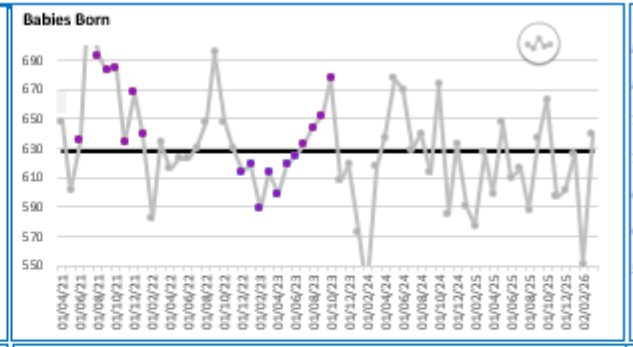

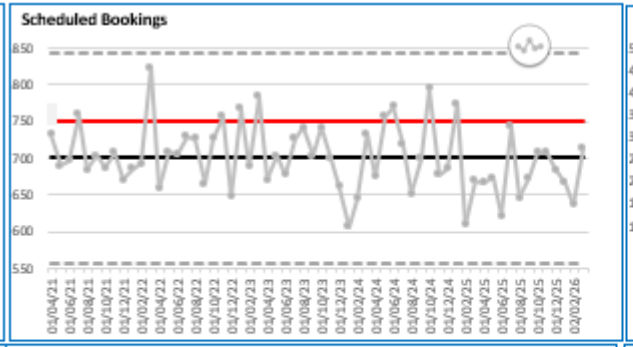

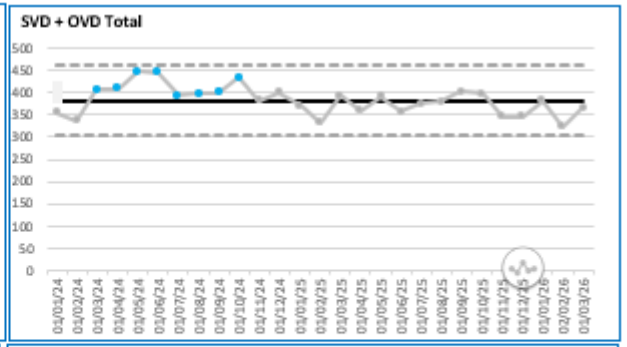

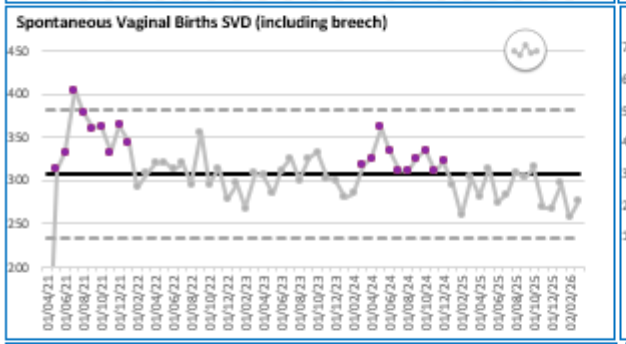

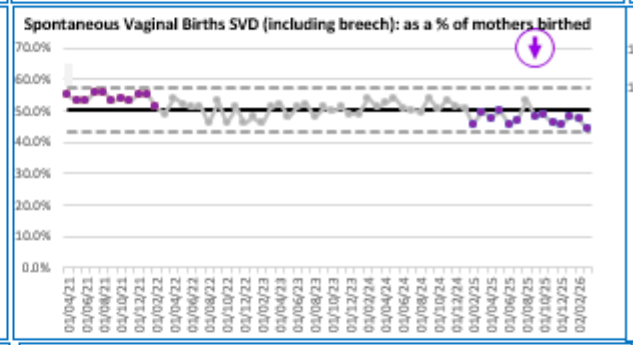

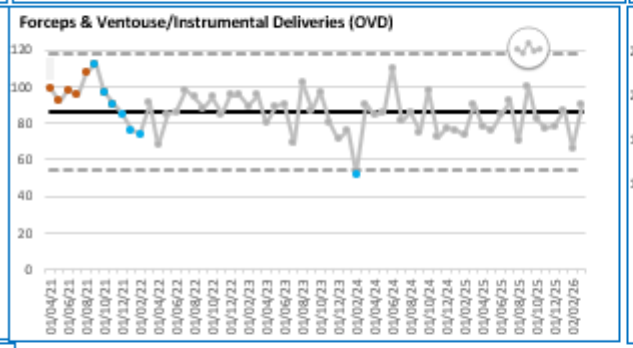

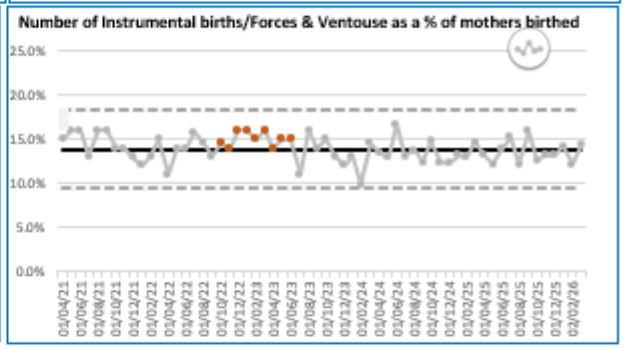

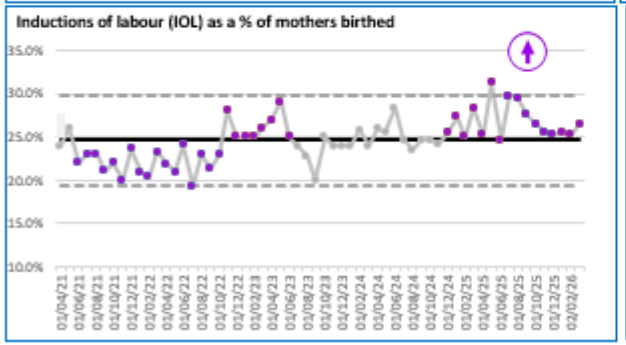

