Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Oversight Model Board Report (including Dashboard)

Presented at Maternity Clinical Governance Committee 16/11/2026

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Presented by the Perinatal Leadership Team

Date: November 2026

Data period: 01/10/26 - 31/10/26 (October Data)

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Executive Summary Narrative

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Board assurance statement:
The Board can be assured that maternity services continued to provide safe care during October despite sustained operational and workforce pressures. A Green/Amber MOSS rating was maintained, with governance reviews confirming no patient harm associated with delays in MAU or induction of labour. Red flags were reported and resolved appropriately.
Positive patient experience remained high, with 93% of respondents rating care as good or very good. Estate improvements to the MAU environment have been completed to support patient flow and triage performance.
The Board should note ongoing risks relating to the workforce, including sickness absence, BSOTS compliance and a rise in overdue incident investigations. A Level 1 MOSS signal was received following a stillbirth and neonatal death and continues to be monitored. Assurance is provided that robust escalation processes, daily staffing reviews, 24/7 operational oversight, and governance compliance remain in place while improvement programmes are embedded and evaluated.

Actions required from the Board:
✅ Decision / approval
☐ Support / escalation
✅ Assurance
The Trust Board is asked to:
- Note the Green/Amber MOSS outcome and maintain active oversight until there is sustained evidence that timely triage, urgent review, safe staffing and escalation processes operate reliably across all shifts and periods of high demand.
- Note the progress on the implementation of the Maternal Care Bundle for quarter 2.
- Record in the minutes that OUH confirms the Trust uses Hadlock charts for estimated fetal weight (EFW), not Intergrowth. The fetal growth surveillance programme was strengthened in August 2026 to align fully with the standard national scanning pathway for late pregnancy in the NHSE Saving Babies' Lives Care Bundle.

Activity
- 667 women birthed 688 babies in October
- 645 maternity bookings received

Clinical Outcomes
- 45% spontaneous vaginal births
- 13% instrumental births
- 45% caesarean births
- PPH ≥1.5 L: 3.90%
- Governance review found no harm from induction delays or triage delays in the Maternity Assessment Unit.

What is going well / Improving trends:
- 100% of women received 1:1 care in labour.
- No closures of community maternity services, JR services or the Butterfly Suite, ensuring women and families were able to access their planned place of birth and bereavement care.
- Breastfeeding initiation remains strong at 93.5%, and unexpected neonatal admissions continue to demonstrate an improving trend.
- MAU estates improvements: Contractor works were completed on 6 November, including a dedicated triage room and CTG lounge capacity. The new triage room became operational on the 9 November 2026.
- Positive patient experience remains high, with 93% of maternity respondents rating care as good or very good and feedback continuing to highlight compassionate, supportive care.

Quality & Safety
- 304 maternity incidents reported; 80 moderate harm or above
- Common harms: PPH, OASI and unexpected term SCBU admissions
- 76 neonatal patient safety incidents reported through Ulysses. Of these, 24 involved harm: 22 minor, 1 moderate and 1 death.
- All incidents were managed in accordance with the Patient Safety Incident Response Framework (PSIRF).
- There were no reported closures of the Butterfly Suite and no exceptions were escalated. OUH was therefore able to provide bereavement care to all families requiring this service.

Alert
- Workforce pressures remain significant, with increased sickness absence and staff unavailability contributing to increased reliance on escalation processes and on-call arrangements.
- Performance deterioration was identified in MAU 15-minute triage compliance and induction of labour timeliness, although governance review has not identified associated patient harm.

Advise
- Continued Board oversight is requested regarding workforce resilience, maternity flow, induction delays and MAU performance while improvement programmes are embedded and evaluated.
- A Level 1 MOSS signal was received in October following a stillbirth and a neonatal death. The Trust has responded and continues to monitor monthly. The individual outcomes remain subject to PMRT review.
- The Baroness Amos programme and Thirlwall Inquiry continue to progress to agreed timescales.
- Monitoring of Test Result Endorsement, VTE compliance and postnatal readmissions should continue through exception reporting until sustained improvement is demonstrated.

Experience
- 333 feedback responses received in Maternity (combined FFT and SOTD)
- 50% response rate
- 93% rated care good or very good
- Positive feedback on service users feeling listened to
- 15 complaints received in Maternity. Two neonatal complaints received.

Assure:
- Governance reviews of induction and triage delays found no evidence of patient harm during October.
- All families requiring bereavement care were accommodated, with no Butterfly Suite closures reported.
- Dynamic workforce escalation arrangements, daily staffing reviews and 24/7 operational oversight continue to support safe service delivery despite ongoing workforce pressures.

Executive Summary Outcome Performance Overview

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Special cause variation - deterioration

- Test Result Endorsement
- % completed VTE admission
- Maternal Postnatal Readmissions

Special cause variation - deterioration

- IOL 0-6 hours
- IOL Delayed 13-23 hours (Red Flag SS)

Special cause variation - deterioration

Summary

Discussed further in Maternity Exception Report slides and Perinatal Improvement Programme slides.

Common cause variation

- Scheduled bookings
- Born before arrival of midwife (BBA)
- Number of women booked by 10+0/40
- Percentage of women booked by 10+0/40
- Number of PSII
- Number of complaints
- Mothers birthed
- Babies born
- Spontaneous vaginal births SVD (including breech)
- Forceps and ventouse/instrumental deliveries (OVD)
- Forceps and ventouse/instrumental deliveries (OVD): as a percentage
- Number of Emergency CS
- Emergency CS births as a %

Common cause variation

- Number of women with a live birth
- SVD + OVD Total
- Robson Group 1 caesarean birth with no previous birth as a %
- Robson Group 5 caesarean birth with 1+ previous birth as a %
- 3rd/4th-degree tears amongst mothers birthed
- 3rd/4th-degree tears amongst mothers birthed as a %
- 3rd/4th-degree tears following an instrumental vaginal birth
- 3rd/4th-degree tears following an instrumental vaginal birth as a %
- PPH equal to or greater than 1.5L (Rate per 1,000)
- PPH 1.5L or greater, caesarean births
- Late Maternal Deaths: Direct
- Late Maternal Deaths: Indirect
- IOL Delayed 07-12 Hours (Red Flag SS)
- Readmission of babies
- ICU/CCU Admissions

Common cause variation

- Stillbirths (24+0/40 onwards; excludes TOPs)
- Neonatal deaths (born in OUH, up to 28 days) All
- Neonatal deaths (born in OUH, up to 28 days) Early
- Neonatal deaths (born in OUH, up to 28 days) Late
- Neonatal deaths (born in OUH, up to 28 days) As rate
- Puerperal Sepsis
- Puerperal Sepsis as a % of mothers birthed
- Unexpected NNU admissions
- Unexpected NNU admissions as a % of babies born
- Elective CS <39 weeks no clinical indication
- Shoulder Dystocia
- Shoulder Dystocia as a % of babies
- Returns to theatre
- Returns to theatre as a % of caesarean section deliveries
- Number of women with a live birth initiating breastfeeding

Special cause variation - improving

- Hospital Associated Thrombosis
- Midwife-to-birth ratio
- HIE
- PPH equal to or greater than 1.5L following an instrumental birth
- PPH equal to or greater than 1.5L following an instrumental birth as a %
- PPH 1.5L or greater, vaginal births (unassisted)
- PPH 1.5L or greater, vaginal births (unassisted) as a %
- PPH equal to or greater than 1.5L, caesarean births as a %

Special cause variation - improving

- Maternal Deaths: All
- Early Maternal Deaths: Direct
- Early Maternal Deaths: Indirect
- Late fetal losses (delivered 22+0 to 23+6/40; excludes TOPs)
- MAU Data Accuracy
- IOL Delayed >24 hours (Red Flag SS)
- Inductions of labour (IOL)
- Inductions of Labour (IOL) as a % of mothers birthed
- 3rd/4th-degree tears following unassisted vaginal birth
- 3rd/4th-degree tears following unassisted vaginal birth as a %

Special cause variation - improving

- Percentage of women initiating breastfeeding
- Number of Women Booked This Month Who Currently Smoke
- Percentage of Women Booked This Month Who Currently Smoke
- Number of Women Smoking at Delivery
- Triage within 15 mins
- Robson Group 2 caesarean birth with no previous birth as a %
- Percentage of Women Smoking at Delivery

Other*

- Spontaneous vaginal births SVD (including breech) as a %
- MAU attendances

*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*

Other*

- Caesarean Section (CS)
- Number of CS births as a % of mothers birthed

*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*

Other*

- Number of Elective CS
- Elective CS births as a %

*(*where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*

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Maternity Summary
October 2026

Oxford University Hospitals NHS Foundation Trust

=1.5%
Blood Loss ≥1,500 mL for CS

3rd- & 4th-degree tears (SVD+OVD births only)
↑ 3.39%

↓ 10 (1.50%)
Freestanding MLU*

Horton 5
Chipping Norton 4
Wantage 1
Wallingford 0



Excellence Reports
↑9



↓ 55.4%
(previous 63.2%)
Initial 15-min Triage in MAU

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

Unplanned Term Admissions to NNU
27 (3.9%)
≥ 37 weeks



↑ 599 births
Delivery Suite



43 ↑(6.45%) Spires births

↑ 23 (16%)
(previous 10 (8%))
Induction of Labour (IOL) delayed >24 hrs





Friends and Family Test and Say on the Day:
93%
Very Good / Good feedback
↓50% response rate

688 Babies Born To 667 Women

100%
1:1 Care in Labour



↑ 45%
Caesarean Sections 300 (CS)
Elective CS: 137 (20.5%)
Emergency CS: 163 (24.4%)

↑ 28.0%
Inductions of Labour

↑ 645 Scheduled Bookings



New Complaints
= 15



↑ 15 (2.25%)
Home Births



↑ 93.5%
Breastfeeding Initiation



*MLU – Midwifery-Led Unit

Neonatal Summary: October 2026

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Milk Bank

↑202 L Breast Milk Pasteurised

22 L Sold / £3.9k Profit

9 Donors Recruited

44 Preterm Admissions (57%)

< 27 weeks – **3** (4%)

27-36 weeks – **41** (53%)

↓ **67%** Born in the right place*

21 Excellence Reports

33 Term Admissions (43%)

≥ 37 weeks



FFT: 100% Very Good (1/1)

Say on the Day: 19 responses, mean score 8.9/10



↑77 Admissions October 2026

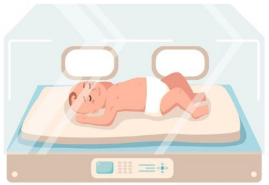
SONeT SOUTHAMPTON OXFORD NEONATAL TRANSPORT

↓**28** Total Transfers

7 Emergency Uplifts

21 Non-Urgent

↑1249 Care Days



Nursing Recruitment



4 Starters

0 Leavers

Outreach Team

↓**97** Home Visits

32 Babies Seen



3 Deaths



<24/40 – Extreme Prematurity

24^{+5}/40 – Cardiac Arrest + Prematurity

26^{+1}/40 – Periventricular Leukomalacia

2 Complaints



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

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Recent Successes



OUH has launched the Leading an Empowered Organisation (LEO) programme. Developed by healthcare professionals for healthcare leaders, this internationally recognised programme focuses on practical leadership development. Colleagues from maternity services are among those taking part in its first cohort.

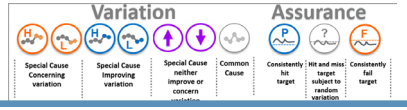


New wall art has been added in the majority of Delivery Suite rooms, creating a more welcoming environment for labouring patients. This improvement has been funded by the Silver Star charity through a donation from a service user. The wall art is a recent example of work to improve patient experience, with the aim of helping patients feel more comfortable and at ease during labour.

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Perinatal Quality Exception Report and Risk Registers

Indicator Overview Summary – Maternity SPC Dashboard



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Inductions of labour (IOL)	Oct 26	187	-			156	110	202
Inductions of labour (IOL) as a % of mothers birthed	Oct 26	28.0%	-			25.5%	19.5%	31.4%
Scheduled Bookings	Oct 26	645	625			691	545	838
Born before arrival of midwife (BBA)	Oct 26	4	-			6	-1	12
Number of women booked by 10+0/40	Oct 26	429	-			429	258	599
Percentage of women booked by 10+0/40	Oct 26	67%	-			66%	55%	77%
Mothers Birthed	Oct 26	667	625			612	531	694
Babies Born	Oct 26	688	-			622	538	707
Spontaneous Vaginal Births SVD (including breech)	Oct 26	298	-			302	244	360
Spontaneous Vaginal Births SVD (including breech): a	Oct 26	44.7%	-			49.3%	42.3%	56.4%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Oct 26	86	-			83	50	116
Number of Instrumental births/Forces & Ventouse as	Oct 26	12.9%	-			13.6%	9.0%	18.2%
Caesarean Section (CS)	Oct 26	300	-			231	187	276
Number of CS births as a % of mothers birthed	Oct 26	45.0%	-			37.8%	31.8%	43.7%
Number of Emergency CS	Oct 26	163	-			133	96	170
Emergency CS births as a %	Oct 26	24.4%	-			21.3%	15.5%	27.1%
Number of Elective CS	Oct 26	137	-			104	64	145
Elective CS births as a %	Oct 26	20.5%	-			16.5%	11.9%	21.0%

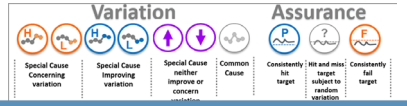
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SVD + OVD Total	Oct 26	384	-			379	306	451
Robson Group 1 c-section with no previous births a %	Oct 26	16.5%	-			14.5%	7.2%	21.8%
Robson Group 2 c-section with no previous births a %	Oct 26	63.8%	-			57.5%	45.5%	69.5%
Robson Group 5 c-section with 1+ previous births a %	Oct 26	86.7%	-			80.6%	63.1%	98.1%
Midwife:birth ratio	Oct 26	25.8	22.9			25.1	21.0	29.2
3rd/4th Degree Tears amongst mothers birthed	Oct 26	13	-			12	-1	24
3rd/4th degree tears amongst mothers birthed as a %	Oct 26	3.4%	3.5%			3.1%	0.1%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Oct 26	6	-			8	-1	17
3rd/4th degree tears following unassisted Vaginal bir	Oct 26	2.0%	-			2.2%	-0.1%	4.5%
3rd/4th degree tears following an Instrumental vagin	Oct 26	7	-			3	-2	9
3rd/4th degree tears following an Instrumental vagin	Oct 26	8.1%	8.0%			4.3%	-3.1%	11.6%
HIE	Oct 26	1	0			0	-1	1
Test Result Endorsement	Sep 26	76.7%	85.0%			78.1%	66.5%	89.7%
Number of PSII	Oct 26	1	0			0	0	0
Number of Complaints	Oct 26	15	-			11	0	22
Hospital Associated Thromboses	Oct 26	0	0			0	-1	1

What are the data telling us?

Exception Reporting highlighted for:

Test Result Endorsement: summary and actions, slide 12

Indicator Overview Summary – Maternity SPC Dashboard



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH equal to or greater than 1.5L following an instrun	Oct 26	6	-			6	0	12
PPH equal to or greater than 1.5L following an instrun	Oct 26	0.9%	-			1.0%	0.0%	2.1%
PPH equal to or greater than 1.5L (Rate per 1,000)	Oct 26	39.0%	-			36.0%	18.5%	53.4%
PPH 1.5L or greater, vaginal births (unassisted)	Oct 26	10	-			11	1	21
PPH 1.5L or greater, vaginal (unassisted) births as a %	Oct 26	1.5%	2.4%			1.8%	0.3%	3.3%
PPH 1.5L or greater, caesarean births	Oct 26	10	-			7	0	14
PPH 1.5L or greater, caesarean births as a % of mother	Oct 26	1.5%	4.3%			1.2%	-0.1%	2.5%
Maternal Deaths: All	Oct 26	0	-			0	0	1
Early Maternal Deaths: Direct	Oct 26	0	-			0	0	0
Early Maternal Deaths: Indirect	Oct 26	0	-			0	0	0
Late Maternal Deaths: Direct	Oct 26	0	-			0	0	0
Late Maternal Deaths: Indirect	Oct 26	0	-			0	0	0
Elective CS <39 weeks no clinical indication	Oct 26	0	0			0	-1	2
Shoulder Dystocia	Oct 26	13	-			9	0	18
Shoulder Dystocia as a % of babies born	Oct 26	1.9%	-			1.4%	0.0%	2.8%
Returns to Theatre	Oct 26	2	0			1	-2	5
Returns to Theatre as a % of caesarean section delive	Oct 26	0.7%	0.0%			0.6%	-1.0%	2.3%
Number of women with a live birth	Oct 26	660	-			605	508	702

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Stillbirths (24+0/40 onwards; excludes TOPs)	Oct 26	3	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Sep 26	3	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Oct 26	2	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Oct 26	3	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Oct 26	2	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Oct 26	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Sep 26	4	3			2	-2	6
Puerperal Sepsis	Oct 26	4	0			4	-2	10
Puerperal Sepsis as a % of mothers birthed	Oct 26	0.6%	1.5%			0.6%	-0.3%	1.6%
Unexpected NNU admissions	Oct 26	27	-			24	8	40
Unexpected NNU admissions as a % of babies born	Oct 26	3.9%	4.0%			3.4%	0.9%	5.8%
ICU/CCU Admissions	Oct 26	2	-			1	-1	3
IOL 0-6hours	Oct 26	50	-			50	30	69
IOL Delayed >24 hours (Red Flag SS)	Oct 26	23	-			27	-15	68
IOL Delayed 13-23 hours (Red Flag SS)	Oct 26	43	-			21	3	40
IOL Delayed 07-12 hours (Red Flag SS)	Oct 26	16	-			19	2	35

What are the data telling us?

Exception Reporting highlighted for:

Induction of labour: summary and actions, slide 34

Indicator Overview Summary – Maternity SPC Dashboard



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Triage within 15 mins	Oct 26	55.4%	-			48.5%	37.7%	59.3%
MAU Attendances	Oct 26	1676	-			1372	1108	1637
MAU Data Accuracy (%)	Oct 26	97.3%	-			90.8%	85.3%	96.2%
Maternal Postnatal Readmissions	Oct 26	25	-			20	3	36
Readmission of babies	Oct 26	31	-			26	-2	53
% completed VTE admission	Oct 26	81.5%	95.0%			91.3%	86.0%	96.6%
Number of Woman with a live birth Initianing Breastf	Oct 26	617	-			534	403	665
Percentage of Women Initiating Breastfeeding	Oct 26	93%	80%			85%	77%	93%
Number Of Women Booked This Month Who Current	Oct 26	26	-			39	17	62
Percentage Of Women Booked This Month Who Curre	Oct 26	4.0%	-			5.7%	2.5%	9.0%
Number of Women Smoking at Delivery	Oct 26	19	-			27	10	45
Percentage of Women Smoking at Delivery	Oct 26	2.9%	8.0%			4.5%	1.6%	7.3%
Number Of Women Booked This Month Who Current	Oct 26	26	-			39	17	62
Percentage Of Women Booked This Month Who Curre	Oct 26	4.0%	-			5.7%	2.5%	9.0%
Number of Women Smoking at Delivery	Oct 26	19	-			27	10	45
Percentage of Women Smoking at Delivery	Oct 26	2.9%	8.0%			4.5%	1.6%	7.3%
Bladder Streches >1000mls	Oct 26	6	-			3	-2	8
Bladder Streches >1000mls as % of babies born	Oct 26	0.9%	-			0.6%	-0.6%	1.8%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PROMPT Midwives	Oct 26	95.0%	90.0%			94.2%	88.0%	100.4%
PROMPT MSW's	Oct 26	94.0%	90.0%			95.0%	83.2%	106.8%
PROMPT Nurses	Oct 26	100.0%	90.0%			93.8%	81.4%	106.2%
PROMPT Obstetric Consultants	Oct 26	95.0%	90.0%			97.0%	86.1%	107.9%
PROMPT Obstetric Registrars	Oct 26	93.0%	90.0%			97.4%	93.3%	101.5%
PROMPT Obstetric SHO	Oct 26	100.0%	90.0%			96.8%	95.0%	98.6%
PROMPT Anaesthetic Consultants	Oct 26	94.0%	90.0%			84.6%	71.6%	97.6%
PROMPT Anaesthetic Registrars	Oct 26	100.0%	90.0%			100.0%	100.0%	100.0%
Fetal Monitoring - Midwives	Oct 26	94.0%	90.0%			94.2%	89.5%	98.9%
Fetal Monitoring - Obstetric Consultants	Oct 26	91.0%	90.0%			95.1%	91.3%	98.9%
Fetal Monitoring - Obstetric Trainees ST1-7	Oct 26	96.0%	90.0%			97.1%	92.7%	101.5%
Newborn Life Support (NLS) - Midwives	Oct 26	92.0%	90.0%			92.9%	88.8%	97.0%
NLS - Neonatal Nurses	Oct 26	88.81%%	90.0%			87.4%	#N/A	#N/A
NLS - Neonatal SHO and registrars	Oct 26	97.4%	90.0%			88.9%	76.8%	100.9%
NLS- Neonatal Consultant	Oct 26	91.7%	90.0%			90.8%	78.5%	103.1%
NLS - ANNP	Oct 26	100.0%	90.0%			100.0%	100.0%	100.0%

What are the data telling us?

Exception Reporting highlighted for:

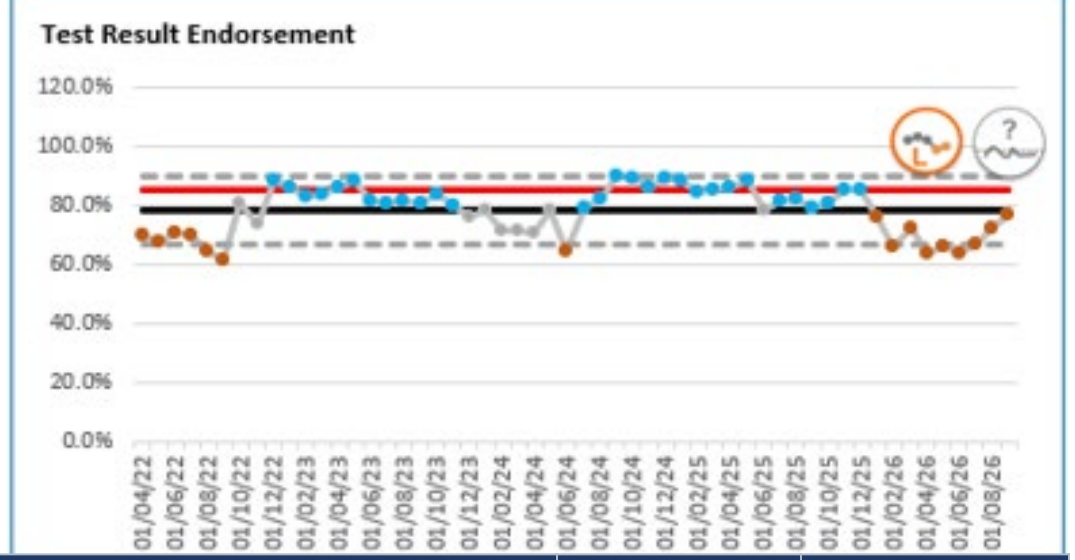
Maternal Postnatal Readmissions: summary and actions, slide 13

VTE risk assessment on admission: summary and actions, slide 14

Training reporting included in slide 26

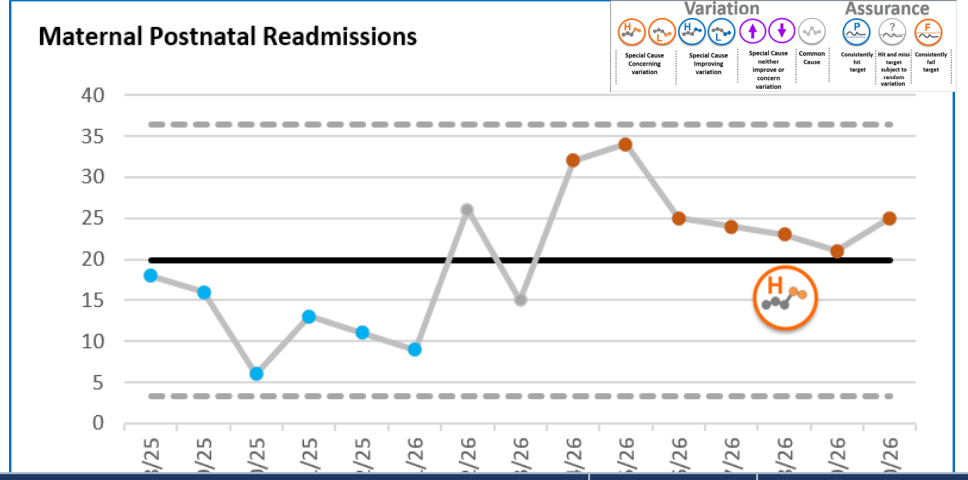
Maternity Exception Report – Test Result Endorsement (within 7 days)

(Note: data are retrospective for this KPI, so the latest figure is for September.)



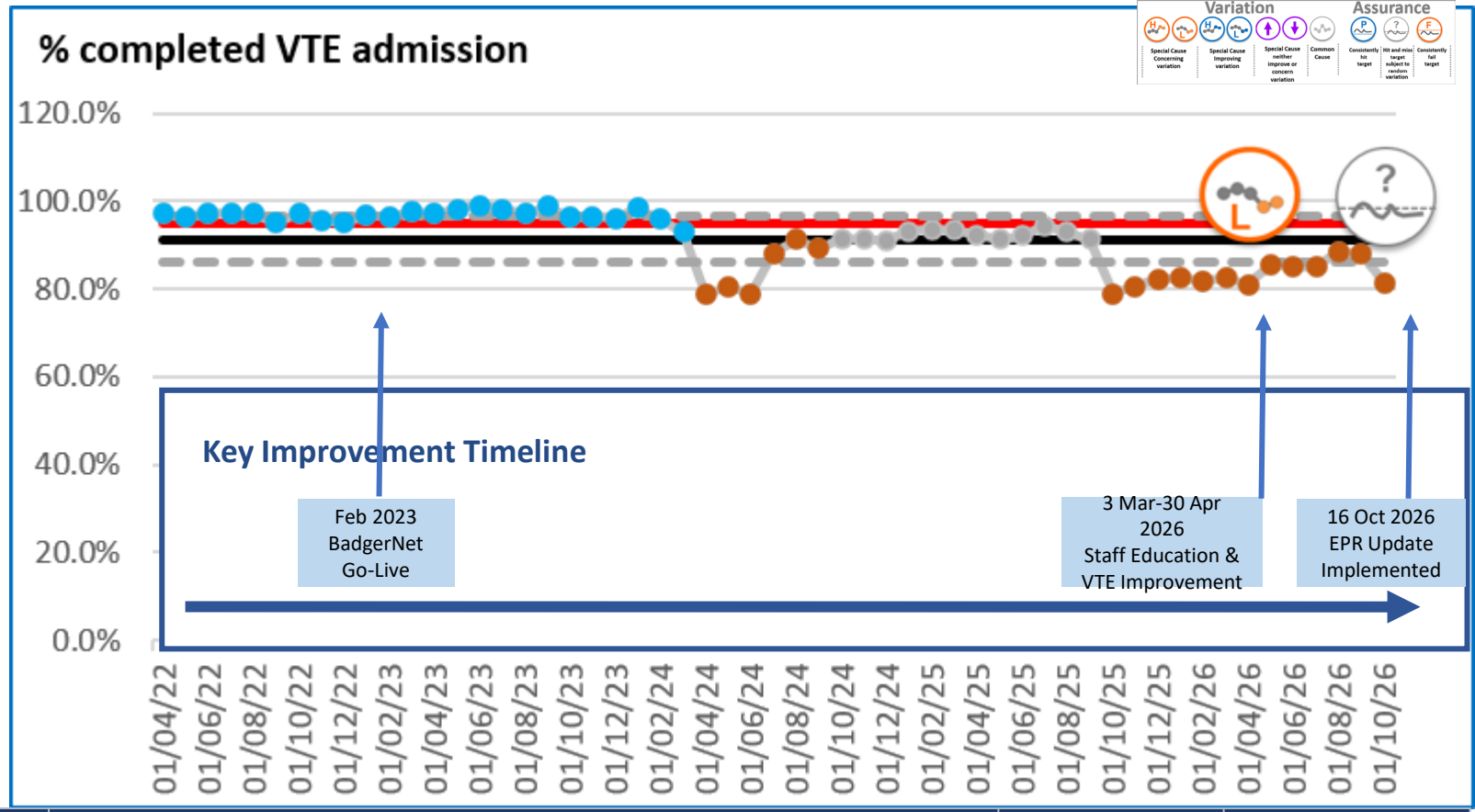
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Test Result Endorsement compliance was 76.7% (compared to 72.3% in August) but remains below the Trust target of 85%.	There are obstetric medical leads assigned to look at Test Result Endorsement in Maternity. This KPI is being managed through a targeted approach with a Task and Finish group set up with representatives from across midwifery and medical teams, ensuring community colleagues are included. Community aspects will consider individual professional responsibility for managing test results. Inpatient considerations will include the rollout of board rounds and how patient lists can include who needs test results endorsing on a shift-by-shift basis. Maternity services are included in the Trust's "auto-endorsing" efforts. Work is ongoing with the data team to remove reporting of blood group, negative MRSA, negative blood cultures and radiology from the inbox, thus removing them from the dashboard as agreed. This work is outside maternity services' control. However, the obstetric leads are stakeholders involved.	MDT Task and Finish group meeting in November. Improvement trajectory to be agreed by the end of November 2026 with an interim milestone of 80%. Responsible leads for each element, and the lead holding overall accountability, will be confirmed by 30 November 2026 with a clear plan for improvement outlined in the Task and Finish Group. Monthly monitoring through Maternity Clinical Governance Committee with exception reporting to Quality Committee until performance is sustained above target for three consecutive months.	12	"Under review" until the underlying data has been obtained and validated.

