

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Maternity Services in Oxfordshire

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Report to:

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- Professor Dr. Andrew Brent (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on maternity services in Oxfordshire during its public meeting on 29 January 2026.
2. The Committee would like to thank Yvonne Christley (Chief Nurse, Oxford University Hospitals NHS Foundation Trust [OUH]) and Professor Dr. Andrew Brent (Chief Medical Officer, OUH); for attending the meeting and answering questions from the Committee.
3. The topic of maternity services is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the acute provider Trust to ensure that maternity patients receive the professional and empathetic support that they require. The Committee is also aware of rising challenges with maternity services on both a local and national scale.
4. PLEASE NOTE: Since the committee scrutinised this item, we were informed by Oxford Health NHS Foundation Trust that there were some errors in the data provided in the report submitted to the Committee. The Chair has acted with advice from the Health scrutiny officer and has written the Chief Executive and Chair of the Trust, seeking additional written clarifications and responses which will be reported and considered by the Committee as part of the Chair's update item in the Committee's public meeting on 16 April 2026.
5. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:
 - Trends in birth injuries and trauma.
 - Perinatal and stillbirth mortality and how OUH compares with peer Trusts.
 - An update on the October 2025 CQC maternity inspection, including: any immediate actions taken.

- Details on workforce planning (including staffing levels, how demand modelling is used, and how safety improvements are balanced against staff wellbeing and burnout).
- Patient experience, complaints, and communication (including how women and families are: communicated with during care, supported when things go wrong, kept informed in accessible formats and languages).
- Details on the engagement with families and community voices.

SUMMARY

6. During the 29 January 2026 meeting, the Committee sought clarity on whether the Trust had met families affected by maternity concerns and whether longstanding campaign groups had been meaningfully engaged, particularly in light of previous tensions and disputes with families. The officers reported that groups such as Keep the Horton General had engaged with the Trust at various times, including at listening events, although concerns had persisted about transparency.
7. Attention then turned to the potential for a fresh approach to engagement with campaign groups and the part that Healthwatch could have played as an independent bridge. The officers acknowledged the longstanding nature of concerns within local groups and recognised that earlier engagement in their view had not always built confidence, partly due to misunderstandings and worries about the treatment of information. They supported a renewed, structured model of engagement that brought campaign groups and the Trust together more effectively. They agreed that Healthwatch's independence made it a valuable, community-facing partner, capable of both facilitating dialogue and offering challenge, particularly while national arrangements for patient-voice functions remained uncertain.
8. The financial environment formed a further line of inquiry. Members explored the implications of NHS tariff changes for maternity services, especially in the context of increasingly complex clinical presentations. The officers noted that national tariff adjustments had been affecting multiple clinical areas. With workloads growing more complex and requiring greater staff time and specialist intervention, the officers questioned whether current tariffs adequately recognised rising acuity especially with the significant change in the average age of motherhood. The Trust had already raised these pressures and advocated for sustainable funding models that reflected the real cost of safe, high-quality maternity care. Members warned that tariff misalignment risked worsening workforce and capacity pressures, and the officers confirmed that the matter would remain a focus for continuing escalation ? scrutiny.
9. The discussion moved to maternity safety outcomes, with reference to the historic spike in postpartum haemorrhage (PPH) and the measures taken to address maternal safety. . The officers explained that the increase in PPH had been linked to several factors, including a more complex maternity population

and service pressures that had undermined consistency of care. The Trust had conducted a detailed review to understand contributory causes and had implemented a targeted improvement plan. The most effective actions had included strengthening clinical guidelines, improving escalation pathways, enhancing staff training and focusing on the early identification and management of risk during labour and birth. These combined measures had produced a clear improvement in PPH rates and greater consistency in practice across teams, with continued monitoring to sustain progress and embed learning.

10. Members examined the newly launched Induction of Labour Improvement Initiative, introduced to address persistent delays for women. The officers stated that the initiative had been designed to streamline the induction pathway, reduce waiting times and improve outcomes for women needing medical initiation of labour.
11. Questions about minimising harm, maintaining safety and responding to shortfalls in outcomes led to further questions on the detail on governance. The officers reported that the Trust had strengthened clinical governance procedures through clearer guidelines, rapid escalation routes and closer outcome monitoring. They added that incident reviews had been completed more quickly, making it possible to apply learning sooner. Complaints and concerns had been tracked for themes and fed into service-improvement discussions.
12. Members asked whether longstanding dissatisfaction of families might have contributed to the heightened reporting of complaints observed in September. The officers acknowledged that unresolved distress and breakdowns in communication could have influenced the pattern of concerns and emphasised that complaints were being reviewed individually, with attention to their emotional impact. Regarding the national requirement for independent review of 50% of baby deaths, the officers confirmed that the Trust was working towards compliance and that independent scrutiny formed part of established governance processes. The Committee reiterated the need for clear support for complainants, sensitive communication, and sustained transparency in oversight.
13. Discussion of the complaints process continued. The officers accepted that earlier failings in communication had undermined trust and reported that work was underway to strengthen practice. They explained that each complaint was reviewed on its merits, that themes were captured and fed into governance and that learning informed improvements in communication, consent and postnatal care. The Committee underlined that confidence would only be rebuilt through consistent, timely responses, improved escalation and clearer explanations when outcomes fell short, and that visible follow-through would be essential.

