Please note that a range of academic studies and cases from other areas around the country have been utilised and referenced to inform the observations and recommendations contained in this report.

You will find that the report contains some key observation points and recommendations around the following areas:

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.

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

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.

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.

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.

Response to Health Scrutiny Committee Recommendations

Oxford University Hospitals NHS Foundation Trust – Maternity Services

Oxford University Hospitals NHS Foundation Trust (OUH) welcomes the recommendations from the Health Scrutiny Committee and recognises the importance of transparency, learning and continuous improvement in rebuilding confidence in maternity services. The Trust is committed to delivering safe, equitable and compassionate care. It has set out below its response to each recommendation, including actions already taken and those planned.

Rec	Trust response	What we are doing (assurance)	How we will measure impact	Governance / reporting
1	**Accept**	Implement and embed a Trust-wide Maternity Communication Standard (listening, clarity/timing, translation/accessibility, expectations at key points of care), co-designed with service users; deliver staff training and updated information resources.	Patient experience (Friends and Family Test and targeted feedback), complaints themes, interpreter offer/uptake, audit of documentation/communication touchpoints.	Maternity governance via Perinatal Quality and Outcomes Meeting and the national patient-facing Perinatal Quality Oversight monthly report; escalated via the maternity quality dashboard to Trust Board.
2	**Accept**	Publish a quarterly public-facing learning and improvement report (themes, experience of complaints process, actions/ownership, independent review involvement in baby deaths, evidence of impact).	Timeliness of publication; completion of actions; service-user feedback on transparency; trends in repeat themes and complaint handling metrics.	Reviewed through Perinatal Quality and Outcomes Meeting and reported to Trust Board; published on Trust website.
3	**Partially accept**	Implement a standard evaluation framework for Equal Start Oxford and wider outreach/translation programmes, with commitment to publish outcomes; expansion beyond OX4 is subject to sustainable funding/commissioning decisions.	Uptake/reach (by locality and demographics), experience/satisfaction, equity indicators, and selected outcome measures (access, timeliness, continuity).	Quarterly review through maternity governance; shared with partners/commissioners; escalated to Trust Board via the maternity assurance route.

4	**Accept**	Set out how tariff, demand modelling and Birthrate Plus inform staffing establishment and burnout mitigation; maintain an explicit workforce risk and mitigation plan.	Workforce indicators (vacancy/retention/sickness), acuity/activity trends, escalation frequency, staff survey/pulse, and wellbeing indicators.	Coordinated finance/workforce review; maternity risk register and Perinatal Quality and Outcomes Meeting; Trust Board reporting.
5	**Accept**	Provide written update to HOSC within 28 days and align local pathway to NHS England maternity bundle epilepsy section; strengthen audit, data reporting, and training.	Bundle compliance, audit findings, and actions; timeliness of referral to MMC; completion of personalised plans; training completion.	Maternity Clinical Governance Committee, Perinatal Quality and Outcomes Meeting and Trust Board reporting; Maternal Medicine Network collaboration.

1. Trust wide maternity communication standard - Accept Recommendation Response and progress

OUH has developed and is implementing a Trust wide Maternity Communication approach co-designed with service users through the Oxfordshire Maternity and Neonatal Voice Partnership. This work has been shaped directly by feedback from listening events, complaint themes, focus groups with families from seldom heard communities and feedback from staff. As a result, the approach is structured around four core communication priorities:

- Listening and empathy, including trauma-informed practice and validation of lived experience.
- Timing and clarity of information, ensuring information is delivered proactively and revisited during care.
- Accessible communication, including compliance with the Accessible Information Standard, routine offer of translation and interpretation services, and culturally appropriate information.
- Expectations at key points of care, including induction of labour, intrapartum care, and postnatal care, with standardised explanations to reduce uncertainty and anxiety.

The approach is being embedded through a clear implementation plan, including:

- Updated maternity information resources and digital content.
- Staff education via mandatory training and induction.
- Local leadership oversight through matrons, Deputy/Head of Midwifery, Director of Midwifery and Trust Patient Experience Team.
- Monitoring via patient feedback, Friends and Family Test and complaint themes. This is reported through the Patient Engagement and Experience Strategic Committee.
- Oversight provided at Board level, including input from Non-Executive Director safety champions.

- External 'critical friend' scrutiny from the Oxfordshire Maternity and Neonatal Voices Partnership, contributing independent service user perspectives.

Assurance: By the end of Q2 2026/27 we will have (1) refreshed induction and mandatory training materials, (2) updated core patient information and key explanations at induction of labour/intrapartum/postnatal touchpoints, and (3) implemented a monthly monitoring pack (Friends and Family Test, complaints themes and accessibility/translation metrics) reviewed through maternity governance.

