Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 21 January 2026

TB2026.04

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

Status:	**For Information**
History:	**Reported to MCGC 15 December 2025**

Board Lead:	**Chief Nursing Officer**
Author:	**Sharon Andrews, Head of Midwifery**
Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

1. This report provides assurance and oversight on maternity and neonatal services at Oxford University Hospitals NHS Foundation Trust, in line with the NHSE Perinatal Quality Surveillance Model (PQSM) and the newly republished Perinatal Quality Oversight Model (PQOM).
2. Births fell in November 2025, with 585 mothers delivering 597 babies.
3. Key Areas of Focus
    - **Safety & Compliance:** All MNSI and PMRT reporting requirements have been met, with rapid reviews confirming no immediate care concerns in referred cases. There was one MNSI report received. The safety recommendations made by MNSI aligns with the findings of the thematic review, around escalation of CTG monitoring and recognition of “loss of contact”. Learning has been woven into the mandatory fetal monitoring study day which all midwives and obstetricians attend annually.
    - **Workforce & Training:** PROMPT, fetal monitoring and newborn life support training compliance are above target for all staff groups. 25 new preceptees are due to start between September and November.
    - **Quality Improvement:** The report demonstrates ongoing stability in perinatal surveillance metrics, with robust reviews ensuring accuracy. The Maternity (Perinatal) Incentive Scheme Year 7 is progressing.
    - **Experience and Feedback:** There has been an increase in complaints and the Friends and Family Test show a high proportion of positive ratings.
4. **Operational Performance:** The maternity triage received 1,373 attendees, and 48.9% of women were seen within 15 minutes. Data accuracy has notably improved since the BSOTS improvement project was implemented. There were no reported gaps in the on-call medical workforce, and consultants attended 100% of clinical incidents.

Recommendations

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

Perinatal Quality Oversight Model Report (November data)

1. Purpose

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

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

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

2. Background

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

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

2.3. The accompanying report presents key information and data up to the end of November 2025 and a summary of the key highlights are presented below.

3. Key Highlights – November 2025

3.1. All MNSI and PMRT reporting requirements met.

3.2. No reported cases to MNSI.

3.3. There was one MNSI report received. The safety recommendations made by MNSI align with the findings of the thematic review, around escalation of CTG monitoring and recognition of “loss of contact”. Learning has been woven into the mandatory fetal monitoring study day which all midwives and obstetricians attend annually.

3.4. Five cases were reviewed through PMRT.

Training Compliance

3.5. Compliance above target of 90% for all staff groups for PROMPT, fetal monitoring and newborn life support training.

Maternity (Perinatal) Incentive Scheme (MPIS) Year 7

3.6. Safety Action 1 – Fully compliant. Quarter 2 Perinatal Mortality Report will be presented at the January Trust Board meeting. Reporting continues on an ongoing basis, irrespective of the MPIS reporting period.

3.7. Safety Action 2 - external verification received – safety action fully compliant.

3.8. Safety Action 3 – Fully compliant.

3.9. Safety Action 4 – Fully Compliant. Action plan in place for the neonatal nursing workforce.

3.10. Safety Action 5 – Biannual Quarter 1 and Quarter 2 Safe Staffing report to Trust Board in January. Compliance achieved with action plan embedded in the report for 1:1 care in labour and supernumerary status of the Delivery Suite coordinator at the start of the shift.

3.11. Safety Action 6 – Quarter 2 Saving Babies Lives Care Bundle (SBLCB) version 3.2 review undertaken by the LMNS – all compliance measures achieved. There are exemptions to element 2 of SBLCB that were agreed in previous years (appendix 4).

3.12. Safety Action 7 – Fully compliant.

3.13. Safety Action 8 – Fully compliant.

3.14. Safety Action 9 – Fully Compliant

3.15. Safety Action 10 – Fully Compliant. Reporting continues on an ongoing basis, irrespective of the MPIS reporting period. Please see appendix 5 for supporting evidence.

MNSI referrals

3.16. No cases were referred in November.

Perinatal Mortality Review (PMR) meeting

3.17. An external reviewer attended 4 out of the 4 PMR meetings.

3.18. The MNVP lead attended 2 out of the 4 meetings.

3.19. There were no cases graded as C or a D.

Maternity triage on the Maternity Assessment Unit (MAU)

3.20. 48.9% of women were seen within 15 mins. This is an increase of 12.1% from the previous report. Since the start of the BSOTS project, data accuracy has improved to 95.4%.

Midwifery Staffing

3.21. Midwifery staffing pipeline is strong with a further 15.85 wte to start in Q4 2025/26, and 4.4 wte support staff.

Training compliance

3.22. Attendance at PROMPT, fetal monitoring training and newborn life support is above the target of 90% for all staff.

Complaints/Patient Feedback

3.23. 18 complaints received which is a slight decrease from the previous month.

3.24. 298 responses from friends and family test (FFT) were received of which 69.7% rated the service as ‘good’ or ‘very good’ and a further 303 responses on the ‘Say on the Day’ devices, of these 87.5% gave a positive rating.

4. Conclusion

4.1. The accompanying report provides a comprehensive monthly update and assurance regarding key maternity quality and safety metrics and ongoing activity. It underscores the Trusts commitment to transparency and continuous improvement, demonstrating progress towards meeting both local and national quality standards.

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

4.3. This report provides evidence of compliance with the revised perinatal surveillance model, highlighting key achievements and areas that require improvement. It is also intended to support maternity and neonatal services to collate evidence for the Maternity (Perinatal) Incentive Scheme.

5. Recommendations

5.1. The Trust Board is asked to:

- Note and take assurance from the report, which highlights the current position in relation to the stability of key metrics.
- Support ongoing improvement initiatives.

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Oversight Model Report including Dashboard

Presented at Maternity Clinical Governance Committee

Authors:

Joana Dias - Perinatal Clinical Governance Lead

Niamh Kelly - Maternity Safety, Risk and Compliance Lead

Claire Litchfield – Maternity Clinical Governance Lead

Amit Gupta – Clinical Lead for Neonates

Renata Gavenciakova – Quality Assurance and Improvement Coordinator

Tanya Santacaterina – Deputy Head of Midwifery

Ruth Houlden – Maternity Clinical Lead

Sharon Andrews – Head of Midwifery

Date: December 2025

Data period: November 2025

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

CONTENTS

Oxford University Hospitals NHS Foundation Trust

Maternity Summary November 2025

Oxford University Hospitals NHS Foundation Trust

1.9% (prev. 0.6%)
Blood Loss >1500mls for CS
3.0% (prev. 3%)
3rd & 4th degree tears

↓18 **Unplanned Term Admissions to NNU**
(3%)
≥ 37 weeks

↓ **12 (2%)**
Freestanding MLU*

Horton	4
Chipping Norton	3
Wantage	1
Wallingford	4

↓534 **Delivery Suite**

32 (5%) Spires

Excellence Reports
15

Friends & Family Test:
89.9% ↑
Good/Very Good

597 Babies Born To 585 Women

↑**43.1%**
Caesarean Sections (CS)
Elective CS –95 (16.2%)
Emergency CS – **157** (26.8%)

↓**25.6%**
Inductions of Labour

707 Scheduled Bookings

99.6%
1:1 Care in Labour
1:23
Midwife to Birth Ratio

18 New Complaints

↓**7** (1.9%) **Home Births**

89.1%
Breastfeeding Initiation

*MLU – Midwifery Led Unit

Neonatal Summary

Oxford University Hospitals NHS Foundation Trust

Milk Bank

133L Breast Milk Pasteurised

21L Sold/ **£3.8k** Profit

9 Donors Recruited

24 Term Admissions (32%)

≥ 37 weeks

50 Preterm Admissions (68%)

< 27 weeks – **6** (8%)

27-36 weeks – **44** (60%)

100% Born in the right place*

12 Excellence Reports

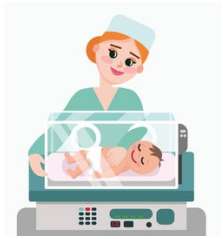
27% Say on the Day

0% Friends and Family Test

74 Admissions

November 2025

1093 Care Days



Nursing Recruitment

6 Recruits

3 Leavers

SONeT

SOUTHAMPTON OXFORD NEONATAL TRANSPORT

21 Total Transfers

6 Emergency Uplifts

15 Non-Urgent

Outreach Team

138 Home Visits

54 Babies Seen

4 Deaths

x2 - Extreme Prematurity ≤24/40

26+2/40 – Severe Pulm. Insufficiency

26+1/40 – Septic Shock

2

MatNeo Complaint

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

Oxford University Hospitals
NHS Foundation Trust

Perinatal Quality Scorecard (Exception Report and Dashboard)

1. Perinatal Quality Scorecard Summary

Oxford University Hospitals NHS Foundation Trust

Overview

A total of 585 mothers gave birth to 597 babies, and 707 scheduled antenatal bookings were completed. Caesarean sections accounted for 252 births, representing 43.1% of all deliveries. Midwifery led settings supported 51 births (8.7%), including 32 on the Spires, 4 at the Horton MLU, 3 at Chipping Norton, 4 at Wallingford and 7 homebirths.

Quality & Safety

238 maternity patient safety incidents were reported via Ulysses with 51 classified as moderate harm or above. Moderate harm incidents related to post-partum haemorrhage (PPH) greater than 1.5 litres, obstetric anal sphincter injury (OASI), and unexpected admissions to Special Care Baby Unit (SCBU).
Appropriate learning responses were implemented in accordance with Patient Safety Incident Response Framework (PSIRF) principles to ensure considered and appropriate response. Immediate learning interventions were implemented on a case-by-case basis to address contributory factors and mitigate future risk, ensuring that learning was embedded promptly and effectively across relevant clinical teams.

During November, there were no cases reported to the Maternity and Neonatal Safety Investigation (MNSI). Additionally, no babies were admitted to SCBU with suspected HIE requiring therapeutic cooling.

Outcomes

In November the majority of births were unassisted vaginal births (252 cases, 43.1%) with 77 births (13.2%) assisted with forceps or kiwi cup; the remainder were caesarean sections.
150 women were booked for an induction of labour (25.6%). Of these, 42 women were affected by a delay >24 hours. This is a decrease of 8 from the previous month. Delays in induction of labour were not found to be contributory factors in any adverse birth as reported below.

There were 16 reported cases of obstetric anal sphincter injury (OASI), 10 in unassisted vaginal birth, and 2 in assisted birth. On examination of the cases, 2 were precipitate labour and 1 case related to a baby born in the community prior to the arrival of a midwife. 3 of these were reported on Ulysses in December. This is an increase from previous months, and learning has been shared with the intrapartum teams.

Postpartum haemorrhage (PPH) greater than 1.5 litres occurred in 19 cases. Of these, 3 cases were associated with unassisted vaginal births (0.5%), 5 with assisted vaginal births (0.85%) and 11 cases with caesarean birth (1.9%).

There were 18 term babies who were unexpectedly admitted to special care. 10 of these babies were born by caesarean section, 6 followed unassisted vaginal births and 2 were associated with vaginal births. These admissions are subject to review to identify any preventable factors and ensure timely escalation of learning.

Experience

In November 2025, there were 18 complaints which is a decrease on the previous month. Several were historical, one dating back to bereavement care received in 2000. The main themes centred on clinical treatment, delay of elective work, communication of risk as well as communication between maternity and neonatal colleagues.

The service received 298 Friends and Family Test (FFT) responses, with 89.9% rating care as ‘good’ or ‘very good’. In addition, the service received 303 responses from the ‘Touch and Tell’ devices with 87.5% reporting Very good or good care.

Efforts are being made to gather input from patients and community groups regarding the Perinatal Improvement Programme, including an open engagement event scheduled for December 12. These activities aim to enhance collaboration and guarantee that service improvements address the needs and preferences of both patients and the wider community.

Training

The 2025–2026 training year commenced in September, featuring PROMPT, fetal monitoring OxMUD, and ongoing neonatal life support sessions. Rolling compliance remains above the 90% target for most staff groups, reflecting strong engagement with the programme. This is despite having to cancel the PROMPT session on the 18 November due to the Junior Doctor industrial action. Members of staff affected have been rebooked to attend.
All maternity staff are allocated time during the training year to complete mandatory online modules, ensuring full compliance with both maternity-specific and general mandatory training within the rolling year.
Information Governance training compliance currently stands at 88.1%. Targeted efforts are underway to support staff who have not yet completed their training, with additional reinforcement through the appraisal process to achieve full compliance.

Patient Group Directive (PGD) compliance for all midwives employed by OUH is currently at 75%. A decrease in compliance levels was noted in October as the service welcomed over 40 new starters during Q1 and Q2. The new starters will complete all their e-learning over the next six months.
The practice development team has introduced focused initiatives to improve PGD compliance further, ensuring safe and effective practice across the service.

Workforce

The midwife-to-birth ratio was 1:23.
There were two instances in November when 1:1 care was not provided to women in established labour. These occurrences happened while awaiting the arrival of on-call midwives and lasted for a brief period only. Additionally, on two occasions, the Delivery Suite coordinator was not working in a supernumerary capacity at the beginning of the shift; this too was for a short duration. A focused review of these incidents is currently underway, and a tactical action plan will be developed to prevent further occurrence.

The service continues with a robust recruitment and retention plan with up to 25 Band 5 midwives joining the service between September to November. However, with a recruitment freeze due to commence on 1st December this may slow onboarding process down. Maternity is working towards being an exemption from this freeze to ensure safe staffing can continue to be assured. Daily staffing meetings continue to assure the service is safely staffed, enabling mitigations, movement of staff between areas and triggering escalation as needed.

There was a significant reduction in the number of on call hours in November, 219 hours, compared with 455 in October.

Indicator Overview Summary – Maternity SPC Dashboard

ER

ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Nov 25	585	625			620	537	704
Babies Born	Nov 25	597	-			630	545	716
Scheduled Bookings	Nov 25	707	750			702	557	848
Inductions of labour (IOL)	Nov 25	150	-			152	108	196
Inductions of labour (IOL) as a % of mothers birthed	Nov 25	25.6%	-			24.5%	19.0%	30.1%
Spontaneous Vaginal Births SVD (including breech)	Nov 25	269	-			309	234	384
Spontaneous Vaginal Births SVD (including breech): a	Nov 25	46.0%	-			50.8%	43.6%	57.9%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Nov 25	77	-			86	55	117
Number of Instrumental births/Forces & Ventouse as	Nov 25	13.2%	-			13.9%	9.4%	18.4%
SVD + OVD Total	Nov 25	346	-			388	313	462

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Nov 25	252	-			220	178	263
Number of CS births as a % of mothers birthed	Nov 25	43.1%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Nov 25	157	-			129	97	162
Emergency CS births as a %	Nov 25	26.8%	-			20.4%	15.1%	25.7%
Number of Elective CS	Nov 25	95	-			100	60	140
Elective CS births as a %	Nov 25	16.2%	-			15.1%	10.9%	19.4%
Robson Group 1 c-section with no previous births a %	Nov 25	17.1%	-			13.7%	7.3%	20.2%
Robson Group 2 c-section with no previous births a %	Nov 25	62.3%	-			56.3%	44.8%	67.8%
Robson Group 5 c-section with 1+ previous births a %	Nov 25	77.1%	-			79.8%	62.6%	97.0%
Elective CS <39 weeks no clinical indication	Nov 25	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Nov 25	109	109			109	109	109
Midwife:birth ratio	Nov 25	23.2	22.9			25.9	21.8	29.9
Maternal Postnatal Readmissions	Nov 25	13	-			8	-1	18
Readmission of babies	Nov 25	20	-			19	3	36
3rd/4th Degree Tears amongst mothers birthed	Nov 25	16	-			12	0	25
3rd/4th degree tears amongst mothers birthed as a %	Nov 25	4.6%	3.5%			3.0%	0.0%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Nov 25	14	-			9	-1	19
3rd/4th degree tears following unassisted Vaginal bir	Nov 25	4.1%	-			2.5%	0.0%	5.0%
3rd/4th degree tears following an Instrumental vagin	Nov 25	2	-			3	-2	9
3rd/4th degree tears following an Instrumental vagin	Nov 25	2.6%	8.0%			4.2%	-2.8%	11.3%
PPH equal to or greater than 1.5L following an instrun	Nov 25	5	-			7	1	13
PPH equal to or greater than 1.5L following an instrun	Nov 25	0.9%	-			1.1%	0.1%	2.2%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Nov 25	3	-			12	0	23
PPH 1.5L or greater, vaginal (unassisted) births as a %	Nov 25	0.5%	2.4%			1.9%	0.2%	3.6%
PPH 1.5L or greater, caesarean births	Nov 25	11	-			7	-2	15
PPH 1.5L or greater, caesarean births as a % of mothe	Nov 25	1.9%	4.3%			1.2%	-0.6%	2.9%
ICU/CCU Admissions	Nov 25	1	-			1	-1	2
% completed VTE admission	Nov 25 ER	80.6%	95.0%			94.0%	89.1%	98.9%
Maternal Deaths: All	Nov 25	0	-			0	0	1
Early Maternal Deaths: Direct	Nov 25	0	-			0	0	0
Early Maternal Deaths: Indirect	Nov 25	0	-			0	0	0
Late Maternal Deaths: Direct	Nov 25	0	-			0	0	0
Late Maternal Deaths: Indirect	Nov 25	0	-			0	0	0

Indicator Overview Summary – Maternity SPC Dashboard

ER

ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Oct 25	1	-			5	-2	13
Puerperal Sepsis as a % of mothers birthed	Oct 25	0.2%	1.5%			0.8%	-0.3%	2.0%
Stillbirths (24+0/40 onwards; excludes TOPs)	Nov 25	0	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Sep 25	3	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Nov 25	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Nov 25	2	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	Nov 25	2	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	Nov 25	0	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Sep 25	3	3			2	-2	5
HIE	Nov 25	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Nov 25	14	-			9	0	18
Shoulder Dystocia as a % of babies born	Nov 25	2.3%	-			1.4%	0.0%	2.7%
Unexpected NNU admissions	Nov 25	18	-			25	8	41
Unexpected NNU admissions as a % of babies born	Nov 25	3.0%	4.0%			3.9%	1.2%	6.5%
Hospital Associated Thromboses	Nov 25	0	0			0	-1	1
Returns to Theatre	Nov 25	0	0			1	-2	5
Returns to Theatre as a % of caesarean section delive	Nov 25	0.0%	0.0%			0.6%	-0.9%	2.2%
Number of PSII	Nov 25	0	0			1	-2	4
Number of Complaints	Nov 25	18	-			9	-2	20
Born before arrival of midwife (BBA)	Nov 25	3	-			6	-2	14

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Oct 25	80.7%	85.0%			77.1%	66.0%	88.3%
Number Of Women Booked This Month Who Current	Nov 25	20	-			42	20	63
Percentage Of Women Booked This Month Who Curre	Nov 25	2.8%	-			6.0%	2.8%	9.2%
Number of Women Smoking at Delivery	Nov 25	11	-			31	14	48
Percentage of Women Smoking at Delivery	Nov 25	1.9%	8.0%			5.0%	2.2%	7.8%
Number of women with a live birth	Nov 25	580	-			606	506	706
Number of Woman with a live birth Initianing Breastf	Nov 25	517	-			525	384	667
Percentage of Women Initiating Breastfeeding	Nov 25	89%	80%			83%	74%	91%
Number of women booked by 10+0/40	Nov 25	429	-			423	225	621
Percentage of women booked by 10+0/40	Nov 25	61%	-			66%	57%	76%

What is the data telling us?

