Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 30 September 2026

TB2026.76

Title:	**Maternity (Perinatal) Incentive Scheme (MIS) Year 8 Safety Action C and PMRT Quarterly Report Quarter 1 2026/27**

Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee 17/08/2026** **Perinatal Assurance Group 22/09/2026**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. Quarter 1 Overview
    - A total of 10 perinatal deaths were reported during the quarter, and 11 PMRT reviews were completed. Compliance with national PMRT standards relating to notification, parental involvement, external multidisciplinary review and governance oversight was maintained at 100%. All reviewed cases received a PMRT grading of A or B, indicating that no care issues were identified that were considered likely to have changed the outcome.
    - Patient experience remained overwhelmingly positive, with women and families consistently describing staff as compassionate, professional, supportive and caring. Opportunities for improvement identified through patient feedback, complaints and Birth Reflections activity primarily related to communication, responsiveness, information sharing and understanding of care pathways.
2. Action and Improvement
    - Learning from Quarter 1 reviews has informed a programme of improvement activity across maternity and neonatal services. Improvement work is being progressed through identified workstreams with named leads, governance oversight arrangements and defined measures of success.
    - Key areas of focus include strengthening communication and shared decision-making, embedding the BRAIN framework, enhancing recognition and escalation of deteriorating patients, improving documentation standards, reducing postnatal readmissions and improving VTE compliance.
3. Assurance and Impact
    - Areas of measurable improvement during Quarter 1 included improvement in maternity triage performance, a reduction in induction of labour delays greater than 24 hours, reductions in postpartum haemorrhage and OASI rates, and continued positive patient experience feedback. Community birth services remained available throughout the reporting period with no service closures.
    - Whilst no specific inequality requiring immediate action emerged from Quarter 1 review data, the small number of PMRT cases and incomplete recording of some protected characteristics limit the level of assurance that can be drawn. Equity data quality has therefore been identified as an improvement priority. Future reports will include demographic completeness rates, comparison with the wider booked maternity population, and triangulation of safety, experience and outcome data by ethnicity, deprivation, language need, disability and reasonable adjustments where data quality allows.
4. Board Assurance
    - The Board can take assurance that:

- PMRT reviews are being completed in accordance with national requirements.
- Learning from reviews and investigations is being systematically triangulated across multiple intelligence sources.
- Recurring themes are informing targeted quality improvement activity.
- Governance arrangements are in place to monitor delivery of actions and measure their impact.
- The service continues to demonstrate an open learning culture focused on improving outcomes and experiences for women, babies and families.
- Further assurance is required on the evidence base underpinning compliance, sustained impact of improvement actions, data quality, workforce metrics, parental involvement outcomes and escalation of residual risks requiring Board oversight.

Recommendations

5. The Trust Board is asked to:

- Note the findings of the Quarter 1 PMRT and Maternity Safety Intelligence and Learning Report.
- Take assurance that learning from PMRT reviews, incidents, MNSI investigations, claims intelligence, patient experience and governance processes is being triangulated in accordance with MIS Year 8 Safety Action C requirements.
- Note the recurring themes relating to communication, shared decision-making, fetal monitoring, escalation, documentation quality and postnatal pathways.
- Support ongoing delivery of improvement actions and monitoring arrangements associated with these themes.
- Continue oversight of MIS Year 8 requirements and emerging national maternity safety programmes.
- Note the current assurance gaps relating to evidence of sustained impact, workforce metrics, equity data completeness, parental involvement outcomes and independent scrutiny, and support strengthened reporting of these areas in future quarterly updates.

Contents

Maternity (Perinatal) Incentive Scheme (MIS) Year 8 Safety Action C and PMRT Quarterly Report Quarter 1 2026/27

1. Purpose

1.1. This report presents the Quarter 1 (April to June 2026) Report on Investigation Learning and Service User Voice, incorporating the Perinatal Mortality Review Tool (PMRT) quarterly report and fulfilling the requirements of Clinical Negligence Scheme for Trusts (CNST) Maternity (Perinatal) Incentive Scheme (MIS) Year 8 Safety Action C.

1.2. The report assures that learning from perinatal mortality reviews, patient safety incidents, Patient Safety Incident Investigations (PSIIs), Maternity and Newborn Safety Investigations (MNSI), claims intelligence, complaints, patient experience feedback and governance processes is systematically reviewed, triangulated and translated into service improvement activity.

2. Background

2.1. The Maternity (Perinatal) Incentive Scheme (MIS) Year 8 Safety Action C requires Trusts to demonstrate that learning from incidents, investigations, mortality reviews, claims intelligence and national safety programmes is reviewed, triangulated and translated into measurable improvement activity. The Board is required to receive quarterly thematic reports that provide assurance regarding the identification of themes, implementation of actions and monitoring of impact.

