Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Integrated Assurance Committee Meeting: Wednesday 29 April 2026

[Keywords]

Title:	**Homebirth Service Urgent Review Report**

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Board Lead:	**Chief Nursing Officer**
Author:	**Amanda Crudgington, Matron Community Midwifery Service**
	Beatrice Culligan, Deputy Head of Midwifery
	Milica Redfearn, Director of Midwifery
Claire Litchfield, Consultant Midwife	
Confidential:	**No**
Strategic Pillar:	**Patients, People**

Executive Summary

1. This paper details Oxford University Hospitals NHS Foundation Trust (OUH) Maternity Service's response to the 05 November 2025 Prevention of Future Deaths Report issued by the Senior Coroner for Manchester North, and the subsequent NHS England letter dated 26 November 2025 from the Chief Midwifery Officer for England requesting all providers undertake an urgent review of the safety and quality of homebirth services, with findings reported to Trust Board level.
2. This review also provides formal assurance to system partners, including Frimley/BOB Integrated Care Board (ICB), in line with the ICB's commissioning and quality oversight responsibilities under the Perinatal Quality Oversight Model (PQOM), specifically:
    - PQOM Quality Domain 1: Safe Care
    - PQOM Quality Domain 5: Well-Led
3. The review supports compliance with the Trust's statutory duties under the NHS Act 2006 (as amended by the Health and Care Act 2022) for quality assurance of commissioned services.
4. The review confirms that the homebirth service provides 24/7 access to midwifery care, supported by a robust on-call rota, clear escalation arrangements and consistent senior clinical and multidisciplinary support. Staff delivering care in the home are appropriately trained, competent and equipped, with clear arrangements in place for supervision, rest periods and fatigue management. Transfer and extraction processes are clearly defined, planned antenatally for each birth, and supported by established communication pathways with South Central Ambulance Service (SCAS) and receiving obstetric and neonatal units.
5. Homebirth activity data for the period April 2025 to February 2026 demonstrates:
    - Total number of completed homebirths: 110 cases
    - Transfer rates (antepartum, intrapartum and postpartum) are routinely monitored via the Community Birth Dashboard and reviewed through maternity clinical governance processes: 38 transfers in total
    - No serious incidents, maternal deaths, neonatal deaths, or significant adverse outcomes involving homebirth: 0 cases
6. The service demonstrates compliance with national standards and NHS England expectations, including:
    - NICE Guideline CG190 – Intrapartum care for healthy women and babies
    - NMC Code (2018) – Professional standards of practice and behaviour
    - RCM Standards for Midwifery Services (2021)
    - NHS England Maternity Safety Standards (2024)

7. This includes assurance in relation to:
    - Safe staffing and skill mix
    - Continuous and dynamic risk assessment and escalation
    - Multidisciplinary working and senior clinical oversight
    - Equipment readiness and emergency preparedness
    - Clear governance, audit and incident review processes
8. While opportunities to further enhance service provision have been identified, the homebirth service operates within a comprehensive governance framework, with risks identified, mitigated and escalated appropriately through established Trust processes. No immediate safety concerns have been identified, and the service is assessed as safe to continue.

Recommendations

9. The Integrated Assurance Committee is asked to:
    - Accept assurance from this review that the operational running of the community and homebirth service is safe, well-governed and aligned with NHS England expectations for maternity services.
    - Note that no serious incidents, maternal or neonatal deaths, or significant adverse outcomes related to homebirth were identified during the period April 2025 to February 2026
    - Support continued monitoring through existing maternity governance and PQOM quality surveillance arrangements

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Homebirth Service Urgent Review Report

1. Purpose

1.1. The purpose of this paper is to provide the Trust Board with assurance on the operational running, care planning and risk assessment of the homebirth service, giving assurance that appropriate systems, processes and controls are in place to minimise risk and support safe care to women, birthing people and babies.

2. Background

2.1. The coroner's inquest into the deaths of Jennifer and Agnes Cahill following a homebirth while under the care of Manchester NHS Foundation Trust, concluded that their deaths were preventable.

2.2. On the 05/11/25 the coroner issued a Prevention of Future Deaths Report. This is attached as Appendix 1.

2.3. In response to this report, on the 26/11/25, NHS England sent a letter requesting an urgent review of the safety and quality of homebirth services. This is attached as Appendix 2.

