Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 March 2026

TB2026.25

Title:	**Thematic Review of Maternity Complaints 2020 - 2025**

Status:	**For Discussion**
History:	**15 January 2025 / Confidential Trust Board**

Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	Performance.

Executive Summary

1. Between 1 January 2020 and 31 December 2025, OUH Maternity Services received 613 complaints. Outcomes were 15% not upheld, 70% partially upheld, and 15% upheld. Risk grading shows 85% low and 15% moderate, with no high-risk complaints.
2. While volumes rose steadily across the period, 2025 saw a step change to 167 complaints (16.06 per 1,000 admissions), driven primarily by communication related issues rather than clinical treatment or patient care related issues rather than clinical.
3. Thematic analysis shows Clinical Treatment remained the largest category in most years. Communication increased from 16.8% (2024) to 31.7% (2025)—notably in "communication with patient", "information/explanation", and "patient not listened to". The 2025 increase is best explained by gaps in information sharing and listening, often exacerbated by delays and handover/coordination issues across pathways.
4. Subthemes underpinning the 2024–25 communication rise include delays and expectation setting, timely/clear pain relief information, partner/visiting updates and support, not feeling listened to, and consent/explanations for procedures. These concentrate around MAU/triage, induction and labour, and early postnatal care.
5. Counterbalancing signals from the Friends and Family Test (FFT) (introduced May 2025) indicate most respondents report very positive experiences (83–94% positive across months reported), suggesting specific pathway bottlenecks rather than universally poor experience. Feedback cites professionalism, clear communication, and calm, reassuring care aligning with targeted improvements underway.
6. The service has progressed several improvement programmes which include maternity triage, Induction of Labour (IOL) pathway and targeted training updates. The Maternity Development Programme strengthened partnership with OMNVP, and a focus on postnatal improvements has likely contributed to stable/improving proportions of Clinical Treatment and Patient Care complaints.
7. An action plan has been created to address issues highlighted in the 2025 complaints, especially those concerning communication and information sharing. These actions and the associated measures of progress are a key component of the Perinatal Improvement Programme.

Recommendations

8. The Trust Board is asked to:
    - Note the findings of this report, including the work that is in progress and future work plans.
    - Note the nine new targeted actions for the Perinatal Improvement Plan to address the emerging themes from 2025, including standardised proactive communication for MAU and IOL delays, a formal review of the Maternity Behavioural Charter, and communication and complaints training.

Contents

Thematic Review of Maternity Complaints 2020 - 2025

1. Purpose

1.1. This paper provides a comprehensive analysis of complaints themes and trends relating to maternity services between 1 January 2020 and 31 December 2025.

1.2. The report builds upon previous updates provided to TME and the Board in 2025 and evaluates the impact of maternity services improvement initiatives on service user experience of care.

2. Background and Introduction

2.1. Maternity Services at Oxford University Hospitals NHS Foundation Trust (OUH) has recently faced intense scrutiny, not only due to concerns raised by campaign groups and inclusion in a national review of maternity services, but also within the broader context of negative press and heightened national attention on maternity care standards across the UK.

2.2. The service is committed to listening to the voices of service users and reinforcing a learning culture that promotes continuous improvement and provision of high-quality care with excellent service user experience.

2.3. This thematic review analyses maternity complaints from 1 January 2020 to 31 December 2025 to evaluate the impact of recent / current service improvement from the perspective of service users and inform future service improvement ensuring governance assurance. It updates prior reports to TME/Board (2025) and assesses the impact of ongoing programmes on experience of care, triangulating complaints trends with FFT evidence and known pathway reforms.

2.4. The findings and proposed actions align with Trust strategic pillars: Patients, People, Partnerships, Performance by (i) ensuring a comprehensive understanding of service user experience of care, and acting on themes and trends identified through triangulation of data; (ii) supporting staff with clearer processes and skills development; (iii) strengthening partnerships with service users via OMNVP; and (iv) enhancing performance through reduced complaint volumes, improved flow/coordination and governance processes and oversight.

3. Methodology

3.1. A report was extracted from Ulysses of all complaints relating to maternity services where the complaint was received between 1 January 2020 and 31 December 2025. This included complaints that related to care delivered

prior to this period, and some that were considered ‘historic’ (relating to care provided more than 12 months prior to receiving the complaint).