3. Quarter 1 Compliance

3.1. The maternity service has maintained established governance arrangements to support compliance with Safety Action C requirements, including:

- Perinatal Mortality Review Tool (PMRT) reviews
- Maternity and Newborn Safety Investigations (MNSI)
- Patient Safety Incident Investigations (PSII)
- Patient safety incident review processes
- Claims intelligence review
- Patient experience and complaints analysis
- Triangulation and Learning Committee oversight

- Board reporting and executive scrutiny arrangements.

4. Compliance Against Safety Action C Standards

Required Standards
1 Notify all qualifying events: All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis. **OUH achieved 100% compliance for Q1** **2 Seek parents' views of care:** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting. **OUH achieved 100% compliance for Q1** **3 External multi-disciplinary reviewers:** For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review, and this should be documented within the PMRT. **OUH achieved 100% compliance for Q1** **4 Provide relevant information:** Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour. **All bereaved families are discharged with an information leaflet regarding PMRT. Relevant duty of candour forms advise of ongoing reviews.** **5 Offer parents a meeting with relevant specialists:** Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

OUH achieved 100% compliance

6 Thematic reports of learning and actions: The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training

OUH achieved 100% compliance

4.1. Compliance with all six Safety Action C standards was achieved during Quarter 1. The service continues to demonstrate robust processes for notification, review, parental involvement, external scrutiny, learning dissemination and Board oversight. Learning identified through PMRT reviews, patient safety investigations, MNSI reports, claims intelligence and patient experience has been incorporated within thematic review processes and has informed the improvement priorities outlined within this report.

4.2. **Additional assurance required:** Future reports should include an evidence checklist for each Safety Action C standard, confirming the source of evidence, responsible owner, date of review by Perinatal Safety Champions, residual limitations and location of supporting documentation.

5. Perinatal Mortality Review Tool (PMRT) Assurance

PMRT Activity and Assurance

5.1. During Quarter 1, ten perinatal deaths were reported through the Submit a Perinatal Event Notification (SPEN) process in accordance with national requirements. A total of eleven cases were reviewed through the Perinatal Mortality Review Tool (PMRT), comprising two cases reported during Quarter 3 2025/26 and nine cases reported during Quarter 4 2025/26.

5.2. The service maintained full compliance with national PMRT requirements throughout the quarter, including timely notification of qualifying cases, meaningful opportunities for parental engagement, external multidisciplinary review and governance oversight. All bereaved families were provided with

information regarding review processes and offered follow-up discussions regarding the findings of reviews.

5.3. PMRT reviews continue to be undertaken within a culture of openness, multidisciplinary learning and external scrutiny, providing assurance that care is reviewed objectively and that opportunities for organisational learning are identified and acted upon.

PMRT Outcomes

5.4. Of the eleven cases reviewed during Quarter 1, all were graded either Category A or Category B.

- Category A: No issues with care identified.
- Category B: Care issues identified that were considered unlikely to have altered the outcome.

5.5. Importantly, no cases reviewed during the quarter were graded Category C or D, meaning no care issues were identified that were considered likely to have changed the outcome. This provides assurance regarding the quality of care provided in the cases reviewed.

5.6. The reviews identified a number of examples of excellent practice, particularly in relation to:

- Compassionate bereavement care.
- Family-centred communication.
- Multidisciplinary working between maternity, fetal medicine, neonatal and bereavement teams.
- Emotional support provided to women and families experiencing loss.

5.7. Parental feedback received through the review process consistently highlighted the kindness, professionalism and compassion demonstrated by staff during extremely difficult circumstances.

5.8. **Additional assurance required:** Board assurance would be strengthened by reporting how many families were offered involvement, how many accepted, how family questions informed the PMRT review, whether meetings were offered following review completion, and how outcomes were communicated back to families.

PMRT Learning and Actions

5.9. Whilst no themes were identified that were considered likely to have altered outcomes, PMRT reviews identified several opportunities to strengthen care processes, documentation and patient experience.

5.10. The principal learning themes are summarised below.

PMRT Learning Theme	Action	Lead	Due Date
Recognition of deteriorating patients	Quality improvement project underway with Adult Resuscitation Team	Patient Safety Midwife	Q4 2026/27
Comfort care provision	Explore neonatal comfort care guideline	Neonatal Governance Lead	Q3 2026/27
Bereavement discharge processes	Process reviewed and learning disseminated	Bereavement Team	Complete
Medication safety	Reflection and shared learning completed	Governance Team	Complete
Booking pathway processes	Shared learning with booking trust	Governance Team	Complete

5.11. Learning arising from PMRT reviews has been incorporated into wider maternity governance arrangements and has informed quality improvement work described throughout this report. Several learning themes identified through PMRT reviews, including communication, escalation of concerns and documentation quality, were also evident within wider safety intelligence sources, including incidents, investigations, complaints and claims intelligence. This triangulation increases confidence that these represent genuine organisational priorities.