Progress and compliance with the communication standard will be reported through maternity governance, including the national patient-facing monthly Perinatal Quality Oversight report, and escalated to Trust Board via the maternity quality dashboard. The Patient Engagement and Experience Committee also provides a route to the Board for oversight.

2. Quarterly public facing learning report - Accept Recommendation
Response and progress

The Trust is implementing a quarterly, public facing maternity learning and improvement report to increase transparency and the public's confidence in the service. This builds on existing governance processes and responds directly to service user feedback requesting greater visibility of learning.

Each report will include:

- High-level themes emerging from complaints and concerns, with anonymised exemplars.
- Feedback on service users' experience of the complaints process, informed through follow-up engagement.
- Actions taken and learning implemented, with clear ownership and timescales.
- Compliance with national guidance, including the percentage of cases involving an independent reviewer in any baby death, aligned to the Perinatal Mortality Review Tool (PMRT) requirements.
- Evidence of impact, including changes to pathways, practice, or outcomes.

Reports will be published on the Trust website and reviewed through the Trust's governance structure, with formal oversight via the Perinatal Quality and Outcomes Meeting (PQOM) and Trust Board reporting to ensure accountability and assurance.

3. Evaluation framework for Equal Start Oxford and outreach programmes - Partially Accept Recommendation

Response and progress
OUH partially accepts this recommendation. The Trust agrees that a robust and consistent evaluation framework is required for Equal Start Oxford and for its wider outreach and translation activity and confirms that this will be implemented. However, expansion of the Equal Start Oxford model to additional localities, including Didcot and Banbury, is dependent on funding and commissioning decisions. OUH will continue to work with system partners to support this where possible.

Equal Start Oxford is a cross-sector partnership between Oxford University Hospitals NHS Foundation Trust and Flo's – The Place in the Park, established in 2022 to address entrenched health inequalities affecting pregnant women and young families in Oxford's OX4 area. As a place-based, community-led early intervention model focused on the first 1001 days of life, Equal Start Oxford demonstrates how collaboration across healthcare, community organisations, and lived-experience leadership can improve health equity.

Equal Start Oxford's current evaluation framework, supported by NIHR ARC, charts uptake of programme offers and includes capture of service user feedback (summarised below), further detailed breakdown is available on request. There is a plan for expanded impact measurement reflecting a commitment to understanding both immediate and long-term outcomes for mothers, families, and communities.

The Equal Start Oxford programme delivers holistic, culturally responsive support that tackles the social determinants of health and improves access to maternity care. Its integrated approach combines health justice casework, tailored antenatal education, peer-led groups, English language provision, and early years support. Qualitative evaluation demonstrates how close working between community partners and OUH maternity services has been central to building trust among underserved populations, improving access to care, and empowering women to navigate complex systems. Service user and professionals feedback indicates improved wellbeing, more positive care experiences, and reduced pressure on maternity teams—highlighting the system-wide benefits of coordinated cross-sector working.

Equal Start Oxford's impact is strengthened by its emphasis on community capacity-building. Initiatives such introduction to community interpreter training programmes enable women to gain skills, confidence, and agency while supporting others. User feedback shows that multilingual, community-informed OUH EDI Midwife- led antenatal education classes improve understanding of pregnancy, birth, and newborn care, leading to greater preparedness and engagement with services. In the ESO health justice casework, Equal Start Oxford maternity advocates have supported 87 new referrals from maternity with over 1,100 actions in the past year addressing issues with housing, welfare entitlements, food insecurity, and immigration issues.

Equal Start Oxford illustrates that cross-sector, community-rooted approaches are essential to improving health equity by aligning services, addressing social need, and strengthening the capabilities and resilience of the communities they serve.

OUH agrees with the recommendation to strengthen evaluation and has developed an evaluation framework for:

- Equal Start Oxford expansion to Didcot and Banbury.
- Support for asylum seekers and underserved groups.
- Translation, advocacy, and outreach programmes.

The framework has been co-designed with service users, community partners and maternity advocates and includes:

- Uptake and reach (e.g. demographic profile, geographical coverage).

- Impact on experience and outcomes, including continuity of care and access to services.
- Service user satisfaction, using qualitative and quantitative feedback.
- Measures to address equity, aligned with known maternity inequalities.

Evaluation findings will be reviewed quarterly by the service, and partners as stated above, and reported through maternity governance and the Trust Board to demonstrate impact and value, supporting continuous improvement and commissioning decisions. This approach builds on the work described in previous HOSC reporting on Equal Start Oxford and planned expansion.

Equality, Diversity, and Inclusion (EDI) – Evaluation Summary

Response and progress
To provide assurance on the impact and evaluation of Equality, Diversity, and Inclusion (EDI) activity within Oxfordshire Maternity Services, with a focus on reducing health inequalities, improving access, and enhancing experience and outcomes for women facing the greatest barriers to care.