3.2. Themes and trends were identified through analysis of complaint categories and sub-categories for each year.

3.3. Free-text thematic analysis was undertaken. This provided enhanced insights and context that further informed the themes underlying the categories.

3.4. Data and findings were cross-referenced against previous thematic reviews undertaken by Maternity Services.

3.5. A review of Friends and Family (FFT) and ‘say on the day’ scores and free-text themes was undertaken, enabling triangulation of themes, providing a more complete picture of service user experience within the service.

3.6. Further drill-down of the 2025 complaints data was undertaken to provide insights into drivers of the service improvements to evaluate the impact.

3.7. Gaps identified from this review were used to inform recommended actions for continued service improvement.

4. Findings

4.1. Between 1 January 2020 and 31 December 2025, maternity services received 613 complaints.

4.2. During this time, 15% were ‘not upheld’, 70% were ‘partially upheld’ and 15% were ‘upheld’.

4.3. The majority (85%) of the complaints were assessed as low risk, with 15% assessed as moderate risk and none that were considered to be high risk complaints. This aligns positively with Trust-wide complaints where 70% are assessed as low risk, and 20% are assessed as moderate risk.

Annual Picture

4.4. Maternity Services has observed an increase in complaints over the five-year period studied for this report with a notable increase to 167 in 2025 (Figure 1). This equates to 16.06 complaints per 1000 admissions for that year (Figure 2). Of these, 26 complaints were considered ‘historic’ as they related to care that was received more than 12 months prior to receipt of the complaint.

4.5. It is worth mentioning that the increase shown in Figure 2 from 2024 onward may be related to increased national attention on maternity services and OUH's participation in the National Review of Maternity Services. The rise in maternity complaints also reflects a wider national increase in NHS complaints across all services, not just maternity care.

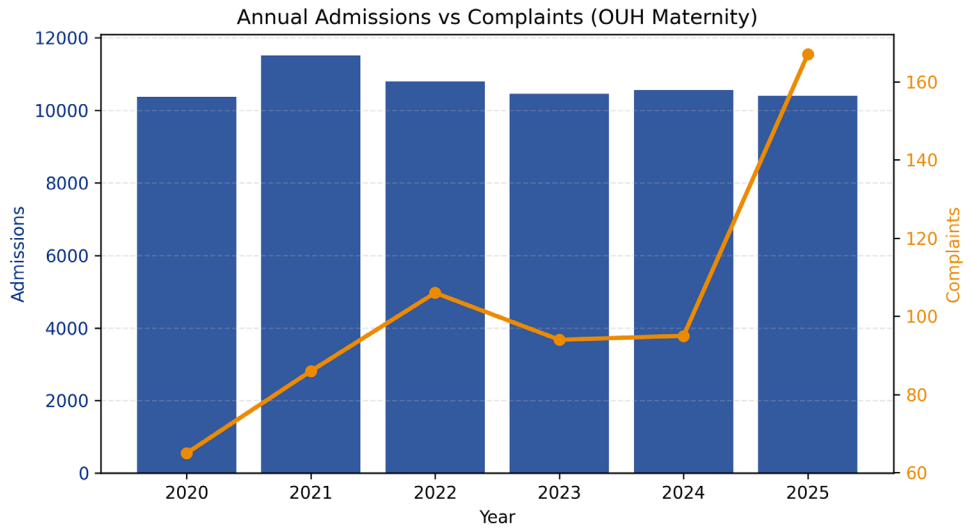

Figure 1: Annual Admissions (bars) and Complaints (line), 2020–2025.

