Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 10 September 2025

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Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC) 11/08/2025
	Previous paper presented to Trust Board 09/07/2025

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Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This paper provides an update to the Trust Board on maternity related activities. The key points are summarised below:
2. **Three-Year Delivery Plan for Maternity and Neonatal Services**: The report outlines progress on the three-year delivery plan and provides an update on progress related to listening to women, workforce, culture and leadership, and standards. The Trust is in contact with and preparing for a meeting with Families Failed by OUH Maternity Services. campaign leaders.
3. **Perinatal Improvement Programme Phase 2:** Focuses on advancing OUH's maternity and neonatal services with an emphasis on service user experience, staff wellbeing, safety, and continuous improvement, supported by robust governance and reporting to delivery committee.
4. **Maternity (Perinatal) Incentive Scheme (MPIS)**: An update is provided as part of the Perinatal Quality Surveillance Model (PQSM) report on the Maternity (Perinatal) Incentive Scheme.
5. **Antenatal and Newborn (ANNB) Screening Assurance:** The Trust has received a letter from NHS England Screening Quality Assurance Service (SQAS) confirming closure of the action plan relating to the quality assurance (QA) visit that was undertaken in April 2024. The action plan included 36 recommendations.
6. **Maternity Safeguarding:** There is a growing number of pregnant women and families experiencing homelessness, raising safeguarding concerns. The Maternity Safeguarding team is working with local councils and charities to address these issues. 'Safe and Sound' learning sessions for staff will start on 12th September, offering guidance and support.
7. **Midwifery Led Unit (MLU) Update:** Community services have remained uninterrupted since December 2024. In July 2025, one woman was unable to birth in her preferred location due to staff availability; she accepted an alternative, and the outcome was positive.

Recommendations

8. The Trust Board is asked to:
    - Receive and note the contents of the update report.

Contents

Maternity Services Update Report

1. Purpose

1.1. The aim of this paper is to provide an update to the Trust Board on the following maternity related activities:

1.2. Three-year Single Delivery Plan for Maternity and Neonatal Services

1.3. Maternity (Perinatal) Incentive Scheme (MPIS) year 7

1.4. Maternity Performance Dashboard

1.5. Perinatal Quality Surveillance Model Report

1.6. CQC Action plan update

1.7. Antenatal and Newborn (ANNB) Screening

1.8. Midwifery Led Unit (MLU) status

1.9. Safeguarding

2. Three Year delivery plan for Maternity and Neonatal Services

2.1. The Three-year Single Delivery Plan for Maternity and Neonatal services was published in March 2023. A summary of progress against each of the themes is summarised below. The actions will be put onto the Action Plan module on Ulysses to enable the team to have greater oversight of these.

3. Theme 1: Listening to Women

3.1. The Trust is in contact with the representatives of the Families Failed by OUH Maternity Services campaign group and is preparing for a meeting with the campaign leaders. The Trust is dedicated to approaching this dialogue with openness, empathy, and deep respect for the concerns raised by families.

3.2. The Trust is finalisng an involvement and engagement strategy and action plan designed to enhance relationships and support service users and families in contributing to the future of maternity care. This work is nearing completion and will introduce clearer structures for patients and families to participate in and influence services.

3.3. The Triangulation and Learning Committee (T.A.L.C), comprised of service users and staff, meets monthly. Ongoing improvements on postnatal wards address 24-hour partner visits and better pain relief. The Friends and Family Test (FFT) response rate increased in July. Following the success of "Say

on the Day" feedback devices in Ultrasound, more devices are being added to other maternity areas in August.

3.4. The Maternity and Neonatal Voices Partnership (MNVP) lead has commenced in post in June 2025 and is currently completing her onboarding and Trust induction.

3.5. In relation to achieving the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027: Maternity Services is at BFI level 2 and neonates are at BFI Level 3. Trusts are classified as having achieved the standard when they have achieved the "Gold Award", "Full accreditation. The new infant feeding lead has commenced in post in July 2025 and will be working collaboratively on both strategy development and operational planning to support the achievement of this.

4. Theme 2: Workforce

4.1. The current vacancy for Midwifery is 12.95 WTE (Whole Time Equivalent), with no vacancies in Nursing and 9.11 WTE vacancies for Maternity Support Workers (MSWs). Monthly recruitment efforts are ongoing, with additional midwifery and MSW interviews scheduled. The workforce task and finish group continue to meet monthly. This includes the leadership team, recruitment and retention team, human resources (HR) representatives and the legacy midwife. The Quarter 3 & 4 24/25 Safe Staffing paper was presented to the Trust Board in July 25.

4.2. To further strengthen the workforce and address challenges associated with midwives on maternity leave, approval has been granted to over-recruit into midwifery posts. This proactive measure is complemented by the implementation of a robust recruitment pipeline, designed to ensure that all vacant posts are filled efficiently and without delay. The approach not only enhances team resilience but also promotes continuity of care within the maternity service.

4.3. Robust processes are in place to ensure that educational supervision for non-trainee doctors is enhanced. Actions are underway to ensure obstetric and neonatal medical staff receive appropriate clinical support and supervision, meeting the standards set out by RCOG and BAPM guidelines. These measures provide assurance that all staff are well supported in their training and clinical duties.

5. Theme 3: Culture and Leadership

5.1. Maternity and Neonatal Safety Champions conduct regular walk rounds, and on July 30, they visited the Postnatal Ward on Level 5 and the Neonatal Unit (NNU).

5.2. All staff are invited to join an open monthly meeting with the Director of Midwifery. This gives staff opportunity to connect, share ideas, and be part of important conversations.

5.3. The service held another Schwartz Round in June with a further planned for the 09 September 2025. These are structured forums where healthcare staff from all disciplines come together to discuss the emotional and social aspects of working in healthcare. These rounds provide a safe space for staff to share their experiences, reflect on their work, and support each other. The goal is to enhance staff well-being, promote compassionate care and improve teamwork and communication within the healthcare setting.

5.4. Work is ongoing in relation to ensuring staff are supported by clear structured routes for the escalation of clinical concerns. This includes robust and clearly communicated standard operating procedures for both midwifery and medical staffing escalation and consistent leadership visibility and presence of the senior teams.

6. Theme 4: Standards

The Perinatal Improvement Programme Phase 2

6.1. The Perinatal Improvement Programme represents the second phase of the Maternity Services Improvement Programme, with a focus on enhancing service user experience, staff well-being, and critical safety elements such as maternity triage and reducing delays in labour induction. Building on the foundations established by the Maternity and Neonatal Development Programmes (MDP and NCDP), the initiative aligns with Year 3 of the Single Delivery Plan.

6.2. The Terms of Reference have been drafted and formally approved by the Delivery Committee, which will oversee programme progress. Under a revised governance framework and unified Terms of Reference, the programme has created task and finish groups and designated workstream leads.

6.3. Saving Babies Lives Care Bundle version 3 is in place, with compliance reported under the Maternity (and Perinatal) Incentive Scheme, safety action 6. The national pilot for NEWTT will begin soon, while MEWS will not start until September; neither national MEWS nor NEWTT 2 are implemented yet. The service met with LMNS on 4 August to review quarter

4 feedback and is awaiting the board report, which will be shared with MCGC and through current governance channels.

7. Maternity (Perinatal) Incentive Scheme (MPIS)

7.1. An update is provided as part of the Perinatal Quality Surveillance Model (PQSM) report on the Maternity (Perinatal) Incentive Scheme.

8. Maternity Performance Dashboard

8.1. There were 8 exceptions reported for the July data, see Appendix 1 for further detail, mitigations, and improvement actions. The dashboard includes data relating to the activity in the community.

9. Perinatal Quality Surveillance Model Report

9.1. The Perinatal Quality Surveillance Model (PQSM) report for June and July will be presented to the Trust Board meeting in September 2025. The data was reported to MCGC in August and is an agenda item at the bi-monthly Maternity and Neonatal Safety Champions meetings.

10. CQC Action Plan Update

10.1. The Maternity Services, in collaboration with the Trust Assurance Team and Corporate Nursing, have continued to meet monthly as part of the Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan. The group last held a meeting on the 28 July 2025.

10.2. In the Horton Midwifery Led Unit CQC action plan there were six ‘Must Do’ actions and seven ‘Should Do’ actions outlined. All Horton specific actions have been completed with ongoing monitoring regarding sustained levels of assurance. In addition, the ligature risk assessment on Delivery Suite was completed in July and reported to the Maternity Clinical Governance Committee (MCGC) in August following completion of the works that were being undertaken.

10.3. Progress against the CQC action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports.

11. Antenatal and Newborn (ANNB) Screening

11.1. The Trust has received a letter from NHS England Screening Quality Assurance Service (SQAS) confirming closure of the action plan relating to the quality assurance (QA) visit that was undertaken in April 2024. The action plan included 36 recommendations.

11.2. The Trust Assurance Team met with the Maternity team in July to monitor and evaluate the progress of the effectiveness of the action plan. The next Evidence group meeting is on the 18 August 2025.

11.3. Progress against the ANNB action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports. It is also discussed at the Antenatal and Newborn Quarterly Board meetings.

12. Maternity Safeguarding

12.1. Homelessness has become an increasingly prominent theme across maternity services, affecting both those with and without recourse to public funds. The Matron for Maternity Safeguarding and the Head of Safeguarding have been meeting with councillors from Oxford City and Oxfordshire County Councils, as well as local homeless charities, to discuss the challenges and identify solutions.

12.2. A key concern is the growing number of pregnant women and families with newborns living in hotel accommodation without access to cooking facilities. This situation poses significant challenges for nutrition, health, and wellbeing during pregnancy and early parenthood.

12.3. Maternity Safeguarding has also been invited by Oxford City Council to contribute to discussions on the Emergency Housing Framework. This is an important opportunity to help shape how safeguarding and practical support are provided for pregnant women and new families in emergency accommodation.

12.4. The introduction of the ‘Safe and Sound’ safeguarding and mental health learning sessions marks a significant development in supporting complex case management within maternity services. These sessions are designed to foster reflection, facilitate shared learning, and highlight examples of exemplary practice in maternity safeguarding. The inaugural session is scheduled for 12th September and will be delivered via TEAMS. All staff are encouraged to participate in and contribute to these important discussions.

13. Midwifery Led Unit (MLU) Status

13.1. Since December 2024 there have been no occasions when community services were suspended.

13.2. In July 2025, one woman could not give birth at her preferred location because community staff were unavailable. She accepted an alternative option, resulting in a positive outcome.

14. Conclusion

14.1. This report provides an update on essential maternity activity which includes the CQC action plan update, Maternity (Perinatal) Incentive Scheme (MPIS), and Antenatal and Newborn Screening Services. It summarises the findings and recommendations as well as the actions taken by the service to address them.

14.2. The report aims to assure the Trust Board of the Maternity service delivery and performance.

15. Recommendations

15.1. The Trust Board is asked:

- Receive and note the contents of the update report.

Appendix 1: Maternity Performance Report

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

Accessible Information Standard notice: We are committed to ensuring that everyone can access this document as part of the Accessible Information Standard. If you have any difficulty accessing the information in this report, please contact us.

Date: August 2025

Data period: July 2025

Presented at: Maternity Clinical Governance Committee

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Executive Summary

Executive Summary

In July 2025, a total of 607 women gave birth at OUH, and 743 antenatal care appointments were scheduled.