PMRT Equity and Demographic Review

5.12. In line with MIS Year 8 requirements, PMRT cases were reviewed using an equity lens to identify potential disparities in outcomes and experience.

5.13. Ten PMRT reportable cases were assessed. Seven involved women from White ethnic groups, two involved Pakistani women and one involved a Black African woman. Cases were identified across deprivation deciles 2 to 9, demonstrating that perinatal mortality affects women and families from a broad range of demographic backgrounds.

5.14. Whilst the small number of cases prevents definitive conclusions being drawn, review identified that the Pakistani and Black African cases reviewed were associated with lower Index of Multiple Deprivation (IMD) scores, indicating higher levels of deprivation than many of the White British cases reviewed. This observation is consistent with nationally recognised evidence describing the interaction between deprivation and ethnicity and reinforces the importance of ongoing monitoring over time.

5.15. Review by the Equality, Diversity and Inclusion specialist midwifery team identified several opportunities to strengthen data quality and understanding of women's experiences, including:

- Improved capture of parental feedback.
- More consistent recording of religion, cultural needs and sexual orientation.

- Improved recording of reasonable adjustments.
- Ongoing monitoring of booking access and timeliness.

5.16. No immediate inequalities theme requiring specific corrective action emerged from Quarter 1 data; however, demographic analysis will continue to be incorporated into quarterly PMRT reviews to support identification of emerging trends and inform targeted service improvement where required.

Equity and Data Quality Assurance Gaps

5.17. The Board should note that the current demographic review provides partial assurance only. The number of PMRT reportable cases is small, denominator data from the wider booked maternity population is not yet included and completeness rates for key protected characteristics are not quantified. This limits the ability to determine whether the absence of an identified inequality theme reflects a true absence of disparity or limitations in the available dataset.

- Ethnicity and deprivation analysis should be compared with the wider maternity booking population to identify over- or under-representation.
- Completeness rates should be reported for ethnicity, IMD, language need, interpreter need, disability, religion or belief, sexual orientation, safeguarding, mental health needs and reasonable adjustments.
- Patient experience, complaints, Birth Reflections and OMNVP feedback should be stratified by key demographic groups where data quality permits.
- Future reports should describe how seldom-heard women and families are being reached, including those requiring interpreters, women from minoritised ethnic communities and women living in areas of higher deprivation.
- Improvement work on triage, induction, postnatal readmissions, VTE and Birth Reflections should include an equity impact lens to demonstrate whether access, experience and outcomes are improving equitably.

5.18. **Suggested Board assurance statement:** The service recognises that equity assurance is currently limited by small numbers and incomplete demographic data. An equity and data quality improvement plan will be monitored through maternity governance routes, with progress reported in future quarterly reports to strengthen assurance on disparities in access, experience and outcomes.

Equity and Data Quality Improvement Plan

Gap Identified	Action	Responsible Lead	Measure of Success
Demographic completeness not quantified	Report completion rates for key protected characteristics and reasonable adjustments.	EDI Specialist Midwifery Team with Digital/Data Lead	Completeness dashboard included in future quarterly reports.
No denominator comparison	Compare PMRT, incidents, complaints and patient experience data with the wider booked population.	Maternity Governance and Business Intelligence Leads	Quarterly equity analysis includes denominator comparison.
Service user feedback not consistently stratified	Triangulate FFT, complaints, Birth Reflections and OMNVP feedback by ethnicity, deprivation, language need and disability where available.	Patient Experience and Engagement Lead	Quarterly report includes stratified patient voice summary.

5.19. Board Assurance: PMRT review demonstrates full compliance with national review standards, no cases graded C or D, strong evidence of compassionate bereavement care, and effective governance arrangements for translating learning into improvement actions. Learning themes identified through PMRT are consistent with those emerging from wider maternity safety intelligence.

5.20. Assurance limitation: The report currently provides stronger assurance on process compliance than on sustained impact. Future updates should distinguish between actions completed, actions embedded in practice, and actions demonstrating measurable reduction in risk or recurrence.

6. Safety Intelligence Reviewed

Overview

6.1. In accordance with MIS Year 8 Safety Action C requirements, maternity and neonatal safety intelligence is reviewed from multiple sources to develop a comprehensive understanding of safety, quality, experience and outcomes across the service. Triangulation of intelligence supports identification of recurrent themes, emerging risks, examples of excellence and opportunities for improvement.