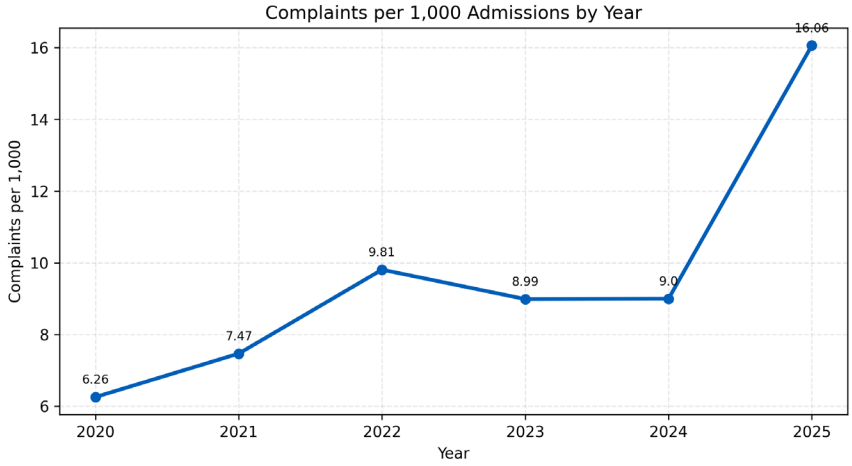

Figure 2: Complaints per 1,000 admissions by year; 2025 step-change is visible.

Annual Themes Overview

4.6. Figures 3 and 4 highlight the predominant complaint categories throughout the review period. Clinical Treatment has consistently been the most frequently attributed category except for 2021 where complaints overwhelmingly corresponded to visiting restrictions during the COVID-19 pandemic. Note: multiple categories can be selected for each complaint.

Category	**2020**		**2021**		**2022**		**2023**		**2024**		**2025**	
Clinical Treatment	29	**50%**	12	**15%**	29	**30%**	36	**39%**	44	**48%**	56	**37%**
Communication	9	**16%**	7	**9%**	29	**30%**	16	**17%**	16	**18%**	53	**34%**
Patient Care	8	**13%**	47	**59%**	23	**24%**	24	**26%**	20	**22%**	27	**18%**
Values and Behaviours	7	**12%**	6	**7.5%**	9	**9%**	14	**15%**	6	**7%**	14	**9%**
Admin/Policy	5	**9%**	8	**10%**	8	**8%**	3	**3%**	5	**6%**	3	**2%**

Figure 3: Complaint Category Types (Top 5) by year

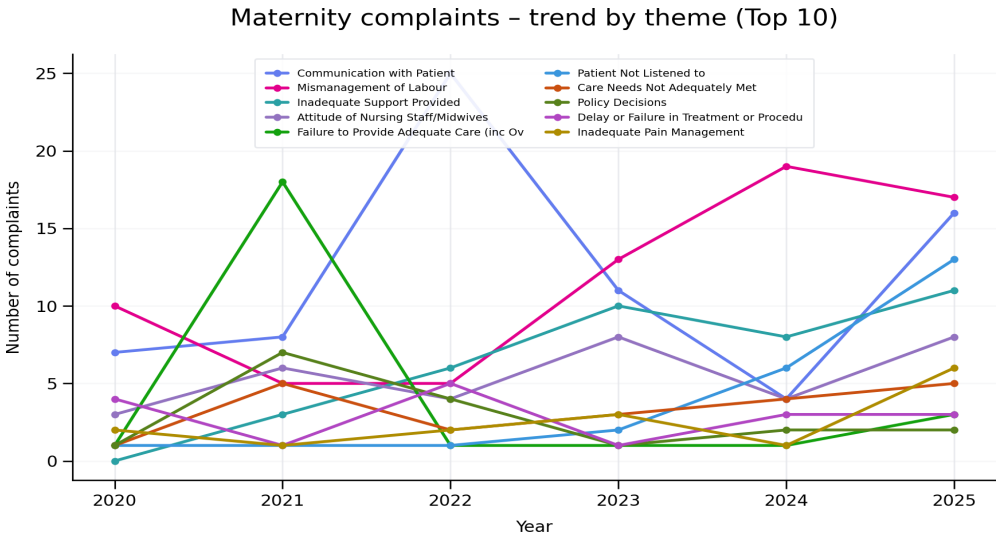

Figure 4: Maternity complaints – trend by theme (Top 10)

4.7. Clinical Treatment was the predominant complaint category in most years, reaching its highest percentage of 48.4% in 2024.

4.8. Patient Care complaints were most prominent in 2021, equalling 58.8%, and reflecting the impact of pandemic-related restrictions.