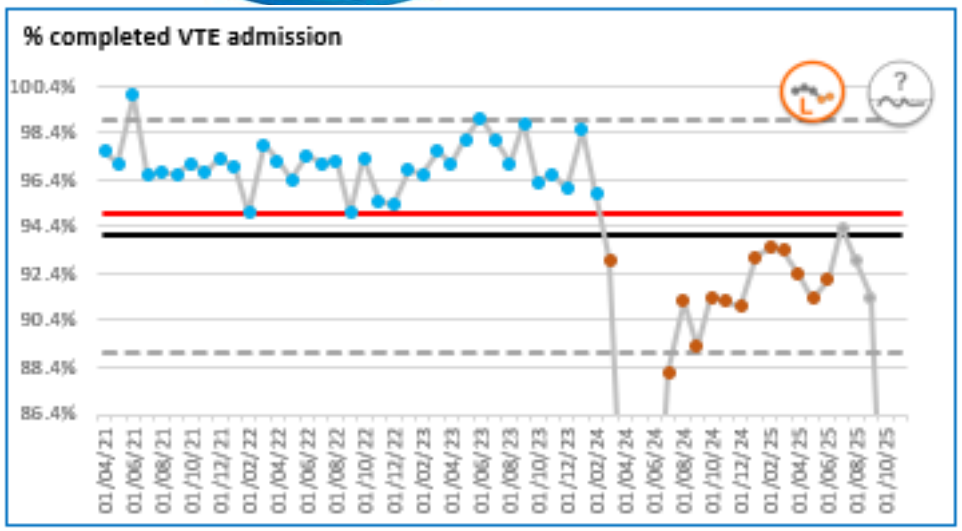
Exception Reporting highlighted for % of completed VTE assessments. Summary and Actions Slide 9

Exception Reporting highlighted for Complaints. Summary and Actions Slide 10

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

Maternity Exception Report

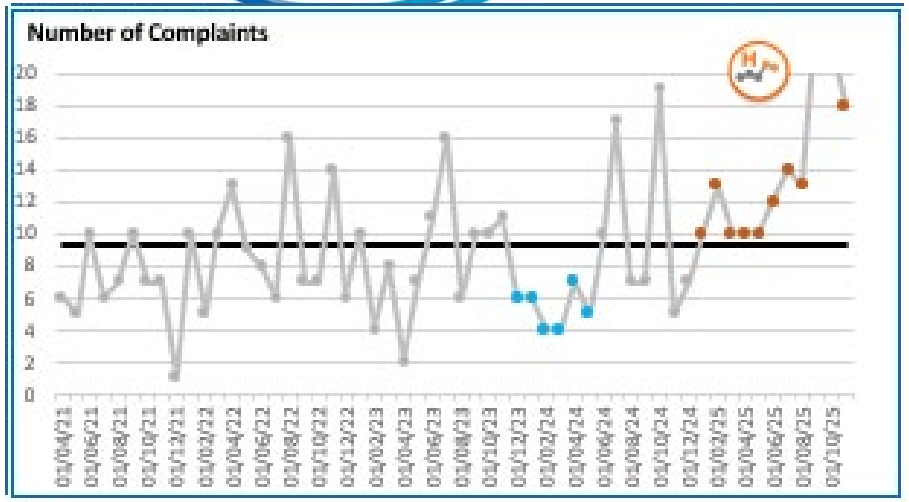
Oxford University Hospitals NHS Foundation Trust



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% of completed VTE admissions	Previously the Maternity VTE data had been taken from BadgerNet however from November 2025 the VTE data will be sourced from Orbit and consistently reported going forward. The data from Orbit is 80.6%. The data from BadgerNet is 89.38%. A multidisciplinary VTE task and finish group was established in March 2025. This group has been developing and testing the alternative system with the objective of achieving 100% compliance of timely and accurate VTE assessment. Current focus is as follows: • Guideline has been reviewed and updated to reflect the reporting change to Cerner – this was ratified at the November 2025 Document Review Group (DRG) to optimise VTE compliance • In November, a message was sent to all maternity staff about the updated process for completing VTE risk assessments in Cerner. This information has also been communicated across the service during safety huddles. • Monthly audit results are tracked, reported in Maternity performance, and reviewed by the Clinical Governance Committee. Exceptions are handled by the Patient Safety team, with immediate actions like sharing weekly learning and updating safety boards as needed.	Continuous audit of VTE assessment completion. Monthly audit results are tracked, reported in Maternity performance, and reviewed by the Clinical Governance Committee. Exceptions are handled by the Patient Safety team, with immediate actions like sharing weekly learning and updating safety boards as needed. Next review: December 2025. The next formal update will be presented at the Trust Board in Public on 21 January 2026.	N/A	N/A

Maternity Exception Report

Oxford University Hospitals NHS Foundation Trust



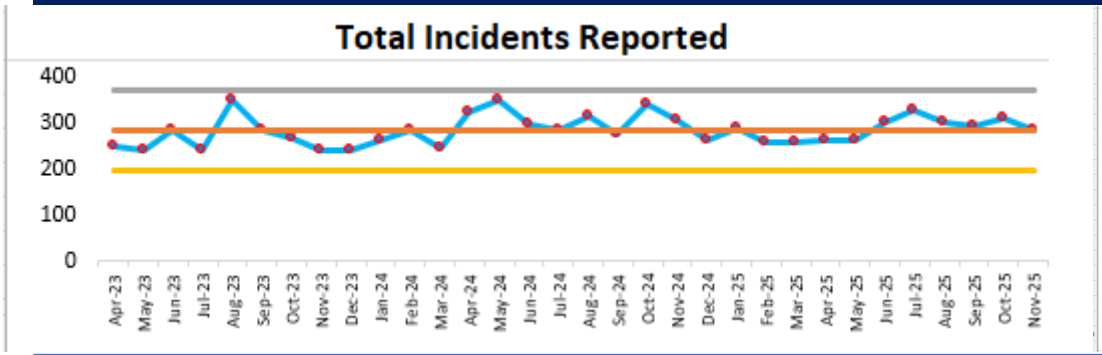
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Number of Complaints shows special cause concerning variation	The service continues to respond promptly to complaints, engaging directly with complainants and involving both rapid responders and the maternity patient safety partner to ensure compassionate, service user-centred responses. In November, there were 18 complaints received. Several were historical, one dating back to bereavement care received in 2000. The main themes centred on clinical treatment, delay of elective work, communication of risk as well as communication between maternity and neonatal colleagues. Efforts are being made to gather input from patients and community groups regarding the Perinatal Improvement Programme, including an open engagement event scheduled for December 12. These activities aim to enhance collaboration and guarantee that service improvements address the needs and preferences of both patients and the wider community.	The identified exception has been reviewed through the established governance process and is actively being addressed. Oversight has been maintained via the Clinical Governance Committee and TALC, with progress monitored against agreed timelines and responsible leads. A thematic complaints review was presented to MCGC in October, identifying consistent themes around postnatal care, listening to women, and compassionate care. Targeted workstreams and training are already underway to address them such as postnatal task and finish group which was re-launched on 3rd November 2025 with an overarching objective of reducing length of stay by Q3 2026/27. There is also a focus on training opportunities such as communication skills and active bystander which has been added to the mandatory training requirements – compliance is monitored on a rolling monthly basis alongside other mandatory training requirements. Progress will be closely monitored through these workstreams, with regular reporting to the MCGC to ensure continued improvement. The next formal update will be presented at the Trust Board in Public on 21 January 2026.	N/A	N/A

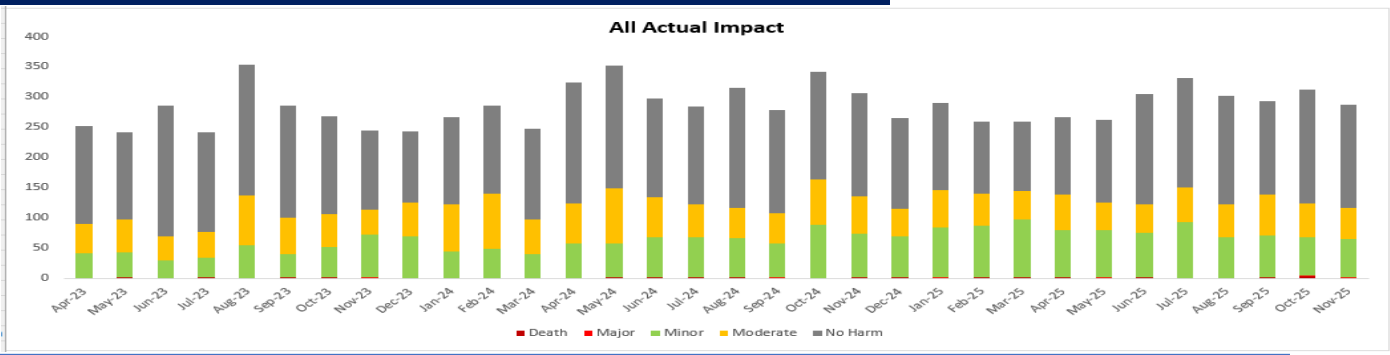
Oxford University Hospitals
NHS Foundation Trust

Perinatal Safety

Perinatal Safety - Maternity Incidents

Oxford University Hospitals NHS Foundation Trust





SUMMARY

Summary of Data

- In November, a total of 238 patient safety reports were submitted via Ulysses. Of these, 50 were reported as moderate harm and one as major harm.
- Moderate harm incidents accounted for 21% of all patient safety incidents. This is the same as the previous month.
- Among the 50 moderate harm incidents the following causes were recorded: 4 bladder stretch/urinary retention, 12 third degree tears, 12 postpartum haemorrhages, 1 missed newborn early warning score (NEWS), 1 failure to comply with BSOTS, 17 unplanned term admissions to SCBU.
- The 1 major harm incident was a maternal admission to the intensive care unit (ICU) following a category 1 emergency caesarean section (EMCS) under general anaesthetic (GA). The patient remains an inpatient in Neuro (ICU).

Strengths

- The number of Ulysses submitted demonstrates a strong reporting culture, supported by monthly trend analysis and escalation processes to ensure learning is captured and timey learning occurs.
- Overdue Ulysses are actively monitored, with a clear recovery plan in place and oversight is managed through the Maternity Clinical Governance Committee (MCGC). There are currently 103 overdue incidents which has risen from 65. The increase is largely due to staff responsible for managing and closing incidents being pulled to work clinically during high levels of acuity across the service in November.
- Communication of 'Learning of the week' is delivered through varying forums and embedded in safety huddles and team briefings. Compliance is monitored via feedback loops to confirm dissemination and impact and spot check audits undertaken where appropriate to ensure safety actions are being consistently undertaken.

Focus

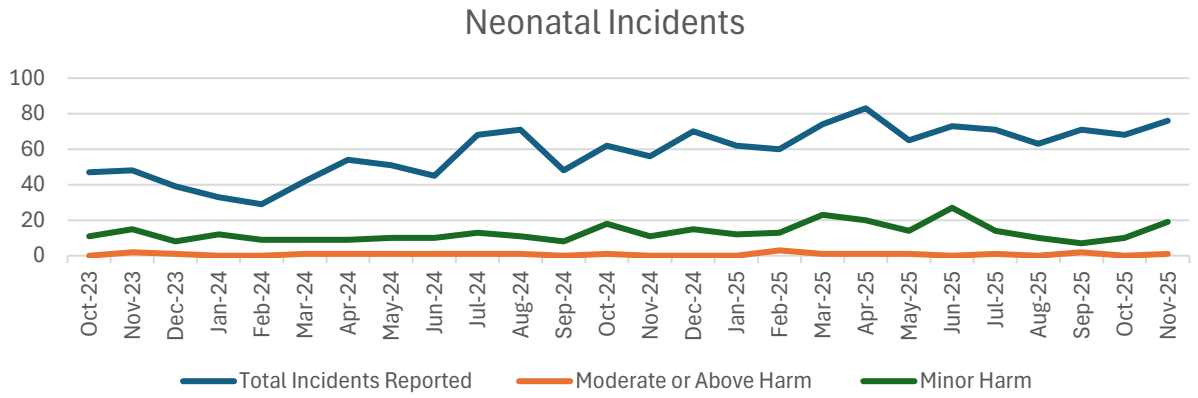
- Timely review of Ulysses
- Adherence to the PEACHES care bundle to prevent obstetric anal sphincter injuries (OASI)
- Bladder care compliance including accurate fluid balance and catheter care

Future

- To address health inequalities, the service are consistently reviewing the ethnicity of users affected by moderate harm incidents.
- This data collection will inform thematic analysis and targeted interventions to address disproportionate outcomes.
- Findings and action plans will be reported to the Maternity Clinical Governance Committee.

Perinatal Safety - Neonatal Incidents

Oxford University Hospitals NHS Foundation Trust



Summary of Data

- In November, 76 patient safety incidents were reported via Ulysses. Of these, 75 were classified as minor or no harm, and one incident involved a neonatal death. The death was subject to immediate escalation and a rapid review by the Patient Safety Team. This review found no clinical safety concerns or immediate learning. In line with our commitment to transparency and continuous improvement, the case will undergo further scrutiny at the upcoming neonatal Morbidity & Mortality (M&M) meeting to ensure any potential learning is identified and shared across the multidisciplinary team.

Strengths

- Incident reporting within neonates remains high reflecting a strong culture of openness and learning. Currently, there are only two overdue incidents, which are being actively managed. This low number of outstanding cases, supported by monthly governance reviews and clear escalation processes, provides assurance that issues are addressed promptly and effectively.
- Neonates continue to rank as the second-highest reporters of excellence within the Children's Directorate, reflecting a strong culture of learning and recognition of good practice.
- In addition, representation at local, directorate, and divisional governance meetings has improved, supporting stronger engagement and alignment with organisational priorities.

Focus

- Education and training on governance within the neonatal team are being enhanced through planned teaching sessions incorporated into nursing team days and the induction programme for doctors. These sessions aim to embed a strong understanding of governance processes, risk management, and accountability across all staff groups.
- The service continues to strengthen its partnership with the Maternity and Neonatal Safety Improvement Programme (MatNeo), ensuring shared learning and best practice are consistently applied. This collaborative approach supports continuous improvement.

Future

- Ongoing governance awareness and education within the neonatal team, supported by targeted teaching sessions and integration into team development activities. This will strengthen understanding of governance processes and accountability across all staff groups and will be a focus over the next three months.

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

Oxford University Hospitals NHS Foundation Trust

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

PMRT Reporting and Learning

- All cases that met the criteria in November 2025 were reported to MBRRACE, in line with national requirements.
- Five multidisciplinary case reviews were completed during November, across four PMRT meetings.
- PMRT meetings are held weekly, and an external reviewer attended all four meetings, in line with MPIS requirements.
- Aligned to Maternity (Perinatal) Incentive Scheme MPIS, PMRT meetings require service user representation. This was achieved in two meetings; compliance will increase as further members of OMNVP undertake the required PMRT training.

MNSI Reporting and Learning

There were no cases referred in November 2025.