6.2. During Quarter 1, intelligence was reviewed from the following sources:

Intelligence Source	Quarter 1 Activity	Key Themes Identified
Patient Safety Incidents	Ongoing incident review across maternity and neonatal services demonstrating a positive reporting culture	Escalation, documentation, fetal monitoring, postpartum haemorrhage, OASI, neonatal admissions and bladder care
Patient Safety Incident Investigations (PSII)	One new PSII commissioned during the reporting period	Clinical review and escalation processes
Maternity and Newborn Safety Investigations (MNSI)	One completed report received, with further investigations ongoing	Shared decision-making, fetal monitoring, CTG loss of contact and documentation
Perinatal Mortality Review Tool (PMRT)	Eleven reviews completed during Quarter 1	Communication, escalation, parental experience and documentation themes

Patient Experience Feedback (FFT/Say on the Day)	Consistently positive feedback received throughout the quarter	Compassion, professionalism, communication, delays and information sharing
Complaints	Complaints reviewed through established governance processes	Communication, staff interactions, delays, follow-up care and feeling listened to
Birth Reflections Service	Ongoing review of referrals and themes	Understanding decisions, explanation of events and birth trauma
Claims Intelligence	Retrospective review of maternity claims scorecard undertaken	Communication, fetal monitoring, delay in diagnosis, escalation and informed consent
Quality and Performance Metrics	Monthly review through governance and quality meetings	Postnatal readmissions, VTE compliance, neonatal admissions and test result endorsement
Risk Registers	Maternity and neonatal risks reviewed regularly	Estates constraints, workforce pressures, clinical infrastructure and operational resilience

7. Triangulated Themes and Analysis

Overview

7.1. The review of intelligence from the below sources identified several themes recurring across multiple intelligence sources. The consistent presence of these themes across independent datasets increases confidence that they represent genuine organisational learning priorities rather than isolated events.

Triangulation Analysis Matrix

Theme	Incidents & Investigations (inc. Ulysses, PSRR, PMR, MNSI)	PMRT	Patient Experience, Service User voice, OMNVP and Patient Safety Partners	Complaints	Claims/ Claims Scorecard	Risk Register/ Governance
Communication	✓	✓	✓	✓	✓	✓
Shared Decision-Making	✓	✓	✓	✓	✓	✓
Fetal Monitoring	✓	✓	-	✓	✓	✓
Recognition and escalation of concerns	✓	✓	✓	✓	✓	✓
Documentation Quality	✓	✓	-	✓	✓	✓
Postnatal Pathways	✓	-	✓	✓	✓	✓
Workforce and Staffing Pressures	✓	-	✓	✓	✓	✓
Estates and Environment	-	-	✓	✓	✓	✓

Analysis of Triangulated Themes

Communication and Information Sharing

7.2. Communication was the most significantly identified theme across all intelligence sources reviewed. Themes relating to communication featured within PMRT reviews, MNSI investigations, patient safety incidents, complaints, claims intelligence and patient experience feedback. Whilst women and families consistently described staff as compassionate and supportive, opportunities for improvement were identified regarding clarity of information, responsiveness to concerns, consistency of communication and understanding of care pathways. The recurrence of this theme across all intelligence sources identifies communication as a key organisational improvement priority.

Shared Decision-Making

7.3. Themes relating to informed choice, consent and involvement in care decisions were identified through PMRT reviews, MNSI investigations, patient experience feedback, complaints and claims intelligence. Women accessing Birth Reflections services frequently sought greater understanding of decisions made during their care, reinforcing the importance of personalised discussions and shared decision-making. This theme aligns with national maternity learning and continues to inform local improvement activity.

Fetal Monitoring

7.4. Fetal monitoring remained a recurring theme across MNSI investigations, incident reviews, PMRT reviews and historical claims intelligence. Recurring issues related to interpretation, recognition of fetal compromise, escalation and timely clinical response. The persistence of this theme across both current and historical intelligence supports continued prioritisation through governance, audit and education programmes.

Recognition and Escalation of Concerns

7.5. Recognition and escalation of deteriorating maternal or fetal condition was identified across PMRT reviews, incidents, investigations, complaints and claims intelligence. Learning identified the importance of timely review, effective communication and escalation pathways to support safe clinical decision-making. This theme is closely linked to communication and situational awareness and remains a priority area for ongoing quality improvement.

Documentation Quality

7.6. Documentation quality was a recurrent finding across investigations, governance reviews, audits and claims intelligence. Concerns related to

completeness of records, documentation of assessments, communication records and documentation that did not consistently reflect the care delivered. Whilst reviews generally concluded that appropriate care had been provided, documentation was not always sufficient to demonstrate the rationale for clinical decision-making.

Postnatal Pathways

7.7. Postnatal care pathways emerged as a developing organisational theme, particularly through review of postnatal readmissions, VTE risk assessment compliance, patient feedback, complaints and governance reviews. Themes included postnatal safety-netting, continuity of care, follow-up arrangements and management of postnatal complications. This remains an area of active review and improvement within the service.