KEY POINTS OF OBSERVATION:

14. This section highlights five key observations and points that the Committee has in relation to maternity services in Oxfordshire. These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Trust-wide maternity communication standard: Effective communication is not an adjunct to safe maternity care; it is a core clinical intervention that underpins informed consent, patient safety, experience, equity, and trust. The report submitted for this item shows a service that is making measurable progress in clinical outcomes and workforce stability, yet continues to face challenges in patient experience and complaints.

Complaints to the Trust have risen since September 2025, with the most common themes being communication, consent and postnatal care. These are not isolated issues but recurring signals across multiple feedback channels, including complaints, listening events and patient experience data. The Trust has acknowledged these themes and initiated improvement work through mechanisms such as the Triangulation and Learning Committee (TALC), enhanced postnatal ward arrangements and the Perinatal Improvement Programme. However, these initiatives, while valuable, operate largely as responsive interventions rather than as part of a single, coherent communication framework that sets clear expectations for staff and service users across the entire maternity pathway.

The OUH report also highlights specific clinical areas—such as induction of labour—where complexity, delays and uncertainty can heighten anxiety and increase the risk of dissatisfaction or harm if communication is inconsistent or poorly timed. Although the Trust reports improvements in induction delays, national evidence shows that induction remains an area where women frequently report inadequate information and a lack of understanding about what will happen and when. Without a Trust-wide standard, communication quality risks varying between teams, sites and individual clinicians, undermining both safety and confidence.

National regulators have repeatedly identified communication as a central weakness in maternity services across England. The Care Quality Commission's National Review of Maternity Services (2022–2024) found that poor communication was one of the most common themes arising from inspections and patient feedback, particularly for women with protected characteristics under the Equality Act. The CQC reported that many women were not given timely, clear or sufficient information to make informed decisions, especially during labour and postnatal care, and that communication failures were a frequent driver of formal complaints and traumatic experiences¹.

¹ <https://www.cqc.org.uk/publications/maternity-services-2022-2024/communication>

Importantly, the CQC has emphasised that communication problems are not confined to individual interactions but reflect system design. Women repeatedly described feeling uninformed about what was happening to them, uncertain about delays, and unable to access staff when they were worried—experiences that are magnified during induction, labour and the immediate postnatal period. The regulator’s findings strongly support the case for formal communication standards that define what information should be given, when, and in what form, rather than relying on informal practice or individual judgement.

A Trust-wide communication standard is also a critical tool for addressing maternity inequalities. Both national data and academic research show that women who face language barriers, cultural differences or lower health literacy experience poorer outcomes and higher levels of dissatisfaction. The CQC has warned that communication failures disproportionately affect women from ethnic minority backgrounds and those who do not speak English fluently, undermining informed consent and safe care.

Academic evidence reinforces this. A 2025 qualitative analysis of maternity incident reports published in *BMJ Open Quality* found that communication failures were a leading contributor to severe maternal morbidity and that these failures disproportionately affected Black women. The study highlighted omissions, lack of shared understanding and unclear responsibilities as recurring problems, concluding that improving communication quality is essential to reducing inequities and preventable harm. Similarly, broader reviews of maternal care consistently link clear, empathetic communication to improved maternal satisfaction, reduced anxiety and better health outcomes².

The OUH report for this item describes positive initiatives such as translated antenatal classes and targeted support for vulnerable groups through programmes like Equal Start Oxford. However, without a Trust-wide standard, such efforts risk remaining fragmented. A formal standard would embed translation, interpreter use and culturally appropriate communication as routine expectations rather than optional enhancements, aligning with the NHS Accessible Information Standard and equality duties.

Induction of labour, labour itself and the postnatal period are phases where uncertainty is highest and communication demands are greatest. Evidence from a large UK postnatal survey published in *BMJ Open* found that many women undergoing induction felt poorly informed about what to expect, experienced significant anxiety, and reported that delays and changes were not adequately explained. The authors concluded that inadequate information and unclear expectations were central

² <https://bmjopenquality.bmj.com/content/14/1/e003112>

contributors to negative experiences, even where clinical care was otherwise appropriate³.