Maternity Exception Report – Maternal Postnatal Readmissions



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
SPC analysis now demonstrates **7 consecutive data points above the historical mean**, meeting the criteria for special cause variation and triggering reporting by exception. Recent improvement seen earlier in the year has not been sustained, with **October recording 25 maternal postnatal readmissions**, an increase from September. Detailed review of October readmissions identified infection-related presentations as the predominant cause (9/25, 36%), including wound infection, endometritis and mastitis. Hypertension-related readmissions remain a significant contributor (6/25, 24%), alongside presentations with headache, blood loss/secondary postpartum haemorrhage and other postnatal complications. Analysis suggests that the increase continues to be associated predominantly with clinical activity and case mix rather than avoidable harm. Ongoing review by the Postnatal Task and Finish Group continues to focus on postnatal hypertension pathways, infection prevention measures, enhanced safety-netting information and optimisation of postnatal follow-up arrangements.	**Key control measures include:** • Task and Finish Group to continue oversight of postnatal readmissions through maternity governance structures. • Completion of targeted quality improvement reviews relating to infection-related readmissions, including wound infection, endometritis and mastitis. • Continued implementation and evaluation of the revised postnatal hypertension pathway. • Introduction of standardised postnatal safety-netting information and digital patient information resources. • Review of community and hospital follow-up arrangements for women presenting with infection and hypertensive complications. **Control effectiveness is monitored through:** • Monthly review of readmission cases and themes. • Ongoing SPC monitoring through governance reporting. • Compliance audits of postnatal hypertension and infection-management pathways. • Review of outcomes following implementation of safety-netting interventions.	As postnatal pathways remain a recurring theme identified through triangulation of maternity data, the Postnatal Task and Finish Group will continue to monitor this indicator and address these quality improvement initiatives: **Progress to date –** safety netting information package has been consolidated and is ready for use. However, the Trust target to reduce paper resources has added a barrier to implementation. **Action** – Inpatient Matron to work with the maternity digital team to find a digital solution. Target completion date: 1 December 2026. **October update** – Infant feeding lead vacancy has caused a delay to the mastitis management pathway. **Action** – Inpatient Matron leading on recruitment. No successful applicants in the first recruitment cycle. Post to be readvertised. Targeted quality improvement reviews have been reported as completed but cannot yet be fully assured because supporting evidence remains pending. Next Task and Finish Group meeting: **25/11/2026**. **Ongoing** Maintain monthly monitoring of postnatal readmissions through maternity governance, supported by dashboards and quarterly trend reviews, with oversight provided by the multidisciplinary Task and Finish Group.	N/A	Satisfactory

Maternity Exception Report – VTE Risk Assessment Compliance



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
Compliance with VTE risk assessment on admission within 14 hours remains below the 95% target. It is currently 81.5%, down from 87.9% in the previous month.	• Continued emphasis on obstetric ward rounds in inpatient areas. • Development of board round initiative with support from the wider Trust. • Continued monthly maternity VTE improvement group.	• Weekly targeted area performance reviews by matrons to address areas of non-compliance and identify themes for escalation into the VTE improvement group • Whilst compliance remains below target, the digital-related system barrier was addressed through an EPR enhancement implemented on 16 October 2026. Compliance will be monitored over the next two reporting cycles to assess sustained improvement. • If this digital update does not achieve sustained improvement, review barriers by the end of December 2026.	Moderate	Satisfactory

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

Oxford University Hospitals NHS NHS Trust

Title	Opened	Description	I	C	T	Key Progress Notes
Replacement and maintenance of cylinders and regulators for Medical Gases (3376)	11/03/26	Non-compliance with policies and regulations for the safe storage, maintenance and management of medical gases.	16	16	4	This risk has been escalated to estates and the central medical gases team to agree a Trust-wide, standardised and compliant solution. Immediate risks to safety have been minimised through appropriate local mitigations as previously reported through governance. A Trust-wide response is underway supported by an Assurance Group for Medical Gases. Until Trust-wide actions to substantively mitigate are completed and embedded, the initial and current risk scores remain the same as compliance is outside maternity's remit. **Target dates therefore sit with the Chief Pharmacist, with oversight by the Medical Gases Committee, and are outside the control of Maternity Services**. Risk will continue to be reviewed on the Committee action log.
Maternity Estates Risks (2221)	26/03/26 (amalgamation of estates risks)	Risk of failing to comply with regulatory requirements due to a number of estates-related risks that do not comply with Health Building Notes (HBN) 00-01 and 09-02. This is an overarching risk, including all estates-related risks applicable to Maternity services within the Women's Centre at the JR. These risks are listed in the 'Links/risk' section and include: 1330, 1491, 175, 2107, 2201, 2203, 2205, 2412, 3020, 3376 This risk is tolerated locally with rationale, under the ownership and leadership of the directorate leadership team.	20	16	8	Actions include the need for continuous efforts to identify funding for future improvements, and collaboration with estates, to ensure systems are actively monitored. Improvements completed to date (such as the Entonox project in DS, completed summer 2025) are reflected within this risk. The risk also includes updates on ongoing work within the Women's Centre: - Wider ventilation project in the Women's Centre: started in August 2026, with work in Delivery Suite currently scheduled for March 2027. - Fire Safety Actions: Investigation works are substantially complete, with remedial works packages being finalised and contractor procurement progressing. Fire door replacement works commenced. Discussions with the Building Safety Regulator are ongoing to establish the appropriate statutory approval route under the Building Safety Act. This remains a key programme dependency for the wider remedial works and is outside Maternity services' control.
Level 5 Maternity drug room temperature (3020)	14/07/25	There is a risk that medicines stored in the drug room could become unstable as they have been stored at a higher temperature than the manufacturer recommends and may therefore not have the desired effect.	15	15	5	The asbestos works required for this project were completed in August 2026. Installation of the actual air-conditioning system remains planned but is subject to the outcome of the application under the Building Safety Act, following specialist legal advice commissioned by the Trust. In the interim, drug-room and refrigerator temperatures continue to be monitored in accordance with Trust policy, with any breaches reported. There is no change to the risk rating because the mitigations are not yet sufficiently implemented. However, an extension to the Estates completion date, subject to confirmation, may increase the risk grading. The Directorate Manager continues to oversee progress and liaise with Estates and awaits the result of the review detailed above.
Impact of increased demand for Elective Caesarean birth on emergency pathways (2426)	22/12/25	The use of midwifery staff for the overspill elective caesarean sections will continue to draw midwives away from women undergoing induction of labour or in labour. This in turn contributes to the delays women face (sometimes waiting 2 to 5 days for an induction of labour).	20	15	5	Recent changes to the EPR system to improve data accuracy support the elective caesarean sections pathway demand and capacity exercise, which is underway in alignment with MIS year 8. The data collected to date show the number of elective caesarean sections undertaken in emergency theatres, with initial findings from the demand-and-capacity exercise recommending a consistent six-day service model. The service is finalising the demand and capacity exercise findings, which will contribute to the development of a business case (expected to go to BPG in December 2026).

Neonatal risk register: October 2026

Oxford University Hospitals NHS Foundation Trust

No	Title	Description	Initial	Current	Target	Key Progress Notes
618	Incomplete transition to an electronic patient record (EPR)	The Neonatal Unit has not fully transitioned to an electronic patient record. It uses CERNER for electronic prescribing and paper records for all other clinical documentation, while Maternity Services use BadgerNet EPR.	16	12	4	All staff can now report incidents, near misses and risks through Ulysses and daily staffing huddles. A Neonatal EPR task and finish group has formed to address the risk.
1928	Neonatal estate constraints affecting safety, infection control and care quality	The ageing estate does not meet current activity and acuity needs. Limited space, particularly in HDU and LDU, affects babies, families and staff. Inadequate sluice facilities and storage increase clutter, disrupt workflow and hinder infection prevention and control.	16	12	4	The housekeeper post has been re-advertised after two unsuccessful recruitment rounds. Band 2–4 job descriptions are under review with Trust recruitment. HDU estate improvements now form part of the Perinatal Assurance Group action plans, in line with CQC recommendations.
3060	Reduced neonatal psychology capacity due to unfilled posts	Recruitment restrictions have left two key psychology posts unfilled, reducing capacity to 23% of recommended staffing. Reduced support for neonatal families and staff risks unmet psychological needs, poorer staff wellbeing, more complaints and greater demand on external services. It also risks reputational harm and non-compliance with national maternity and neonatal standards.	16	12	4	Workload prioritisation is ongoing to make best use of current capacity, alongside work on a long-term workforce model.
3121	Risk of SONeT/SORT transport service failure	Ageing ambulances, recurrent faults, delayed repairs and driver rota gaps risk disruption to neonatal and paediatric transfers. Gaps in driver orientation and communication with clinical teams can delay resolution.	15	8	4	Changes in BEARS leadership have improved repairs, maintenance and financial stability, reducing the reported risk. Re-procurement remains unapproved, pending Trust commissioning discussions.

Neonatal risk register: October 2026

Oxford University Hospitals NHS Foundation Trust

No	Title	Description	Initial	Current	Target	Key Progress Notes
2172	Gaps in neonatal medicines guidance and staff training	Gaps or delays in medicines governance, guideline and monograph updates, and staff training risk inconsistent practice, reduced safety compliance and medication-related harm. Daily reviews of high-risk patients and consistent provision of bespoke parenteral nutrition may also be affected.	15	12	4	Neonatal, pharmacy and divisional teams continue to develop libraries and safeguards. The risk remains on the EPR hazard log.
2935	Facial recognition access-control limitations	The parental facial recognition system may allow staff to enter without Trust swipe cards and may accept photographs instead of live faces. Managers cannot audit access logs, creating a risk of unauthorised entry.	16	12	4	Improved processes now manage access for parents, carers and service users. Awareness and staffing at unit entry and exit points have also improved.

Oxford University Hospitals
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Perinatal Safety

Perinatal Safety - Reported maternity incidents and thematic learning from investigations

Oxford University Hospitals NHS Foundation Trust

Reviewed incidents from SPEN, PMRT, MNSI, MOSS, PSIRF findings and national reports

Incident type	Incident	What learning has been identified?	Family view / DoC	External Reviewer	Grading of care up to birth/ diagnosis of IUD	Grading of care following the death of the baby
PMRT	NND	• Communication between maternity and neonatal teams	Feedback requested twice	Yes	B	B
PMRT	IUD	• Intrapartum care not provided in bereavement room due to capacity.	Feedback requested twice	Yes	A	B
PMRT	IUD	• Intrapartum care not provided in bereavement room due to capacity.	Feedback received	Yes	B	B
PMRT	IUD	• No care issues identified	Feedback received	Yes	A	A
PMRT	NND	• Earlier antibiotic administration at local trust prior to transfer	Feedback received	Yes	B	A

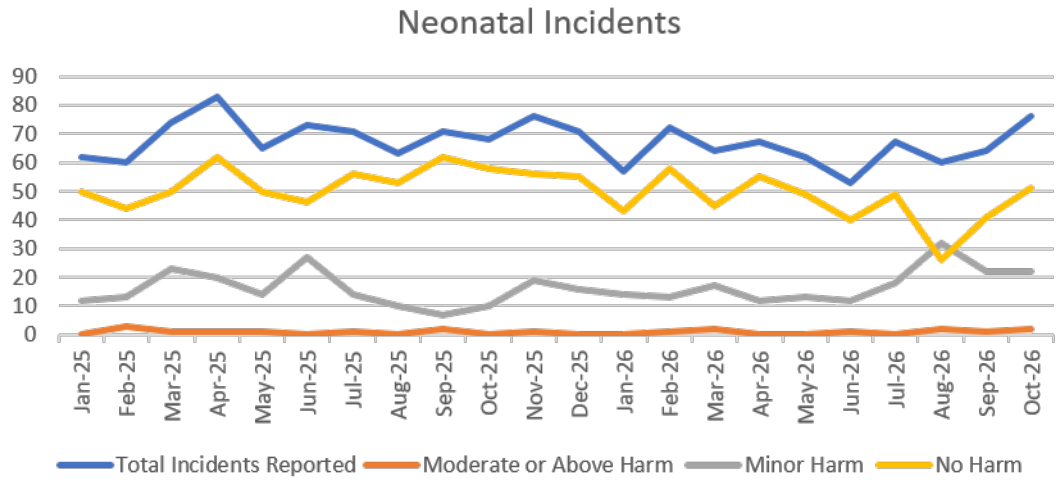
Assurance: All families were given multiple opportunities to provide feedback for the reviewing team to consider. Follow-up has been arranged with a consultant obstetrician to discuss findings. Maternity (Perinatal) Incentive Scheme (MIS) requires that at least 60% of Perinatal Mortality Review Tool (PMRT) meetings are attended by peer colleagues from other Trusts and service user representatives to agree grading and any necessary next steps. External reviewer attended 5 out of 5 PMRT meetings.

Learning from incidents: summary of learning and actions. Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals.

Type of review	Theme	Outcome / Learning / Actions / Improvements	What support is required from the Executive Board?
2L haemorrhage rapid review	Elective caesareans with known risk factors for haemorrhage.	Discussion has taken place with the anaesthetic and elective teams to identify opportunities to optimise patient safety for women with known risk factors for haemorrhage. This includes ensuring appropriate preparations are made in advance, such as pre-booking cell salvage and arranging cross-matching of blood prior to delivery, to support timely intervention should a haemorrhage occur.	N/A
PMR	Communication	A joint communication action plan is being implemented across maternity and neonatal teams to strengthen communication and shared situational awareness when babies deteriorate on the Neonatal Unit (NNU). Morning safety huddles, including the Level 5 safety huddle, now provide an opportunity to highlight babies whose condition is deteriorating to the maternity bleep holder, supporting timely information-sharing, coordinated team responses and improved continuity of communication across both services.	

MNSI: One referral in October involved therapeutic cooling. The Trust has received the factual accuracy report for MI-059204.

Perinatal Safety: Neonatal Incidents



Summary of data

- In October, staff reported 76 patient safety incidents through Ulysses. Of these, 24 involved harm: 22 minor, 1 moderate and 1 death.
- The main themes in minor-harm incidents were medicines, medical devices, and communication or documentation.
- The two incidents classified as moderate harm or above, comprising one moderate-harm incident and one death, were associated with hospital-acquired *Aspergillus fumigatus* complex. Both remain under investigation, with ongoing multidisciplinary discussions involving neonatal leads, Infection Prevention and Control (IPC), and Estates. Ventilation works and incubator cleaning have been identified as probable contributory factors, subject to confirmation through the investigations.
- Reporting has remained consistent over 12 months, predominantly for no-harm events. Reporting levels alone do not establish the effectiveness of safety controls.

Strengths

•Overdue incidents remain low and under active management. Monthly governance reviews and escalation processes support follow-up.

•The neonatal service is the second-highest reporter of excellence in the Children's Directorate, supporting recognition and shared learning.

•Representation at local, directorate and divisional governance meetings continues to improve.

Current actions

•Planned teaching during nursing team days and doctors' induction will cover governance, risk management and accountability.

•Doctors' induction will focus on medicines and prescribing PowerPlans to help reduce medication incidents.

•Collaboration with the Maternity and Neonatal Safety Improvement Programme (MatNeo) continues to support shared learning.

Next steps

•Continue governance teaching through induction and team development sessions, with a focus on risk management and accountability across staff groups.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Improvement Programmes
Maternity and Neonatal Workforce

Theme 1 - Staff Experience

Maternity Workforce and Operational Activity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- 667 people birthed 688 babies
- 3.75% community birth rate (25/667 women: 10 MLU and 15 home) with 6 intrapartum transfers and 5 postnatal transfers – reviewed.
- No closures or suspensions affected JR or community. Due to high acuity levels mutual aid was however requested on 23 October resulting in 1 woman being transferred to another trust for ongoing inpatient care.

OPEL shift status = 13 Green, 12 Amber, 6 Red – All were appropriately risk-assessed and escalated

Red flags

All red flags reported were appropriately reviewed and resolved.

1 red flag was reported in relation to the Delivery Suite coordinator not remaining supernumerary. This was escalated to the manager on call. Maternity declared on OPEL 3 throughout the day. Risk mitigated appropriately. No adverse effect.

Workforce establishment:

Midwifery establishment aligned to Birthrate Plus is 332.45 WTE with an additional agreed 23 WTE uplift for maternity leave, giving a total establishment of **355.45 WTE**.

- Vacancy: **15.68 WTE** (against 355.45)
- Total unavailability RM: **55.98 WTE.**
- MSW vacancies: 10.5 WTE, with unavailability of 23.72 WTE.

On-call data

- 92 midwives were called into JR as part of escalation arrangements.
    - 61 from the hospital on-call rota covering 467.25 hours.
    - 31 were community midwives covering 161.25 hours
- Community worked a total of 608 on-call hours across 313 call-outs.
- The longest call-out time worked was 12 hours 20 minutes, which when added to the working day totalled 19 hrs and 20 mins, thereby breaching the maximum 16-hour-in-24-hour rule. This circumstance is under review.
- On-call use has increased significantly compared with previous months and correlates with higher sickness absence, staff unavailability and births.

Strengths

- New starters (midwives): 9.64 WTE Band 5/6 in October, with projected 6.76 WTE in November.
- Further Band 5/6 interviews in November.
- Maternity-specific leavers' questionnaires and exit interviews. Themes from leavers collated.
- Promote an inclusive and supportive workplace through the perinatal improvement plan, active bystander, Schwartz rounds
- 24/7 bleep holder role continues to receive positive feedback
- 3 on-call RMs each night
- Safe staffing is dynamically risk assessed and reviewed daily with MDT support.
- Daily triangulation of staffing levels, patient acuity, activity, NHSP utilisation, vacancies and sickness provides assurance that staffing decisions remain responsive to clinical demand.
- Escalation arrangements, including on-call provision and OPEL review processes, continue to support safe service delivery despite ongoing workforce pressures.
- Raising and timely resolution of red flags on SafeCare
- Medirota for medical staffing is regularly reviewed by the directorate team with the aim of achieving compliance with the six-week leave policy and maintaining oversight of session planning and rota integrity

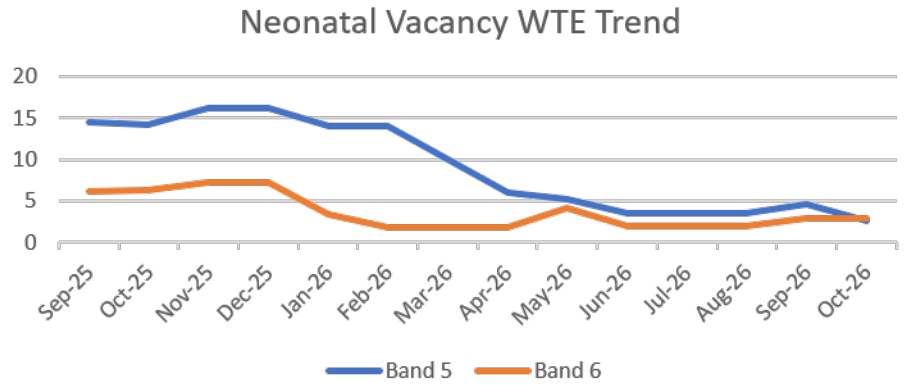
Operational Focus

- Leavers RM 2.84 WTE in October
- 9.64 Brookes students started in October and a further 3.76 booked to start in November.
- Further Band 5 and Band 6 interviews booked for November
- Birthrate Plus establishment review final report
- MSW recruitment: 0 WTE new starters in October and 1 WTE due in November
- Focus on exit interviews and turnover data
- Workforce Task and Finish Group in operation

Future

- Succession planning: 4 starting short courses in September and 2 starting apprenticeships in January 2027, subject to interview.
- 2 replacement resident doctors were recruited at end of October and are expected to commence by 31 January 2027, subject to pre-employment checks.
- 1 higher-tier and 1 lower-tier resident doctor post added to the budget for conversion to training posts in Aug 27. Recruitment to locally funded training posts anticipated from Feb 27.
- Consultant job plan compliance in October was 100%, with no outstanding job plans.
- Departmental job planning has commenced.
- 3 consultant vacancies: 2 due to colleagues leaving. Substantive recruitment in October requires interim locum cover. One new TME-funded post supports USS pathway changes. Interviews for 2 posts were in mid-October. The third will be advertised in Nov.
- Addition of 1 WTE from Aug 26 has supported out-of-hours care, particularly overnight. However, unavailability affects rota resilience.

Neonatal nursing workforce



Summary of data

•In October vacancies totalled 2.53 WTE at Band 5 and 2.98 WTE at Band 6, after accounting for staff in the recruitment pipeline. In addition, staff representing 8.4 WTE were on maternity leave.

•Regular staffing reviews and cross-divisional critical care redeployment remain in place to manage capacity pressures.

•Divisional governance reviews recruitment progress and temporary staffing use.

Recruitment progress

• Two Band 5 nurses are in the recruitment pipeline and awaiting start dates.

•Weekly meeting with recruitment to work on the Band 2/3 recruitment programme.

Current actions

•Band 6 and Band 7 development programmes support leadership skills, career progression and retention.

•Work continues to embed the Unit Ethos, with a focus on safety and collaboration.

•The support workforce review covers updated job descriptions, induction and career pathways.

Next steps

•Continue rolling Band 5 and Band 6 recruitment. New Band 5 starters will initially reduce the proportion of nurses qualified in specialty (QIS).

•Interviews for the Band 6 educator post are complete. A start date is awaited.

•Two internal Band 7 appointees await HR checks, with November 2026 starts planned.

•Re-advertise the senior housekeeper post after unsuccessful interviews and progress the Band 2–4 workforce review.

Neonatal Workforce: Specialist Training

Qualified in specialty (QIS): 70% target	2023	2024	2025	2026	2027	2028	2029
QIS proportion	42%	46%	48%	51%	60%	70%	80%
				As of 10th November 2026	Forecast		

Current position

•At the end of October, 86 of 170 nurses (51%) held a QIS qualification, below the 70% BAPM target. Recruitment and retention affect this proportion.

•The recovery plan prioritises internal training, supported by external recruitment. Competition for qualified candidates remains a constraint.

Progress

•The service reported compliance with MIS Year 7 Safety Action 4 for 2025, supported by an action plan. This does not mean the 70% QIS target has been met.

•Staff undertaking QIS training increased from 8 to 17 across two cohorts. Seven places were secured for September 2026.

•External advertising for Band 6 and Band 7 posts has approval.

•In August, the TV&W Neonatal ODN confirmed recurrent NHSE funding through the Education Training Activity Plan for foundation and specialist course fees.

Current actions

•Prioritise QIS training by service need, secure continuing professional development funding and increase mentor capacity.

•Phase training cohorts to limit operational disruption.

•The Neonatal Education and Workforce Group monitors delivery and reports progress to divisional governance.

Recovery trajectory

•The forecast is 60% QIS in 2027, 70% in 2028 and 80% in 2029. The 70% target remains unmet.

•Explore in-house provision to improve training access and flexibility, and review whether the two-cohort model meets service needs.

•Continue monitoring training delivery and progress against the forecast through divisional governance.

Staffing Vacancy Rates

Oxford University Hospitals NHS Foundation Trust

Staff group	SIP WTE	Vacancy rate (%)
Midwifery Inpatient Est = 166.33 WTE	166.71	0.23% over
Community Midwifery Est = 94.2 WTE	87.63	6.97%
Management and Specialist MWs Est = 71.92 WTE	62.43	13.2%
Maternity Support Workers	90.25	10.43%
Obstetric Consultants*	22.03	14.8%
Obstetric resident doctors**	47.07	5.1%
Neonatal nurses Establishment: 162.72 WTE	156.97	3.53%
Neonatal clinical support staff Establishment: 32.45 WTE	15.55	52.1%
ANNP	5	40%
Neonatal Consultants	13.3	1.75%
Neonatal Resident Doctors	39.5	10%

*Consultant figures exclude University consultants. **Resident doctors include all non-consultant grades. September figures are presented, as October figures are not available.
Midwifery staff in post (SIP) do not include staff on maternity leave (15.9 WTE).

Risks	Mitigations	Escalations
Midwifery: October new starters reduced the overall vacancy compared to September (9.7 WTE) Total October vacancy 15.68 WTE. However, all new starters are supernumerary	Mitigating actions include enhanced workforce oversight, careful deployment of existing resources, summer mitigations, and active monitoring of staffing levels to maintain safe staffing and service delivery. External recruitment from other universities will continue throughout the year, including recruitment of midwives qualifying in January and April.	Daily, weekly and monthly review of staffing deficits. Real-time management of NHSP release in line with real-time acuity review and response mechanisms. Summer and October mitigations include the proactive redeployment of office-based staff to clinical shifts to reduce clinical deficits.
Midwifery: Unavailability = 55.98 WTE (This includes maternity leave **15.9 WTE**, sickness/non-medical absence, supernumerary midwives and BR+ calculated establishment vacancy)	Mitigating actions are in place, including enhanced workforce oversight, implementation of agreed summer and October mitigations, and active monitoring of staffing levels. These measures provide assurance that workforce capacity is being managed proactively to maintain safe staffing and service delivery throughout this transitional period. To mitigate the high unavailability described within the risk, maternity is supported to recruit an additional 23 WTE above the Birthrate Plus recommended establishment of 332.45 WTE giving a total establishment of 355.45 WTE.	Daily triangulation of staffing levels, patient acuity, activity, NHSP utilisation, vacancies and sickness provides assurance that staffing decisions remain responsive to clinical demand. Escalation arrangements, including on-call provision and OPEL review processes, continue to support safe service delivery despite ongoing workforce pressures.
Midwifery: Leavers. Maintaining workforce establishment figures through new starters and a reduction in leavers in 25-26. Increased leavers since April 26 – 29.38 WTE in Q1 / Q2 Reduction in leavers WTE compared to September. Leavers for October (2.84 WTE) April to October leavers 32.22 WTE	Implemented exit interviews and maternity-specific leavers' survey Number 1 reason – Relocation Flexible working committee implemented for operational transparency and fairness utilising Trust policy to guide decisions.	Daily workforce oversight, incorporating staffing levels, patient acuity, activity, NHSP utilisation, vacancy rates and sickness absence, provides assurance that resources are aligned to clinical demand. Escalation and operational review processes, including on-call arrangements and OPEL monitoring, support proactive risk management and the continued delivery of safe care in the context of sustained workforce pressures.
Neonatal support staff vacancies and shift fill rates	Updated job descriptions and a training plan support recruitment and retention. Staffing reviews at least twice daily inform deployment and escalation.	Work continues with divisional HR and the Recruitment and Retention lead. Divisional, cross-divisional critical care and Trust staffing meetings review pressures and mitigations. Rolling Band 5–6 recruitment continues, with an open day planned for November 2026. Band 2–4 job descriptions are under review.