Workforce and Staffing Pressures

7.8. Workforce pressures were identified through risk register review, complaints, patient experience feedback and historical claims intelligence. Whilst safe staffing standards continued to be maintained throughout the quarter, ongoing recruitment challenges, sickness absence and increasing service demand continue to create operational pressures that require ongoing monitoring.

Estates and Environment

7.9. Environmental and estate-related constraints were identified through patient feedback, complaints and organisational risk registers. Concerns primarily related to capacity, patient flow and the physical environment within maternity areas. Although not directly identified within PMRT reviews or incident investigations, the consistency of feedback across multiple intelligence sources demonstrates the importance of maintaining focus on environmental improvements as part of the wider improvement programme.

Key Message

7.10. The triangulation process identified consistency across independent sources of maternity safety intelligence. Communication, shared decision-making, fetal monitoring, recognition and escalation of concerns, documentation quality and postnatal pathways emerged as the most significant recurring themes and have therefore informed the service's quality improvement priorities for 2026/27. Improvement actions, responsible leads and measures of success are outlined in the following section.

8. Translating Learning into Improvement

Overview

8.1. Learning identified through PMRT reviews, incidents, investigations, MNSI reports, claims intelligence, patient experience feedback and governance processes has informed a series of targeted quality improvement initiatives. Improvement priorities have been aligned to the recurring themes identified through triangulation, with delivery monitored through established governance and quality improvement structures.

8.2. The table below summarises the actions being undertaken in response to the themes identified within Quarter 1 intelligence.

Theme	What We Learned	What We Are Doing	Responsible Lead	Measure of Success
Communication and Information Sharing	Communication was the most consistently identified theme across complaints, PMRT, patient experience, Birth Reflections and investigations. Women and families described opportunities to improve clarity, consistency and responsiveness.	Appointment of a Patient Experience and Engagement Lead; enhancement of Birth Reflections services; communication improvement work within triage, induction of labour and postnatal pathways; strengthening of patient information resources; OMNVP engagement and co-production.	Patient Experience and Engagement Lead	FFT themes, complaints trends, Birth Reflections feedback, maternity survey results and patient experience reporting.
Shared Decision-Making	Themes relating to informed choice and understanding of clinical decisions were identified through MNSI investigations, complaints, PMRT reviews and Birth Reflections.	Embedding the BRAIN framework within patient information, guidelines and clinical practice; patient information review through OMNVP; implementation of Martha's Rule principles within maternity services.	Obstetric Leads, Clinical Effectiveness Midwife (guidelines lead), Consultant Midwife (once appointed), Patient Experience and Engagement Lead, Maternity Clinical Governance Lead.	Reduction in complaints relating to informed choice; patient feedback; documentation audit of decision-making discussions.
Fetal Monitoring	Fetal monitoring remains a recurring learning theme across incidents, MNSI investigations, PMRT reviews and claims intelligence.	Continued PROMPT, CTG, OxMUD and NLS training programmes; intrapartum shared learning events;	Practice Development Team, Fetal Wellbeing Team	Training compliance; incident review trends; audit findings; MNSI action plan monitoring.

		revision of patient information regarding monitoring during labour.		
Recognition and Escalation of Concerns	Delayed recognition or escalation of maternal or fetal deterioration continues to feature within reviews and investigations.	Deteriorating patient quality improvement programme; MEWS reinforcement; escalation pathway review; SBAR improvement initiatives; Martha's Rule implementation planning.	Patient Safety Midwife and Maternity Clinical Governance Risk Lead	Audit compliance; incident trends; triage performance indicators; governance review findings.
Documentation Quality	Reviews identified instances where documentation did not fully reflect care provided or clinical decision-making processes.	Documentation audit programme; reinforcement of SBAR standards; review of documentation requirements through governance, training and guideline updates.	Clinical maternity leads/matron team, with oversight from Clinical Governance Team	Documentation audit compliance; review findings and claims intelligence trends.
Postnatal Pathways	Postnatal readmissions, VTE compliance and postnatal experience emerged as recurring themes during the quarter.	Postnatal readmission task and finish group; review of infection and hypertension pathways; postnatal safety-netting improvements; VTE recovery programme.	Inpatient Matron and Consultant Obstetrician Lead	Reduction in readmissions; VTE compliance; patient feedback; PQOM performance indicators.
Workforce and Staffing Pressures	Workforce challenges continue to present operational risk despite maintenance of safe staffing standards.	Recruitment and retention initiatives; introduction of 24/7 maternity bleep holder role; staffing escalation processes; wellbeing and fatigue management initiatives.	Deputy Heads of Midwifery	Vacancy rates, fill rates, one-to-one care in labour compliance and workforce metrics.
Estates and Environment	Environmental limitations and capacity concerns were identified through patient feedback, risk register reviews and governance monitoring.	MAU redesign; CTG lounge expansion; additional clinical capacity; ventilation and environmental improvement programmes.	Maternity Senior Leadership Team	Patient flow metrics, patient experience feedback and delivery of estates programmes.