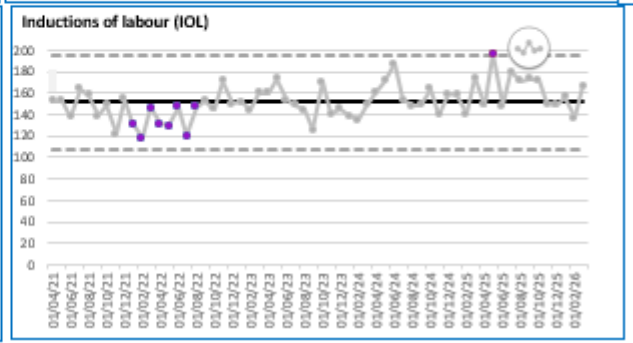

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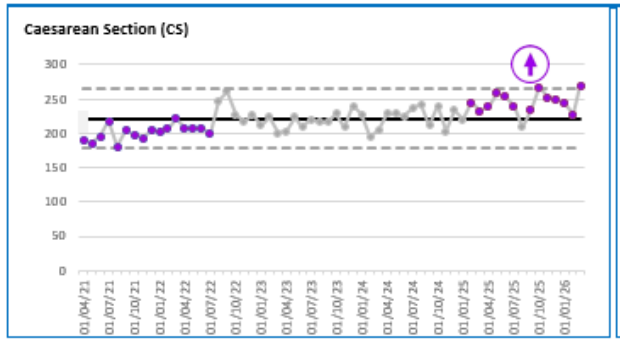
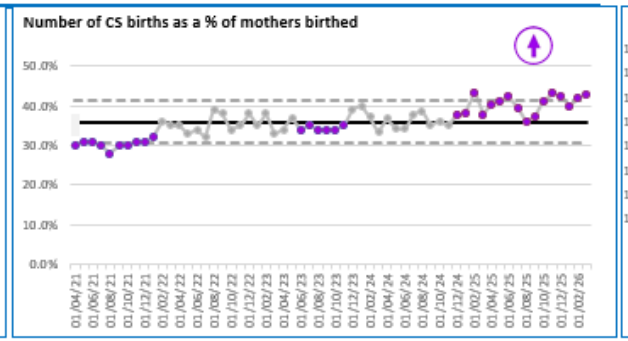
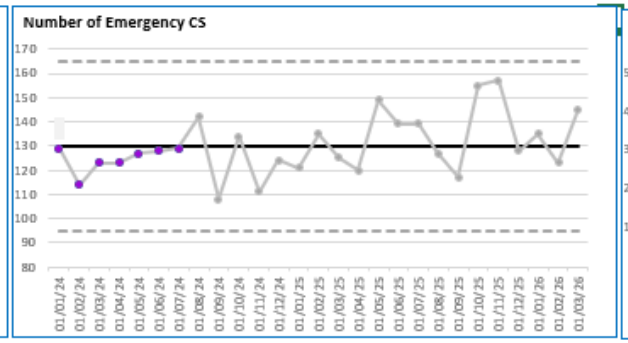
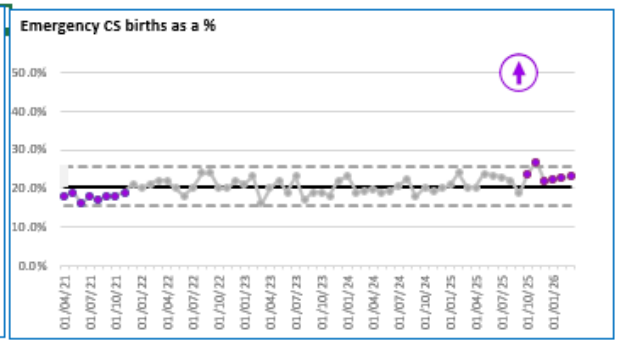
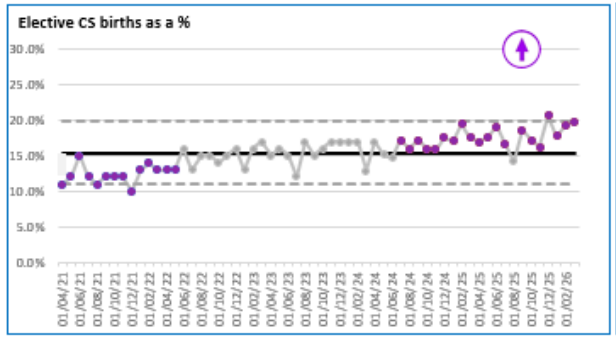
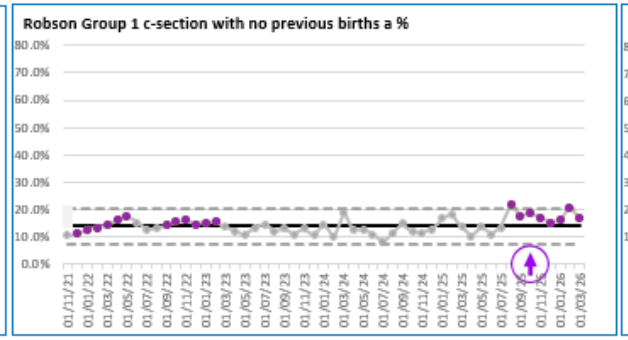