Key Achievements:

- All quality assurance actions resulting from antenatal and newborn screening recommendations were fully completed, receiving recognition from NHS England for maintaining high standards and excellent engagement.
- GMC staff survey results show significant improvement, indicating that OUH is a good place to work.
- Concentric (Digital Consent) successfully went live on the 9th July 2025.
- The National Neonatal Audit Programme (NNAP) reported the following outstanding results:

➢ Antenatal Magnesium Sulphate administration: 75 cases (100%), compared to the national average of 86.7%

➢ Breastmilk feeding by Day 2: 153 cases (91.6%), surpassing the national average of 66.8%

➢ Deferred cord clamping: 148 cases (87.1%), above the national average of 73.5%

➢ Non-invasive ventilation treatment effect: minus 18.8%, whereas the national average is 0% (a positive effect indicates a better-than-expected rate)

➢ Retinopathy of Prematurity (ROP) screening on time: 93 cases (92.1%), exceeding the national average of 80%•Timely temperature regulation between 36.5°C and 37.5°C: 156 cases (91.8%), compared to the national average of 77.6%

Executive summary

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	In July, a total of 607 mothers gave birth at OUH, which is an increase of 9 from the previous month. During this time, there were 743 scheduled antenatal bookings completed. Of the births, 240 were caesarean sections, making up 39.5% of the total. Breaking down the delivery settings: 63 women, or 10%, gave birth in midwifery-led settings, while 29 women (4.8%) had their births in community settings. Specifically, 34 women (5%) delivered at the Spires alongside midwifery unit. Additionally, there were 8 home births (1.3%), 12 deliveries (1.97%) at freestanding midwifery units in Wantage, Wallingford, and Chipping Norton, and 9 births (1.4%) at the Horton freestanding midwifery unit.
Workforce/Red flags	The midwife to birth ratio was 1:24.91, and there were no occasions in July when 1:1 care was not provided for women in established labour. There was one occasion when the delivery suite coordinator was not working in a supernumerary capacity and lasted only briefly at the start of a shift. Additionally, the number of on-call midwifery hours utilised by the service decreased from 261.5 hours in June to 219.25 hours in July. Furthermore, the number of instances when staff did not have a break slightly decreased from June to 70 occasions. Daily staffing meetings occur consistently within the service, allowing for mitigations and timely escalation as needed to ensure safe staffing and operational efficiency. In total, there were 21 delays in the induction of labour (IOL) exceeding 6 hours, compared to 23 in June. Additionally, there were 32 delays exceeding 12 hours, an increase from 15 in June, and 35 delays exceeding 24 hours, also up from 15. The IOL task and finish group continues to progress improvement work which is detailed in the exceptions reporting.
Maternal Morbidity	The reported rate of third-degree tears among mothers who had vaginal births in July 2025 was 1.86% (n=7), with 4 unassisted (SVD) and 3 assisted (forceps and ventouse).This falls within the national average of 0 to 8%. The ethnic backgrounds of these women were: White British (n=2), Not stated (n=4), and White-Other (n=1). The rate of postpartum haemorrhage (PPH) greater than 1500mls among mothers who had assisted vaginal births in July was 0.66% (n=4). This falls well below the national mean reported by the National Maternity and Perinatal Audit (NMPA), which is 2.80%. The ethnic backgrounds of these mothers included: White British (n=2) and Not Known (n=2). In July, the rate of PPH greater than 1500 mL among mothers who had unassisted vaginal births was 1% (n=6). This figure is similarly well below the national mean of 2.8% reported by the NMPA. The ethnic backgrounds of these mothers were as follows: White British (n=4), White Other (n=1), and Not Stated (n=1). The rate of PPH exceeding 1500ml among mothers who underwent caesarean births was 1.3% (n=8). This figure is consistent with and below the national mean reported by the NMPA, which is 2.80%. The ethnic backgrounds of these mothers included White British (n=4), White Other (n=2), and unspecified ethnicity (n=2). Please note that the ethnicity data is currently being reviewed to identify any outcomes that may disproportionately affect specific groups.
Perinatal Morbidity and Mortality	In July 2025, three cases were reviewed using the Perinatal Mortality Review Tool. All cases were graded as A for both care prior to the diagnosis and following the death of the baby. In July, 20 full-term infants (3.4%) were unexpectedly admitted to the neonatal unit. All cases are currently being reviewed under the ATAIN framework, and the assessments for July have been graded as either A (14 cases) or B (6 cases). Key learning points from these reviews highlight the need for improved documentation. A clinical audit is currently underway, and recommendations will be provided and implemented once the audit cycle is complete. Additionally, it was noted that neonatal observations should be conducted for infants born to mothers identified as septic. This guidance will be shared by the patient safety team.
Maternity safety	The maternity service submitted 256 patient safety reports through Ulysses in July 2025, of which 58 were rated as moderate harm. Appropriate learning responses were initiated in line with the Patient Safety Incident Response Framework (PSIRF) principles to ensure considered and proportionate responses, and appropriate, timely actions and interventions were undertaken on a case-by-case basis. There were no cases reported to MNSI in July, nor were there any reported Never Events.

Executive summary (continued)

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Test Endorsement	The test result endorsement figure is reported monthly and retrospectively since the ORBIT system does not update the final endorsement compliance rate until the 8th of each month. For June, the endorsement figure was 94.5%, indicating an improvement trajectory, but it remains 0.1% below the target.
Service User Experience	In July 2025, there were 14 complaints. Of these, 57% (8) were from individuals of white British ethnicity, 14% (2) from Asian – Asian British, Pakistani ethnicity, and 28% (4) from other or unstated backgrounds. The Triangulation and Learning Committee (TALC) reviews feedback monthly to identify themes and creates both immediate and long-term improvement strategies. Postnatal care continues to be a significant focus in feedback regarding complaints, particularly concerning support for infant feeding and mobility after caesarean sections. The recruitment of inpatient volunteers to assist service users is ongoing, and the recruitment and restructuring of the infant feeding team will significantly contribute to improvements in these areas, alongside existing initiatives. In July 2025, the service collected 287 responses for the Friends and Family Test (FFT), receiving 87.5% positive feedback. Recently, additional 'Say on the Day' devices have been installed throughout the service, including in the community and the Maternity Assessment Unit, featuring multi-language support to meet diverse patient needs. The positive feedback primarily highlighted themes such as timely and efficient management, as well as the compassionate and kind nature of the staff. The maternity safety team continues to visit families affected by patient safety incidents as part of their rapid responder role. The service is currently being evaluated. So far, there have been 73 visits, and positive feedback has been received regarding communication and an improved understanding for the service users impacted by these incidents.
Staff Experience (Cultural Improvement work)	In the context of ongoing external scrutiny and media reporting the service remains deeply committed to supporting the workforce. The service recognise the emotional and professional impact this climate can have and have responded with a strengthened focus on staff wellbeing through the Care Assure programmes, which continue to provide proactive and compassionate support across teams. This is complemented by access to a comprehensive suite of wellbeing resources, including Professional Midwifery Advocates (PMAs), psychological services, and Schwartz rounds—each playing a vital role in fostering resilience, reflection, and peer support. Crucially, these efforts are underpinned by a sustained commitment to the Equality, Diversity, and Inclusion (EDI) agenda, ensuring that every member of staff feels respected, valued, and empowered to contribute within a culture of belonging. Together, these interventions reflect the Trust values and create a supportive environment where staff can continue to deliver high-quality, compassionate care, even in difficult circumstances.
Public Health	In July 2025, 90.85% of women-initiated breastfeeding, an increase of 2.43% from the previous month, continuing to surpass the national average of 73.4%. The two vaccines currently offered at the immunisation hubs are for respiratory syncytial virus (RSV) and pertussis (whooping cough). Service users continue to provide positive feedback about the flexibility of the drop-in immunisation service available at both the John Radcliffe Hospital and Horton General Hospital. In July alone, over 500 vaccinations were administered.
Exception reports	Eight exceptions were identified from the data for July 2025 and are annotated on Slides 8 to 12 below.

Indicator overview summary (SPC dashboard)

ER Exception report

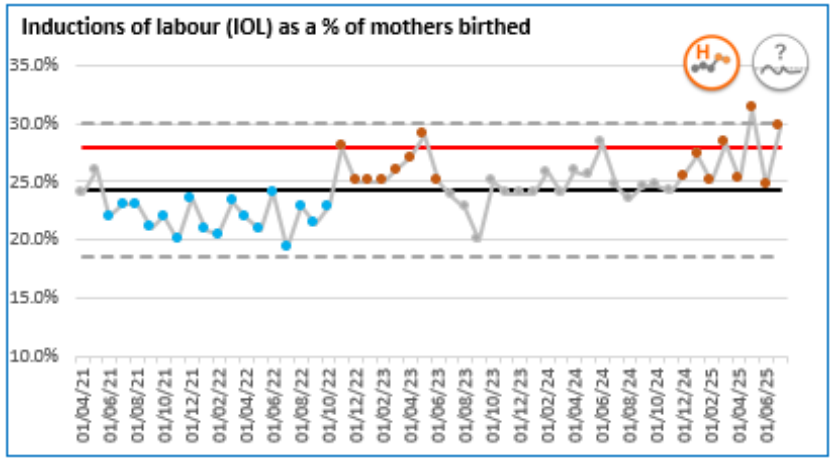
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Jul 25	607	625			621	539	702
Babies Born	Jul 25	616	-			631	547	714
Scheduled Bookings	Jul 25	743	750			704	555	853
Inductions of labour (IOL)	Jul 25	180	-			151	105	197
Inductions of labour (IOL) as a % of mothers birthed ER	Jul 25	29.7%	28.0%			24.3%	18.6%	30.1%
Spontaneous Vaginal Births SVD (including breech)	Jul 25	284	-			310	234	386
Spontaneous Vaginal Births SVD (including breech): a ER	Jul 25	46.8%	-			50.9%	44.0%	57.8%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Jul 25	92	-			87	57	116
Number of Instrumental births/Forces & Ventouse as	Jul 25	15.2%	-			14.0%	9.7%	18.3%
SVD + OVD Total	Jul 25	376	-			389	310	468

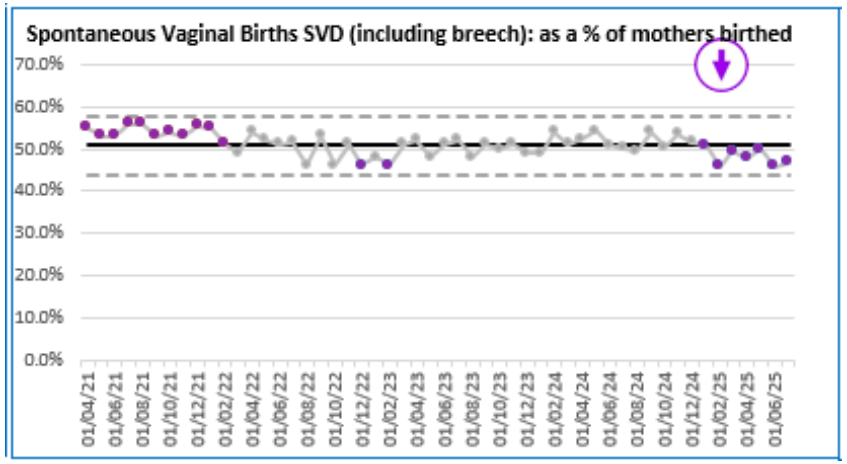
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS) ER	Jul 25	240	-			219	178	259
Number of CS births as a % of mothers birthed ER	Jul 25	39.5%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Jul 25	139	-			127	96	158
Emergency CS births as a % ER	Jul 25	22.9%	-			20.2%	15.2%	25.2%
Number of Elective CS ER	Jul 25	101	-			100	63	137
Elective CS births as a % ER	Jul 25	16.6%	-			15.0%	10.9%	19.1%
Robson Group 1 c-section with no previous births a %	Jul 25	13.2%	-			13.3%	7.1%	19.4%
Robson Group 2 c-section with no previous births a %	Jul 25	54.4%	-			56.1%	44.6%	67.6%
Robson Group 5 c-section with 1+ previous births a %	Jul 25	88.2%	-			79.8%	62.9%	96.8%
Elective CS <39 weeks no clinical indication	Jul 25	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Jul 25	109	109			109	109	109
Midwife:birth ratio	Jul 25	24:91	22.9			26.0	#N/A	#N/A
Maternal Postnatal Readmissions	Jul 25	12	-			8	-1	17
Readmission of babies	Jul 25	19	-			19	4	35
3rd/4th Degree Tears amongst mothers birthed	Jul 25	7	-			12	-1	24
3rd/4th degree tears amongst mothers birthed as a %	Jul 25	1.9%	3.5%			2.9%	0.0%	5.9%
3rd/4th degree tears following unassisted Vaginal bir	Jul 25	4	-			8	-1	17
3rd/4th degree tears following unassisted Vaginal bir	Jul 25	1.1%	-			2.4%	0.2%	4.5%
3rd/4th degree tears following an Instrumental vagin	Jul 25	3	-			4	-3	10
3rd/4th degree tears following an Instrumental vagin	Jul 25	3.3%	8.0%			4.4%	-3.5%	12.2%
PPH equal to or greater than 1.5L following an instrun	Jul 25	4	-			8	2	14
PPH equal to or greater than 1.5L following an instrun	Jul 25	0.7%	-			1.2%	0.2%	2.2%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Jul 25	6	-			12	0	24
PPH 1.5L or greater, vaginal (unassisted) births as a %	Jul 25	1.0%	2.4%			2.0%	0.2%	3.8%
PPH 1.5L or greater, caesarean births	Jul 25	8	-			7	-2	15
PPH 1.5L or greater, caesarean births as a % of mothe	Jul 25	1.3%	4.3%			1.2%	-0.6%	3.0%
ICU/CCU Admissions	Jul 25	1	-			1	-1	2
% completed VTE admission ER	Jul 25	94.4%	95.0%			94.6%	90.2%	99.0%
Maternal Deaths: All	Jul 25	0	-			0	0	1
Early Maternal Deaths: Direct	Jul 25	0	-			0	0	0
Early Maternal Deaths: Indirect	Jul 25	0	-			0	0	0
Late Maternal Deaths: Direct	Jul 25	0	-			0	0	0
Late Maternal Deaths: Indirect	Jul 25	0	-			0	0	0

