



Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Oxfordshire Joint Health Overview and Scrutiny Committee
Thursday 29 January 2026

Title:	Oxford University Hospitals NHS Foundation Trust Maternity Service Update Report
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Oxford University Hospitals NHS Foundation Trust Maternity Service Update Report

Introduction

- 1.1. This report provides an update on maternity services at Oxford University Hospitals NHS Foundation Trust (OUH) for the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC). It outlines recent developments, clinical outcomes, patient and staff experience, and responses to external reviews, including the October 2025 Care Quality Commission (CQC) inspection and the National Maternity and Neonatal Investigation. The report also highlights initiatives addressing health inequalities, service improvement programmes, and workforce developments.
- 1.2. The terms “mothers” and “women” are used inclusively for all birthing individuals.

Trends in Birth Injuries, Deaths, and Birth Trauma

Birth Injuries

- 1.3. OUH monitors birth outcomes to identify trends and implement improvements that reduce risk and enhance care. Key indicators for birth injuries are monitored for both mothers and babies.

Birth Injuries – Women

- 1.4. OUH monitors two key indicators of maternal birth injury - postpartum haemorrhage (PPH) >1500ml and third- or fourth-degree perineal tears and benchmarks performance against national standards (NMPA 2023: PPH 3.41%, tears 3.29%).
- 1.5. As indicated in the table below OUH rates have remained below national benchmarks and the rates of these injuries have remained consistently below the published UK rates and targets.

Year	Total Births	PPH >1500ml	3 rd or 4 th degree tear
2020	6768	2.25% (152)	2.25% (152)
2021	7343	2.02% (148)	1.78% (131)
2022	7396	2.35% (168)	1.71% (122)
2023	6789	2.74% (186)	2.08% (141)
2024	7389	4.13% (305)	2.16% (160)
2025	7218	2.86% (207)	1.84% (133)
Published UK Rates/ Target		3.41%	3.29%

NMPA 2023			
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Table 1: Number and Percentage of PPH >1500ml and 3rd or 4th-degree Tear at OUH

- 1.6. In 2024/25, maternal birth injuries were designated a quality priority. Themes and learning are shared with clinical teams, informing training, pathway refinement, and audit. Oversight is maintained through daily operational review and routine reporting.
- 1.7. A new induction of labour (IOL) improvement initiative was launched to reduce delays and improve outcomes. Measures include daily risk assessments, scheduling changes, and monitoring of delays at 6, 12, and 24-hour intervals. Early results show a reduction in delays over 24 hours from 42 in November to 14 in December 2025.
- 1.8. OUH is committed to minimising harm and delivering safe, person-centred maternity care. It benchmarks nationally, acts promptly where outcomes fall short, and demonstrates improvement transparently through continuous monitoring, staff education, and strong clinical governance.

Birth Injuries – Babies

- 1.9. OUH monitors two key indicators for birth injuries in babies: (1) full-term admissions to neonatal units (as part of the NHS England ATAIN programme), and (2) the number of babies requiring therapeutic cooling due to low oxygen levels at birth (hypoxic ischaemic encephalopathy, HIE).
- 1.10. Table 2 below provides a summary of the percentage and number of babies who were admitted to the neonatal unit after 37 weeks and the number and percentage of babies who required therapeutic cooling after 37 weeks.

Year	Total Births	NNU at >= 37weeks (ATAIN)	Cooled>= 37weeks
2020	6768	4.64% (314)	0.21% (14)
2021	7343	4.58% (336)	0.25% (18)
2022	7396	4.06% (290)	0.10% (7)
2023	6789	3.86% (262)	0.07% (5)
2024	7479	3.62% (271)	0.08% (6)
2025	7281	3.81% (278)	0.09% (7)
Published UK Rates / Target		National Target 6%	National Target 0.1 - 0.35%

Table 2: Number and Percentage of babies admitted to NNU after 37 weeks and cooled after 37 weeks.

- 1.11. As indicated in Table 2, there has been a significant improvement in the outcomes and a significant reduction in HIE requiring therapeutic cooling in

term infants (≥ 37 weeks) and fewer unplanned term admissions to the neonatal unit.

- 1.12. Work is underway to create a unified reporting system and harm level for birth injuries within the Buckinghamshire Oxfordshire and West Berkshire Integrated Care System (BOB ICS) and to establish consistent benchmarks for all providers.

