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NHS Foundation Trust

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PRIVATE EMAIL ADDRESS

Councillor Jane Hanna OBE
Chair
Health Oversight & Scrutiny Committee
Oxfordshire County Council

By email only to:
Omid.Nouri@Oxfordshire.gov.uk.

13 April 2026

Dear Councillor Hanna and Members of the Committee,

Thank you for your letter dated 18 March 2026 regarding maternity services at Oxford University Hospitals (OUH). We value the Committee's scrutiny and the feedback from families. We apologise unreservedly for the data inaccuracies in our January HOSC report and any distress or confusion they have caused. Below we address each of the points raised, and we hope this response provides the clear, accurate information the Committee seeks.

1. **Data Accuracy in the January 2026 HOSC Report:** The Trust acknowledges inaccuracies in the maternity data reported to HOSC on 29 January 2026, notably a stillbirth statistic/figure from 2022 was mistakenly attributed to 2023. This was promptly corrected, and an updated report was submitted on 13 February 2026 with accurate figures and dates. All data have since been thoroughly checked. The Trust regrets the mistake and has strengthened internal sign off processes to prevent future errors.

2. **Impact on Families and the Committee**: We recognise and are deeply sorry for the distress this error may have caused to families and the committee. We acknowledge that accurate reporting is essential, and the Trust acted promptly to correct the record. We remain committed to ensuring the accuracy and completeness of all data shared publicly and with families. Relevant perinatal and stillbirth data are published openly and remain accessible via the MBRRACE-UK website.

3. **2023 Mortality Statistics**: We are very sorry for the confusion in relation to our presentation of the 2023 MBRRACE mortality data. We hope that the explanation below provides the necessary clarity. These data are publicly available via the MBRRACE website, screenshots of which we have provided. Please note that it is important when reviewing the data to ensure that the "stabilised and adjusted" figures are selected and that the correct filters are applied in the mauve bar on the left of the dashboard.

Figure 1 shows the MBRRACE stabilised and adjusted stillbirth data for Oxford in 2023 compared with other Level 3 NICU and neonatal surgery units. The plot on the left shows that Oxford was an outlier for stillbirths in 2023, with a stillbirth rate of 3.6 per 1000 (0.36%). This compared to a group average of 3.42 per 1000 (0.342%), an *absolute* difference of 0.18 per 1000, or 0.018%.

The 'amber' zone in MBRRACE data represents those organisations that are within -5% to +5% *relative to the national average*. Oxford's stillbirth rate of 0.36% in 2023 represented a *relative* difference of 5.3% compared to the comparator national rate of 0.342% (0.018 is 5.3% of 0.342).

Since congenital abnormalities have a higher mortality rate and are associated with demographic and other factors that might be outside a Trust's control, MBRRACE-UK also presents mortality data excluding congenital abnormalities. This facilitates a fairer comparison of organisations that is more likely to reflect differences in care, by removing variation that might be outside their direct clinical control, and on reflection it may have been more helpful to present the MBRRACE-UK data excluding congenital abnormalities.

Figures 2-4 show the MBRRACE stabilised and adjusted stillbirth, neonatal and extended perinatal mortality rates for Oxford in 2023 *excluding* congenital abnormalities. The mortality trend graphs on the right of each of these screenshots show that while Oxford was an outlier for stillbirths in 2023 (and for the composite extended perinatal mortality metric driven by the higher stillbirth rate that year), for most years the Trust's stillbirth and neonatal mortality rates (and therefore the combined extended perinatal mortality rate) have been in line with or below the national average.

We would like to stress that while the available MBRRACE data on stillbirth and perinatal mortality trends do not suggest that Oxford is a significant outlier nationally, we recognise the profound significance of every perinatal death and the lasting impact on families. We also acknowledge that our original report did not present the mortality data sufficiently clearly for which we apologise.

We remain firmly committed to reducing perinatal loss wherever possible and to engaging with and supporting those affected to learn from their experience as part of our continued focus on improving safety and support for all families in our care. Each case is subject to thorough multidisciplinary review to identify opportunities for learning and improvement, and we continue to benchmark our outcomes transparently against comparable high-performing centres.