One MNSI report was returned in November MI-041927. The case related to a baby who was admitted to SCBU for therapeutic cooling with suspected hypoxic ischemic encephalopathy. This case formed part of a thematic review undertaken comprising of three cases which occurred in May 2025. The safety recommendations made by MNSI aligns with the findings of the thematic review, around escalation of CTG monitoring and recognition of “loss of contact”. Learning has been woven into the mandatory fetal monitoring study day which all midwives and obstetricians attend annually.

Learning from PMRT Reviews

Five cases were reviewed in November. All were graded either A or B, meaning care was safe and appropriate. There were however some areas of improvement identified. There were no cases graded C or D.

Summary of Cases

- **Case 1**: Stillbirth at 31+2 weeks. Care during pregnancy and labour was appropriate. Graded B because an obstetric review did not take place before discharge, this would not have changed the outcome.
- **Case 2:** Intrauterine death at 23+2 weeks. Known abnormalities and termination planned. Graded B for antenatal care (domestic violence screening not documented) and B for postnatal care (no obstetric review before discharge). Neither of which would have changed the outcome.
- **Case 3:** Neonatal death at 26+2 weeks following transfer for specialist care. Graded B because domestic violence screening was not completed at booking (booking occurred at another hospital).
- **Case 4:** Neonatal death at 23+3 weeks. Graded B due to missed domestic violence screening and a delay in antibiotics (no impact on outcome). Good care planning noted.
- **Case 5:** Neonatal death of a twin with a known diaphragmatic hernia. Born at 35+5 weeks and transferred for surgery. No care issues identified.

Key Learning and Actions

- **Domestic Violence Screening:** Learning disseminated to community teams as a reminder that this must be completed at booking for all women.
- **Obstetric Review:** Learning has been disseminated to all Consultants as a reminder that all women with intrauterine death should have an obstetric review before discharge.
- **Medication Administration:** Learning shared with Postnatal and Neonatal teams to ensure timely administration of medicines for women visiting babies in SCBU.

Assurance to the Board

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

Oxford University Hospitals
NHS Foundation Trust

Maternity Operational Activity

Maternity Operational Activity

Oxford University Hospitals NHS Foundation Trust

Summary

Summary of Data

- In November, births decreased by 10% from the previous month.
- 2% of births were in community settings.
- There was a decrease in on call hours used in November, with 105 hospital on calls and 66.5 hours of community night on call. The community team provided 47.75 hours of day on call hours.
- There were 42 delays in induction of labour (IOL) exceeding 24 hours, with 14 delayed for more than 6 hours and 26 for more than 12 hours.
- There was a slight decrease in the number of caesarean births, with an increase of 3% in emergency caesarean sections compared to the previous month and a 1% decrease in the number of elective caesarean sections.
- Category 1 caesareans (the most urgent cases) were completed within the recommended 30 minutes in 83% of cases. Category 2 caesareans (urgent but less critical) were completed within the recommended 75 minutes in 54% of cases. An audit is currently underway to review the timing of caesarean sections and identify the reasons for any delays, this will be reported through the existing clinical governance processes
- There were 13 maternal postnatal readmissions (2.2%) – 2 x sepsis, 1 x pain, 5 x hypertension, 2 x mastitis and 3 were categorised as other.
- MAU managed 1373 attendances. 48.9% of women were seen within 15 mins. This is an improvement from the previous month of 8.8%.
- There were no closures of the obstetric unit.

Strengths

- On call community midwives attended the JR unit responsively to support in escalation, demonstrating flexibility and commitment to maintaining safe staffing levels.
- Specialist midwives and Ward Managers also provided timely support to operational colleagues during periods of escalation, ensuring continuity of care and effective risk management.
- Antenatal risk assessments were completed in 99.3% of cases, providing assurance that risk identification and mitigation processes are robust.
- Additionally, place of birth suitability was recorded at 85%.

Focus

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

Future

- The service will continue to monitor safe staffing levels across both acute and community sites through daily monitoring and escalation processes, assuring dynamic risk assessment and patient safety.
- A Birthrate+ review has been commissioned and commenced in November 2025, providing an independent assessment of workforce requirements to inform future planning.
- From January 2026, a 24-hour bleep holder role will be rolled out to strengthen operational oversight and escalation management.

Oxford University Hospitals
NHS Foundation Trust

Maternity and Neonatal Workforce

Workforce -Maternity

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Summary of Data

- The current Midwife to birth ratio is 1:23.18 - a midwife-to-birth ratio indicates how many births a midwife is responsible for, aiming to ensure safe, quality care supporting 1:1 care in labour. The ratio is decreased this month due to the positive increase in clinical staff, alongside the significant reduction in births compared to the two previous months.
- There were 2 occasions when the Delivery Suite (DS)coordinator was not supernumerary, this was for a short period of time whilst staff redeployment, and safe service user transfer was undertaken.
- The service was unable to provide 1:1 care on 2 occasions. This was during periods of high peaks of activity and acuity and was for a short period of time whilst awaiting the arrival of on-call midwives.
- In November the service had a vacancy of 6.1 wte midwives/obstetric nurses and 9.04 wte for midwifery support workers (MSW).
- There has been 100% attendance by consultants at clinical incidents as per RCOG guidance.

Strengths

- 11.52 wte new midwifery preceptees due to start/started during Q3 2025/26
- 5.71 wte new Band 6-7 midwives due to start/started during Q3 2025/26
- Vacancy rate is 6.1 wte for midwives/obstetric nurses with a predicted reduction in December to +0.47wte.
- Midwifery staffing pipeline is looking very healthy with a further 15.85 wte to start in Q4 2025/26, and 4.4 wte support staff.
- As part of the Perinatal Improvement Programme, the staff experience workstream enhances staff wellbeing, care, and retention through ongoing leadership development, comprehensive support services (including counselling and resilience activities), regular reflective forums like Schwartz Rounds, and mandatory Active Bystander Training to promote an inclusive and supportive workplace.
- Proactive pastoral and wellbeing support continues for all staff cohorts, including internationally trained staff, with uptake monitored and feedback informing improvement actions.

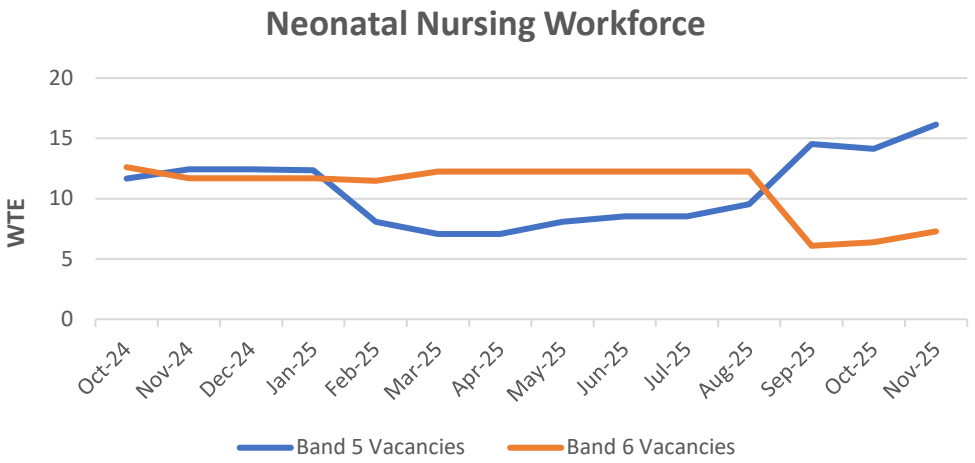
Focus

- Any short notice gaps in the roster are mitigated through tactical staff redeployment and NHSP with shifts proactively released to maintain safe staffing levels for both registered and non-registered staff.
- Safe staffing is dynamically risk assessed and supported by real-time oversight by the bleep holder and at daily staffing meetings.
- To ensure the consistent provision of accurate planned versus actual staffing data, the service has re-launched a robust daily process that is fed into the daily staffing and fill rate meetings – this is assured through senior leadership spot checks and fail safing.
- Continuous and consistent provision of 1:1 care in labour and supernumerary status of 2nd DS coordinators - targeted communication and education programme now in place.
- Focused Quality Improvement to support staff affected by racially motivated behaviour incidents
- Active recruitment for Band 5 and Band 6 midwives is ongoing, Active recruitment of MSW's is ongoing.
- Return-to-work interviews supported by HR, providing assurance that staff wellbeing and compliance with policy are maintained.
- Staff experience workstream focused on consistent support of staff wellbeing, care and retention (Part of Perinatal Improvement Programme)

Future

- A recruitment plan is in place to address Registrar vacancies, with progress monitored through maternity clinical governance committee.
- MediRota is now reviewed monthly by directorate team, ensuring compliance with the six-week leave policy and maintaining oversight of session planning and rota integrity. Medical staffing escalation SOP under development.
- Consultant Appointment and subsequent job planning to support in progress to support additional high risk antenatal clinics at the Horton.
- Team based job planning
- An updated BirthRate Plus review has been commissioned and commenced in November 2025, providing an independent assessment of workforce requirements to inform future planning and resource allocation.
- Innovative succession planning and development opportunities are being implemented, including short courses and apprenticeship programmes, to build leadership capability and future workforce resilience.

Workforce – Neonatal Nursing Workforce



Summary of Data

- In November, there were 7.29 WTE Band 6 and 16.14 WTE Band 5 vacancies in Neonates. Additionally, there are 9 WTE staff on maternity leave. Despite these challenges, mitigation strategies are in place, including regular staffing reviews and cross-divisional critical care redeployment, ensuring that patient safety and service continuity are maintained at all times.
- Progress against recruitment targets and temporary staffing usage is monitored through and reviewed through divisional governance.

Strengths

- 8 Band 5 Neonatal Nurses have been recruited and commenced in October 2025, which will help address current workforce gaps and improve staffing resilience.
- Recruitment efforts have also been expanded to include newly qualified nurses, ensuring a sustainable pipeline of talent.
- Neonates is compliant with MPIS Safety Action 4 for 2025, supported by a clear action plan and regular progress reviews.

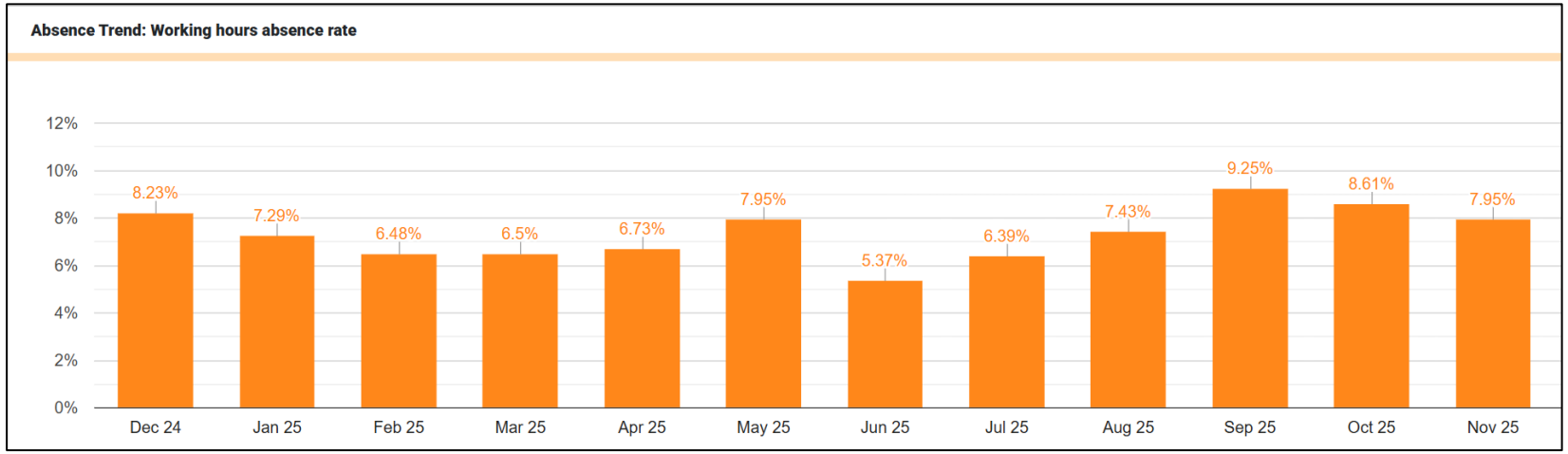
Focus

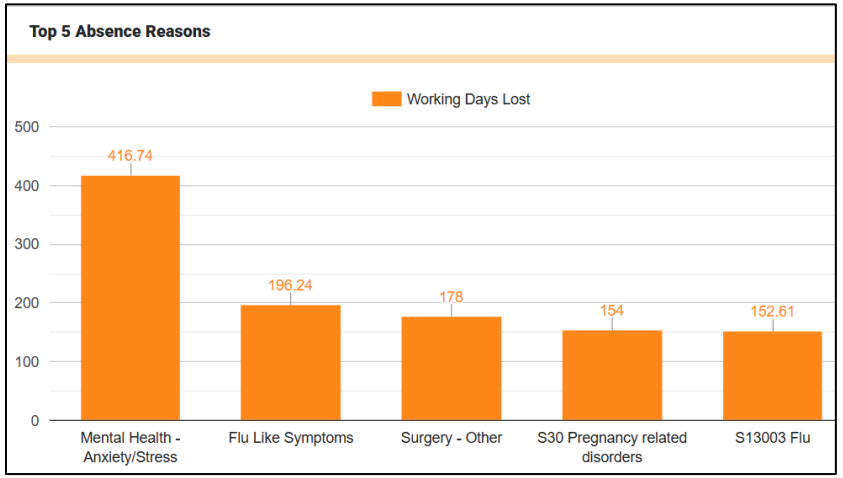
- The rolling recruitment programme for Band 5 and Band 6 nurses is currently paused due to newly implemented financial controls; the impact of this is under continuous review, and any significant issues or risks identified are escalated through the appropriate governance channels for timely action.
- Development programmes for Band 6 and Band 7 staff are being implemented to build leadership capability and support career progression, contributing to workforce stability and retention.
- The Unit Ethos continues to be embedded across teams, reinforcing a culture of safety, collaboration, and excellence.

Future

- Recruitment efforts include a specific focus on Band 4 roles and the expansion of apprenticeship programmes to build a sustainable workforce pipeline and support career progression.

Workforce – Neonatal Nursing Workforce





Summary of Data

- Sickness absence rates were 7.95 % in November and remain broadly in line with wider divisional trends, indicating no disproportionate impact on this service compared to other areas.
- Mental Health – Anxiety/ Stress related absences are increasing, which are being monitored closely to inform targeted interventions.
- Return-to-work interviews are encouraged to be completed within agreed timeframes, and wellbeing support is actively promoted to staff, including access to occupational health.
- Absence data is reviewed monthly at divisional governance meetings, and any emerging risks are escalated providing assurance that sickness absence is being managed proactively within a robust governance framework.

Strengths

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

Focus

- Timely and effective return-to-work interviews will continue to be prioritised in line with the Trust's sickness management procedure, ensuring compliance and consistency across all teams.
- Enhanced monitoring will be maintained through workforce dashboards, with regular audits and HR oversight to provide assurance that interviews are completed promptly and any underlying issues are addressed.
- Two newly qualified Professional Nurse Advocates (PNA) have protected time to focus on providing wellbeing support and restorative clinical supervision to staff.

Future

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

Data collected from Goodshape Central

Workforce – Specialist Training (Neonatal)

Oxford University Hospitals NHS Foundation Trust

Qualified in Speciality (QIS) Training	Target	2023	2024	2025	2026	2027	2028	2029
Compliance	**70%**	42%	46%	48%	60%	72%	84%	96%
				Correct as of 8th December 2025	Prospective Data			

Summary of Data

- Current compliance with BAPM standards for Qualified in Specialty (QIS) training is 48% and there is a clear trajectory in place for improvement supported by a structured action plan.
- The current action plan is reliant on training staff internally and looking ahead, the trajectory will be broadened to recruit external candidates who are already qualified in the speciality. However, this approach remains difficult as such candidates are rare, making recruitment highly competitive and challenging.

Strengths

- The neonatal service is fully compliant with MPIS Safety Action 4 for 2025, supported by a clear and structured action plan, which is monitored through divisional governance.
- In addition, significant progress has been made in increasing the number of staff undertaking QIS training which has increased from 8 to 17 staff across two cohorts—7 nurses commenced training in September, and a further 10 are scheduled to start in February 2026.
- This upward trajectory demonstrates a strong commitment to workforce development.

Focus

- QIS training is being delivered in line with the agreed action plan to improve compliance with BAPM standards. The plan includes prioritising staff for training based on service need, securing CPD funding for external provision, and increasing mentor capacity to support trainees.
- Progress is monitored through the Neonatal Education and Workforce Group and reported to divisional governance, ensuring transparency and accountability. Phased scheduling of training cohorts is in place to minimise operational impact while meeting compliance targets.
- These measures provide assurance that the Trust is actively addressing current gaps and implementing a structured approach to achieve full compliance within a robust governance framework.

Future

- The neonatal service has set a clear trajectory to achieve 70% QIS compliance in line with BAPM standards, supported by a structured action plan.
- To accelerate progress, in-house QIS training provision is being explored, reducing reliance on external providers and improving cost efficiency. This approach also enhances flexibility in scheduling and supports better integration with clinical practice.
- The suitability of the current two-cohort programme will be reviewed to ensure it meets operational needs and maximises training capacity.
- Progress against compliance targets and training delivery is monitored through the Neonatal Education and Workforce Group and reported to divisional governance, providing assurance that workforce capability and quality standards are being actively managed within a robust governance framework.