National survey data from the CQC echoes this pattern. While overall communication during antenatal care has improved, communication during labour and especially postnatal care continues to score more poorly, with a notable minority of women reporting that they were not given information about options, were left alone when worried, or did not know who to contact for help after discharge. These findings underline the need for standards that specify not only *what* information should be shared, but *when* it should be provided and *how* expectations should be managed across transitions of care⁴.

Furthermore, other NHS trusts have begun to formalise communication as part of their maternity strategies. Trusts such as West Suffolk and North Tees and Hartlepool explicitly frame personalised, accessible information and clear communication as strategic priorities, co-produced with Maternity Voices Partnerships. While these strategies vary in scope, they demonstrate a growing recognition that communication requires system-level standards rather than ad hoc initiatives.

At a national level, NHS England's Maternal Care Bundle and the Royal College of Obstetricians and Gynaecologists' *Standards for Maternity Care* both emphasise consistency, clarity and equity in care delivery, including communication. Although these frameworks do not prescribe local communication scripts, they strongly support the principle that variation in information provision contributes to unequal outcomes and undermines safety⁵.

A Trust-wide maternity communication standard would not remove clinical judgement or reduce compassionate care to a checklist. Rather, it would provide a shared baseline that ensures every woman and birthing person in Oxfordshire can expect timely, understandable communication and appropriately translated information for those that need this, regardless of where or by whom they are cared for. It would support staff by clarifying expectations, reduce variation across sites and teams, and provide a framework against which improvement can be measured.

From a governance perspective, such a standard also strengthens accountability. Communication failures are frequently cited in serious incidents, complaints and litigation. By setting clear expectations, the Trust can better demonstrate learning, assurance and compliance with national guidance, while providing the JHOSC and the public with clearer lines of sight over progress.

³ [bmjopen.bmj.com]

⁴ [cqc.org.uk], [cqc.org.uk]

⁵ [england.nhs.uk], [rcog.org.uk]

The JHOSC recommendation to implement a Trust-wide maternity communication standard is therefore well-founded, proportionate and evidence-based. It responds directly to local patient experience data from Oxfordshire, aligns with national regulatory concerns, and is strongly supported by academic research linking communication quality to safety, equity and outcomes. In a maternity system under sustained national scrutiny, such a standard represents not an additional burden, but a necessary foundation for safe, respectful and equitable care.

Recommendation 1: *To implement a Trust wide maternity communication standard covering: listening, timing, clarity and translation of information, as well as expectations during induction, labour and postnatal care.*

Public reporting on complaints and patient experience: Public confidence in maternity services is shaped not only by clinical outcomes, but by how health systems listen, learn and respond when things go wrong. The report submitted to the Committee for this item acknowledges a rise in complaints relating to maternity services since September 2025, with dominant themes including communication, consent and postnatal care. The report describes the Trust's internal mechanisms for learning, including the Triangulation and Learning Committee (TALC), which reviews complaints, patient feedback, incidents and legal claims to identify themes and drive improvement. While this demonstrates a commitment to learning, the report also makes clear that much of this learning currently remains internal to the organisation, with limited visibility for complainants, service users and the wider public.

Evidence from listening events held in December 2025, attended by families, campaign groups and staff, further indicates that families are not only seeking reassurance that issues are recognised, but want to understand what has changed as a result of raising concerns. In this context, a public-facing learning report would provide a structured and transparent means of closing the feedback loop between families and the Trust, reinforcing that complaints are treated as a source of improvement rather than defensiveness.

National regulators have repeatedly emphasised that poor handling of complaints and inadequate communication with families following adverse events are systemic weaknesses in maternity services. The Care Quality Commission's National Review of Maternity Services in England 2022–2024 found that while most trusts had mechanisms for incident reporting and learning, many families did not feel listened to or informed about what had changed as a result of raising concerns, particularly following baby deaths or serious harm⁶. There was no evidence that OUH had any system or procedure to address this locally.

The CQC's dedicated analysis of communication in maternity services highlights that complaints about communication are among the most

⁶ <https://www.cqc.org.uk/publications/maternity-services-2022-2024>

common issues raised nationally and that failure to respond transparently can compound trauma and erode trust⁷. Importantly, the regulator stresses that learning must be visible and demonstrable, not simply recorded internally.

This expectation aligns closely with what the Committee is recommending. A quarterly learning report would allow OUH to show how complaints themes are identified, how families experience the complaints process, and how learning translates into service change over time.

Moreover, the CQC's Focus on Maternity section within the State of Care 2024/25 report reinforces that meaningful engagement with families and robust, independent review processes are essential to improving safety and preventing recurrence⁸. By publishing data on independent reviewer involvement, OUH would provide a clear and measurable indicator of assurance, demonstrating alignment with national expectations and best practice.