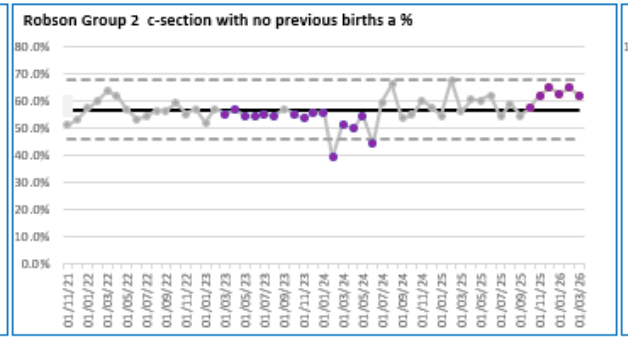


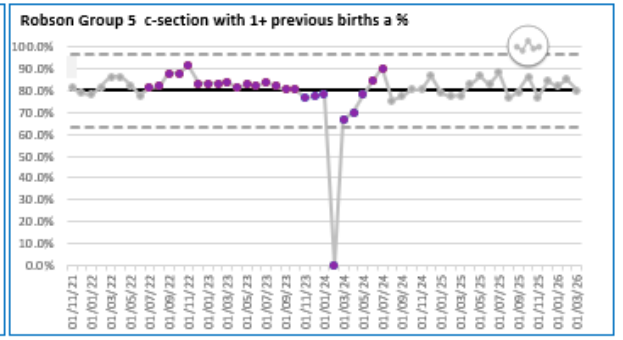


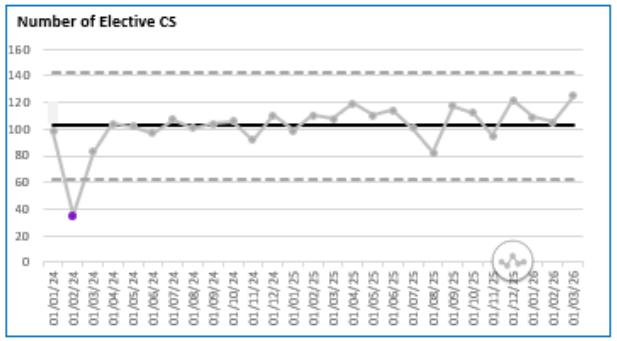


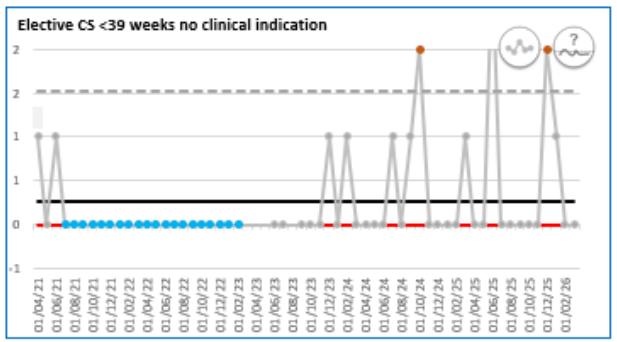




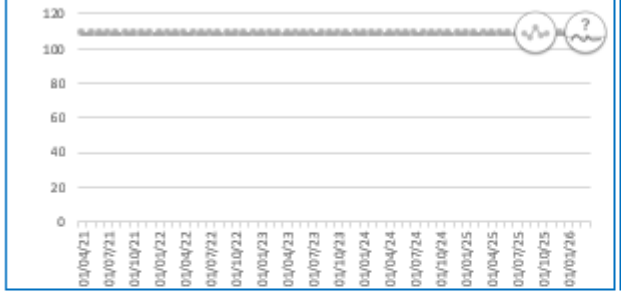




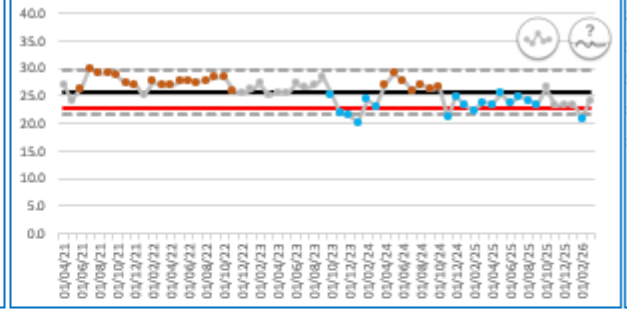




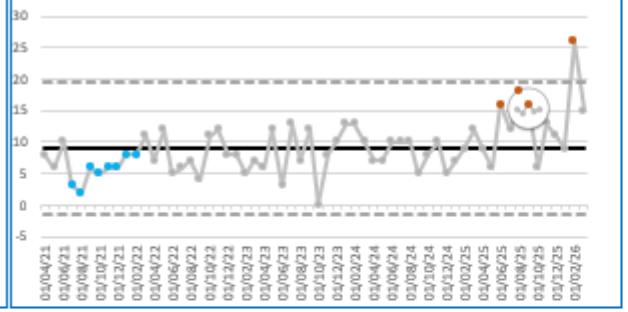
Prospective Consultant hours on Delivery Suite



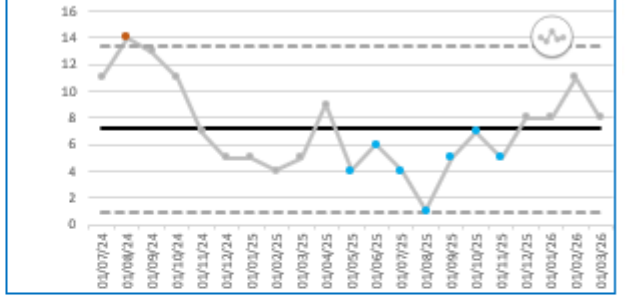
Midwife:birth ratio



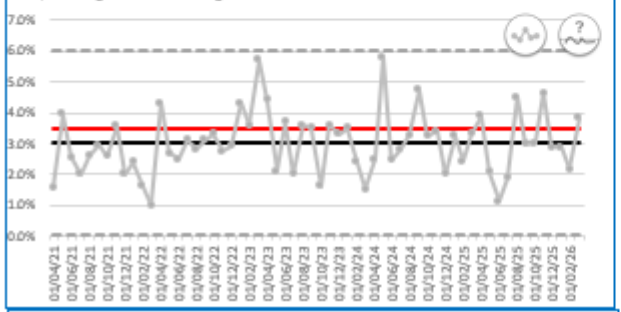
Maternal Postnatal Readmissions



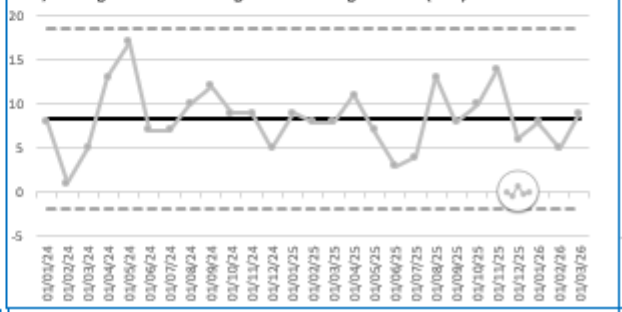
PPH equal to or greater than 1.5L following an instrumental birth (OVD)



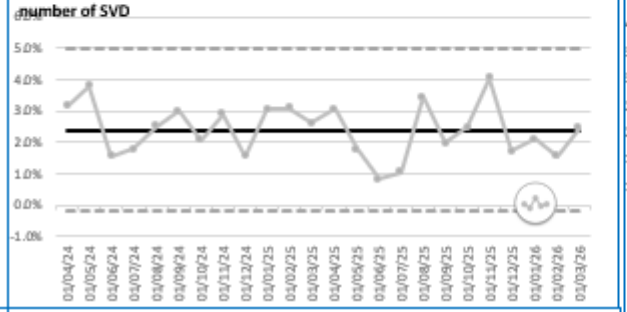
3rd/4th degree tears amongst mothers birthed as a %



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



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



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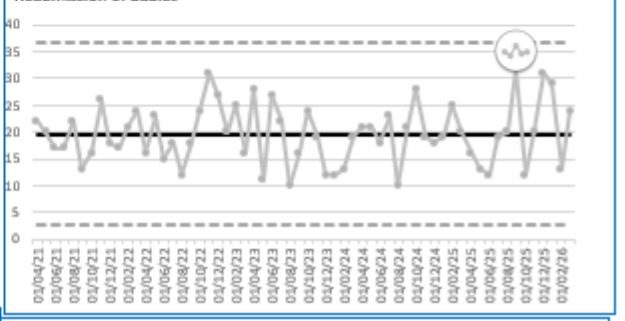
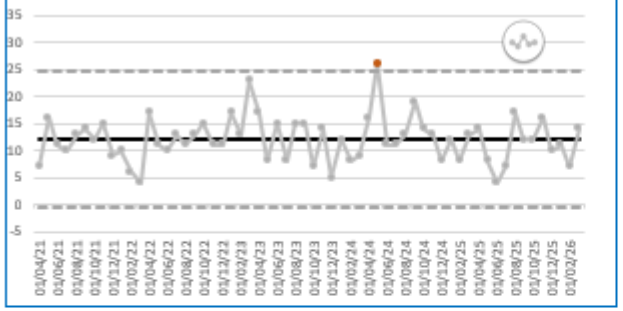
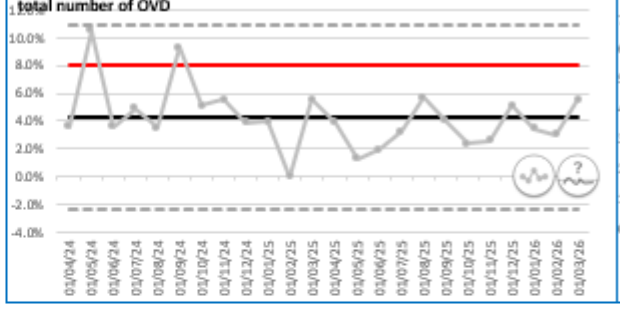