Workforce – Neonatal Medical Workforce

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

- Consultants - 11WTE (includes 3 Locum)
- Resident doctor's workforce established 39 WTE (following BS in 2025)
    1. Current gaps – 2 WTE
    2. 18 WTE deanery
    3. 19 MTI trainees – resident medical doctors
    4. 2 ANNPs

Summary of Data

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

Strengths

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

Focus

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

Future

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

Perinatal Training

Oxford University Hospitals NHS Foundation Trust

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

Data
- The data is collected on a monthly basis
- Training compliance for all staff groups is above the target of 94%.
- Training compliance for neonatal nurses has increased and is above the target of 90%.

Positive
- Fetal monitoring compliance >90% for all relevant groups.
- Training weeks in Maternity that include PROMPT, fetal monitoring training, OxMUD and Neonatal Life Support restarted in September 2025 with compliance for all staff groups above the 94% target.

Focus
- Attendance of anaesthetic staff at PROMPT – targeted attendance
- Moving and Handling training compliance - dates planned monthly, and staff reminded to complete the e-learning as well as attending practical sessions

Future
- To be above the 90% target for all staff groups for PROMPT, Fetal Monitoring and NLS
- To continue working with ward managers to organise tactical skills and drills sessions across the service
- Staff in Maternity are given protected time to undertake their e-learning as part of their training week.

Core Skills Modules below target	Maternity Directorate
Core Skill - Infection Prevention and Control Level 2	↓81%
Core Skill - Information Governance and Data Security	↔88%
Core Skill - Moving and Handling Level 2	↓73%
Core Skill – Resuscitation Level 1	81%

Core Skills Modules below target	Neonatal Unit
Core Skill - Information Governance and Data Security	89%
Core Skill - Safeguarding Children Level 1	82%
Core Skill - Safeguarding Children Level 2	79%

PROMPT	Midwives	96%
	Nurses working in maternity	92%
	MSW's	97%
	Consultant Obstetricians	100%
	Trainees ST1-7	98%
	Obstetric anaesthetic consultants	100%
	All anaesthetic doctors who contribute to obstetric rosters	100%
Fetal Monitoring	Midwives	97%
	Consultant Obstetricians	100%
	Trainees ST 1-7	93%
Newborn Life Support	Midwives	97%
	Neonatal/Paediatric: Consultants Junior neonatal Dr's (who attend births) ANNP's	 100% 94% 100%
	Neonatal Nurses	97%

Oxford University Hospitals
NHS Foundation Trust

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Maternity (Perinatal) Incentive Scheme (MPIS) Safety Actions

Oxford University Hospitals NHS Foundation Trust

Safety Action	RAG	Comment
1: Use of Perinatal Mortality Review Tool		On track to meet increased requirements for completed reviews and external reviewer attendance. Quarter 2 Perinatal Mortality Review report due to go to Trust Board In January 2026.
2: Submitting data to the Maternity Services Data Set		CNST scorecard validation received – compliant in both metrics.
3: Transitional Care and Avoiding Term Admissions to Neonatal Unit		Transitional Care Unit (TCU) requirements met ATAIN QI project has been registered. Presented to Safety champions on 09 October and LMNS on 12th November.
4. Clinical workforce planning		Neonatal medical staffing meets BAPM standards, neonatal nursing staffing compliant with action plan. RCOG 3-month audit 100% compliant for consultant attendance at medical emergencies. LMNS and ODN have oversight.
5. Midwifery workforce planning		BirthRate plus (BR+) review commenced November 2025. This will evidence requirements of a systematic evidence-based process to calculate midwifery staffing establishment. Current BR+ review still within necessary time frame to meet compliance requirements. Bi-annual reports to Trust Board – Q1/2 due in January. This report will include an action plan for supernumerary status of Delivery Suite coordinator and 1:1 care in labour reported as not 100%.
6. Saving Babies Lives Care Bundle		Q2 review with LMNS fully compliant. All requirements of safety action have been met. SBL regional exemptions currently going through governance processes – see appendix 4.
7. Listening to women, parents and families		Awaiting updated ToR for Safety champions meetings. Current change in MNVP lead position (Mid November – January), interim will need to complete training before attending PMRT.
8. Multidisciplinary training		On track to be fully compliant with all standards by end of reporting period.
9. Board oversight on safety and quality		No anticipated concerns
10. MNSI and Early Notification Scheme reporting		Fully compliant – see appendix 5

Saving Babies Lives (SBL) Care Bundle v3.2

Oxford University Hospitals NHS Foundation Trust

Maternity services met with the Local Maternity and Neonatal System (LMNS) on the 26 November 2025 to review compliance for quarter 2 (Q2).

Summary of implementation progress

Summary of Data

- All areas have been fully implemented and verified as compliant by the Local Maternity and Neonatal System (LMNS).
- The Trust is fully compliant with Maternity (Perinatal) Incentive Scheme (MPIS) for Year 7.
- A steady improvement trajectory is evident for carbon monoxide (CO) measurement at both booking and 36 weeks, demonstrating ongoing commitment to maternal safety and risk reduction.

Strengths

- The Trust is achieving excellent results in key measures that support the best outcomes for mothers and babies in the perinatal optimisation metrics.
- For Element 6, both auditable components are performing above the national benchmark, demonstrating high-quality and consistent practice.

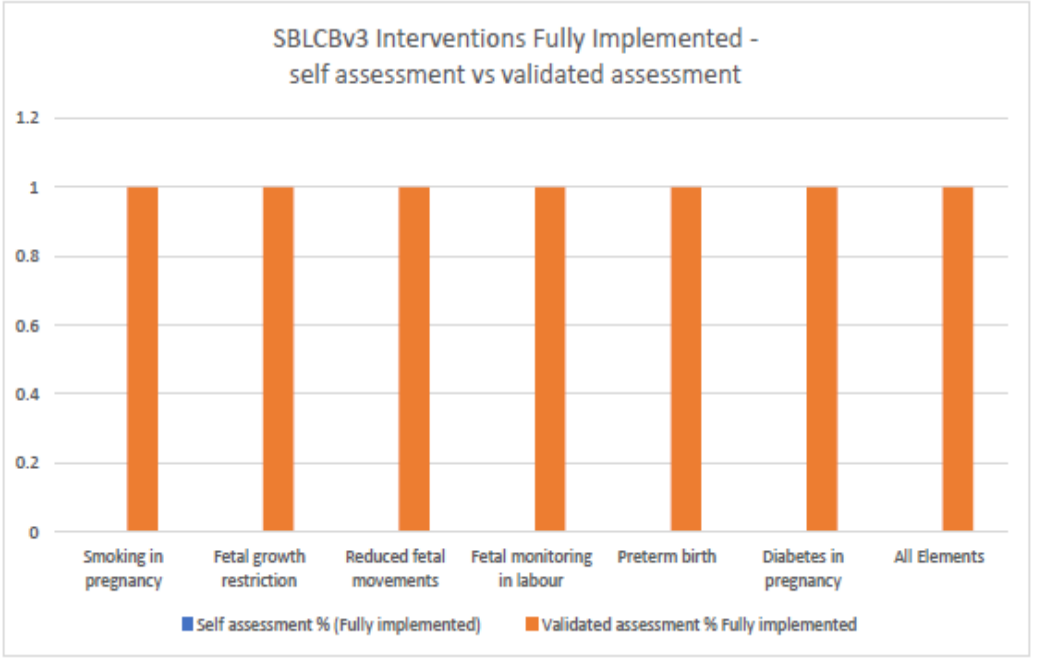
Focus

- An action plan is in place specifically focused on supporting pregnant smokers to set a quit date and remain smoke-free. This is then verified by carbon monoxide checks at 4 weeks and again at 36 weeks.
- Work continues to ensure that women reporting reduced fetal movements receive an ultrasound scan on the next working day, in line with best practice standards.
- The Maternity (Perinatal) Incentive Scheme lead maintains a SBL dashboard for the metrics. She meets quarterly with the key stakeholders for each element to review the results. She meets with the matrons to ensure they have oversight of the compliance for each area.

Future

- Better data recording: Improvements in how the data is captured for the first temperature of newborns when they are admitted, ensuring accurate monitoring and reporting.
- Supporting preterm babies: Work is ongoing to increase the proportion of babies born before 34 weeks who receive their mother's own milk within the first two days of life, promoting optimal nutrition and outcomes.
- SBL SE regional exemptions currently in governance processes prior to final regional submission.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy		0%	Fully implemented	100%
Element 2	Fetal growth restriction		0%	Fully implemented	100%
Element 3	Reduced fetal movements		0%	Fully implemented	100%
Element 4	Fetal monitoring in labour		0%	Fully implemented	100%
Element 5	Preterm birth		0%	Fully implemented	100%
Element 6	Diabetes		0%	Fully implemented	100%
All Elements	TOTAL		0%	Fully implemented	100%



Oxford University Hospitals
NHS Foundation Trust

Patient Experience

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

Oxford University Hospitals NHS Foundation Trust

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

Summary

Summary of Data

- In November 2025, the service collected feedback from service users through two platforms: The Friends and Family Test (FFT) and 'Say on the Day' devices. From FFT, the services received 298 responses, representing 49.9% of all births. Of these, 69.7% rated our services as 'good' or 'very good'. From the 'Say on the Day' devices, the service received 303 responses, covering 50.7% of all births. Of these, 87.5% gave a positive rating.
- 18 new complaints were received. Several were historical, one dating back to bereavement care received in 2000. The main themes centred on clinical treatment, delay of elective work, communication of risk as well as communication between maternity and neonatal colleagues.

Strengths

- In response to staff and service user feedback an appropriate self-medication pathway has been introduced for women during their postnatal stay. This enables timely access to essential pain relief and routine medications, assuring responsiveness and improving overall comfort and recovery.
- Positive responses are seen through both feedback platforms. Recognition of supportive staff and kindness and compassion is expressed throughout.
- Further devices have been ordered to give level 6 (Antenatal ward) service users access to an alternative feedback platform.
- Volunteers are a consistent feature on the postnatal ward, supporting service users with responsive access to care whilst releasing time to care for staff.

Focus

- The service has introduced an additional Transitional Care Unit task and finish group which will focus on working alongside the Neonatal unit to stabilise and optimise TCU pathways.
- Feedback has highlighted the need for clearer real time communication on waiting times across the maternity pathways. Work is ongoing with service users to understand their preferences and to codesign an approach that provides timely, accurate updates and reduces uncertainty during their care journeys. This work aims to strengthen transparency, improve patient experience and support smoother operational flow.
- Average length of stay data within the postnatal period is now accessible, this will enable further streamlining of pathways.

Future

- The service has initiated a Quality Improvement project focused on optimising service user flow through their pregnancy journeys. .
- Review, analysis and action the full results of the annual CQC Maternity Survey, co-creating solutions with the OMNVP. Actions will be prioritised based on identified themes and tracked through improvement plans, with quarterly updates to Maternity Clinical governance Committee.
- Continue to monitor and evaluate improvement actions to assure sustainability and improved patient experience through appropriate governance processes.

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

Oxford University Hospitals NHS Foundation Trust

Summary of Data

- A revised approach to the Friends and Family Test (FFT) was successfully launched in Neonates in May 2025, providing a structured mechanism for capturing patient experience. In November, no responses were received.
- While the response rate remains low, mitigation measures are in place including repurposing 'Say on the Day' devices to capture real-time feedback, which has yielded positive written comments. A more robust plan is being implemented from December involving the admin team to support service user engagement.
- Two joint Maternity and Neonatal complaints were received in November, both highlighting communication challenges between teams and families. These cases are under active investigation, with a clear commitment to sharing learning at safety huddles and embedding improvements into future practice. This approach ensures that feedback—both positive and constructive—is used to drive service development and enhance patient safety.

Strengths

- There is increased awareness among staff and families regarding the Friends and Family Test (FFT) and "Say on the Day" devices, supported by proactive engagement and improved accessibility.
- 20 responses were received from Say on the Day in November (representing 27% of admissions), with overall experience rated 9.8/10.
- Positive responses are seen through both feedback platforms. Recognition of supportive staff and kindness and compassion is expressed throughout.
- Comments consistently highlight exceptional care, kindness, and professionalism, with examples such as "*everyone is so attentive, kind and caring*" , "*lovely support*" and "*awesome staff*".

Focus

- While feedback received to date has consistently highlighted exceptional care and professionalism within the neonatal service, the current response rate for formal patient experience remains below expectations. To address this, a clear improvement plan has been implemented.
- Additional 'Say on the Day' devices have been deployed to increase accessibility and convenience for families, and staff have been briefed to actively encourage completion of FFT at key touchpoints, including admission, discharge, and during longer inpatient stays.
- Engagement will be further strengthened through targeted communication campaigns and digital options to ensure inclusivity and representation from diverse communities.
- Response rates and feedback themes will be monitored monthly through divisional governance.

Future

- The neonatal service is committed to increasing Friends and Family Test (FFT) and 'Say on the Day' response rates to ensure a more representative view of service user experience and to capture constructive suggestions for improvement. To achieve this, additional devices have been deployed in high-traffic areas to make feedback collection more accessible and convenient.
- Staff engagement remains central to this plan, with training and reminders embedded into daily huddles to encourage families to provide feedback at key touchpoints such as admission, discharge, and during longer inpatient stays.
- Progress will be monitored through monthly governance reviews, with a measurable target to increase neonatal feedback response rates by 50% over the next six months.
- Feedback themes will be triangulated with complaints and patient safety data to identify improvement opportunities, and written comments will be analysed to inform service development.

Maternity & Neonatal Safety Champions Walkaround

Oxford University Hospitals NHS Foundation Trust

Date: 25 November 2025

Visited Areas: Observation Area (OA) and Neonatal Unit (NNU)

Summary of Findings: Parents and staff expressed appreciation for care and collaboration during the walk round undertaken by the Director of Midwifery (DoM). Constructive feedback focused on continuity and documentation in NNU, and bed management in OA. Positive engagement and adaptability was noted across teams. Thank you to all staff for your continued commitment to safe, compassionate care.

Neonatal Unit Visit

- Spoke with two parents who had been in the unit for two weeks following the pre-term birth of their twins. Sadly, one twin passed away soon after birth, but the second twin is doing very well.
- Parents described their experience as a "roller coaster of emotions" but felt very well cared for by both maternity and neonatal teams. They appreciated being kept informed about their baby's progress.
- **Feedback provided:**
    1. **Continuity of care:** Suggested ensuring consistent nursing staff for their baby to maintain familiarity with care needs and progress.
    2. **Feeding chart completion:** Noted variability in how consistently charts were completed by different staff.
- Parents emphasised these were constructive suggestions and expressed gratitude for the care received.

Staff Feedback – Neonatal Unit

- A member of the nursing team reported feeling well supported and valued the cross-working across intensive care areas, which benefits skill development.

Observation Area (OA) Visit

- Spoke with staff following the recent changes:
    - **Recovery nurses:** Felt welcomed by maternity staff and reported initial anxiety had eased.
    - **Midwives:** Viewed changes as mainly positive, understood the rationale, and clearly articulated OA's criteria and function.
    - Staff appreciated being able to contribute to improvements after the initial implementation.

- **Challenges raised:** Occasional bed blockages due to antenatal women being cared for on OA. Staff queried whether care could be provided on Level 6 antenatal ward. Shared that obstetric colleagues are reviewing this, and changes are anticipated.

Oxford University Hospitals
NHS Foundation Trust

Quality Improvement

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

Oxford University Hospitals NHS Foundation Trust

TRIAGE QUALITY IMPROVEMENT: SUMMARY

The triage quality improvement initiative was established in response to identified issues in the provision of timely access to triage. By implementing the Birmingham Symptom-specific Obstetric Triage System (BSOTS), the aim is to deliver safer, more timely, and effective risk assessments for women and birthing people, ensuring a standardised approach that aligns with CQC expectations and supports high-quality, consistent care across the maternity service.

Focus

- Reconfiguration of 2 x clinical rooms in MAU entrance by end Q4 2025/26 (Dependant on university relocation)
- Develop display of 'mean' wait times in response to service user feedback by end Q4 2025/26
- Two new medical posts (total of 3.00) on TRAC going through approval process – require exemption from recruitment freeze by end December 2025
- Mobilise Ipads for documentation (focus on initial triage data capture) by end December 2025
- Consider QI project focused on senior decision maker being present at all times (aligned to ED QI project)

Future

- BOB LMNS Mamas Triage line externally sited (ICB led)
- Education triage competency package review including E-learning package for telephone triage competencies by end Q4 2025/26
- Ongoing call analysis from monitored and recorded calls
- Explore the feasibility of air conditioning in clinical rooms – action progressing with estates.

- **Progress monitored and reported through MCGC**

IOL QUALITY IMPROVEMENT: SUMMARY

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

Focus

- Continued dynamic daily risk assessment to inform operational staffing decision making in response to potential delays
- Map outcomes to those undergoing IOL and add to reporting by end Q4 2025/26
- Report quantitative improvement trajectory aligned to recent interventions and actions
- MDT consultation on updated risk assessment document to support decision making – launched January 2026
- Continued dynamic daily risk assessment to inform prioritisation and planning
- Review of scheduling – spot check audits to be undertaken from January 2026
- Improved communication throughout IOL patient pathway – proactive and responsive from MDT evidenced by service user feedback.

