Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 March 2026

TB2026.23

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

Status:	**For Information**
History:	**Reported to:**
	Maternity Clinical Governance Committee 16 February 2026
	Trust Clinical Governance Committee 18 February 2026
	Safety Champions Meeting 25 02 2026
	Maternity and Neonatal Governance and Operational Delivery Committee 05 March 2026

Board Lead:	**Chief Nursing Officer**
Author:	**Sharon Andrews, Head 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 Surveillance Model (PQSM) and the newly republished Perinatal Quality Oversight Model (PQOM).
2. Key Areas of Focus
    - **Safety & Compliance:**
        - There have been no Maternity Outcomes Signal System (MOSS) alerts for Oxford University Hospitals up to 31 January 2026. All MNSI and PMRT reporting requirements have been met, with rapid reviews confirming no immediate care concerns in referred cases.
        - Unexpected term admissions to neonatal care: An increase to 5.8% of babies born was noted, representing a key safety focus. Early indications suggest possible association with elective caesarean section pathways; a full review is underway with updates to governance committees.
        - Venous thromboembolism (VTE) assessment compliance: VTE completion within 14 hours fell to 82.6%, showing special-cause variation. A clear recovery plan is in place, including updated guidance, audit and Trust-wide communication, providing assurance of active risk management.
    - **Workforce & Training:**
        - Compliance with fetal monitoring and newborn life support training remains above the 90% target for most staff groups. PROMPT attendance showed a marginal decline in January for anaesthetic consultants to 78%. Consultants requiring attendance have been rebooked.
        - Midwifery and neonatal recruitment pipelines remain active, mitigating vacancy risk. Neonatal medical staffing remains compliant with BAPM standards, with risks managed through escalation and rota controls.
    - **Quality Improvement:** The report demonstrates ongoing stability in perinatal surveillance metrics. The service declared compliance with year 7 of the Maternity (Perinatal) Incentive Scheme Year 7 at Trust Board in January 2026.
    - **Experience & Feedback:** There has been an increase in complaints, primarily relating to communication, consistency of information and service reliability. Most complaints were addressed through local resolution, with themes identified and shared with relevant teams for targeted improvement. Despite the rise in complaints, the Friends and Family Test continue to show a high proportion of positive ratings, indicating that overall patient satisfaction remains strong. Ongoing efforts are being made to respond to feedback and complaints,

using them as valuable opportunities to drive service improvement and enhance the patient experience.

- **Operational Performance:** Maternity triage saw 1492 attendees, 51.1% of women were seen within 15 minutes, with data accuracy improving significantly since the BSOTS improvement project was implemented. No gaps were reported in the on-call medical workforce, and 100% consultant attendance at clinical incidents was achieved.

Recommendations

3. The Trust Board is asked to:

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

Perinatal Quality Oversight Model Report (January data)

1. Purpose

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

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

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

2. Background

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

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

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

3. Key Highlights – January 2026

3.1. There have been no Maternity Outcomes Signal System (MOSS) alerts for Oxford University Hospitals up to 31 January 2026, and all perinatal deaths and serious incidents have been reviewed through established national and Trust governance processes.

3.2. All MNSI and PMRT reporting requirements met.

3.3. Three cases reported to MNSI. There were no final MNSI reports received.

3.4. Unexpected term admissions to neonatal care: An increase to 5.8% of babies born was noted, representing a key safety focus. Early indications

suggest possible association with elective caesarean section pathways; a full review is underway with updates to governance committees.

3.5. Venous thromboembolism (VTE) assessment compliance: VTE completion within 14 hours fell to 82.6%, showing special-cause variation. A clear recovery plan is in place, including updated guidance, audit and Trust-wide communication, providing assurance of active risk management.

4. Maternity (Perinatal) Incentive Scheme (MPIS) Year 7

4.1. The Trust reported compliance with all 10 Safety Actions for MPIS year 7 to Trust Board in January 2026.

5. Perinatal Mortality Review (PMR) meeting

5.1. Four multidisciplinary case reviews were completed during January, across four PMRT meetings.

5.2. All four meetings were attended by an external reviewer and had representation from service user groups.

5.3. All concluded maternity PMRT cases were graded A or B, with no cases graded C or D, providing assurance that no significant care failings were identified.

6. Operational Performance

6.1. 51.1% of women were triaged within 15 mins of arrival in the Maternity Assessment Unit (MAU). This is a slight increase of 5.2% from the previous report. Since the start of the BSOTS project, data accuracy has improved to 95.8%.

6.2. There has been a reduction in induction of labour delays over 24 hours, improved use of on-call capacity, and no obstetric unit closures in January. Daily operational oversight and escalation processes continue to provide assurance during periods of high demand.

7. Workforce

7.1. The midwife-to-birth ratio remained stable at 1:23.47, with 100% compliance with 1:1 care in labour and supernumerary delivery suite coordinators on all shifts.

7.2. In January, the service had a vacancy of 14.3 WTE for midwives. This brings us above the Birth Rate plus establishment of 332 WTE. The vacancy for Maternity Support Workers is 9.64 WTE.

7.3. Midwifery and neonatal recruitment pipelines remain active, mitigating vacancy risk. Neonatal medical staffing remains compliant with BAPM standards, with risks managed through escalation and rota controls.

8. Training compliance

8.1. Mandatory multidisciplinary training (PROMPT, fetal monitoring, newborn life support) remains above 90% for most staff groups, supporting safe practice and national safety expectations.

8.2. PROMPT attendance showed a marginal decline in January for anaesthetic consultants to 78%. Consultants requiring attendance have been rebooked.

9. Complaints/Patient Feedback

9.1. Nineteen new complaints were received in January (including five historic cases), with recurring themes of communication, consistency of information and service reliability. Targeted actions are underway, including the development of a Patient Experience Lead role and pathway-specific improvements.

9.2. Patient feedback remains strong, with 95% of respondents rating care as good or very good and a high response rate compared to activity levels. Feedback frequently highlights compassionate, professional care across maternity and neonatal pathways.

10. Conclusion

10.1. 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.

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

10.3. 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.

11. Recommendations

11.1. 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.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Oversight Model Report including Dashboard

Presented at Maternity Clinical Governance Committee

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Date: February 2026

Data period: January 2026

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Oxford University Hospitals NHS Foundation Trust

Maternity Summary
January 2025

Oxford University Hospitals NHS Foundation Trust

1.1% (prev. 1.2%)
Blood Loss >1500mls for CS

2.87% (prev. 2.9%)
3rd & 4th (SVD+OVD births only) degree tears

↑28 (4.5%)
Freestanding MLU*

Horton 12
Chipping Norton 6
Wantage 4
Wallingford 6

Excellence Reports
↓11

↑36 **Unplanned Term Admissions to NNU**
(5.8%)
≥ 37 weeks

↑547 **Delivery Suite**

↑29 (4.7%)
Spires

Friends & Family Test:
95%
Good/Very Good feedback
Providing 71.5% response

626 Babies Born To 612 Women

↑3.6%

↑100%
1:1 Care in Labour
1:23.4
Midwife to Birth Ratio

↓ 39.9%
Caesarean Sections (CS)
Elective CS –109 (17.8%)
Emergency CS – 135 (22.1%)

↑ 25.5%
Inductions of Labour

↓667 Scheduled Bookings

19New Complaints

↓8 (1.3%) Home Births

93.59%
Breastfeeding Initiation

*MLU – Midwifery Led Unit

Neonatal Summary

Oxford University Hospitals NHS Foundation Trust

Milk Bank

↑74L Breast Milk Pasteurised

35L Sold/ £6.5k Profit

16 Donors Recruited

↑37 Preterm Admissions (46%)

< 27 weeks – 9 (11%)

27-36 weeks – 28 (35%)

↓19 Excellence Reports

↑43 Term Admissions (54%)

≥ 37 weeks

88% Born in the right place*

↓39% Say on the Day

↓1.3% Friends and Family Test

↑80 Admissions January 2026

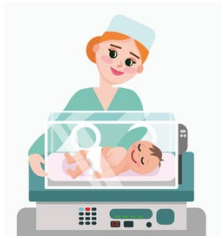
SONeT Southampton Oxford Neonatal Transport

↑33 Total Transfers

11 Emergency Uplifts

22 Non-Urgent

↓928 Care Days



Nursing Recruitment

0 Recruits

1 Leaver

Outreach Team

↓ 135 Home Visits

52 Babies Seen

↑ 4 Deaths

25+4/40 – Congenital Hydrops

34+1/40 – Fulminant NEC

38+1/40 – Cardiogenic Shock

39+5/40 – Complex Congenital

0 Complaints

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

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Scorecard (Exception Report and Dashboard)

1. Perinatal Quality Scorecard Summary

Oxford University Hospitals NHS Foundation Trust

Overview

A total of 612 mothers gave birth to 626 babies, and 667 scheduled antenatal bookings were completed. Caesarean sections accounted for 244 births, representing 39.9% of all deliveries. Midwifery led settings supported 65 births (↑10.6%), including 29 on the Spires, 12 at the Horton MLU, 6 at Chipping Norton, 6 at Wallingford, 4 at Wantage and 8 homebirths. There has been no Maternity Outcome Signal System (M.O.S.S) alerts for OUH up to the 31 January 2026.

Quality & Safety

During January, 259 maternity patient safety incidents were reported, with 74 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.

Three cases were referred to the Maternity and Neonatal Safety Investigations (MNSI) programme (one from December). Two cases were subsequently rejected following review, while one case involving an unresponsive postnatal term infant, has been accepted for full investigation

Outcomes

In January most births were unassisted vaginal births (296 cases, 48.4%) with 87 births (14.2%) assisted with forceps or kiwi cup; the remainder were caesarean sections.156 women were booked for an induction of labour (25.5%).
Of these, 9 women were affected by a delay of >24 hours. This is a significant decrease from the previous month. Delays in induction of labour were not found to be contributory factors in any adverse maternal or birth outcomes as reported below.

There were 11 reported cases of obstetric anal sphincter injury (OASI) (2.87% which is below the published UK national rate of 3.29%), during January. 8 occurred in unassisted vaginal birth, and 3 in assisted birth.

Postpartum haemorrhage (PPH) greater than 1.5 litres occurred in 23 (3.4%) cases which is comparative with the published UK national rate of 3.41% . Of these, 10 cases were associated with unassisted vaginal births, 5 with assisted vaginal births and 7 cases with caesarean birth.

There were 36 term babies who were unexpectedly admitted to special care, this equates to 5.8% as a % of babies born, an increase of 1.8% compared to the previous month.

Experience

In January 2026, the service received 19 new complaints, including 5 historic cases (relating to care over 12 months ago). The key recurring themes were communication concerns, feeling not listened to, staff attitude and behaviours, and issues relating to access, scheduling and service reliability. Feedback also highlighted inconsistent information sharing across the Maternity Assessment Unit, Induction of Labour and Infant Feeding pathways. These themes reinforce the ongoing need to strengthen the quality of communication between multi-disciplinary teams and service users and continue to actively listen and engage with women and birthing people to improve experience.

A total of 156 FFT responses and 281 'Say on the Day' responses were received, with 95% rating their experience as 'Very Good' or 'Good' and an overall response rate of 71.5% compared to the delivery rate.

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.

Workforce

The midwife-to-birth ratio for January remained at 1:23.47, this has remained stable since November 2025 and is achieved through increased clinical staffing and a reduced birth rate. Throughout the month, the service maintained full compliance with one to one care in labour, and the Delivery Suite coordinator remained supernumerary on all shifts.

The midwifery workforce establishment is now aligned to BirthRate+ staffing levels (332 WTE) with an additional uplift of 23 WTE to cover maternity leave, giving a total funded establishment of 355 WTE. In January, the midwifery workforce stood at 340.7 WTE, representing success in the SMART recruitment strategy and backfill into high maternity leave absence. The Maternity Support Worker vacancy was 9.64 WTE.

Recruitment pipeline and activity remains strong, with 6.72 WTE Band 5/6 midwives commencing in post during January with ongoing pro-active recruitment continuing.

Indicator Overview Summary – Maternity SPC Dashboard

ER

ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Jan 26	612	625			620	538	701
Babies Born	Jan 26	626	-			630	546	713
Scheduled Bookings	Jan 26	667	750			701	559	844
Inductions of labour (IOL)	Jan 26	156	-			152	109	195
Inductions of labour (IOL) as a % of mothers birthed	Jan 26	25.5%	-			24.6%	19.2%	29.9%
Spontaneous Vaginal Births SVD (including breech)	Jan 26	296	-			309	235	382
Spontaneous Vaginal Births SVD (including breech): a	Jan 26	48.4%	-			50.6%	43.6%	57.7%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Jan 26	87	-			86	56	117
Number of Instrumental births/Forces & Ventouse as	Jan 26	14.2%	-			13.9%	9.5%	18.3%
SVD + OVD Total	Jan 26	382	-			386	313	458

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Jan 26	244	-			221	180	263
Number of CS births as a % of mothers birthed	Jan 26	39.9%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Jan 26	135	-			130	95	164
Emergency CS births as a %	Jan 26	22.1%	-			20.5%	15.1%	25.8%
Number of Elective CS	Jan 26	109	-			101	61	142
Elective CS births as a %	Jan 26	17.8%	-			15.3%	10.8%	19.7%
Robson Group 1 c-section with no previous births a %	Jan 26	16.2%	-			13.8%	7.5%	20.1%
Robson Group 2 c-section with no previous births a %	Jan 26	62.9%	-			56.6%	45.3%	67.8%
Robson Group 5 c-section with 1+ previous births a %	Jan 26	82.1%	-			79.9%	62.9%	97.0%
Elective CS <39 weeks no clinical indication	Jan 26	1	0			0	-1	2

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Jan 26	109	109			109	109	109
Midwife:birth ratio	Jan 26	23.5	22.9			25.8	21.8	29.7
Maternal Postnatal Readmissions	Jan 26	9	-			9	-1	18
Readmission of babies	Jan 26	29	-			20	3	36
3rd/4th Degree Tears amongst mothers birthed	Jan 26	11	-			12	0	24
3rd/4th degree tears amongst mothers birthed as a %	Jan 26	2.9%	3.5%			3.0%	0.0%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Jan 26	8	-			8	-2	19
3rd/4th degree tears following unassisted Vaginal bir	Jan 26	2.1%	-			2.4%	-0.2%	5.1%
3rd/4th degree tears following an Instrumental vagin	Jan 26	3	-			3	-2	9
3rd/4th degree tears following an Instrumental vagin	Jan 26	3.5%	8.0%			4.2%	-2.7%	11.1%
PPH equal to or greater than 1.5L following an instrun	Jan 26	8	-			7	1	13
PPH equal to or greater than 1.5L following an instrun	Jan 26	1.3%	-			1.1%	0.1%	2.2%
PPH equal to or greater than 1.5L (Rate per 1,000)	Jan 26	34.3%	-			35.4%	19.3%	51.4%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Jan 26	6	-			11	0	22
PPH 1.5L or greater, vaginal (unassisted) births as a %	Jan 26	1.0%	2.4%			1.8%	0.2%	3.5%
PPH 1.5L or greater, caesarean births	Jan 26	7	-			7	-2	15
PPH 1.5L or greater, caesarean births as a % of mother	Jan 26	1.1%	4.3%			1.2%	-0.6%	2.9%
ICU/CCU Admissions	Jan 26	1	-			1	-1	2
% completed VTE admission ER	Jan 26	82.6%	95.0%			93.6%	88.8%	98.4%
Maternal Deaths: All	Jan 26	0	-			0	0	1
Early Maternal Deaths: Direct	Jan 26	0	-			0	0	0
Early Maternal Deaths: Indirect	Jan 26	0	-			0	0	0
Late Maternal Deaths: Direct	Jan 26	0	-			0	0	0
Late Maternal Deaths: Indirect	Jan 26	0	-			0	0	0