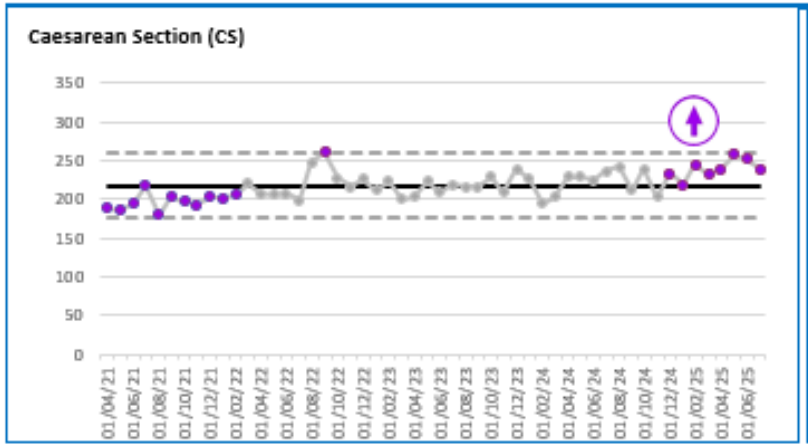
Maternity Exception Report (1)

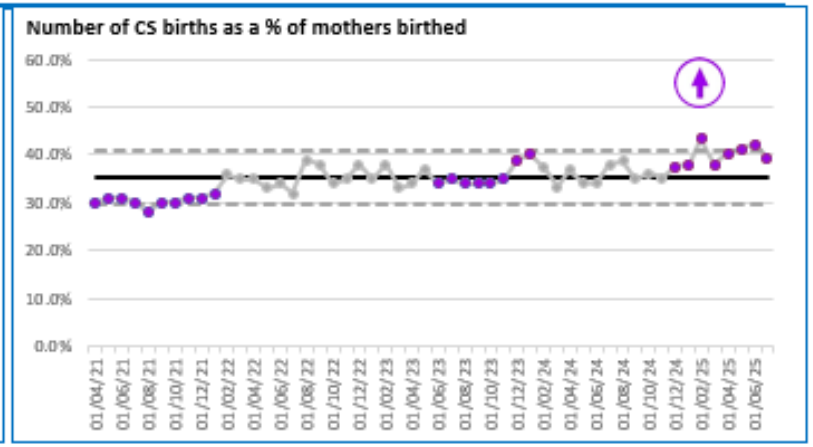




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
The Induction of labour (IOL) as a % of mothers birth shows special cause concerning variation Spontaneous Vaginal Births SVD (including breech):as a % of mothers birthed shows special cause neither improve or concerning variation	As in previous months the % of IOL has flagged as an exception. The timely induction of labour (IOL) can help reduce stillbirth rates, and research with NMPA shows hospitals with higher induction rates have lower risks at birth. The national average IOL rate has increased to 34% from 20% over ten years and is expected to rise further due to increasing complexity in maternity cases. It is proposed to remove the set target for IOL percentage from the dashboard, while continuing monthly audits which show 94-96% of IOLs are medically indicated and nationally recommended. Monitoring performance through quantitative measurement of length of delays e.g. >6hrs; >12hrs and >24 hrs is recommended, aligned to the updated IOL framework. A multidisciplinary induction of labour task and finish group has been established with a focus on the following areas: • Optimisation of midwifery and medical staffing through improved escalation pathways • Recognising and recording delays from 6 hours • Introduction of a 'fire-break Friday'	Progress and monitoring of actions and improvement plans will be reported monthly at Maternity Clinical Governance Committee. Proposed removal of 'targets' from September 2025 performance dashboard and replace with quantitative measurement of length of delays.		

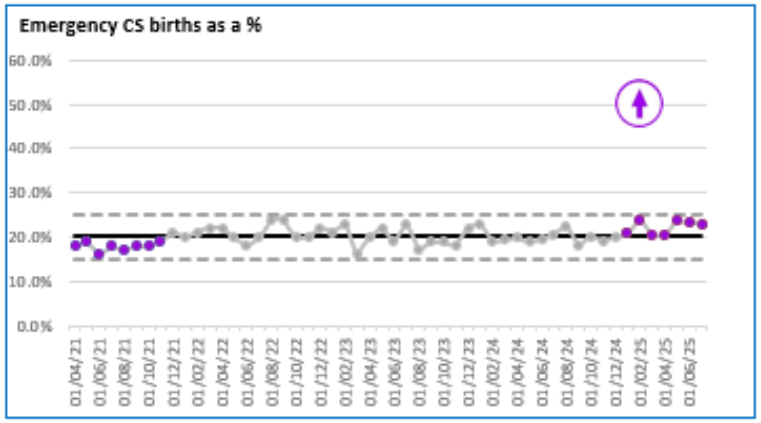
Maternity Exception Report (2)

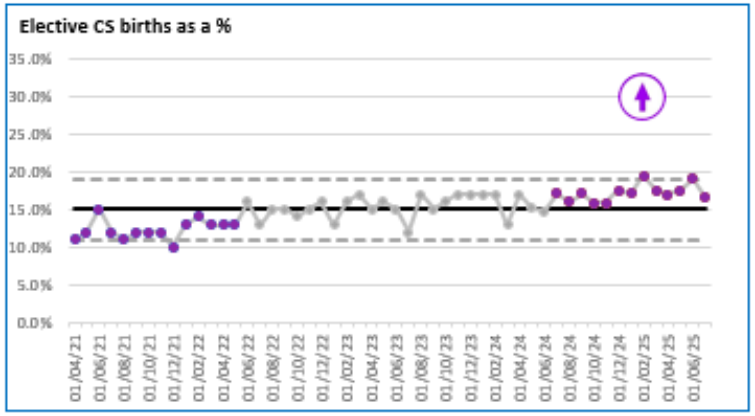


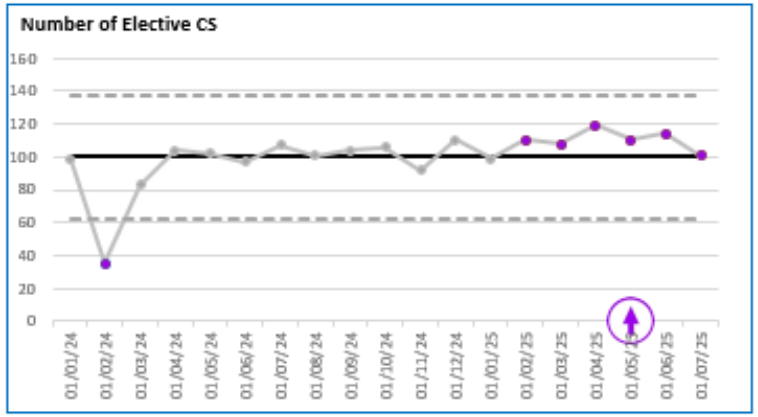


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Caesarean Section (CS) shows special cause neither improve or concerning variation Number of CS births as a % of mothers birthed shows special cause neither improve or concerning variation	As reported in previous months there is no national target for caesarean birth and these trends are reflective of national data with increasing demand for caesarean and higher levels of complexity. The maternity service will continue to quantitatively report caesarean sections by type so trends can be analysed and capacity planning can be undertaken, however from September 2025 it is proposed that the 'target' should be removed. Capacity to match the demand for the increase in caesarean birth is reflected in the maternity risk register with mitigations in place, such as additional regular weekend lists.	The Executive Board reviewed and approved the business case proposing a substantive solution to the increased capacity in April. Recruitment for weekend lists has now begun, and updates will be reported monthly through both the Maternity Clinical Governance and Maternity Directorate Performance meetings. Proposed removal of 'target' from September 2025 performance dashboard.		

Maternity Exception Report (2)

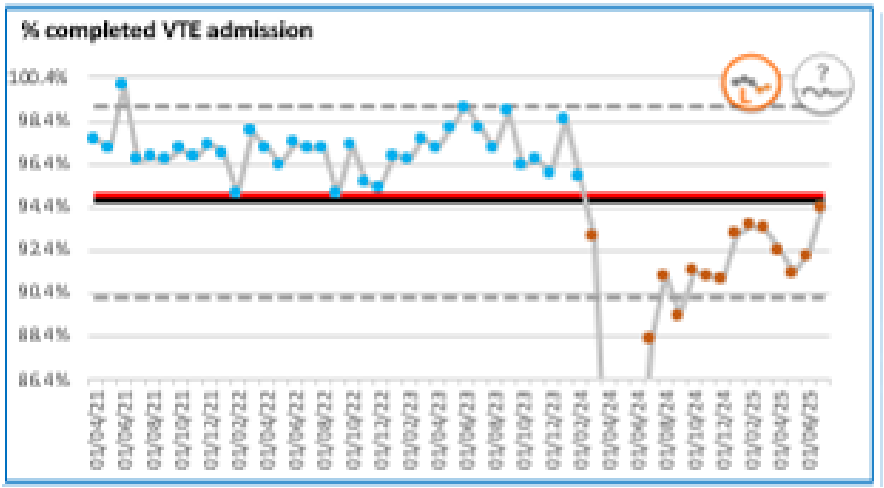






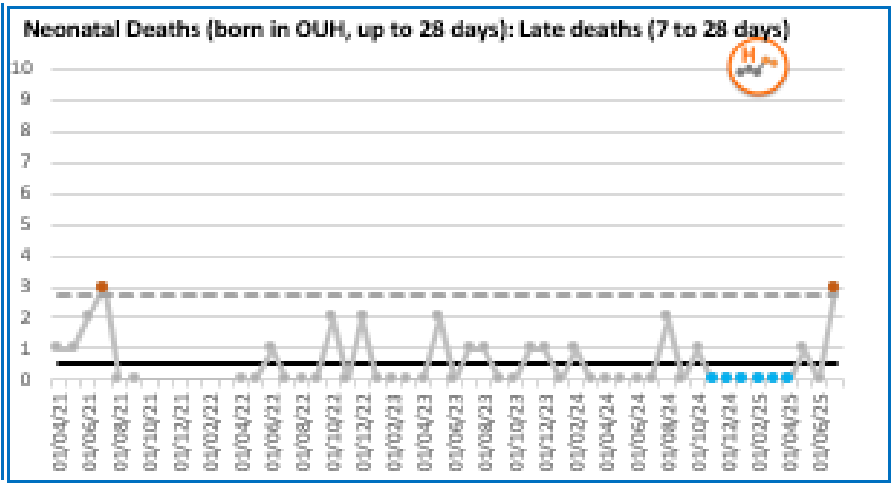
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Emergency CS births as a % shows special cause neither improve or concerning variation Elective CS births as a % shows special cause neither improve or concerning variation Number of Elective CS shows special cause neither improve or concerning variation	As reported in previous months there is no national target for caesarean birth and these trends are reflective of national data with increasing demand for caesarean and higher levels of complexity. The maternity service will continue to quantitatively report caesarean sections by type so trends can be analysed and capacity planning can be undertaken, however from September 2025 it is proposed that the 'target' should be removed. Capacity to match the demand for the increase in caesarean birth is reflected in the maternity risk register with mitigations in place, such as additional regular weekend lists. Recent industrial action did not impact planned or emergency caesarean sections.	The Executive Board reviewed and approved the business case proposing a substantive solution to the increased capacity in April. Recruitment for weekend lists has now begun, and updates will be reported monthly through both the Maternity Clinical Governance and Maternity Directorate Performance meetings. Proposed removal of 'target' from September 2025 performance dashboard.		