Future

- Consider alternative induction methods, including outpatient options by end of Q1 2026/27
- Review of service user education throughout the pathway by end of Q1 2026/27
- Provision of education and training for healthcare providers involved in the induction of labour – developed following review during Q2 2026/27
- Consider midwifery led post-dates clinic with proposal by end of Q1 2026/27

- **Progress monitored and reported through MCGC**

Progress on the Horton CQC and the Antenatal and Newborn Screening Assurance Action Plan

Oxford University Hospitals NHS Foundation Trust

SUMMARY

Horton CQC Action Plan

- There are no overdue 'Must Do' or 'Should Do' actions. Work continues to embed practice and sustain improvements from the changes that were previously made. Assurance is reviewed as part of the Evidence Review Group.
- The Maternity Services, in collaboration with the Trust Assurance Team and Corporate Nursing, have continued to meet monthly as part of the Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan. The next meeting will be on the 29 December 2025.

Antenatal and Newborn Screening(ANNB) Action Plan

- Work continues to embed practice and sustain the improvements from the changes made following the ANNB Assurance visit in April 2024. There are no overdue actions. Additional information from the October ANNB has been added to the open actions and these will be reviewed at the next Evidence Review Group meeting.
- The Maternity Services, in collaboration with the Trust Assurance Team and Corporate Nursing, have continued to meet monthly as part of the Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan. The next meeting will be on the 29 December 2025.

Health Inequalities - EDI: Collecting & Using Local Data to Address Inequalities

Oxford University Hospitals NHS Foundation Trust

The service is dedicated to actively reducing health inequalities by prioritising Equity, Diversity, and Inclusion (EDI) across all facets of maternity care. By systematically collecting and analysing local data, the service identifies where disparities exist—whether in access, outcomes, or experiences—and ensures that any disproportionalities are specifically targeted through tailored interventions. This EDI-focused approach strives to guarantee that every individual, regardless of background, ethnicity, or circumstance, receives equitable, high-quality care. Leveraging insights from local data enables the service to implement practical solutions, monitor progress, and continuously refine strategies to make maternity care more inclusive and responsive to the diverse needs of communities.

Summary of data 2025/26 year to date:

- Of those accessing maternity services: ethnicity mainly British (62%), lowest Black Caribbean (0.33%).
  - Sociodemographic: 49% mental health needs, 11% recent migrants, 9% learning difficulties, 6% language barriers.
  - Most common translated maternity languages: Tetum, Bengali, Romanian, Arabic, Turkish.
- Booking and Screening Access Inequalities:
  - Late booking highest among Black & Chinese women (13%);
  - Late booking lowest in Mixed race (5%) and White women (6%).

- Enablers to timely booking appointments:
  - Clear information, flexible appointments
  - Barriers: access issues, limited awareness.
- Ongoing improvements:
  - Accessible screening information Standard Operating Procedure under development.
  - Co-produced ‘BOOKBY10’ posters distributed across community locations.
  - Databank partnership: over 40 pre-loaded SIMs issued
  - Screening information now included in translated Antenatal Classes – with up to 5 translators attending each session.

- Next Steps:
  - Ongoing review of patient safety data by ethnicity and deprivation using mother’s postcode to ensure any disproportionalities are effectively addressed.

Oxford University Hospitals
NHS Foundation Trust

National Updates

Perinatal Quality Oversight Model (PQOM)

The Perinatal Quality Oversight Model (PQOM) is a revised and updated version of the previous Perinatal Quality Surveillance Model (PQSM). The core difference is the shift in emphasis from a basic surveillance approach to a more proactive and integrated system of quality oversight aimed at identifying and addressing potential issues earlier, before they become serious problems.

Key Changes: PQSM → PQOM

From Surveillance to Oversight

- PQSM focused mainly on data monitoring and early warning of risks. PQOM expands this to include active assurance, escalation, and intervention when concerns arise.

Stronger Governance

- PQOM formalises clearer accountability at Trust, regional, and national levels. Oversight bodies now have explicit roles to challenge and support Trust Boards.

Broader Scope

- PQSM was centred on data flows and safety signals.
- PQOM incorporates workforce capacity, service user feedback, and learning from audits/reviews as part of the model.

Escalation Pathways

- PQSM flagged concerns but left action less defined.
- PQOM sets defined escalation routes, ensuring rapid response and system level action.

Trust Expectations

- Under PQSM, the emphasis was on reporting data.
- Under PQOM, Trusts are expected to demonstrate improvement, embed service user voice, and take proactive responsibility for safety culture.

Next Steps:

- Review opportunities to sort key data by ethnicity and deprivation
- Meeting planned with BOB/Frimley Joint engagement LMNS/PQOM Future Model planned for 15 January 2025.
- Need to ensure focus on improvement against key indicators including audit and learning

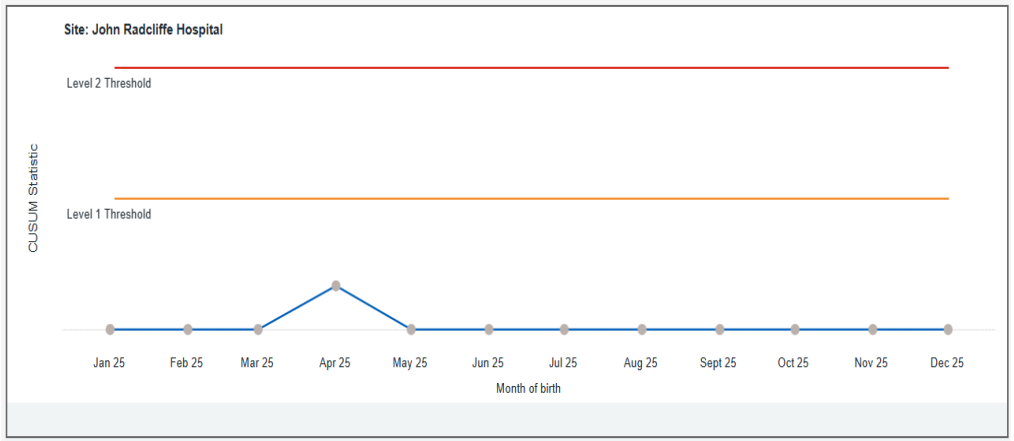
Feature	Perinatal Quality Surveillance Model (PQSM)	Perinatal Quality Oversight Model (PQOM)
Status	The previous model, published in December 2020	September 2025 (updated and republished)
Primary Focus	Focused on monitoring and surveillance of quality metrics	Focuses on proactive and methodical oversight to identify trusts requiring support before serious issues arise.
Approach	Emphasised a "ward-to-board" approach with clear lines for responsibility and accountability.	Integrates more closely with the broader NHS Oversight Framework and National Quality Board (NQB) guidance on risk response and escalation. It encourages an "appreciative inquiry" (strengths-based) approach to improvement where possible.
Implementation	Trusts were expected to implement actions with immediate effect following its 2020 publication.	Provides a structured approach with clear lines of responsibility for addressing and escalating risks at trust, Integrated Care Board (ICB), regional, and national levels.
Data Usage	Required a minimum data set for board reporting.	Utilises a wider range of quantitative and qualitative data sources for more robust understanding and action, including the Maternity and Neonatal Three Year Delivery Plan Oversight Tool and MBRRACE-UK data
Goal	To have robust oversight and ensure accountability.	To ensure consistent, methodical oversight of NHS services and collect the necessary information and insight to drive service improvement and reduce health inequalities

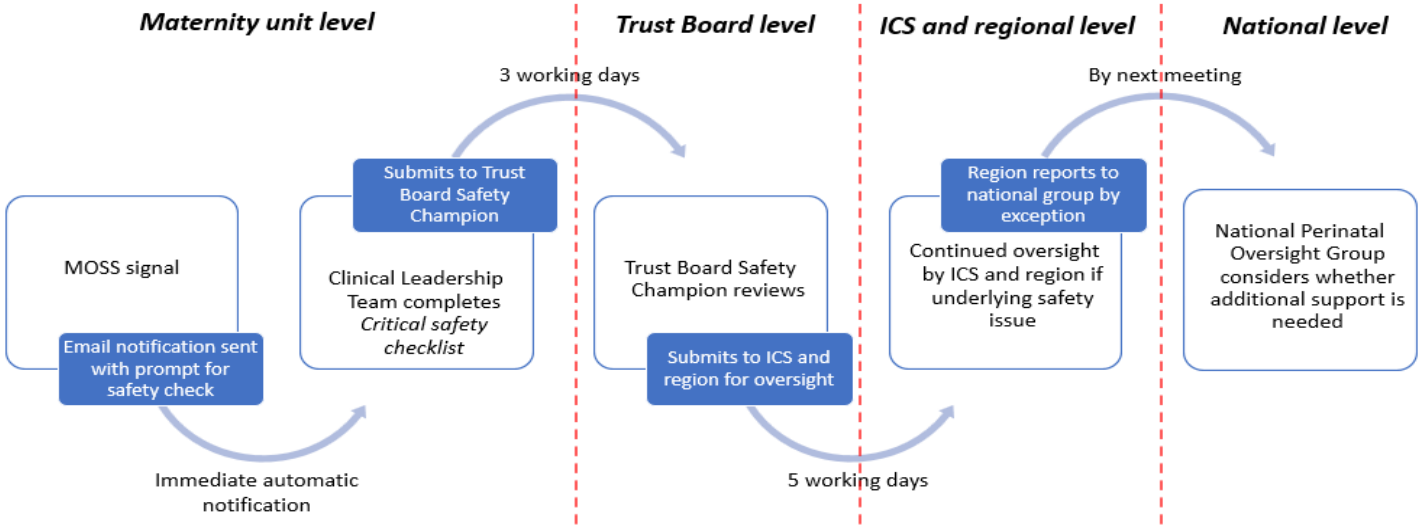
Maternity Outcomes Signal System (MOSS)

Oxford University Hospitals NHS Foundation Trust

The Maternity and Neonatal programme (NHS England) commissioned the development of a Maternity Outcomes Signal System (MOSS) in response to the recommendation made in the Reading the Signals report. This went live on the 28 November 2025. MOSS uses near real-time monitoring, generating signals with trend changes:

- Signals identify potential declines in safe care during labour
- Signals prompt safety checks of care in labour enabling actions to reduce harm
- Responses to signals will be managed through the national PQOM pathway
- MOSS does not replace existing investigation processes
- MOSS is a prompt to check and not an indicator of outlier status.
- When a unit triggers a MOSS signal, an automated email is sent immediately, outlining the signal, the site, and next steps for the perinatal leadership team. The service then has eight working days to complete the Critical Safety Check, and the outcome must be reported via PQOM.
- **There has been no alerts for OUH.**





<u>Roles and responsibilities of organisations with MOSS</u>

Detailed guidance will be available via a SOP

At maternity site level: The perinatal leadership team is responsible for routinely monitoring MOSS and leading completion of critical safety checks, with support from staff working on the labour ward.

At Trust level: Perinatal trust board safety champions are responsible for checking and challenging completed checks.

At ICB level: The ICB is responsible for oversight of safety issues identified, providing support or escalating to region in line with the Perinatal Quality Surveillance Model. There is no action for ICBs to take if a check does not identify an underlying safety issue.

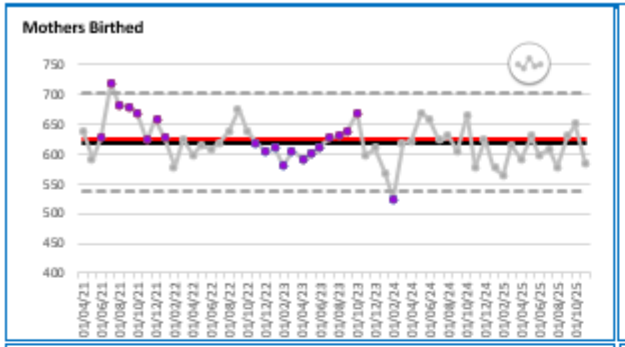
At regional level: Regions can provide further oversight and support or escalate nationally in line with the Perinatal Quality Surveillance Model

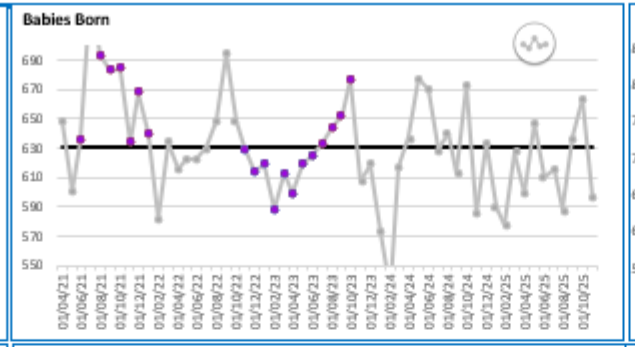
At national level: Safety issues in units are discussed every 6 weeks in national meetings to coordinate further support.

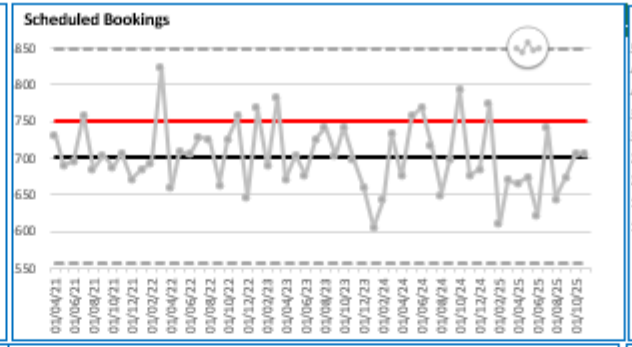
Oxford University Hospitals
NHS Foundation Trust