Indicator Overview Summary – Maternity SPC Dashboard

ER ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Jan 26	1	-			5	-2	12
Puerperal Sepsis as a % of mothers birthed	Jan 26	0.2%	1.5%			0.8%	-0.3%	1.9%
Stillbirths (24+0/40 onwards; excludes TOPs)	Jan 26	2	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Dec 25	4	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Jan 26	1	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Jan 26	4	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jan 26	3	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Jan 26	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Dec 25	2	3			2	-2	5
HIE	Jan 26	1	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Jan 26	6	-			9	0	18
Shoulder Dystocia as a % of babies born	Jan 26	1.0%	-			1.4%	0.0%	2.8%
Unexpected NNU admissions	Jan 26	36	-			25	8	42
Unexpected NNU admissions as a % of babies born	Jan 26	5.8%	4.0%			3.9%	1.2%	6.6%
Hospital Associated Thromboses	Jan 26	0	0			0	-1	1
Returns to Theatre	Jan 26	2	0			1	-2	5
Returns to Theatre as a % of caesarean section delive	Jan 26	0.8%	0.0%			0.7%	-0.9%	2.2%
Number of PSII	Jan 26	0	0			1	-2	4
Number of Complaints ER	Jan 26	19	-			10	-1	21
Born before arrival of midwife (BBA)	Jan 26	7	-			6	-2	14

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Dec 25	84.9%	85.0%			77.4%	66.5%	88.4%
Number Of Women Booked This Month Who Current	Jan 26	37	-			45	24	66
Percentage Of Women Booked This Month Who Curre	Jan 26	5.5%	-			6.4%	3.3%	9.5%
Number of Women Smoking at Delivery	Jan 26	32	-			31	14	48
Percentage of Women Smoking at Delivery	Jan 26	5.2%	8.0%			5.0%	2.1%	7.8%
Number of women with a live birth	Jan 26	608	-			606	511	701
Number of Woman with a live birth Initianing Breastf	Jan 26	569	-			527	391	663
Percentage of Women Initiating Breastfeeding	Jan 26	94%	80%			83%	75%	91%
Number of women booked by 10+0/40	Jan 26	423	-			425	234	616
Percentage of women booked by 10+0/40	Jan 26	63%	-			66%	56%	76%

What is the data telling us?

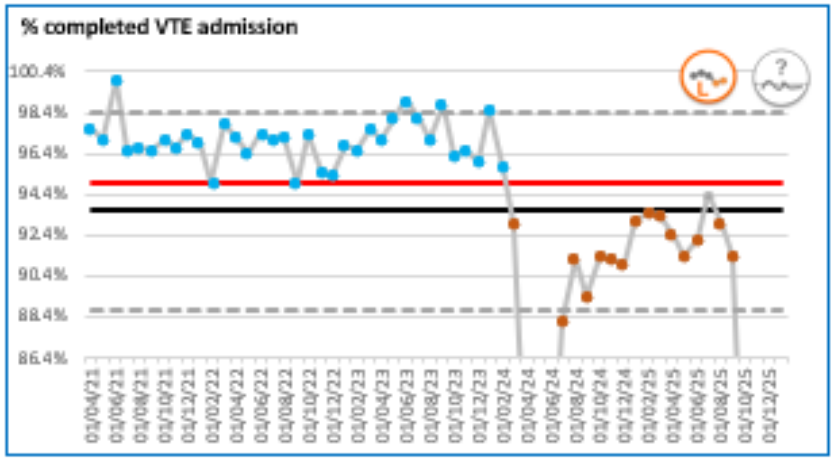
Exception Reporting highlighted for % of completed VTE assessments. Summary and Actions Slide 9

Exception Reporting highlighted for Complaints. Summary and Actions Slide 10

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

Maternity Exception Report

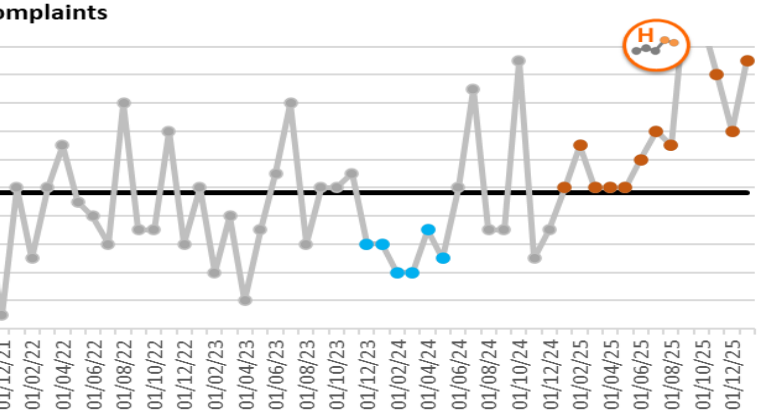
Oxford University Hospitals NHS Foundation Trust



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
% completed VTE admission shows special cause concerning variation	In January, the service's performance completion of VTE assessment within 14 hours of admission, decreased slightly by 0.2% to 82.6%. Targeted work continues to ensure a consistent improvement trajectory: • From January 14th 2026 Maternity guidance was updated to align to the Trust LMWH (Inhixa) prescribing guideline • Trust wide communications to all staff will continue to be sent out during February 2026 and this is followed up by maternity specific messaging through learning of the week and threaded through safety huddles and SBARRs. • Messages also include continued promotion of the use of CERNER to undertake risk assessments and targeted work is planned with inpatient and admitting areas during February to drive compliance. • Maternity representatives will attend the Trust wide VTE improvement group in February 2026 and align and feedback best practice improvement actions. • Monthly audit results are tracked, reported in Maternity performance, and reviewed by the Clinical Governance Committee. Exceptions are handled by the Patient Safety team, with immediate actions like sharing weekly learning and updating safety boards as needed.	Continuous audit of VTE assessment completion. Monthly audit results are tracked, reported in Maternity performance, and reviewed by the Clinical Governance Committee. Exceptions are handled by the Patient Safety team, with immediate actions like sharing weekly learning and updating safety boards as needed. Next review: February 2026.	n/a	n/a

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
Number of complaints shows special cause concerning variation	19 new complaints were received in January, 5 related to related to care delivered more than 12 months ago. The service continues to respond promptly to complaints, engaging directly with complainants and involving both rapid responders and the maternity patient safety partner to ensure compassionate, service user-centred responses Themes identified this month included women and birthing families experiencing inconsistent or conflicting information sharing around Maternity Assessment Unit, Induction of Labour and Infant Feeding pathways. Additional concerns related to unhelpful or unprofessional interactions, judgemental language or feeling dismissed alongside distress from uncertainly around caesarean section bookings and inconsistent coordination when escalated. To address these and support the responsive strategy, a Patient Experience Lead role has been developed and is expected to be advertised for recruitment by the end of February 2026. These themes underscore the continued importance of enhancing communication quality among multi-disciplinary teams and service users, as well as maintaining active listening and engagement with women and birthing people to improve their experiences. To build on these efforts, a follow-up communication was distributed in January to all participants and contributors of the open engagement event. Additionally, throughout February and March, the service will leverage established community channels to gather feedback on the experiences, needs, and preferences of service users and the broader community.	Several targeted initiatives were launched in January in response to feedback. Infographics were created for the Maternity Assessment Unit, making average wait times more transparent and enhancing the patient experience. The required training week now also covers communication skills and active bystander modules. Efforts continue to address persistent concerns and to ensure improvements are meaningful and long-lasting. Progress is regularly shared with relevant governance committees.	N/A	N/A

Oxford University Hospitals NHS Foundation Trust

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

Title	Description	Initial Rating	Current Rating	Target Rating
Missed referrals for preterm birth referrals (3230)	Without timely specialist preterm birth care for women with high and moderate risk factors, appropriate assessment, action and mitigation of these risks cannot be undertaken, which could potentially lead to extreme preterm birth. Following the transition to BadgerNet, where referrals are not automatic or prompted, there has been a significant increase in the number of missed referrals to the fetal medicine team (preterm specialist team) for women with high and moderate risk factors for preterm labour and birth for cervical length screening.	**20**	**20**	**12**
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.	**20**	**15**	**5**
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**
Maternity Access Team (2920)	Inadequate staffing of midwifery access team – impact on clinical activity and clinical staff being used to deliver admin tasks. Lack of cover for urgent and priority phone lines for maternity, including ultrasound, maternal medicine, fetal medicine and day assessment. Current work to address included revieing all flexible and WFH contracts and requests and targeted recruitment.	**20**	**9**	**4**
Drug Room Temperatures (Level 5) (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**	**8**
Increased volume and delays in IOL processes (2428)	Increase in demand for IOL slots. This impacts on bed capacity, midwifery staffing (women requiring 1:1 labour care). Impacts on patient experience if care is delayed.	**16**	**12**	**4**

Oxford University Hospitals
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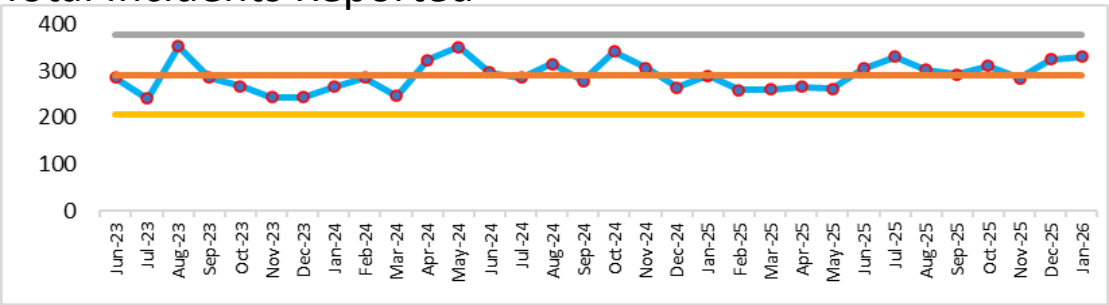
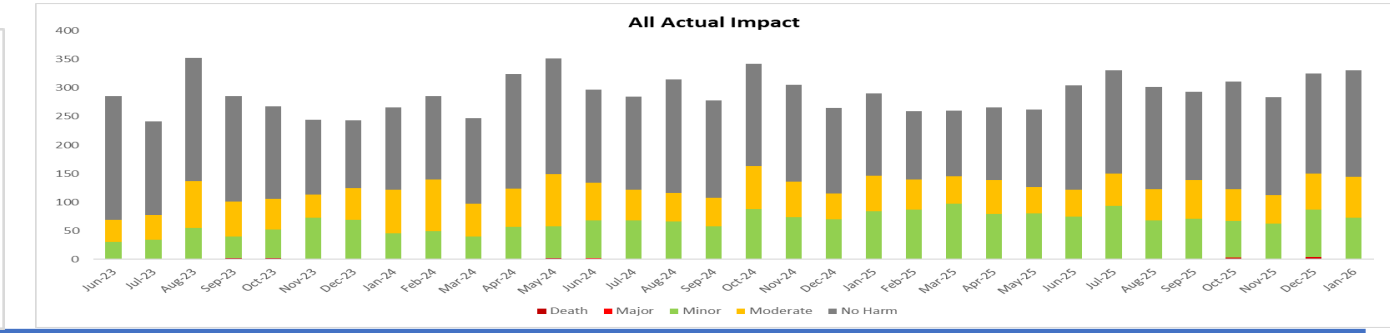
Perinatal Safety

Perinatal Safety - Maternity Incidents

Oxford University Hospitals NHS Foundation Trust

Total Incidents Reported





SUMMARY

Summary of Data

- In January, a total of 259 patient safety reports were submitted via Ulysses. Of these, 73 were reported as moderate harm and one as a death (intrauterine death). These accounted for 28% of all patient safety incidents, an increase of 3% from the previous month.
- Among the 73 moderate harm incidents the following causes were recorded: 1 bladder stretch/urinary retention, 11 third degree tears, 23 postpartum haemorrhages, 2 return to theatres, 35 unplanned term admissions to SCBU and 1 admission to ITU.
- The death was an intrauterine death (IUD) at 25 weeks following a premature rupture of membranes (PROM). The patient was admitted to ITU with Sepsis.
- The number of term admissions to the neonatal unit increased by 1.8% from December to January to 5.8%. Early indications are that this may be associated with elective caesarean sections, a full review is ongoing and an update will be provided at MCGC in March.

Strengths

- The high 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 76 being overdue at the end of the reporting period. 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

- Noted increase in ATAIN cases, thematic analysis to be undertaken.
- There has been an increase in readmissions for jaundice, in response tea trolley training on recognising and monitoring jaundice levels have been mobilised by the practice development team with a focus on diverse skin tones.

Future

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

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

Oxford University Hospitals NHS Foundation Trust

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

PMRT Reporting and Learning

- All cases that met the criteria in January 2026 were reported to MBRRACE, in line with national requirements.
- Four multidisciplinary case reviews were completed during January, across four PMRT meetings.
- PMRT meetings are held weekly, and an external reviewer was invited to every meeting, in line with MPIS requirements. All four 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 January, three cases were referred to the Maternity and Neonatal Safety Investigations (MNSI) programme. Two cases were not accepted following review, and one case met the national criteria for full MNSI investigation.

- Accepted case:
  - Unexpected neonatal collapse 1 hour post-birth, required full resuscitation and therapeutic cooling.
- Rejected cases:
  - Placental abruption with emergency caesarean section (CS).
  - Poor neonatal condition post-birth but no evidence of hypoxic-ischaemic encephalopathy (HIE)

Learning from Maternity PMRT Reviews

Four cases were concluded in January. All were graded either A or B, meaning care was safe and appropriate. There were however some areas for improvement identified. There were no cases graded C or D.

Summary of Cases

- **Case 1**: A woman was transferred from Stoke Mandeville Hospital (SMH) for threatened preterm labour. Baby was born at 22+1 and received care on the neonatal unit until they sadly died on day 25. This case was graded B for care up until the birth of the baby, as it was acknowledged that communication between consultants at SMH and OUH could have been improved. Care in the postnatal period was graded A.
- **Case 2:** Intrauterine death (IUD) at 23+1 following admission for threatened preterm labour. Care prior to diagnosis of IUD was graded an A. Care following diagnosis was also graded A.
- **Case 3:** Intrauterine transfer from Milton Keynes for PPROM. Decision for induction of labour due to maternal chorioamnionitis. Care was graded a B up until the point of birth due to multiple transfers between MAU, Level 6 and Observation Area and delay in chasing blood results. Care in the postnatal period was graded B due to a lack of clarity from the obstetric review prior to discharge.
- **Case 4:** MDA twins under joint care with Wexham Park Hospital (WPH). Twin to Twin Transfusion Syndrome diagnosed with 21% growth discordance. Post laser TAPS diagnosed at 24/40, parents attended for selective termination of pregnancy (TOP) 24+6 and diagnosis of twin 1 IUD was made at this appointment. Both twins delivered at 32+2, twin 2 now discharged home with parents. Care of mother up to the diagnosis of IUD was graded an A. Care following diagnosis was also graded an A. Good collaborative care between teams was identified as good practice.

Key Learning and Actions

- **Escalation pathway for postnatal MEOWS:** Learning was disseminated to the obstetric team regarding postnatal reviews for women who score on MEOWS.
- **Intrauterine Transfer Checklist:** Preterm Specialist Midwife will be relaunching the intrauterine transfer (IUT) checklist to encourage digital usage.