Perinatal Training

MIS Year 8 Safety Action B requires 90% training compliance across relevant staff groups for PROMPT, fetal monitoring and newborn life support (NLS). The training year runs from October to July, aligned with the Core Competency Framework. Annual content reviews cover nationally mandated topics.

Oxford University Hospitals NHS Foundation Trust

Summary of data:

- Moving and handling Level 2 - 90%
- Oliver McGowan training compliance is as follows:
  - Part 1: 83%
  - Part 2: 28.1% of maternity staff have attended in-person training (increased from 27%). Some staff had this training cancelled in September due to staffing shortages. Affected staff have been encouraged to rebook.
- PGD training compliance is 86%.
- Mandatory training compliance declined following the decision to defer the start of the 2026/27 training year to October 2026 because of staffing pressures and increased clinical acuity. Following 4 training weeks in Oct and Nov 26, all staff groups are now above the 90% threshold for PROMPT and fetal monitoring.
- Following an MDT debrief after the first 3 training weeks (this included feedback from both faculty and attendees), 2 scenarios have been revised slightly to support realism and high-fidelity simulation.
- Neonatal nurses' Newborn Life Support (NLS) compliance increased to 89% in October. Instructor sickness led to cancelled training in September, but the resumed programme is quickly addressing the gap.

Strengths

- Fetal wellbeing training compliance remains above the 90% threshold across all relevant staff groups.
- Most other reported core-skills modules were at or above 90%; both Level 3 safeguarding measures remained below 90%.
- 17 Band 5 midwives have commenced at OUH since Sept 26, with a further 4 expected in November 2026. Each has been allocated a named Practice Educator to provide structured preceptorship and clinical support.
- One clinical skills workshop, one RAID assessment session and a skills and drills session in USS were delivered in October to support the competence and readiness of new clinical staff.
- The PROMPT faculty completed a dedicated training day on 30 September to rehearse delivery and support consistent implementation of the forthcoming programme.

Focus

- Statistical process control (SPC) charts are in place to monitor compliance with PROMPT, fetal monitoring training and neonatal life support, enabling earlier identification of variation and targeted action.
- Monthly moving and handling updates for maternity staff commenced in September 2026 and continue monthly. Additional Trust training dates are supporting recovery in compliance. A shortage of trained Back Care Facilitators remains a constraint to bespoke delivery and has been escalated to the maternity leadership team.
- Bespoke Level 3 children's safeguarding training is being provided for preceptees and internationally educated midwives to strengthen compliance and ensure training meets their specific learning needs.

Future

- Practice Development Team vacancies mean skills and drills remain paused.
- October and November priorities are mandatory training and trolley teaching. Materials, including a video, will support the Maternity Early Warning Score launch in BadgerNet on 23 November.

Training Compliance 26/27

KPI	Latest month	Measure	Target	Variation	Assurance
PROMPT Midwives	Oct 26	95.0%	90.0%		
PROMPT MSW's	Oct 26	94.0%	90.0%		
PROMPT Nurses	Oct 26	100.0%	90.0%		
PROMPT Obstetric Consultants	Oct 26	95.0%	90.0%		
PROMPT Obstetric Registrars	Oct 26	93.0%	90.0%		
PROMPT Obstetric SHO	Oct 26	100.0%	90.0%		
PROMPT Anaesthetic Consultants	Oct 26	94.0%	90.0%		
PROMPT Anaesthetic Registrars	Oct 26	100.0%	90.0%		
Fetal Monitoring - Midwives	Oct 26	94.0%	90.0%		
Fetal Monitoring - Obstetric Consultants	Oct 26	91.0%	90.0%		
Fetal Monitoring - Obstetric Trainees ST1-7	Oct 26	96.0%	90.0%		
Newborn Life Support (NLS) - Midwives	Oct 26	92.0%	90.0%		
NLS - Neonatal Nurses	Oct 26	88.8%	90.0%		
NLS - Neonatal SHO and registrars	Oct 26	97.4%	90.0%		
NLS- Neonatal Consultant	Oct 26	91.7%	90.0%		
NLS - ANNP	Oct 26	100.0%	90.0%		

Core Skills Modules monitored	Maternity Directorate
Core Skill – Safeguarding Adults Level 3	86.9%
Core Skill - Safeguarding Children Level 3	87%

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NHS Foundation Trust

Perinatal Improvement Programme

Patient Experience

Theme 2 – Patient Experience

Patient Experience and Engagement – Maternity Friends and Family Test (FFT), Complaints, Concerns & Compliments

Oxford University Hospitals NHS Foundation Trust

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

Summary

Summary of data

- Feedback from both Friends and Family Test (27 responses) and Say on the Day (306 responses) demonstrates consistently high levels of satisfaction across OUH maternity services. This equates to a 50% response rate against births in October.
- The feedback response rate for FFT is lower than in previous months due to a change in provider.
- The positive response rate of 93% for combined FFT and SOTD feedback remains high.
- Overall, maternity FFT feedback was predominantly positive, with women and families highlighting compassionate, supportive and attentive care, particularly during labour and birth, immunisation appointments and perinatal mental health care.
- Areas for improvement focus on MAU wait times (similar to last month's feedback), infant feeding support and access to pain relief in the postnatal period.
- 15 complaints were received in October. Themes related to communication, listening and involvement in decision-making, timely escalation, coordination and escalation of care, safe personalised care and service capacity concerns.

Strengths

- **Compassionate and supportive care**, with women and families describing staff as kind, caring, reassuring and attentive.
- **Positive labour and birth experiences**, with high levels of satisfaction with the care and support provided during birth.
- **Excellent individualised care**, including particularly positive feedback regarding perinatal mental health support.
- **Strong experience of the Maternity Immunisation Hub**, with staff described positively and care reported as efficient, informative and reassuring.
- Several positive accounts of feedback were also received through the maternity feedback email, highlighting both the overall positive experience and individual staff members.
- For two months, the postnatal ward has been using drug trolleys (1 trolley for every midwife) in each hub. This is an improvement from a single stock for the whole ward, improving access to pain relief for women.

Focus

- Continuous development of MAU focusing on the environment, CTG lounge and improvement towards the BSOTS 15-minute target.
- Development of the Accelerator Programme and the Accelerator Team focused on community engagement to drive and inform service improvement
- All actions following complaints investigations and responses are now uploaded to the Ulysses 'Action Management' platform. Evidence of completion and closing of the loop on agreed actions will be reported via the Triangulation and Learning Committee (TALC).

Future

- The service will continue to strengthen engagement with women, families and community groups to ensure that lived experience informs service planning, quality improvement and the delivery of equitable, personalised maternity care.
- Continue the Accelerator Programme. Projects commenced include a maternity ultrasound pathway feedback project and a MAU triage project.
- Embed actions from the 15 Steps report and the outcome of the September co-production session.
- The Divisional Director of Nursing will complete an in-person audit and report findings to the Postnatal Task and Finish Group in November.
- Midwives will commence intentional rounding

Neonatal patient experience: feedback, complaints and compliments

Oxford University Hospitals NHS Foundation Trust

Summary of data

•October Friends and Family Test (FFT) received 1 response, rated very good.

•Say on the Day received 19 family responses, with overall experience rated 8.9/10.

•Feedback participation remains low, limiting assurance about the wider family experience.

•Two complaints were received in October, both raising concerns about communication between clinical teams and families. The neonatal service has submitted its response to inform the ongoing complaint investigation. Any learning identified will be shared following completion of the investigation.

Family feedback: strengths and improvement themes

What families valued

•Feedback was overwhelmingly positive. Families praised staff kindness, compassion and dedication, describing staff as supportive, reassuring and willing to go the extra mile.

•Comments are consistently positive with examples such as "*The staff that dealt with us were incredible. Despite the unit being understaffed at the time, they were very attentive and warm to our baby. This made a huge difference to us at a stressful time. We always felt she was in safe hands*".

Opportunities for improvement

•More consistent communication, fuller involvement in care decisions and clearer explanations using less technical language.

Current actions

- FFT information has been included in admission and discharge packs since the end of August. Additional unit walk rounds to be undertaken by the newly appointed feeding lead to support face-to-face FFT. Cot-side training for FFT is planned during December.
- The Patient Experience Team and Perinatal Engagement Lead are supporting a feedback improvement plan and work to address data access.
- Staff encourage feedback at admission, discharge and during longer stays. Targeted communications and digital options aim to reach a wider range of families.
- Divisional governance reviews response rates, feedback themes and complaints monthly.

Next steps

•Increase FFT and Say on the Day participation to obtain a more representative view of families' experiences.

•Use daily huddles and staff reminders to support feedback collection. A 15 Steps visit moved to November.

•Meet monthly with the Perinatal Engagement Lead and review progress through governance.

•Compare feedback themes with complaints and patient safety data to inform improvement priorities.

Neonatal Trajectory and Current State Against This Trajectory

Oxford University Hospitals NHS Foundation Trust

Neonatal FFT-Only Improvement Trajectory 2026–27

Aim: increase formal FFT responses from 2 per month to 15 per month by August 2027, while maintaining ≥95% positive feedback



Four Delivery Actions

1 PSP / volunteer collection

By Nov 2026 | Target 5 responses/month

Recruit and brief PSPs/volunteers; establish weekly feedback rounds; approach ≥50 families each month.

Accountable owner: Annabel England

2 Redesign discharge packs

By Feb 2027 | Target 8 responses/month

Include clear FFT information and QR access in 100% of discharge packs, with accessible options.

Accountable owner: Nadine Purdy

3 Staff education

By May 2027 | Target 12 responses/month

Train ≥90% of neonatal staff in how and when to invite feedback; add an FFT prompt to discharge conversations.

Accountable owner: Patient Experience team/NN education team

4 Visibility and accessibility

By Aug 2027 | Target 15 responses/month

Provide ≥10 visible FFT access points and refresh "You Said, We Did" displays monthly.

Accountable owner: Nadine Purdy

Definition: Formal Friends and Family Test submissions only. Excludes Say on the Day feedback. PQOM reports 2 FFT responses in June and 2 in July 2026; an FFT response-rate % cannot be calculated until the eligible denominator is consistently recorded.

Executive sponsor: Florian Stoemer

Current state against trajectory:

The neonatal unit received 10 FFT responses across September (9) and October (1). All 10 FFT responses received across September and October were positive; the small sample provides limited assurance about overall family experience. We are working with clinical teams and the Patient Experience Team to increase patient feedback participation. Overall, the FFT responses for the Trust have been lower since a change in provider in September. Work is ongoing to support staff to feel confident speaking to families about providing FFT, as well as utilising the Patient Safety Partners (PSP)/volunteers.

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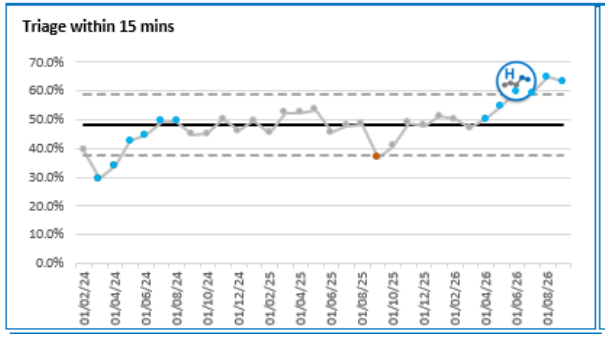
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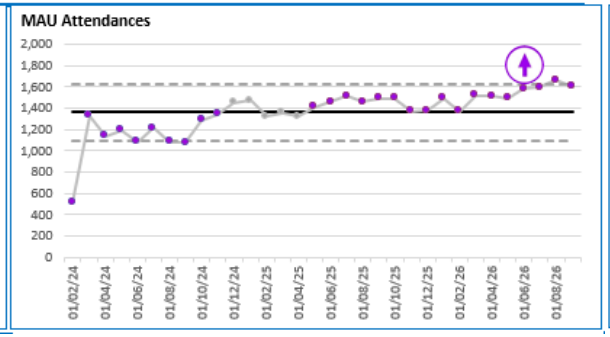
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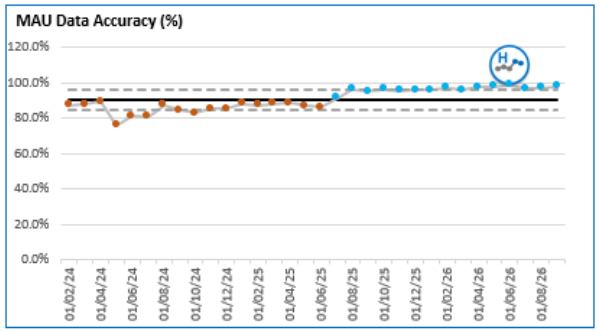
Theme 3 – Safety

Focus Quality Improvements: Triage (BSOTS) Perinatal Improvement Programme – Safety (1)

Oxford University Hospitals NHS Foundation Trust







TRIAGE QUALITY IMPROVEMENT: SUMMARY

- Performance has declined this month, with 15-minute face-to-face triage compliance reducing to **55.4%, a 7.8-percentage-point decrease** compared with the previous reporting period. This is below the expected standard and remains an area requiring focused improvement and sustained oversight.
- 2 red flags reported in October, both escalated appropriately and resolved by the Bleep Holder.
- The reduction in performance needs to be considered alongside the ongoing operational pressures within MAU. These include continued workforce capacity challenges, with sickness absence reaching **16% in October**, alongside ongoing constraints in the availability of clinical space.
- Whilst these factors present significant challenges, they do not diminish the importance of achieving the required standards. Focus remains on strengthening operational oversight, maximising staffing capacity, improving patient flow and ensuring opportunities to improve compliance are identified and acted upon.
- The position will continue to be closely monitored, with targeted actions to address the identified barriers and support a sustained improvement in performance. Matron and Ward Manager to maintain clinical presence. Matron to review escalation process.

Exception for October

Strengths

- While initial overall 15-minute triage compliance decreased to 55.4%, compliance exceeded 70% on several individual days, demonstrating the potential to achieve improved performance more consistently.
- Ongoing Midwifery Care remains stable at 99% for Green, 86.9% for Yellow and 75.6% for Orange pathways.
- Ongoing Medical Care is stable and improving: 90.9% Green, 54% Yellow, 57.9% Orange (average across urgent and non-urgent pathways).
- Good engagement with bleep holders and the manager on call (MOC).
- Quality Improvement Project team meeting twice weekly with a midweek touchpoint to highlight concerns.

Focus

- Matron to review and streamline escalation process and continue to work with Bleep Holders to ensure MAU staffing is prioritised and staff are able to escalate and obtain support early.
- MAU Patient Information Leaflet (PIL) went to Document Review Group (DRG) on 11 November 2026. Review with Accelerator Programme before uploading.
- Focus on reducing unwarranted variation in ongoing medical review times, particularly within the Orange pathways, to minimise delays that may contribute to patient flow pressures.
- Progression of automated monitoring and reporting processes.
- Maintain enhanced monitoring and monthly performance reviews, using real-time data and feedback loops to track progress, identify barriers promptly, and ensure improvements are sustained.
- Structured analysis of the impact of the third registrar on performance, using shift and day comparisons, to be conducted in the same manner as previously completed for midwifery staff.

Future

- As of 9 November, the contractors have completed the work, providing additional clinical space through a dedicated initial face-to-face triage room and a CTG monitoring room, offering capacity for three additional fetal monitoring spaces. This increased capacity is expected to improve patient flow through the unit, support more timely assessment and monitoring, and have a positive impact on the achievement of BSOTS targets.
- Continue recruitment to MAU to achieve full establishment based on the new staffing model. 2 WTE midwives planned to rotate and commence in MAU at the beginning of December.
- Matron to review and streamline escalation process and continue to support real-time day-to-day operational performance.
- Maintain monthly performance reviews and quality improvement cycles, focusing on sustained improvement in 15-minute initial triage compliance of over 85% and reducing extended waits by the end of December 2026.
- Patient Visible Wait times solution – data being collected to explore feasibility of displaying approximate waiting times. Action owner: Matron. Completion date: end of November. Digital solution being explored to display real-time BSOTS waiting data.

Maternity Assessment Unit (MAU)

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Month: October Year: 2026

Attendances: 1676 Calls: 1853

Initial Triage

Data Accuracy	97.3%
Seen within 15mins	55.4%

Feedback

No suitable feedback this month

Quietest Day

Sun 4th
35

Busiest Day

Tues 13th
69

Midwifery Care

Data Accuracy	95.5%
Seen within 4 hours	99.0%
Seen within 1 hour	86.9%
Seen within 15mins	75.6%

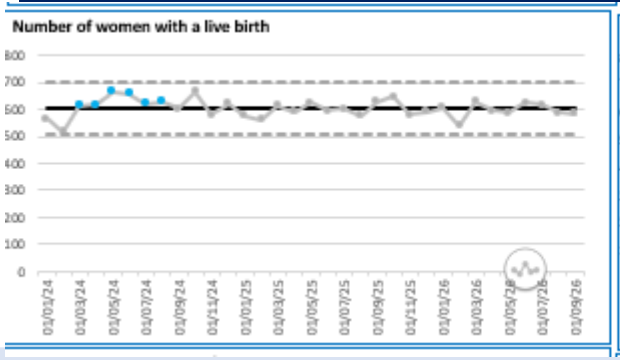
Medical Care

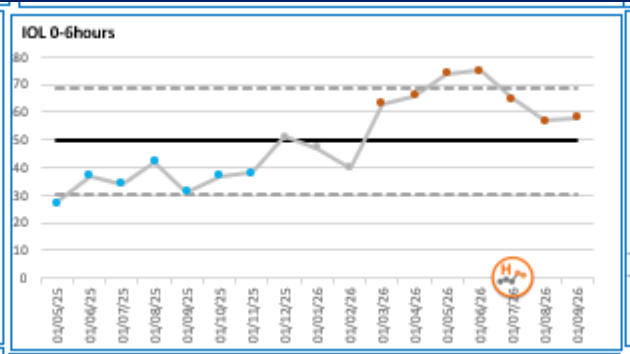
Data Accuracy	73.7%
Seen within 4 hours	90.9%
Seen within 1 hour	54.0%
Seen within 15mins	57.9%
Total cases reviewed	912

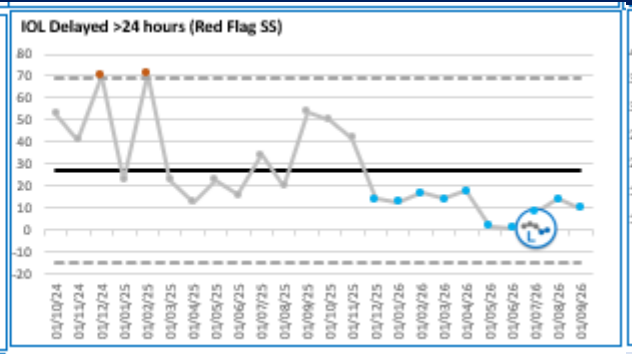
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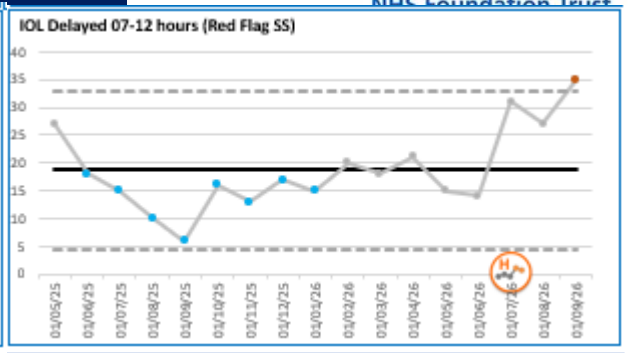
Focus Quality Improvements: IOL Perinatal Improvement Programme – Safety (1)

Oxford University Hospitals NHS Foundation Trust









Summary of Data

- The IOL quality improvement programme provides assurance that induction of labour delays are being actively managed, with improved oversight, communication and patient information supporting safety, experience and flow for women, birthing people and neonates.
- The data are also providing an opportunity to review the impact of different methods of induction and the impact on delay.
- 23 inductions were delayed in October: 22 due to acuity and 1 due to midwifery staffing. Whilst this is an increase in delays, there were 90 more births than in September 2026.

Strengths

- All delayed cases were reviewed in a timely manner, demonstrating effective governance, oversight and risk management.
- All delays over 24 hours were captured through Ulysses reporting and reviewed, and clear causes were identified. This provides assurance that delays are recognised, monitored and acted upon.
- Despite the increased acuity, there were no delays in induction of labour over 72 hours. The longest delay was 67 hours, with an average wait time of 14 hours.

Focus

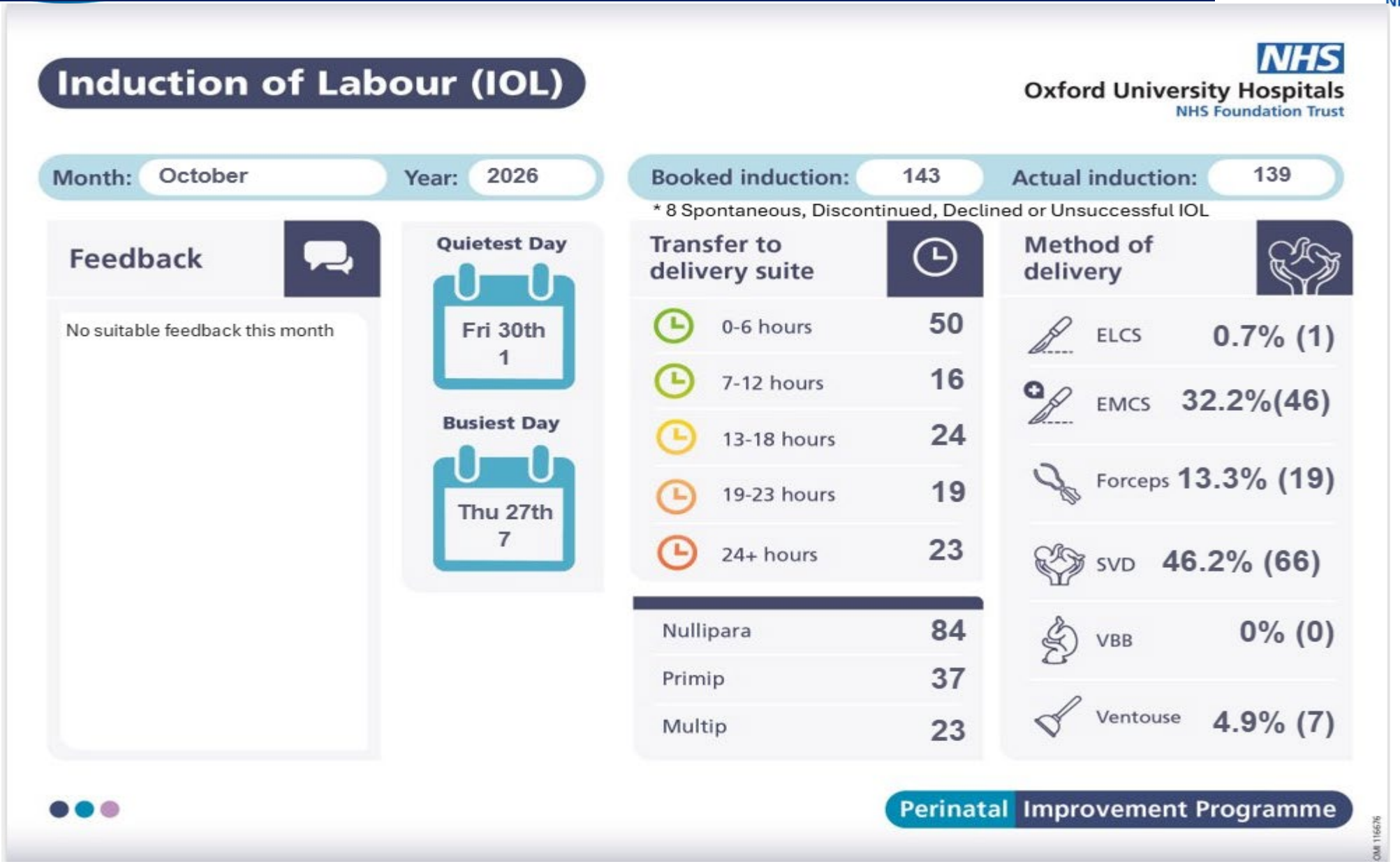
- Booked IOL cohort (n=143): 112/143 (78.32%) transferred to Delivery Suite in under 24 hours, compared with the reported 91.54% last month.
- Three of 143 birthed prior to the booked IOL date or declined IOL.
- Transfer within 6 hours: 50/143 (34.97%). Transfer at 7–12 hours: 16/143 (11.19%), versus the reported 31.54% in September. Recorded timing categories total 135/143 (94.41%): 8/143 (5.59%) require reconciliation. All delays over 24 hours have been reported via Ulysses and reviewed.
- A business plan is being developed to support the long-term use of misoprostol and sustain improvements in induction flow.

Future

- Continued work to embed red flag reporting on Optima and real-time Ulysses reporting.
- Continue discussion about activity undertaken on the Delivery Suite to maximise the space to reduce delays due to acuity. Current activities on Delivery Suite include waiting for ELCS, ECV clinic and initial bereavement care that does not require an intrapartum setting.
- Postnatal care project to commence on Delivery Suite to reduce time postnatal patients spend on Delivery Suite to improve flow throughout the unit.

Focus Quality Improvements: IOL Perinatal Improvement Programme – Safety (1)

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Thirlwall Inquiry response

Position assessed on 12 November 2026 at the Trust Management Executive (TME) meeting, using evidence available up to 9 November 2026.

Progress

- A live action plan tracks OUH's response to the Inquiry's 17 recommendations through 36 identified actions.
- SUDIC staff communication met the national deadline. Board notification and confirmation of neonatal readiness to implement the revised SUDIC pathway remain outstanding.
- Insulin security controls are in place. The laboratory insulin/C-peptide safeguard was implemented on 4 November.
- Mortality-monitoring arrangements are established. Further assurance is required that cross-case patterns will be identified and trigger predetermined escalation.

Assurance gaps and next steps

- Before Trust Board on 25 November: complete the remaining SUDIC, mortality, speaking-up and safeguarding evidence, together with the parent-reassurance communication and review of staff support.
- Interim CCTV for neonatal insulin storage and the interim suspected deliberate-harm protocol are due by 30 November; delivery of the CCTV action remains at risk. GIRFT-compliant insulin storage is due by 31 March 2027.
- Actions will close only when supported by evidence, with quarterly PQOM oversight proposed until completion.