Maternity Exception Report (3)



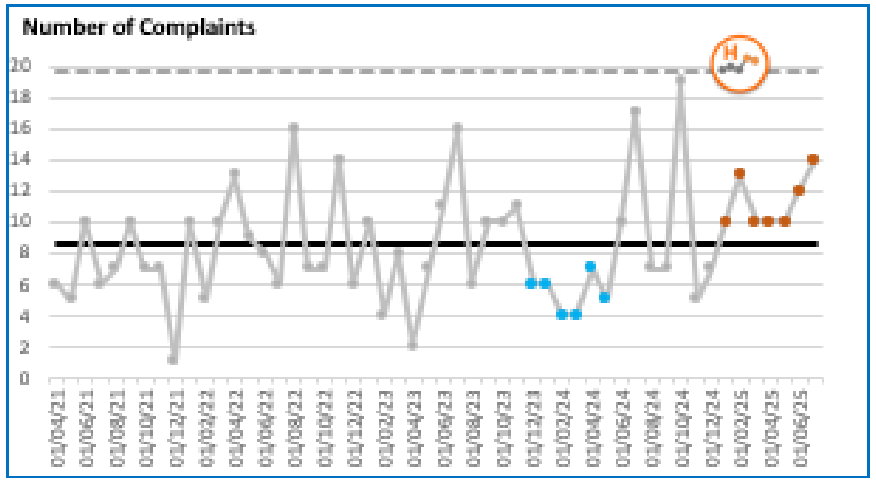
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% of completed VTE admission shows special cause concerning variation	VTE completion on admission has significantly improved, with compliance rising by over 6% from last month to 94.4%. A multidisciplinary VTE task group now leads efforts to reach 100% timely and accurate VTE assessment. Current priorities include: • Digital review of BadgerNet V's Cerner VTE assessment tool to optimise compliance • Continued communication as required • Ongoing additional audit	Progress and monitoring of any action plans will be reported monthly at Maternity Clinical Governance Committee.	N/A	N/A

Maternity Exception Report (5)



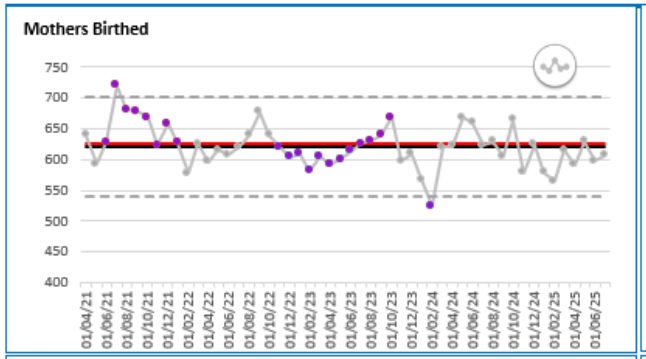
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Neonatal Death (born in OUH, up to 28 days): Late deaths (7 to 28 days): shows special cause concerning variation	There were three cases reported in July 2025. Case 1 This was a neonatal death of a baby born preterm at 23+3. The baby was transferred in utereo from RBH, was born at OUH and sadly died aged day 7. Case 2 This was a neonatal death of a baby born preterm at 34+5 with significant and complex cardiac abnormalities, sadly the baby died aged day 7. Case 3 This was a neonatal death of a baby born preterm at 22+4, the mother had attended with threatened pre-term labour having had private antenatal care.	No immediate care concerns or thematic learning has been identified in respect of these cases on immediate review. All cases will be reviewed by the multidisciplinary team using the perinatal mortality review tool (PMRT).	N/A	N/A

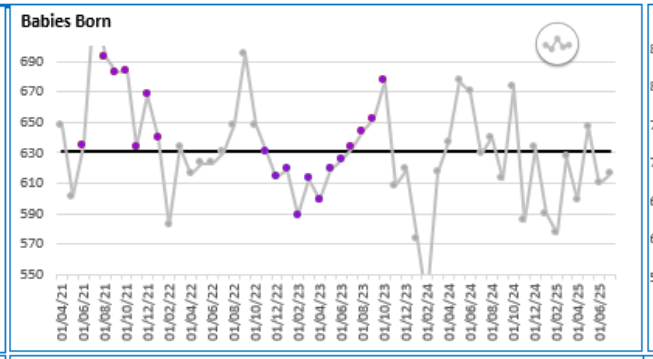
Maternity Exception Report (6)

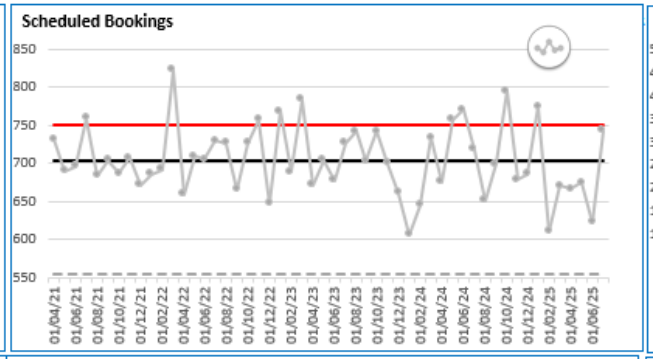


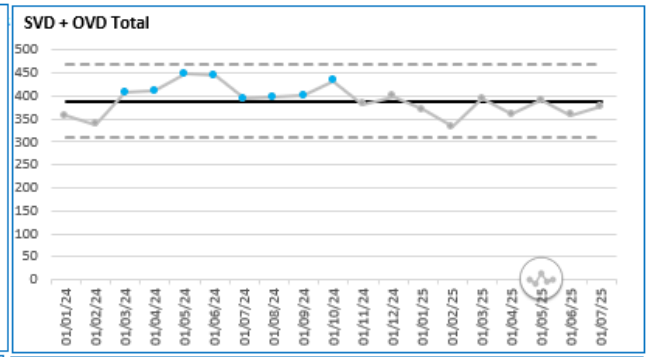
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Number of Complaints shows special cause concerning variation	For context, in July, there was an increase in complaints across the Trust with total complaints received exceeding 200. To address and reduce these complaints, the service has implemented the monthly Triangulation and Learning Committee (TALC). This committee consists of representatives from patient experience, safety, legal services, and maternity and neonatal operations. Review and analysis of feedback for common themes is undertaken and both immediate and long-term improvement plans are developed, with the goal of being responsive to service users and reducing complaints over time. In addition, the maternity safety team continue to visit families affected by patient safety incidents in the rapid responder role. There have been 73 visits and positive feedback has been provided about communication and an improved understanding for those service users impacted by patient safety incidents. This role provides critical, timely opportunities for patients and families to reflect on their care experience, especially when outcomes are less favourable, such as with OASI (Obstetric Anal Sphincter Injury). This proactive approach extends the duty of candour and is expected to reduce complaints and litigation over time.	Progress and monitoring of any action plans from TALC will be reported monthly at Maternity Clinical Governance Committee. Maternity complaints task and finish group to be established in August chaired by Patient Experience team, further supporting the triage and triangulation of complaints and freedom of information requests.		

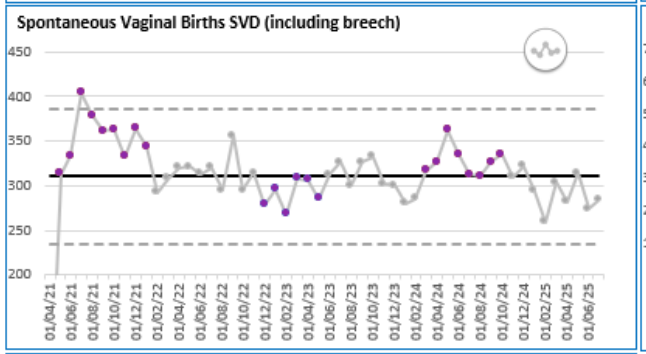
Appendix 1. SPC charts (1)