4.9. In 2022, Clinical Treatment and Communication complaints were equally significant, each accounting for 29.6% of cases.

4.10. Communication complaints saw a substantial increase in 2025, rising from 17.6% in 2024 to 34.2%, with case numbers in the top five categories increasing from 16 to 53.

4.11. Values & Behaviours is relatively stable through time, suggesting that the 2025 change is primarily a communication effect rather than a broad deterioration in behaviours.

4.12. Admin/Policy remains a consistently small share (≤10% each year, 2.0% in 2025), indicating fewer complaints centre on policy/administrative factors relative to clinical care or communication.

Themes by year

4.13. In 2020, complaints were mainly concentrated in three key departments:

- JR Delivery Suite – 13
- JR Maternity Assessment Unit (MAU) – 9
- JR Level 5 Women's Centre – 5

4.14. Clinical treatment themes related to concerns about mismanagement of labour, delays in induction, retained placenta and missed or delayed diagnoses. Recurring issues included pain relief, episiotomy repair and instrumental delivery injuries.

4.15. Communication themes centred on COVID restriction due to poor explanations, conflicting advice and lack of updates. Complaints highlighted insufficient explanations of risks, birth options and scan findings.

4.16. Complaints relating to patient care highlighted women feeling neglected, particularly during high pressure periods, and postnatal gaps including missed observations, limited feeding support, and delayed assistance with mobility.

4.17. Reports of rudeness and lack of empathy with insensitive communication from clinical and administrative staff featured within the values and behaviours category. This included concerns raised about perceived discriminatory comments, particularly around ethnicity.

4.18. In 2021, the three predominant departments for complaints were:

- JR MAU – 37
- JR Level 5 Women's Centre – 12
- JR Outpatients Women's Centre - 11

4.19. Clinical treatment categories continued to identify delays in monitoring, missed diagnoses and issues with clinical procedures (e.g. misinterpreted scans). There was an emerging theme relating to post birth complications such as infections and retained products. Induction and triage delays are also mentioned.

4.20. Communication failures were cited relating to breaking bad news, inconsistent messaging and limited antenatal explanation of risks. There were rising reports of not feeling listened to, especially during early labour.

4.21. Patient care issues predominantly related to partner exclusion due to visiting restrictions during the pandemic. Women felt unsupported postnatally, particularly after caesarean sections and concerns about environmental factors (cleanliness, noise, lack of rest) also featured strongly.

4.22. Complaints referenced staff appearing dismissive or patronising especially in MAU and scan areas.

4.23. In 2022, the three predominant departments for complaints were:

- JR Delivery Suite - 23
- JR Level 5 Women's Centre – 20
- Community Midwifery Services - 14

4.24. Clinical Treatment complaints highlighted a notable growth in complaints about missed or incorrect diagnoses including jaundice and maternal complications. Issues relating to delayed treatment, late escalation,

analgesia availability also featured. There was a clear shift in focus towards clinical capacity issues and staffing constraints.

4.25. Communication themes focused more on conflicting information between teams (community, MAU and Delivery Suite) with communication failures associated with complications noted.

4.26. Feeding, pain relief and post-operative care reappear in relation to patient care with rising concerns related to inadequate documentation leading to poor continuity of care.

4.27. Insensitive comments and lack of trauma-informed approached emerge in relation to values and behaviours during this period. Complaints about attitude during phone triaging, staff impatience and poor handling of emotionally complex situations are noted.

4.28. In 2023, the three predominant departments for complaints were:

- JR Delivery Suite - 21
- JR Level 5 Women's Centre – 19
- Community Midwifery Services - 15

4.29. Clinical Treatment complaints focus on complications relating to sepsis, delayed induction, missed waters breaking and neonatal checks.

4.30. Communication concerns continue relating to confusing explanations, poor handover between areas and lack of updates. Women and birthing people report not being informed about clinical plans especially relating to induction and caesarean section decisions.

4.31. Growth in complaints relating to staffing pressures impacting on care such as missed medications, unanswered buzzers and long waits. Continued themes relating to postnatal care including feeding advice, pain management, help with mobilisation and neonatal care coordination.

