HOSC Meeting: 21st November 2024

Introduction

This report provides an update on Maternity Services at Oxford University Hospitals NHS Foundation Trust (OUH). It highlights key updates and offers a comprehensive overview of the current state and future for maternity services at OUH. At the request of the Health Overview and Scrutiny Committee a narrative overview of the trends in birth injuries, perinatal and maternal mortality, birth trauma, and the implementation of various action plans and initiatives are included alongside an update on the CQC action plan and the Keep the Horton General Campaign Group (KTHG) Birth Trauma Dossier.

Please note that in this document, the terms "mothers" and "women" also encompass all other birthing individuals.

1. Trends in Birth Injuries, Deaths, and Birth Trauma

1.1 Birth Injuries

OUH routinely collects and analyses outcomes for women and babies who give birth within its service. These outcomes are reviewed within the maternity directorate, as well as at divisional and board levels. This systematic approach helps identify patterns and implement targeted interventions aimed at reducing risks and improving patient outcomes. In terms of birth injuries there two indicators for women and two for babies that are reported locally and nationally.

Please note that OUH Maternity Services offers care to the local community and is a tertiary referral centre for women at high risk of complications. These women are referred to OUH from Buckinghamshire, Berkshire, Northamptonshire, Wiltshire, and parts of Warwickshire. The service also receives referrals for women with severe medical conditions (such as major cardiac disease) and those who may face complicated caesarean births.

Birth Injuries - Women

The standard reported birth injuries in women are postpartum haemorrhage (PPH) of more than 1500mls and 3rd or 4th-degree anal sphincter tears. Table 1 below provides a summary of the number and percentage of PPH of more than 1500mls and 3rd or 4th-degree anal sphincter tears at OUH over the past six years.

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

Year	Total Births	PPH >1500ml	3rd or 4th-degree Tear

2018	7199	2.81% (202)	2.72% (196)
2019	7146	2.39% (171)	2.64% (189)
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)
Published UK Rates / Target		**3.3% (3.1%-3.5%)**	**2.9% (0-8%)**

As indicated in the table above the rates of these injuries have remained consistently below the published UK rates and targets. The Trust is committed to reducing these injuries to the lowest possible levels, and in 2024/25, identified this area as a focus for a quality priority. As part of this initiative, the Trust has implemented new training programmes and revised its induction of labour care pathways. These improvements aim to reduce delays, as improving the induction of labour processes is linked to better outcomes and reduced rates of PPH above 1500mls and third- or fourth-degree tears.

Birth Injuries - Babies

The standard reported birth injuries in babies relate to an NHS England initiative aimed at reducing the number of full-term babies (born at or after 37 weeks) admitted to neonatal units. This programme is referred to as a ATAIN (Avoiding Term Admissions into Neonatal Units). The second reporting measure related to birth injuries in babies relates to the babies requiring therapeutic cooling, which is a treatment for babies born affected by low oxygen level and at risk of potential brain injury (also called hypoxic ischemic encephalopathy or HIE) after 37 weeks.

Table 2 below provides a summary of OUH 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.

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

Year	**Total Births**	**NNU at >= 37weeks (ATAIN)**	**Cooled >= 37weeks**
2018	7199	4.50% (324)	0.19% (14)
2019	7146	4.04% (289)	0.14% (10)
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)
Published UK Rates / Target		**National Target 6%**	**National Target 0.1 – 0.35%**

As indicate in the table there has been a significant improvement in the most serious outcome reported (cooled >= 37 weeks therapeutic cooling). Since implementing a

foetal physiology-based CTG interpretation in February 2022, risk assessment has improved, leading to better neonatal outcomes. This approach helps clinicians recognise and manage CTG patterns by educating them on foetal adaptations to hypoxia during labour. Consequently, there has been a notable reduction in Hypoxic Ischemic Encephalopathy (HIE)—where babies require cooling for potential brain injury—and fewer unplanned term admissions to the neonatal unit, highlighting the initiative's success.