Neonatal CQC Action Plan Update

PQOM | position at 16 November 2026

Oxford University Hospitals NHS Foundation Trust

CQC rated the service Good overall. The action plan now provides a CQC-only view of the two regulatory findings, with estates delivery and evidence capture remaining the principal assurance concerns.

TOTAL ACTIONS	GREEN	AMBER	RED	GREY	OUTSTANDING
35	22	11	1	1	13

REGULATION 15 | Premises and equipment

1 RED • 10 AMBER • 7 GREEN • 1 GREY

Current position

- Walk-round and multidisciplinary review completed; NNU work is linked to the wider maternity estates programme.
- Plans and recommendations are being developed to clarify feasible options and next steps.
- Operational mitigations continue while the permanent estates route is determined.

Critical milestones

30 Nov 2026	Survey, floor plan, HBN 09-03 gap analysis and risk-control review
31 Jan 2027	Options appraisal, scope and indicative costs
28 Feb 2027	Technical assessment and recommended route to PAG

REGULATION 17 | Governance of record-system risks

15 GREEN • 1 AMBER

Assurance in place

- Ward clerks and administrative colleagues included in daily safety huddles.
- Formal escalation available through Ulysses, supported by training.
- Monthly review through the NNU quality report and governance meeting, with learning shared through PSIRF and staff communications.

Residual assurance requirement

Continue to demonstrate sustainability through huddle records, Ulysses themes, monthly quality reporting and escalation records. The wider electronic patient record dependency remains.

PQOM focus — **Maintain Regulation 15 as open until delivery and post-implementation assurance are evidenced; urgently populate the evidence log and exception-report overdue, red/amber or blocked actions.**

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National Updates and Maternity (Perinatal) Incentive Scheme (MIS) Safety Actions

Year 8: reporting period 1 April 2026 – 30 November 2026

Maternity (Perinatal) Incentive Scheme (MIS) Safety Actions

Monthly

Oxford University Hospitals NHS Foundation Trust

	Assessment of compliance (met/partially met/not met)	Is there clear evidence to support compliance?	Gaps requiring action
A – Workforce and Capacity	Partially Met	Q3 and Q4 Perinatal Workforce Report went to Trust Board in July 2026	Q1 & Q2 Perinatal Workforce Report to Trust Board in January Elective caesarean birth capacity and demand exercise. A divisional paper with a mitigation plan for neonatal medical staffing is due for consideration at Divisional Business Planning Group
B – Training	Partially Met	Q1 training update reported via PQOM Q2 training update reported via PQOM in October (September data) SPC charts in use	Further evidence required in relation to collaboration with other services and service user feedback.
C – Learning from reviews and investigations	Partially Met	Quarterly thematic report due from Quarter 1 onwards. This was reported to MCGC and Perinatal Assurance Group (PAG) in August and Quality and Performance Committee (QPC) in September. Quarter 2 will be reported through the governance cycle in November.	Completion of the quarter 2 (Q2) reporting through the governance cycle.
D – Service User Voice and Equity	Partially Met	15 Steps visit undertaken in September. Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care. Engagement and ongoing work with community accelerator programme.	Awaiting report from 15 Steps Trust Equity dashboard due by December 2026. Work required on assurance of equity requirements and related reporting.
E – Care Bundles	Partially Met	Saving Babies' Lives Care Bundle reported via PQOM – Q4 reported in June 2026, Q1 reported in September 2026. Q2 included on slide 40. Maternal Care Bundle – implementation plan discussed at the Quality and Performance Committee (QPC) in October 2026. The QPC report to Trust Board will request that the Board approve the implementation plan based on QPC scrutiny. Q1 and Q2 updates provided to Board. Neonatal Pulse Oximetry guideline updated in line with BAPM, with a new Patient Information Leaflet.	Monitoring of the Maternal Care Bundle. Quarter 3 will be reported in January 2027.
F – Board Oversight, Governance, Culture and Leadership	Partially Met	MOSS critical safety checklist completed and reported to Board Safety Champions walk rounds reported via PQOM.	Further evidence required on the Perinatal Culture Improvement Programme.
What is going well?		Quarterly Reporting to Trust Board continues. Reporting continues via SPEN for eligible cases.	
What is of concern?		Outstanding evidence for aspects of safety action B, further evidence of collaboration with external services and service users required.	

Saving Babies' Lives Care Bundle (v3.2) Quarter 2 Update

Quarterly

NHS Oxford University Hospitals

Element	Exceptions/progress/action	Responsible (Role)	By when
1: Smoking in pregnancy	• Continue tobacco-dependence improvement work, specifically focusing on conversion of referral into sustained quitting; review the 4-week and 36-week quit outcomes; address the RN CO-training gap; and validate the referral numerator/denominator methodology so rates above 100% are no longer reported as a compliance measure.	Public Health Matron	31/12/2026
2: Fetal growth	• Percentage of women booked who had a risk assessment for aspirin at booking – exemption in place • Vitamin D recommendation at booking remains compliant at 97.2% against a 90% requirement. • FGR risk assessment **decreased during Q2, from 96.6% in July to 73.1% in August and 68.2% in September, producing 79.3% Q2 compliance**, below the 90% LMNS requirement. **Action:** This relates to a change in BadgerNet and is a reporting risk and not a clinical risk. Additional FGR screening is in place. • Uterine artery Doppler assessment for women at high risk of FGR remains 100% compliant. • Babies below the 3rd birthweight centile born after 37+6 weeks are reported at 40%, within the stated <50% threshold. • Using the corrected definition, antenatal SGA detection is 65.7% in Q2. • No FGR-related issue was identified in the reported Q1 or Q2 perinatal mortality reviews for 2026/27.	Community Matron Consultant Obstetrician	31/12/2026
3: Reduced fetal movement	• Computerised CTG for eligible women presenting with RFM is 90.9% in Q2, exceeding the 80% LMNS requirement. • Ultrasound assessment following recurrent RFM is reported at 66% in Q2, against an LMNS threshold of 55% • No RFM management issue was identified in the Q2 stillbirth/neonatal-death measure.	MAU manager	Ongoing
4: Fetal monitoring	• Q2 fetal-monitoring training compliance is above the 90% LMNS threshold across all reported professional groups: midwives 92%, obstetric consultants 92%, ST3–7 94%, and ST1–2 100%. • There were no reported Q1 or Q2 2026/27 cases where intrapartum-monitoring failure was identified as a contributory factor in the specified adverse outcomes.	Fetal Monitoring Midwife	Ongoing
5: Preterm births	• Singleton preterm birth remains below the stated <10% threshold at 6.2% in Q2; late-second-trimester birth is 0.2%. • Mortality among babies born <32 weeks improved from 10.5% in Q1 to 7.4% (2/27) in Q2, bringing Q2 below the <10% threshold. • 100% of eligible extremely preterm babies were born on a site with a NICU. • Antenatal corticosteroid compliance is 64.1%, above the stated 50% requirement. • Magnesium sulphate administration is 89.5%, well above the 70% requirement. • Severe neonatal brain injury measures remain within the stated threshold, including 0% cPVL and 6.7% IVH/death measure reported in Q2. • Delayed cord clamping is 83%, above the 80% LMNS threshold. • Admission temperature **improved from 72% in Q1 to 85% in Q2**, following the action plan in Q1, now meeting the 85% threshold. • Own mother's milk within 48 hours **improved substantially from 71% in Q1 to 89% in Q2**, exceeding the 75% threshold.	Consultant Neonatologist	Ongoing
6: Diabetes in pregnancy	• 100% of women with type 1 diabetes were offered a pregnancy-specific HCL system, exceeding the >60% standard. • Third-trimester HbA1c measurement is 93.33% in Q2, exceeding both the LMNS requirement and >80% national standard.	Diabetic Midwives	Ongoing
For Trust Board to note	In line with Safety Action E requirements, OUH confirms the Trust uses Hadlock charts for estimated fetal weight (EFW), not Intergrowth. OUH surveillance pathways meet the most recent national safety advice. OUH also confirms that the Trust has further improved its fetal growth restriction (FGR) surveillance by 1) adopting integrated screening for pre-eclampsia as advised by Tommy's Charity and 2) additionally scanning pregnancies with lesser reported risk factors. The fetal growth surveillance programme was strengthened in August 2026 to align fully with the standard national scanning pathway for late pregnancy in the NHSE Saving Babies' Lives Care Bundle.		

Maternal Care Bundle (MCB) Implementation Progress

Quarterly

Oxford University Hospitals NHS Foundation Trust

Fully implemented (Green) 3/14 (21.4%)

Partially implemented (Amber) 4/14 (28.6%)

Not yet implemented (Red) 7/14 (50.0%)

Element	Intervention Reference			Actions in progress	Responsible (Role)	By when
1. VTE	1.1	1.2	1.3	1.1 Pathways are being reviewed for when first contact is a non-OUH service and when the first contact is OUH (including BadgerNet self-referral, community midwife, early pregnancy unit and any other OUH ward or acute unit). 1.2 The lead is working with the ICB in relation to prescribing in early pregnancy. 1.3 The VTE self-assessment form is on the internet on the same page as the BadgerNet self-referral form. Guideline updated. Further work is required to define pathways for women identified as high risk and to ensure timely LMWH prescribing.	Consultant Obstetrician	31/03/2027
2. Pre-hospital and Acute Care	2.1	2.2	2.3	2.1 The new Maternity Early Warning Score (MEWS) is available in BadgerNet but is not yet live. It will be rolled out in maternity ahead of the rest of the Trust. Digital solution for the wider Trust being developed. 2.2 The intrapartum matron is working with SCAS to standardise the pre-alert communication and to review signage. Costs to be identified. There is a plan for the telephone line to be in place by the end of November. 2.3 The Maternal Medicine team are reviewing the acute referral pathways from local services to the maternal medicine team.	Consultant Obstetrician Intrapartum matron	31/03/2027
3. Epilepsy in Pregnancy	3.1	3.2		3.1 Consultant interviews took place at the beginning of October. Epilepsy clinic set up and women booked from triage. The network guideline is currently being updated. 3.2 BadgerNet referral form to be updated to include epilepsy status and current anti-seizure medication (ASM) regimen. **Requires a digital solution**. Pathway from community referral to admin to EPR triage pool to be strengthened.	Maternal Medicine	31/03/2027
4. Maternal Mental Health	4.1	4.2	4.3	4.1 Further work required to enable women to self-administer the Whooley questions ahead of the booking appointment. The gold standard would be to send the self-administration questions via BadgerNet. Work in progress with digital team on a solution. 4.2 and 4.3 Perinatal Mental Health Guideline to be updated when 4.1 is completed.	Maternal Mental Health Obstetrician	31/03/2027
5. Obstetric Haemorrhage	5.1	5.2	5.3	5.1 and 5.2 Postpartum Haemorrhage Guideline updated. 5.3 Multidisciplinary team (MDT) meeting to review PPHs of 2 litres and above in progress. Terms of Reference developed for the meeting.	Intrapartum Lead Obstetrician	Ongoing

What is going well?	Element 5: Postpartum Haemorrhage (PPH) guideline update. Multidisciplinary team (MDT) meeting in place to review PPHs of 2 litres and above. Audits are being undertaken for this element.
What is of concern?	A digital solution is required for elements 1, 3 and 4 A Trust-wide digital solution is required to support safe MEWS implementation outside maternity. Updating the guidelines to reflect recent changes and reviewing associated pathways to ensure alignment with the revised guidance. Review of signage to Delivery Suite with the ambulance service has not yet taken place. A review date is planned.
What are the top contributors to under-/overachievement?	Digital infrastructure

Baroness Amos 10-Point Plan

Oxford University Hospitals NHS Foundation Trust

The Trust received feedback from the NHSE South-East region on the completed baseline assessment and maternity triage audit for the 10-point plan for maternity and neonatal services. The next regional progress report is due by 31 December 2026.

National action	Current position	Change since September
1. Martha's Rule	1 complete	No change
2. Real-time outcomes, experience and clinical audit acted on at Board	1 complete, 2 in progress	Board reporting of perinatal intelligence (2.2) is newly complete. The other two deliverables (2.1, 2.3) are in progress. The Perinatal Quality Oversight Model (PQOM) report covers the requirements of the deliverable. The assessment for September identified gaps relating to the neonatal experience feedback in terms of mechanisms and volumes. There is an improvement plan to increase the formal Friends and Family Test (FFT) responses. This has commenced and there was an increase in the number of FFT responses received in September 2026.
3. Dual Board-level accountability	2 complete	No change
4. Amos into Action	Nationally led, no return	No return required
5. Addressing inequalities	1 on hold, 2 in progress	The national equity programme (5.1) moved to on hold until April 2027, confirmed by the regional review. The inequalities dashboard (5.2) and Maternal Care Bundle reporting (5.3) are in progress.
6. 24/7 safety and responsiveness	5 complete, 1 in progress, 1 not applicable	6.7 moved to in progress following the regional review. Board scrutiny of this report provides the evidence identified as missing.
7. Homebirth review	1 complete, 1 not applicable	The homebirth review (7.1) is evidenced as complete, closing the gap identified by the regional review.
8. Incidents, complaints and concerns	1 complete, 2 in progress	Quarterly report to Board.
9. Safe and effective triage	1 complete, 2 in progress	The benchmarking audit (9.1) is evidenced as complete, closing the gap identified by the regional review. 9.2 and 9.3 are unchanged.
10. Post-death care	2 complete	No change
Total (24 rated, 2 not applicable)	**14 complete, 9 in progress, 1 on hold**	Three deliverables are newly complete since September (2.2, 7.1 and 9.1). One moved to on hold (5.1) and one to in progress (6.7), both following the regional review. All other positions are unchanged.

Quarterly assurance summary

Progress is evident across all six themes, but assurance remains dependent on completed reviews, measurable impact and confirmed delivery arrangements.

6	3	31 Dec 2026	24/34
themes progressing	priority assurance gaps	national progress submission	registered staff joined Your Voice

1. Antenatal scanning pathway

IMPLEMENTATION / REVIEW

Update: Revised pathway remains in implementation alongside a commissioned independent review. Latest documentation does not confirm review completion.

Next assurance required: Confirm final terms of reference, review stage and reporting timetable.

Lead: Chief Medical Officer and Chief Nursing Officer; supported by the Antenatal Scanning Pathway Task and Finish Group.

2. Midwifery staffing

BUSINESS CASE INITIATED

Update: Divisional approval was received on 16 October 2026 for a business-case initiation proposal. This is not Trust-level investment approval or implementation.

Next assurance required: Address the modelled establishment gap and provide evidence that staffing is fully assured.

Lead: Director of Midwifery, with workforce oversight through the Chief People Officer route where required.

3. Listening to service users, families and communities

DELIVERY PROGRAMME DEFINED

Update: Programme includes survey development, community-informed improvement and follow-up of the September maternity 15 Steps visit.

Next assurance required: Evidence completed changes and demonstrate their effect on service-user experience.

Lead: Perinatal Experience Lead, working with OMNVP, community partners and corporate patient-experience colleagues.

4. Equity in care and experience

DASHBOARD IN DEVELOPMENT

Update: The September baseline identified inconsistent Board reporting of ethnicity, deprivation, language and wider inequalities. A detailed delivery plan now uses the Trust Health Inequalities Dashboard, with maternity and neonatal reporting across access, experience, safety and outcomes. Initial scope and minimum dataset were completed in October.

Next assurance required: Complete remaining milestones for the 31 December 2026 national submission and show intelligence translated into measurable improvement.

Lead: Equality, Diversity and Inclusion Midwives and Obstetric Equity Lead.

5. Estates

IMMEDIATE RISK CONTROL COMPLETED

Update: A reception desk and revised door access mean women no longer wait behind a locked MAU door. The new triage room became operational on 9 November 2026, with access to three CTG machines.

Next assurance required: Progress MAU flow, equipment and computer access, delivery-suite ensuite scoping, and cost estates/digital requirements.

Lead: Maternity operational leadership and Estates leads, overseen through PAG and divisional governance.

6. Culture, leadership and staff voice

NATIONAL LISTENING COMPLETED

Update: Your Voice: Building a Better Future for Maternity and Neonatal Care ran 21 September to 2 November 2026, facilitated by Clever Together. OUH ranked sixth in the NHS South-East region: 34 registered, 24 joined, 19 participated and 140 contributions.

Next assurance required: Receive and review the individual Trust report and translate findings into local action.

Lead: Chief People Officer and Director of Midwifery, with Freedom to Speak Up and psychology leads.

MOSS

Oxford University Hospitals NHS Foundation Trust

A **Level 1 MOSS signal** relating to maternity services at the John Radcliffe Hospital, part of Oxford University Hospitals (OUH), was generated on **04 October 2026**. Team members registered to receive notifications were sent the alert. A meeting took place on the first working day to confirm responsibility for completing the critical safety checklist and timeframes to send to the Trust Board Executives, the region and ICB, after which a live copy was provided to the key stakeholders. The checklist was completed by the perinatal leadership team and shared with Trust Board executives, the ICB and region as per the national Standard Operating Procedure (SOP) within the agreed 8 working days.

Overall assurance: Green/Amber

The critical safety checklist was completed, approved and shared with the South-East regional team within the required timeframe. Regional review confirmed the Trust has recognised the identified risks and that appropriate actions and mitigations are progressing.

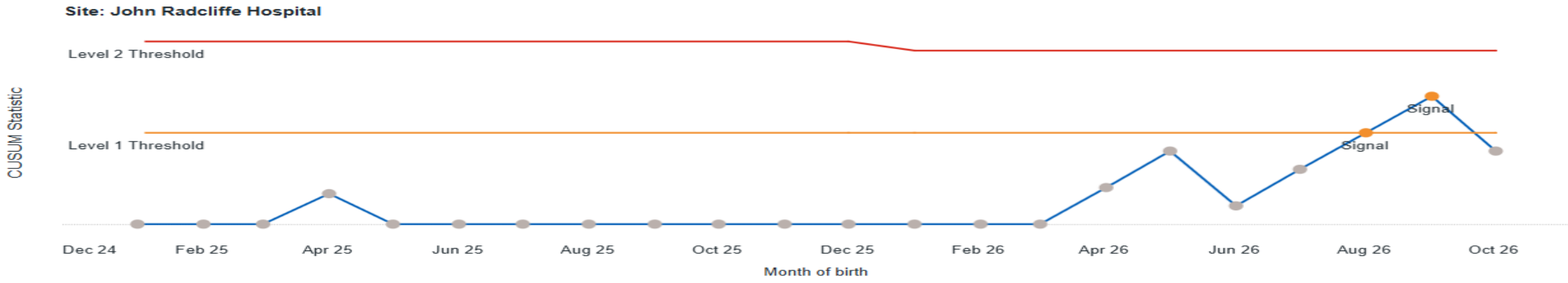
Key Findings

- Multidisciplinary review of the cases contributing to the MOSS signal found **no common causative factor, immediate new safety concern or evidence of harm attributable to a shared system failure.** The individual outcomes remain subject to PMRT/MNSI review (two cases referred to MNSI – 1 accepted, 1 rejected). No immediate safety concerns were identified in the initial rapid review.
- **Triage and patient flow**: timely initial triage and urgent clinical review are not yet achieved consistently, particularly during periods of peak activity.
- **Workforce resilience**: vacancies, sickness, turnover and redeployment continue to create pressure across medical and midwifery staffing.
- **Sustainability:** improvements are evident, including strengthened escalation, workforce investment and enhanced governance oversight, but are not yet reliably embedded across every shift.

Actions and oversight

- Existing improvement plans for maternity triage, induction of labour, workforce, escalation and patient flow continue through the Perinatal Improvement Programme.
- Performance and evidence of impact will be monitored through PQOM, the Perinatal Assurance Group, maternity governance and regional oversight.
- Learning from outstanding PMRT and MNSI reviews will be incorporated and escalated promptly if new themes or concerns emerge.

The **Trust Board is asked to** note the Green/Amber MOSS outcome and maintain active oversight until there is sustained evidence that timely triage, urgent review, safe staffing and escalation processes operate reliably across all shifts and periods of high demand.

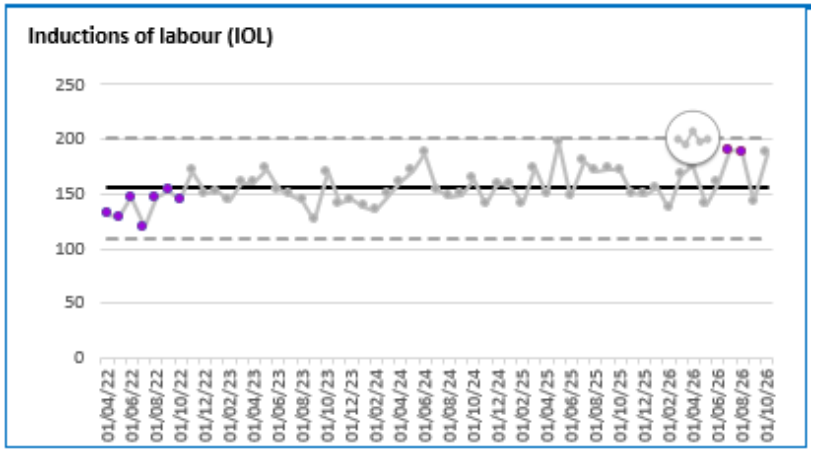


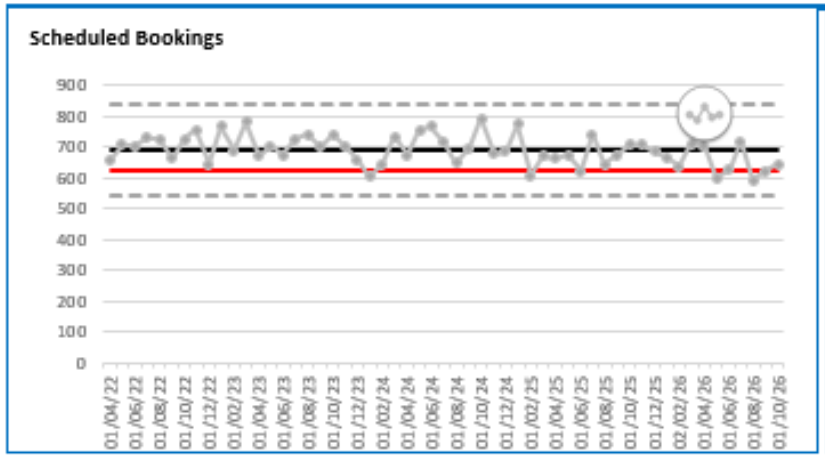
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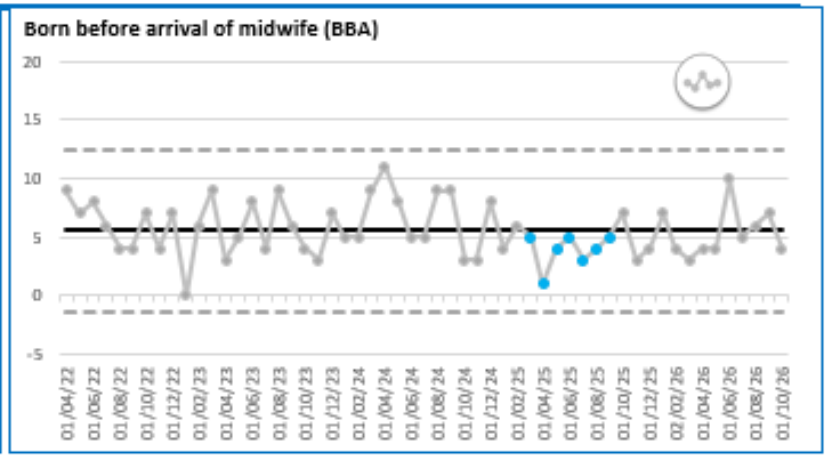
Appendices

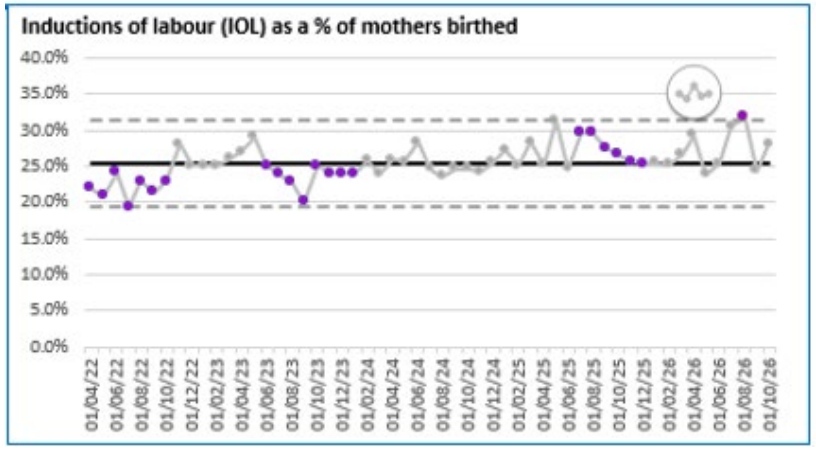
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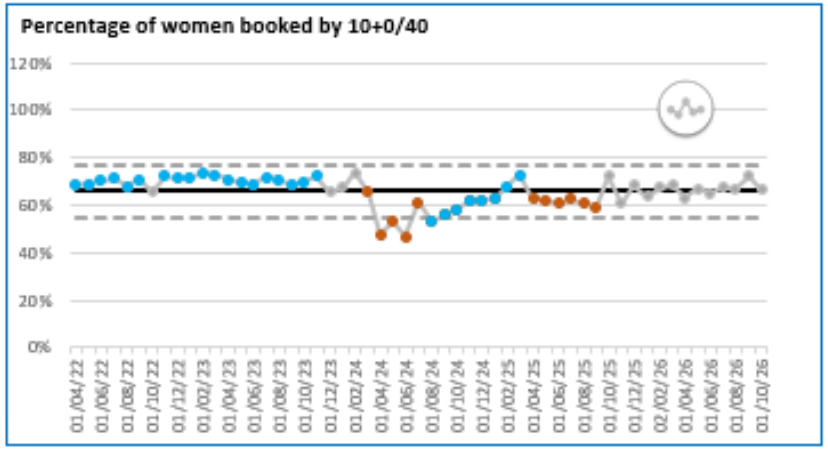
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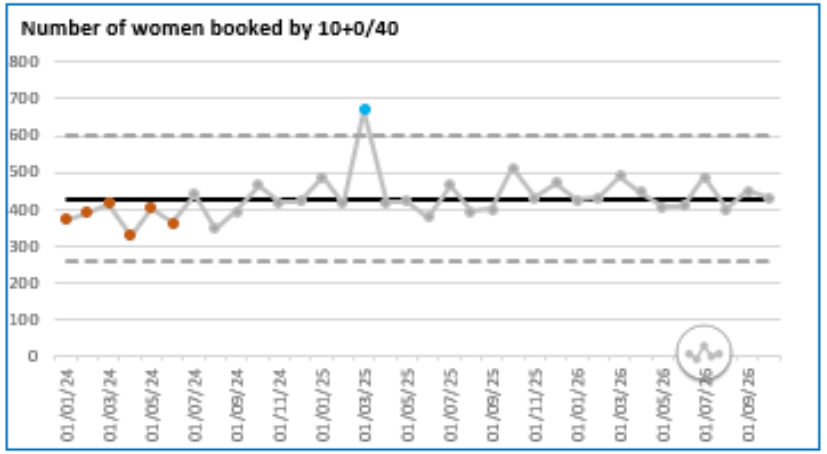