Perinatal Mortality

- 1.13. MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national programme led by the National Perinatal Epidemiology Unit. It provides detailed, risk-adjusted data on perinatal and maternal mortality for NHS trusts. These figures are adjusted for maternal age, ethnicity, and socio-economic status to ensure fair comparisons across different populations.
- 1.14. Trusts are grouped by their level of maternity and neonatal service provision to account for variations in case mix. OUH, as a tertiary-level centre with neonatal surgery and a Level 3 neonatal intensive care unit, receives referrals for the most complex and high-risk pregnancies from across the region. MBRRACE-UK compares OUH's outcomes with other similarly specialised Trusts rather than general hospitals.
- 1.15. In May 2025, MBRRACE UK published the Perinatal Mortality Surveillance Report for UK perinatal deaths in 2023 (the latest available data). This report indicates that the OUH 2023 perinatal mortality figures were broadly in line with expectations for a tertiary maternity unit. As indicated in figure 1 below the stabilised and adjusted stillbirth rate of 3.6% (0.36%) is slightly above the peer average (by 0.18%), and the adjusted extended perinatal mortality rate of 6.23% is approximately average for the OUHs comparator group.

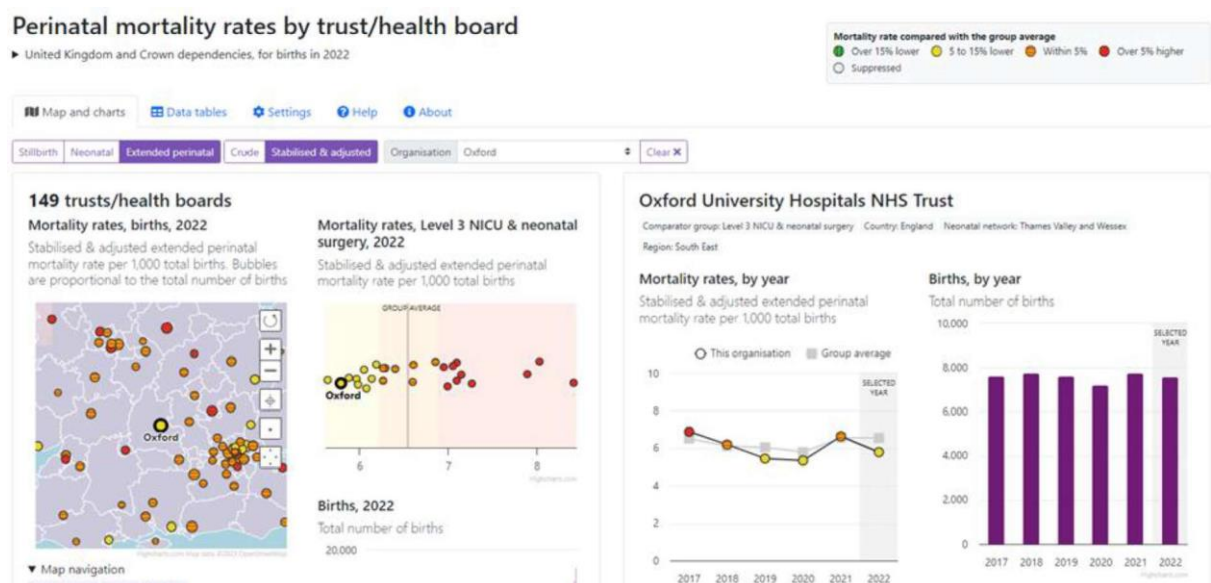


Figure 1: MBRRACE data from 2023

- 1.16. In real terms, these differences are very small, and OUH's outcomes remain within the normal range for complex tertiary maternity services. Year-to-year variations are to be expected; importantly, OUH's figures remain comparable with those of similar Trusts.
- 1.17. To access the specific perinatal mortality rates for Oxford, you can visit the [MBRRACE-UK website](#).

Birth Trauma and Birth Reflections Service

- 1.18. The definition of birth trauma can vary, but it generally includes both the psychological impact of a difficult birth and any physical complications that may arise. According to the Birth Trauma Association, up to one in three women in the UK experience a traumatic birth.
- 1.19. In 2022, OUH collaborated with Oxford Health to develop a Birth Trauma Pathway. This service offers direct access to the Birth Reflections service. The service is designed to assist individuals in processing their birth experiences and managing any emotional challenges they may face. In addition to self-referrals, general practitioners (GPs) can direct people to this service. Typically, the service caters to individuals up to one year postpartum, but it also considers referrals after a longer period on a case-by-case basis.
- 1.20. The table below outlines the rates of accessing the Birth Reflections service between 2021 until 31 December 2025.