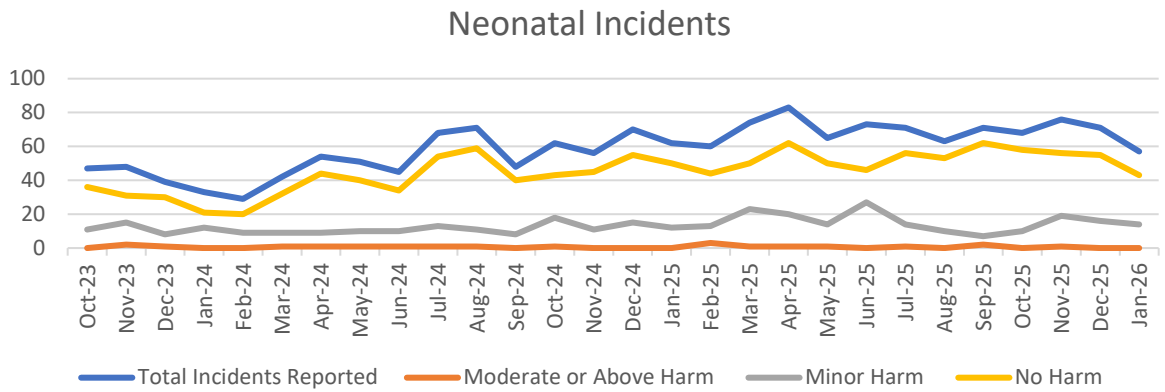
Both of these actions have been completed.

Assurance to the Board

- All cases were reviewed and reported appropriately through the Trust's governance process.
- No cases were identified as having significant failings in antenatal or intrapartum care.
- Actions have been taken to address identified improvement areas.
- Shared learning has been cascaded to relevant teams to prevent recurrence.

Perinatal Safety - Neonatal Incidents

Oxford University Hospitals NHS Foundation Trust



Summary of Data

- In January, 57 patient safety incidents were reported via Ulysses. Of these, 14 were classified as resulting in minor harm. No incidents were associated with moderate or above harm.
- The main causes of minor harm incidents included medication issues, unexpected patient deterioration, and documentation and records.
- The graph above outlines that over the past two years, the Neonatal Unit has seen an overall rise in total incident reporting, driven mainly by an increase in “no harm” events. The number of incidents resulting in harm remains low and stable, typically under 20 per month. This pattern reflects a strong safety culture where staff are empowered to report all events, enabling 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
NHS Foundation Trust

Maternity Operational Activity

Maternity Operational Activity

Oxford University Hospitals NHS Foundation Trust

Summary

Summary of Data

- 612 mothers birthed in January which is an increase of 3.73% from the previous month.
- In January, 5.8% of all community births took place in community settings, including Freestanding Midwifery Led Units (FMLU) and homebirths. Activity across these settings remained safely managed, supported by established escalation pathways and oversight from the maternity leadership team.
- Seven women transferred from the midwifery led units (MLU) and homebirths into the John Radcliffe hospital. All transfers were appropriate, timely and aligned with established escalation pathways, providing assurance that safety-critical decision-making and risk management processes are functioning effectively.
    - Horton MLU: three transfers (pain relief, fetal heart rate concerns, delay in second stage)
    - Chipping Norton MLU: one transfer for meconium
    - Homebirth: one transfer for fetal heart rate concerns and meconium: out of guidance (OOG) birth flagged for review.
    - Wallingford MLU: Two transfers (meconium; raised BP/BMI with birth before arrival during the ambulance transfer)
- In January, on-call utilisation decreased, with 116.75 hours of on-call time used compared with 211.55 hours in the previous month. Within this total, hospital on-call usage decreased from 121.3hours to 96.25 hours, demonstrating the service's ability to flex resources to meet clinical demand and ensure safe staffing during periods of heightened activity. Conversely, community on-call usage reduced significantly, from 90.25 to 20.5hours, reflecting improved capacity management and appropriate escalation processes within both hospital and community settings. The community team contributed three hours of day on-call and 17.5 hours of night on-call, ensuring continuity of service provision and timely support to both planned and unplanned care needs.
- There were 9 induction of labour (IOL) delays exceeding 24 hours, an ongoing significant reduction from previous months, demonstrating early positive impact from ongoing improvement work. Monitoring at earlier thresholds shows that 24 women experience delays between 6-12 hours, and 24 women experienced delays between 12-24 hours, both of which remain consistent with patterns seen in previous months.
- MAU managed 1492 attendances which is an 8.35% increase from the attendances in December. 51.1% of women were seen within 15 mins for initial triage. This is an improvement of 5.2% from the previous month.
- There were no closures of the obstetric unit.

Strengths

- There was a significant reduction in the number of delayed inductions over 24hrs. These delays continue to be closely monitored through daily operational oversight.
- The reduction in on call hours utilised reflects effective deployment and strengthened oversight of staffing resources across maternity services.
- 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 98.8% of cases, providing assurance that risk identification and mitigation processes are robust.
- Additionally, place of birth suitability was recorded as per Ockenden requirements at 86.5% which is a positive position for the service

Focus

- The service will continue to closely monitor staffing, patient flow, and capacity through daily staffing meetings, ensuring timely escalation and proactive management of risk.
- A quality improvement programme is underway to 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 is addressing induction of labour (IOL) processes and patient experience, with improvement actions monitored through the Perinatal Improvement Programme.
- The National Maternity Operational Pressures SitRep (NMOPS) was implemented on the 15 December 2025. This replaced the current Sitrep report and the daily BOB LMNS Safety Huddle. Submission of data will be required by 11:30am, 7 days a week, to help produce a daily OPEL status.

Future

- 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.
- A Birthrate+ review has been commissioned and commenced in November 2025, providing an independent assessment of workforce requirements to inform future planning, due to complete in Q4 2025/26
- Training is ongoing for the delivery of a 24-hour bleep holder role that will strengthen operational oversight and escalation management. Launch is planned for Q4 2025/26

Oxford University Hospitals
NHS Foundation Trust

Maternity and Neonatal Workforce

Workforce -Maternity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- The current Midwife to birth ratio is 1: 23.47 - a midwife-to-birth ratio indicates how many births a midwife is responsible for, aiming to ensure safe, quality care supporting 1:1 care in labour. The ratio has been static since November This correlates with increased available clinical staffing and reduced birth rate.
- There were no occasions when the Delivery Suite (DS)coordinator was not supernumerary. There were no occasions where the service could not provide 1:1 care in labour.
- The midwifery workforce establishment is now aligned to BirthRate+ staffing levels (332 WTE) with an additional uplift of 23 WTE to cover maternity leave, giving a total funded establishment of 355 WTE.
- In January, the midwifery workforce stood at 340.7 WTE, representing a true vacancy of 14.3 WTE.
- Recruitment pipeline and activity remains strong, with 6.72 WTE Band 5/6 midwives commencing in post during January with ongoing pro-active recruitment continuing.
- The vacancy for Maternity Support Workers is 9.64 WTE
- There has been 100% attendance by consultants at clinical incidents as per RCOG guidance.

Strengths

- Midwifery workforce stood at 340.7 WTE, representing a true vacancy of 14.3 WTE.
- Recruitment pipeline and activity remains strong, with 6.72 WTE Band 5/6 midwives commencing in post during January
- Ongoing pro-active recruitment
- 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.
- Significant decrease in amount of on-calls hours November – January used for hospital and community staff since increased substantive staffing levels

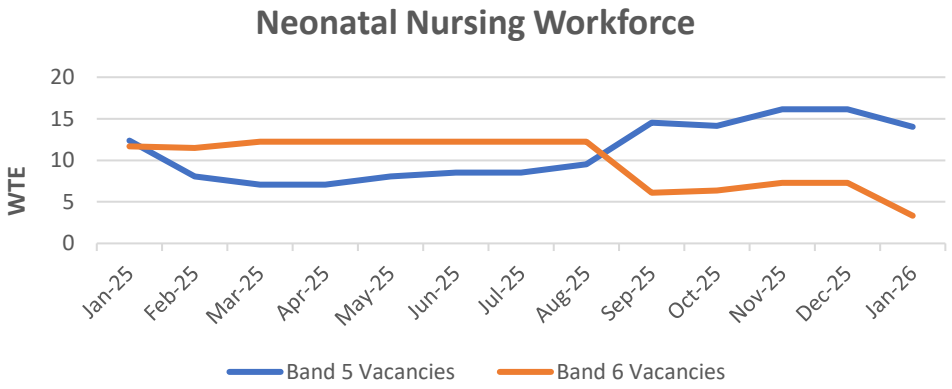
Focus

- Any short notice gaps in the roster are mitigated through tactical staff redeployment and NHSP with shifts proactively released to maintain safe staffing levels for both registered and non-registered staff.
- 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.
- Chief Nursing Establishment review to be undertaken during February
- Birthrate plus establishment review draft report expected end Q4 2025/26
- Preceptee midwife recruitment for Autumn 2026 starting in Spring 2026
- Continuous and consistent provision of 1:1 care in labour and supernumerary status of 2nd DS coordinators - targeted communication and education programme now in place.
- Return-to-work interviews supported by HR, providing assurance that staff wellbeing and compliance with policy are 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

- 5.00 wte middle grade vacancies currently being recruited to. Interviews took place and appointments made at the end of January, with HR checks underway. Start dates TBC.
- Current gaps on middle grade rosters resulting from vacancies have been escalated to the Division and wider Trust, mitigated by extra shifts filled via Patchwork and consultants needing to step down where needed.
- MediRota is now reviewed monthly by directorate team with the aim to achieve compliance with the six-week leave policy and maintaining oversight of session planning and rota integrity.
- Medical staffing escalation SOP under development – draft shared with consultant colleagues.
- 1x Consultant recruited to support additional high risk antenatal clinics at the Horton. Start date: March 2026.
- All consultants within the service are currently job planned and all job plans are up to date. As per Trust's directive, the directorate team is currently exploring the concept of departmental job planning
- An updated BirthRate Plus review has been commissioned and commenced in November 2025, providing an independent assessment of workforce requirements to inform future planning and resource allocation. Report due by end of Q4 2025/26.
- Innovative succession planning and development opportunities are being implemented, including short courses and apprenticeship programmes, to build leadership capability and future workforce resilience.

Workforce – Neonatal Nursing Workforce



Summary of Data

- In January, there were 3.33 WTE Band 6 and 14.01 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

- 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.
- Currently, we have six Band 5 nurses in the pipeline awaiting a start date and further interviews for Band 5 and Band 6 nurses are planned for February 2026.
- Positive feedback from student nurses requesting final year placements in view of wishing to come and work in Neonates once qualified.

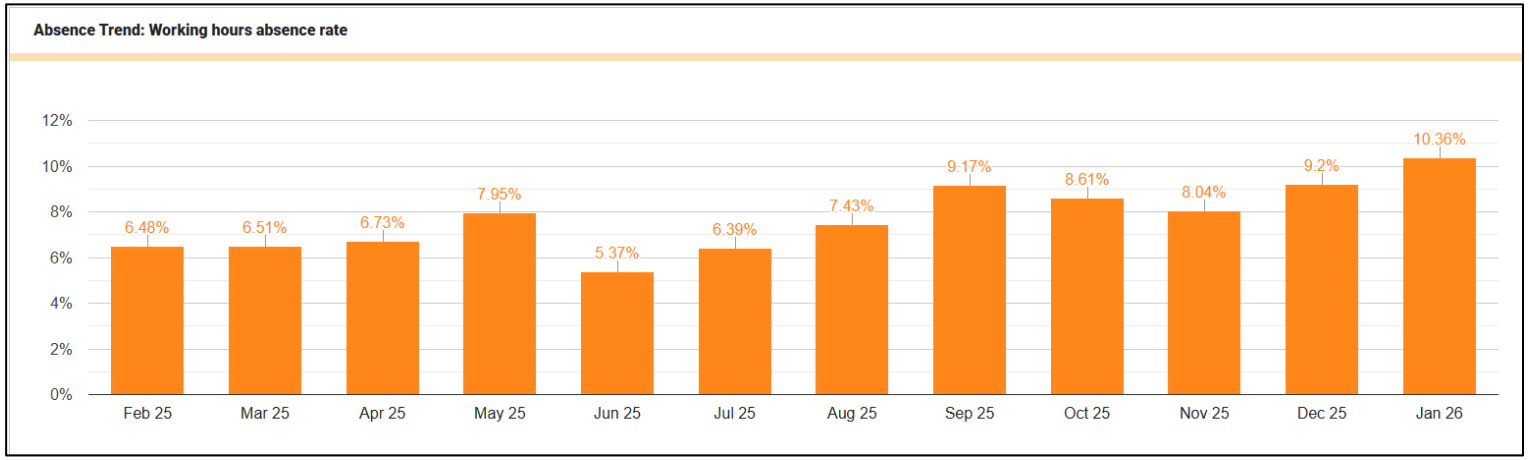
Focus

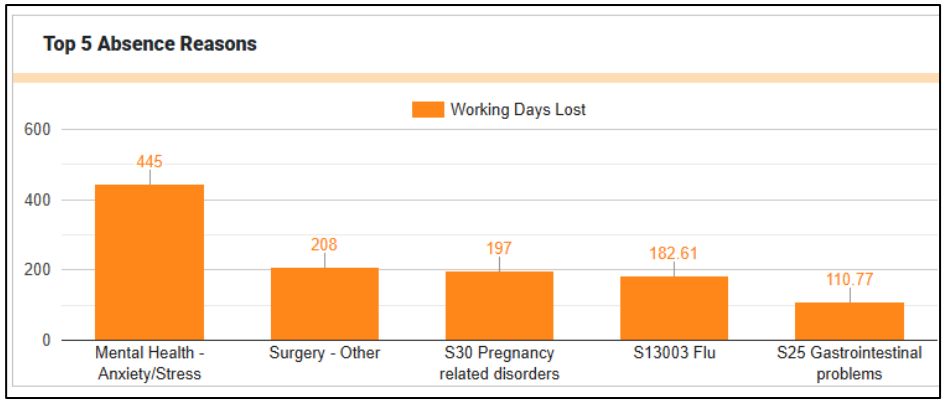
- Development programmes for Band 6 and Band 7 staff are being implemented to build leadership capability and support career progression, contributing to workforce stability and retention.
- The Unit Ethos continues to be embedded across teams, reinforcing a culture of safety, collaboration, and excellence.
- 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

- Plans underway for dedicated graduate recruitment days in 2026 to attract newly qualified nurses, helping to build a stronger, more sustainable workforce pipeline and address existing vacancy gaps.

Workforce – Neonatal Nursing Workforce





Summary of Data

- Sickness absence rates for January were 10.36%, reflecting an increase from previous months. However, one long-term absence—which accounted for a significant proportion of working days lost—was closed at the end of January following a successful return-to-work process.
- Notably, mental health-related absences—particularly those linked to anxiety and stress—continue to represent a significant proportion of overall sickness. This trend is being closely monitored, with targeted interventions in place to address underlying causes and support staff wellbeing.
- The current compliance rate for the timely completion of return-to-work interviews is 40%, representing a decline compared with the previous month. This reduction is attributable to sustained operational pressures and the need for clinical staff to prioritise direct patient care during periods of heightened activity and acuity, which has temporarily limited capacity for completing non-clinical tasks.
- Absence data is reviewed monthly at divisional governance meetings, ensuring that any emerging risks are promptly escalated and addressed within a robust governance framework.

Strengths

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

Focus

- Timely and effective return-to-work interviews will continue to be prioritised in line with the Trust's sickness management procedure, ensuring compliance and consistency across all teams.
- Administrative time for line managers continues to be rostered and is reviewed regularly to ensure they are able to take their allocated hours, recognising that clinical duties will always take priority during periods of increased operational pressure.
- Staff wellbeing support is actively promoted, including access to occupational health and EAP.
- Additionally, our Professional Nurse Advocates (PNA) have protected time to focus on providing wellbeing support and restorative clinical supervision to staff.