Analysis of 8,474 women booked into maternity services demonstrates a diverse population with significant social and health complexity, including:

- 31% women from Black, Asian, Mixed or Other ethnic backgrounds
- 17% with a primary language other than English; 4.7% requiring interpreter support
- High prevalence of mental health needs (33%), recent migration (7%), and other social vulnerabilities.

This data underpins targeted, proportionate EDI interventions.

Improving Access to Care
- Targeted outreach (e.g. maternity immunisation hubs) showed improved engagement among ethnic minority women when clinics were delivered locally with interpreters and senior clinical presence. Qualitative staff feedback supports improved reach and acceptability, leading to extension of this model to additional localities.
- Migrant focused multidisciplinary clinics (ROSE and ISIN RUA) demonstrated strong qualitative impact, with women reporting reduced anxiety, improved understanding and high satisfaction with holistic, joined up care. Evaluation to date is predominantly service user feedback, with further quantitative work planned.
- The “Book by 10” campaign addressed late booking into maternity care, particularly among Black and Chinese women. Baseline audit identified delays occurring prior to system entry. Screening lead feedback indicates an observed >10% increase in booking by 10 weeks; formal re-audit is scheduled in 2026.

Improving Experience and Engagement
- SAPLINGS community-based support (Banbury) combined clinical care, therapy, parent education, and peer support for women with complex socio-economic needs. Evaluation is qualitative, with consistent reports of

reduced isolation, increased confidence, and improved engagement with services.
- Translated antenatal education and unit tours, delivered through community partnerships, supported over 100 women. Women reported increased confidence, reduced fear of childbirth and improved understanding of care pathways. Attendance and feedback data demonstrate strong engagement, with repeat participation.

Tackling Structural Barriers

- Digital inclusion support mitigated digital exclusion risks following implementation of a fully digital maternity record. Over 70 women were supported through provision of phones or data-enabled SIM cards, improving safeguarding, engagement, and access to urgent care. Evaluation focuses on reach and access rather than longer-term outcomes.
- Improved ethnicity data quality was achieved through regular leadership reminders and incorporation of ethnicity discussions into mandatory Active Bystander training. A sustained reduction in "unknown/not stated" ethnicity recording has been observed, strengthening inequality monitoring, though impact has not been formally evaluated.

Workforce Culture and Capability

- Active Bystander Training evaluation (27 respondents) showed improvements in staff confidence (78%), motivation (96%), and self-reported intervention behaviour (70%). Opportunity barriers remain (time, hierarchy, reporting clarity), highlighting the need for organisational systems to reinforce learning.

Summary

- EDI activity is data driven, targeted and proportionate, aligned to local population needs.
- Evaluations demonstrate clear improvements in access, experience, and staff capability, particularly for migrant women and those facing social, language and digital barriers.
- Evidence is strongest where community partnership and co-production models are used.
- Further formal quantitative evaluation is planned to strengthen assurance, alongside continued use of qualitative service user feedback.

4. Alignment of maternity tariff, demand modelling, and staffing sustainability - Accept recommendation

Response and progress

The Trust recognises the national constraints associated with the maternity payment model and the increasing acuity and complexity of care. OUH provides assurance that staffing decisions and risk mitigations are explicitly aligned to demand and safety by triangulating national funding assumptions with local activity/acuity intelligence and Birthrate Plus workforce methodology, and by escalating sustainability risks through formal governance.

National maternity tariff assumptions
Maternity services across England are largely commissioned by the Integrated Care Boards (ICBs). The payment model for Maternity services is based on fixed payment made to the Trust, designed to cover the expected annual costs for service. This means that any increase in activity across the service is not reflected in income given to the Trust. The fixed payment is split between to obstetric and midwifery care and broken down to reflect levels of complexity and types of deliveries. However, the payment amount is based on national data and does not reflect specific populations' needs. Hence the Trust receives same funding however complex or extensive the care needed

In recent years, this is particularly challenging in relation to increase number of elective c- sections. While there is a set amount of money dedicated to the Trust to cover that type of activity, it does not match the recent demand on the service.

There will be a marginal increase of overall fixed element for Maternity from 1st April 2026- to be agreed. The increase will reflect inflation and will not accommodate specific changes to activity types or levels.

- Local demand modelling
- Birthrate Plus workforce projections
- Staff wellbeing and burnout risks

This is overseen through a coordinated workforce and finance approach, with:

- Regular review of Birthrate Plus data to inform staffing establishment.
- Measurement of triage and Maternity Assessment Unit (MAU) contacts and attendances, including analysis of trends and demographic breakdowns.
- Ongoing review and consultation regarding community on-call requirements versus available capacity to ensure safe and responsive service delivery.
- Escalation of workforce risks, including fatigue and burnout, via the maternity risk register and PQOM.
- Targeted workforce investment and wellbeing initiatives, including retention, support, and flexible working.
- Transparent reporting to Trust Board on workforce sustainability and risk.