Rate of Attendance at the Birth Reflections Service	
Year	Total
2021	207
2022	205
2023	237
2024	297
2025	333

- 1.21. The Trust also has in place a designated birth trauma midwife and the clinical lead consultant in Postnatal Care provide additional targeted support for women after childbirth. They also collaborate with specialised mental health midwives to identify and address mental health concerns that may require different referrals.
- 1.22. As of January 2026, a review of the Birth Reflections service has commenced with a focus on; promoting awareness of the service parameters, reducing the referral to appointment wait time, reducing Do Not Attends, the location and type of appointment (virtual /face-to-face) and how this service links to the Birth Trauma service. The service continues to

monitor the ethnicity of referrals, and the pending service review will include input and support from the EDI midwives to ensure any barriers for accessing the service are minimised.

CQC Inspection 2025 National Maternity and Neonatal Investigation

- 1.23. In October 2025, the Care Quality Commission (CQC) undertook an inspection of the Trusts maternity services. Inspectors reviewed the John Radcliffe Hospital and the Horton General Hospital simultaneously, and the visit spanned inpatient, outpatient and community maternity services. The Trust are awaiting the CQC's report.
- 1.24. OUH is one of the NHS trusts included in the independent National Maternity and Neonatal Investigation led by Baroness Valerie Amos. The investigation team has visited maternity and neonatal services at the John Radcliffe Hospital and the Horton General Hospital on 6–7 November and returned on 5 December for further walk rounds and staff discussions. The team fed back that staff engagement during the December visit was positive and constructive. The outcomes will be shared once the Investigation publishes its findings.

Tackling Inequalities in Maternity Care

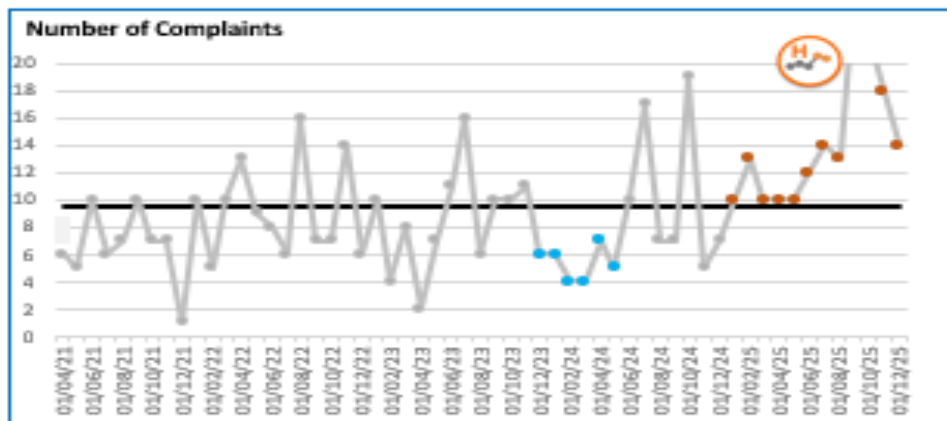
- 1.25. OUH is addressing maternal and perinatal health inequalities through targeted, community-led initiatives. The Equal Start Oxford programme, launched in early 2023, supports vulnerable populations by addressing non-clinical needs such as immigration, housing, and food insecurity, with tailored support for the East Timorese community. The model is expanding to Didcot and Banbury in 2026.
- 1.26. The Maternity Health Justice Partnership offers joint obstetric-midwifery clinics for vulnerable women, particularly asylum seekers in Section 95 accommodation. Monthly clinics at the Oxford Witney Hotel and Horton Hospital, supported by Asylum Welcome caseworkers, help address language and access barriers.
- 1.27. Between June 2023 and August 2025, OUH implemented a comprehensive equity programme addressing ethnic disparities, language needs, and screening inequalities, alongside enhanced staff training and community engagement. Translated antenatal classes reached 101 women across multiple languages.
- 1.28. While progress has been made, OUH remains committed to removing access barriers and raising awareness of available services to ensure equitable maternity care for all families in Oxfordshire.

Patient Experience

- 1.29. OUH maternity services use a variety of patient-experience data including: FFT, 'Say on the Day' feedback, complaints, PALS, incident reports, legal claims, OMNVP insights and listening events to identify priorities and improve care.

Complaints

- 1.30. Complaints have risen since September 2025, with a significant proportion relating to care delivered in previous years. The most common themes are communication, consent, and postnatal care.