Future

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

Data collected from Goodshape Central

Workforce – Specialist Training (Neonatal)

Oxford University Hospitals NHS Foundation Trust

Qualified in Speciality (QIS) Training - Target 70%	2023	2024	2025	2026	2027	2028	2029
Compliance	42%	46%	48%	48%	72%	84%	96%
				Correct as of 11th February 2026	Prospective Data		

Summary of Data

- Current compliance with BAPM standards for Qualified in Specialty (QIS) training is 48%, but the service is actively addressing 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.

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 are scheduled to start in February 2026.
- This upward trajectory demonstrates a strong commitment to workforce development.
- Approval to externally advertise for band 6&7 post which 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.

Workforce – Neonatal Medical Workforce

Oxford University Hospitals NHS Foundation Trust

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

- Consultants - 12WTE (includes 3 Locum)
- Resident doctor's workforce established 39 WTE (following BS in 2025)
    1. Current gaps – 3 WTE
    2. 18 WTE deanery
    3. 19 MTI trainees – resident medical doctors
    4. 2 ANNPs

Summary of Data

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

Strengths

- The budget for 39 WTE medical rota positions for the resident medical doctor workforce has been confirmed, ensuring financial stability and alignment with the approved business case.
- Recruitment activity is progressing as planned, with clear milestones in place to achieve full establishment by March 2026. The current pause in recruitment will impact our safety compliance if posts are not approved for recruitment via the established escalation pathways.

Focus

- The service will convert locum consultant posts into substantive positions to improve workforce stability, continuity of care, and long-term resilience. Recruitment plans are in place, and progress will be monitored through divisional governance.
- Although recruitment is currently on hold, we have a process in place to make sure staffing remains safe. Where posts are essential, we will escalate them through the agreed exception reporting route. This approach will help us meet all anticipated MPIS requirements for safe staffing in 2026.

Future

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

Perinatal Training

Oxford University Hospitals NHS Foundation Trust

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

Summary of Data

- The data is collected on a monthly basis
- Patient Group Directive (PGD) compliance is 74%
- Oliver McGowan Part 1 is 82%.
- Training compliance for neonatal nurses is above the target of 90%.

Strengths

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

Focus

- Attendance of anaesthetic consultants at PROMPT in Jan is <90% . Consultants requiring attendance are all booked on.
- Moving and Handling training compliance: 74% - dates planned monthly, and staff reminded to complete the e-learning as well as attending practical sessions.

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
- Staff in Maternity are given protected time to undertake their e-learning as part of their training week however they are aware that if staffing is low, they could be told to work clinically instead.

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	→78.%
Core Skill - Information Governance and Data Security	↓83%
Core Skill - Moving and Handling Level 2	↓74%
Core Skill – Resuscitation Level 1	↓81%
Core Skill - Resuscitation Level 2, 3 OR 4	→84%
Core Skill - Safeguarding Children Level 3	↔86%

Core Skills Modules below target	Neonatal Unit
Core Skill - Information Governance and Data Security	↔86%
Resuscitation Level 1	↔81%
Core Skill - Safeguarding Children Level 2	↔84%

PROMPT	Midwives	94%
	Nurses working in maternity	90%
	MSW's	92%
	Consultant Obstetricians	100%
	Trainees ST1-7	94%
	Obstetric anaesthetic consultants	78%
	All other anaesthetic doctors who contribute to obstetric rosters	100%
Fetal Monitoring	Midwives	94%
	Consultant Obstetricians	96%
	Trainees ST 1-7	97%
Newborn Life Support	Midwives	95%
	Neonatal/Paediatric: Consultants Junior neonatal Dr's (who attend births) ANNP's	 100% 94% 100%
	Neonatal Nurses	95%

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Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions Year 7 : reporting period 1st April 2025 – 30th November 2025

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Oxford University Hospitals NHS Foundation Trust

Safety Action	RAG	Comment
1: Use of Perinatal Mortality Review Tool		Quarter 2 Perinatal Mortality Review report went to Trust Board in January 2026. Ongoing reporting and monitoring of all cases is business as usual despite end of reporting period.
2: Submitting data to the Maternity Services Data Set		CNST scorecard validation received.
3: Transitional Care and Avoiding Term Admissions to Neonatal Unit		Transitional Care Unit (TCU) requirements met – quarterly audit to demonstrate compliance with guideline on Ulysees. ATAIN QI project ongoing.
4. Clinical workforce planning		Action plan in place and continuously monitored for neonatal nursing QIS.
5. Midwifery workforce planning		Action plan in progress following Q2 midwifery staffing report. Is closely monitored by red flag data.
6. Saving Babies Lives Care Bundle		Q2 review with LMNS fully compliant. All requirements of safety action have been met. SBL regional exemptions submitted to LMNS, awaiting submission to region. Monitoring ongoing – Q3 review scheduled with LMNS for 11th February 2026.
7. Listening to women, parents and families		Current interim MNVP lead.
8. Multidisciplinary training		Training percentages monitored on ongoing basis.
9. Board oversight on safety and quality		Standard continues as business as usual.
10. MNSI and Early Notification Scheme reporting		Standard continues as business as usual.

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

Summary

Summary of Data

- In January 2026, the service collected feedback from service users through two platforms: The Friends and Family Test (FFT) and 'Say on the Day' devices. 156 responses were received from FFT and 281 from 'Say on the Day' devices, this combined feedback rated the service 95% Very good or good with an overall responses rate of 71.5% when compared to delivery rate.
- In January 2026, 19 new complaints were received with 5 of these classified as historic (related to care delivered more than 12 months ago).
- The three key recurring themes centred on; communication and not being listened to, staff attitude, values & behaviours as well as access, scheduling and service reliability issues. Women and birthing families highlighted inconsistent or conflicting information around Maternity Assessment Unit, Induction of Labour and Infant Feeding pathways. Additional concerns related to unhelpful or unprofessional interactions, judgemental language or feeling dismissed alongside distress from uncertainly around caesarean section bookings and inconsistent coordination when escalated.
- These issues underline the need for continued focus on improving communication standards and continued collaboration with our birthing population. We continue to proactively engage with our service user to better understand their experience and where improvement can be made via listening to and responding to service user feedback.

Strengths

- Feedback across January reflects overwhelmingly positive patient experience within maternity services, with consistently strong praise for the compassion, professionalism, and reassurance provided by midwives, MSWs, medical staff, and specialist teams across community, intrapartum, and postnatal care.
- Women frequently reported feeling listened to, safe, well-informed, and supported in their birth choices, including during complex labours, breech births, and high-risk pathways. Notable strengths include excellent breastfeeding support, high-quality vaccination services, and continuity of care in community teams.
- Overall, the feedback highlights exceptional individual care delivered, underscoring both staff commitment and the need for continued focus on workforce resilience and operational flow.

Focus

- Areas requiring attention centre on system pressures: delays due to capacity constraints, inconsistent communication during long waits, environmental challenges on the postnatal ward, and strains on staffing that affect timeliness of support at night.
- The 2025 CQC Maternity Survey was published on the 10 December 2025. There is a planned review meeting with the OMNVP, on the 06 February 2026 to co-create the action plan in response. This will be reported at the TALC meeting in March and then to MCGC.

Future

- Gain access to additional clinical rooms on MAU to improve flow and access to CTG monitoring to prevent unnecessary waiting times.
- Review night shift staffing model for postnatal ward
- Continued awareness through antenatal, intrapartum and postnatal pathways of infant feeding support through patient information portal, delivery of face to face sessions and self-referral for infant feeding support.

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

Oxford University Hospitals NHS Foundation Trust

Summary of Data

- A revised approach to the Friends and Family Test (FFT) was successfully launched in Neonates in May 2025, providing a structured mechanism for capturing patient experience. In January, one response was received which is a reduction from the previous month.
- While the response rate remains low, mitigation measures are in place including repurposing 'Say on the Day' devices to capture real-time feedback, which has yielded positive written comments. A more robust plan is being implemented from February involving the admin team to support service user engagement on a regular basis.
- No complaints were received in the month of January.

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.
- A positive improvement was sustained in January, with 31 family responses captured via the Say on the Day devices, representing 39% of all admissions. Overall experience was rated 7.2/10, demonstrating that families continue to report a good standard of care. The service continues to monitor real-time feedback daily, with prompt escalation processes in place should any concerns arise. Current data provides robust assurance that patient and family experience remains positive and that the team's improvement actions are having a measurable impact.
- Positive responses are seen through both feedback platforms. Recognition of supportive staff and kindness and compassion is expressed throughout.
- Comments consistently highlight exceptional care, kindness, and professionalism, with examples such as "*amazing lovely staff*" , "*we are happy*", and "*staff were nice and accommodating*".

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

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

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, more timely, 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)
- Additional CTG machines to be relocated to MAU rooms to support flow and reduce waiting times by end of March 2026
- Service user infographics now displayed each month with specific message on mean wait time
- Two new medical posts (total of 3.00) on TRAC going through approval process – require exemption from recruitment freeze by end December 2025
- Mobilise Ipads for documentation (focus on initial triage data capture) by end March 2026.
- Plan to implement 'Perfect Week' utilising additional member of clinical staff between peak times to reduce waiting times by end March 2026

Future

- BOB LMNS Mamas Triage line externally sited (ICB led)
- Education triage competency package review including E-learning package for telephone triage competencies by end Q4 2025/26
- Development of policy to govern use of ongoing call analysis from monitored and recorded calls
- Explore the feasibility of air conditioning in clinical rooms
- Consider QI project focused on senior decision maker being present at all times (aligned to ED QI project)
- **Progress monitored and reported through MCGC**

IOL QUALITY IMPROVEMENT: SUMMARY

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

Focus

- Continued dynamic daily risk assessment to inform operational staffing decision making in response to potential delays
- Map outcomes to those undergoing IOL and add to reporting by end Q4 2025/26 (Included in January PQOR patient safety update)
- Report quantitative improvement trajectory aligned to recent interventions and actions – reporting template to be developed by end January 2026.
- MDT consultation on updated risk assessment launched January 2026
- IOL 'ward round' to commence daily from 16th February 2026, compliance measured through daily safety huddle
- Continued dynamic daily risk assessment to inform prioritisation and planning
- Service user feedback survey to be developed by end of February 2026 to measure improved communication

Future

- Extraordinary MDT IOL meeting held on 6th January 2026, agreement gained to consider Misoprostol as alternative induction method – business plan to be drafted by end of March 2026.
- Review of service user education throughout the pathway 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 & Using Local Data to Address Inequalities - staff and service user

Oxford University Hospitals NHS Foundation Trust

Jan 2026 Updates:	Activity	Total Encounters
Translated Antenatal classes	Languages: Tetum, English, Oromo	13
Digital Inclusion support	Free preloaded Sim cards	2
	Donated mobile phones	0
EDI Working group	Monthly	2
Staff consultations-ad hoc	Enquiries	15
	Concerns	0
Clinical & Non clinical Staff: Active Bystander Training	Complete attendance	44
	Partial attendance	0
Health inequalities projects	Access to Screening Audit	The next data set will be available in April 2026. Screening access: Bookings beyond 14+1 weeks were audited, results shared, and poster consultation completed with staff, service users, and OMI. Dissemination is complete. A repeat audit is planned for April 2026.
	Patient Information Videos	Voicing of first 4 animations booked for 1st and 2nd week of March. Resources will be voiced in Tetum with English subtitles. Animations to be created by OMI.
	Tackling Bias amongst Staff QI	The QI project is live on Ulysses QI 10530, with a deadline of March 2026. This work is also highlighted via the Perinatal Improvement Programme (workforce stream) for further follow-up.
Community engagement monthly (pregnant & new mothers)	AFIuk	0
	East Oxford Stay & Play (1 session)	6
Total		**82**

- The Maternity EDI service works to reduce unfairness by focusing on Equity, Diversity and Inclusion (EDI).
- We listen to workforce feedback to spot where some staff may be disadvantaged and take action to fix this.
- We also listen and audit service user data to understand any barriers different groups face when accessing maternity care.
- Our aim is to make sure both staff and service users have a fair access to support, opportunities and a positive environment.
- We use what we learn from data and feedback to make practical changes and improve inclusion for staff and families.

EDI: Collecting & Using Local Data to Address Inequalities – Staff Experience

Oxford University Hospitals
NHS Foundation Trust

HOW MATERNITY EDI (EQUITY| DIVERITY|INCLUSION) SUPPORTS YOU

Translated Antenatal Classes and Unit tour
- Multi-lingual & at Florence Park
- Refer via BadgerNet/EPR/Email
- Second evaluation ongoing

Ongoing Active Bystander Workshops:
- Now mandatoryfor all OUH staff, both clinical and non-clinical
- Impact evaluation in progress with Health Innovation Oxford and Thames Valley – for maternity

Maternity Audits: Screening - focus on access:
- Look out for 'Book by 10' posters in GP waiting rooms, children centres, pharmacies, and churches near you.
- If you have not seen any, please collect a printed copy from the EDI office (Level 4, JR) or request one to be posted to your hub.
- Coming soon: 'SOP: Identification and Provision of Antenatal and Newborn Screening Information in Accessible Formats'

Neuro-inclusion, Disability & Aaccessibility conversations:
- Continuing 1:1 and group support.
- Trust Reasonable adjustments policy now live

Engagement:
- For support or questions, email: EDImidwives@ouh.nhs.uk
- Outreach visits: Flo's, AFiUK, East Oxford Stay and Play
- Join your Maternity EDI working group
- Connect with Trust Staff Networks for additional support

Digital inclusion funded by 'Good Things Foundation':
- Provision of free pre-loaded SIMs and mobile phones for eligible women and birthing people (see SOP: Databank Sim Cards)
- Refer via BadgerNet, EPR, or Email
- In collaboration with Digital Midwives and Public Health Matron

Tackling bias & discrimination:
- Continuing 1:1 and group support.
- Ongoing QI project: 'Tackling Bias to improve staff Inclusivity and Cultural Safety in Maternity'

Patient Information 'Animations' (PIAs) - Burdett Grant Project:
- With Consultant Brenda Kelly, Maternity Clinical Governance, OMI and OUH communications
- Production of resources voiced in Tetum with English Translation

Staff EDI resources:
- Find a wide range of EDI materials and useful links on the Maternity EDI SharePoint page.

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National Updates

Maternity Outcomes Signal System (MOSS)

Oxford University Hospitals NHS Foundation Trust

The Maternity and Neonatal programme (NHS England) commissioned the development of a Maternity Outcomes Signal System (MOSS) in response to the recommendation made in the Reading the Signals report. This went live on the 28 November 2025.

- There have been no MOSS alerts for OUH up to 31 January 2026. All relevant staff have registered with the NHS applications required to access MOSS and receive notifications; however, access is still pending for two members of the perinatal leadership team and the Clinical Governance Lead. This is being actively progressed to ensure full visibility and timely oversight of future alerts.

- In January, there was one term neonatal death, which did not trigger a MOSS alert. The pregnancy was booked at another Trust, with joint care provided through the Fetal Medicine Unit (FMU). The baby had multiple congenital abnormalities associated with a very poor prognosis. The case will now undergo full review through the Perinatal Mortality Review (PMR) process. No immediate learning has been identified at this stage.