This alignment ensures staffing decisions are evidence based and responsive to demand, while prioritising staff wellbeing as essential to patient safety.

Assurance: During 2026/27 the Trust will publish (via the maternity assurance route) an updated demand-and-capacity narrative summarising tariff context, local activity/acuity trends, Birthrate Plus conclusions and agreed establishment, and the associated burnout/fatigue mitigations. Workforce risks will remain explicit on the maternity risk register with defined actions, owners and review dates, and exceptions will be escalated via PQOM to Trust Board.

- Access to mental health support — 24/7 mental health services, counselling, and occupational health pathways to provide timely professional support.

- Flexible working options — Remote working arrangements, flexible scheduling, and autonomy over work patterns to reduce stress and improve work–life balance.

5. Epilepsy pathway update and alignment with NHS England maternity bundle - Accept recommendation

Response and progress
OUH confirms that a full written update on epilepsy in maternity care will be submitted to HOSC within 28 days, in line with the previously accepted recommendation. This summary provides an overview of current progress, alignment with national standards, and governance arrangements.

The recent Epilepsy Maternity Self-Assessment (April 2026) demonstrates strong foundations in several areas:

- Established preconception pathways, including epilepsy specific input and comprehensive risk-based counselling.
- Named clinical leads for obstetrics and neurology/epilepsy.
- A functioning epilepsy pregnancy MDT, including neurology, maternal medicine, and obstetric medicine.
- Robust emergency escalation, with automatic obstetric/midwifery review for PWE attending ED.

Areas requiring further development include:

- Consistent referral of all pregnant PWE to the Maternal Medicine Centre within two weeks.
- Universal provision of personalised care plans, birth plans, and intrapartum seizure plans by 37 weeks.
- Strengthening postnatal review, particularly timely specialist review after ASM changes.
- Embedding epilepsy-specific audit, data reporting, and governance processes.

OUH is aligned with several core elements of the national bundle:

- Multidisciplinary leadership is in place and accessible.
- Comprehensive preconception information is routinely provided.
- 24-hour maternity advice is consistently available.
- Seizure management plans are routinely included in care.

Further work is underway to:

- Ensure personalised care planning is consistent for all PWE.
- Strengthen escalation pathways into Maternal Medicine Centre for first seizures in pregnancy.
- Improve partner facing information and discharge planning documentation.
- Expand training and competency assessment for maternity and neurology teams.

The self-assessment highlights the need to formalise epilepsy specific governance:

- Annual audit of epilepsy maternity care is not yet embedded.
- Service user review of the epilepsy pathway is not currently undertaken.
- Data reporting to the Maternal Medicine Network is inconsistent.
- Epilepsy training is included in mandatory training every three years, but training needs analysis is not routinely completed.

OUH will implement:

- Annual epilepsy maternity audit covering the full pathway.
- A structured service user review process.
- Quarterly reporting through maternity governance.
- Clear risk register entries for identified gaps.
- Strengthened data flows to the Maternal Medicine Network.

This work is overseen through established maternity governance structures, including:

- Maternity Clinical Governance Committee
- Perinatal Quality and Outcomes Meeting (PQOM)
- Trust Board reporting through the Maternity Assurance Framework
- Maternal Medicine Network collaboration

These structures will ensure ongoing monitoring, compliance with the NHS England Maternity Care Bundle, and continuous improvement.

Conclusion

OUH welcomes the Health Scrutiny Committee's recommendations and provides assurance that they are being implemented through a clear programme of work, with defined deliverables, measurable impact, and Board-level oversight. The Trust accepts recommendations 1, 2, 4 and 5 in full and partially accepts recommendation 3. OUH will implement a robust evaluation framework for Equal Start Oxford and wider outreach/translation activity, while recognising that any expansion to additional localities is dependent on sustainable funding and commissioning decisions.

Over 2026/27 the Trust will evidence progress by: embedding the Maternity Communication Standard (including accessibility/translation metrics) and implementing routine monitoring via patient feedback, Friends and Family Test and complaints themes; publishing a quarterly public-facing learning and improvement report; maintaining an explicit workforce sustainability and burnout risk plan informed by demand modelling and Birthrate Plus; and submitting the epilepsy pathway update to JHOSC within 28 days alongside implementation of strengthened audit, training and data reporting. Delivery will be tracked through the maternity risk register and PQOM, with escalation through the maternity quality dashboard to Trust Board. This governance approach, alongside ongoing co-design with service users through OMNVP, underpins the Trust's commitment to transparency, equity and continuous improvement and supports the restoration of confidence in OUH maternity services.