- 1.31. Actions taken in response to complaint themes have prioritised patient experience and safety. Recent improvements include 24-hour visiting on postnatal wards, self-administration of pain relief, enhanced postnatal ward staffing models, and better information provision.
- 1.32. The monthly Triangulation and Learning Committee (T.A.L.C), comprising representatives from multiple departments and service users, meets monthly to analyse feedback from complaints, PALS, patient safety reports, and legal claims. This structured, data driven approach identifies trends and drives transparent, consistent improvements and has progressed improvement work in areas such as communication, pain assessment, and postnatal discharge processes. These mechanisms reflect the Trusts commitment to continuous quality improvement and optimal patient safety and experience, with clear alignment between patient experience themes and quality improvement priorities across the service.

CQC Maternity Experience Survey

- 1.33. The Care Quality Commission's 2025 national maternity survey published in December included feedback from 256 women who used Oxford University Hospitals' maternity services. The results showed strong performance, with seventeen survey questions scoring nine or higher out of ten—particularly for birth location choices, antenatal communication,

respect and dignity, partner involvement, and postnatal mental health support.

- 1.34. Compared to the 2024 survey, 24 scores improved, nine declined (notably pain management), and four stayed the same. Areas needing improvement include support for infant feeding and information provision, especially in post-birth and postnatal care, which lagged behind other Trusts and remain targets for future progress and improvement.
- 1.35. The results of the CQC maternity experience survey have been thoroughly reviewed and work has commenced to address the areas identified for improvement. Action plans are being developed in collaboration with staff and service users to ensure that the feedback translates into tangible enhancements in care quality and patient experience.

Patient Experience and Engagement Strategy

- 1.36. The OUH Patient Experience and Engagement Strategy (2026 to 2029) will accelerate maternity improvements by making feedback easier to collect, interpret and act upon. It widens feedback routes, introduces core patient experience questions, and provides a real time dashboard to identify and address issues such as communication. It also strengthens collaboration with service users by clarifying patient partner roles, improving partnership frameworks, and giving staff better support to work alongside people who have lived experience. The strategy prioritises equity by targeting engagement with underserved groups and it embeds clear processes for prioritisation, so maternity experience data informs decisions, resource allocation and governance reporting. Taken together, these measures provide a trust wide framework that supports ongoing maternity improvements.
- 1.37. The service also collects feedback from service users through two platforms: The Friends and Family Test (FFT) and 'Say on the Day' devices. In December 2025, the service received 176 responses from FFT and 319 from 'Say on the Day' devices, this combined feedback rated the service 96% Very good or good with an overall response rate of 85% compared to our delivery rate.
- 1.38. On the 12 December 2025, Maternity Services held a Listening Event attended by families, staff and partners. The event was advertised widely and open to members of the public. Members of Keep the Horton General and Families Failed by OUH participated. Insight and feedback captured are being reviewed will be used to shape approaches to communication and drawn upon for service improvement. Further events are being planned and are being developed with service users.

- 1.39. Learning from the stakeholder event in December are being fed into a new Perinatal Involvement and Engagement Plan. This plan outlines OUH's intent to proactively engage with the community to hear what is important to service users and to build confidence and trust, particularly in hard-to-reach populations.
- 1.40. The service continues to value and incorporate feedback from external partners and service users. In response to a Healthwatch report, the Banbury Sunshine Centre has launched various support services for vulnerable families. This includes the Saplings group, which offers weekly antenatal classes on healthy eating, oral hygiene, and mental health awareness. The centre also hosts a baby group to foster community among families after birth and has established a Multicultural Team to provide peer support and help families connect with relevant voluntary services.
- 1.41. The Trust also works alongside internal and external partners to improve maternity services. External stakeholders include the Buckinghamshire, Oxfordshire, and Berkshire Local Maternity and Neonatal System (BOB LMNS), NHS England, The National Childbirth Trust, Sands, and the Maternity and Neonatal Safety Improvement (MNSI) programme. The focus of these activities is on enhancing patient safety, integrating digital solutions, and addressing health inequalities. Internally, the Trust works with the Executive team, divisional leadership, and specialist teams, such as those in Patient Experience, Patient Safety, Governance and Assurance.