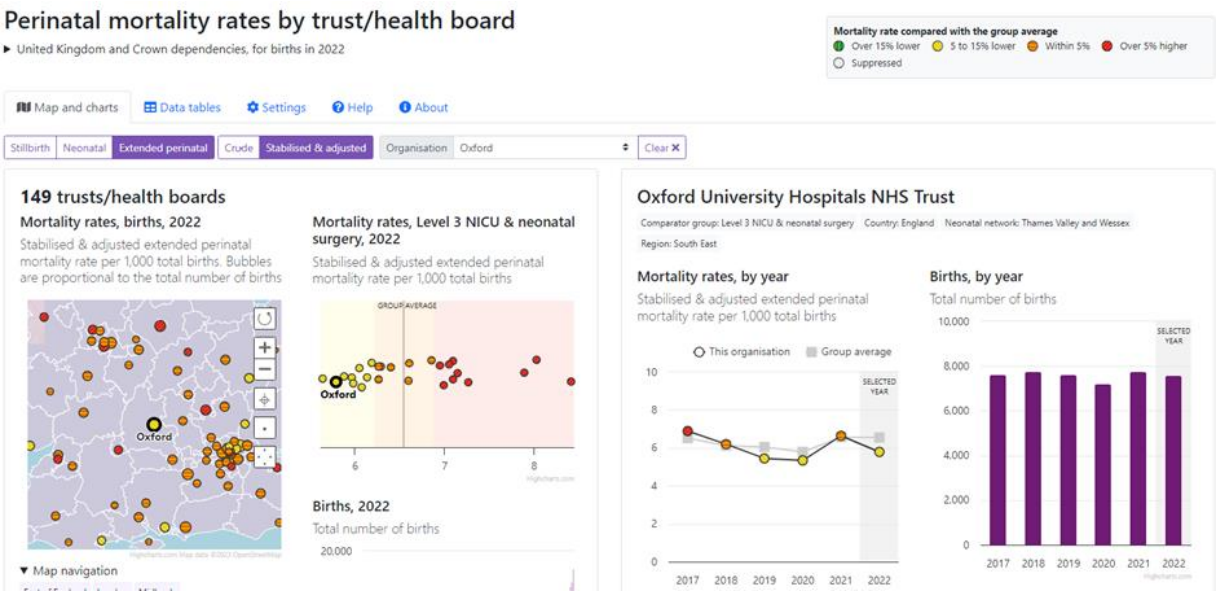
In addition, work is underway to create a unified reporting system and harm level for the birth injuries described within the BOB Integrated Care System (ICS) and to establish consistent benchmarks for all providers. The Trust's quality priority is to reduce maternal and neonatal morbidity by tracking harm metrics for women undergoing induction of labour. Additionally, the service is monitoring the impact of reducing delays in IOLs and performing thematic analyses in accordance with the Patient Safety Incident Response Framework (PSIRF) to identify trends and inform necessary interventions and improvements.

1.2 Perinatal Mortality

Perinatal and maternal mortality data is reported to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) programme at the National Perinatal Epidemiology Unit. MBRRACE-UK is a national initiative to improve health outcomes for mothers, newborns, and infants. The programme provides detailed data on perinatal mortality rates for individual Trusts, including rates for stillbirths, neonatal deaths, and extended perinatal mortality. These rates are adjusted for maternal age, socio-economic status, and ethnicity to ensure fair comparisons.

Trusts are categorised into groups based on their level of service provision, allowing for more accurate comparisons by considering variations in case mix. OUH is a tertiary-level unit with neonatal surgery (the highest risk category), complex pregnancies from other units are referred to OUH for care. MBRRACE UK considers this and compares OUH with similar-level units. In July 2024, MBRRACE UK published the Perinatal Mortality Surveillance Report for UK perinatal deaths in 2022.

As illustrated in figure 1 below the MBRRACE data from 2022 (the latest to be analysed) shows that the OUH perinatal mortality rate to be 5.79 per 1000 births. This rate is the 2nd best out of 26 similar units that OUH were compared against and is 5-15% lower than the average of the comparator group.