Governance and Monitoring

8.3. Progress against improvement actions is monitored through the Maternity Clinical Governance Committee, Triangulation and Learning Committee, Perinatal Mortality Review meetings, Maternity Services Performance Meeting and the Perinatal Improvement Programme. Escalation processes are in place where actions are delayed or where expected improvements are not demonstrated.

8.4. **Strengthened governance assurance required:** Each improvement theme should identify the accountable committee, named lead, reporting frequency, escalation route and expected date for Board-level update. This will provide clearer assurance that actions are monitored to completion and escalated where progress or impact is not evident.

8.5. Improvement measures have been aligned to each theme to ensure the impact of interventions can be assessed over time. Future quarterly reports will provide updates regarding delivery, emerging learning and evidence of improvement arising from these actions.

Board Message

8.6. The triangulation of intelligence has not only identified recurring themes but has informed a programme of targeted improvement work with named leads, oversight arrangements and measurable outcomes. This provides assurance that learning identified through reviews and investigations is being translated into action and monitored for impact.

9. Demonstrating Impact and Measuring Improvement

Overview

9.1. MIS Year 8 Safety Action C places increasing emphasis on demonstrating that learning identified through reviews, investigations and governance processes results in measurable improvement. Whilst some improvement initiatives require longer timeframes before impact can be fully realised, Quarter 1 has demonstrated several positive improvements across key maternity performance and safety indicators.

9.2. The following measures provide assurance regarding the impact of improvement activity undertaken by maternity and neonatal services during the reporting period.

Improvement Outcomes During Quarter 1

Improvement Area	Baseline Position	Quarter 1 Position	Direction of Travel	Measure of Success
Maternity Triage Performance	April average assessment time: 21 minutes	June average assessment time: 18 minutes	Improving	Achieve and sustain national BSOTS standard where possible N.b. this is now reported as a %
Induction of Labour Delays >24 Hours	18 women delayed in April	1 woman delayed in June	Significant improvement	Reduction in delays and enhanced patient experience
Patient Experience (FFT)	83% positive feedback in April	94% positive feedback in May and 87% in June	Sustained positive performance	Maintain high levels of patient satisfaction
Postpartum Haemorrhage (>1500ml) at vaginal delivery	Q4 2025/26 baseline	Reduction observed during Quarter 1	Improving	Continued reduction in severe haemorrhage

Obstetric Anal Sphincter Injury (OASI)	Previous quarterly baseline	Reduced to 1.83% in June	Improving	Sustain reduction and maintain OASI care bundle compliance
Community Birth Service Availability	Community service maintained	No community birth service closures	Sustained	Maintain equitable access to birth choices
PMRT Compliance	National standards compliance	100% compliance achieved	Sustained	Maintain full compliance with PMRT standards
Parent Engagement in PMRT	National requirement	100% compliance with offer achieved	Sustained	Maintain family involvement in review processes

9.3. Additional impact assurance required: The Board should be provided with baseline, current position, target, denominator, timeframe and trend/SPC data for each improvement metric. This is particularly important for triage, induction delays, PPH, OASI, VTE compliance, postnatal readmissions and patient experience, where early improvement signals should be distinguished from sustained improvement.

Areas Where Impact Is Still Being Evaluated

9.4. A number of improvement programmes were initiated or remain in progress during Quarter 1. These programmes are expected to require longer periods of implementation before meaningful impact can be demonstrated.

Improvement Programme	Intended Outcome	Measure of Impact	Current Status
BRAIN Shared Decision-Making Programme	Improved informed choice and involvement in decisions	Complaints themes, patient feedback, Birth Reflections feedback and documentation audit	In Progress
Communication and Patient Experience Programme	Improved communication and understanding of care pathways	FFT themes, complaints, maternity survey results and qualitative feedback	In Progress
Deteriorating Patient Quality Improvement Project	Earlier identification and escalation of deterioration	Audit findings, incident review themes and compliance measures	In Progress
Documentation Quality Improvement Programme	Improved quality and consistency of clinical records	Documentation audit findings and governance review outcomes	In Progress
Postnatal Readmission Improvement Programme	Reduction in avoidable readmissions	Readmission rates, pathway compliance and patient feedback	In Progress
VTE Improvement Programme	Achievement of Trust compliance standards	Monthly VTE compliance monitoring	In Progress
Birth Reflections Improvement Programme	Improved access and reduced waiting times	Waiting time performance and service user feedback	In Progress
Martha's Rule Implementation	Improved escalation and listening to women and families	Assurance reporting, patient feedback and governance metrics	In Progress

How We Will Know Improvement Activity Is Working

9.5. In response to the themes identified through triangulation, a number of outcome measures have been aligned to each improvement priority to support ongoing evaluation.