Figure 1: MBRRACE stabilised and adjusted stillbirth rate for Oxford, 2023 (All births)

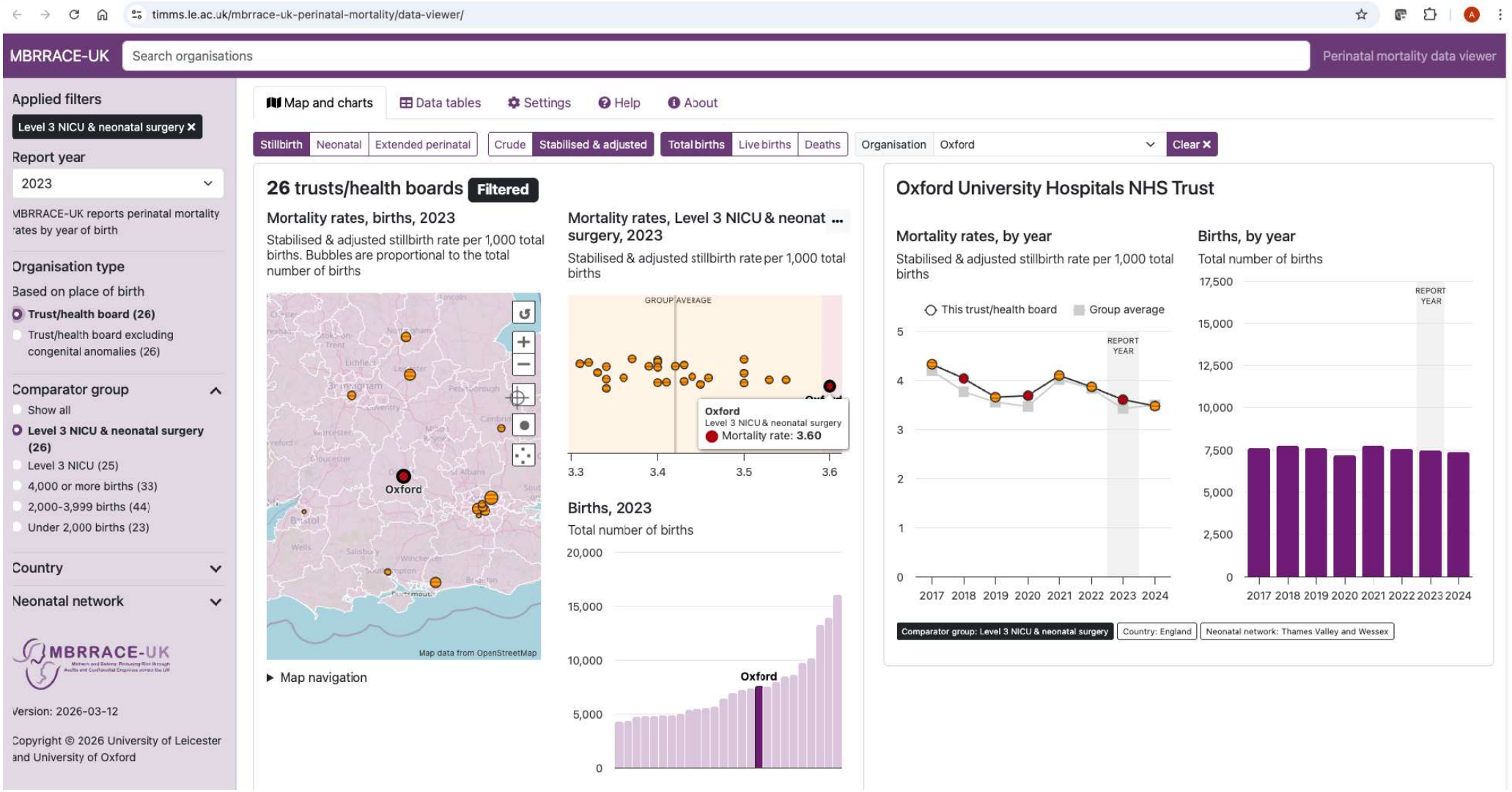


Figure 2: MBRRACE stabilised and adjusted stillbirth rate for Oxford, 2023 (Excluding congenital abnormalities)