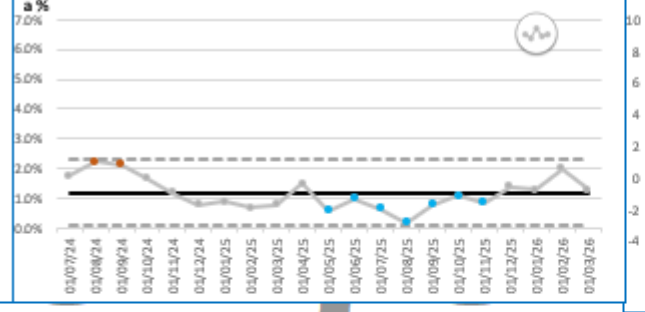
3rd/4th Degree Tears amongst mothers birthed



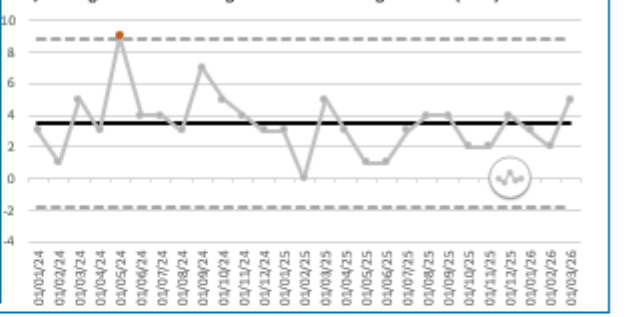
3rd/4th degree tears following an Instrumental vaginal birth (OVD) as a % of total number of OVD



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



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



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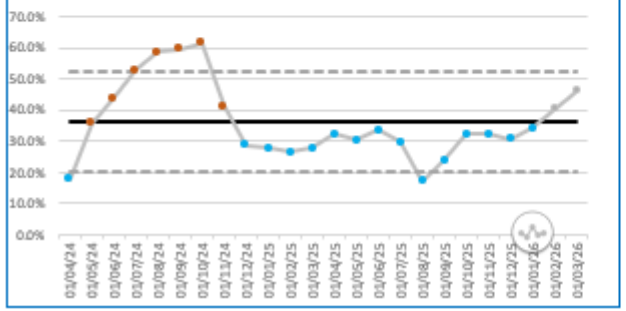

Appendix 2: SPC Charts

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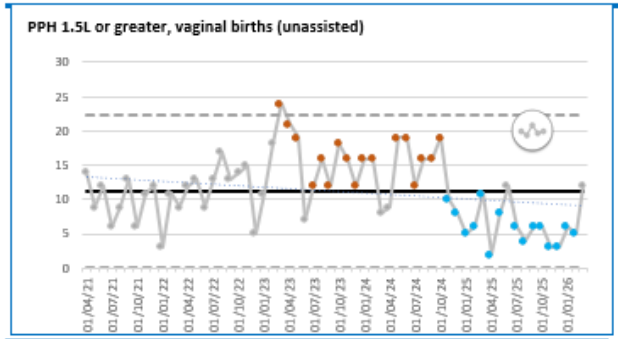
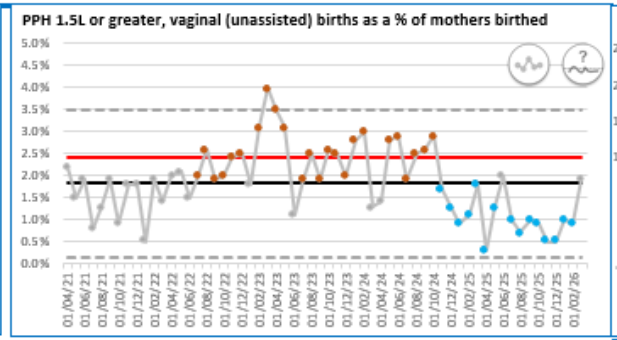
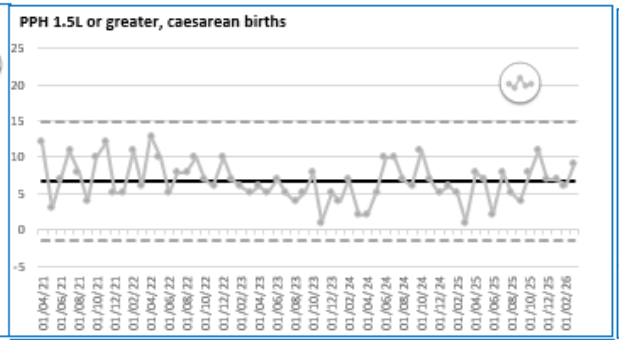
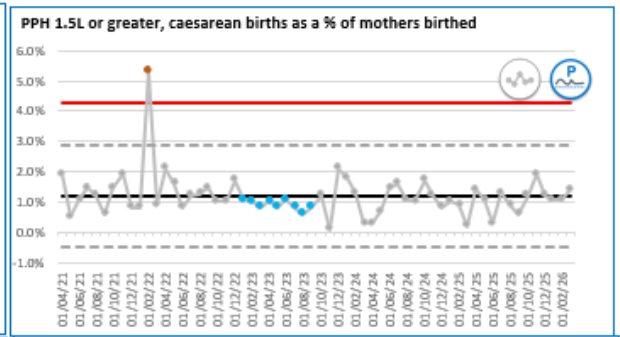
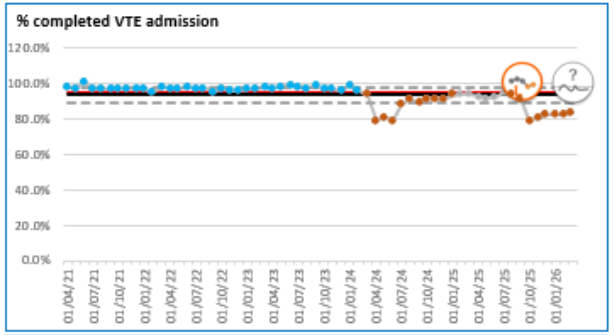
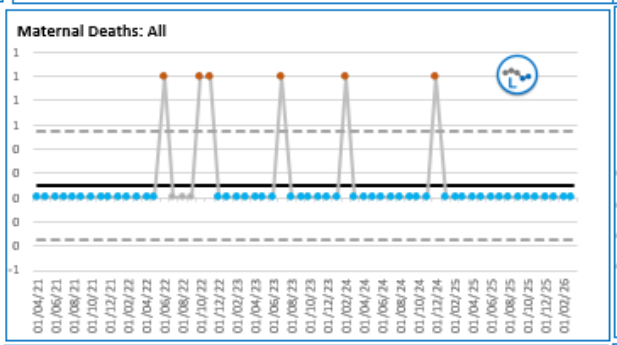