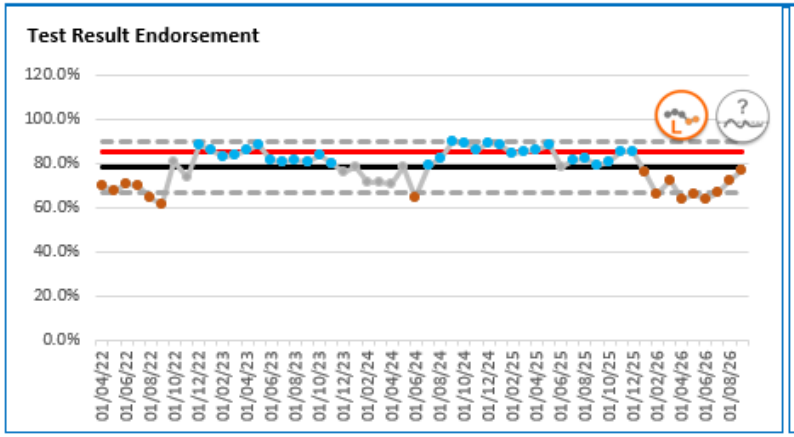


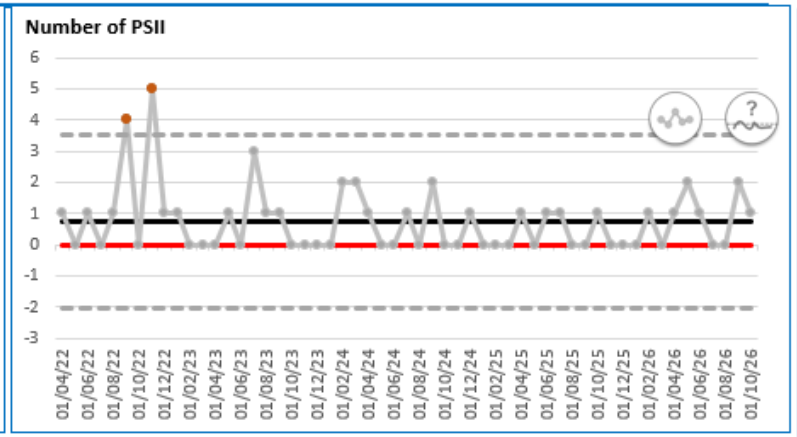


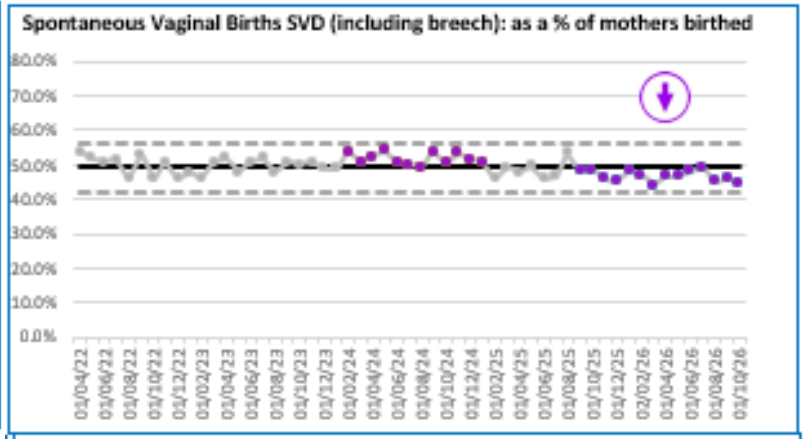


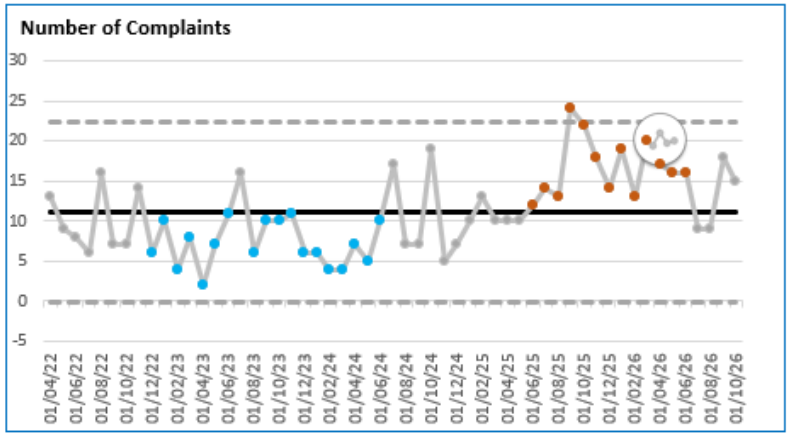
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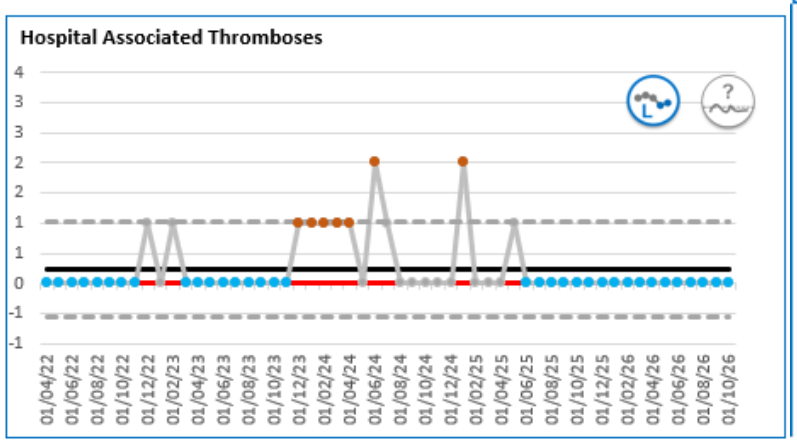
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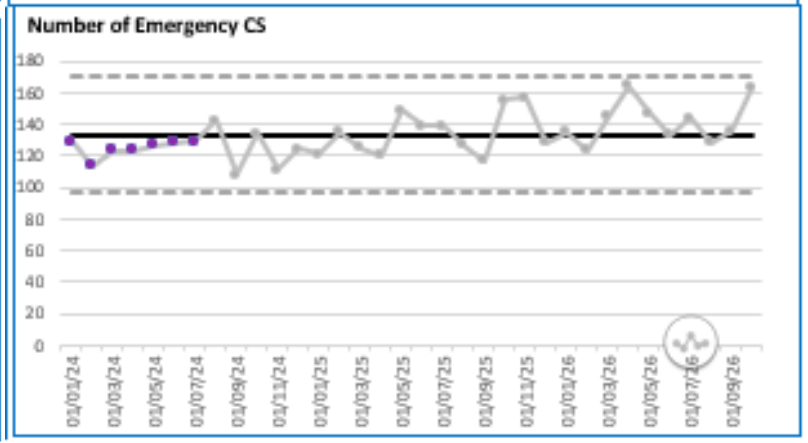






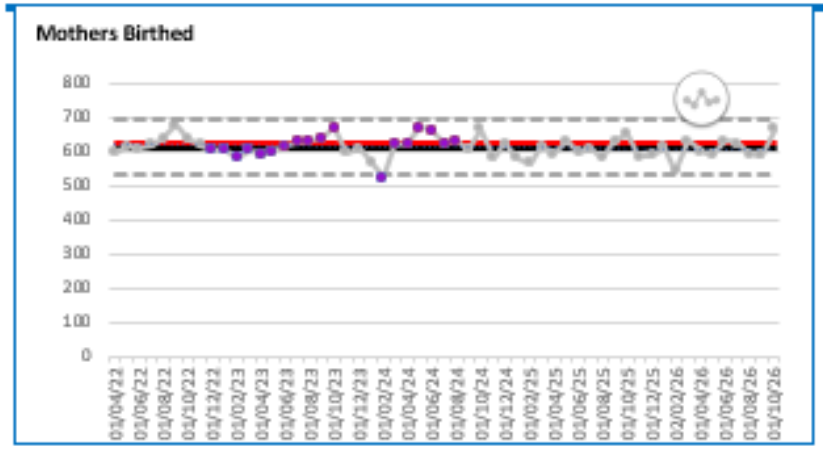


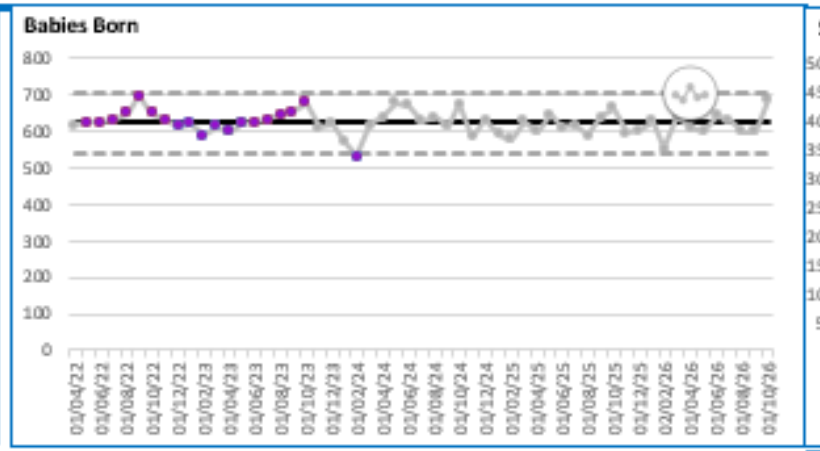


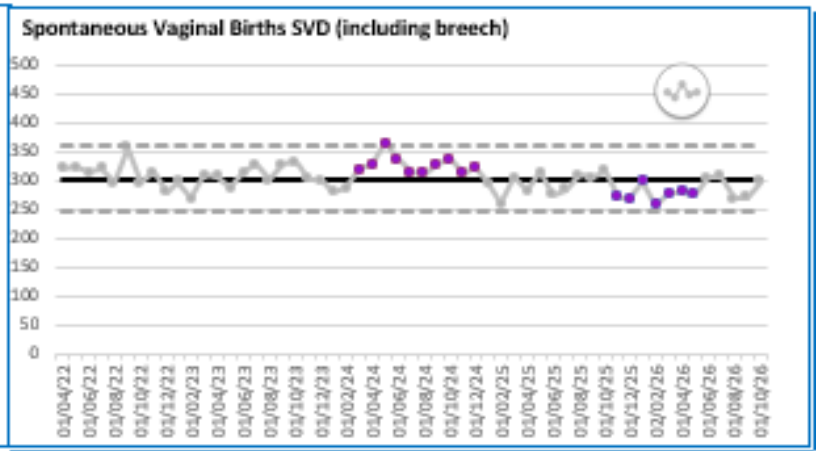


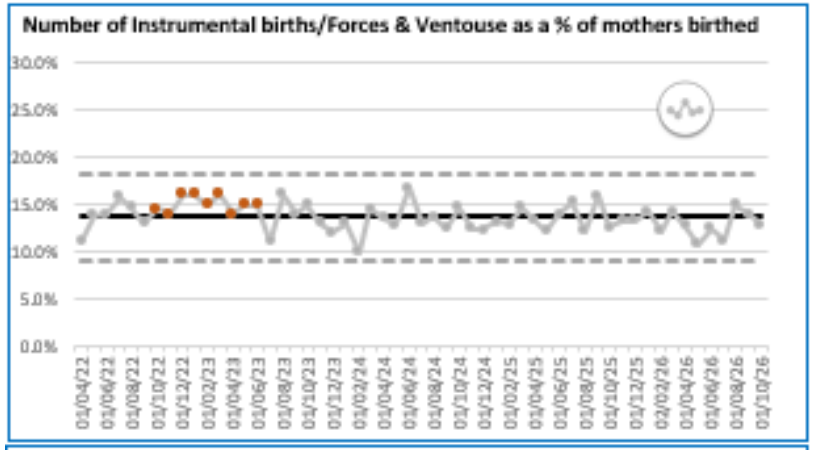
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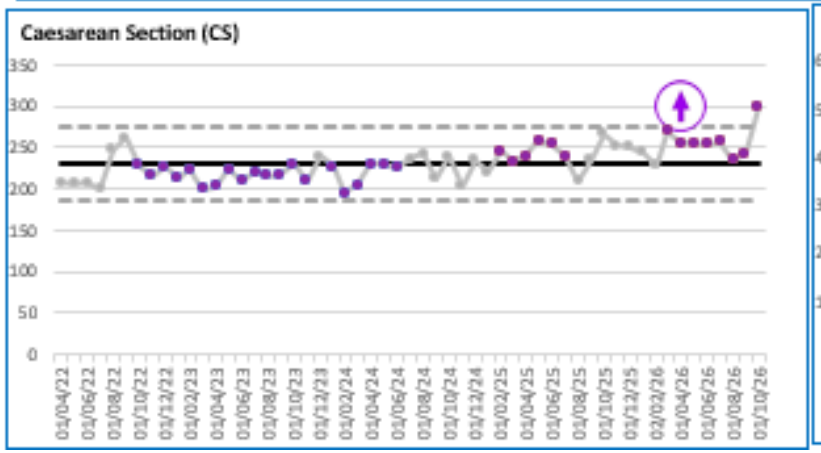
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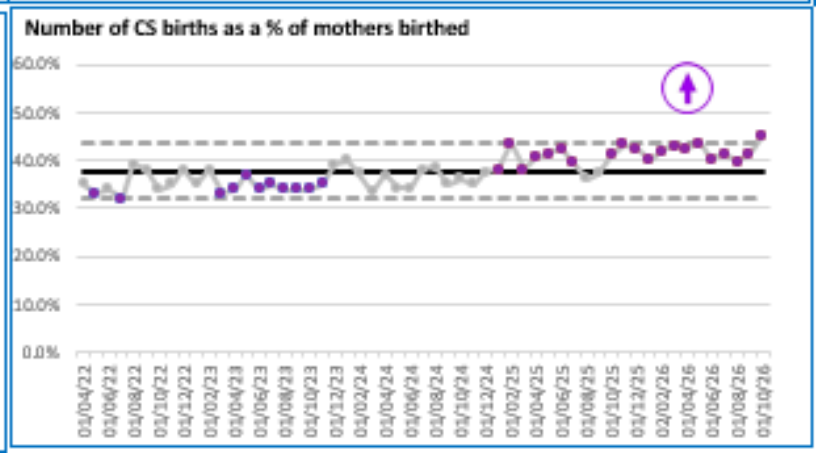






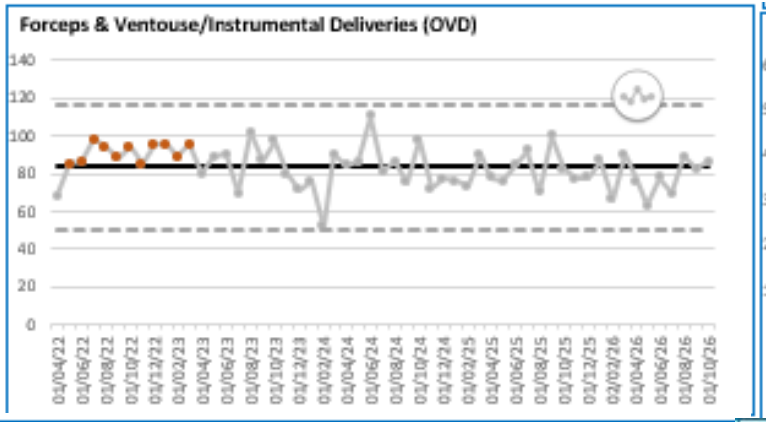


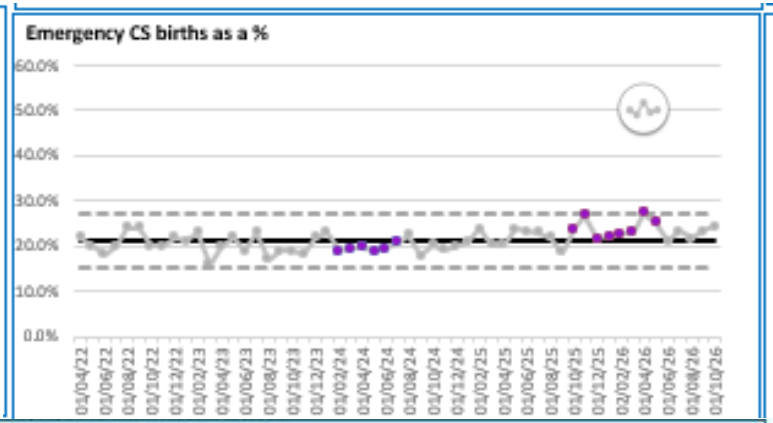


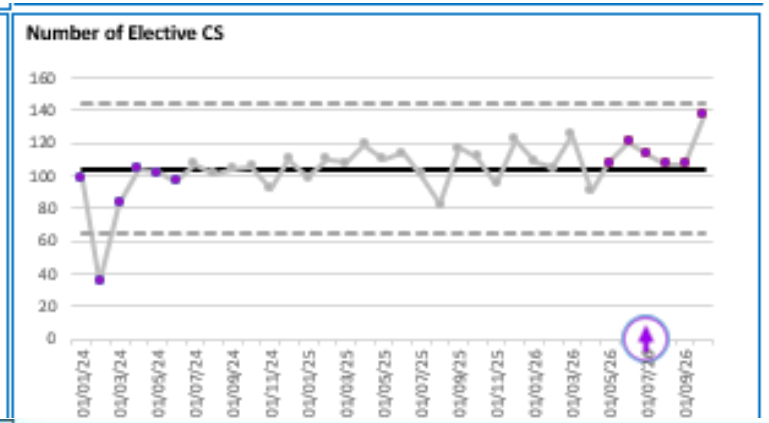


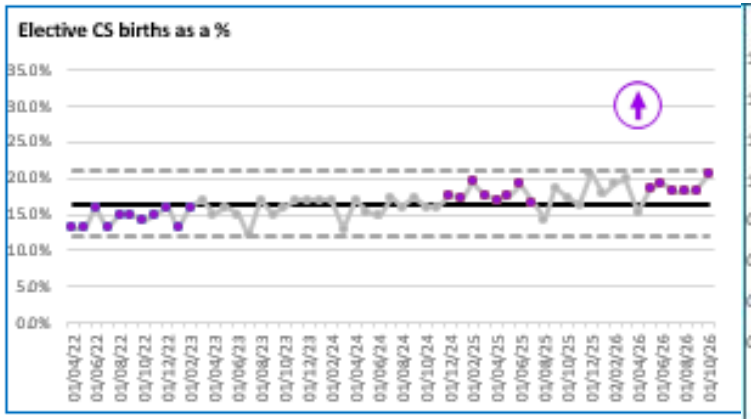
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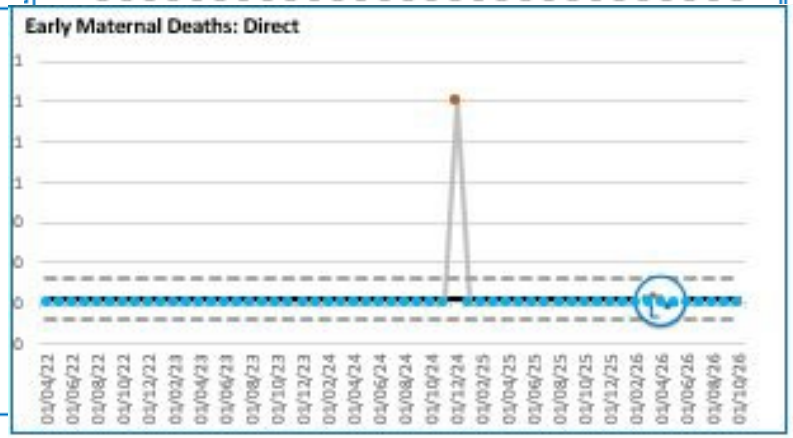
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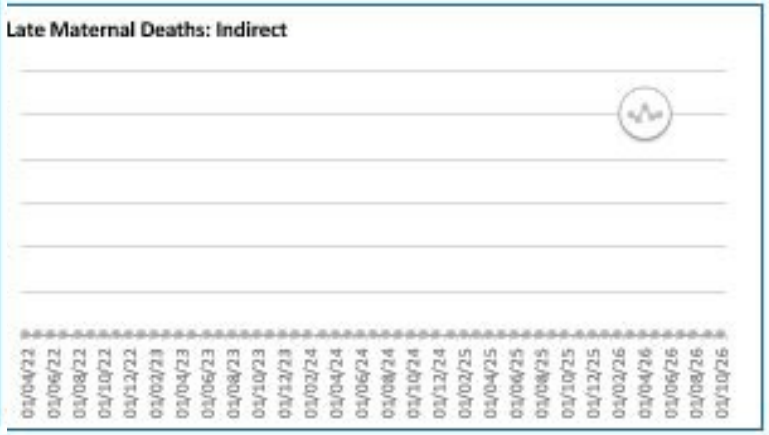






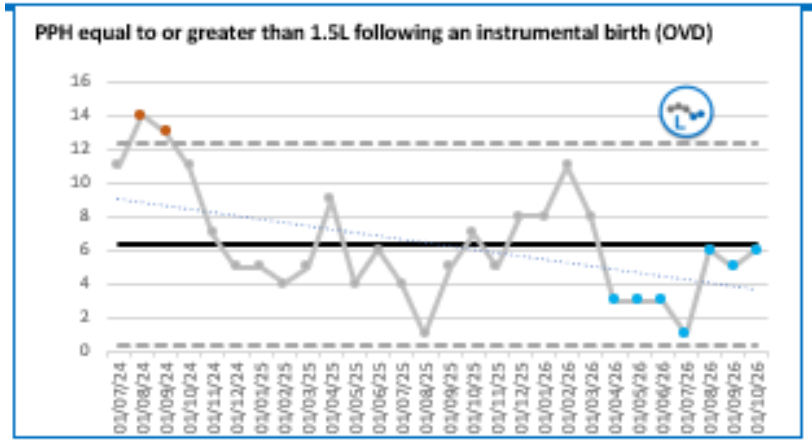


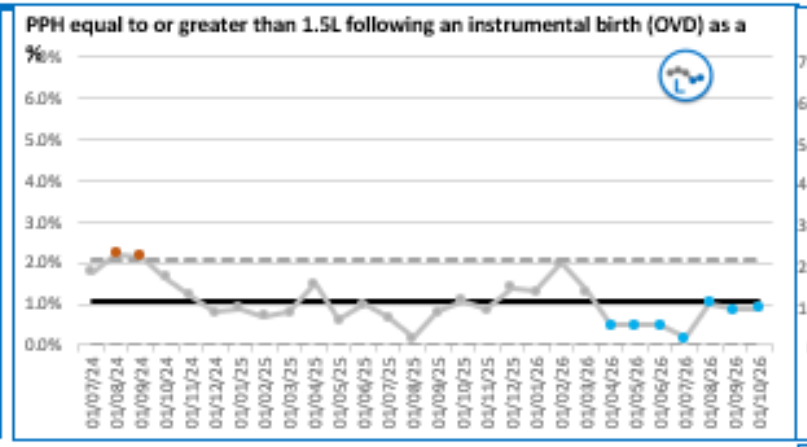


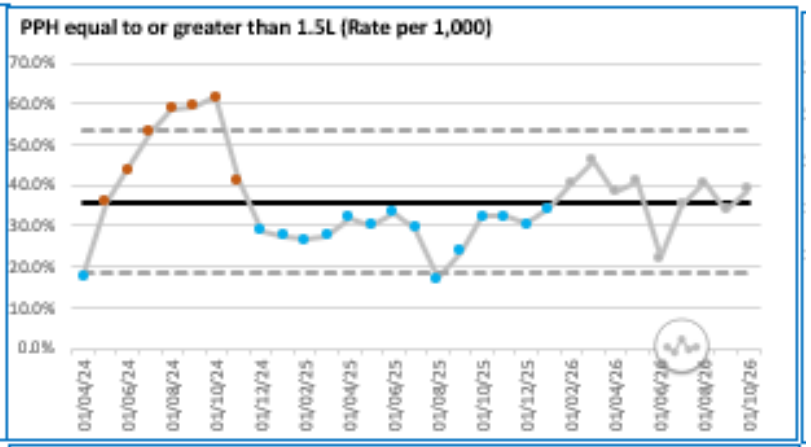


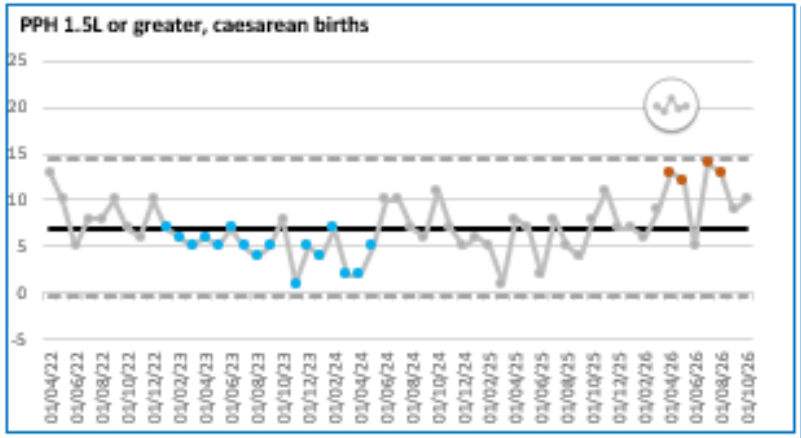
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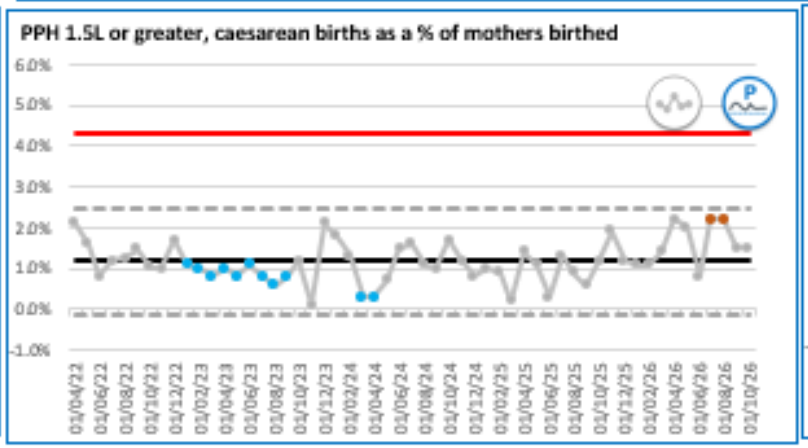
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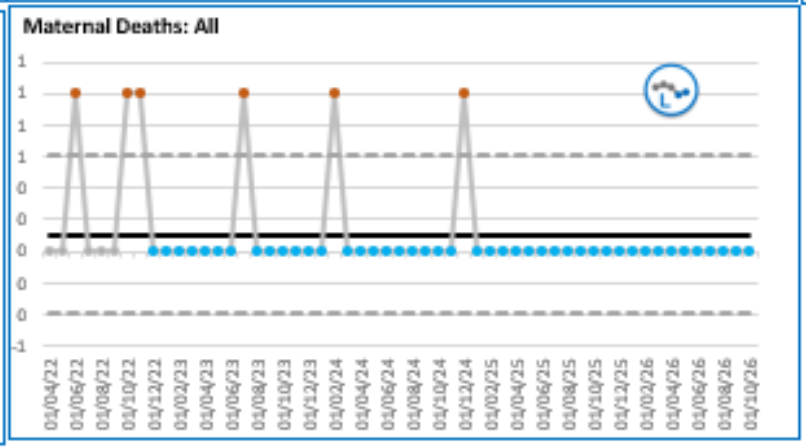