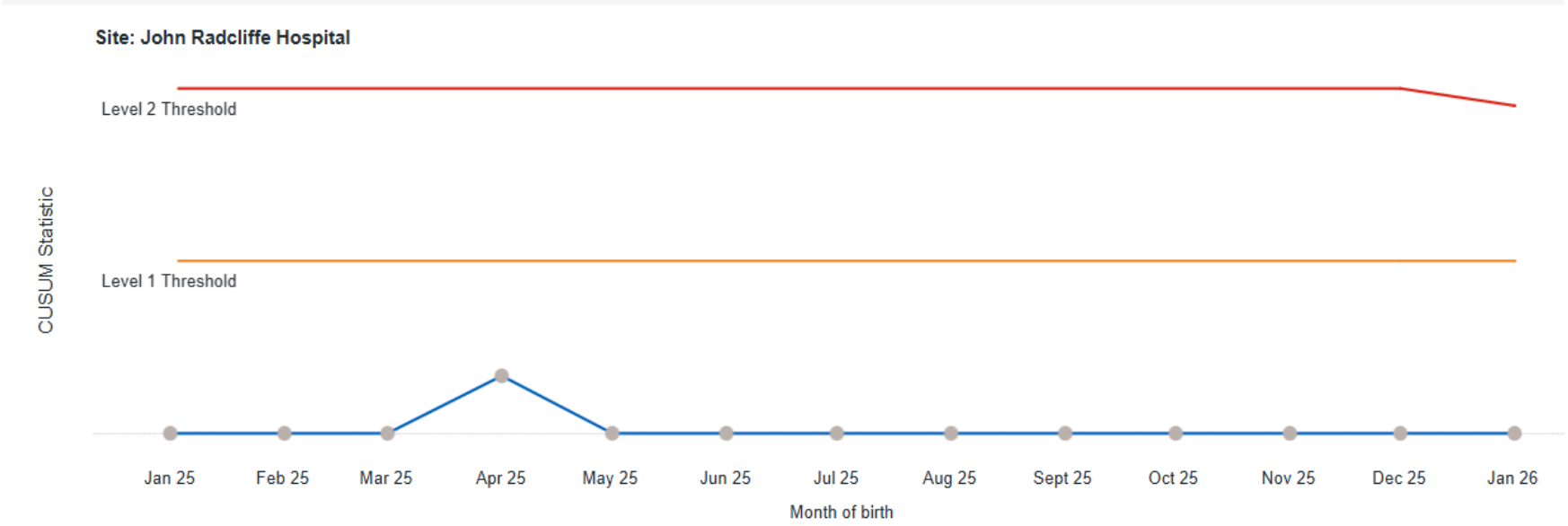

Table of Events - Trust: Oxford University Hospitals NHS Foundation Trust

Date of term birth	Events (term only)	Site name
20 Jan 26	1 Term Neonatal Death(s)	John Radcliffe Hospital
14 Sept 25	1 Term Stillbirth(s)	John Radcliffe Hospital
18 Aug 25	1 Term Neonatal Death(s)	John Radcliffe Hospital
22 Apr 25	1 Term Neonatal Death(s)	John Radcliffe Hospital
21 Apr 25	1 Term Neonatal Death(s)	John Radcliffe Hospital
19 Mar 25	1 Term Stillbirth(s)	John Radcliffe Hospital
27 Feb 25	1 Term Stillbirth(s)	John Radcliffe Hospital

Maternal Care Bundle

The Maternal Care Bundle (MCB) was published on the 06 January 2026. There are five elements to the MCB:

1. **Venous Thromboembolism** - reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified as at high risk.
2. **Pre-hospital and acute care** - ensuring unwell pregnant women receive the right care at the right time through improving access to urgent obstetric and maternal medicine care; and implementing a common approach to the monitoring, identification and management of maternal deterioration across all care settings.
3. **Epilepsy in pregnancy** - improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy.
4. **Maternal Medicine health** - improving the identification and response to perinatal mental health concerns through the consistent use of National Institute for Health and Care Excellence (NICE) recommended screening tools and timely referral to appropriate specialist support.
5. **Obstetric haemorrhage** - improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

An initial planning meeting for the Maternal Care Bundle (MCB) took place on 12 January 2026, during which key stakeholders were identified and next steps agreed. A further meeting is scheduled for 23 February 2026, ensuring continued coordinated oversight of the implementation programme.

NHS England (NHSE) is supporting Trusts through a series of national webinars covering each element of the MCB. During the NHSE webinar held on 10 February 2026, the following key points were highlighted:

- A Trust-level implementation tool will be published by March 2026.
- The tool will mirror the structure and approach of the Saving Babies' Lives implementation tool, enabling Trusts to:
    - baseline their performance,
    - set local improvement trajectories, and
    - monitor delivery against actions.
- Trusts will not be held to account nationally for specific metrics in 2026/27.
    - Year one is intended to support development and embedding of local measurement processes, ensuring robust foundations for future performance monitoring.

Three Year Single Delivery Plan Progress

Oxford University Hospitals NHS Foundation Trust

Positive Outliers:

- Sickness absence rates – data from October 2025. The sickness absence rate is monitored monthly and reported as part of this report.

Negative Outliers:

- The results of the 2025 Maternity CQC survey were received in December. A meeting is planned for the 06 February 2026 with the Maternity & Neonatal Voices Partnership (MNVP) to co-create an action plan to address the findings. This will be reported to the Triangulation and Learning Committee (TALC) in March and to the Maternity Clinical Governance Committee (MCGC).
- Strategy development to achieve BRI accreditation will commence in Q1 2026/27. In preparation audits are being undertaken on an ongoing basis.
- Stillbirth rate (data from 2023). In 2023, there were 63 perinatal mortality reviews. These have all been previously reported to the Trust Board.

Ongoing projects

- The new national MEWS is going live in BadgerNet on the 24 March 2026.
- An initial stakeholder meeting has taken place on the 04 February to plan the implementation of NEWTT 2. A lead is required from neonates and maternity.

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 suppor

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

MBRRACE-UK metrics: Better outcomes – Poorer outcomes

All other metrics: More positive – Improvement / support needed

Select ICB

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

	Total measures	Negative outliers	Positive outliers
Total	41	4	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	1	

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

Review of NHS Resolution Scorecard – Quarter 3 data

Oxford University Hospitals NHS Foundation Trust

Themes identified from Claims Scorecard (10 years)

Causes:

- Fail/delay in treatment (22)
- Failure/Delay in Diagnosis (15)
- Not specified (5) – cause was not identified but the injuries were: uterine rupture, psychiatric/psychological, additional/unnecessary operations, brain damage
- Fail to make response to abnormal fetal heart rate (5)

Themes identified from Complaints

Communication:
Patient not listened to, incorrect/no information given, insufficient information provided, communication with patient / GP / relatives, method/style of communication
Clinical treatment:
Mismanagement of labour, missed or incorrect diagnosis, delay/failure to diagnose, delay/failure in treatment or procedure or ordering tests, incorrect procedure, inappropriate treatment
Patient care:
Call bell out of reach, call bell failure to respond, inadequate support, care needs not adequately met
Consent:
Failure to give informed consent or obtain appropriate consent
Prescribing:
Dispensing error or delay
Appointments / access / administration:
Appointment cancellations, treatment cancellations, patient record management issues, incorrect entry onto medical record

Themes identified from Maternity Patient Safety Incidents

- **Neonatal safety incidents**: neonatal observation omissions particularly among babies of diabetic mothers, infants requiring NAS monitoring and jaundice checks at 24 hours.
- **Postpartum haemorrhage management** – Clinical management was often within guidance, documentation inconsistencies and delays in theatre transfer.
- **Workforce/acuity-related delays** – operational pressure noted across MAU and Delivery Suite, high activity levels contributed to delays in triage (BSOTS), delayed assessments and challenges with transferring women into appropriate care areas.
- **Fetal monitoring** – recognition and action in response to continuous monitoring.

Themes identified from other sources (e.g. staff feedback, family feedback, FSU)

- **Key themes:** Across the quarter, nearly all respondents were satisfied with their maternity care (85–96% positive ratings each month). Women consistently praised the kindness and supportiveness of midwives, the clear communication and professionalism of staff, and efficient service in antenatal clinics.
- The few negative comments mainly concerned waiting times (especially in ultrasound/triage) and occasional communication delays during busy periods. Overall, the Friends & Family Test and “Say on the Day” feedback for Q3 2025 reflects very high satisfaction with OUH’s maternity services, and only isolated areas for improvement (e.g. reducing clinic waits and enhancing on-the-day communications).

Review of NHS Resolution Scorecard – Quarter 3 data (actions)

Oxford University Hospitals NHS Foundation Trust

Themes identified	Actions	Responsible	By when
Jaundice readmissions	• Tea trolley training about recognition and monitoring of jaundice • Shared learning about ensuring cord clamping within 5 minutes when having active 3rd stage. • Care in Labour guidance updated to include optimal cord clamping.	Practice Development Team	January 2026
Increase in medication incidents	• Learning of the week shared in response to these incidents, for example, about PPID and supervision of students.	Clinical Governance team	January 2026
Blood results not being reviewed in the community	• Introduction of a blood results tracker to the community teams.	Community matron	January 2026
Complaints	Complaint action management is monitored via the Ulysees Action Management Platform. Examples of improvements are; • Communication - infographics for MAU in waiting room. • Patient care - Hub model implemented on postnatal ward • Appointments – New system implemented for elective caesarean section appointment	Deputy HoM	January 2026
Fetal Monitoring	“Loss of contact" action required, included in mandatory fetal monitoring training and assessment	Fetal monitoring lead	September 2026 (all staff trained)
Triage waiting times	• Triage project launched – focus on reducing waiting times, increasing room capacity and dedicated telephone triage staffing	Matron for MAU	September 2026

Maternity & Neonatal Safety Champions Walkaround

Oxford University Hospitals NHS Foundation Trust

Date: 15 January 2026

Visited Areas: Neonatal Unit (NNU)

Neonatal Unit Visit

During the visit to the Neonatal Unit on 15 January 2026, the Divisional Director of Nursing and the Deputy Divisional Director of Nursing for NOTSSCaN met with both parents and staff. The parents of an infant receiving intensive care for the past month reported that their child was progressing well and described a high level of confidence in the care being provided. They stated that they consistently felt safe, well supported, and fully informed regarding their baby's condition and planned surgical intervention. They expressed strong praise for the team and reported no areas requiring improvement.

Staff feedback indicated that, although the unit remained busy, they felt well supported, positively engaged, and satisfied in their roles. A second-year student also highlighted the quality of the learning environment, noting that she felt well supported, valued, and able to develop her clinical skills effectively.

Collectively, the feedback provides strong assurance to the Board regarding the quality of care, effectiveness of communication, and the positive culture within the Neonatal Unit.

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Appendices

Appendix 1: SPC Charts

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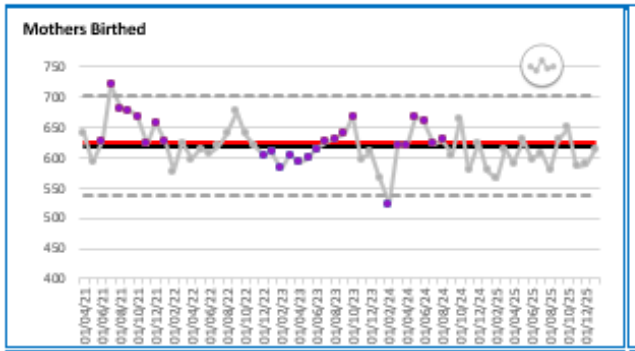
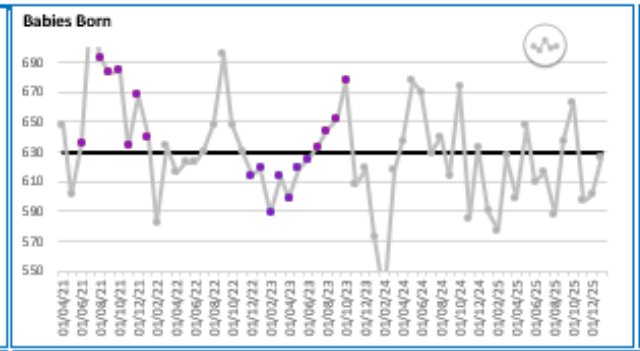
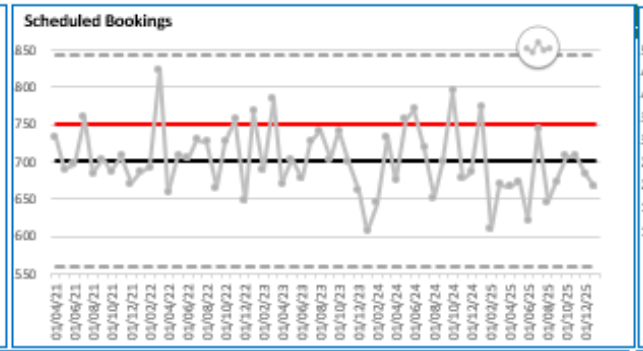
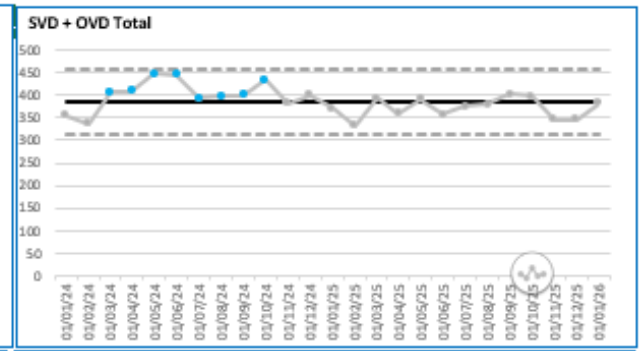
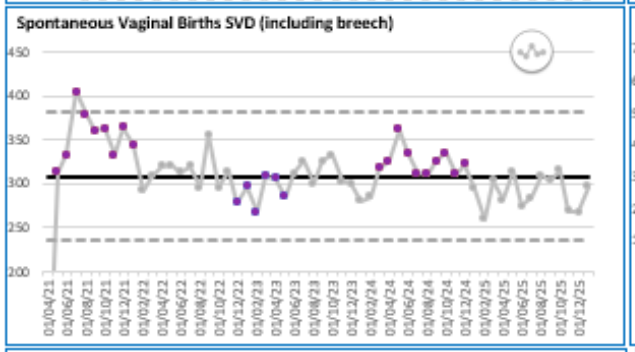
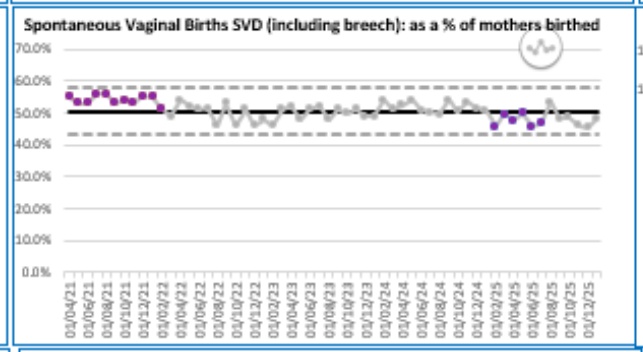