[To access the specific perinatal mortality rates for Oxford, you can visit the MBRRACE-UK section on the National Perinatal Epidemiology Unit (NPEU) website](). This will provide you with detailed statistics and analysis.

1.3 Maternal Mortality

Maternal mortality data is also reported to MBRRACE-UK annually. For OUH, this includes the deaths of mothers who either gave birth or passed away in Oxford. Maternal deaths are defined as deaths occurring during pregnancy or within six weeks following the end of the pregnancy.

As a tertiary referral centre, OUH receives referrals for and provides care to women with complex medical issues from other Trusts for high-risk maternal medicine. While maternal mortality has increased nationally, OUH has not experienced the same trend. Including referred pregnancies, there were two reported deaths in both 2020 and 2021, two in 2022, and one in 2023. All cases of maternal death undergo a national review and are rigorously investigated by the Trust and external partners to continuously enhance maternal healthcare services.

The Trust has implemented a new pre-eclampsia screening process, based on the Tommy's app in November 2024. This new screening process aims to improve prevention through aspirin, reducing complications such as perinatal and rarely maternal mortality. The Trust are also increasing growth scans for foetal growth restriction, the primary precursor of stillbirth, and enhance access to specialist care for women at the Horton by expanding outreach clinics. OUH is also developing an integrated screening program for perinatal mortality, with a new phase launching in January 2025. These efforts will specifically support women from ethnic minorities and those facing disadvantage.

1.4 Birth Trauma and Birth Reflections Service

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.

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.

The table below outlines the rates of accessing the Birth Reflections service between 2021 until 1st November 2024.

Rate of Attendance at the Birth Reflections Service	
Year	**Total**
2021	207
2022	205
2023	237
2024 (to 01/11/2024)	260 (projected 334)

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. The Trust are currently conducting a gap analysis on the recent parliamentary reports on birth trauma and are mapping Birth Reflections capacity to ensure demand is met.

2. CQC Action Plan for Midwifery-led Unit (MLU) at the Horton General, the Keep the Horton General Campaign Group (KTHG) Birth Trauma Dossier and Independent Review Panel

2.1 CQC Action Plan for Midwifery-led Unit (MLU) at the Horton General

In October 2023, the Care Quality Commission (CQC) inspected the Midwifery-led Unit (MLU) at Horton General. Following the inspection, the CQC rated the service as "Requires Improvement" in both the Safe and Well-led domains. The report outlined six must-do actions. A summary of progress against each action is summarised below:

- **Must Do Action 1:** The Trust must ensure thorough checks of emergency equipment and consumables to identify outdated items for replacement. The Trust has implemented 'MyKitCheck,' a digital system that replaces paper checklists and provides real-time updates on medical equipment. This system streamlines the management of equipment and safety checks, ensuring they are current and compliant.

- **Must Do Action 2:** The Trust must ensure staff complete risk assessments for women, birthing individuals, and babies, addressing any identified risks. The Trust has now digitalised these risk assessments, which form part of the electronic patient record in maternity. A monthly audit programme is in place and is reported and shared with the Maternity Clinical Governance Committee (MCGC) and the Trust Clinical Governance Committee (CGC).

- **Must Do Action 3**: The Trust must that all medicines are in date and stored within the correct temperature range. The Trust has put in place a cold chain room temperature monitoring form and room temperature monitoring action log. All areas within Maternity Services have completed the Trust's Safe and Secure Storage of Medicines audit. Weekly leadership care assurance visits have been implemented a core component of which is a thorough review of medicines safety and storage. Recent audits showing a 98% compliance rate in medication storage standards.

- **Must-Do Action 4:** The Trust must ensure that staff adhere to the established policies, procedures, and guidelines, including the decontamination of the birthing pool. The cleaning and decontamination instructions for the birthing pool have been updated and are now posted in the area where the pool is used. Additionally, funding has been secured for a new birthing pool, which is set to be installed at the Horton MLU in November 2024.