Theme	Outcome Measures
Communication and Information Sharing	FFT feedback, complaints trends, Birth Reflections themes, patient survey findings
Shared Decision-Making	Patient feedback, complaints relating to informed consent, documentation audits, Birth Reflections referrals
Fetal Monitoring	Training compliance, incident review findings, MNSI recommendations and governance review outcomes
Recognition and Escalation of Concerns	Audit findings, incident trends, triage performance and deterioration review outcomes
Documentation Quality	Documentation audits, governance reviews, claims intelligence and incident findings
Postnatal Pathways	Readmission rates, VTE risk assessment compliance, patient feedback and pathway audits
Workforce and Staffing	Vacancy rates, fill rates, one-to-one care in labour compliance and workforce metrics
Estates and Environment	Patient feedback, flow metrics and monitoring of environmental improvement programmes

Key Message

9.6. Quarter 1 has demonstrated measurable improvement across a number of operational, safety and experience indicators, including maternity triage performance, induction of labour delays, postpartum haemorrhage rates and OASI rates. Whilst several improvement programmes remain in the early stages of implementation, governance arrangements are in place to monitor delivery, evaluate impact and provide ongoing assurance that learning identified through PMRT reviews, investigations and wider safety intelligence is resulting in tangible service improvement.

10. Board Assurance, Emerging Risks and Executive Oversight

Overall Assurance

10.1. This report provides assurance that maternity and neonatal safety intelligence is reviewed systematically through established governance arrangements and that learning identified through PMRT reviews, patient safety incidents, investigations, MNSI reports, claims intelligence, patient experience feedback and governance processes is triangulated to identify recurring themes and inform improvement activity.

10.2. Quarter 1 demonstrated a strong culture of multidisciplinary review, learning and continuous improvement. Compliance with PMRT and MIS Year 8 Safety Action C requirements was maintained throughout the reporting

period, with evidence of robust governance oversight, family engagement and learning dissemination.

10.3. The triangulation of intelligence identified recurring themes relating to communication, shared decision-making, fetal monitoring, recognition and escalation of concerns, documentation quality and postnatal pathways. These themes have informed targeted improvement programmes with identified leads, monitoring arrangements and measures of success.

Areas of Assurance

10.4. The Board can take assurance from the following:

- No maternal deaths occurred during Quarter 1.
- No never events were reported.
- No Maternity Outcomes Signal System (MOSS) alerts were received.
- PMRT compliance standards, including parental engagement and external multidisciplinary review requirements, were achieved.
- All PMRT reviews completed during the quarter were graded Category A or B, with no cases identifying care issues considered likely to have altered outcomes.
- Positive patient experience feedback continued throughout the reporting period, with women and families consistently describing staff as compassionate, supportive and professional.
- Improvements were demonstrated in maternity triage performance, induction of labour delays, postpartum haemorrhage rates and OASI rates.
- Community birth services remained available throughout the quarter with no service closures.
- Learning identified through PMRT reviews, investigations and wider safety intelligence has been translated into structured improvement programmes with ongoing governance oversight.

Executive Oversight Required

10.5. The Board is asked to maintain oversight of:

- Progress and improvement programmes against the recurring thematic priorities identified through triangulation relating to communication, shared decision-making, fetal monitoring, escalation, documentation quality and postnatal pathways.
- Continued compliance with CNST MIS Year 8 requirements.

- Delivery of MNSI, Ockenden, Martha's Rule and other nationally mandated maternity improvement programmes.
- Workforce and infrastructure requirements needed to sustain improvements in safety, experience and outcomes for women, babies and families.

Assurance Still Required

- Introduce a Safety Action C evidence checklist confirming source evidence, document location, owner and date of Safety Champion review.
- Strengthen parental involvement reporting by including numbers offered involvement, numbers accepting, themes raised by families and evidence of feedback to families after review completion.
- Add a RAG-rated action tracker showing action status, evidence of completion, evidence of embedding and measurable impact.
- Include workforce assurance metrics including vacancy rate, fill rate, one-to-one care in labour, red flag events, escalation use and supernumerary coordinator cover.
- Provide clearer assurance on fetal monitoring through training compliance, competency, audit results, incident trends and action plan progress.
- Strengthen VTE assessment and postnatal readmission assurance with baseline, current position, target, trajectory, accountable lead and thematic analysis and clear action plan.
- Include a risk and escalation table identifying risks managed locally, risks requiring divisional oversight and risks requiring Board-level support.
- Residual assurance gaps for Board oversight: Further assurance is required on workforce fill rates, vacancy position, one-to-one care in labour, supernumerary labour ward coordinator cover, red flag events, escalation use, VTE recovery trajectory, postnatal readmission themes, fetal monitoring competency and evidence of independent scrutiny by Safety Champions or external reviewers.