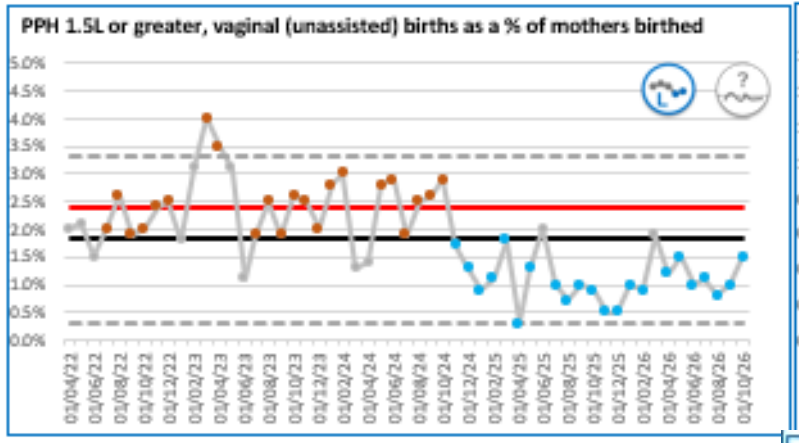


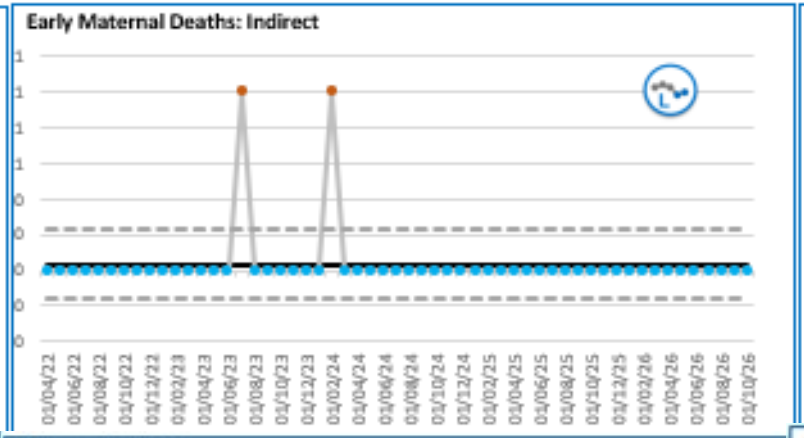


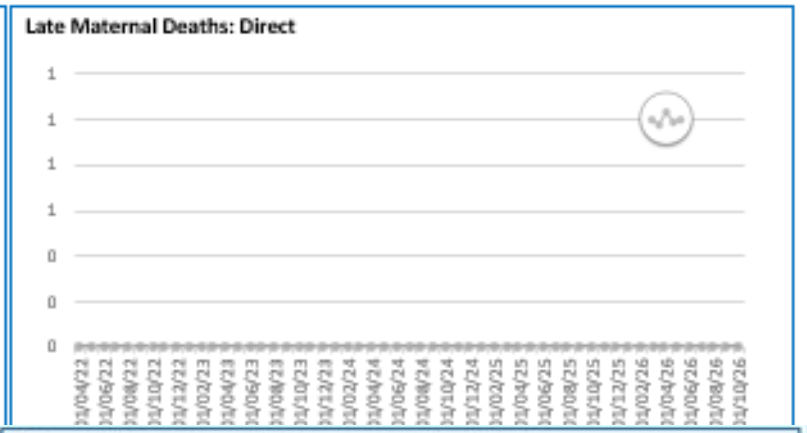


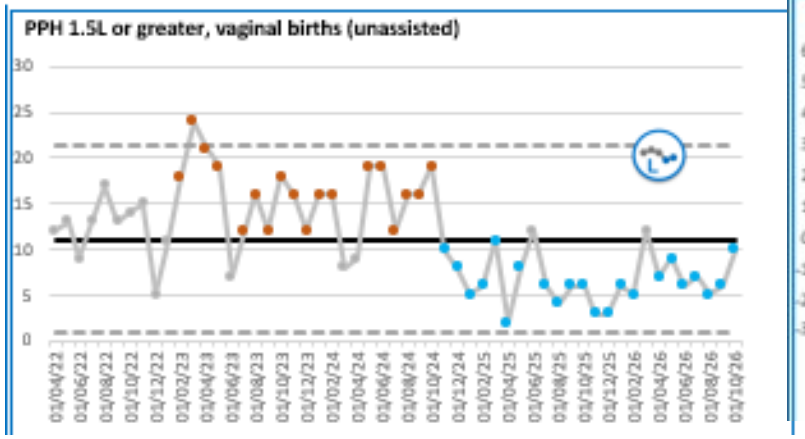
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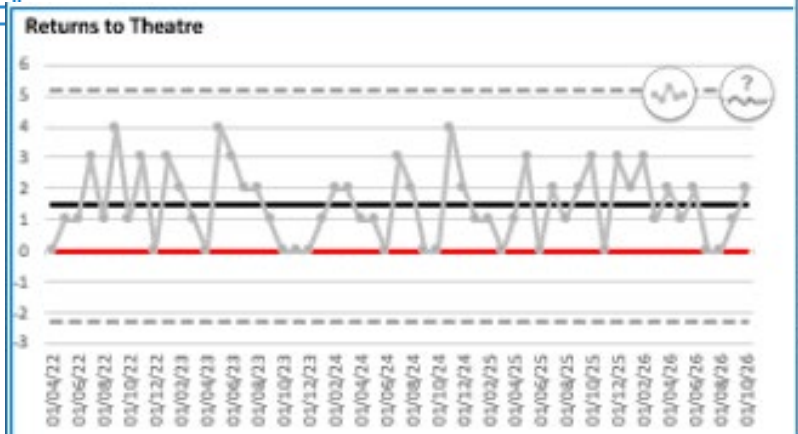
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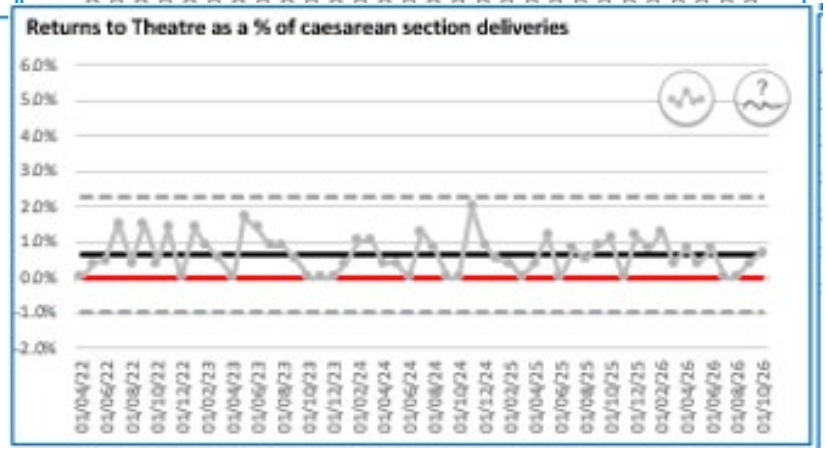






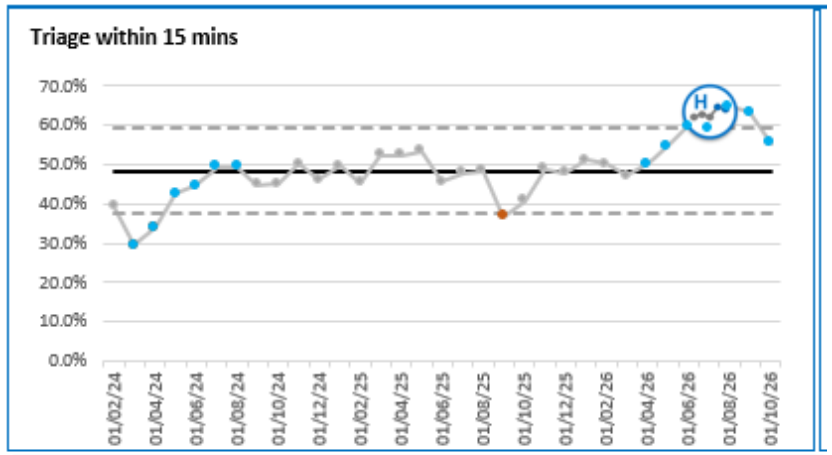


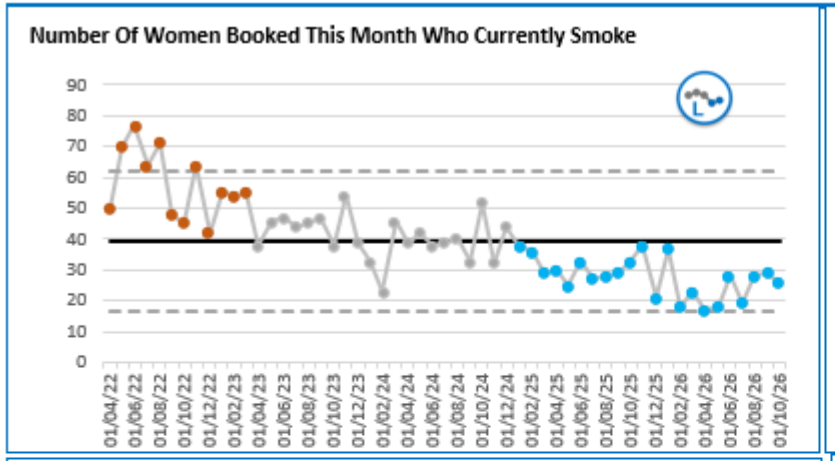


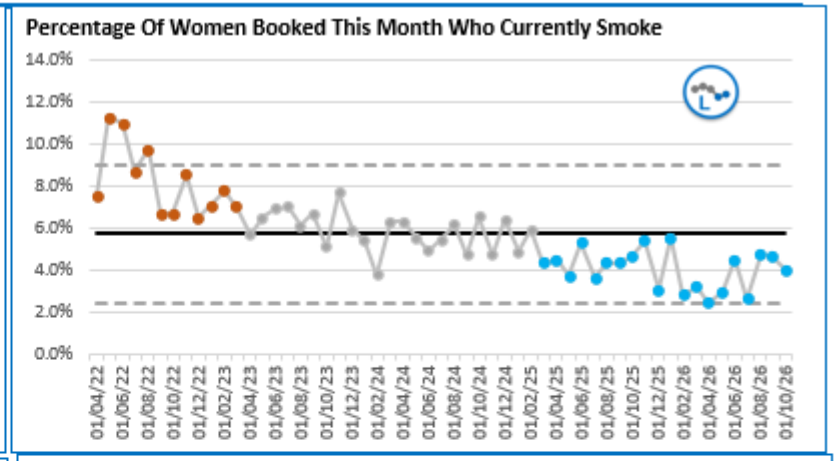


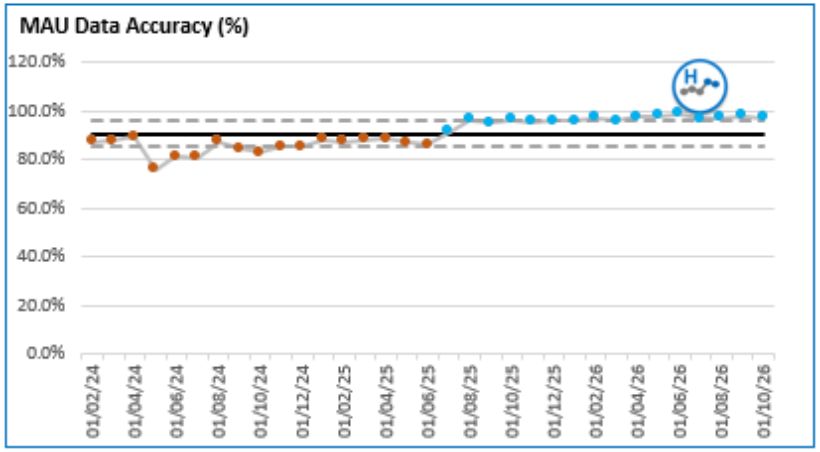
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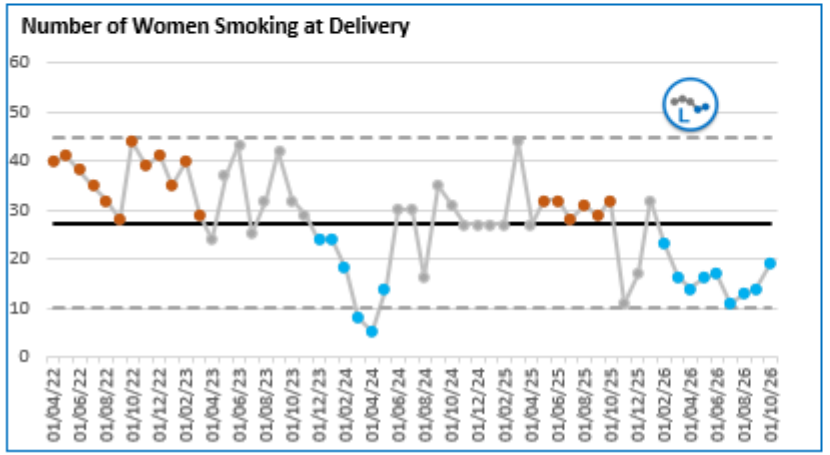
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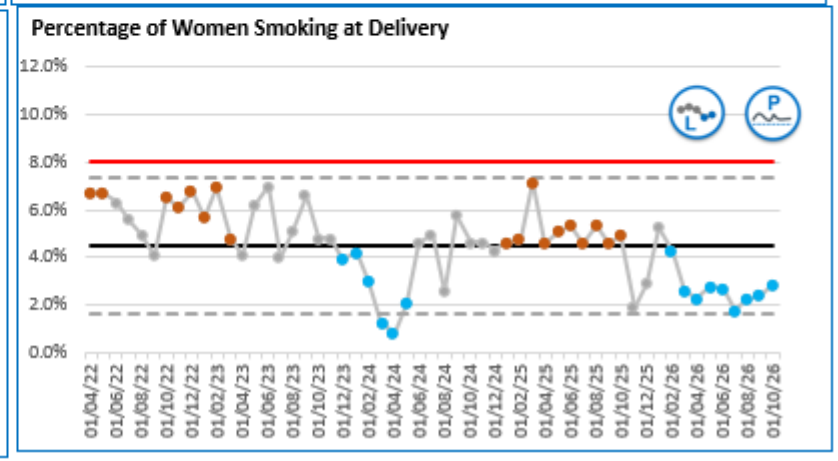






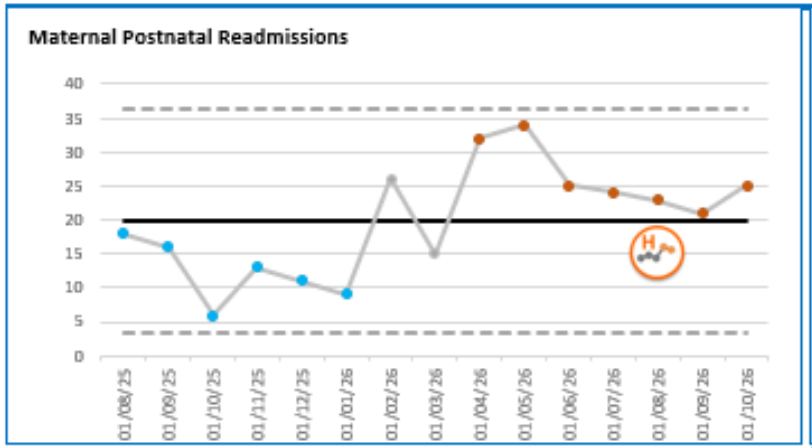


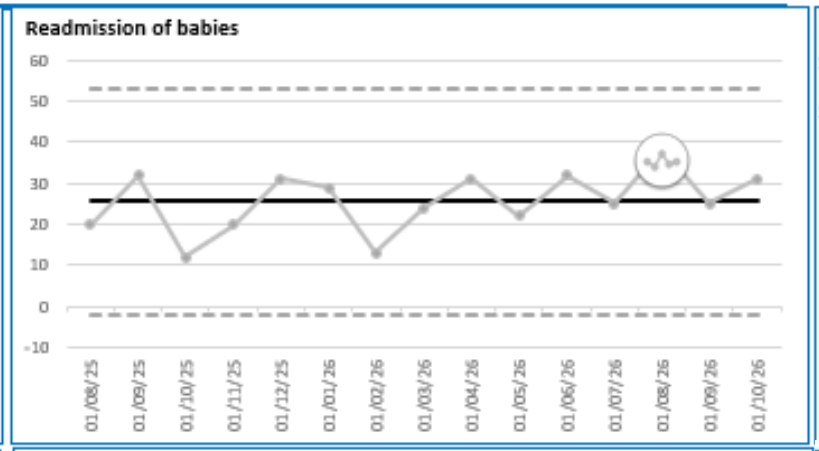


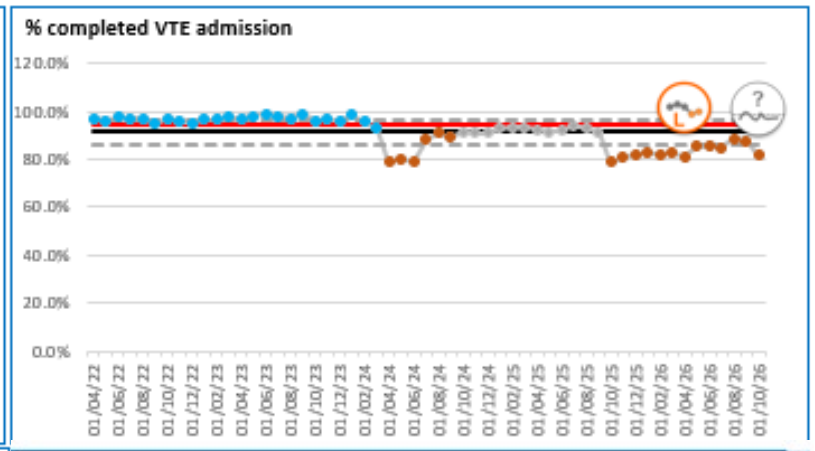


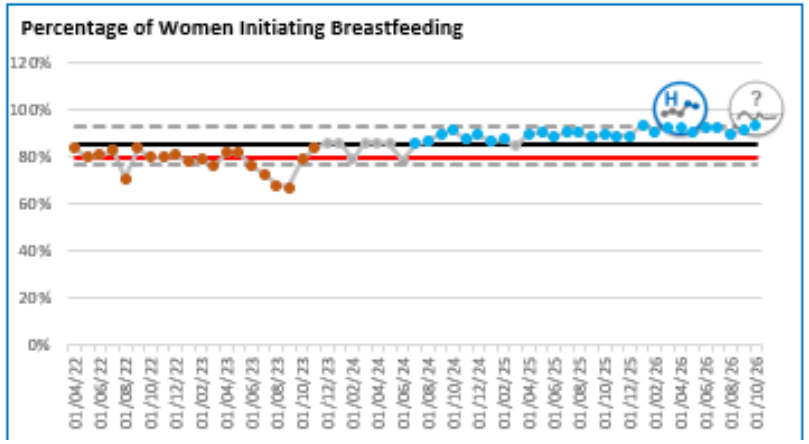
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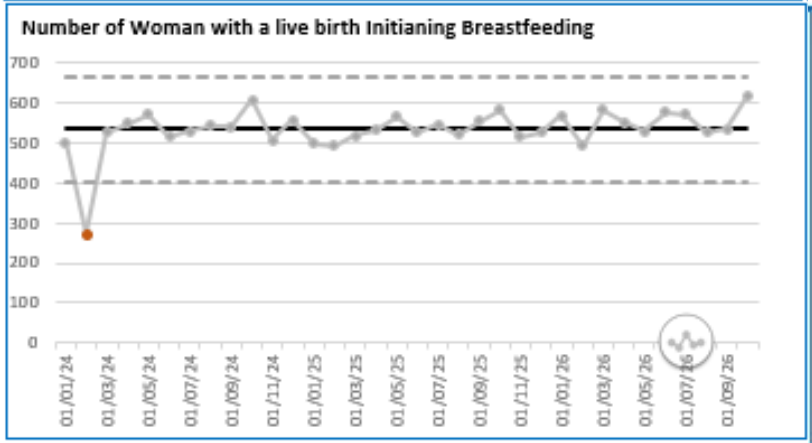
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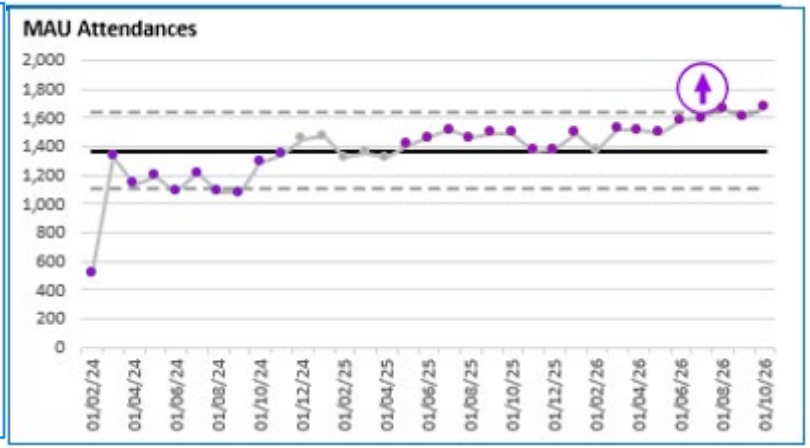






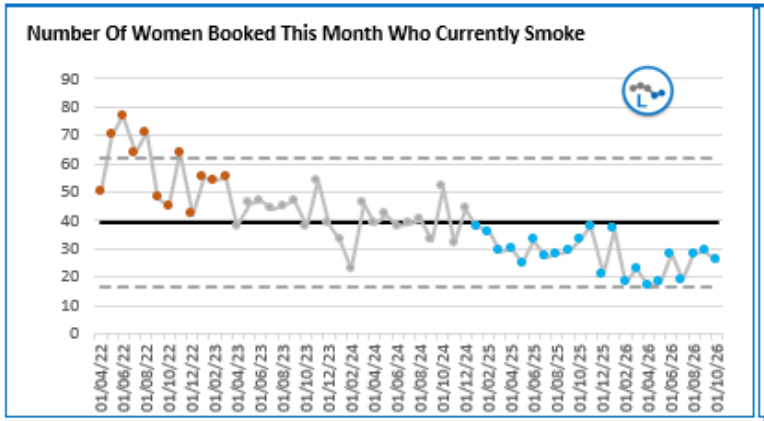


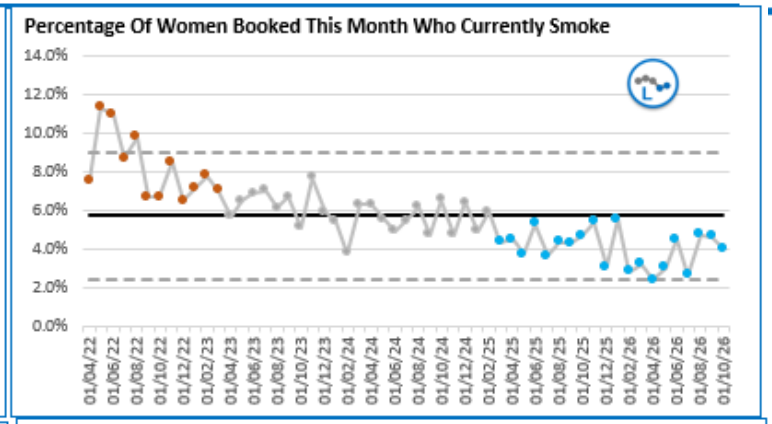


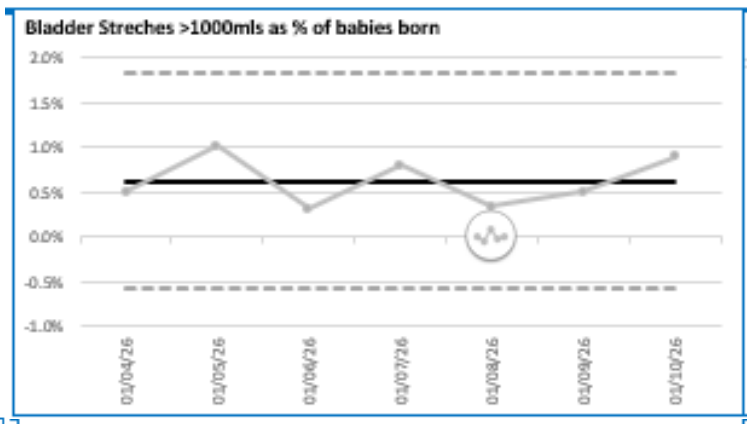


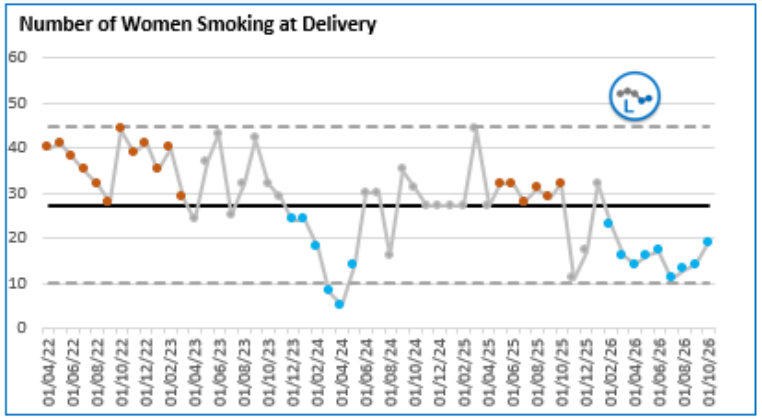
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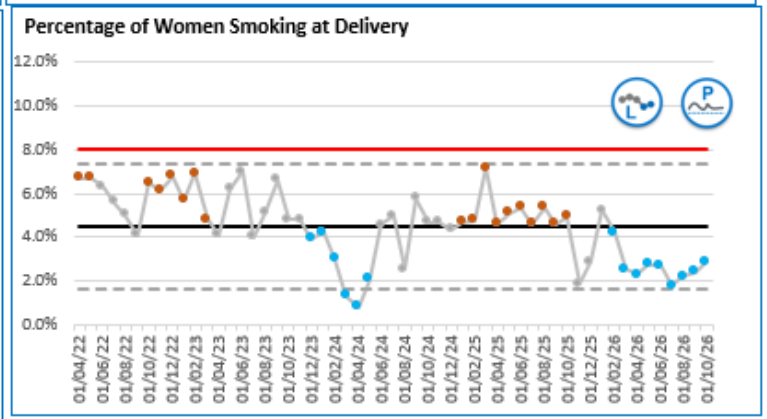
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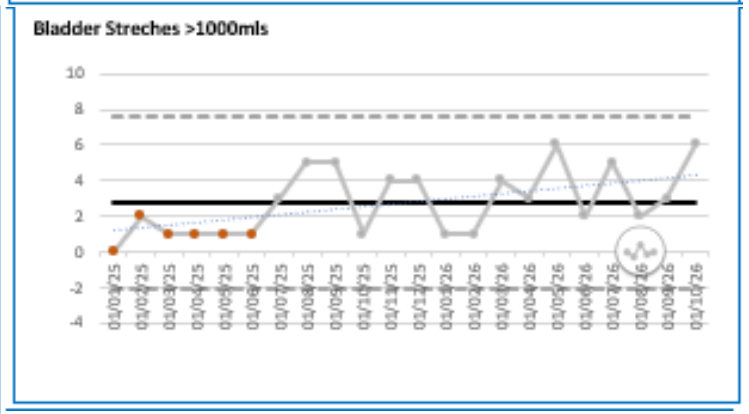