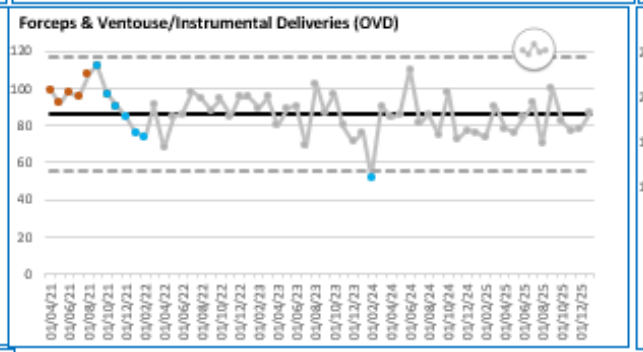


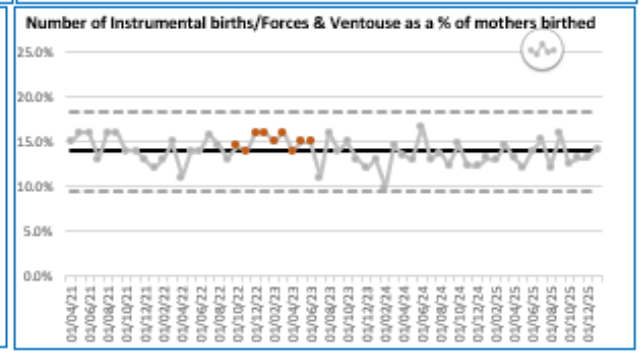


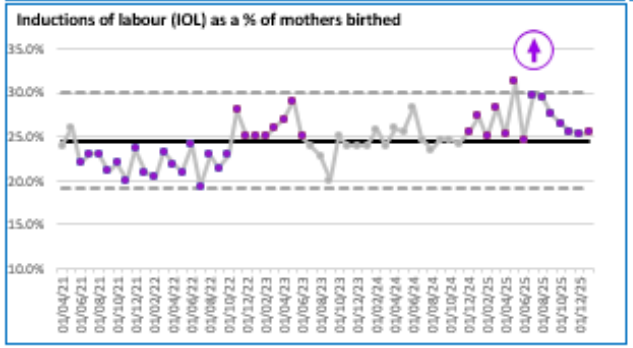


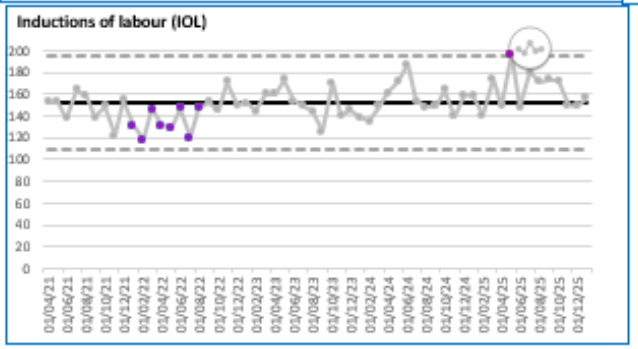






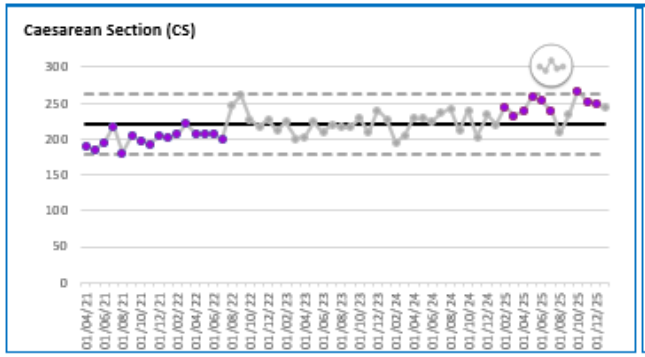


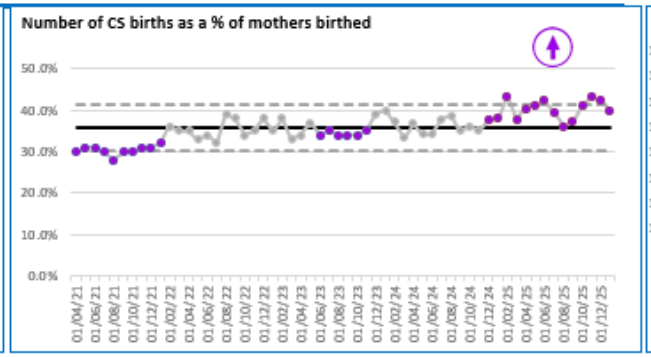


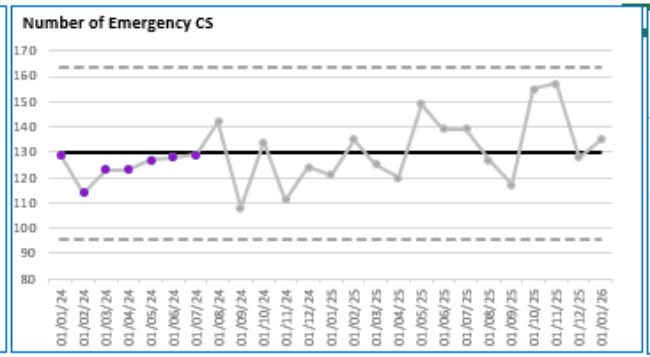


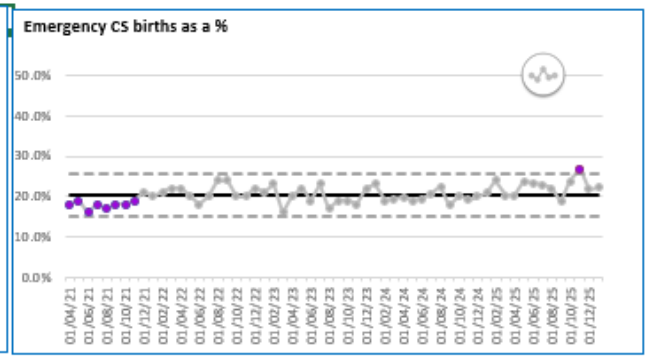
Appendix 1: SPC Charts

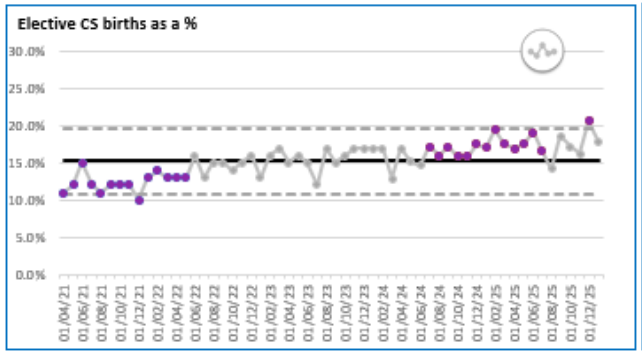
Oxford University Hospitals

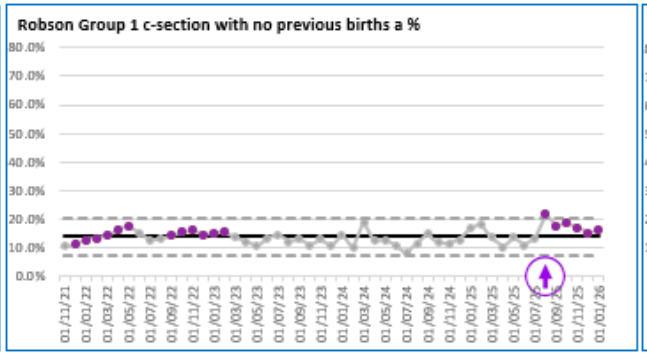


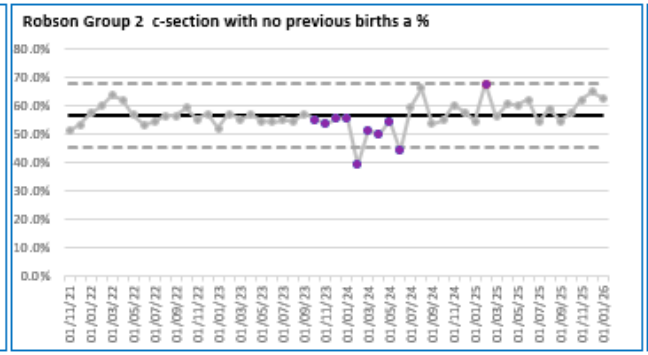


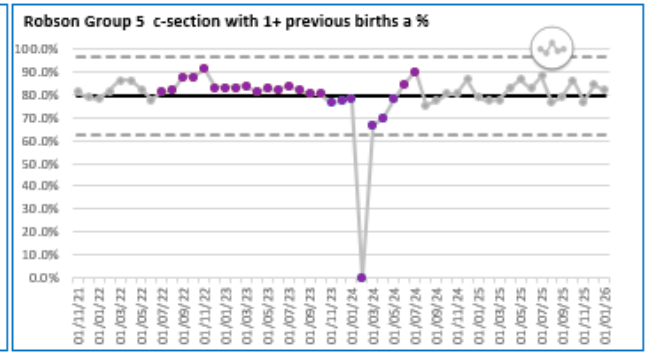


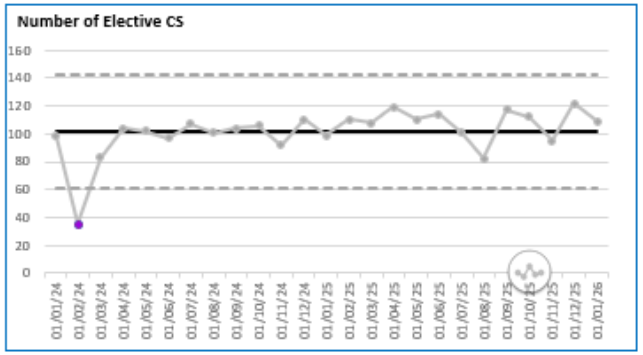


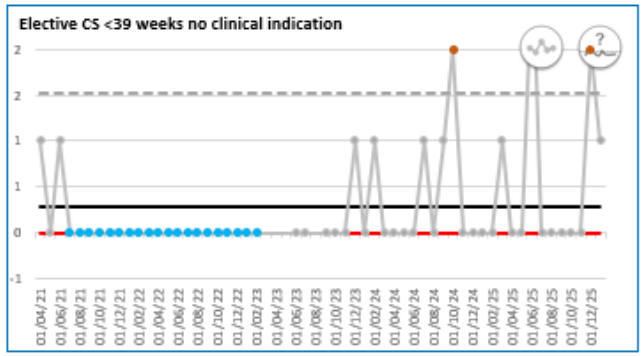












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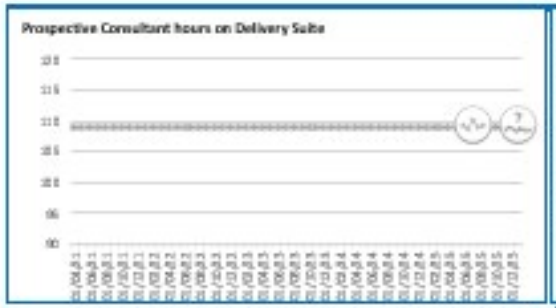

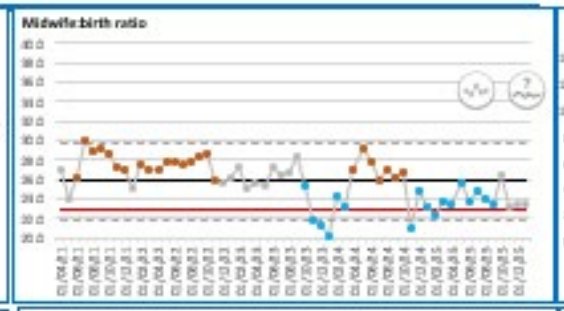

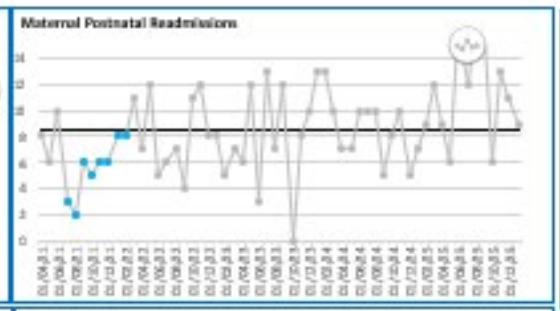

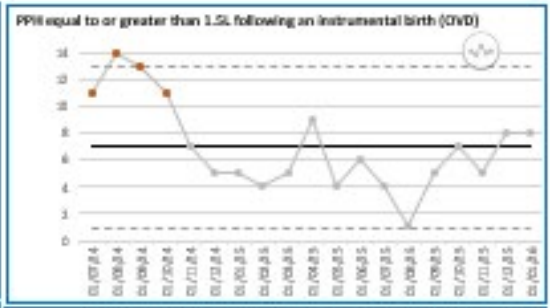

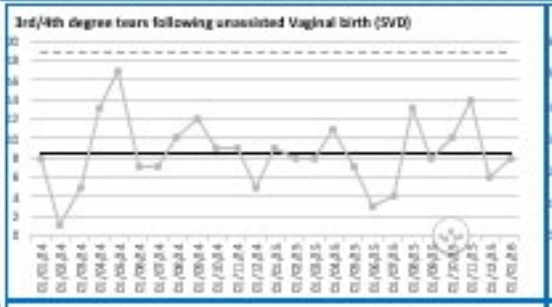

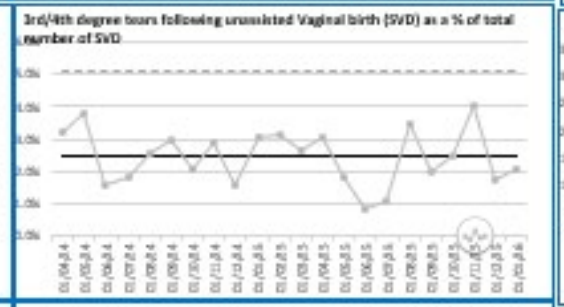

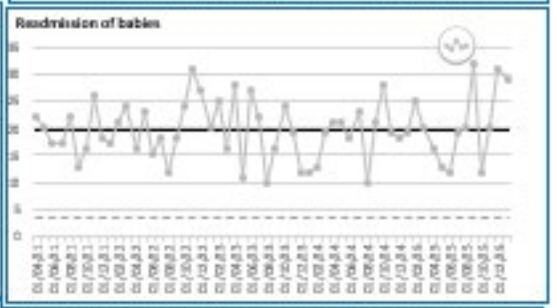

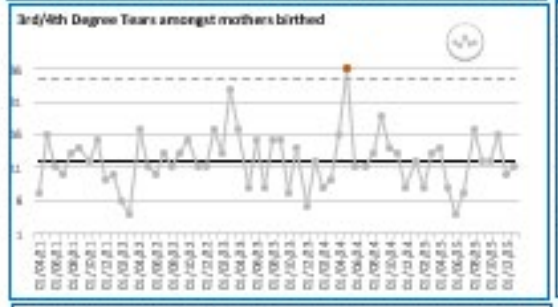

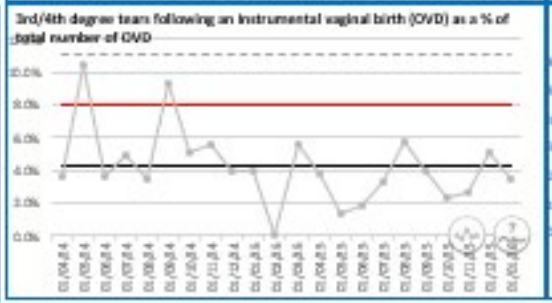

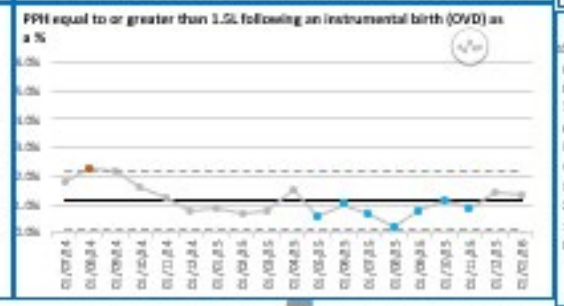

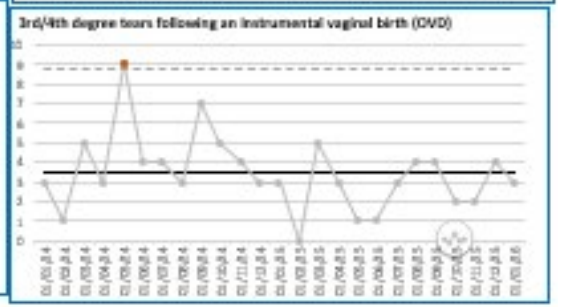

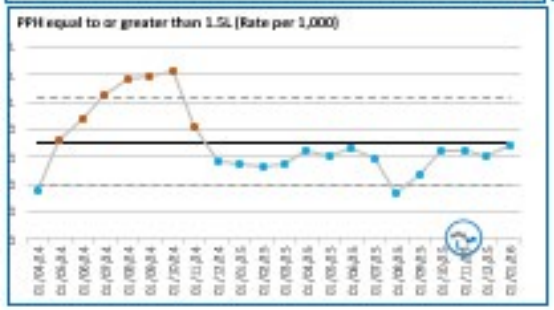

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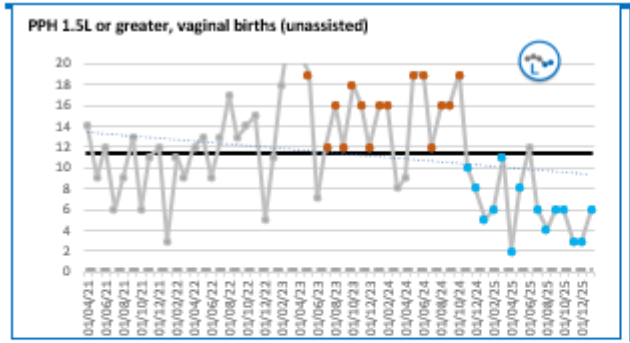