4.32. Dismissive attitudes and insensitive remarks continue, with several concerns raised regarding perceived racial bias, judgement or lack of compassion.

4.33. In 2024, the three predominant departments were:

- JR Delivery Suite – 27
- JR Level 5 Women's Centre – 16
- Community Midwifery Services - 12

4.34. 2024 complaints included Mismanagement of Labour with notable, but smaller contributions from inadequate support, patient not listened to and communication with patient. Overall, the pattern suggests complaints relate

to specific process issues (labour/induction, clinical delays) with communication as a contributing factor.

4.35. During 2024, there was also an increase of more complex, multi-themed complaints referencing known themes such as delays in induction and delay in receiving pain relief, feeling unheard and postpartum issues.

4.36. In 2025, the three predominant departments were:

- JR Delivery Suite - 41
- JR Level 5 Women's Centre – 35
- JR MAU – 25

4.37. In 2025 communication type categories (e.g., Communication with Patient, Patient Not Listened To) collectively became prominent contributors, alongside Mismanagement of Labour and Inadequate Support. Subthemes show information/explanation and listening issues as the core drivers of the increase, with values/attitude/behaviours (notably staff attitude) present but not the main source.

4.38. Ongoing concerns raised included missed diagnoses, particularly for neonatal jaundice, infections and post-operative complications such as bladder care. Themes relating to capacity and wait times in MAU continue.

4.39. Postnatal care gaps continued, relating to timely pain management, nutrition, infant feeding, emotional support and wound care.

What themes changed in 2025?

4.40. There was a 32% increase in complaints where communication was identified as a contributing factor. As shown in Figure 5, complaints specifically related to patient communication rose from 5 to 21, those regarding information or explanation increased from 5 to 19, and complaints about patients not being listened to grew from 6 to 13. This increase highlights that shortcomings in communication—such as unclear information, inadequate explanations of care plans, and patients feeling their concerns are unheard—are now key sources of dissatisfaction. These challenges affect patient experience and indicate broader issues in delivering clear, compassionate, and responsive communication throughout maternity care pathways.

Year	Total	Communication (no.)	Communication (%)	VAB (no.)	VAB (%)
2020	65	11	16.9%	6	9.2%
2021	86	12	14.0%	10	11.6%
2022	106	32	30.2%	10	9.4%
2023	94	19	20.2%	15	16.0%
2024	95	16	16.8%	6	6.3%
2025	167	53	31.7%	14	8.4%

Figure 5: Communication and Values, Attitude, Behaviours (VAB) trend

4.41. A keyword scan of the 2024-2025 complaints identified the sub-themes relevant to complaints where communication was a factor (figure 6).

Sub-theme (free-text)	Cases
Delays / waits & poor expectation, setting	12
Pain relief – options, timeliness, clarity	12
Partner/visiting communication & support	11
Handover/coordination & notes clarity	10
“Not listened to” / dismissed symptoms	8
Tone/rudeness/abrupt or insensitive language	8
Results/explanations (e.g., tests, scans, neonatal)	8
Consent/information for procedures	7
Triage/assessment communication	7
Safeguarding related language & handling related language & handling	2
Privacy/dignity (curtains, exposure, room moves)	2

Figure 6: Subthemes of communication complaints 2024/25

4.42. Listening and empathy issues are the dominant complaint driver: “patient not listened to” and “communication with patient” together account for >60% of all cases and both rise in 2025.

Positive patient experience data

4.43. In May 2025, the Maternity Service re-launched the Friends and Family Test (FFT) and ‘say on the day’ devices. This is an important tool that provides an additional source of valuable data about the quality of care services are providing. The response rate target was set at capturing 50% of women birthed in the month.

4.44. It is important to note that this data source demonstrates that most service users completing the survey rate their experience as very positive suggesting that there are specific pathway bottlenecks and issues rather than a universally poor experience (See Figure 7).