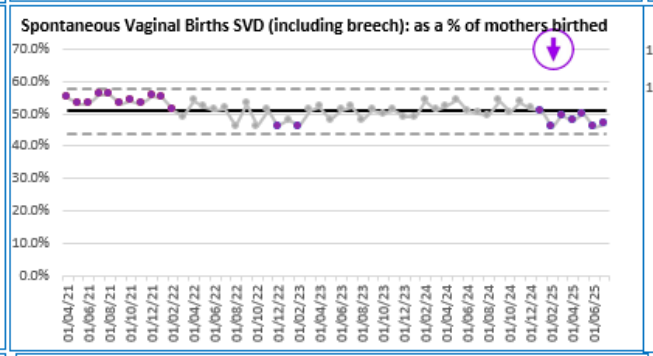


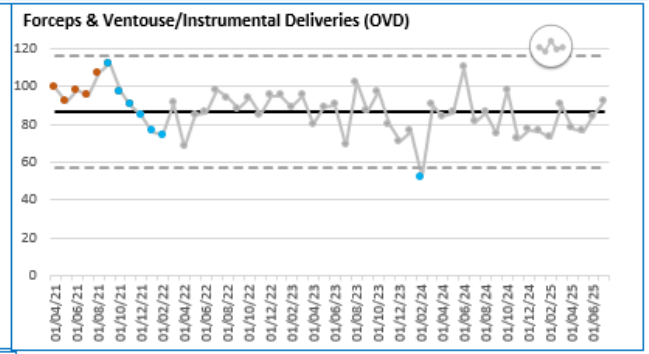


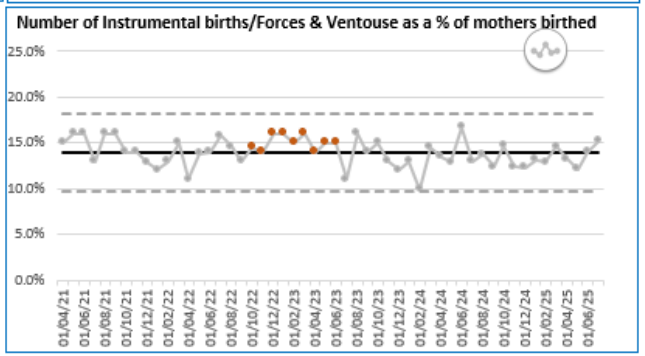


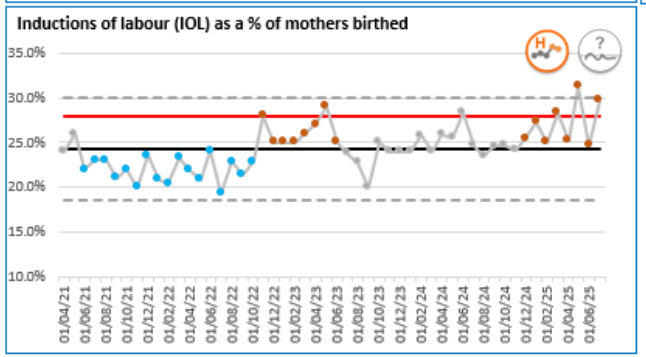


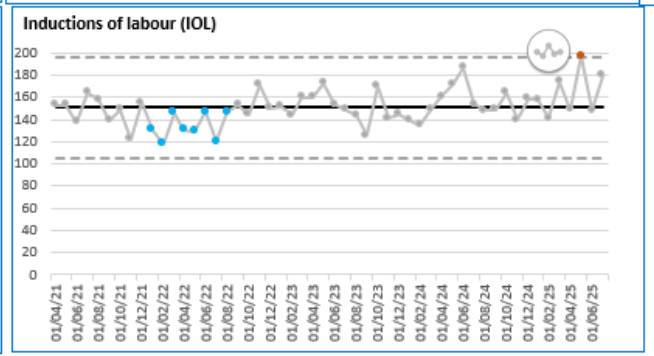




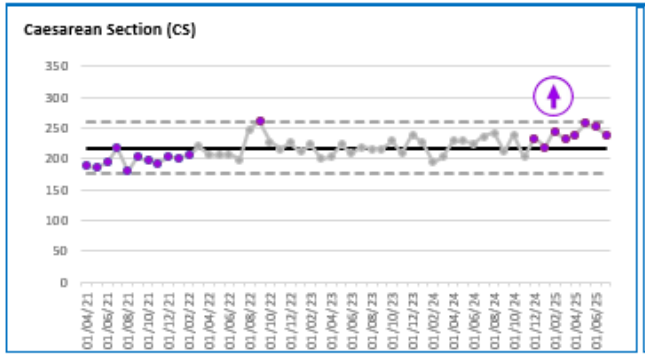


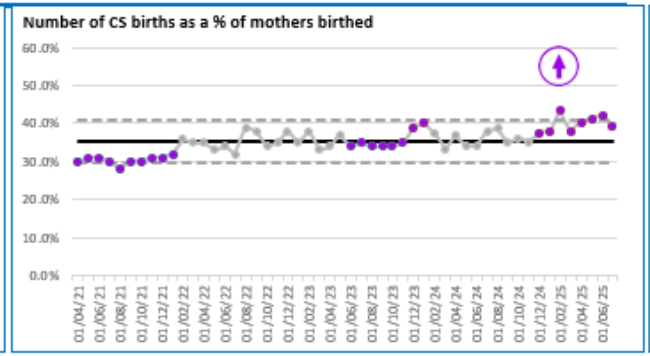


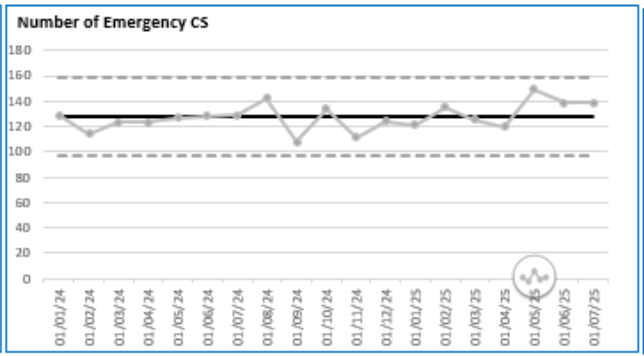


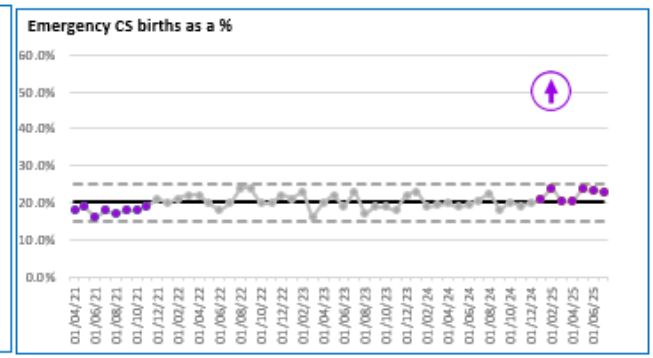


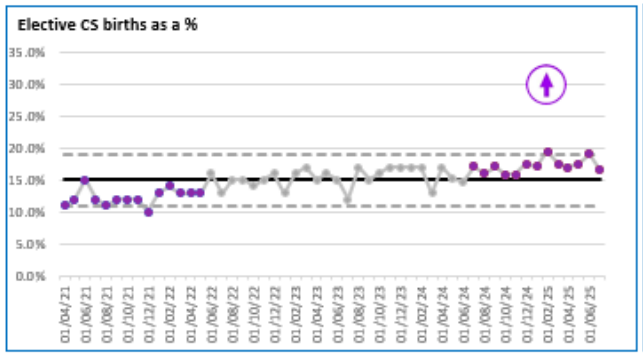
Appendix 2. SPC charts (2)

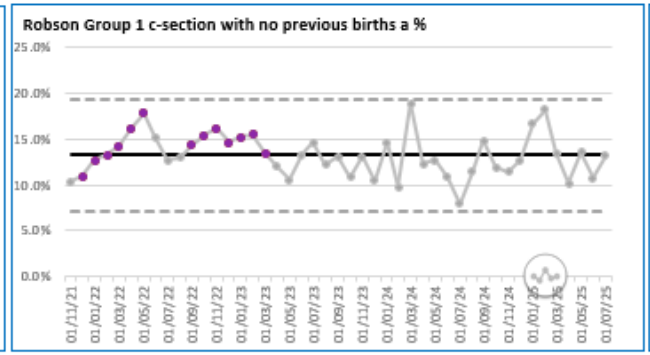


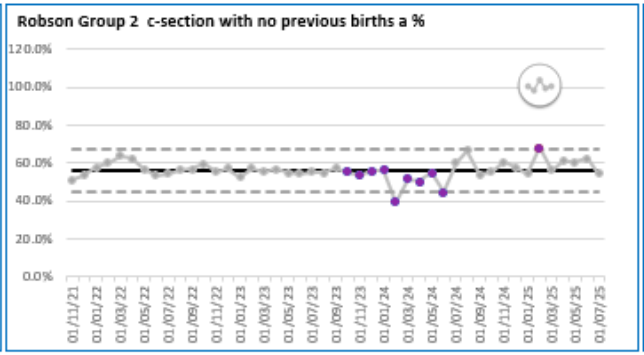


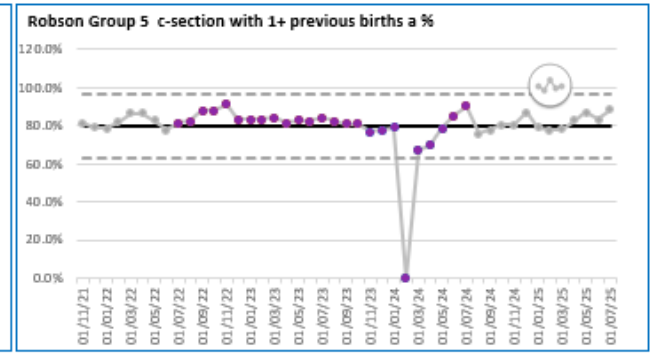


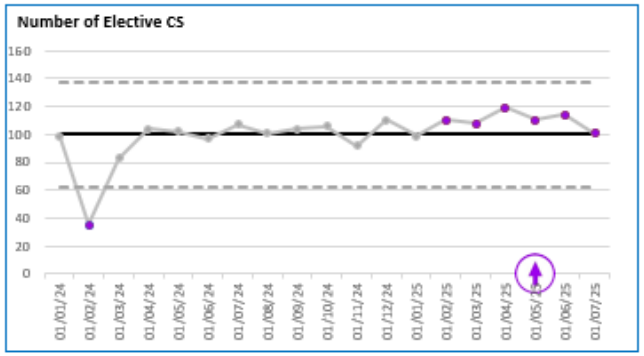


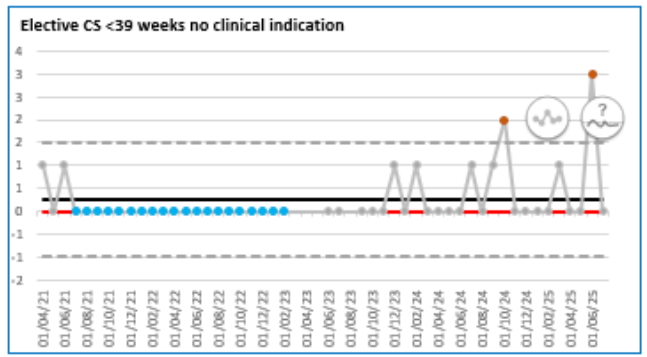




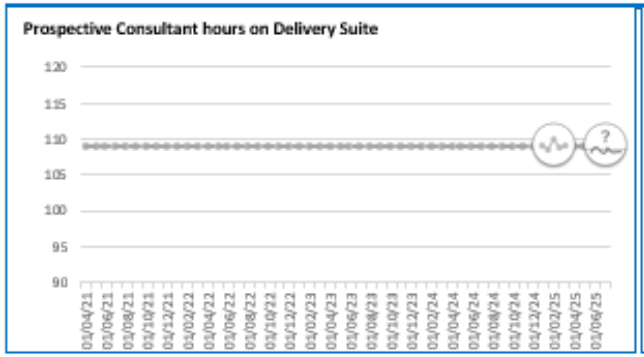


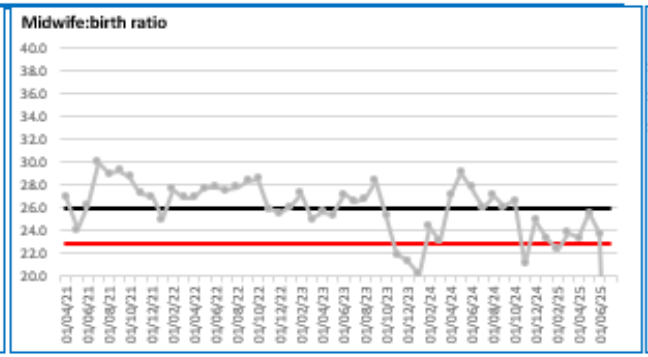


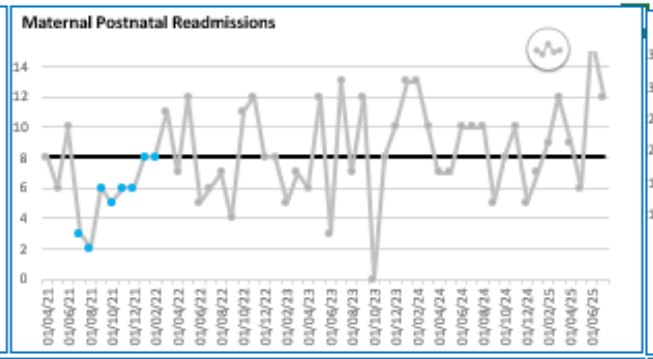


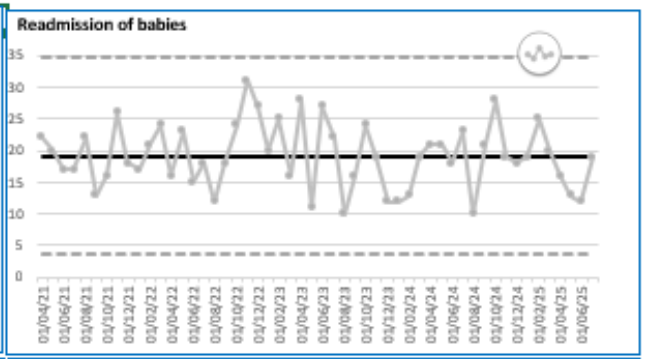


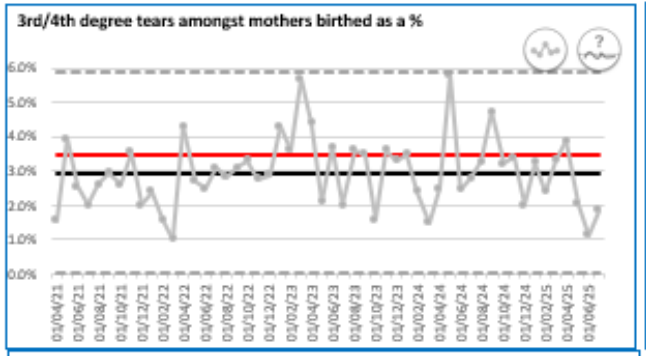
Appendix 3. SPC charts (3)