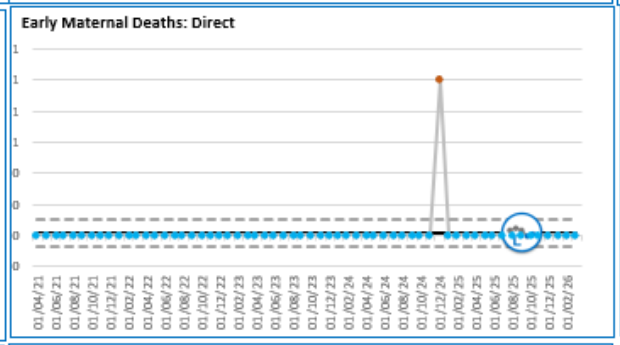


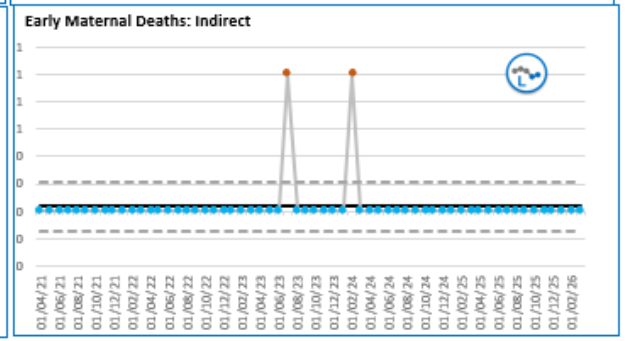


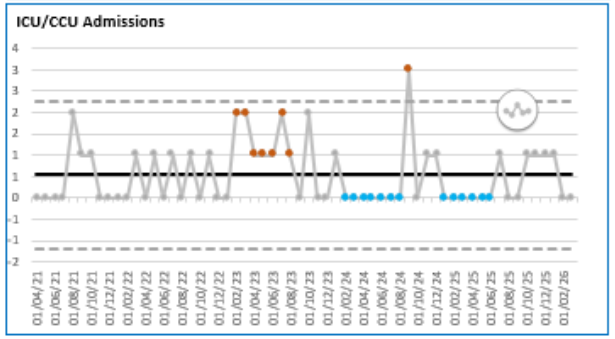


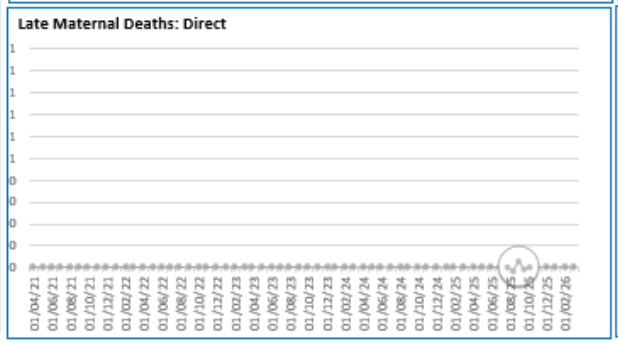


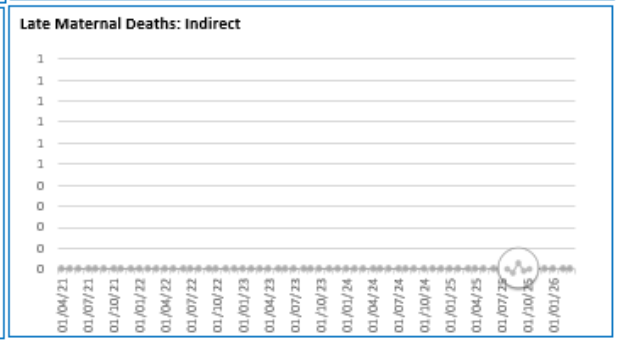




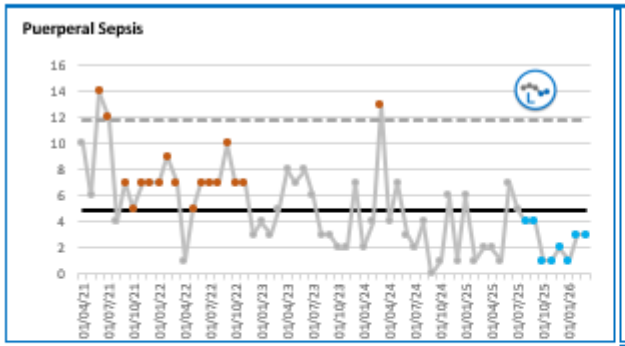


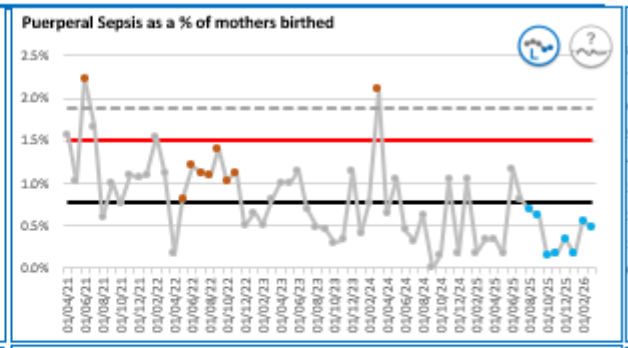


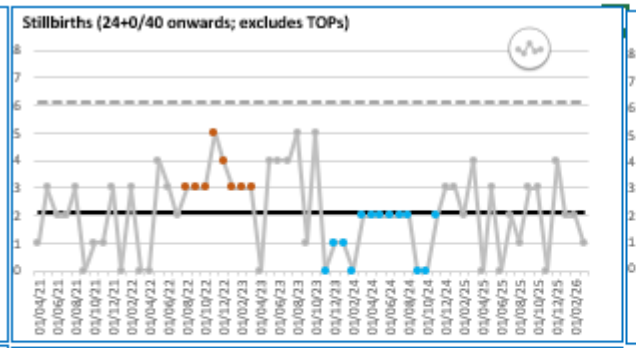


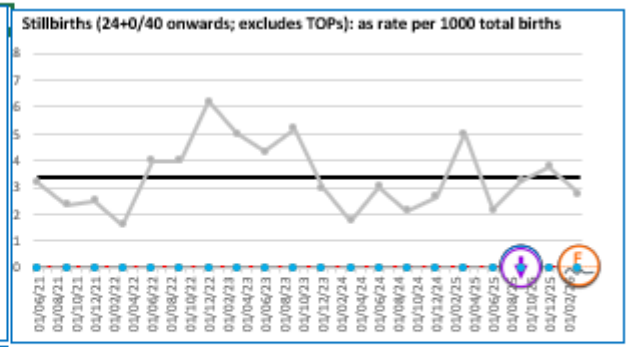