2.4. This paper is the OUH maternity service response.

3. Matters of concern reviewed within this paper

3.1. While the coroner identified 10 key concerns in the Prevention of Future Deaths report, NHS England wrote to provider Trusts requesting a review of homebirth services be undertaken to look specifically at **3 key issues** highlighted in the report, namely:

3.2. **Issue 1 - The operational running of the service,** 'in*cluding how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multidisciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth'.*

3.3. **Issue 2 – Care planning and risk assessment,** '*including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and*

how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period'.

3.4. **Issue 3 – Governance and oversight,** *'including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care'.*

3.5. Additionally, NHS England requested that findings should be reported to the Trust board, and subsequently the regional NHS England team should be notified immediately about any urgent safety issues.

4. Integrated Care Board Assurance Context

4.1. OUH has adopted the assurance framework established by NHS Kent and Medway ICB to further strengthen the quality and safety of the OUH homebirth service. This framework places a strong emphasis on multidisciplinary collaboration, robust escalation protocols and systematic auditing to drive continuous improvement in homebirth outcomes. By aligning our operational standards and governance structures with those of NHS Kent and Medway ICB, we ensure our service reflects regionally recognised best practice and encourages a culture of learning and excellence across Integrated Care Boards.

4.2. Our integration of this framework includes regular joint reviews of clinical guidelines, participation in peer audits across ICBs, and involvement in shared learning initiatives. Through these ongoing efforts, we are committed to continually evaluating and refining our homebirth pathways, so that the OUH maternity service consistently delivers safe, well-led, and responsive care to women and birthing people who choose homebirth.

4.3. This review provides assurance aligned to the ICB's responsibilities under the Perinatal Quality Oversight Model (PQOM)**,** specifically addressing:

- PQOM Quality Domain 1: Safe Care
- PQOM Quality Domain 5: Well-Led

4.4. Evidence within this paper demonstrates that the OUH homebirth service meets these requirements and that appropriate Trust Board oversight, governance, audit and escalation arrangements are in place.

5. Issue 1. The operational running of the homebirth service:

Staff availability 24/7

5.1. Rostering: The community midwifery service operates on a 24-hour basis, 365 days a year to ensure timely access to labour and delivery care for women and birthing people planning to birth at home, as well as those wishing to birth in Freestanding Midwifery-Led Units (Cotswold, Horton, Wantage and Wallingford).

5.2. On-call provision: An on-call rota ensures community midwives are readily available to provide homebirth care throughout Oxfordshire, with coverage from nine community teams. The service aims to maintain at least six on-call midwives for both day and night shifts to provide safe care around the clock. OUH maternity service follows the community midwife on call SOP, in appendix 3, with monthly compliance checks conducted by the community matron before payroll rosters are released.

5.3. Mitigation: Staffing levels and skill mix for on-call shifts are planned and reviewed weekly and daily to address changes due to sickness, vacancies, clinic cover, or flexible working.

5.4. Escalation: Escalation processes manage any short-term staff reductions safely. Clear escalation routes are provided through the Band 7 Community Bleep Holder and the Midwifery Leadership Team ‘Manager on Call’ to help maintain operational resilience, continuity, and safe care when facing increased demand or unexpected staff shortages.

5.5. Suspension of service: Where the available on-call resource has been fully mobilised and there is continued demand for home birth, a risk assessment is completed by the operational manager to suspend the homebirth service in collaboration with the Trust’s duty manager, in line with the Maternity Manager on Call policy (Appendix A Ulysses report is submitted wherever women are unable to access their preferred place of birth. The figure for ‘number of births where the place of birth was changed due to staffing’ is included on the Trust’s monthly safe staffing dashboard.

Any suspension of homebirth services is reported through the daily sitrep to NHS England, any suspension of over 12 hours is reported to the CQC via the Trust’s assurance team.

Staff training, preparation and competence

5.6. All midwives providing community and homebirth care are registered with the Nursing and Midwifery Council (NMC) and meet revalidation requirements.