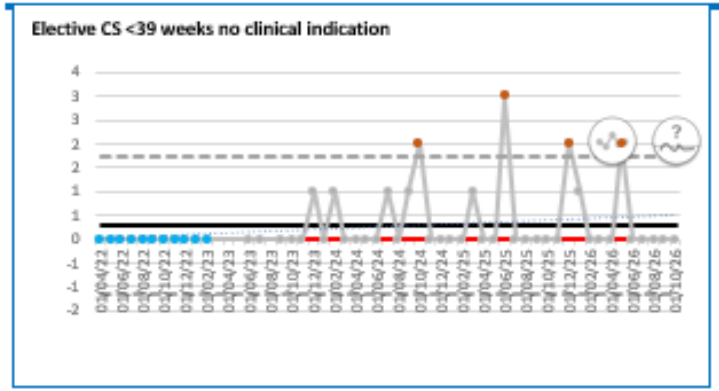


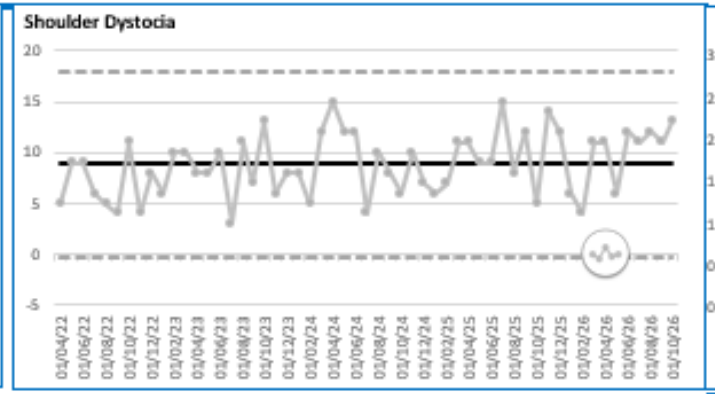


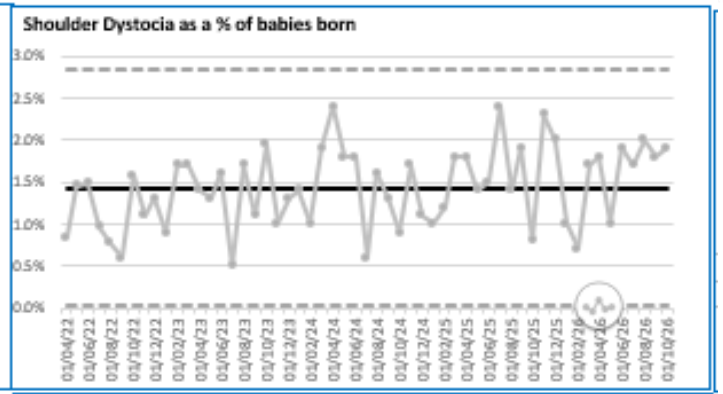


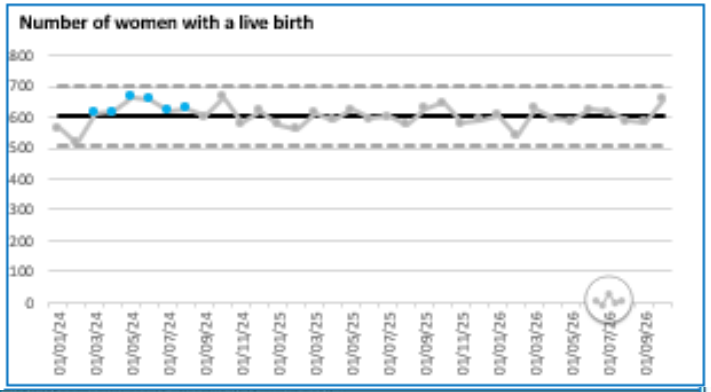
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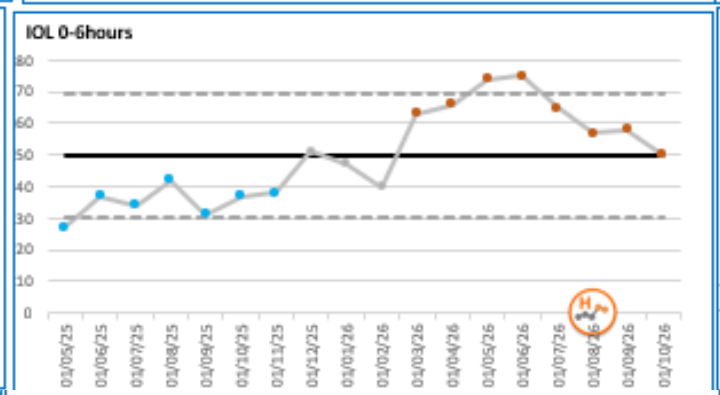
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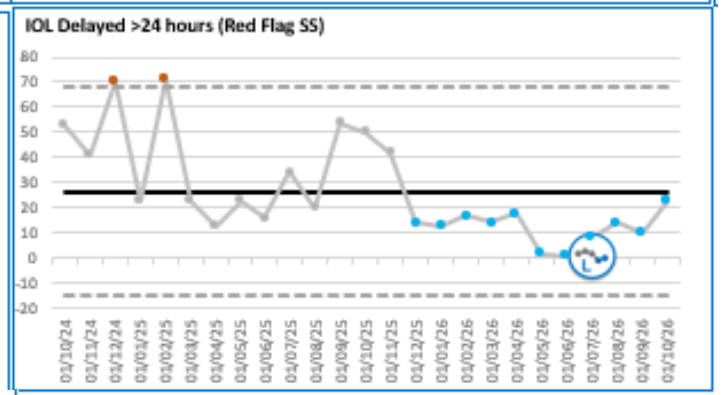


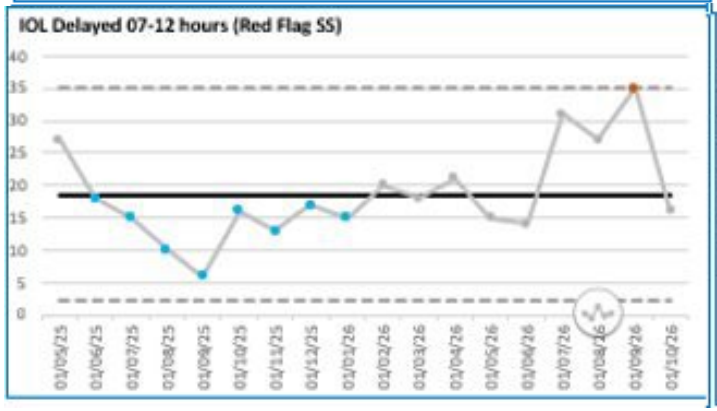


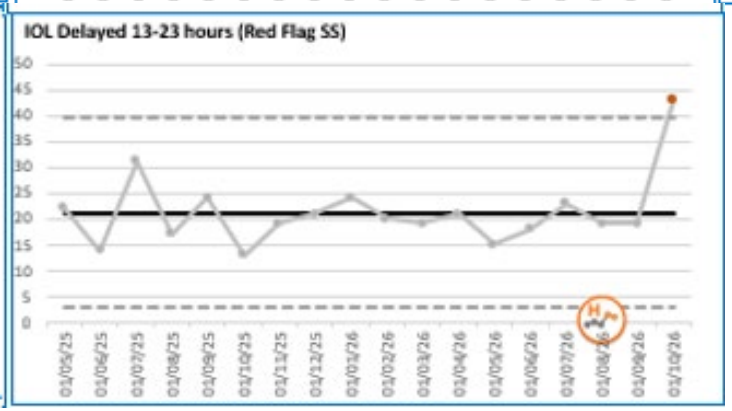






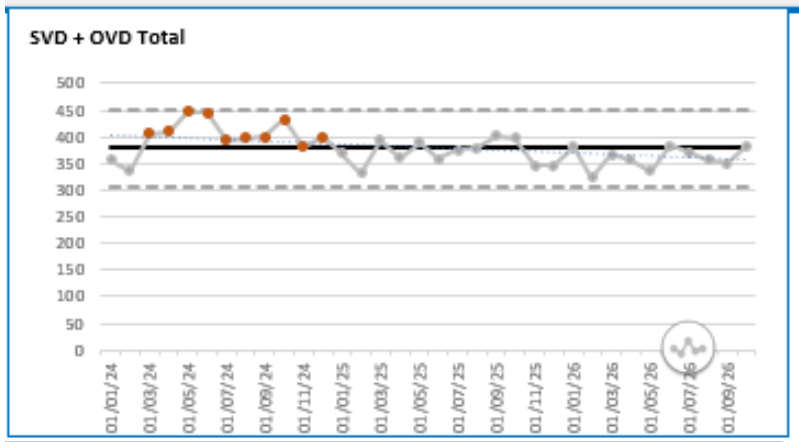


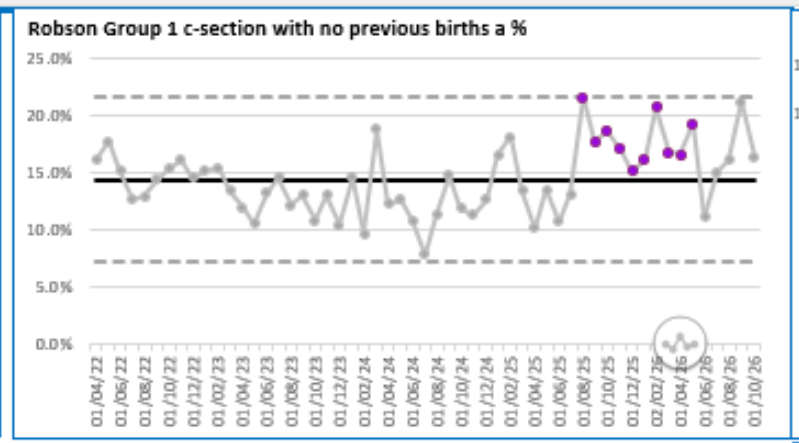


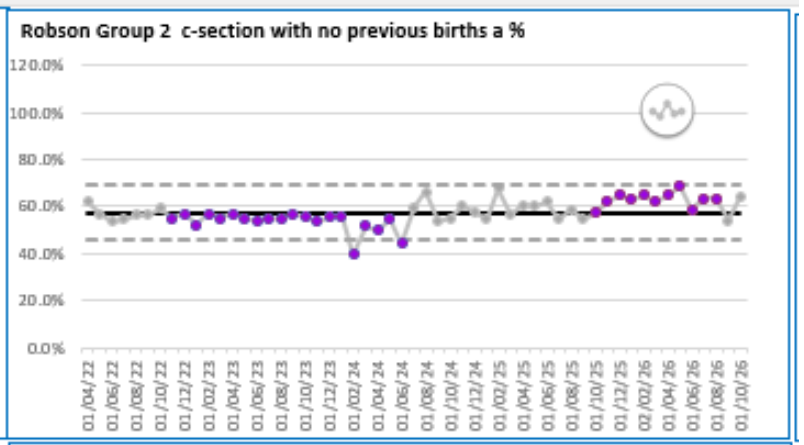


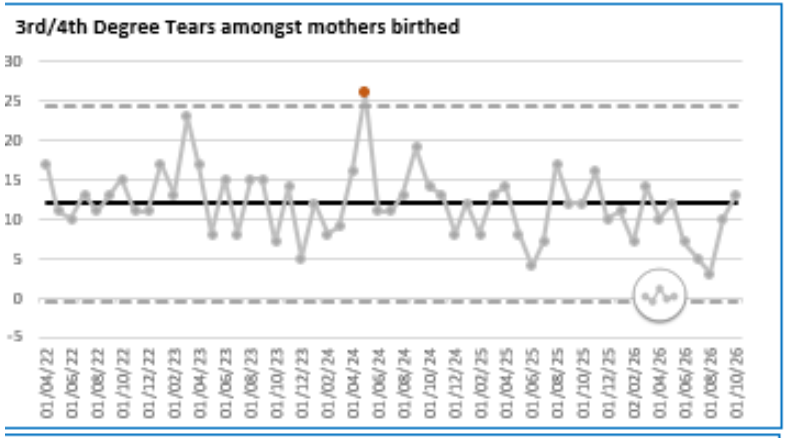
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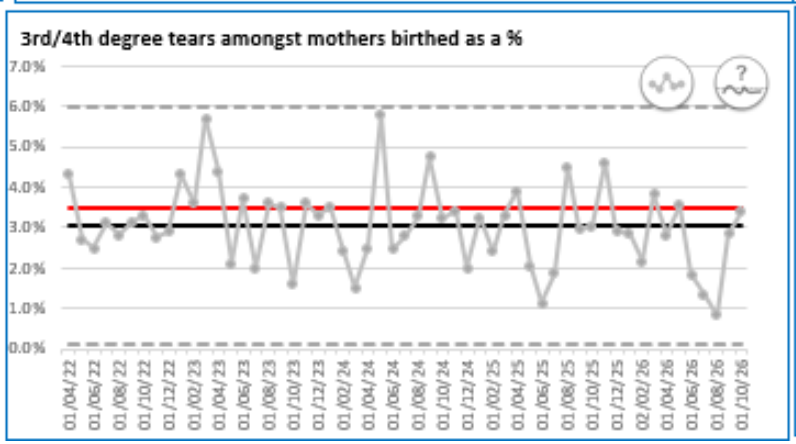
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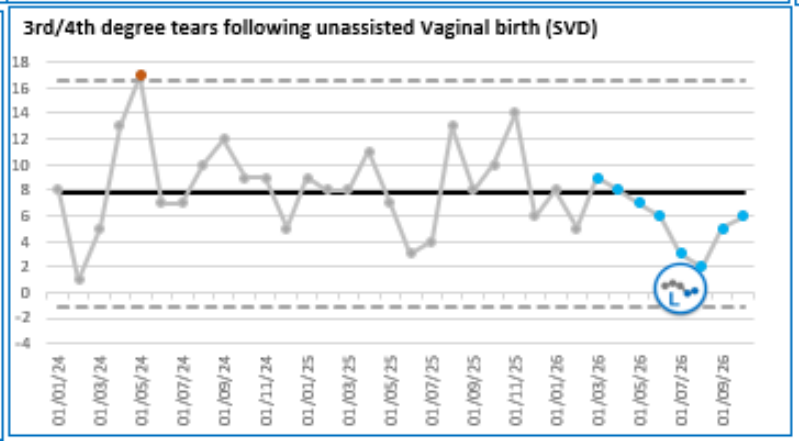






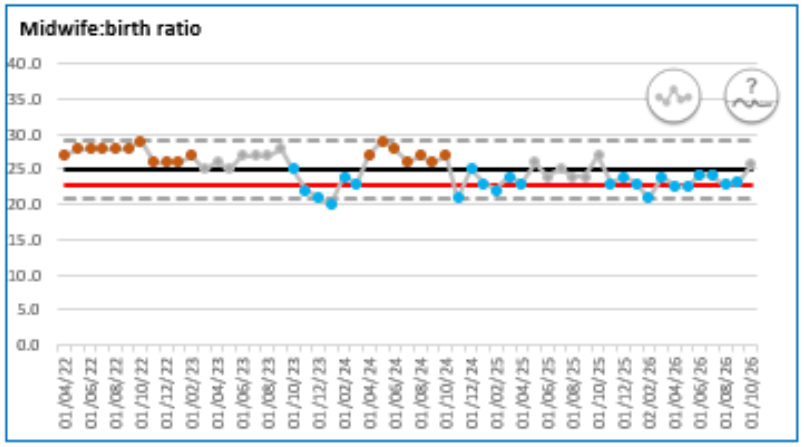


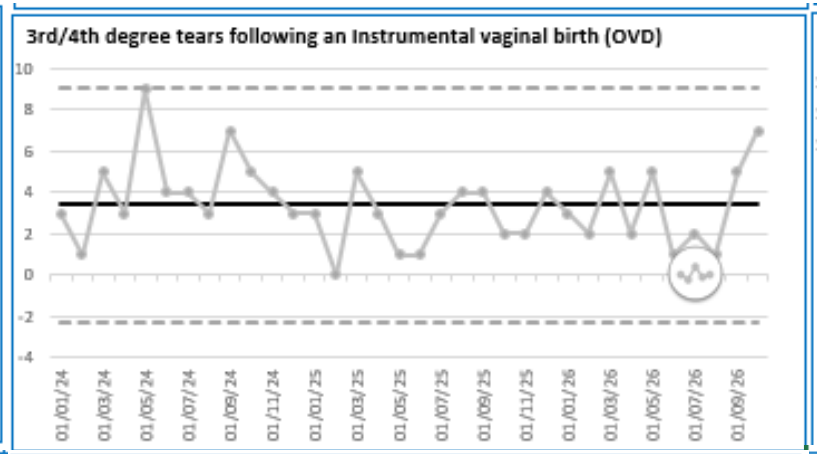


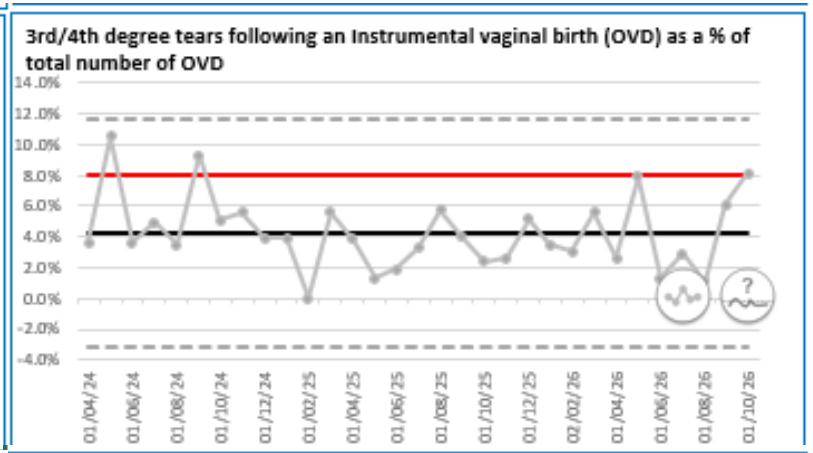


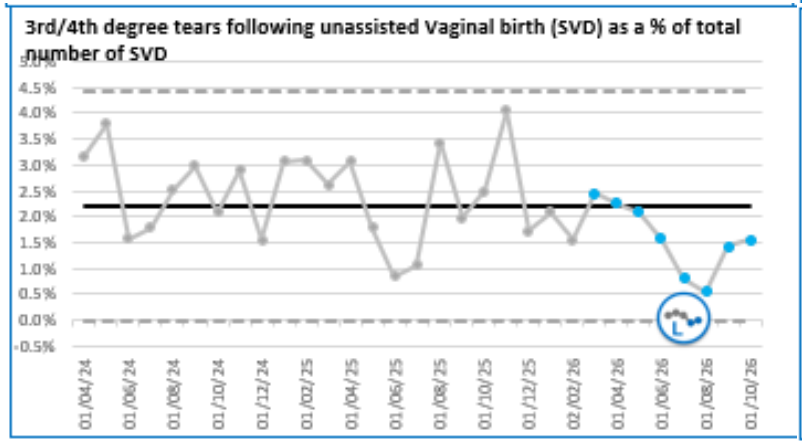
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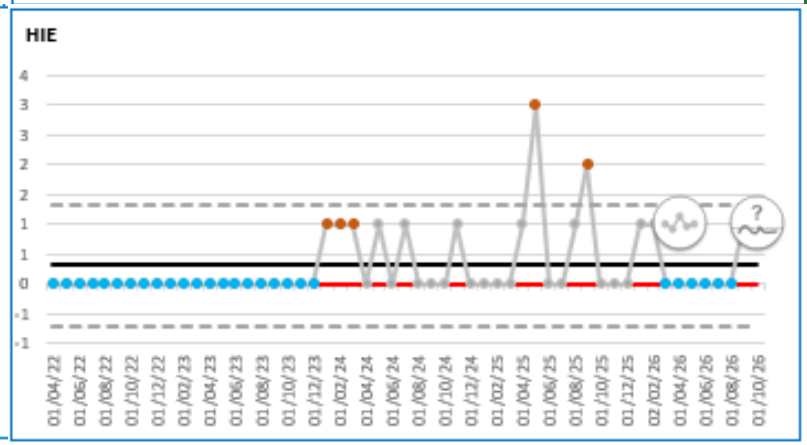
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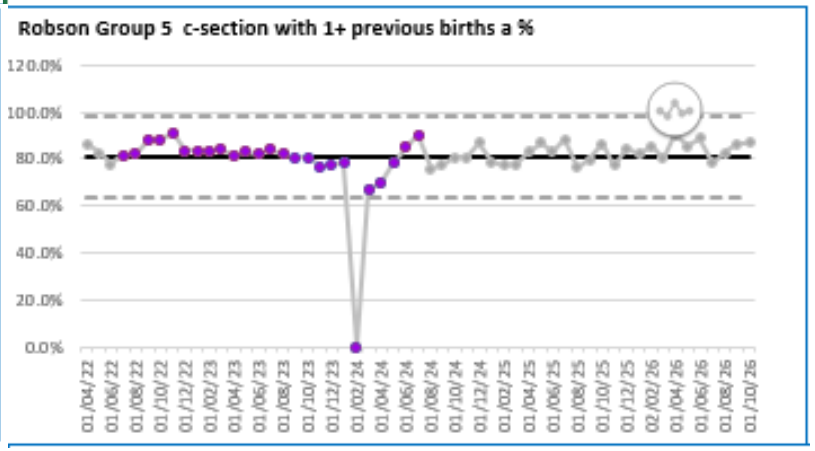






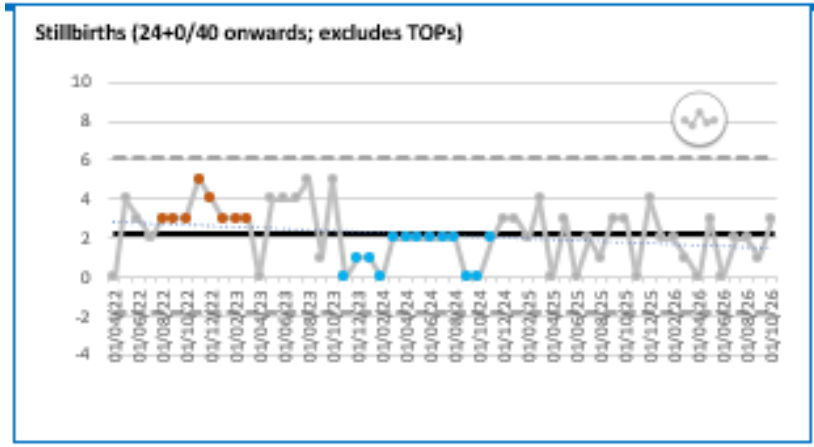


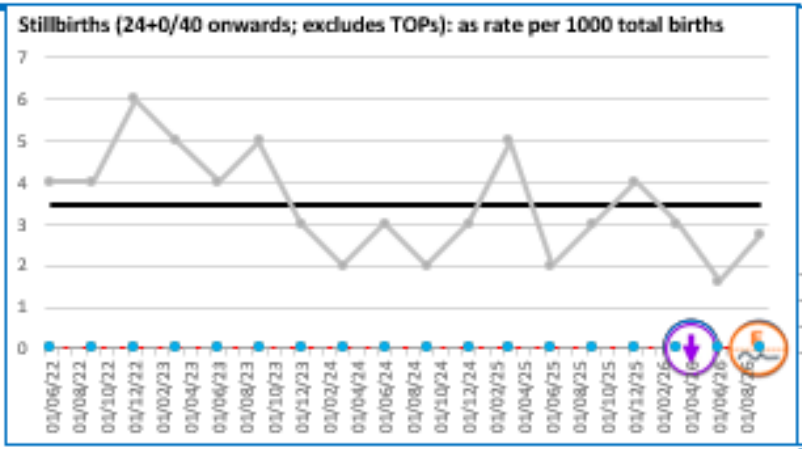


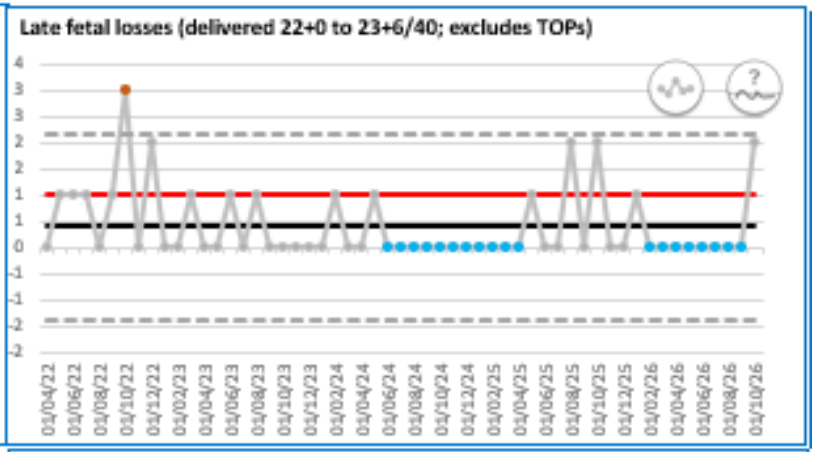


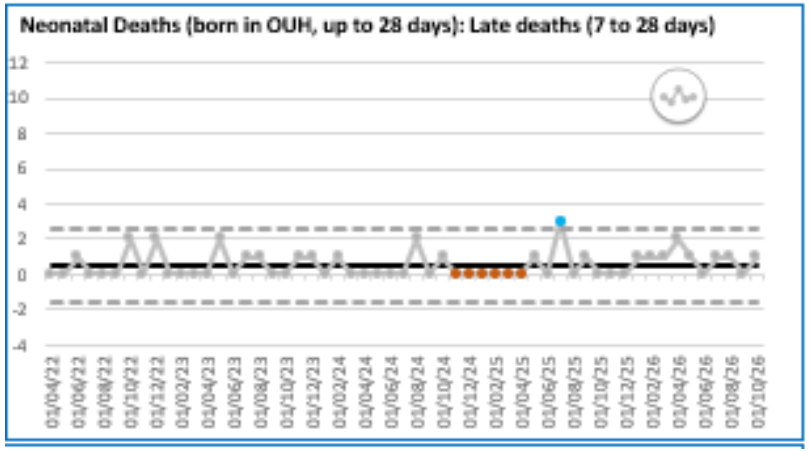
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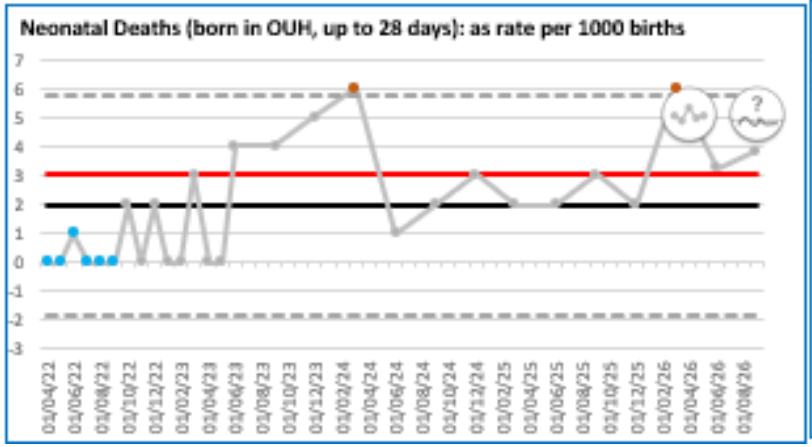
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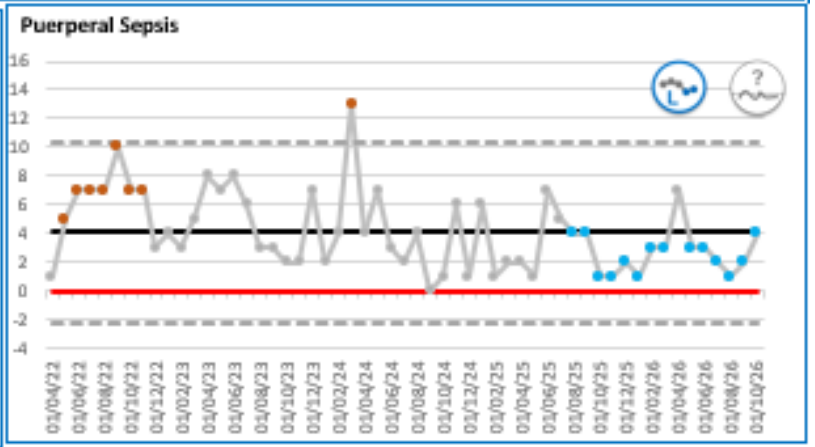