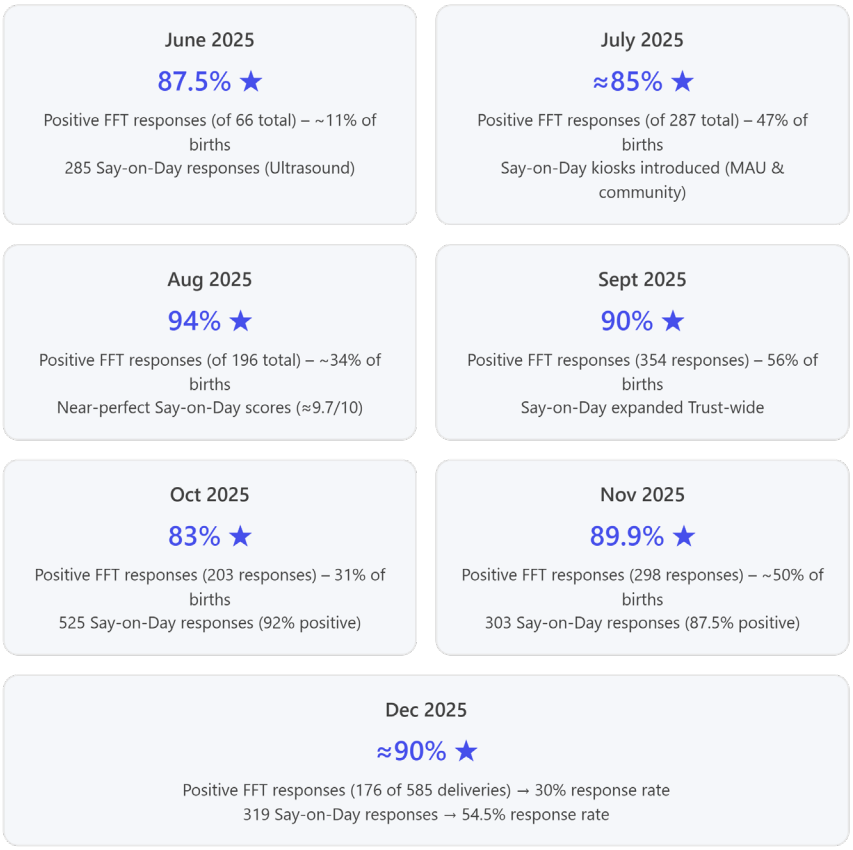

Figure 7: Friends and Family Test results

4.45. Many patients highlighted the high quality and efficiency of care, sometimes noting improvements compared to past experiences. Feedback in late summer mentioned well-organised care and timely interventions, contributing to the strong 94% approval in August.

4.46. Several women who were not first-time mothers commented that this time the service was better, citing things like quicker pain relief, smoother discharge processes, and more personal attention.

4.47. One FFT comment specifically noted “great service, lovely staff”, and another thanked the team for their “professionalism, clear communication, and calm, reassuring presence” during a difficult situation. Such feedback suggests that the maternity unit’s recent quality initiatives (for example, the postnatal improvements in discharge and a new pain relief strategy) were noticed and appreciated by patients, leading to tangible improvements in experience.

4.48. These themes are further evidenced with OUH midwives recently receiving awards for outstanding compassionate care, with their achievements celebrated, both locally and in the media, reinforcing the Trust’s patient-centred ethos.

Summary of complaints themes 2020 – 2025

4.49. Throughout the complaints review period, there were consistent themes identified. These were:

Clinical Treatment

- Delays in induction and escalation
- Missed or delayed diagnoses
- Errors around suturing, instrumental delivery, and postnatal wound care

Communication

- Not being listened to
- Conflicting information between teams
- Poor updates during delays
- Issues around consent and explanation of risks

Patient Care

- Postnatal support deficits: feeding, pain relief, mobility
- Missed observations
- Environmental issues: cleanliness, rest, overcrowding

Values and Behaviours

- Lack of compassion or empathy
- Rudeness or insensitive comments
- Cultural insensitivity and occasional racialised remarks

5. Recent and Current Service Improvements that Address the Themes

Clinical Treatment:

5.1. In 2023, Maternity Services piloted and implemented the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This system plays a crucial role in prioritising care based on clinical need, ensuring that urgent cases receive timely attention through a standardised triage process. Compliance audits conducted in 2025 demonstrated improvements across all audited domains including timeliness of initial triage assessment within 15 minutes. There is scope to continue improvements relating to initial triage assessments and midwifery and obstetric reviews which are workstreams within the ongoing service wide triage improvement project.