Perinatal Improvement Programme

- 1.42. Launched in July 2025, the Perinatal Improvement Programme (PIP) integrates and enhances maternity and neonatal services as the second phase of the Trust's developmental initiatives. The PIP is organised around Service User Experience, Safety, and Staff Experience workstreams, with governance provided by the Trust's Delivery Committee.
- 1.43. During its initial six months, the programme delivered quantifiable improvements across key areas. Maternity triage performance was notably enhanced, with 70% of women now seen within 30 minutes, and induction of labour delays were reduced by 37% through targeted measures such as the "Fire Break Friday" initiative. Engagement with patient feedback has also increased, as indicated by Friends and Family Test response rates rising from 11% to 47%. In December 2025, a stakeholder engagement event focused on the PIP content facilitated co-production of solutions with service users, including representation from campaign groups, which continues to inform ongoing improvements in communication, equity, and care experience.

- 1.44. Staff wellbeing and organisational culture are central to the PIP. The Staff Experience workstream has introduced several health and wellbeing programmes, increased psychological support, and integrated reflective practices such as Schwartz Rounds. The section below offers a summary of several of these initiatives. Programmes like Active Bystander Training and leadership development are designed to create a more inclusive and supportive workplace atmosphere.

Workforce and Staff Support

- 1.45. The midwifery workforce is currently in a strong position, with no vacancies and a surplus of 8.7 Whole Time Equivalent (WTE) staff above both the planned staffing levels and the BirthRate Plus recommendation of 332 WTE. This intentional overstaffing aims to build resilience, ensure continuity of care, and mitigate the effects of staff absences, such as maternity leave. Additionally, the service is actively recruiting 25 more WTE midwives to further increase capacity and maintain staffing levels throughout all clinical areas.
- 1.46. To ensure workforce planning remains evidence-based and responsive to service demands, an updated BirthRate Plus review was commissioned and completed in December 2025. This independent assessment provides a robust foundation for future workforce modelling and informs strategic decisions regarding midwifery deployment and resource allocation.
- 1.47. In addition, safe staffing is continuously monitored through dynamic risk assessments and real-time oversight by senior clinical leaders. Multiple daily safe staffing huddles are embedded into operational routines, enabling timely escalation and mitigation of any emerging risks. This approach ensures that staffing levels remain safe, responsive, and aligned with patient acuity and service pressures.
- 1.48. The Trust is firmly committed to fostering a positive, inclusive, and supportive workforce culture. A comprehensive suite of staff support initiatives is in place, reflecting the organisation's recognition that staff wellbeing is integral to delivering high-quality, compassionate care.
- 1.49. Staff development is prioritised through a wide range of Continuing Professional Development (CPD) opportunities, including access to Level 7 Master's modules, national and international conferences, and targeted study days. These opportunities are designed to support career progression, clinical excellence, and leadership development across all staff groups.
- 1.50. Since April 2023, the Trust has provided access to psychological support services for maternity and neonatal staff. This includes confidential one-to-

one therapy sessions and group interventions tailored to address work-related stress, trauma, and emotional fatigue. These services are well-utilised and positively evaluated by staff, contributing to improved morale and retention.

- 1.51. In addition, the Professional Midwifery Advocate (PMA) team plays a pivotal role in supporting staff wellbeing and professional reflection. In October 2025, the PMAs introduced dedicated reflective clinical supervision sessions and regular wellbeing drop-in clinics. A clinical psychologist is also available to provide specialist mental health support. The PMA team also attends daily Maternity Patient Safety Incident Review meetings to proactively identify staff who may require follow-up support following clinical incidents.
- 1.52. The Staff Experience workstream in the Perinatal Improvement Programme (PIP) focuses on workforce wellbeing, retention, and leadership. Initiatives include Active Bystander Training, Schwartz Rounds for reflective practice, and support for internationally educated staff. Service uptake and feedback are monitored to refine offerings, aligning with the Trust's People Strategy to foster psychological safety, inclusivity, and ongoing improvement in perinatal services.
- 1.53. In January 2026, a new series of wellbeing workshops was launched, covering key topics such as 'Living with Anxiety', 'Finding Purpose', and 'Introduction to Mindfulness'. These sessions are designed to equip staff with practical tools to manage stress and support emotional wellbeing.

Conclusion

- 1.54. OUH maternity services is making steady progress through robust safety monitoring, active service user engagement, and strong workforce support. The Trust's targeted interventions are improving outcomes and reinforcing a culture of accountability. While challenges remain especially in postnatal care, patient experience and communication the service is committed to ongoing improvement, transparency, and high standards. The Trust will continue to act on feedback and respond proactively to external partners and regulators to deliver safe, equitable, and high-quality maternity care.