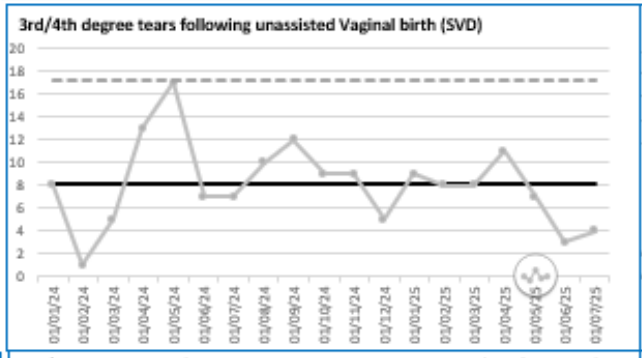


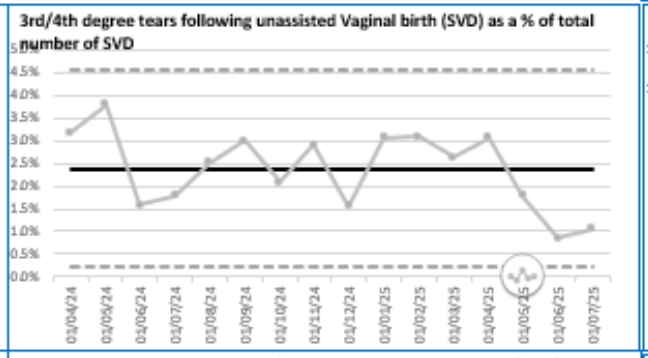


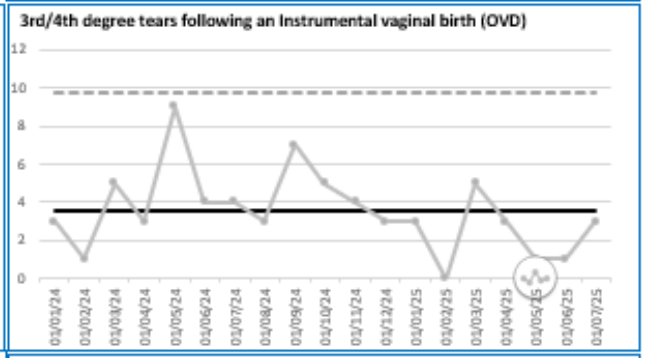


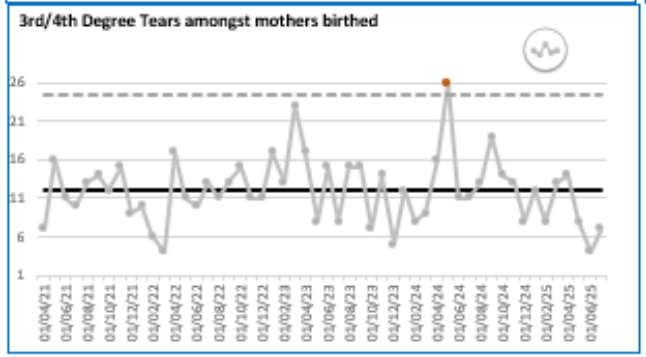


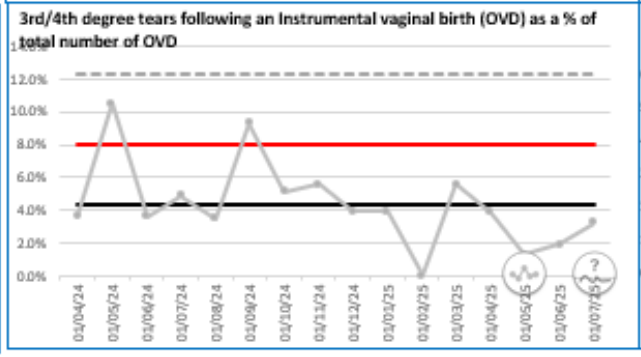


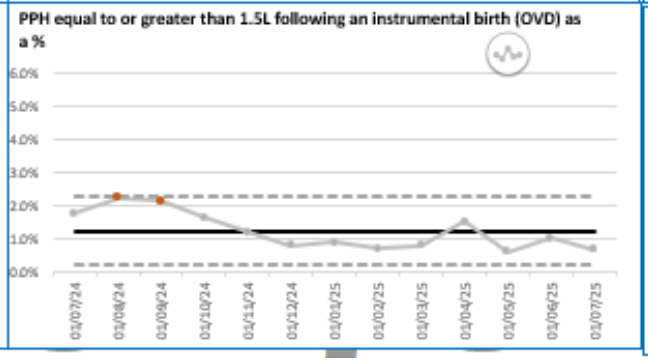


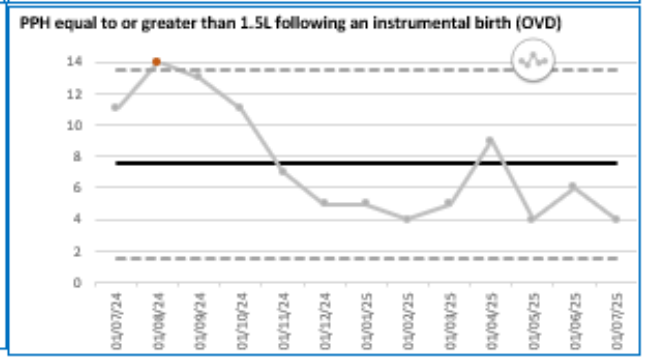




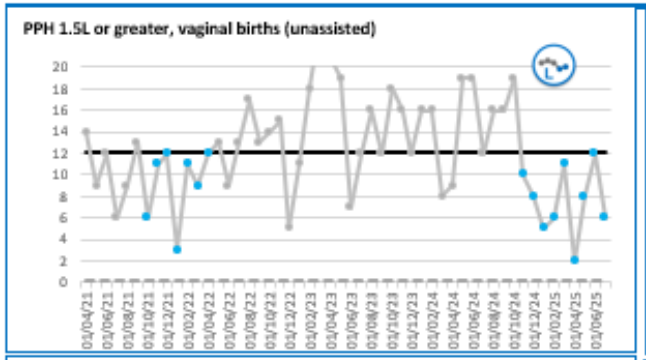


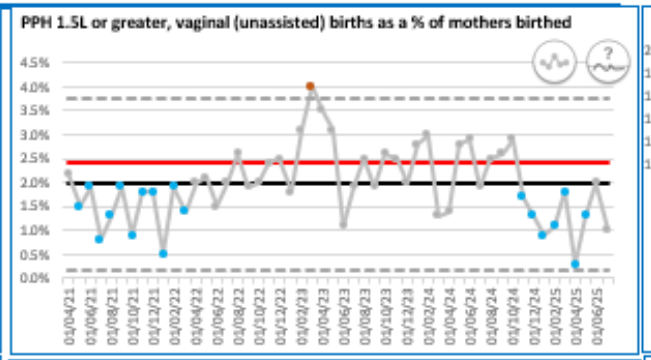


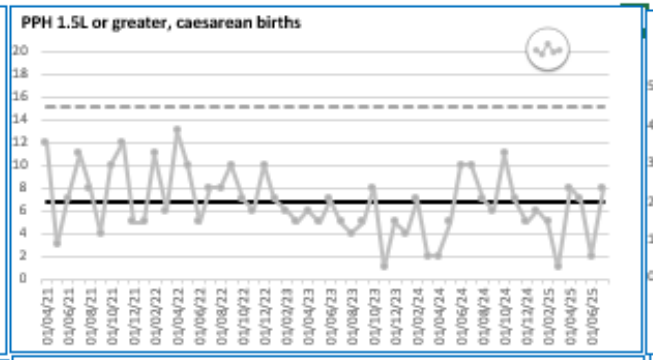


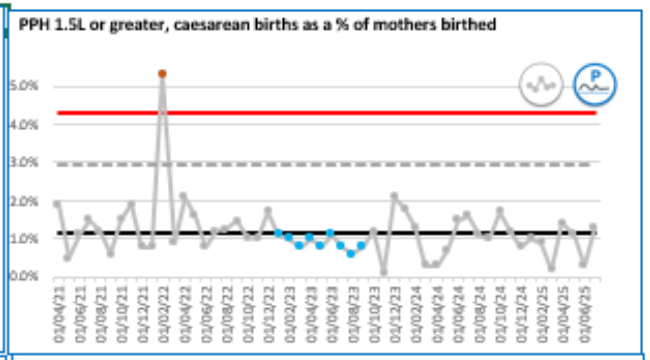


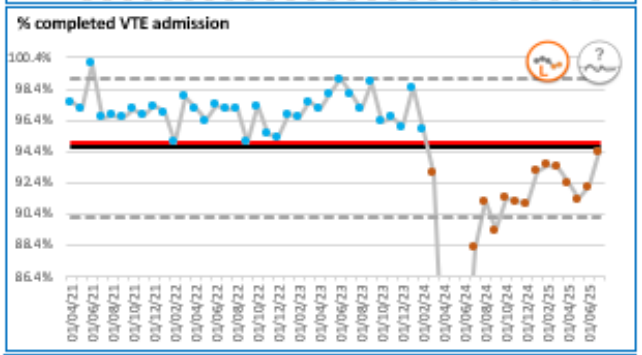
Appendix 4. SPC charts (4)