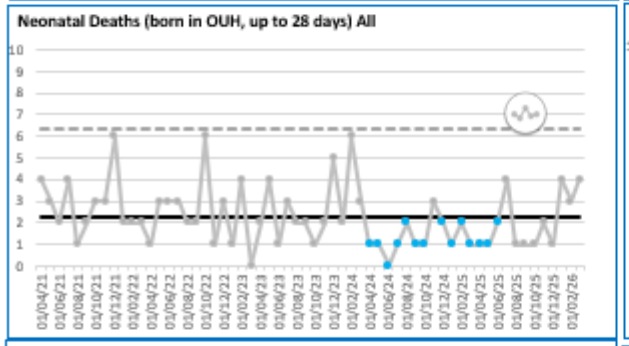
Appendix 2: SPC Charts

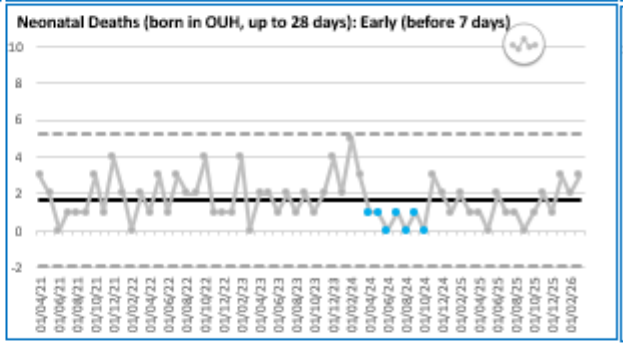


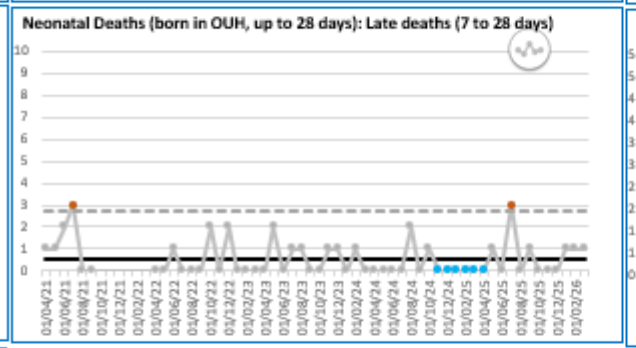


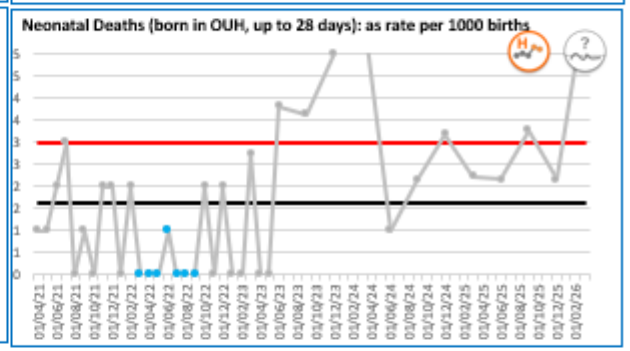


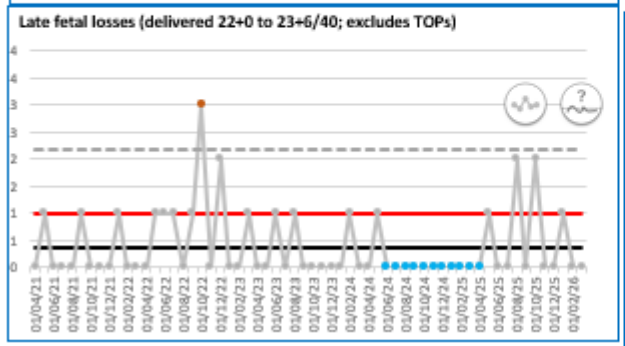


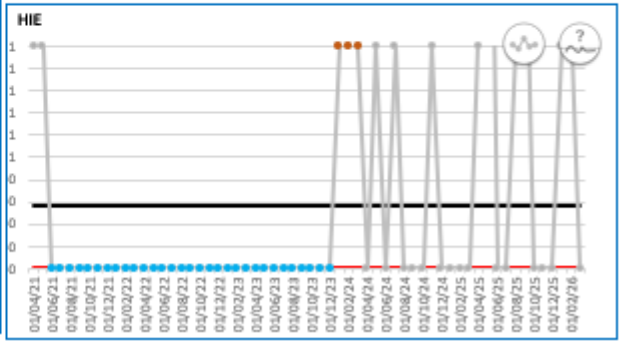












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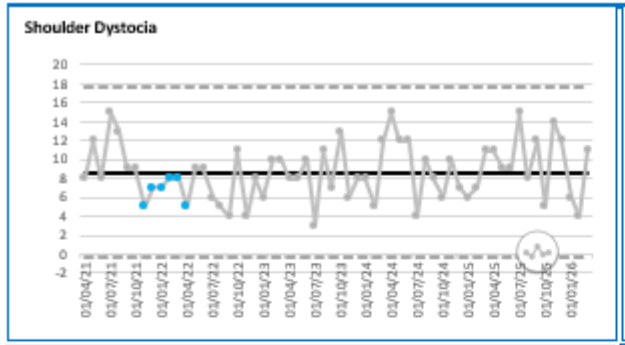