5.7. Staff undertake regular mandatory training relevant to birth and neonatal care in the community setting as follows:

- Neonatal life support and maternal resuscitation
- Obstetric and neonatal emergency management
- Safeguarding adults and children
- Infection prevention and control
- Medicines management and documentation

5.8. Newly appointed or rotated Band 6 midwives complete a structured induction programme when joining the community service and are supported until competency is confirmed.

5.9. Band 5 midwives participate in a structured preceptorship programme designed to develop the competencies necessary for community and homebirth care. They are supported by a Band 6 or above throughout this process, with ongoing competency assessments and emergency skills drills conducted in community settings. Support and supervision continue until Band 5 midwives are confirmed as competent for autonomous practice in homebirth environments.

5.10. Between May 2022 and January 2025 community midwives attended the PHONE 999 training day, delivered in collaboration with South Central Ambulance Service (SCAS). This programme brings together community midwives and ambulance clinicians to undertake joint training using simulated pre-hospital emergency scenarios, supporting effective multidisciplinary working in emergency situations. A total of 150 community midwives attended the course of which 133 continue to work within the Trust. Due to current resource restraints SCAS have paused the programme, the service is working with other inter-professional agencies to reinstate a similar training day.

5.11. Rolling competency assessments and emergency skills drills are undertaken routinely in community settings with support from the midwifery practice education team, to ensure staff remain confident and prepared to manage emergencies in a home environment.

Equipment and clinical resources

5.12. Midwives use standardised, fully stocked homebirth kits containing essential maternal and neonatal monitoring equipment, emergency medications, and resuscitation tools. These kits are checked after every use and weekly, with robust systems for stock control and expiry monitoring overseen by the MyKitCheck system. Senior staff conduct weekly and monthly audits to ensure readiness and compliance with clinical guidance. Audits of this equipment are reported via the maternity quality report on a monthly basis.

5.13. Equipment is strategically located across community and freestanding sites to ensure timely access for staff. Operational information (including access arrangements, emergency equipment, medicines storage and site-specific guidance) is accessible to all community staff via shared team resources. See Appendix 4 for equipment location.

Senior and multidisciplinary support

5.14. Senior and multidisciplinary clinical support is accessible to community midwives providing homebirth care at all times. Midwives can receive real-time guidance and clinical decision-making support during labour, birth, or postnatal care via access to

- Formal 4 hourly buddy and review process with the senior band 7 Horton midwife and/or labour ward coordinator
- Senior band 7 midwife bleep holders (community and/or hospital)
- 24-hour Manager on Call support
- Direct obstetric, anaesthetic and/or delivery suite coordinator support via the red phone located on delivery suite at the JR obstetric unit site
- Dedicated ambulance services telephone line
- Neonatal teams via switchboard bleep

Staff wellbeing and rest periods

5.15. Duty rotas are written to comply with working time regulations and the promotion of staff wellbeing.

5.16. In April 2025 the community matron led a community midwife on-call consultation. This provided the community midwives with options of moving from the current system of 2 on-call shifts per 24hr period (i.e 2 X 12 hour on call shifts) to 3 on-call shifts of 8 hours duration. The outcome was to remain on current 2 on-call shifts per 24-hours system.

5.17. An audit conducted in November 2025 examined the wrap-around hours for shifts before and after on-call duties across each of the nine community midwifery teams. Reviewing data from August 1st to October 31st, 2025, the analysis confirmed that OUH's Community Midwifery on-call system is safe, meets national maternity guidelines, and complies with both NMC regulations and Agenda for Change terms and conditions. Appendix 5 is the assurance statement from this audit.

5.18. Adequate compensatory rest periods are built into on-call arrangements and supported by the community on-call Standard Operating Procedure (SOP). Through the SOP, staff are made aware of the mechanisms in place to provide relief or additional support during prolonged or complex births.

5.19. Staff well-being is actively monitored. All community teams join a morning safety huddle that incorporates a review and gives oversight of the previous night on call hours worked to ensure appropriate sleep time and compensatory rest is provided to those individuals. This is further monitored via a monthly review by the Community Matron of the digital timesheet prior to locking for payment.

5.20. Fatigue risk is managed via direct escalation by the community to the 24/7 Manager On-Call to maintain safe and effective care delivery.