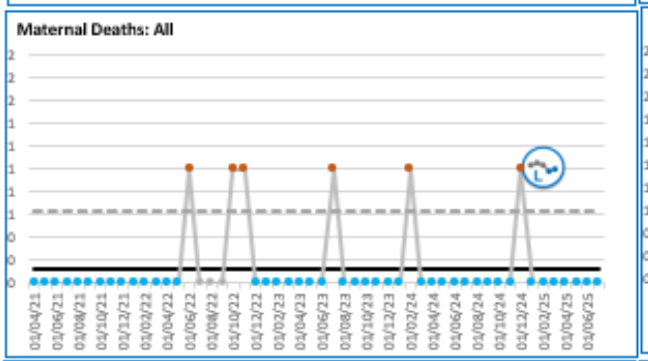


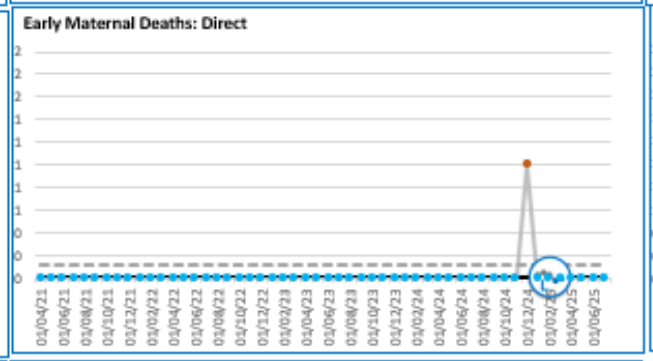


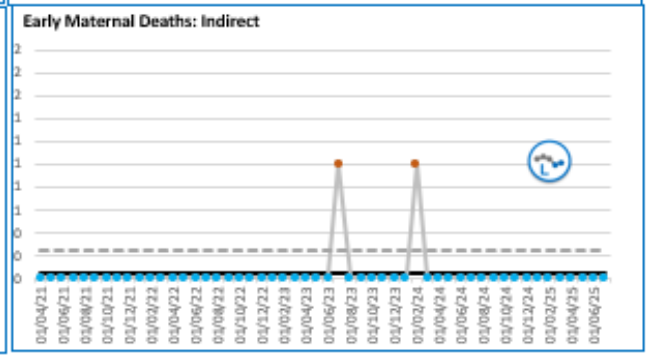


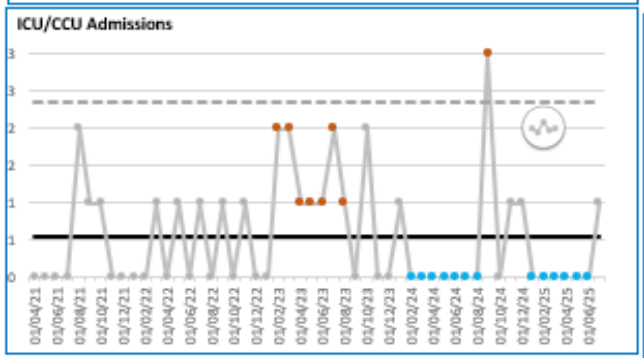


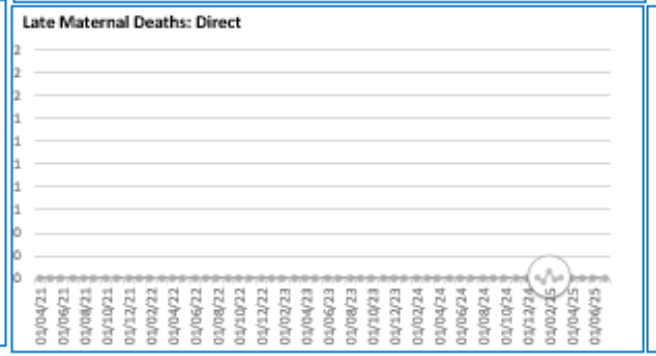


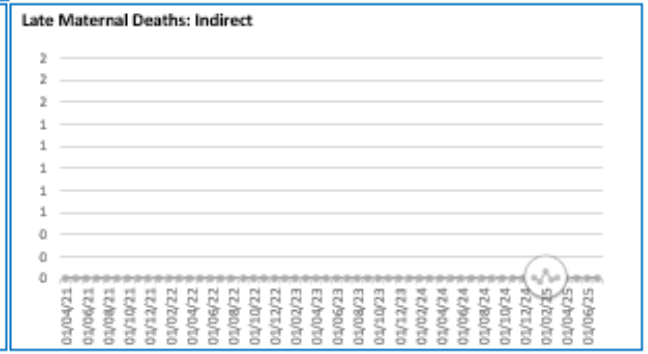




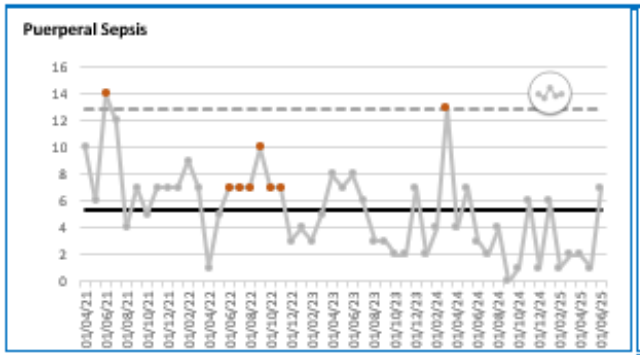


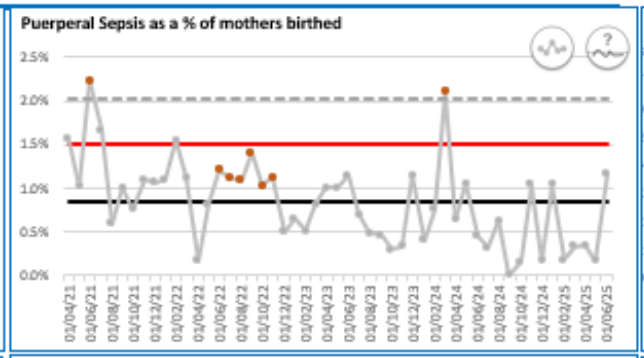


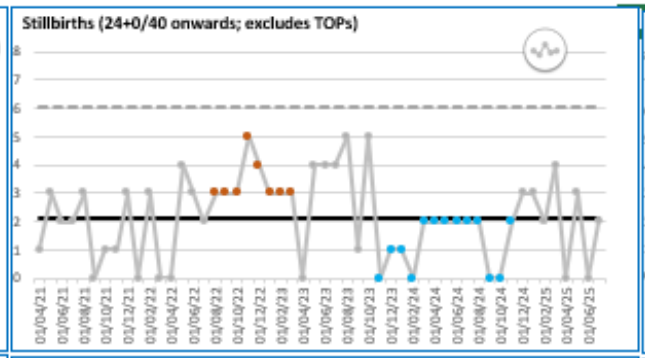


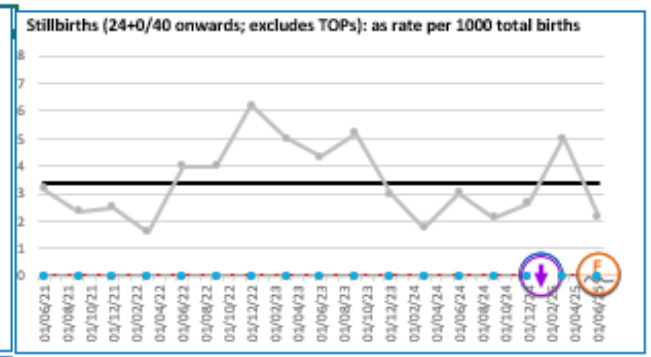


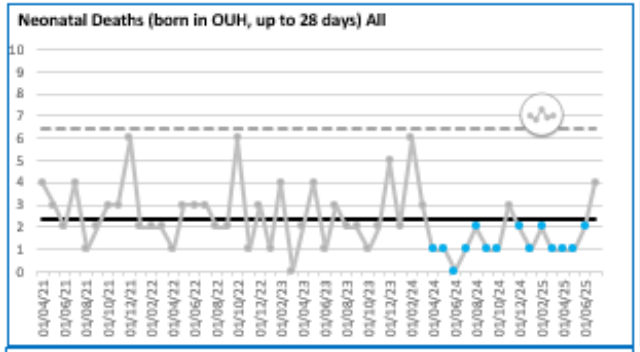
Appendix 5. SPC charts (5)

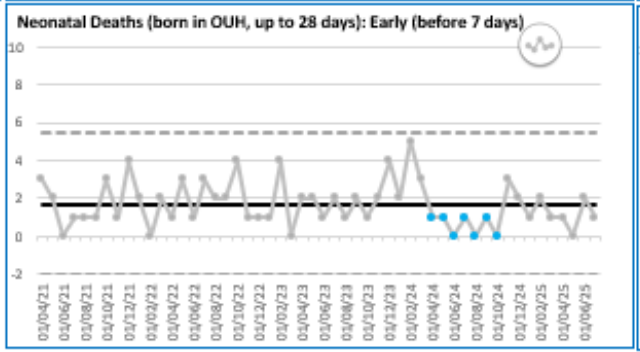


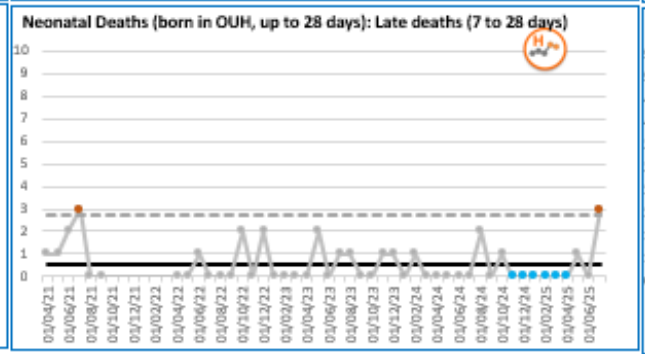


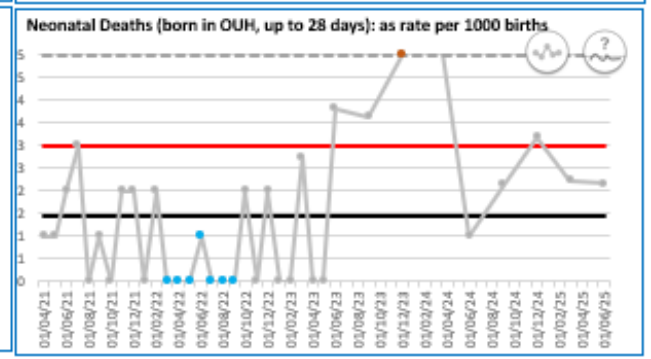


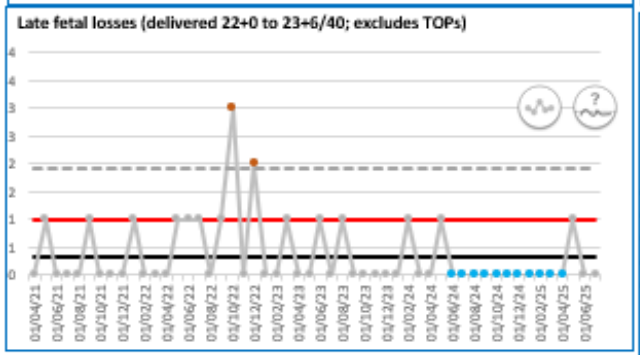


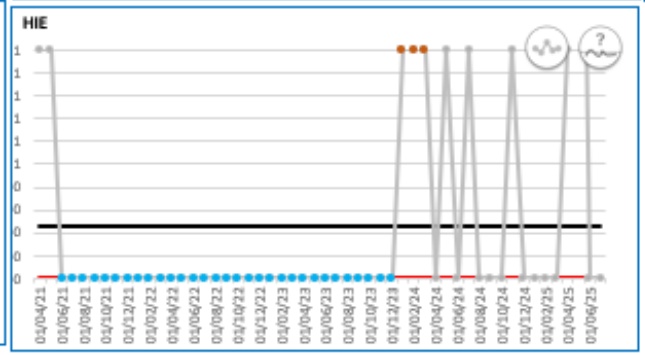




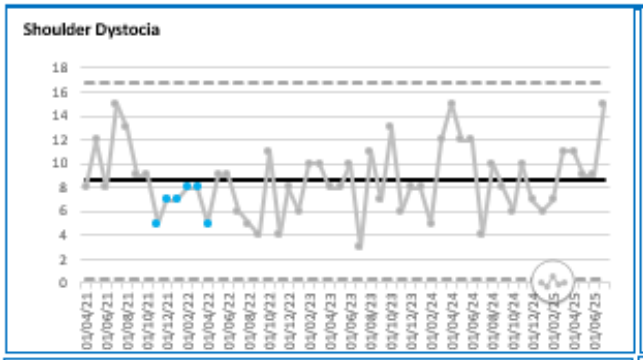


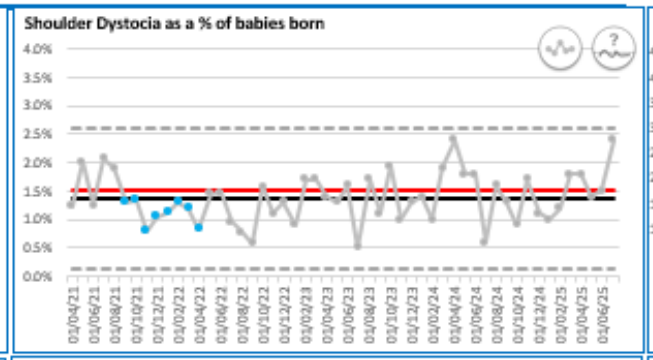


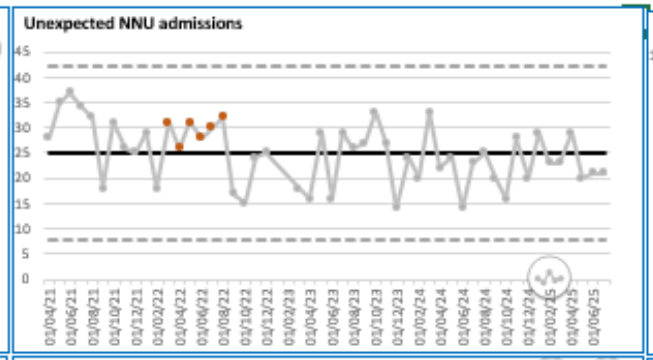


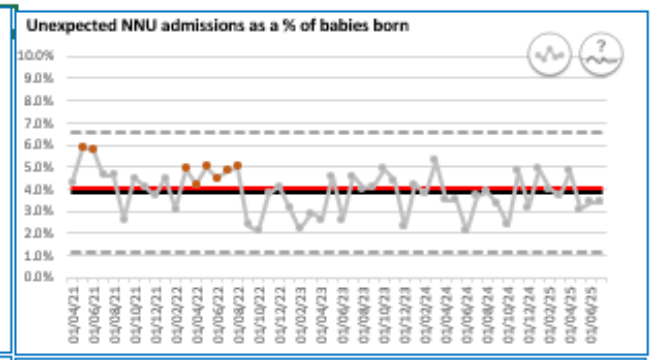


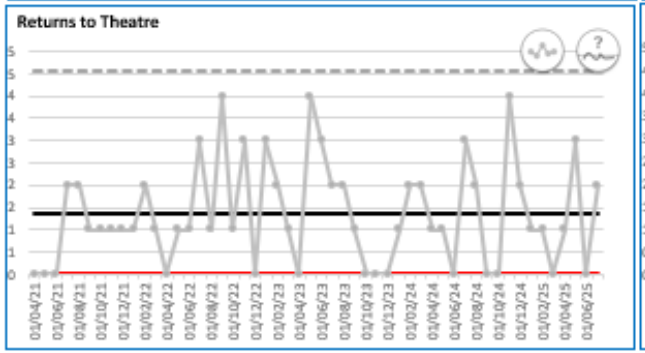
Appendix 6. SPC charts (6)