- **Must-Do Action 5:** The Trust must conduct regular audits to ensure patient safety. A schedule for routine maternity audits for 2024-25 has been established, along with additional audits to assess the activity of the Midwifery Led Unit. A monthly audit programme is in place and is reported and shared with the Maternity Clinical Governance Committee (MCGC) and the Trust Clinical Governance Committee (CGC).

- **Must-Do Action 6:** The Trust must ensure that effective risk management and governance systems are in place to support safe and quality care within the midwifery-led unit. The Standard Operating Procedure (SOP) for the Manager on Call has been reviewed, updated, and implemented. The development of the community dashboard is progressing well and the service is actively working to refine and enhance data collection. Audit reports, actions, and compliance data are reported to the Maternity Care Governance Committee.

The Trust has formed an Evidence Group to monitor and evaluate the progress, effectiveness and embeddedness of the CQC actions outlined above. Updates on the progress are provided through established governance processes, which include the Maternity Clinical Governance Committee and the Trust Clinical Governance Committee as part of the maternity quality reports.

2.2 Keep the Horton General Campaign Group (KTHG) Birth Trauma Dossier

In May 2024, KTHG published a dossier of mothers' accounts of their pregnancy care at OUH since 2016. The dossier comprises 50 anonymised cases of women and families in the Banbury area who had childbirth experiences between 2016 and 2024. The cases were gathered following a media request by the KTHG and are part of a campaign to restore full maternity service to Banbury.

On receipt of the dossier the Trust thoroughly assesses the quality of maternity care in the 50 cases and identifies key themes and areas for improvement. These include distance and travel to the John Radcliffe (JR) Hospital, delays in the induction of labour, inadequate postnatal and bereavement care, lack of compassion and kindness, and poor estate and facilities.

The Trust has developed an action plan in response to the dossier enhance the quality and experience of maternity care. These actions include reviewing transport and parking arrangements, improving postnatal and bereavement care, addressing information needs, and dealing with the lack of care and compassion through visible and supportive leadership, training, education, and acting on feedback from service users. Progress has already been made on the actions summarised below. The Trust has extended visiting hours in the postnatal areas to allow birthing partners to stay overnight. Currently, two high-risk diabetes antenatal clinics are operating at the Horton, as well as a specialist mental health clinic. In addition, a Consultant Midwife clinic will be added to the schedule, and plans are underway to increase the scan capacity at Horton after receiving funding for a new scanner from the LMNS. Parking at the JR remains challenging due to congestion; four emergency patient parking spaces have been allocated outside Maternity to help address this issue.

The Trust has met twice with representatives from Keep the Horton General Campaign Group at the Horton General Hospital on 18 July 2024 and at the John Radcliffe Hospital on 13 September (this second meeting included BOB ICB colleagues) to discuss the response to the dossier and the associated action plan. The Oxfordshire

Maternity and Neonatal Voices has been actively involved throughout this process and are participating in the co-design and implementation of the improvement actions.

2.3 Independent Review Panel

In October 2016, the consultant-led obstetric services at the Horton General Hospital were temporarily closed due to obstetric staffing issues. A free-standing midwifery-led unit with a dedicated ambulance service was established. Obstetric services remained closed, and the governing body of Oxfordshire CCG decided on 10 August 2017 to remove obstetric care from the Horton permanently and replace it with a midwife-led unit. The Secretary of State referred this decision to the Independent Review Panel (IRP), which published their findings on 9 February 2018.

The IRP review acknowledged that the consultation process regarding these changes was limited to Oxfordshire. It called for a more inclusive and comprehensive consultation method for future healthcare transformations. Although the maternity service has remained unchanged since this review, any future changes require commissioning bodies to engage with all relevant local authorities with health scrutiny powers, ensuring their active participation. Additionally, the IRP recommended improved communication and collaboration with all stakeholders, including residents and healthcare professionals, to make their involvement and feedback essential to the decision-making process.