5.2. In 2024/25 the service implemented new mandatory training programs including Active Bystander Training and updated emergency training

content to include learning from complaints. The revision of induction of labour pathways, aiming to reduce delays and mitigate risk of postpartum haemorrhage and fourth-degree tears was also undertaken.

5.3. Major recruitment campaigns since 2023 have improved staff ratios and enabled more one-to-one care. International midwives are supported through mentoring and bridging programmes, enhancing the team's skill mix. Initiatives like the maternity Behavioural Charter, regular "Staff Listen" sessions, and mandatory Active Bystander training have contributed to a positive culture promoting safety, boosting morale, supporting staff retention, and improving staff survey results.

Communication:

5.4. Close collaboration with the Oxford Maternity and Neonatal Voices Partnership (OMNVP), including initiatives like the "15 Steps for Maternity" challenge, has led to improvements in signage, communication, and personalised care planning, making services more responsive and welcoming.

5.5. The Badger Notes maternity record app (launched early 2024) gives women easy access to appointments, test results, and tailored advice. Maternity Electronic Patient Records (BadgerNet) has improved communication between clinical teams supporting better continuity of care by ensuring that the right information follows the woman, baby and family across settings, teams and time, reducing reliance on handover memory, paper records or fragmented systems.

5.6. Introduction of the Rapid Responder role supports responsiveness to patient needs and escalation of care. This role can support improved communication with women, birthing people and families when there is a complication.

5.7. Introduction of a new proactive approach to improve responsiveness to complaints, including provision of opportunities to speak to a Consultant Midwife, offering family meetings early and establishment of a dedicated maternity feedback email address, has enabled a constructive dialogue and greater understanding of issues contributing to a poorer experience, ensuring the patient feels heard and issues are addressed.

Patient Care:

5.8. Introduction of epidural information videos in May 2025 has enhanced women's confidence in pain relief choices by providing clear, evidence-based information.

5.9. Enhanced pain relief strategies, including self-medication, give women more control over their care.

5.10. 24-hour visiting now offers families greater flexibility and support.

5.11. Teaming models, with consistent groups of staff, strengthen continuity of care and relationships between families and staff.

5.12. Accessing support from volunteers specifically for postnatal areas, enhancing support for new mothers and families.

Values and Behaviours:

5.13. Initiatives like the maternity Behavioural Charter, regular “Staff Listen” sessions, and mandatory Active Bystander training have contributed to a positive culture promoting safety, boosting morale, supporting staff retention, and promoting compassionate care.

5.14. The service has adopted a proactive strategy to strengthen culture and professionalism and the recruitment of internationally trained staff, supported by mentoring and bridging programmes, has contributed to a more diverse skill mix and fostered a culture of respect and positive behaviour. These improvements are integrated into governance and quality improvement processes, with the launch of the Perinatal Improvement Programme an additional vehicle supporting the continued drive for improvements in culture, leadership, staff wellbeing, communication, and governance, ensuring that lessons learned from complaints lead to lasting change and better experiences for women, families, and staff.

6. New and Planned Initiatives

6.1. Introduction of a new Patient Experience Survey enabling monitoring and responsiveness to key themes including:

- The degree to which care was compassionate and respectful
- The degree to which women, birthing people and their families were involved in decision-making about their care
- The degree to which women, birthing people and their families were communicated if there was a complication or unexpected outcome.
- The degree to which staff listened and took concerns seriously
- How well pain was managed.

6.2. Recruitment of a new Perinatal Patient Engagement Lead to provide strategic leadership for patient and public engagement within maternity services.

6.3. Implement the 'Your Voice Matters' programme by the end of Q1 2026/27, supporting collaborative communication and amplifying patient perspectives within maternity services.

6.4. Introduce a new Maternity Patient Safety Partner by the end of Q4 2025/26 to enhance safety oversight and strengthen the patient's voice in maternity care.

6.5. Implementation of complaints training ensuring consistent, empathetic, and effective handling of service user concerns.