Furthermore, several NHS organisations have begun to recognise the importance of public learning in maternity care. For example, Trusts such as West Suffolk NHS Foundation Trust explicitly commit in their maternity strategies to publishing learning from patient feedback and complaints as part of building confidence and co-production with families⁹. Similarly, improvement frameworks supported by The King's Fund emphasise that safety improvement in maternity services depends on openness, shared learning and visible feedback to service users¹⁰. While approaches vary, these examples demonstrate a growing national recognition that transparency is not optional but integral to safe maternity systems.

Academic literature also strongly supports the link between transparent learning processes and improved patient trust and outcomes. Research published in *BMJ Open Quality* analysing maternity incident reports found that communication failures and inadequate learning responses were key contributors to severe maternal morbidity and that families' trust was significantly affected by how organisations responded after harm occurred¹¹.

Broader reviews of patient complaints handling in healthcare show that when organisations openly report themes, actions and outcomes, complaints decrease over time and patient satisfaction improves. Studies on continuity and informational transparency in postnatal care, such as those published in the *European Journal of Public Health*, further

⁷ <https://www.cqc.org.uk/publications/maternity-services-2022-2024/communication>

⁸ <https://www.cqc.org.uk/publications/major-report/state-care/2024-2025/focus/maternity>

⁹ <https://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Strategy/Our-maternity-and-neonatal-strategy.pdf>

¹⁰

https://assets.kingsfund.org.uk/f/256914/x/027ccc6bcf/improving_safety_maternity_toolkit_communication.pdf

¹¹ <https://bmjopenquality.bmj.com/content/14/1/e003112>

highlight that clear communication about changes and follow-up enhances confidence and reduces anxiety for families¹².

It is of significant concern that national official reports show there have been 31 recommendations to improve mental health and support services, but that maternal death rates from suicide are now 74% higher than in 2019 in the UK. Whilst a rare outcome and with a complexity of risk factors associated, it is important to be cognisant that a recent large observational study found the risk of suicide and postpartum depression is significantly higher for women who feel they were treated inadequately during childbirth (Martinez-Galliano, Risk of suicide and postpartum depression in women who feel they were treated inadequately during childbirth, *Women and Birth* Vol 38, Issue One). Any maternity complaints process needs to be fully cognisant of the importance of supporting maternal well-being through the process and analysing the experiences of the process by the complainants.

Importantly, the evidence suggests that learning reports are most effective when they go beyond description and include evidence of impact, such as changes in practice, reductions in repeat complaints, or improvements in patient experience metrics.

The proposed quarterly frequency that the Committee is recommending strikes an appropriate balance between responsiveness and rigour. It allows trends to be identified without overwhelming staff, while providing families and the public with regular assurance that learning is ongoing. Making the report public reinforces accountability and supports the Trust's wider Patient Experience and Engagement Strategy.

Crucially, such reporting would not be about attributing blame. Rather, it would demonstrate a mature safety culture in which complaints, baby deaths and adverse experiences are treated as opportunities for improvement, consistent with national patient safety principles and the NHS Constitution's commitment to openness.

Therefore, the Committee's recommendation for OUH to produce a quarterly, public-facing learning report on maternity complaints, patient experience, independent review involvement and impact is firmly grounded in local evidence, national regulatory expectations and academic research. In a maternity system where public confidence has been repeatedly tested, transparency is not an additional requirement but a foundational one. By adopting this recommendation, OUH would take a significant step towards rebuilding trust, strengthening learning and demonstrating leadership in maternity safety and accountability.

Recommendation 2: *For the Trust to produce a quarterly, public-facing learning report showing: complaint themes, patients' experience of the complaints process, actions taken, percentage achieved of involvement of independent reviewer in any baby death,*

¹² <https://academic.oup.com/eurpub/article/30/4/749/5497816>.

and evidence of impact. This is to ensure transparency and restore confidence in maternity services.

Evaluation framework: Reducing inequalities in maternity care requires more than good intentions and innovative programmes; it requires robust, transparent evaluation to ensure that interventions are effective, equitable and sustainable. The report submitted to the Committee for this item describes significant progress in addressing maternity inequalities through targeted initiatives. Chief among these is Equal Start Oxford, a community-led programme developed in partnership with local organisations to support women and birthing people from minoritised ethnic and migrant communities, particularly in East Oxford. The report highlights tailored antenatal education, outreach to the East Timorese community, translation support and collaboration with voluntary sector partners as key components of this work. The Trust also outlines its intention to expand this approach to Didcot and Banbury, recognising similar patterns of deprivation and unmet need.

Equal Start Oxford itself is well documented as a place-based intervention designed to address barriers in access, experience and outcomes for women from diverse migrant communities¹³. However, while these initiatives are widely regarded as positive, the OUH report provides limited detail on how success will be measured as the programme scales. In the absence of a structured evaluation framework, there is a risk that expansion decisions are driven by anecdotal success rather than demonstrable impact, and that learning is not systematically captured or shared.