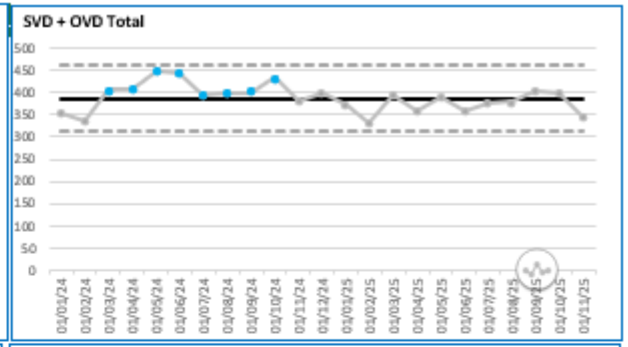
Appendices

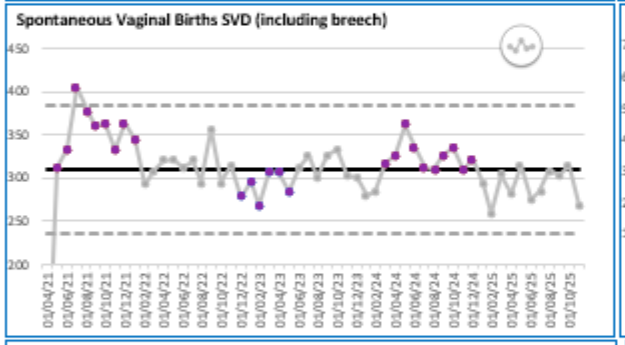
Appendix 1: SPC Charts

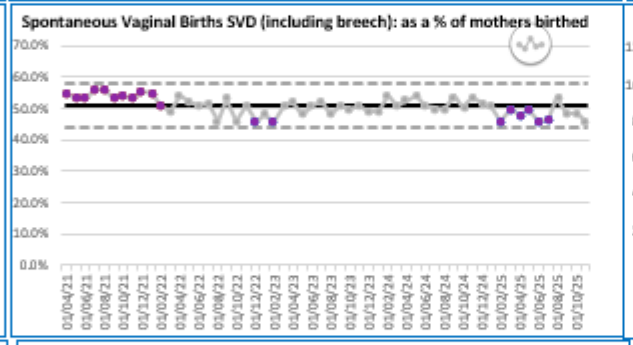


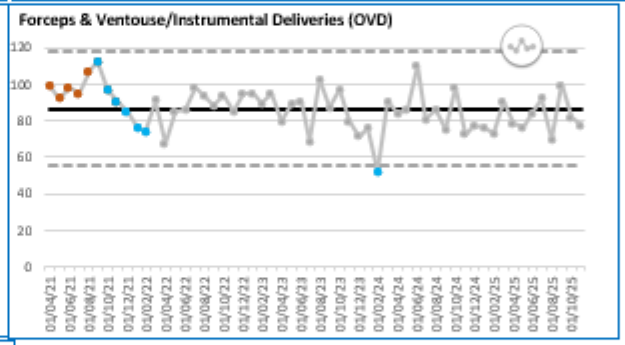


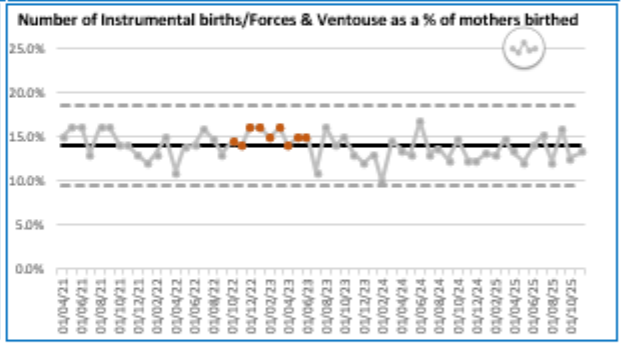


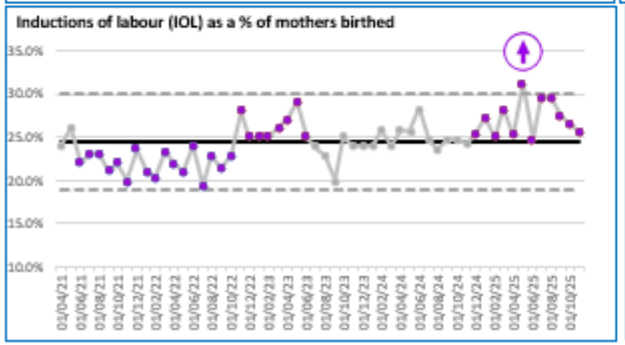


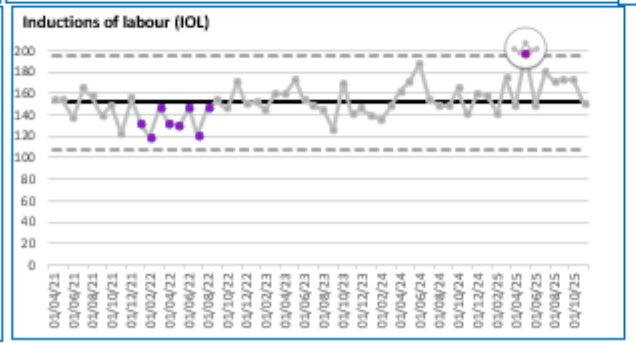




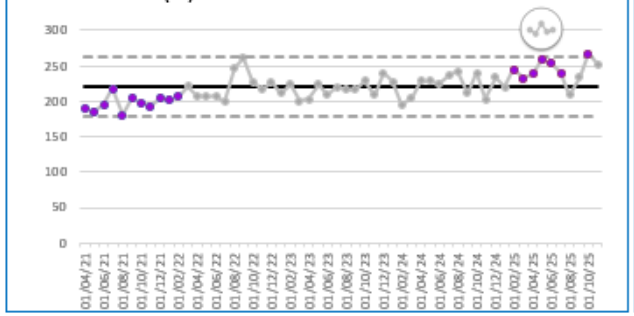




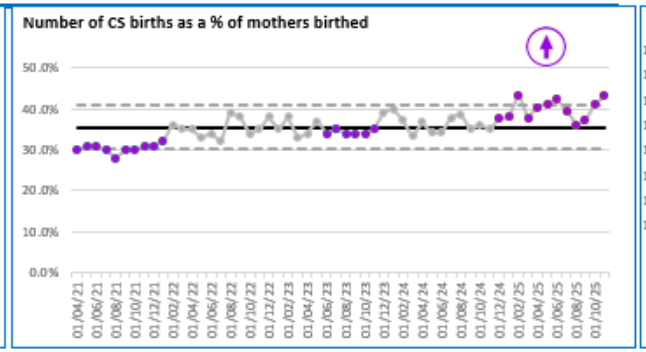




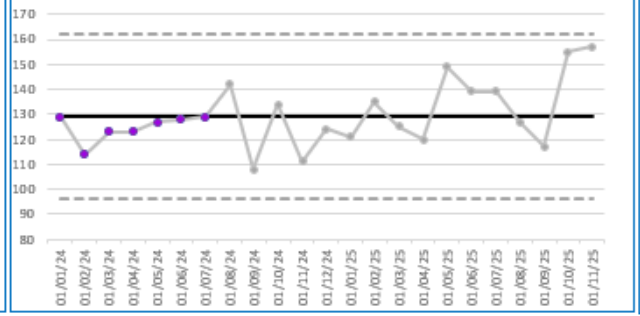
Caesarean Section (CS)



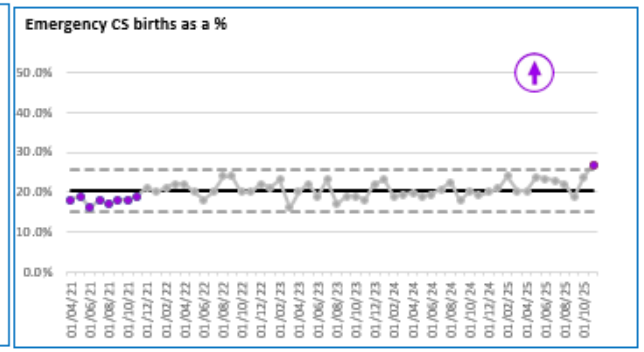
Number of CS births as a % of mothers birthed



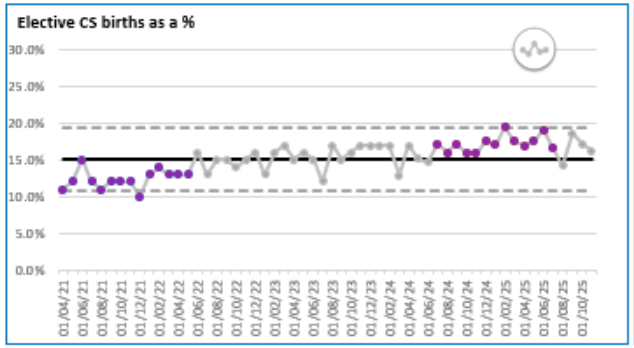
Number of Emergency CS



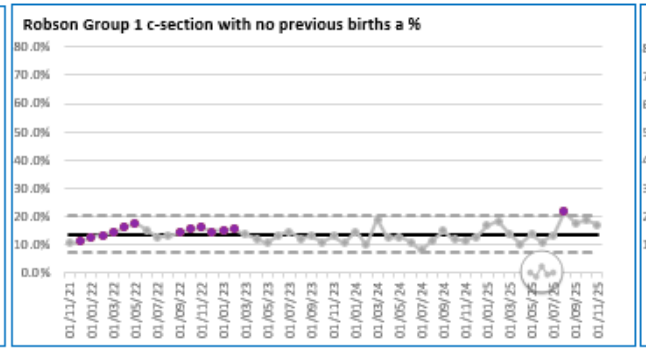
Emergency CS births as a %



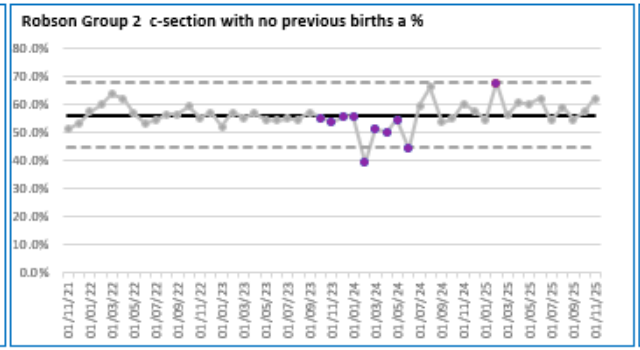
Elective CS births as a %



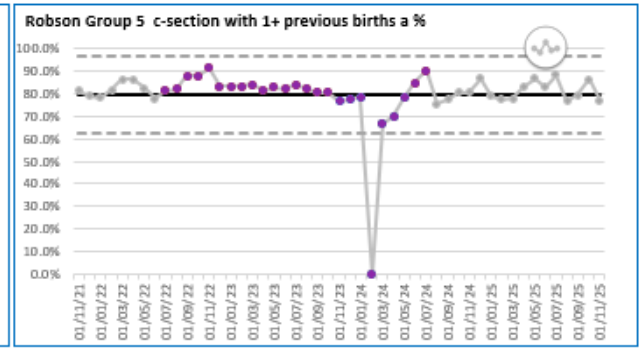
Robson Group 1 c-section with no previous births a %



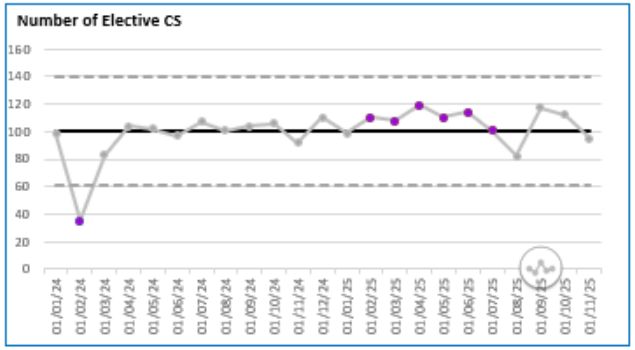
Robson Group 2 c-section with no previous births a %



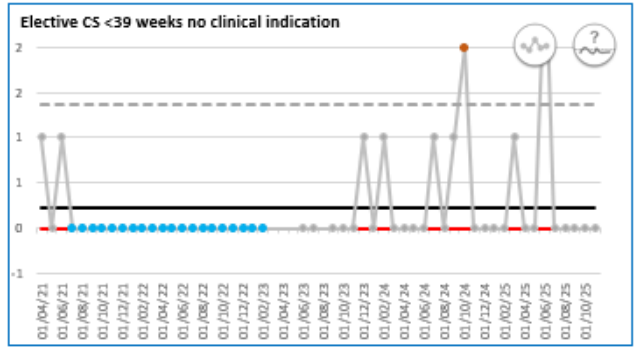
Robson Group 5 c-section with 1+ previous births a %



Number of Elective CS

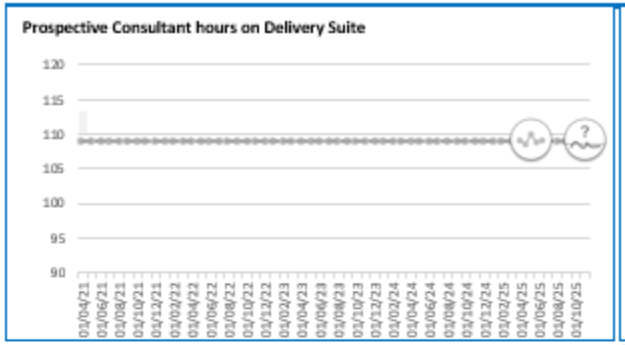


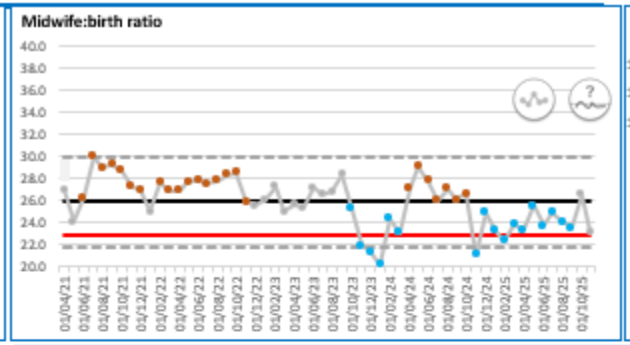
Elective CS <39 weeks no clinical indication

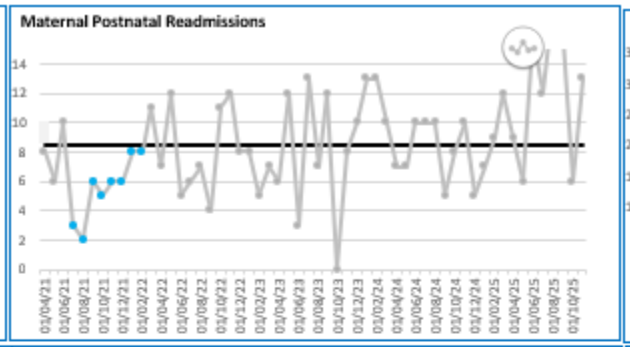


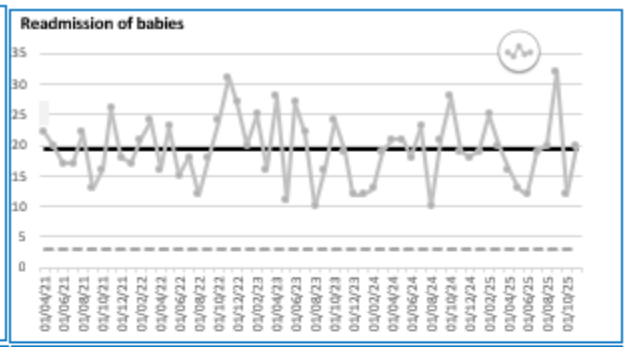
Appendix 1: SPC Charts

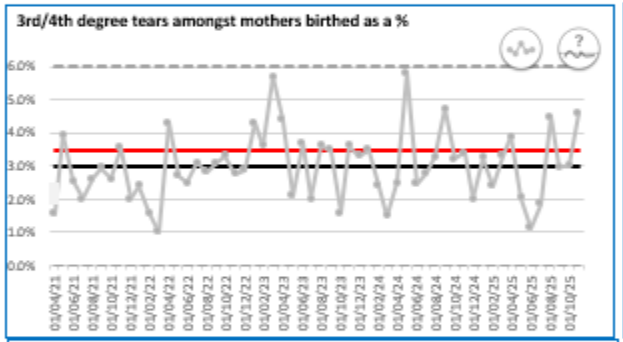
Oxford University Hospitals
NHS Foundation Trust