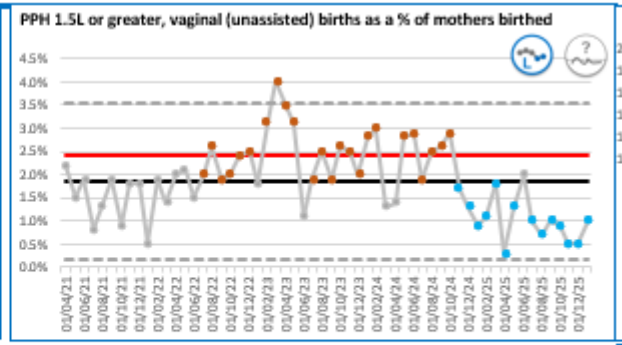

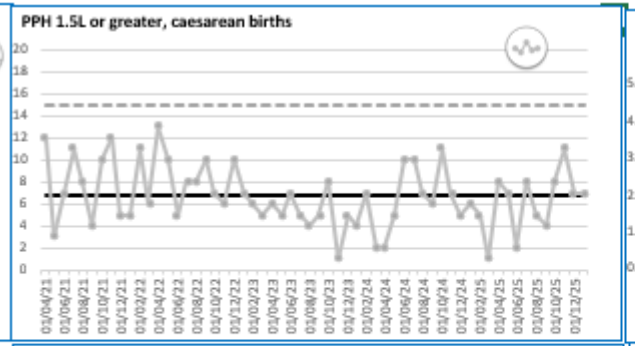

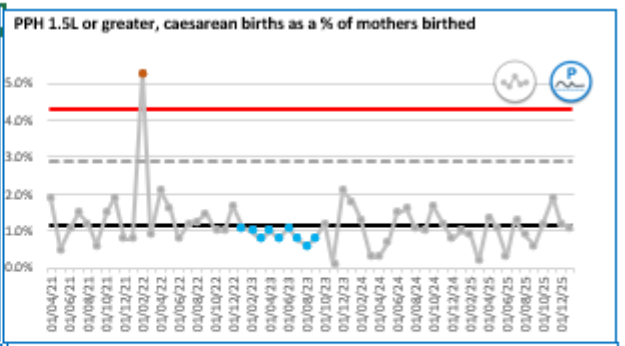

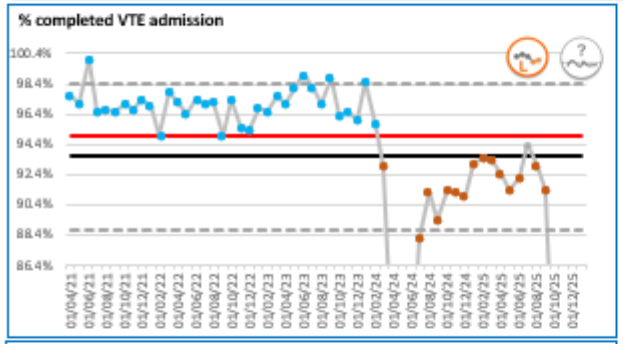

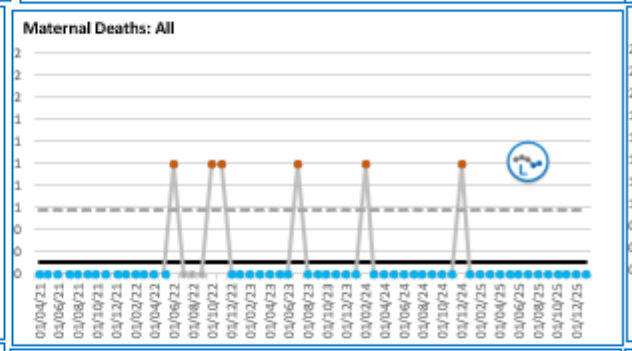

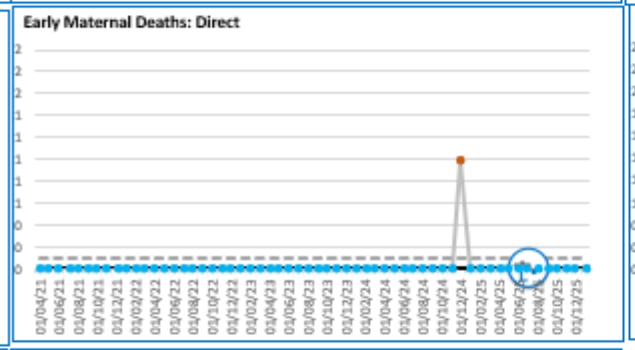

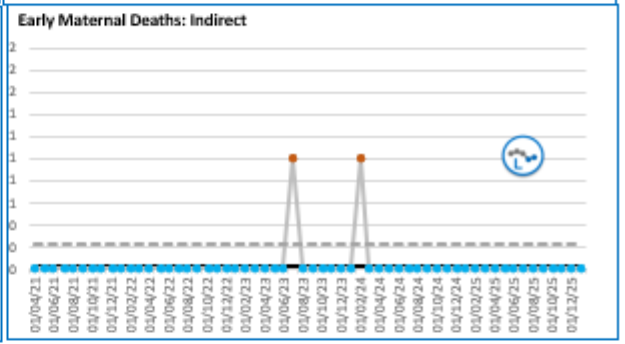

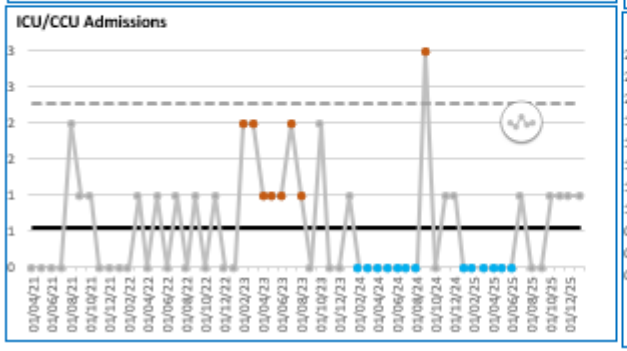

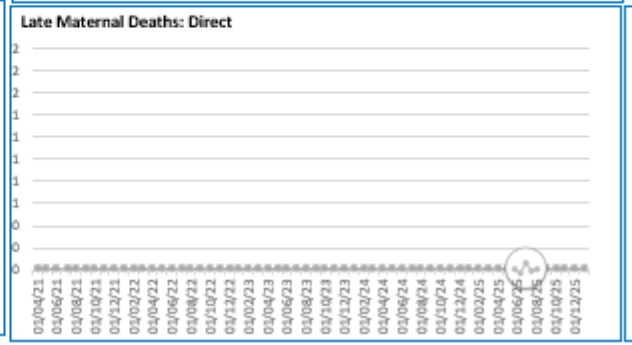

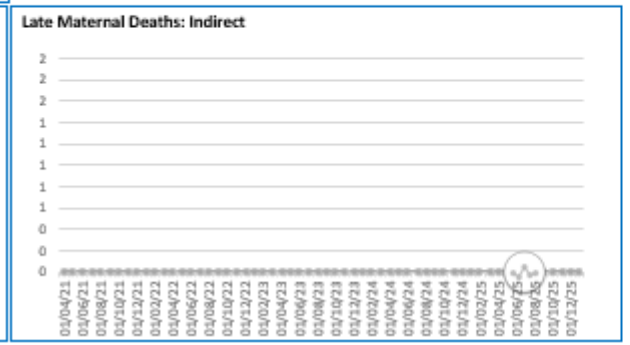

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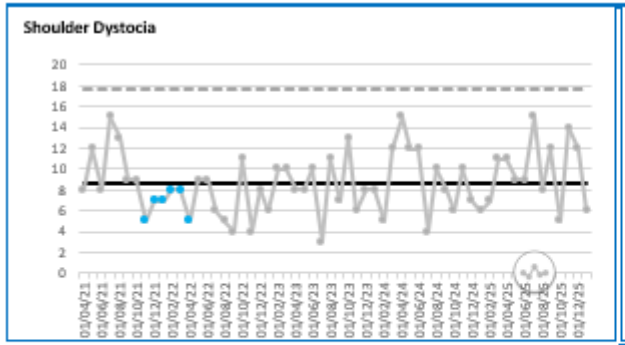

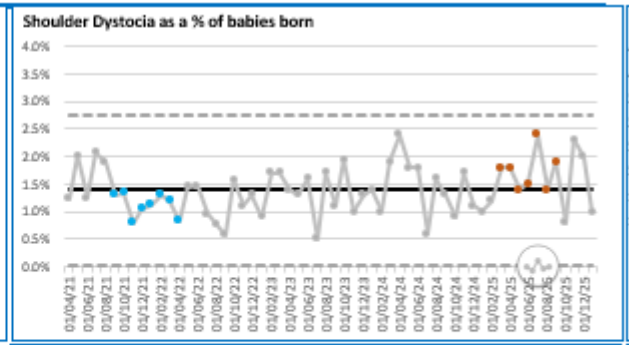

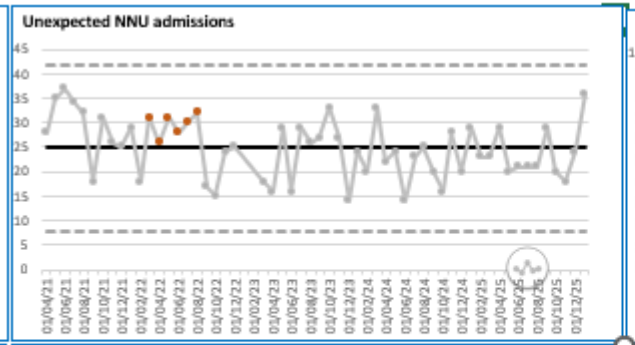

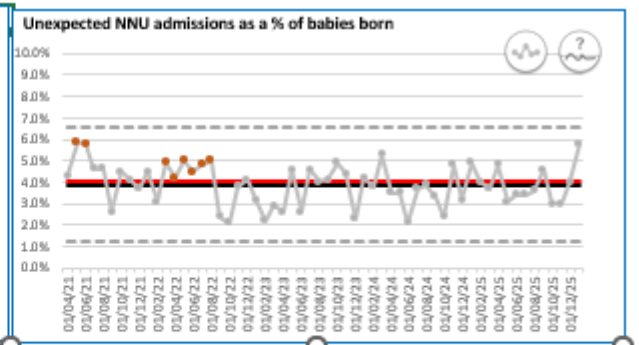

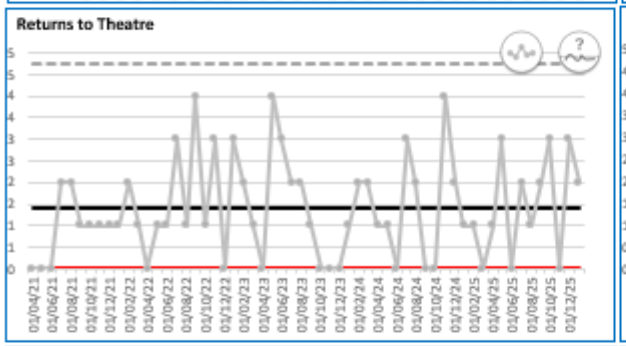

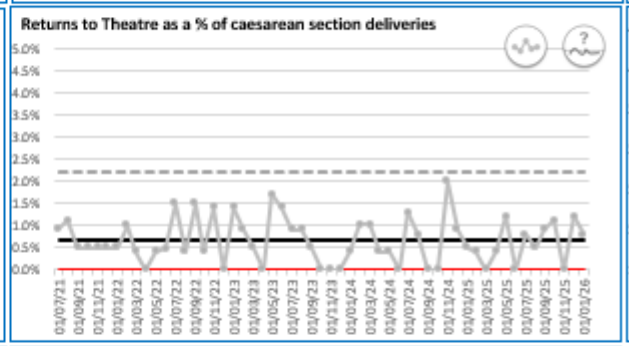

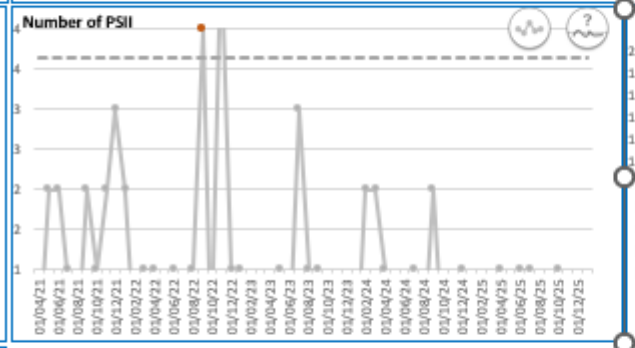

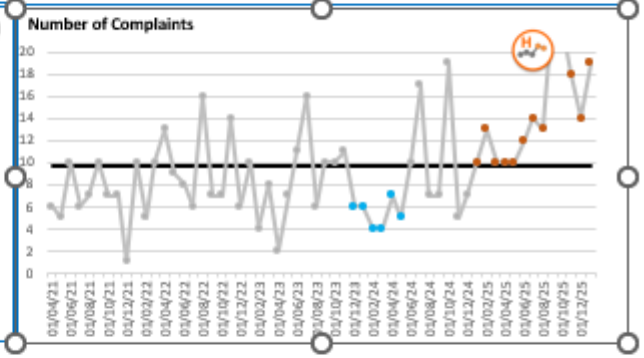

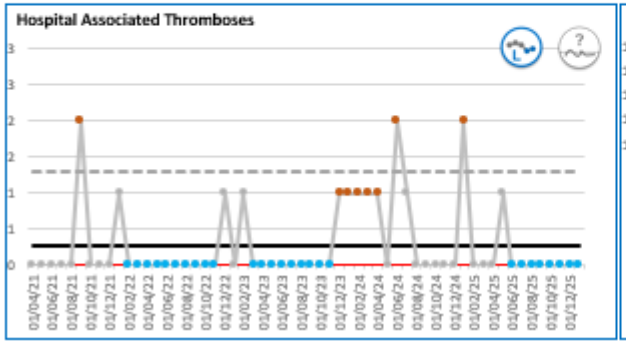

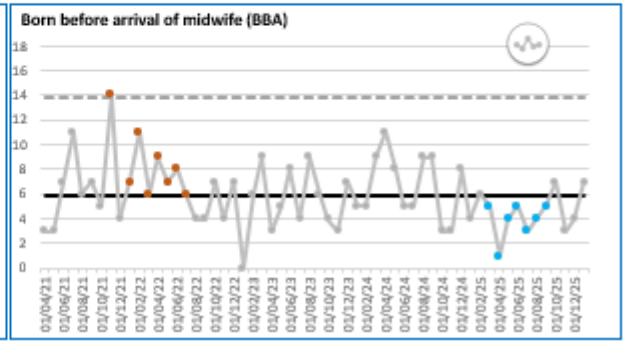

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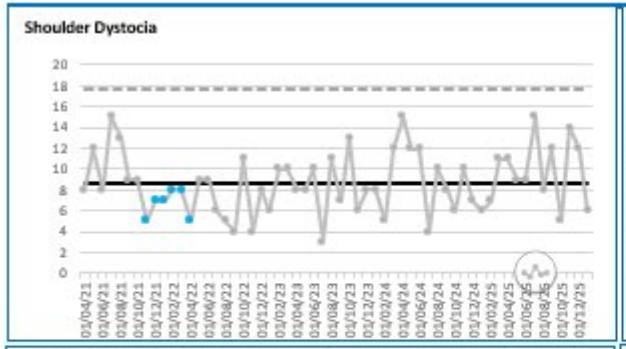