Transfer and extraction planning

5.21. OUH has a *Homebirth Booking and Referral Criteria Guideline that operates* alongside a *Maternal Transfer by Ambulance Guideline* (appendix 6). Together these provide clear information for clinicians on all aspects of transfer and extraction planning.

5.22. Midwives are trained and supported to initiate and manage transfers appropriately, promptly and safely.

5.23. Transfer guidance, including potential reasons for transfer and the expected transfer time, is shared with women and birthing people during personalised homebirth planning discussions. These are documented within the woman's digital record and reviewed through spot-check documentation audit processes.

5.24. All transfers and relevant incidents are reviewed in line with the Trust's clinical governance process to support learning and continuous improvement.

5.25. Women planning home births have an at home antenatal appointment prior to birth (usually 36/40 gestation) which follows a risk assessment checklist which includes an assessment of the safety of the physical environment, access and extraction planning.

6. Issue 2. Care planning and risk assessment:

Systematic assessment of complexity and risk

6.1. The maternity service has a structured, woman-centered approach to care planning and risk assessment for those considering or planning a homebirth which is guided by national and local clinical guidance.

6.2. Discussions around homebirth commence from approximately 16 weeks' gestation with preferences documented in the service users digital record enabling regular review as part of routine antenatal care.

6.3. Women and birthing people are supported to access evidence-based information through multiple routes; via the birth choices patient

information leaflet (Appendix 7), structured education sessions such as *"Birthplace choices in Oxfordshire – Where can I give birth?"* and structured conversations with the midwife ensuring discussions and decisions are informed from an early stage.

6.4. Risk consideration is continuous and dynamic. It is completed within the maternal digital record, taking into account:

- medical, obstetric and social complexity
- emerging antenatal concerns
- previous obstetric history
- environmental and logistical considerations relevant to homebirth
- neonatal considerations

6.5. Pregnancy, labour, postnatal and neonatal risks are prompted, systematically assessed, communicated with the woman, reviewed and recorded within the digital record throughout the pregnancy, birth and postnatal period.

6.6. Any change to risk is discussed with the woman and recorded in the digital record to ensure all clinicians share a common understanding of the risk, planning and escalation requirements.

Personalised MDT care planning when homebirth is not recommended, communication at all stages of care with women and between all teams including ambulance service.

6.7. Women or birthing people who choose to birth at home where it is not recommended (i.e. "Out of Guidance") are referred to a specialist clinic with either an Obstetrician in antenatal clinic or a Consultant Midwife in Birth Choices Clinic.

6.8. A personalised care plan is formulated collaboratively by the consultant midwifery team, in partnership with the woman or birthing person, and is reviewed during the Birth Choices MDT meeting attended by members of the obstetric, community, safeguarding and midwifery leadership team, as appropriate to the risk identified. The agreed plans, developed with direct involvement from the woman or birthing person, are then disseminated in advance of episodes of care within the community midwifery teams.

6.9. The service collaborates with South Central Ambulance Service (SCAS) to maintain an efficient pre-hospital alert system, using dedicated red phones for direct communication with the delivery suite to ensure patients arrive at the appropriate location.

6.10. Patient safety incidents involving the ambulance service are jointly reviewed by maternity and SCAS to ensure opportunities for learning are optimised.

6.11. Opportunities to replace the PHONE 999 training day and provide MDT (midwife and ambulance crew) joint learning within a stimulated homebirth environment are currently being explored further, in particular on the management and transfer of obstetric emergencies from a homebirth setting.

7. Issue 3. Governance and oversight:

Robust oversight of homebirth services by the organisation

7.1. The comprehensive guidelines implemented by OUH maternity service not only supports clinicians in assessing risk but also establishes a clear pathway for onward referral to specialist opinion. This ensures women and birthing people receive the necessary support to understand their individual risks, empowering them to make informed decisions regarding their personalised care and choice of birth setting. By incorporating standard operating procedures for every stage and aspect of care, the guidance provides strong assurance of robust oversight and governance of homebirth services, safeguarding both clinical quality and patient safety throughout the process.

7.2. Monthly homebirth numbers are collated and reported through the Maternity Clinical Governance Committee, ensuring organisational oversight up to executive board level.