An action recommended in the response to the KTHG Birth Trauma Dossier is to review maternity services. The ICB (Integrated Care Board) aims to provide the best possible healthcare for the diverse populations across BOB (Berkshire, Oxfordshire, and Buckinghamshire) and values feedback from individuals who have used healthcare services. The new government has committed to developing a 10-year plan for the NHS, which will be published in the spring of 2025. This plan is expected to offer additional guidance for maternity services, women's health hubs, and support for children and young people (CYP). Through the Change.nhs listening exercise, patients and the public can contribute to identifying priorities and goals for both local and national services. This national initiative will also facilitate planning and prioritization across various clinical interdependencies.

BOB recently completed an internal restructuring to enhance its capability and capacity for long-term planning and adopt a more strategic approach to service commissioning. As part of this effort, BOB is committed to reviewing maternity services within the system and collaborating with other services, providers, and local authorities as part of this process.

3. Engagement with Partners, Stakeholders, and Patients

In the past two years, funding for the Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP) has doubled, improving the breadth of activities and participation. This increased funding has allowed the Trust to include 'Neonatal' in its work plan. OMNVP representatives actively engage in the Maternity Clinical Governance Committee and Safety Champions meetings, providing valuable user perspectives. The OMNVP collaborates with the Trust on initiatives like the Culture Review and Maternity Development Programme. This includes co-facilitating events and establishing a Maternity Patient Experience Working Group.

The OMNVP also supports with improvement projects, such as enhancing parent education sessions, revising visitor policies, and improving the Maternity Assessment Unit. Theu also undertake regular feedback surveys, including those on baby loss and neurodivergence and help the Trust to better understand family experiences. These efforts have led to significant changes within the OUH Maternity Service, ensuring a patient-centred approach to improvements.

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.

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.

4. Improvements in Safety Checks and Medication Storage

Significant improvements have been made in processes around safety checks and the safe storage of medications as discussed in section 2 of this report.

5. Risk Assessment Processes

Risk assessment and triage are vital for high-quality maternity care. Ongoing risk assessments are conducted at booking, antenatal appointments, during labour, and postnatally and audited in keeping with the Ockenden report and the Maternity

Perinatal Incentive Scheme (MPIS). The Trust has introduced digital tools such as BadgerNet, a maternity-specific electronic patient record system. This system enables dynamic information sharing and timely access to patient records, facilitating more accurate and comprehensive risk assessments. As a result, there has been a 20% improvement in the early identification of high-risk pregnancies.

The Trust has also recently implemented the Birmingham Symptom-Specific Obstetric Triage System (BSOTS). BSOTS establishes a structured and standardised process for triaging maternity care. This system prioritises care based on clinical need, ensuring that urgent cases receive timely attention. The Trust is implementing BSOTS across all relevant departments to improve the consistency and quality of triage services. In addition, the Horton Maternity Assessment Centre (MAC) has specific processes for effectively triaging women and birthing individuals. Low-risk cases can be assessed at the MAC, enabling care to be provided closer to home. A clear escalation pathway for high-risk cases is also in place for those women who require emergency transfers to the John Radcliffe Hospital (JR).

Efforts are also underway to establish a centralised triage phone service, with plans for expansion in collaboration with BOB Trusts. This initiative aims to enhance accessibility and coordination of care. The expansion is a strategic decision intended to ensure that triage services maintain a consistently high standard across the region.

6. **Tackling Inequalities in Maternity Care**

OUH are dedicated to addressing maternal and perinatal health inequalities with various initiatives aimed at improving access, experiences, and outcomes for women and birthing individuals at high risk of poor health outcomes. The Trust partners with communities through Equal Start Oxford (ESO), an initiative launched in early 2023 to improve maternal and perinatal health for vulnerable populations in Oxfordshire. Collaborating with local midwifery teams, ESO includes maternity advocates who address non-health-related issues such as immigration, welfare benefits, housing, and food insecurity. They also provide interpreting services and support drop-in spaces for pregnant women and new parents, particularly benefiting the East Timorese community. The Equal Start framework will expand to high-need areas like Didcot and Banbury later this year and will work with local communities to assess needs and implement initiatives to improve healthcare access.