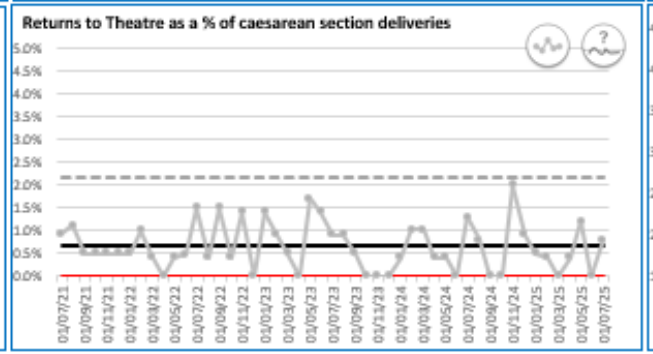


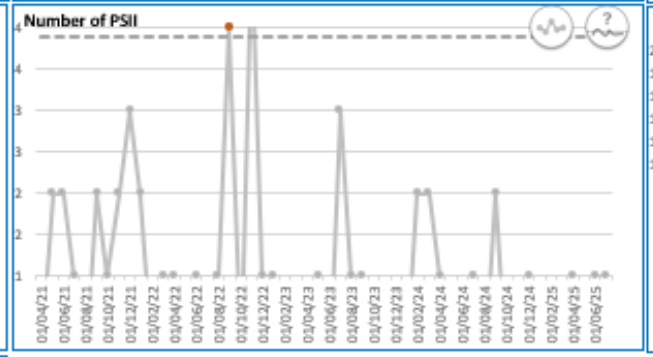


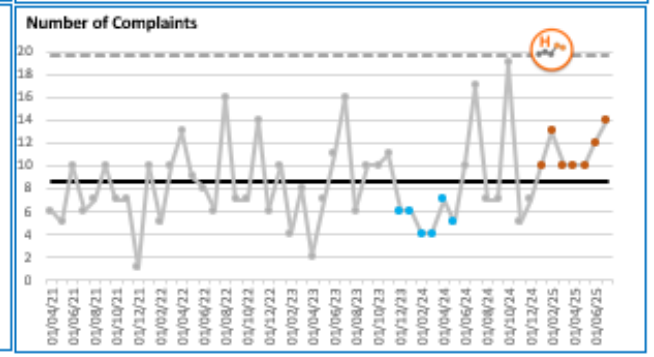


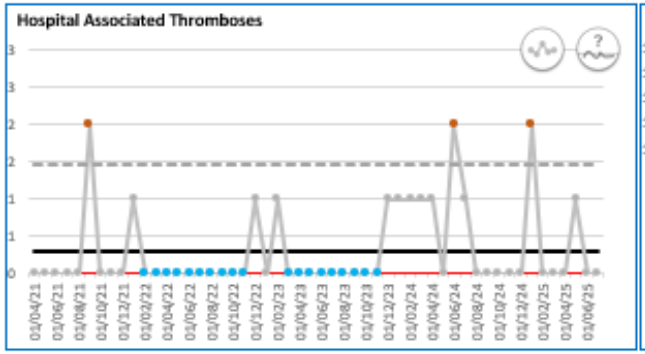


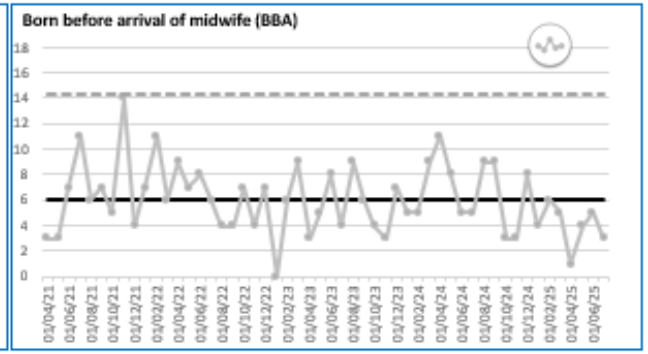




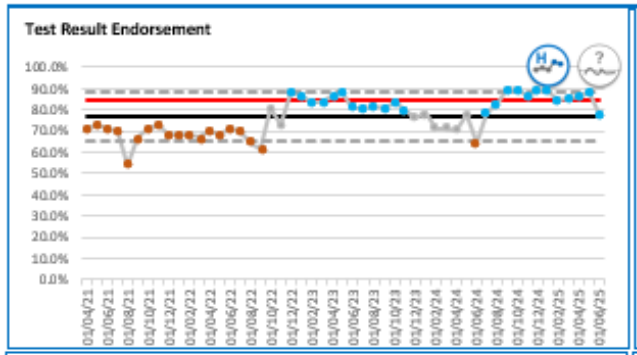


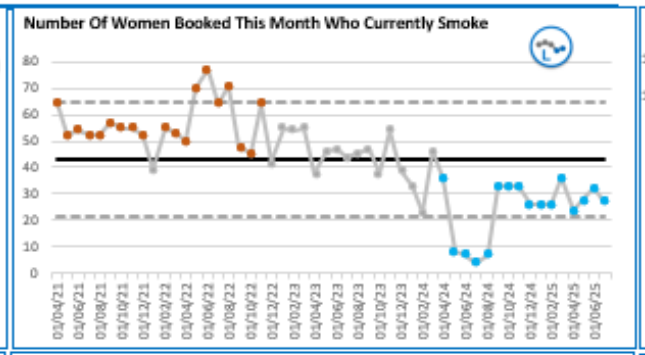


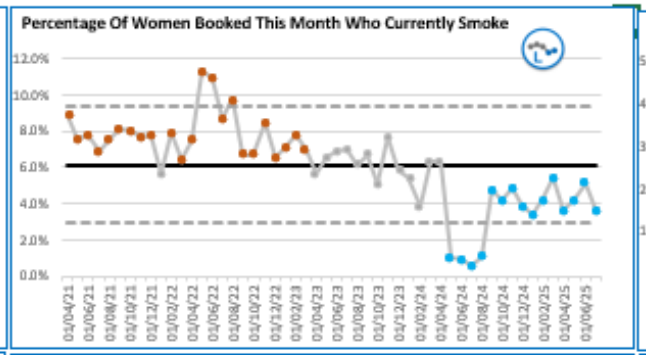


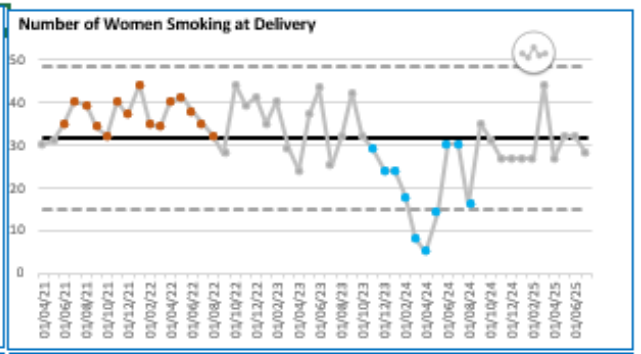


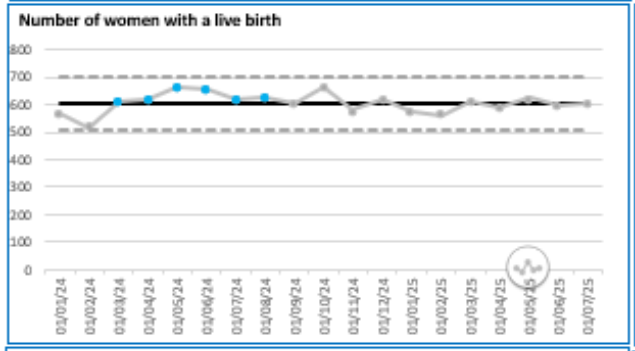
Appendix 7. SPC charts (7)

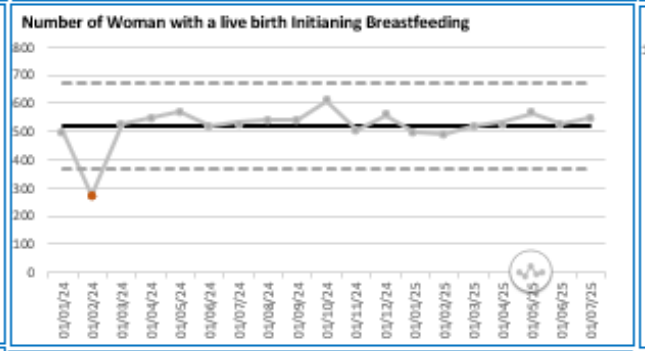


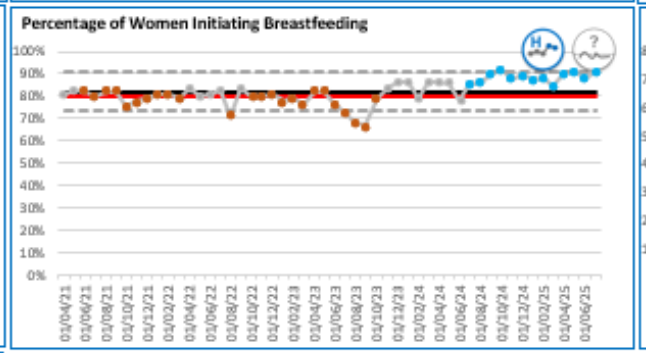


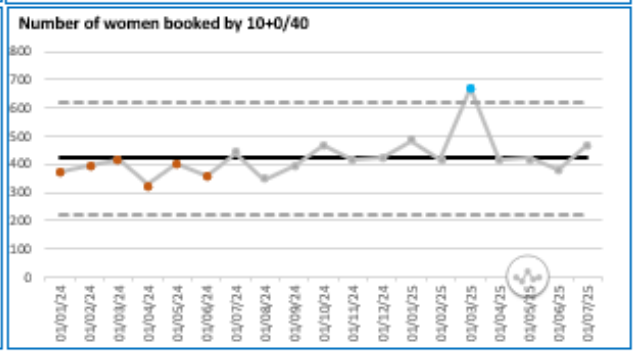


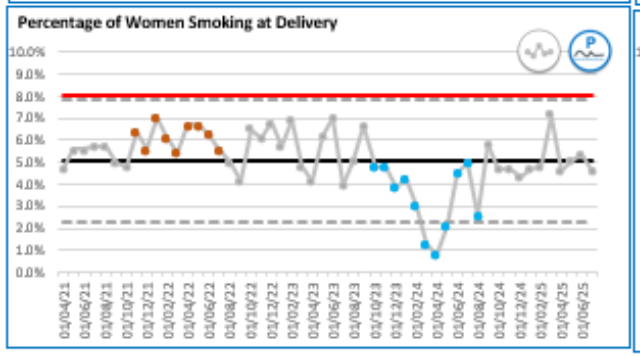


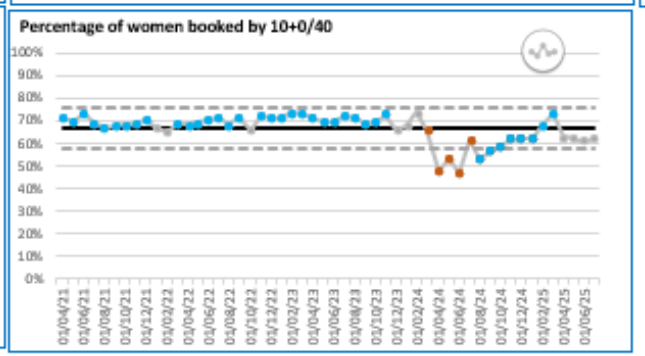












Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

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