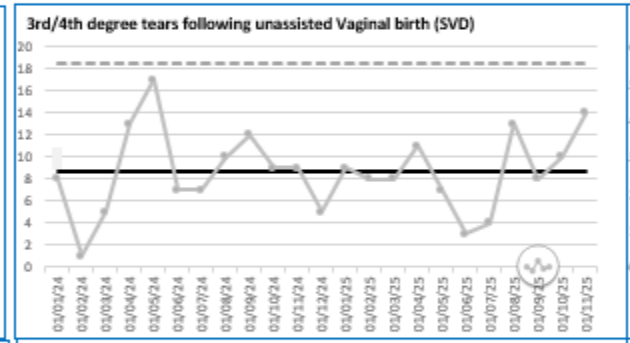


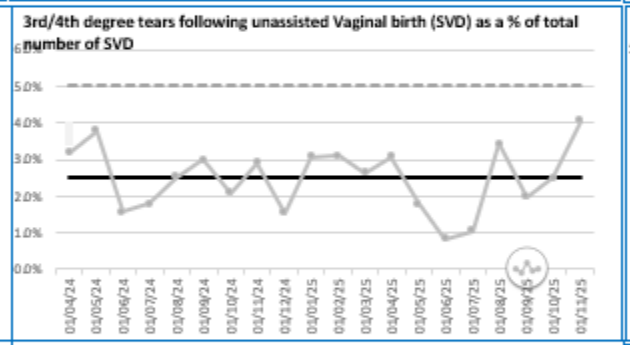


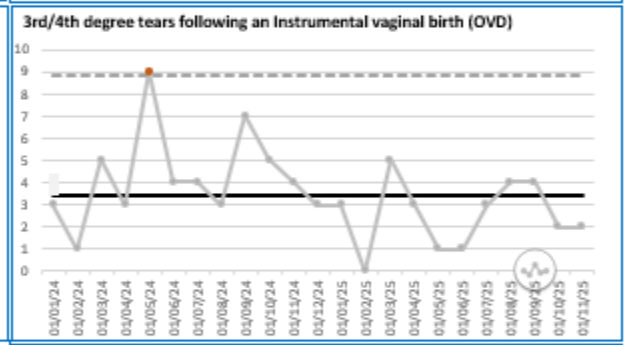


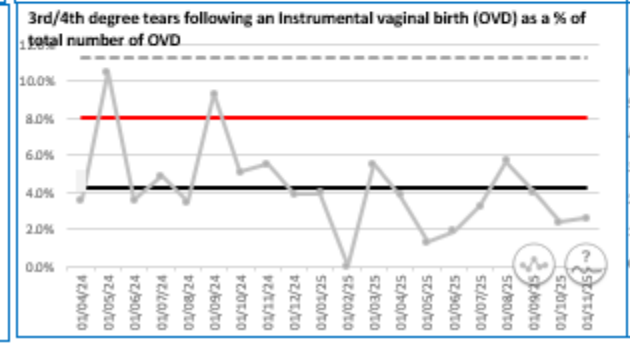


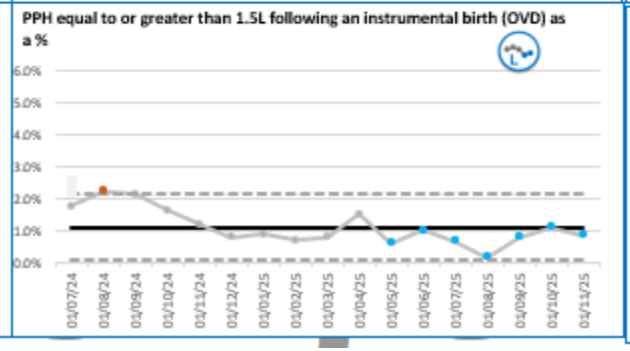


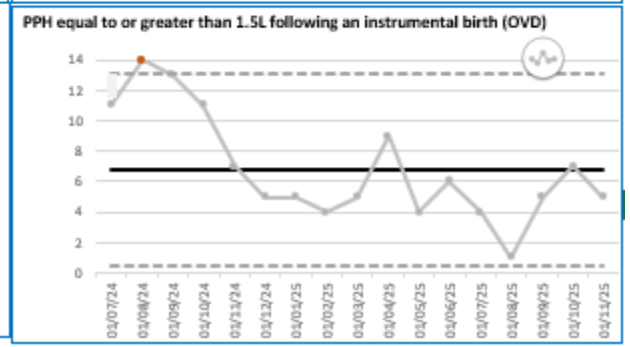






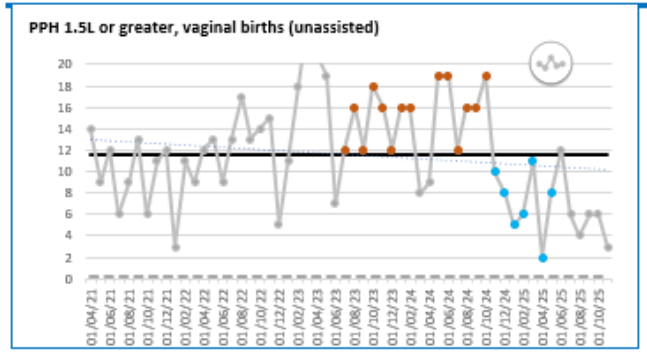


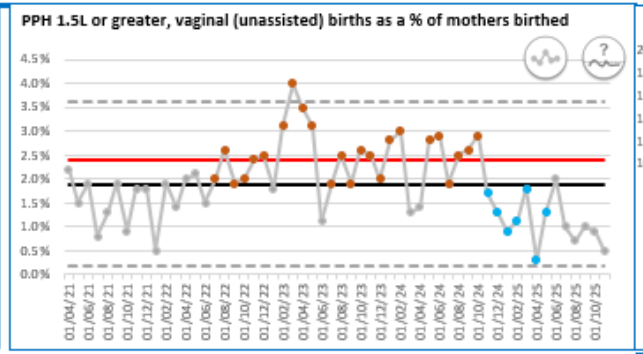


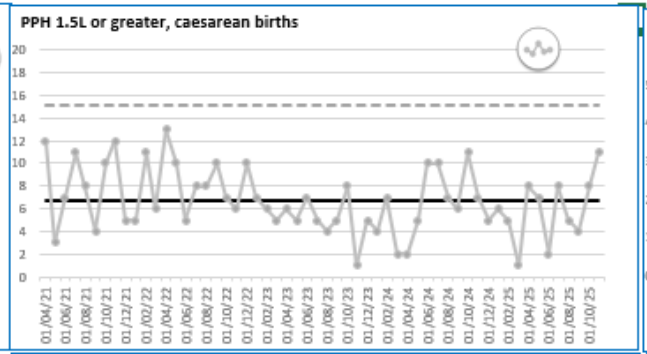


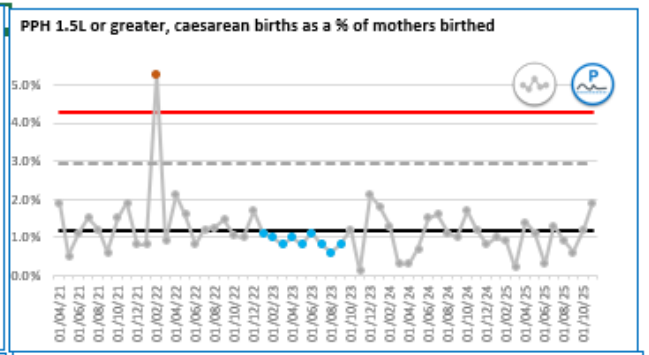
Appendix 1: SPC Charts

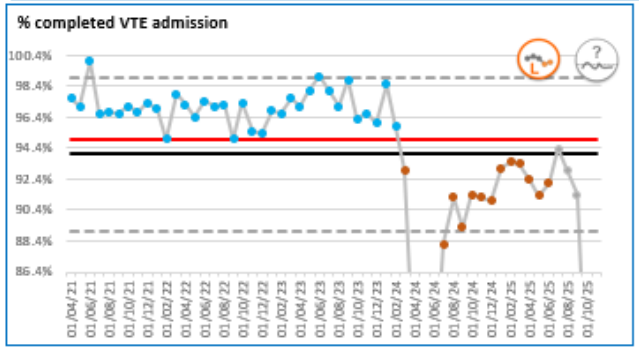
Oxford University Hospitals
NHS Foundation Trust