6.6. Implementation of Martha's Rule within Maternity Services.

7. Action Plan

7.1. The action plan outlined below (Figure 8) has nine targeted initiatives designed to address key areas for improvement within maternity services, as highlighted by recent data and feedback. Each priority area is accompanied by a specific action, timeline for completion, and measures for assurance. These actions focus on enhancing communication at critical points in the care pathway, improving pain relief information and timeliness, reviewing and embedding behavioural standards, strengthening listening and empathy skills, ensuring consistency of information across teams, enriching postnatal experiences, advancing complaint responsiveness and learning, monitoring governance, and developing leadership capabilities. By implementing these actions, the service aims to reduce complaints, increase patient satisfaction, and foster a culture of continuous improvement and compassionate care.

Priority Area	Action	Current RAG	Target Timeline	Assurance Measures
1. Communication at Pathway Pinch Points	Standardise proactive communication for delays, plans and escalation in MAU/triage, induction, labour and early postnatal care		Dec 2026	↓ complaints citing "not listened to" and delays; ↑ FFT narrative feedback
2. Pain Relief Information & Timeliness	Standardised pain relief discussions (options, timing, escalation) supported by patient information		Sep 2026	Reduction in pain related complaints; improved FFT pain management responses
3. Behavioural Charter Review	Formal review and relaunch of the Maternity Behavioural Charter with service users and staff		Sep 2026	Updated Charter approved and embedded in practice
4. Listening & Empathy Skills	Mandatory training in active listening, empathy and trauma-informed communication (e.g. Sage and Thyme Training)		Sep 2026	Training compliance; ↓ complaints citing dismissive tone
5. Information Consistency Across Services	Align key messages between community, MAU and inpatient teams using		Q3 2026	Fewer complaints citing conflicting

Priority Area	Action	Current RAG	Target Timeline	Assurance Measures
	BadgerNet and shared guidance			information; improved handover audits
6. Postnatal Experience	Strengthen postnatal communication on pain, feeding, emotional support and discharge		On-Going	Improved postnatal FFT feedback; ↓ postnatal complaints
7. Complaint Responsiveness & Learning	Implement advanced Complaint Response Training for senior staff ensuring high quality, comprehensive written and verbal complaint responses that validate the service user's experience.		On-Going	Reduced reopening rate of complaints Improved quality and tone of complaint responses measured through quality review
8. Governance & Monitoring	Monthly monitoring of complaints and FFT themes via Perinatal Improvement Programme		Ongoing	RAG rated reporting to TME and Trust Board
9. Leadership Development	Programme delivery of Maternity Matron Leadership and Development Programme and Mentoring Programme.		Dec 2026	Strengthens leadership capability and addresses the direct link between leadership behaviours and patient experience

Figure 8: Actions and Timelines

8. Conclusion and Next Steps

8.1. The main themes have remained stable over five years, but 2025 saw more complex complaints and a rise in communication-related issues.

8.2. Subthemes underpinning the 2024–25 communication rise include delays and expectation setting, timely/clear pain relief information, partner/visiting updates and support, not feeling listened to, and consent/explanations for procedures. These concentrate around MAU/triage, induction and labour, and early postnatal care.

8.3. Several improvement initiatives have been implemented, are underway or scheduled to commence that aim to address most of the themes that have been identified.

8.4. Considering the findings within this report, the Maternity Behavioural Charter will be formally reviewed to assess its current visibility, relevance and impact on staff behaviours and patient experience. The review will involve input from service users, frontline staff and leadership, and consider whether the principles are consistently reflected in day-to-day practice. The outcome of the review will inform any necessary updates to the Charter and identify opportunities to strengthen its integration into staff training, induction, supervision and appraisal processes.

8.5. Opportunities to further improve patient experience exist through building on the work that is underway and implementing the nine new actions under the governance of the Perinatal Improvement Programme to address the emerging subthemes from the 2025 data.

9. Recommendations

9.1. The Trust Board is asked to:

- Note the findings of this report, including the work that is in progress and future work plans.
- Note the nine new targeted actions for the Perinatal Improvement Plan to address the emerging themes from 2025, including standardised proactive communication for MAU and IOL delays, a formal review of the Maternity Behavioural Charter, and communication and complaints training.