A significant aspect of ESO is the Maternity Health Justice Partnership, where advocates assist midwives with non-health needs and support modifiable social determinants of health. This initiative features a joint Obstetric/Midwife clinic for vulnerable pregnant women, ensuring they receive necessary care. Overall, ESO aims to enhance access to maternity services for marginalized groups, promoting the well-being of every mother and baby in Oxfordshire.

Oxfordshire has seen an increasing number of dispersed asylum seekers arriving into Section 95-supported hotel accommodation. Pregnant women in these hotels often struggle to access maternity care in a timely manner for a variety of reason such as

language barriers, a lack of knowledge about how NHS maternity services operate, and challenges related to transportation to hospitals. In response to these challenges, a proactive approach has been taken. A monthly joint obstetric and midwifery clinic has been established at the Oxford Witney Hotel and Horton Hospital. This initiative is supported by a caseworker from Asylum Welcome to meet the needs of pregnant asylum seekers residing in the two hotels near the hospital.

7. Support for Staff and Workforce Culture

The Trust is committed to supporting and developing its staff to foster a positive workforce culture. This includes continuous training, mentorship programs, and initiatives aimed at addressing workplace incivility. The significant progress made under the NHS England Maternity Development Programme and results from staff engagement surveys, which show a 30% increase in job satisfaction and a decrease in poor workplace behaviour, demonstrate this.

The Maternity Development Programme, initiated in August 2022, focuses on culture, leadership, and staff well-being. Listening events generated 170 actionable solutions and a comprehensive action plan. The program's cultural changes have created a safe and supportive care environment for staff and service users.

Staff development has been a priority, with numerous Continuing Professional Development (CPD) opportunities available, including Level 7 Master's modules, conferences, and focused study days. Additionally, since April 2023, psychological support has been offered to staff, providing both individual therapy sessions and group interventions to address work-related issues such as stress, burnout, and trauma.

8. Resources and Workforce Sufficiency

The Trust has focused on maintaining safe staffing levels in maternity services. In response to the Ockendon review, it has increased its obstetric and midwifery workforce over the past two years, adding 1.5 full-time equivalent (FTE) obstetricians in 2022. To support safe midwifery provision, the Trust approved the Birthrate Plus recommendations in 2023, which call for an increase of 22.38 FTE staff members. This includes 3.89 FTE managers, 16 FTE clinical midwives, and 2.49 FTE maternity support workers. Recruitment efforts have been proactive, and the midwifery workforce is expected to be fully recruited by January 2025. This investment underscores the Trust’s dedication to maintaining optimal staffing ratios, enhancing patient safety, and improving overall maternity care.

As the maternity service is nearly fully recruited, work has begun to adapt recruitment and retention strategies to meet the preferences of different age groups. The service is conducting surveys and focus groups to gather insights into the career aspirations and expectations of various generations of midwives. The recommendations from this

work will focus on increasing flexible working arrangements and professional development opportunities.

9. Plans for Digital Integration between Primary and Secondary care

Since April 2021, the digital landscape of maternity care has improved significantly with the Maternity Digital Strategy. A key advancement was the implementation of the BadgerNet Maternity electronic patient record. The Trust transitioned from paper to digital records in February 2024 and enhanced safety through timely and accessible patient information. Upgrades to IT infrastructure, including replacing community devices and improving Wi-Fi, have further supported this transformation.