National evidence shows that maternity inequalities are persistent, complex and deeply rooted in social determinants of health. Systemic biases have been a consistent finding of MBRRACE reports on maternal deaths with a 50 percent rise in the UK's maternal death rate between 2013 and 2023. Underserved groups include socio-economically disadvantaged women; ethnic minority groups (black women are nearly three times more likely to die) and women with health inequalities (women with physical and mental health conditions).

The *National Maternity and Perinatal Audit inequalities report* demonstrates clear disparities in outcomes by ethnicity and deprivation, underlining the need for targeted interventions and continuous monitoring¹⁴. NHS England's *Equity and Equality Guidance for Local Maternity Systems* explicitly calls on systems to co-produce interventions with communities and to evaluate their impact using meaningful data on access, experience and outcomes¹⁵.

¹³ <https://www.flosoxford.org.uk/equalstart/>; <https://researchequity.phc.ox.ac.uk/Projects/equal-start-oxford>

¹⁴ https://maternityaudit.org.uk/FilesUploaded/RCOG_Inequalities%20Report_Lay_Summary.pdf

¹⁵ <https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf>

Without formal evaluation, well-designed programmes risk becoming vulnerable to funding cuts, policy shifts or scepticism about their value. A structured framework allows Trusts to demonstrate that resources directed at underserved groups are not only ethically justified but also effective in improving outcomes and reducing long-term demand on services.

Moreover, other NHS systems and community-based maternity programmes increasingly recognise evaluation as integral to addressing inequalities. NHS England's Maternity and Neonatal Equalities Dashboard has been developed specifically to make disparities visible and support monitoring of progress over time¹⁶. At a local level, evaluations of community connector models, such as those reported in Kent, demonstrate how structured evaluation can inform refinement and scaling of equity-focused interventions¹⁷.

Academic reviews of large-scale maternity improvement programmes published in *BMJ Quality & Safety* highlight that many initiatives fail to demonstrate impact precisely because evaluation is weak or absent, limiting learning and sustainability¹⁸. These findings underscore the importance of embedding evaluation from the outset, particularly when programmes are expanded geographically.

Furthermore, the Committee is also recommending that the evaluation framework include uptake, impact on outcomes and service user satisfaction. This reflects a comprehensive and proportionate approach. Uptake data indicates whether programmes are reaching intended populations; outcome measures demonstrate whether they are making a tangible difference; and satisfaction data captures the qualitative dimensions of dignity, trust and cultural safety that are central to maternity care. Public health research consistently shows that community-based and outreach interventions are most effective when communities perceive them as relevant, respectful and responsive¹⁹.

The need for evaluation is particularly acute for maternity support provided to asylum seekers and refugees, who face well-documented barriers to accessing timely and appropriate care. A systematic review published in *BMJ Open* found that immigrant and asylum-seeking women in the UK are more likely to book late for antenatal care and experience poorer outcomes, driven by language barriers, lack of system knowledge and fear linked to immigration status²⁰. Reports by *Doctors of the World UK* similarly highlight delayed access, poor maternal mental health outcomes and inconsistent support for migrant women²¹.

¹⁶ <https://digital.nhs.uk/dashboards/maternity-and-neonatal-equalities-dashboard>

¹⁷ https://www.involvekent.org.uk/wp-content/uploads/2025/05/Maternity-Inequalities-Report-FINAL_compress.pdf

¹⁸ <https://qualitysafety.bmj.com/content/qhcearly/2023/11/28/bmjqs-2023-016606.full.pdf>

¹⁹ <https://www.ssph-journal.org/journals/international-journal-of-public-health/articles/10.3389/ijph.2023.1605239/full>

²⁰ <https://bmjopen.bmj.com/content/9/12/e029478>

²¹ <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/06/Maternity-care-report.pdf>

Specialist maternity services for migrant women, such as those evaluated at King's College Hospital, show high levels of user satisfaction but also underline the importance of capturing service user experience to understand gaps beyond clinical care²². These findings reinforce the importance of evaluation frameworks that include service user satisfaction alongside uptake and outcomes, ensuring that interventions respond to lived experience rather than solely clinical metrics.

Furthermore, the Royal College of Obstetricians and Gynaecologists' standards on cross-cultural communication and language support emphasise that interpretation and culturally safe communication must be routinely evaluated to ensure they are effective and trusted by service users²³. An evaluation framework that tracks uptake of translated services, changes in engagement and outcomes, and user satisfaction would allow OUH to move beyond counting provision towards understanding real-world impact.

In essence, the recommendation for OUH to develop a formal evaluation framework for Equal Start Oxford's expansion, asylum seeker support and translation and outreach programmes is firmly grounded in local evidence, national guidance and academic research. As Oxfordshire seeks to reduce entrenched maternity inequalities, evaluation is not an administrative burden but a vital enabler of learning, accountability and improvement. By adopting a framework that systematically assesses uptake, outcomes and service user satisfaction, OUH can ensure that innovation translates into measurable progress and that equity remains central to maternity care across the county.