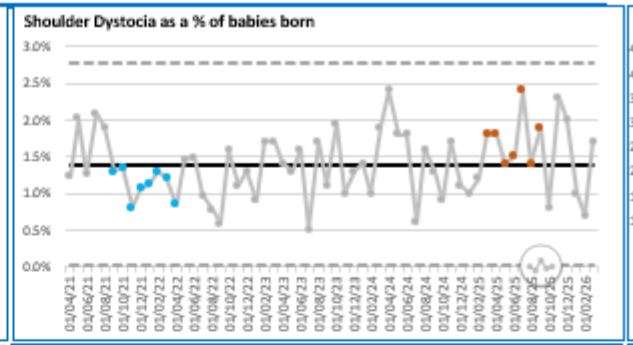

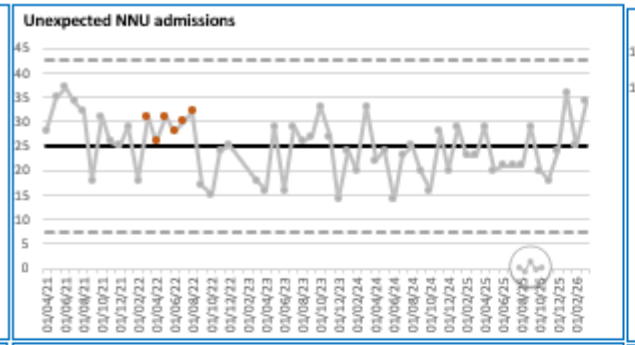

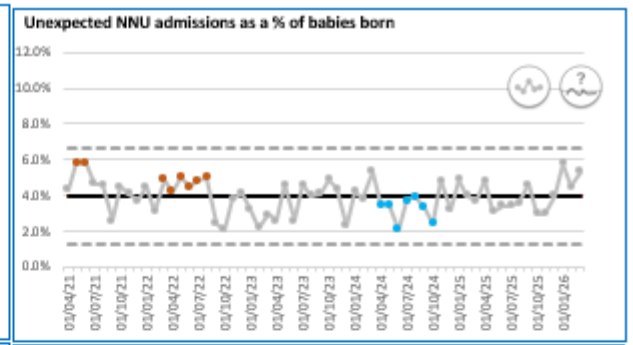

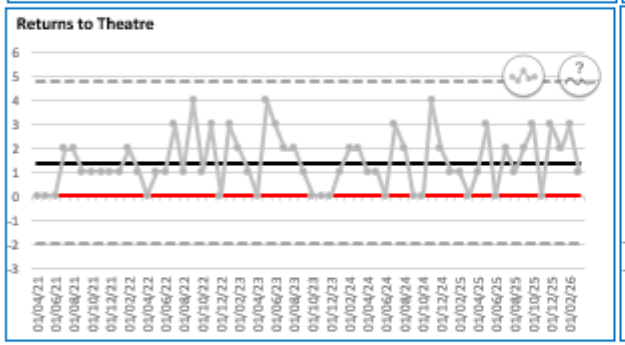

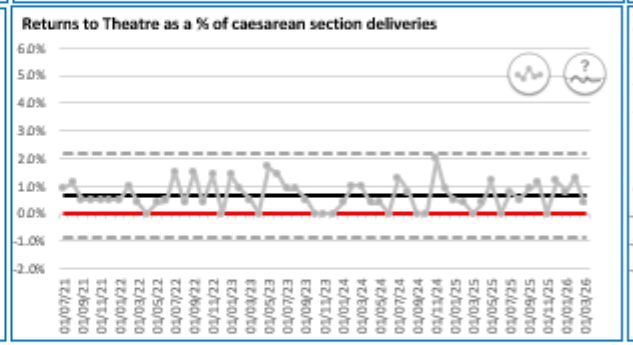

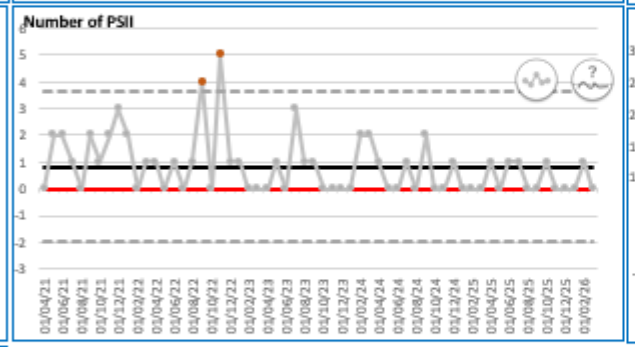

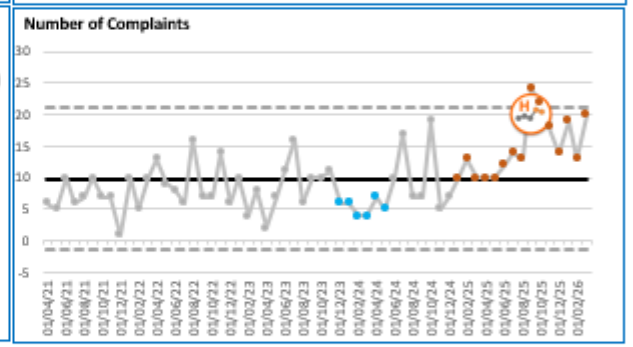

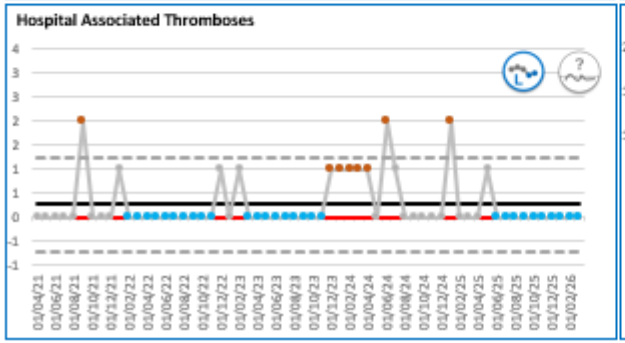

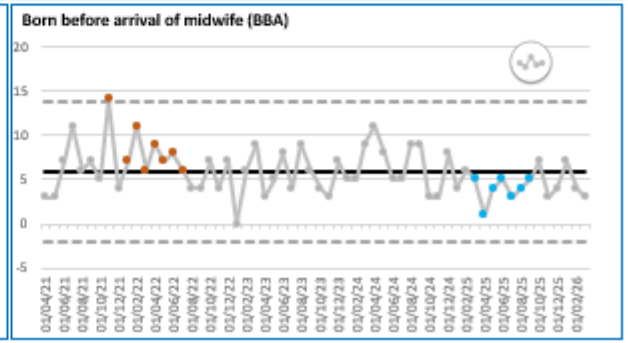

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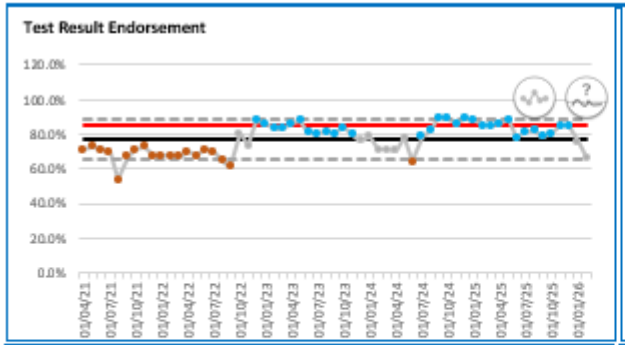