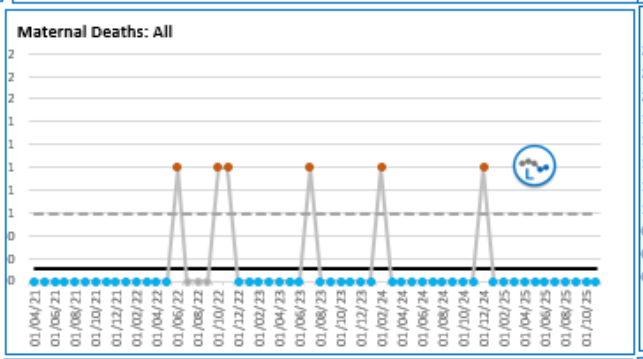


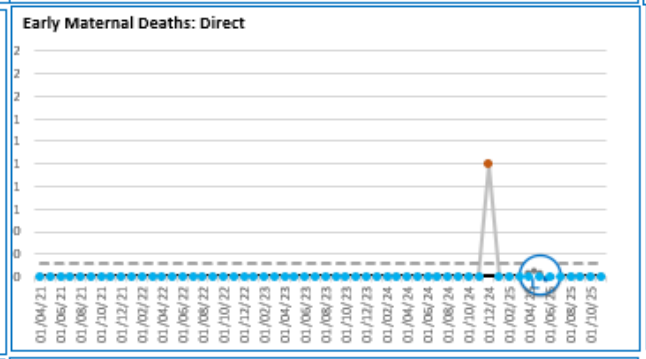


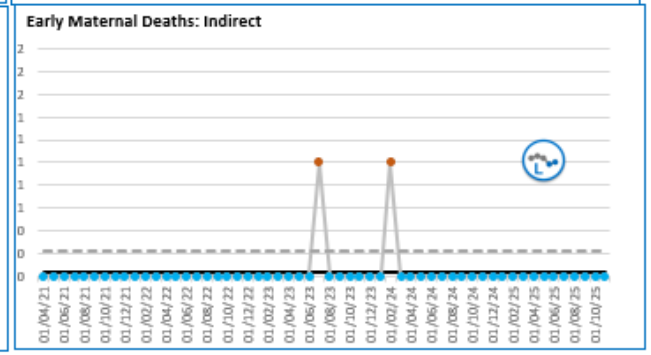


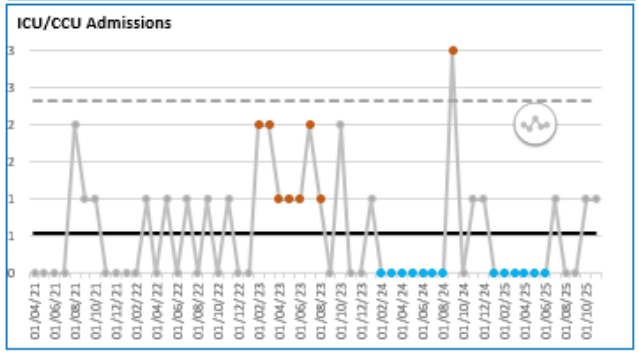


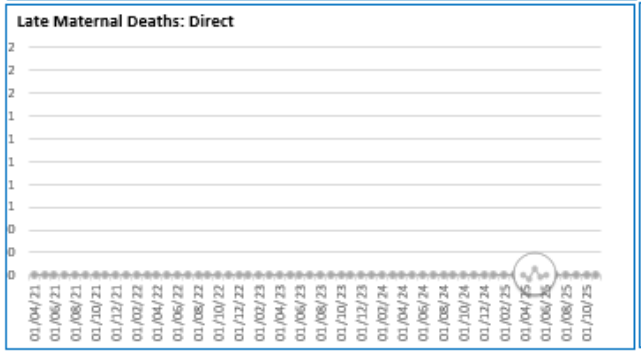


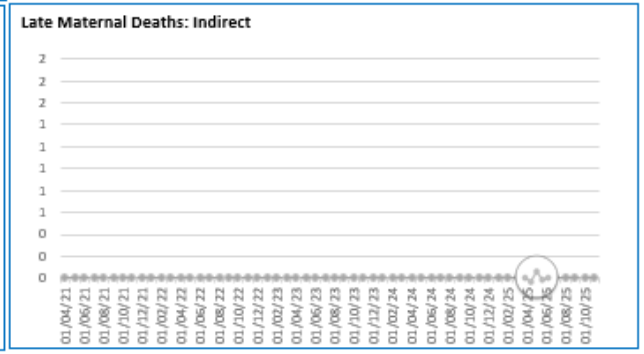




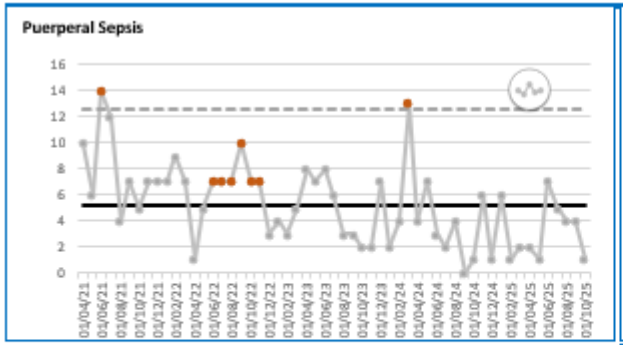


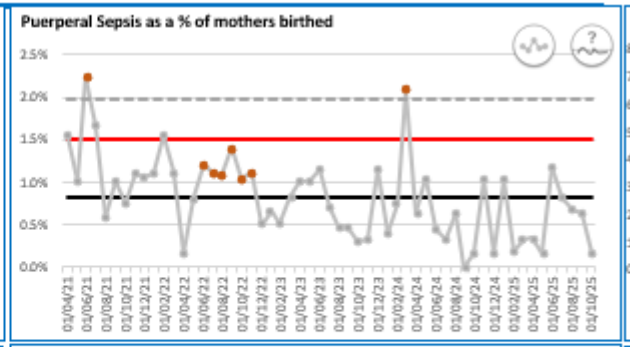


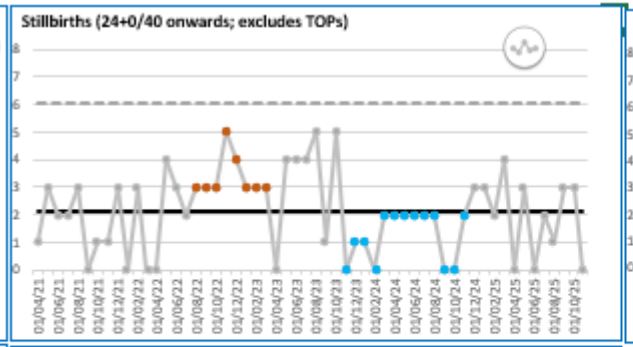


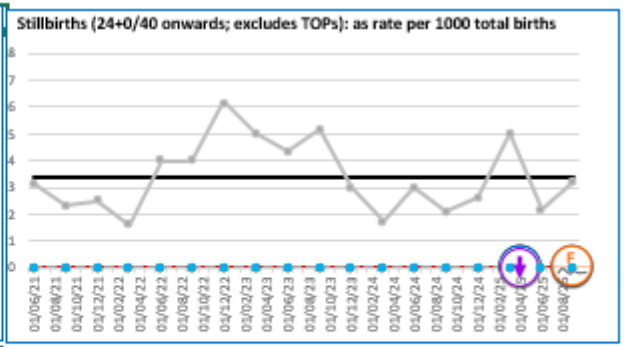


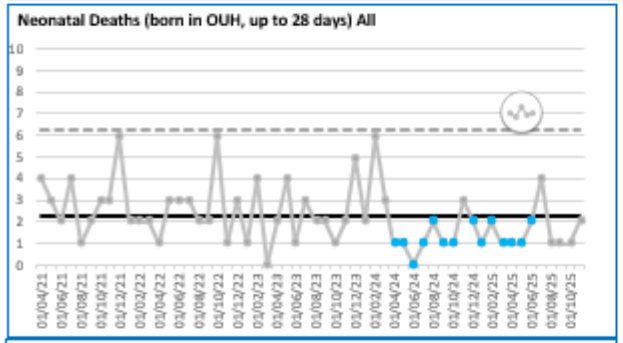
Appendix 1: SPC Charts

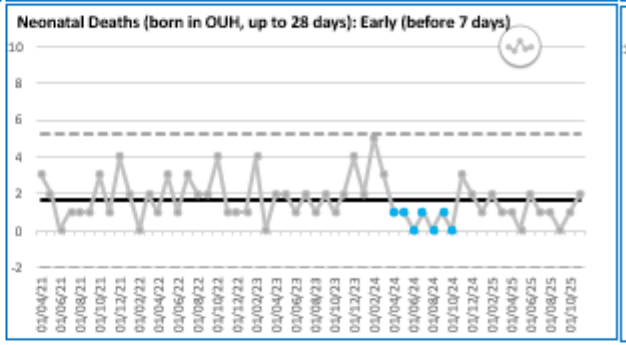


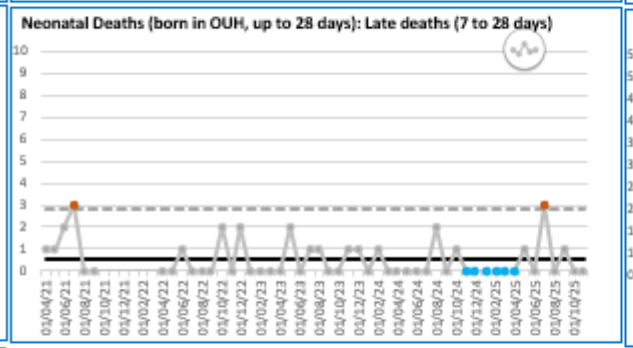


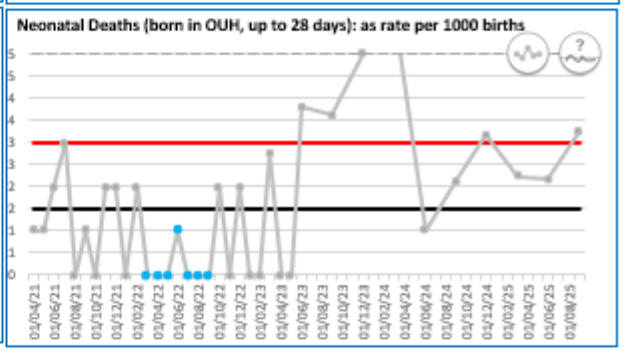


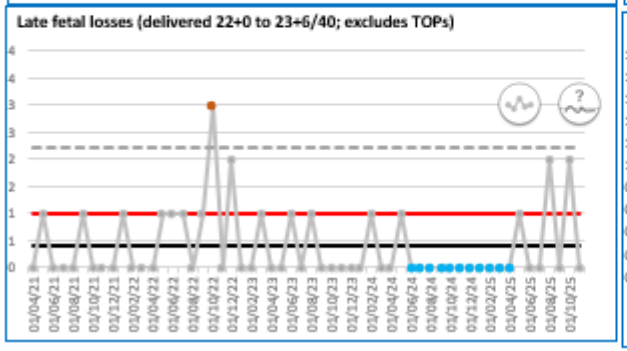


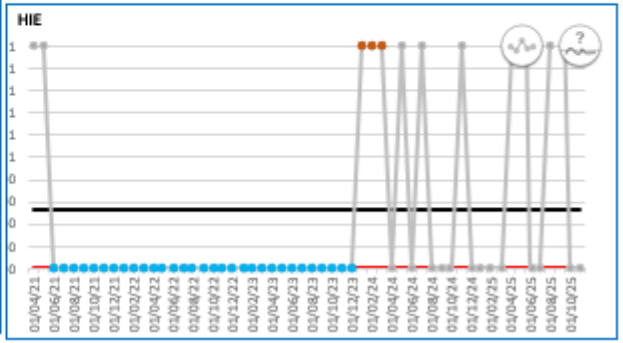






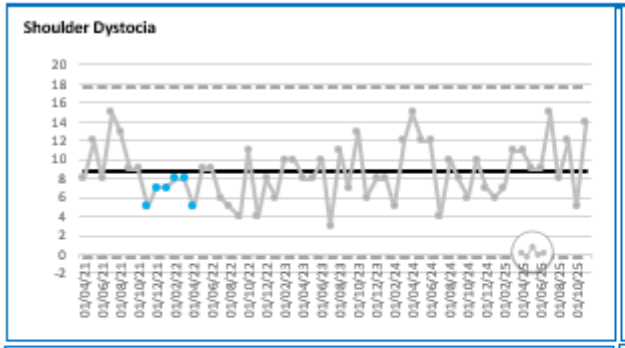


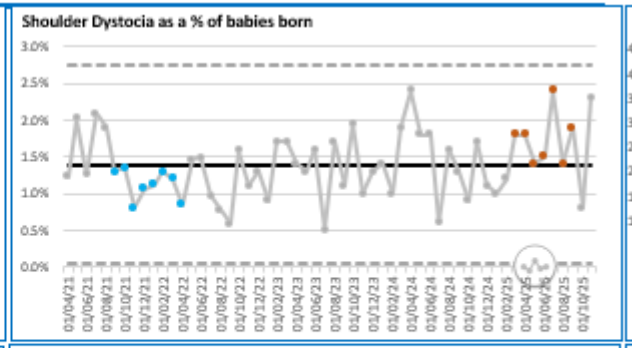


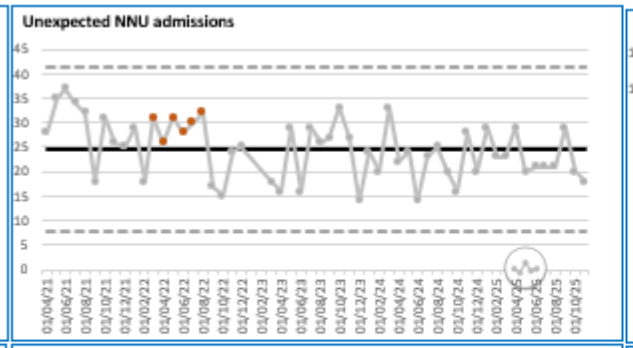


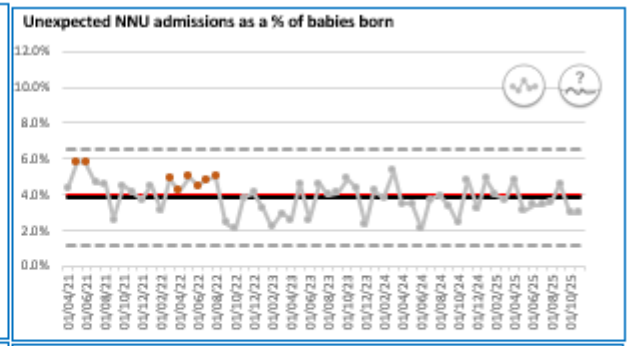
Appendix 1: SPC Charts

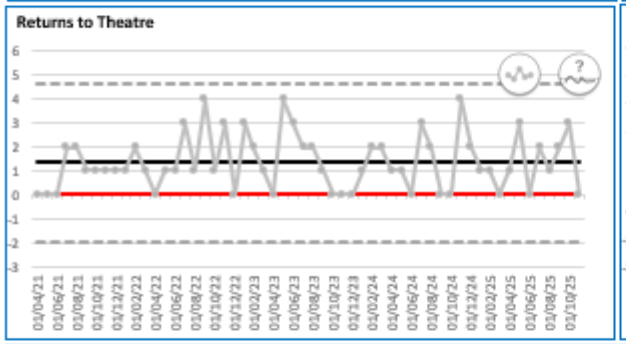
Oxford University Hospitals
NHS Foundation Trust

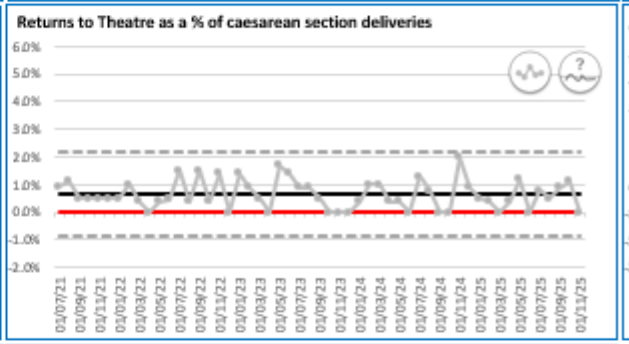


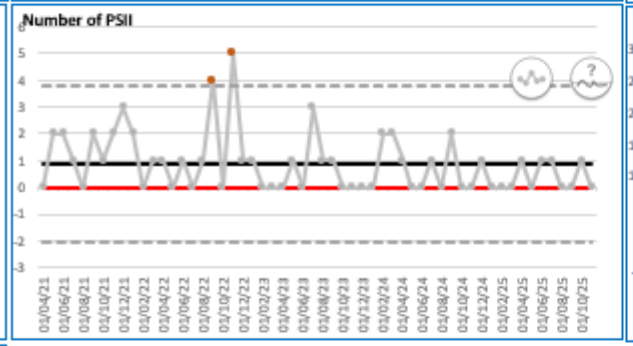


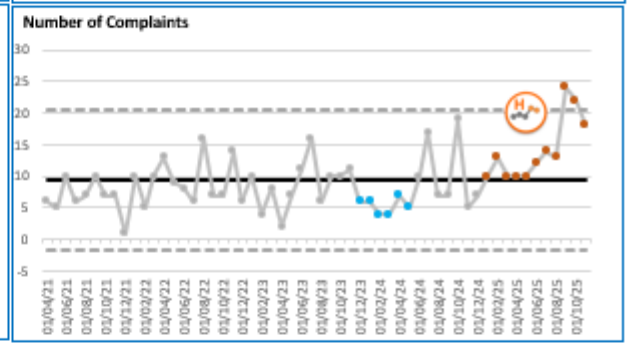


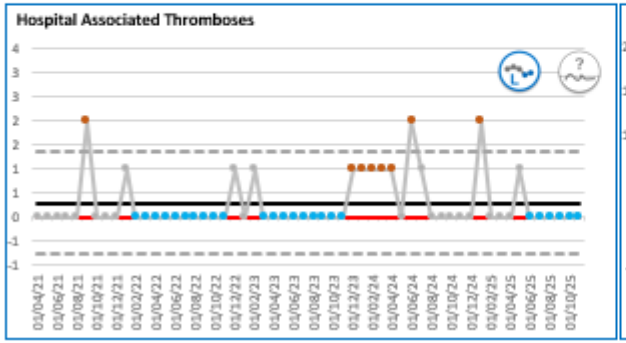


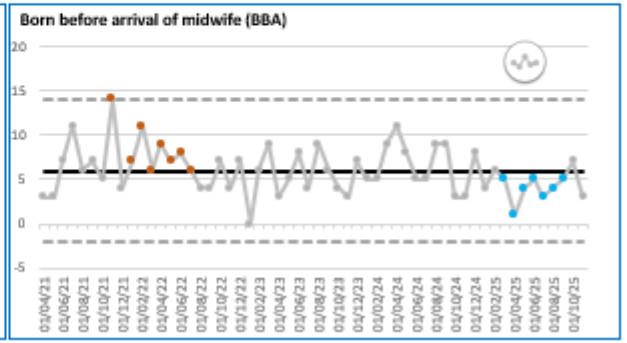




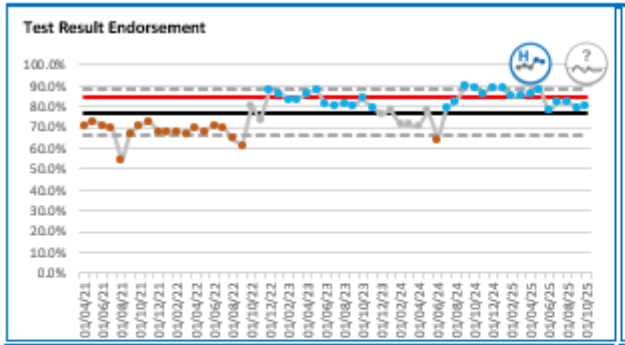


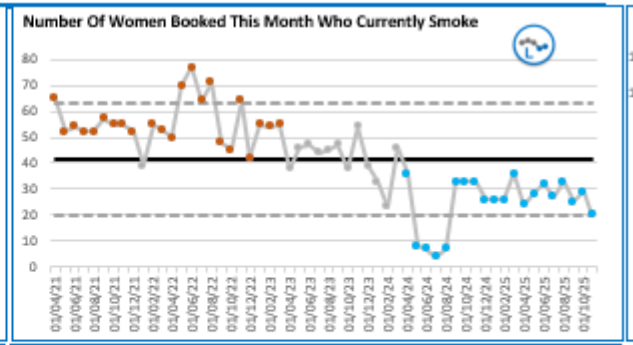


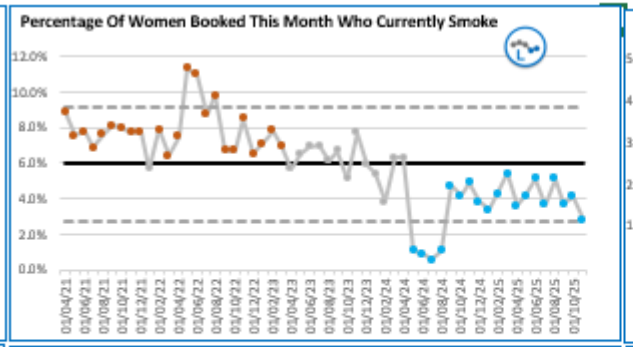


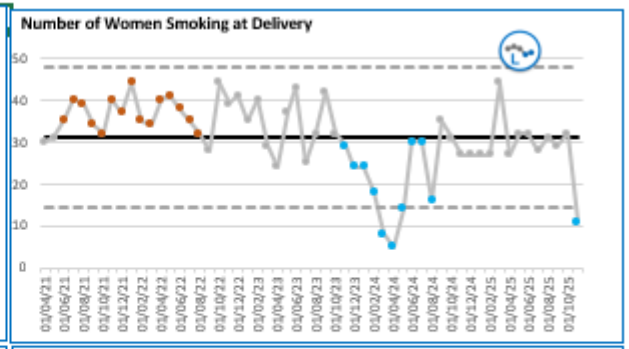


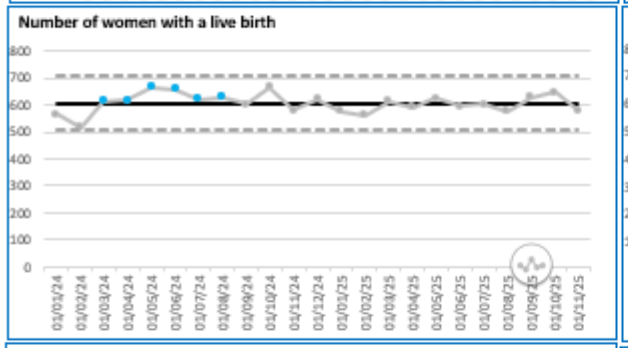
Appendix 1: SPC Charts

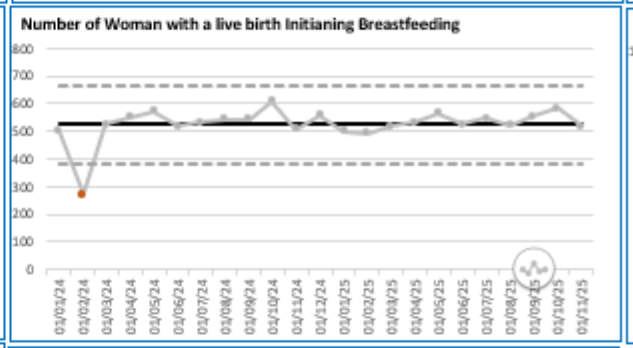


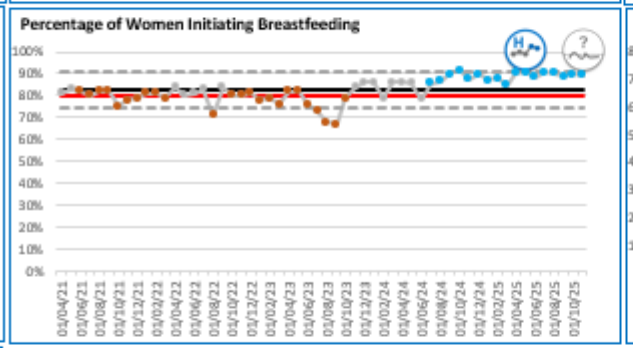


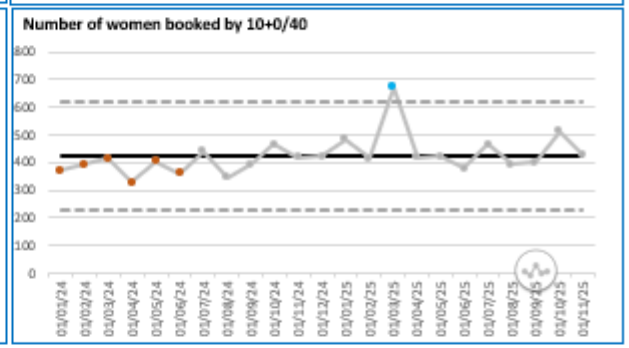


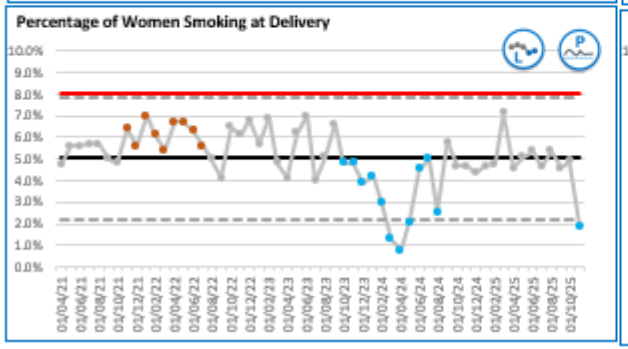


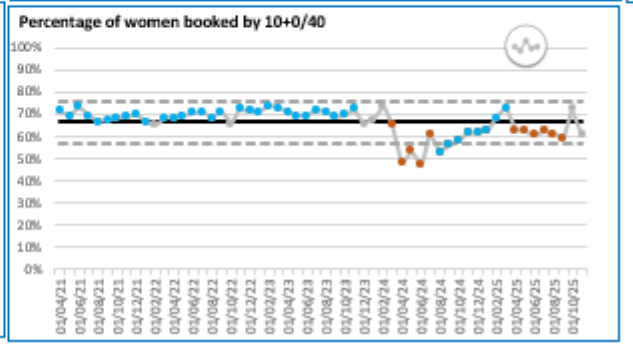












Appendix 2: Categories used for grading of care for perinatal mortality reviews (PMR)

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

Appendix 3: Acronyms

Oxford University Hospitals NHS Foundation Trust

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

Appendix 4: Maternity (Perinatal) Incentive Scheme (MPIS) - Safety Action 6 Exemptions

Oxford University Hospitals NHS Foundation Trust

The Saving Babies Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. Version 3.2 was published on 24 April 2025.

It is expected that maternity and neonatal service provider Trusts and LMNSs/ICBs will align with national guidance by implementing and embedding all elements of SBLCB as per the released document to achieve full compliance. This is monitored through Safety Action 6 of MPIS. There may, however, be instances when providers choose to modify local care pathways described in the SBLCB: “Where there is unresolved clinical debate about a pathway, providers may wish to agree a variation to an element of the SBLCB with their ICB."

Whilst provider Trusts remain responsible and accountable for these decisions, this notification and review process has been developed to ensure appropriate regional oversight and will support governance in assurance of the provision of safe, personalised and equitable care for women and families using maternity and neonatal services in the South-East. There were no new exemptions requested for OUH in year 7 of the MPIS. (A copy of the SE regional exemptions documents are in the reading room).

OUH Exemptions are as follows:

Element 2 SBLv3.2 fetal growth: risk assessment, surveillance and management
2.1 Universal screening for women requiring aspirin is performed at dating scan rather than booking appointment
2.7 Uterine artery dopplers on all pregnant women is universally performed
2.12 Symphysis fundal height (SFH) is not ceased for women undergoing serial scans unless they have a scan in the previous 14 days or a body mass index (BMI) over or equal to 35 at booking
2.13/2.15 High risk scan pathway variations

Appendix 5: Maternity (Perinatal) Incentive Scheme - Safety Action 10 Evidence

Oxford University Hospitals NHS Foundation Trust

The requirements of Safety Action 10 are: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025.

Key assurance Points

- 8 qualifying cases reported to MNSI via the national portal.
- 7 families accepted MNSI investigations; 1 family declined a MNSI investigation.
- Duty of Candour complied with for all cases, including provision of MNSI/EN information.
- The family received the MNSI Family Information booklet either in person or with the Duty of Candour letter.
- Accessible information provided to 1 family as required.

EN reporting:

- Up to 20 Oct 2025: All eligible cases reported via the Claims Reporting Wizard.
- Post-20 Oct 2025: Submit a Perinatal Event (SPEN) portal launched; no cases requiring EN referral to date.

Overall Assurance

- All qualifying cases were reported in line with national standards.
- Families were informed appropriately and sensitively.
- Duty of Candour requirements were fully met.

Date	MNSI Eligibility	Incident ID	MNSI Number	Duty of Candour date	EN notified	EN eligible
01/12/2024	Intrapartum Intrauterine death (IUD)	392445	MI- 039123	12/02/2025	N/A	N/A
27/02/2025	Intrapartum IUD	403892	MI-040229	04/03/2025	N/A	N//A
02/03/2025	Cooling	404287	MI-040233	04/03/2025	Yes	Yes
21/04/2025	Cooling and neonatal death (NND)	410912	MI-041518	23/04/2025	N/A	N/A
01/05/2025	Cooling	412321	MI-041786	02/05/2025	Yes	Yes
02/05/2025	Cooling	412559	MI-041927	06/05/2025	Yes	Yes
24/08/2025	Cooling - declined	428241	MI-045805	04/09/2025	Yes	No
05/09/2025	Cooling-declined	429707	MI-045805	11/09/2025	Yes	Yes
13/09/2025	Cooling	430775	MI-046794	22/09/2025	Yes	No