Recommendation 3: *For the Trust to produce an evaluation framework for: Equal Start Oxford's expansion to Didcot and Banbury, general support for asylum seekers and underserved groups, and translation and outreach programmes. It is recommended that such an evaluation framework should include uptake, impact on outcomes, and service user satisfaction.*

Relationship between maternity tariffs, demand modelling, and BirthRate Plus projections with staffing expansion and burnout: Safe, high-quality maternity care depends on a delicate alignment between funding mechanisms, realistic demand modelling and sustainable workforce planning. The report submitted to the Committee for this item presents a picture of a service that has invested significantly in its workforce. The Trust reports a surplus of midwifery whole-time equivalents against its planned establishment and ongoing recruitment to build further resilience. At the same time, the report acknowledges the intensity of maternity work, the complexity of the caseload and the

²² <https://www.britishjournalofmidwifery.com/content/research/a-service-evaluation-of-a-specialist-migrant-maternity-service-from-the-users-perspective>

²³ <https://www.rcog.org.uk/media/l1ypcshk/cross-cultural-communication-and-language-support-standards-for-maternity-care-and-womens-health.pdf>

importance of staff wellbeing initiatives, including psychological support and professional advocacy. This juxtaposition—numerical workforce strength alongside persistent concern about pressure—raises an important question for scrutiny: how do staffing decisions relate to the funding and activity assumptions that underpin them?

Without a clear explanation of how staffing expansion is supported by tariff income and demand forecasts, it becomes difficult for non-executive oversight bodies, staff and the public to understand whether workforce growth is sustainable or whether it risks creating hidden pressures elsewhere in the system.

The Committee understands that maternity services in England are funded through the NHS Payment Scheme, which replaced the National Tariff in 2023. Maternity prices are largely activity-based, covering antenatal, intrapartum and postnatal care, and are informed by national cost modelling and policy adjustments²⁴. NHS England's development of the maternity formula for 2025/26 allocations explicitly recognises that maternity activity is complex, unpredictable and influenced by population characteristics, deprivation and clinical acuity²⁵.

However, national bodies and professional organisations have repeatedly noted that the tariff does not always fully reflect the true cost of rising complexity in maternity, safeguarding responsibilities and non-clinical workload borne by maternity staff. This creates a risk that Trusts expand staffing to meet safety expectations without a commensurate increase in sustainable income, placing pressure on budgets and, indirectly, on staff through efficiency demands. Explaining how OUH reconciles tariff income with workforce expansion is therefore essential for transparency and assurance.

Demand modelling in maternity must go beyond headline birth numbers. While national birth rates have fluctuated, multiple analyses show that clinical complexity, social vulnerability and acuity per birth have increased, requiring more staff time per woman and baby. The **National Audit Office's** modelling of maternity services demonstrated that changes in demand characteristics, rather than volume alone, can significantly affect workforce requirements and service pressure²⁶.

Contemporary NHS planning approaches, such as those used by The Strategy Unit, emphasise collaborative modelling that incorporates population growth, deprivation, clinical risk and service configuration rather than simple activity counts²⁷. Other systems, including North East London, have published demand and capacity reviews explicitly linking

²⁴ <https://www.england.nhs.uk/long-read/25-26-nhsps-annex-d-prices-and-cost-adjustments/>.

²⁵ https://www.england.nhs.uk/wp-content/uploads/2025/06/PRN01693_i-development-of-the-maternity-formula-for-2025-26-allocations.pdf

²⁶ <https://www.nao.org.uk/wp-content/uploads/2013/11/Modelling-of-maternity-services-in-England.pdf>

²⁷ <https://www.strategyunitwm.nhs.uk/our-work?f%5B0%5D=topic%3A278>

population projections, workforce modelling and service redesign to ensure sustainability²⁸.

Against this backdrop, the JHOSC recommendation seeks assurance that OUH's staffing plans are grounded in similarly sophisticated demand modelling, and that the assumptions underpinning recruitment are explicit and that they can be subject to scrutiny.

Birthrate Plus remains the nationally endorsed tool for midwifery workforce planning and is recommended by NICE and the Royal College of Midwives as the basis for establishing safe staffing levels²⁹. The methodology uses local activity, case mix and models of care to calculate recommended establishments and is widely used across the NHS.

However, an independent review of the Birthrate Plus methodology published in 2026 highlighted that while the tool is robust, it must be interpreted in the context of rising acuity, expanded non-clinical responsibilities and workforce wellbeing considerations³⁰. The review cautioned against treating Birthrate Plus outputs as a complete solution to workforce sustainability, emphasising the importance of professional judgement and transparency in how results are applied.