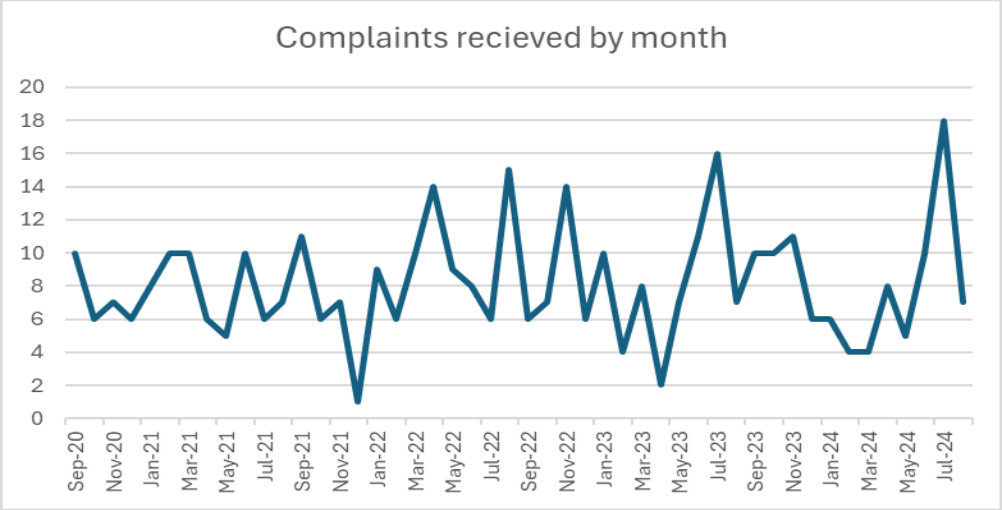
Plans are also underway to improve digital integration and enhance communication between primary and secondary care. As part of this strategy, the rollout of the ICE system for community midwives and necessary system upgrades will ensure a seamless flow of information and coordinated care. Across the BOB LMNS, efforts are being made to enhance existing systems and expand the Cerner Health Information Exchange, which will securely share data between EMIS Web users and the broader health sector.

Additionally, an information-sharing platform is being implemented between OUH and all London hospitals. These systems are scheduled to be launched within the next 12 months, providing clinicians with the most relevant and up-to-date information about their patients.

10. Patient Experience

Maternity services take a multidisciplinary approach to effectively address and respond to concerns and complaints related to pregnancy, delivery, and postnatal care. Initiatives such as the Postnatal Improvement Working Group and the Kindness in Action training have been implemented to improve service quality. The Friends and Family Test (FFT) allows for continuous patient feedback. Additionally, a new monthly Patient Experience Forum, chaired by the OMNVP, highlights service improvements based on patient feedback, complaints, and engagement. These efforts demonstrate the Trust's proactive commitment to addressing patient concerns.

Post-Covid-19, there has been a 10% increase in written complaints about maternity services across England. OUH, by contrast, has experienced a 3% rise compared to this figure.



As shown in the chart above, the OUH maternity service averages 8.1 complaints per month. The chart below illustrates the common themes which include compassionate communication, staff attitude, and delays in pain relief and nutrition. Analysis of maternity complaints data for 2024 shows four women reporting birth trauma or psychological distress after childbirth. These complaints will have a distinct category in Maternity complaints analysis to ensure the service is responding appropriately and compassionately and can offer the correct support for long term recovery.

In August 2024, the Maternity Leadership Team formed a Triangulation and Learning Committee with representatives from various departments and service users. This committee uses feedback from complaints, PALS, patient safety reports, and legal claims to enhance care quality. It reinforces positive practices, such as effective teamwork and emergency protocol adherence, while addressing areas for improvement, like timely pain assessments and postnatal discharge processes. This structured approach reflects OUH's commitment to continuous quality improvement and optimal patient safety and experience.

Conclusion

In conclusion, the report highlights the progress made in improving maternity services. The Trust has shown a strong commitment to enhancing patient safety, reducing birth injuries, and addressing both perinatal and maternal mortality rates. The implementation of the Birth Trauma Pathway and the Birth Reflections service demonstrates the Trust's dedication to supporting individuals who have experienced birth trauma. Additionally, the advancements made in response to the CQC action plan and the KTHG Birth Trauma Dossier reflect the Trust's proactive approach to continuous improvement and patient care. Moving forward, the Trust aims to build on these achievements by further enhancing its services and addressing any remaining challenges to ensure the highest standards of maternity care. The journey of improvement in OUH maternity services is ongoing. While substantial progress has

been made in enhancing safety, quality, and patient experience, the service recognises that there is still much work to be done. The Trust is committed to tackling these improvements and seizing opportunities for further development and enhancement.