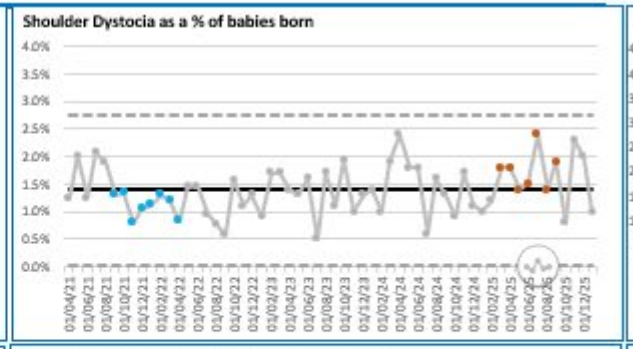

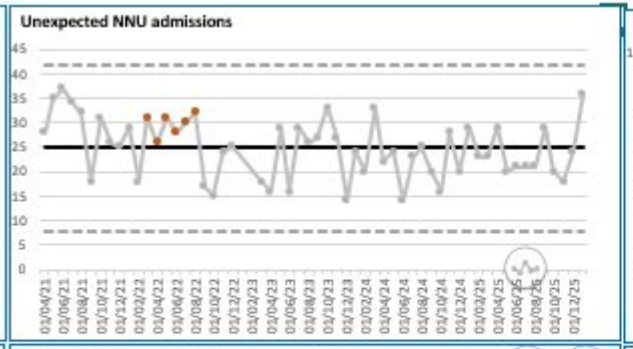

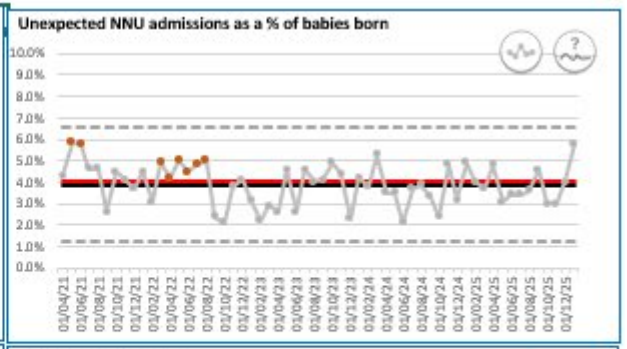

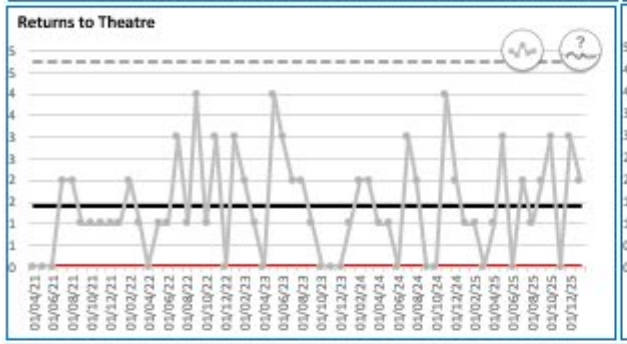

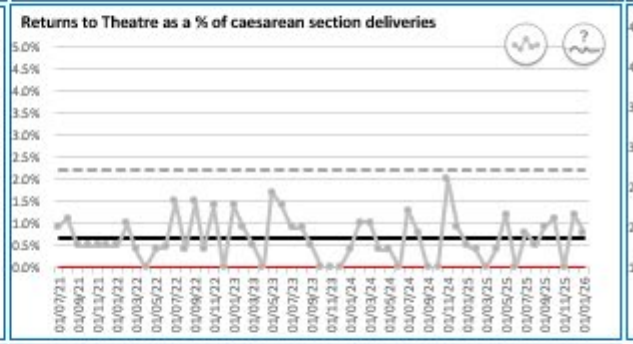

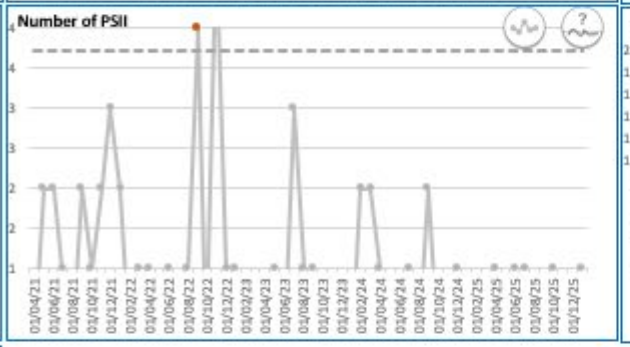

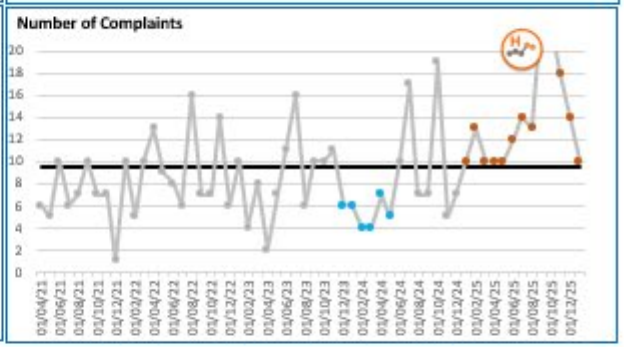

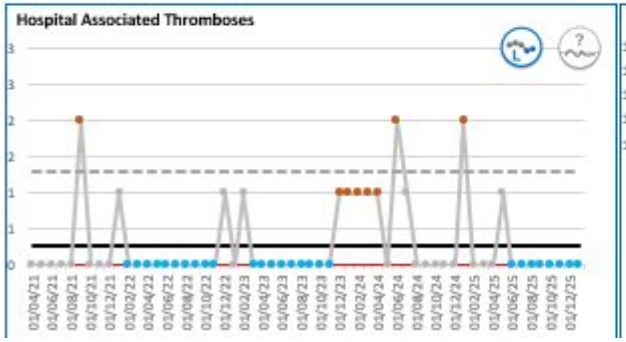

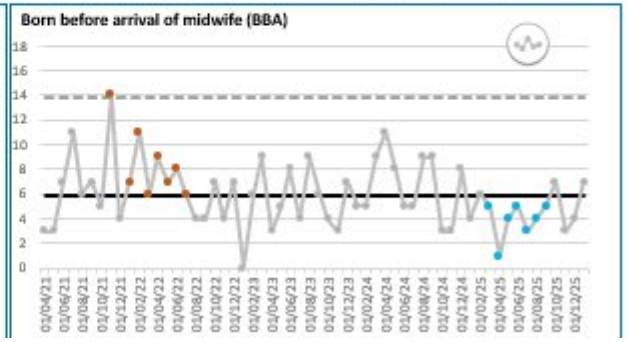

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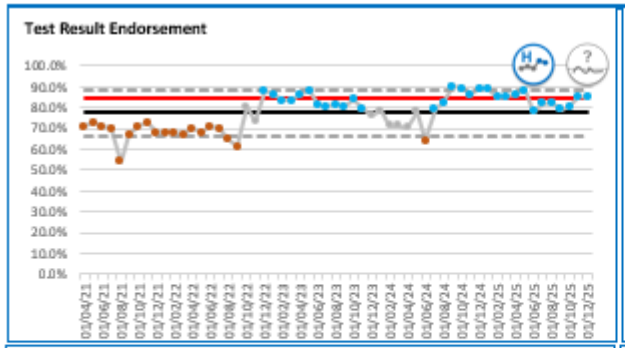

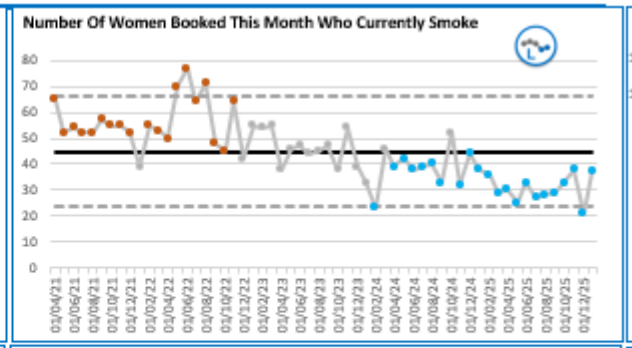

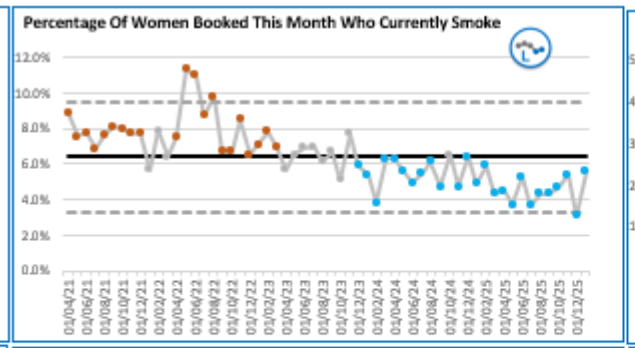

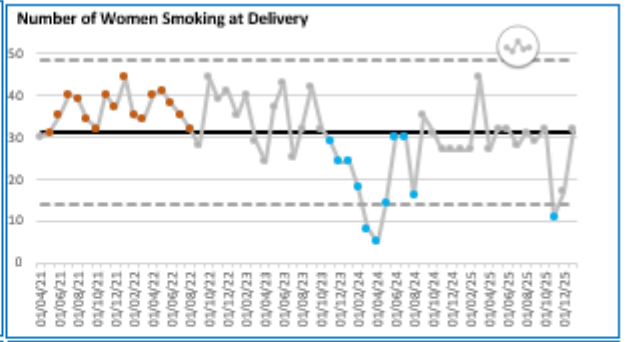

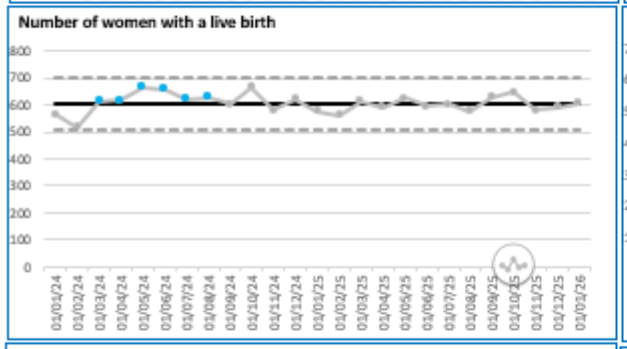

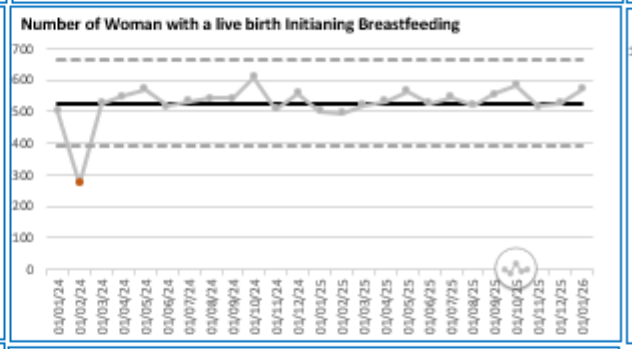

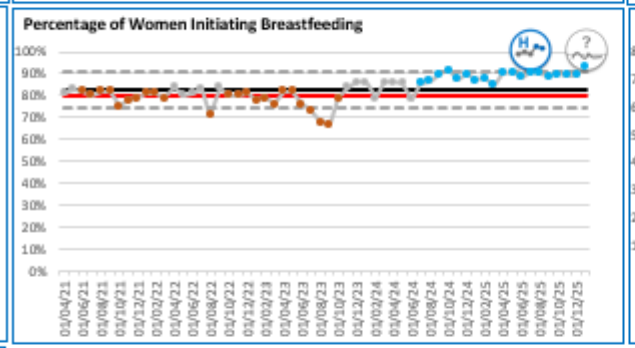

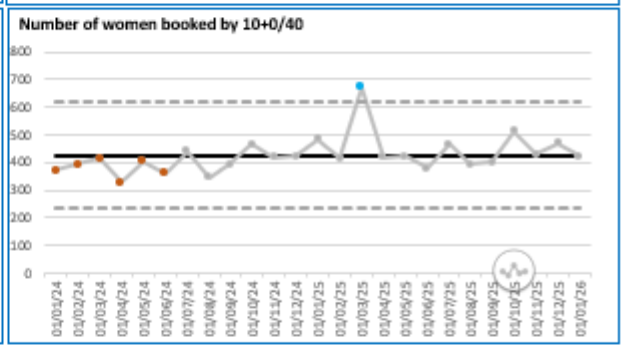

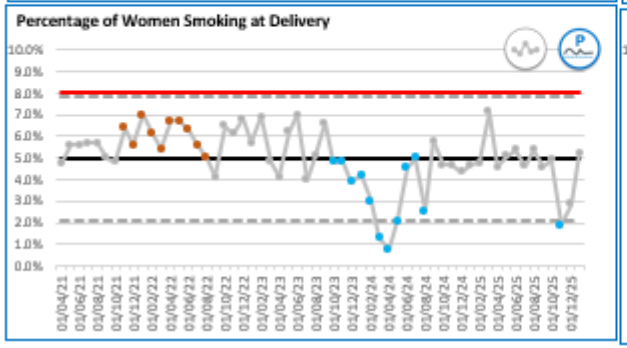

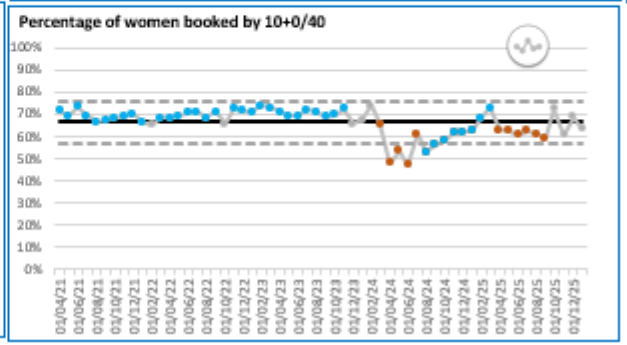

Appendix 2: Categories used for grading of care for perinatal mortality reviews (PMR)

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

Appendix 3: Acronyms

Oxford University Hospitals NHS Foundation Trust

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