This is particularly relevant to the Committee's recommendation. Publishing Birthrate Plus projections without explaining how they interact with funding constraints and burnout risks can create a false sense of assurance. Conversely, openly describing how OUH uses Birthrate Plus alongside demand modelling and financial planning would demonstrate mature workforce governance.

A growing body of academic evidence also shows that staffing levels alone do not protect against burnout if workload intensity, recovery time and organisational pressures remain unaddressed. A large UK survey published in Midwifery found high levels of burnout and stress among midwives, with staffing shortfalls and lack of recovery time strongly associated with poorer emotional wellbeing and intentions to leave the profession³¹.

Research from the University of Bath, funded by the NIHR, similarly identified workload, staffing pressure and organisational demands as key drivers of stress and attrition among midwives, noting that recruitment

²⁸ <https://northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/Best-start-in-life-shaping-future-maternity-neonatal-services-summary-July-2024.pdf>

²⁹ <https://www.rcm.org.uk/wp-content/uploads/2025/02/birthrate-plus-what-it-is-and-why-you-should-be-using-it.pdf>; <https://www.nice.org.uk/guidance/ng4/resources/birthrate-plus-workforce-planning-methodology-and-birthrate-plus-intrapartum-acuity-tool-pdf-3300074199493>

³⁰ <https://birthrateplus.co.uk/wp-content/uploads/2026/01/Birthrate-Plus-Methodology-Review-REPORT.pdf>

³¹ <https://researchprofiles.herts.ac.uk/en/publications/the-importance-of-recovery-and-staffing-on-midwives-emotional-wel/>

without systemic change risks perpetuating burnout³². The UK WHELM study, commissioned by the Royal College of Midwives, further demonstrated that emotional distress and poor working conditions are closely linked to workforce sustainability and patient safety³³.

These findings underscore why scrutiny bodies increasingly expect trusts to explain not only how many staff they employ, but why those numbers are appropriate given funding, demand and wellbeing considerations.

The JHOSC's recommendation does not seek to challenge OUH's commitment to workforce investment. Rather, it calls for a clear narrative that connects tariff income, demand forecasts, Birthrate Plus outputs and burnout mitigation strategies. Such an explanation would allow stakeholders to understand whether staffing expansion is financially sustainable, whether demand modelling adequately reflects complexity, and how workforce planning contributes to reducing burnout rather than simply absorbing pressure.

Other NHS trusts, such as Sheffield Teaching Hospitals, routinely publish board papers linking Birthrate Plus assessments, funding decisions and risk management, providing a useful model for transparency³⁴.

In essence, the recommendation that OUH plan and explain how the national maternity tariff, demand modelling and Birthrate Plus projections align with staffing expansion and staff burnout is firmly grounded in national policy, financial reality and workforce evidence. In a service where demand is complex, funding is constrained and staff wellbeing is under sustained pressure, transparency is essential to maintaining confidence and ensuring sustainable improvement. By articulating this alignment clearly, OUH can demonstrate responsible stewardship of public resources, commitment to staff wellbeing and a robust approach to safe maternity care in Oxfordshire.

Recommendation 4: *For the Trust to plan and explain how the current national maternity tariff, demand modelling, and BirthRate Plus projections align with staffing expansion and staff burnout.*

Previous JHOSC recommendations on epilepsy and maternity:

Epilepsy remains one of the most significant medical causes of maternal mortality in the United Kingdom, despite being a condition for which much of the risk is potentially preventable through timely, specialist and coordinated care. There has been a near doubling of maternal deaths in this population since 2015 with MBBRACE recognising system bias and

³² <https://www.bath.ac.uk/announcements/midwife-stress-research-reveals-what-creates-most-stress-for-midwives-and-the-best-interventions/>

³³ <https://www.rcm.org.uk/wp-content/uploads/2024/06/work-health-and-emotional-lives-of-midwives-in-the-united-kingdom-the-uk-whelm-study.pdf>

³⁴ https://www.sth.nhs.uk/clientfiles/File/Ciii%20-%20Midwifery%20Workforce%20Current%20Position%20and%20Future%20State%20Proposal%20BoD%2026_09_2023.pdf

recommending specialist risk assessment and communication. The Oxfordshire Joint Health Overview and Scrutiny Committee's recommendation that Oxford University Hospitals NHS Foundation Trust (OUH) provide a written update on progress against the previously accepted JHOSC recommendation on epilepsy (January 2025), and explain how it will align with the NHS England Maternal Care Bundle element on epilepsy in pregnancy that was published last Autumn is therefore rooted in both local accountability and national patient-safety priorities.