Audit programme and standard operating procedures

7.3. Comprehensive audit programmes monitor reasons for transfer, transfer times, and homebirth outcomes via the Community Birth Dashboard, driving continual clinical and operational improvement.

7.4. Robust community birth guidance, including standard operating procedures for all stages and aspects of care (Appendix 6), underpins the governance framework and maintains high standards of safety and quality.

Trust Board and Executive Oversight

7.5. Homebirth safety and quality assurance has been reviewed through the Maternity Clinical Governance Committee and Safety Champions Meeting and is planned to be presented to the Trust Board in Public on 11 March 2026, ensuring appropriate executive and non-executive oversight.

7.6. The Chief Nursing Officer holds executive responsibility for homebirth services, with operational leadership provided by the Director of Midwifery and Head of Midwifery

7.7. This governance structure provides assurance that risks relating to homebirth services are visible at Board level and managed in line with Trust and system governance arrangements.

8. Conclusion

8.1. While the community birth service currently meets the required standards, this review has identified opportunities to further enhance practice

8.2. Opportunities related to the operational running of the service:

- Consider standardising day shift hours to either 7.5hrs or 10hrs worked and whether this would optimise rest time opportunity between finishing a day shift and commencing night on call shift.
- Additional enhanced community-based simulation training focused on caring for women who choose to birth outside of clinical guidance. This would support community midwives to further develop advanced communication skills for complex, sensitive and challenging discussions, including shared decision-making, risk communication and escalation.
- Strengthening homebirth emergency skills through targeted education and scenario-based training, reflecting the unique clinical and environmental challenges of the homebirth setting.
- Continued development of joint training with ambulance services by building on existing education collaboration to improve interdisciplinary working, mutual understanding of roles, and co-ordinated emergency response.
- Exploration of future training partnerships with HEMS, including the potential to develop education sessions at the Stokenchurch HEMS training site, to further enhance preparedness for rare but high-acuity community birth emergencies.

8.3. Opportunity related to governance and oversight include:

- Additional reporting of ‘outside of guidance births’ for monthly community dashboard.

8.4 An action plan has been developed which will be documented through the Ulysses platform, with progress and oversight monitoring through the maternity clinical governance committee.

9. Recommendations

9.1. The Integrated Assurance Committee is asked to:

- Take assurance from this review that the operational running of the community and homebirth service is safe, well-governed and aligned with NHS England expectations for maternity services.
- Note that no serious incidents, maternal or neonatal deaths, or significant adverse outcomes related to homebirth were identified during the period April 2025 to February 2026
- Support continued monitoring through existing maternity governance and PQOM quality surveillance arrangements

10. Appendices

Appendix 1: Prevention of Future Deaths Report

https://www.judiciary.uk/prevention-of-future-death-reports/jennifer-cahill-and-agnes-cahill-prevention-of-future-deaths-report/#:~:text=The%20conclusion%20of%20the%20Inquests,complications%20contributed%20to%20by%20neglect.

Appendix 2: NHS England letter requesting an urgent review of the safety and quality of homebirth services

Letter from NHS England

Appendix 3: Community Midwife on-call SOP

GS206 - Community Midwife On Call Service SOP v1.0

Appendix 4: Equipment location

4.1 For community births in the **north** of the county kits are kept in:

Horton MLU x 2

Chipping Norton MLU x 1

4.2 For community births in the **south** of the county kits are kept in

Wantage MLU x 2 kits

Wallingford MLU x 2

4.3 For community births in the **east** of the county kits are kept in

Bicester Bucknell office x 1

4.4 For community births in the **west** of the county kits are kept in

Witney Hospital x 2

4.5 For **central** community births kits are kept in

JR Women's Centre main entrance x 2

Appendix 5: Assurance statement regarding community midwifery on calls

Assurance statement regarding community midwifery on calls .docx

Appendix 6: Homebirth booking and referral criteria and maternal transfer by ambulance guideline

GS61 MLU and Homebirth Booking and Referral Criteria Guideline v4.4

GS23 Maternal Transfer by Ambulance Guideline v6.1

Appendix 7: Birthplace choices in Oxfordshire Patient Information Leaflet

Birthplace Choices in Oxfordshire

Appendix 8 Manager on Call Policy (Maternity)

GS141 - Manager On Call SOP v2.3