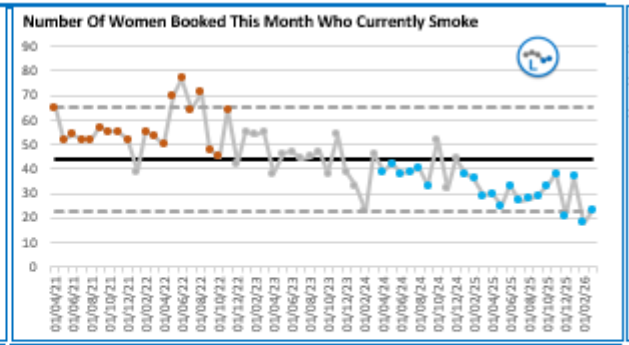

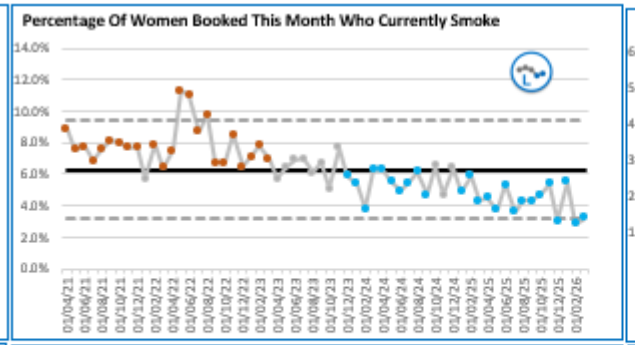

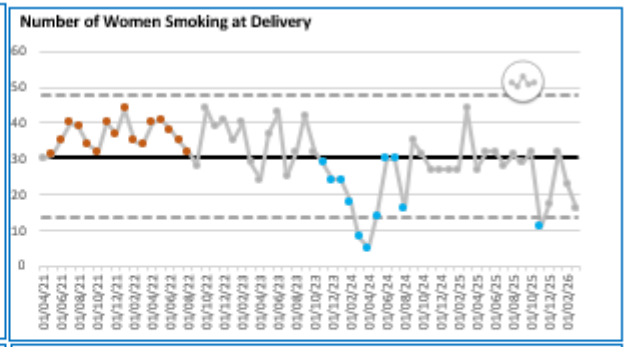

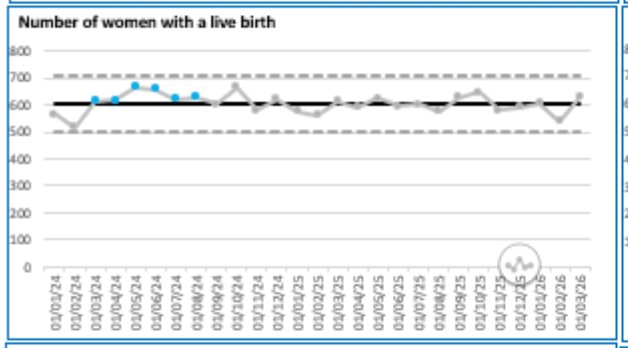

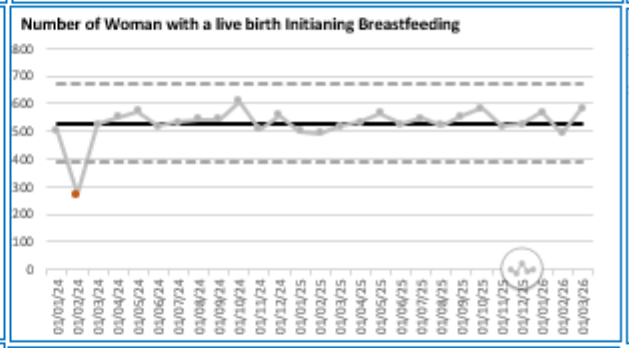

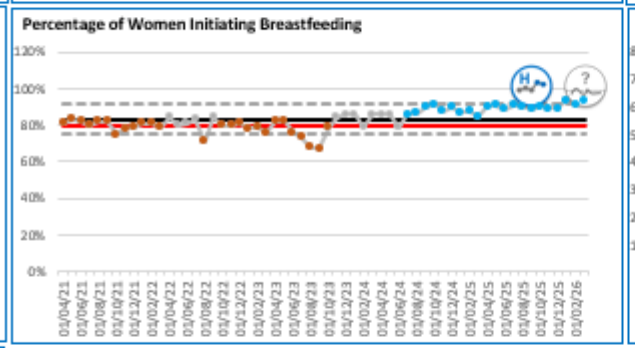

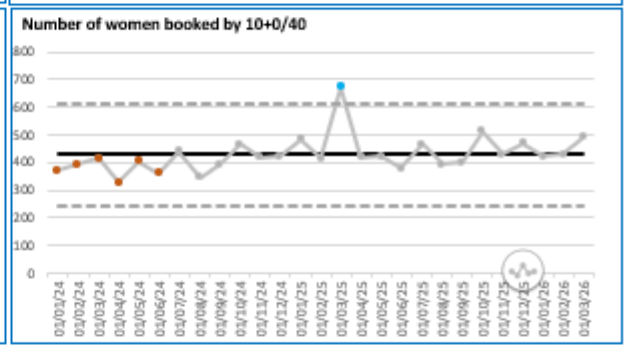

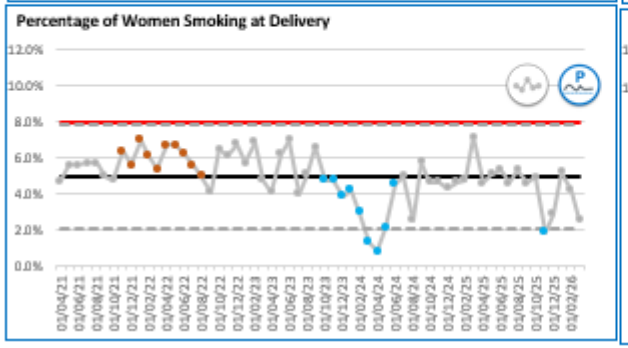

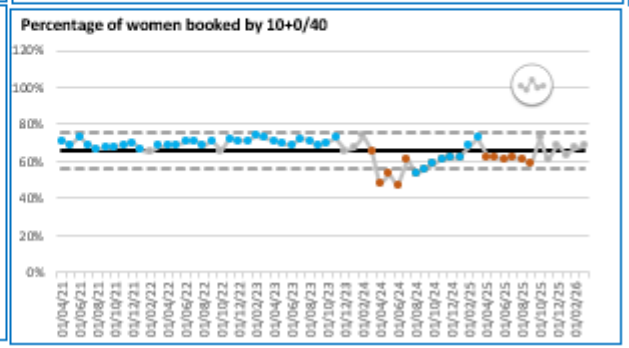

Appendix 3: Categories for Grading Care in Perinatal Mortality Reviews (PMR)

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

Appendix 4: 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