The report submitted to the Committee for this item focuses primarily on trends in birth outcomes, patient experience, workforce and inequality initiatives. While it outlines a range of improvement programmes and partnerships, it contains limited explicit detail on epilepsy-specific pathways, learning or progress against earlier scrutiny recommendations. In the context of a condition associated with rare but catastrophic outcomes, the absence of a visible update does not imply inaction, but it does create an assurance gap for scrutiny bodies and the public.

The Committee had previously made recommendations relating to epilepsy, recognising national evidence that epilepsy-related maternal deaths frequently involve missed opportunities for pre-conception counselling, early specialist review, medication optimisation and postnatal safety planning. The recommendations included increasing the epilepsy workforce and co-production on mitigating harms. A written update would therefore allow the Committee to understand what has changed in practice since the recommendation was accepted, what remains outstanding, and how learning is being embedded across maternity, neurology and primary care services.

In January 2026, NHS England published The Maternal Care Bundle, establishing a national baseline for reducing maternal mortality and morbidity across five clinical areas, one of which is epilepsy in pregnancy³⁵. The inclusion of epilepsy reflects long-standing findings from MBRRACE-UK that epilepsy, particularly sudden unexpected death in epilepsy (SUDEP), is a recurrent cause of maternal death, often linked to fragmented care, lack of specialist input and inadequate postnatal planning.

The epilepsy element of the Maternal Care Bundle emphasises early identification of women with epilepsy, timely referral to specialist epilepsy services, coordinated obstetric-neurology care, clear intrapartum and postnatal plans, and robust communication across services. NHS England has been explicit that Trusts are expected to assess their current practice against the bundle and implement system-level changes where gaps are identified³⁶.

³⁵ <https://www.england.nhs.uk/long-read/the-maternal-care-bundle>

³⁶ <https://www.nhsbmnetwork.org.uk/wp-content/uploads/2026/01/NHS-England-The-Maternal-Care-Bundle.pdf>

In this context, the JHOSC's recommendation is not merely about reporting, but about alignment with a new national safety framework that now sets clear expectations for providers.

Independent safety investigations reinforce the importance of transparency and follow-up. The Maternity and Neonatal Safety Improvement Programme (MNSI) has published safety spotlights highlighting repeated themes in epilepsy-related maternal deaths, including lack of contraception counselling including lack of person-centred communication on risk of SUDEP, missed opportunities for medication review and optimisation, and insufficient postnatal follow-up³⁷. These investigations consistently stress that learning must be demonstrable and shared, rather than remaining implicit within organisations.

Providing a written update to the Committee would allow OUH to demonstrate how national learning is being translated into local practice, including whether epilepsy-related incidents or near misses have been reviewed, and how findings have informed service changes.

Moreover, academic literature consistently shows that women with epilepsy face substantially higher risks in pregnancy, particularly when seizures are poorly controlled or specialist care is delayed. A large systematic review and meta-analysis published in *PLOS Medicine* found that epileptic seizures during pregnancy are associated with increased risks of preterm birth, low birth weight and perinatal complications, with socioeconomic factors influencing seizure control³⁸. Research published in *NIHR Open Research* further demonstrates that women with severe or uncontrolled epilepsy are at particularly high risk and should be prioritised for early specialist review and multidisciplinary planning³⁹.

Qualitative research also highlights that women with epilepsy often experience fragmented care and uncertainty about who is responsible for their management during pregnancy and the postnatal period. A 2025 systematic review in *Seizure: European Journal of Epilepsy* emphasises the importance of clear pathways, continuity and communication to improve both safety and experience⁴⁰.

These findings underline why scrutiny bodies increasingly expect providers not only to state that guidance exists, but to demonstrate progress in implementing it.

A written update to JHOSC would serve several critical functions. First, it would provide assurance that the Trust has acted on an accepted scrutiny recommendations, respecting the accountability relationship

³⁷ <https://www.mnsi.org.uk/news/maternal-care-bundle-safety-spotlights/>.

³⁸ <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004580>

³⁹ <https://openresearch.nihr.ac.uk/articles/4-53>

⁴⁰ [https://www.seizure-journal.com/article/S1059-1311\(25\)00279-1/fulltext](https://www.seizure-journal.com/article/S1059-1311(25)00279-1/fulltext)

between the NHS and local democratic oversight. Second, it would allow OUH to set out explicitly how its current epilepsy pathways align with the Maternal Care Bundle, including any gaps, risks or planned improvements. Third, it would support transparency for service users who gave evidence to the committee, many of whom are acutely aware of national safety concerns relating to epilepsy in pregnancy.

Recommendation 5: *For the Trust to provide a written update on progress on the accepted JHOSC recommendation on epilepsy within 28 days, and how it plans to align with the NHS England maternity bundle section on epilepsy.*

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 - Power to scrutinise health bodies and authorities in the local area
 - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 - Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.
16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.
17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.
18. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Barbara Shaw
Sylvia Buckingham

Annex 1 – Scrutiny Response Pro Forma

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