11. Conclusion

11.1. Quarter 1 demonstrates a maternity service with robust governance arrangements, strong multidisciplinary review processes and an embedded culture of learning. PMRT reviews, safety investigations, complaints, claims

intelligence and patient feedback continue to identify consistent themes that are informing local improvement priorities.

11.2. The service has demonstrated measurable improvements across several key performance and safety indicators during the reporting period. Governance arrangements are in place to ensure learning continues to be translated into action, monitored for impact and reported through future quarterly Board reports. The Board can therefore take assurance that systems are in place to identify learning, drive improvement and support the delivery of safe, equitable and compassionate maternity and neonatal care.

12. Recommendations

12.1. The Trust Board is asked to:

- Note the findings of the Quarter 1 PMRT and Maternity Safety Intelligence and Learning Report.
- Take assurance that learning from PMRT reviews, incidents, MNSI investigations, claims intelligence, patient experience and governance processes is being triangulated in accordance with MIS Year 8 Safety Action C requirements.
- Note the recurring themes relating to communication, shared decision-making, fetal monitoring, escalation, documentation quality and postnatal pathways.
- Support ongoing delivery of improvement actions and monitoring arrangements associated with these themes.
- Continue oversight of MIS Year 8 requirements and emerging national maternity safety programmes.
- Note the current assurance gaps relating to evidence of sustained impact, workforce metrics, equity data completeness, parental involvement outcomes and independent scrutiny, and support strengthened reporting of these areas in future quarterly updates.

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

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

Appendix 2: Summary of Cases Reviewed by Perinatal Mortality Review Panel in Quarter 1

Summary	Grading of care of the mother and baby up to the point that the baby was confirmed as having died (IUD) or the point of birth of the baby	NND- Grading of care of the baby from birth up to the death of the baby- Graded by neonates	Grading of care of the mother following the death of her baby	Issues identified	Actions assigned at meeting	Action status /deadline
A mother delivered at home at 27 weeks in the presence of paramedics. Baby diagnosed antenatally with lethal urethral atresia- indeterminate intrauterine death.	A	N/A	A	NIL	NIL	N/A
A mother attended MAU at 39+4 in spontaneous labour. An intrauterine death was diagnosed on admission. Risk assessment in pregnancy indicated that she was suitable for midwifery led care.	B	N/A	B	Poor parental experience on observation area following birth. Missed opportunity for tokophobia screening	Learning distributed	Complete
Community Midwife referred a mother into MAU due to being unable to auscultate the fetal heart at 25 weeks gestation. An intrauterine death was diagnosed.	A	N/A	B	Medication error	Personal reflection by staff involved	Complete
A baby was born at 39 weeks gestation following an	A	A	A	Missed cord bloods for genetics – AN screening had	Patient Safety Midwife to include in patient safety newsletter	Complete

antenatal diagnosis of complex congenital abnormalities. They sadly passed away shortly after birth.				already been performed		
A mother with a baby with congenital abnormalities was delivered emergency due to ongoing clinical instability at 35 weeks gestation. Baby sadly passed away shortly after birth.	A	A	A	NIL	NIL	N/A
A baby with an antenatal diagnosis of congenital structural abnormality passed away on day 24 after being born at 34 weeks gestation.	A	B	A	NIL	NIL	N/A
A baby was born at 34 weeks following a pregnancy that was complicated by recurrent polyhydramnios and fetal congenital abnormality. Baby passed away on day 3.	A	A	A	NIL	NIL	N/A
The birth of a mother with a DCDA pregnancy was expedited at 26 weeks gestation due to concerns regarding chorioamnionitis. One of the twins passed away on day 26	A	B	A	NIL	NIL	N/A
A mother with a history of prolonged	B	N/A	B	Delayed detection of chorioamnionitis	QI project ongoing to improve detection	Ongoing

preterm rupture of membranes developed chorioamnionitis and was diagnosed with an intrauterine death at 22 weeks gestation.				Missed discharge to local trust	and escalation of deteriorating patients Discharge process clarified with trust and disseminated amongst bereavement team	Complete
A baby was born at 23 weeks gestation, following neonatal counselling the mother opted for comfort care of the baby. The baby passed away at 1 day old	B	B	B	Delay in provision of analgesia for baby	Team to explore the possibility of a comfort care guideline in line with neonatal recommendations	Ongoing
The birth of a diabetic mother was expedited due to a diagnosis of chorioamnionitis at 25 weeks gestation. Baby had an antenatal diagnosis of a congenital abnormality and passed away shortly after birth.	B		B	Missed opportunity for HBA1C to be performed at booking.	Joint care review, booking trust to distribute learning	Complete