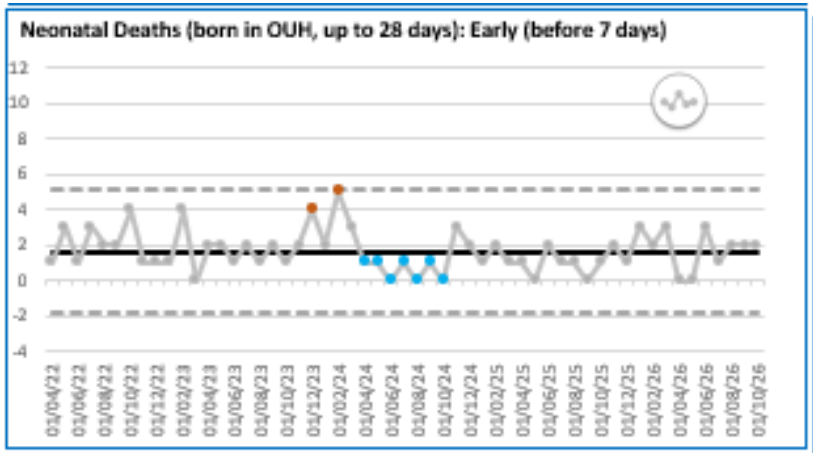


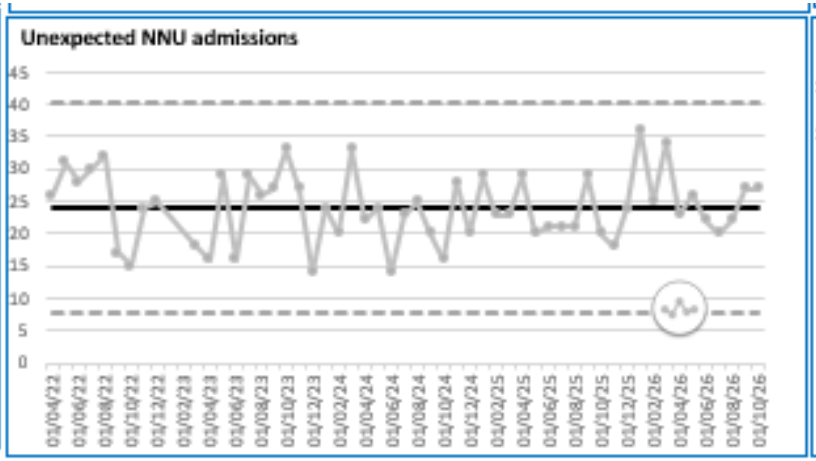


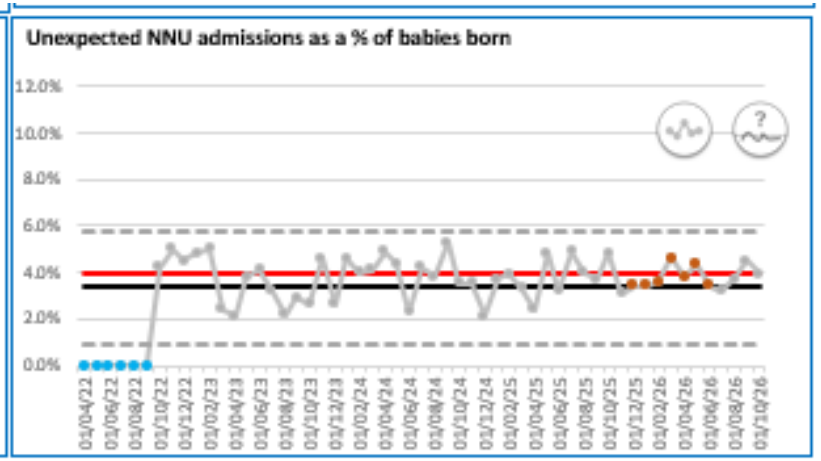


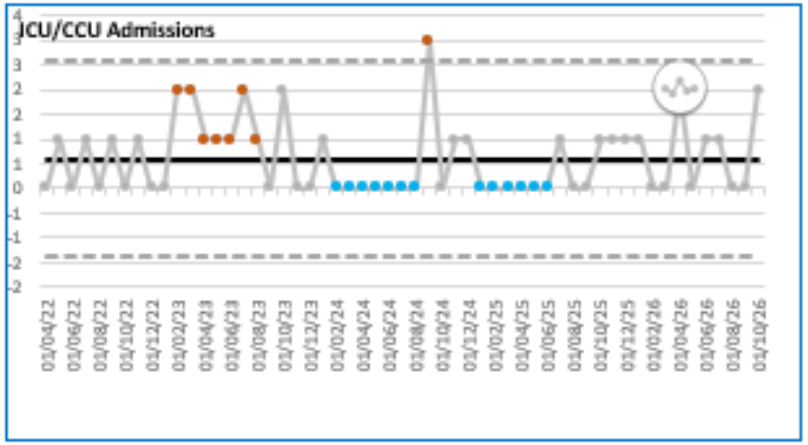
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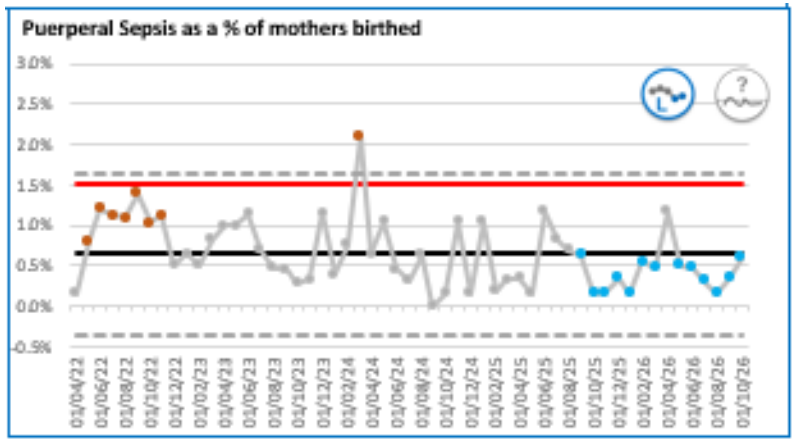
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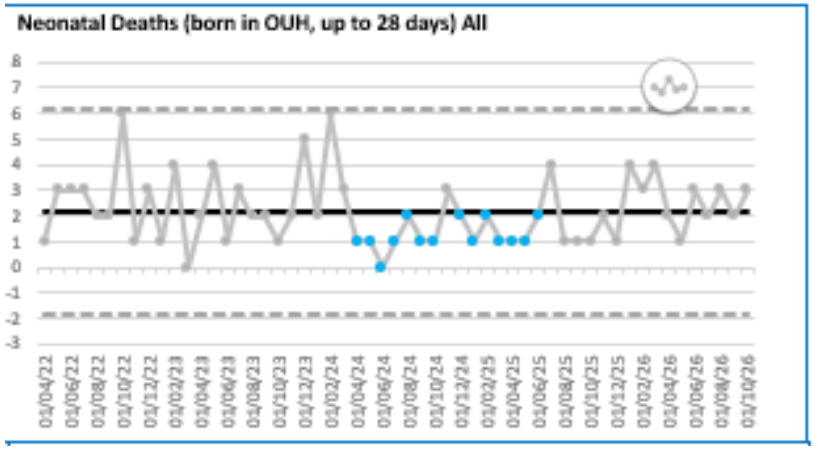








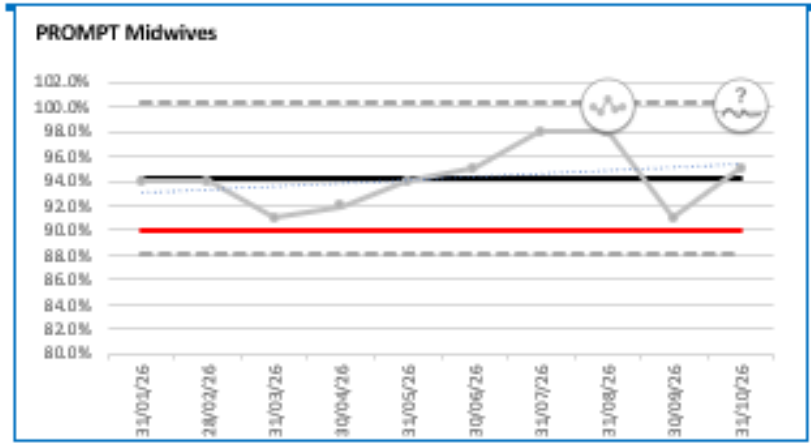


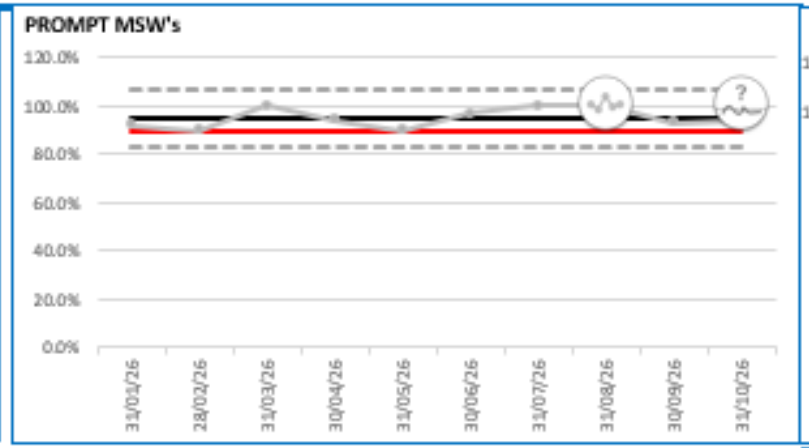


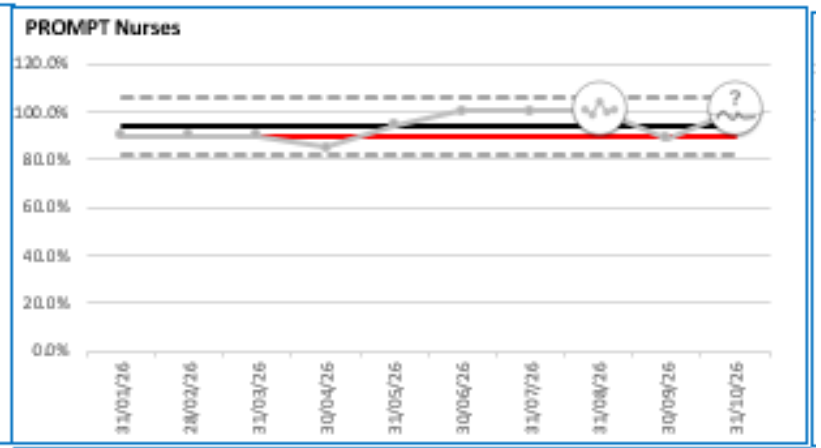
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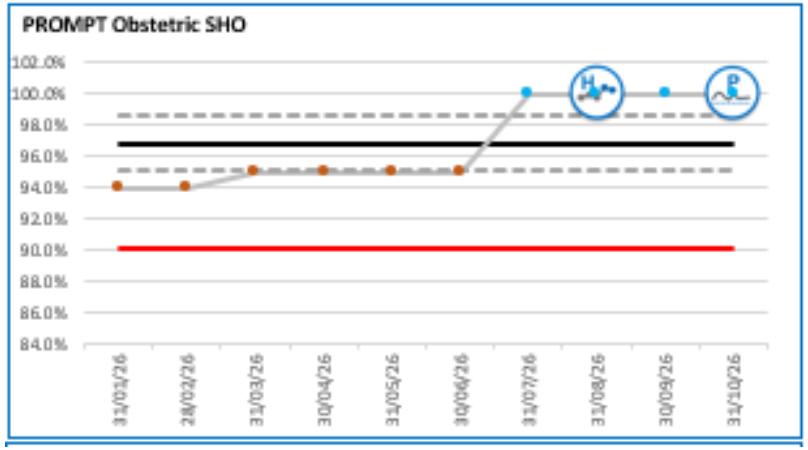
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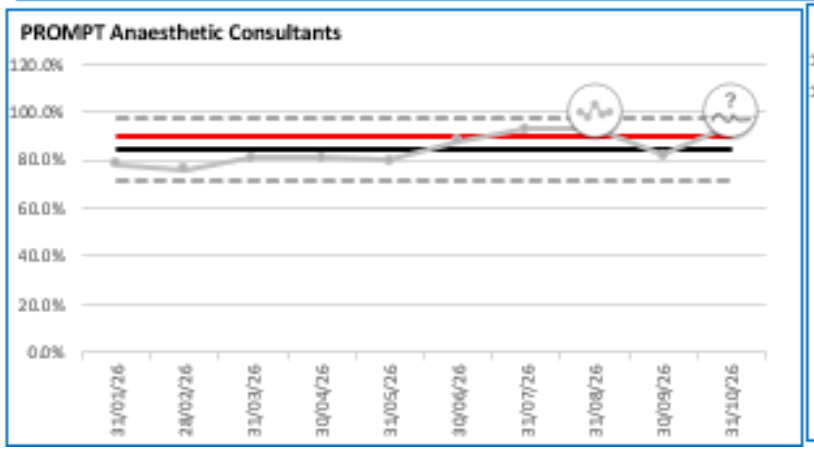
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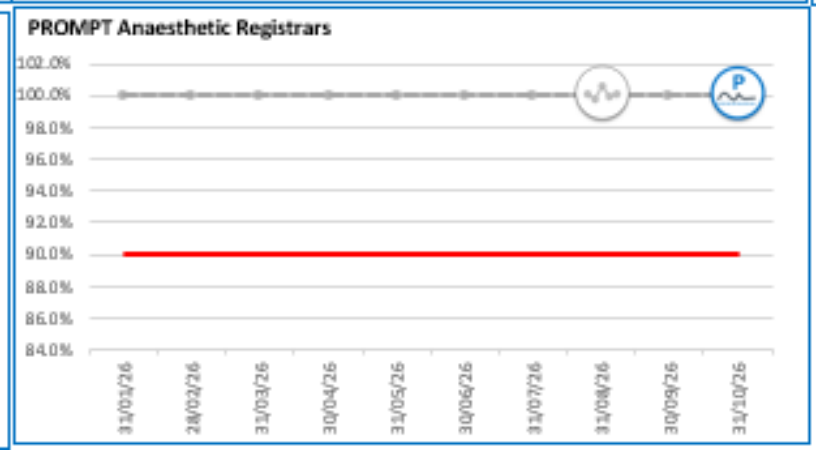








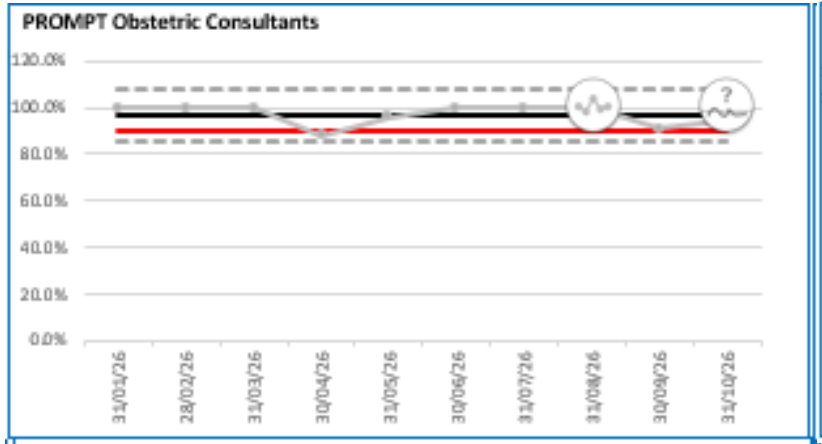


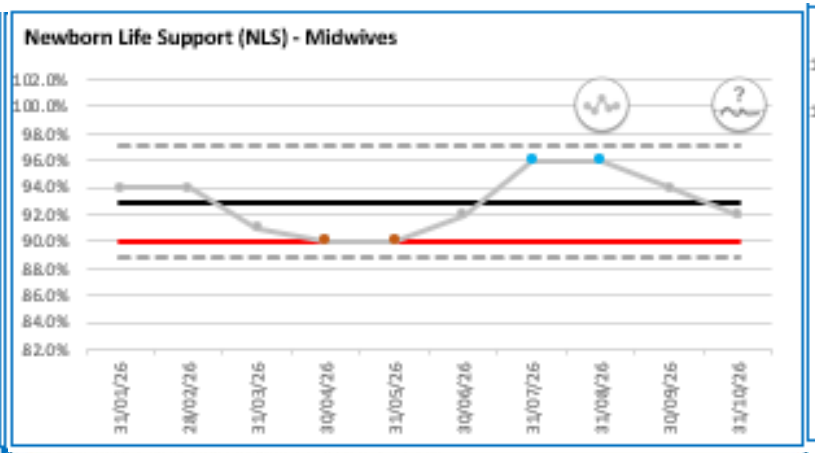


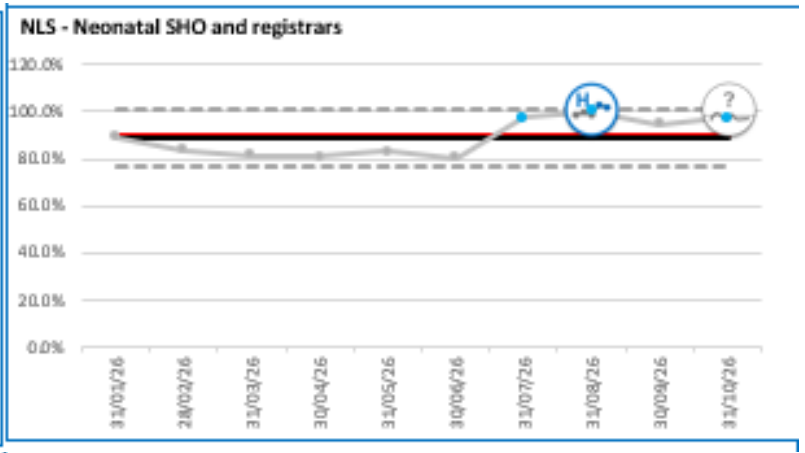
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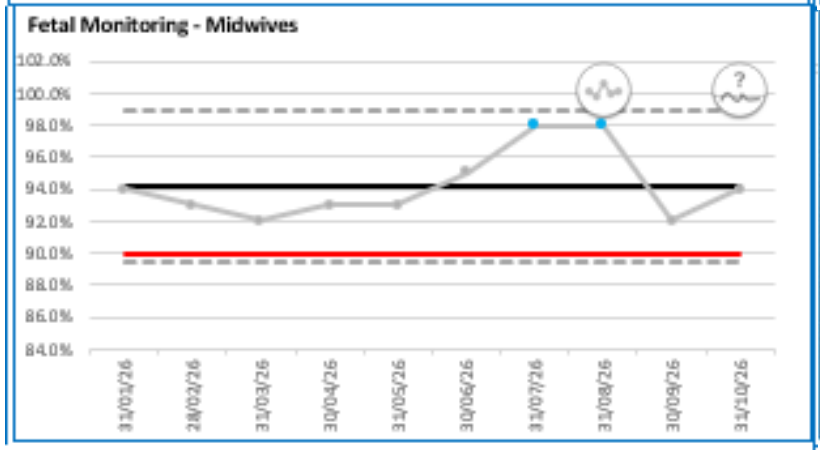
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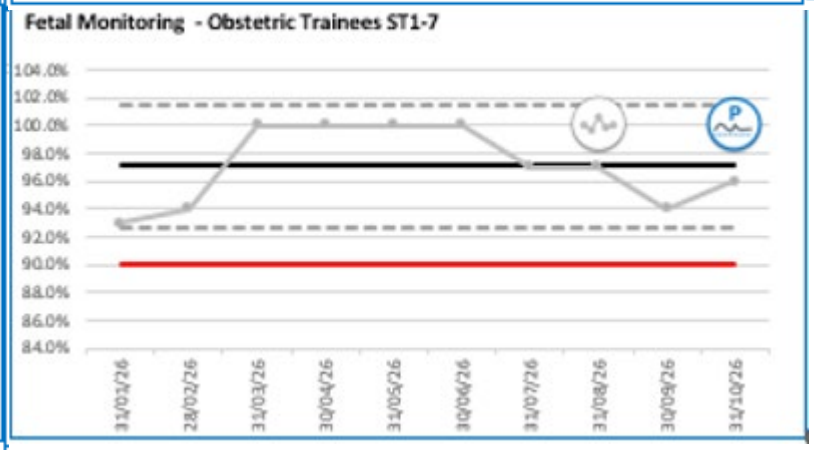
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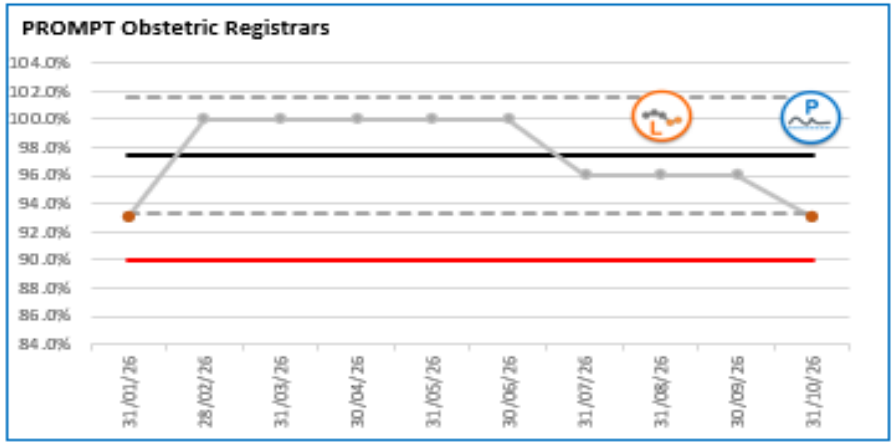


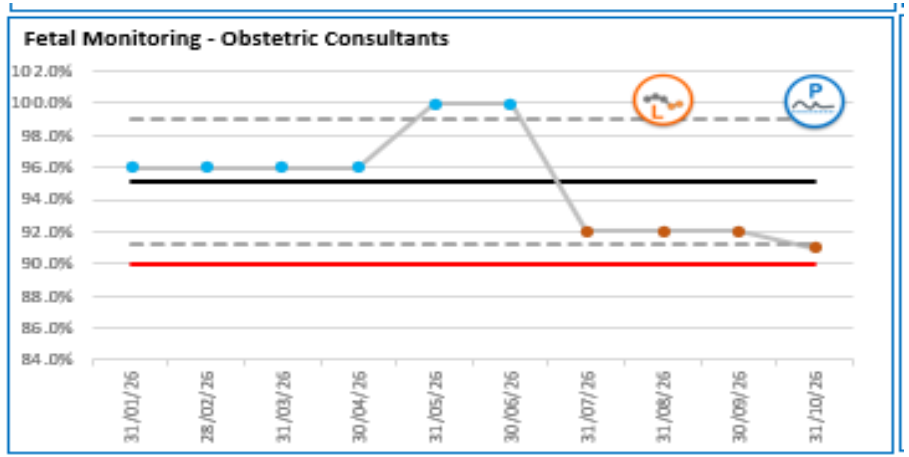


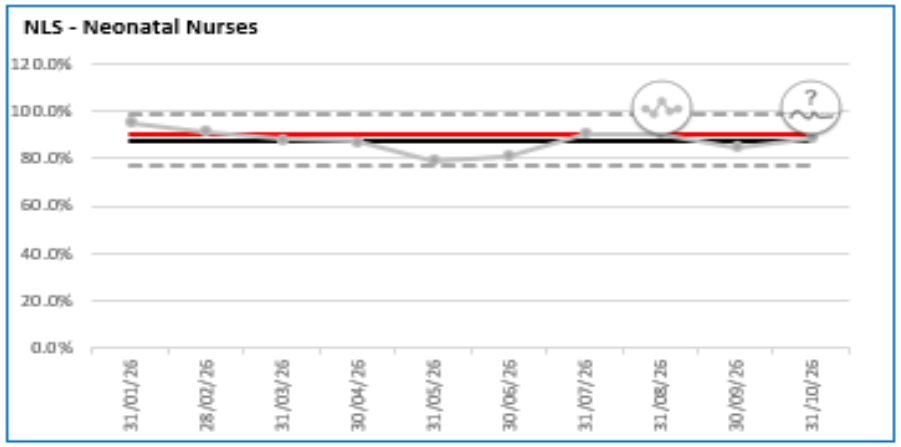
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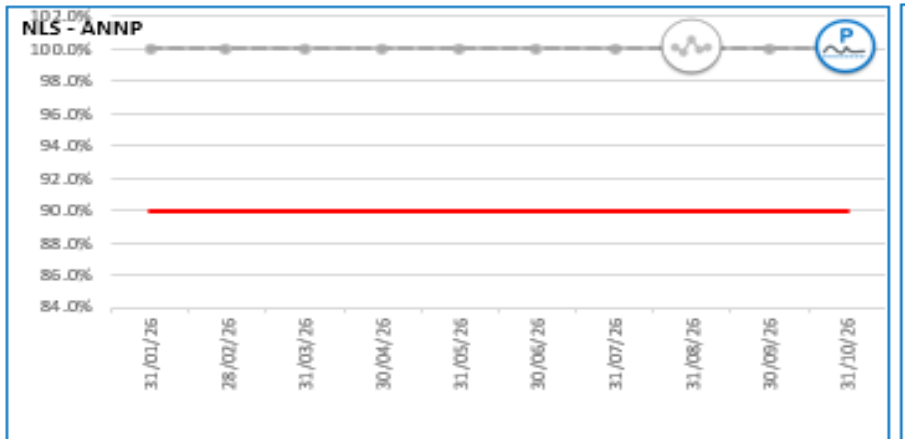
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Appendix 2: Categories used for grading of care for perinatal mortality reviews (PMR)

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

Appendix 3: Acronyms

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Name	Definition
ATAIN	Avoiding Term Admissions into Neonatal Units. National programme to reduce harm leading to avoidable neonatal admission for babies born at or after 37 weeks.
BFI	Baby Friendly Initiative. This is a global programme launched by UNICEF and WHO to support and promote breastfeeding.
HIE	Hypoxic-ischaemic encephalopathy. Brain injury associated with lack of oxygen. Severity is graded from 1 (mild) to 3 (severe).
LMNS	Local Maternity and Neonatal System. Supports national plans for safer, more equitable and personalised care for women, babies and families.
MIS	Maternity (Perinatal) Incentive Scheme. A financial incentive scheme supporting maternity and neonatal safety through defined safety actions, including prevention of deaths and brain injury.
MNSI	Maternity and Neonatal Safety Investigations. A national programme hosted by the CQC, formerly part of HSIB. Investigations cover cases meeting eligibility criteria, including early neonatal deaths, intrapartum stillbirths, severe brain injury in term babies following labour, and maternal deaths in England.
MCGC	Maternity Clinical Governance Committee
PMRT	Perinatal Mortality Review Tool. A national tool for standardised reviews of perinatal deaths.
PPH	Postpartum haemorrhage. The dashboard captures PPH of 1,500 mL and above.
1:1 Care in Labour	When a woman/birthing person in labour is cared for by a midwife who is not providing care for any other woman (does not have to be the same midwife continuously). One-to-one care should be provided to all women/birthing people in labour.
SBLCBv3.2	Saving Babies' Lives Care Bundle version 3.2
QIP	Quality Improvement Project

Appendix 4: Ward to Board

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