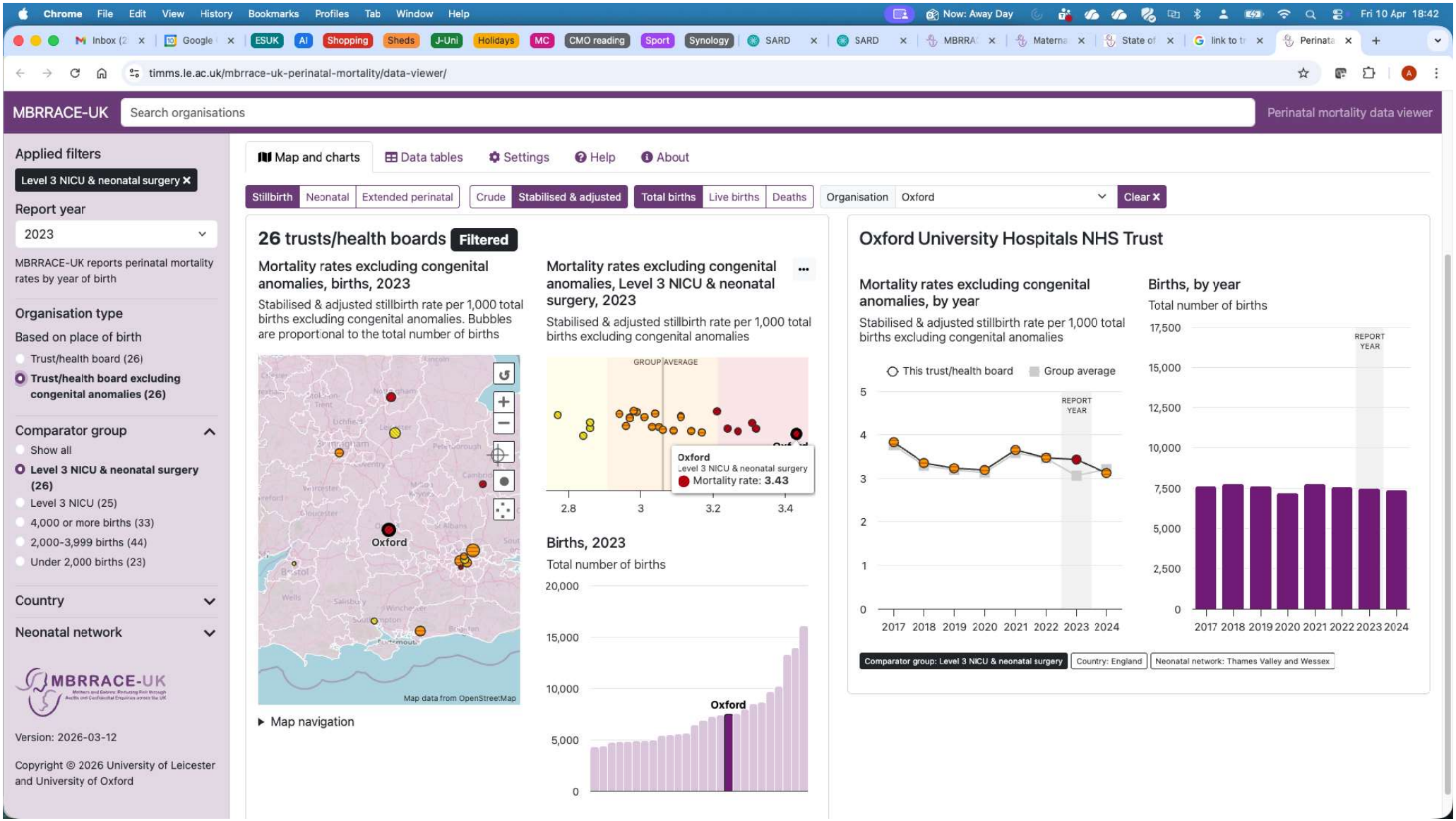


Figure 3: MBRRACE stabilised and adjusted neonatal mortality rate for Oxford, 2023 (Excluding congenital abnormalities)

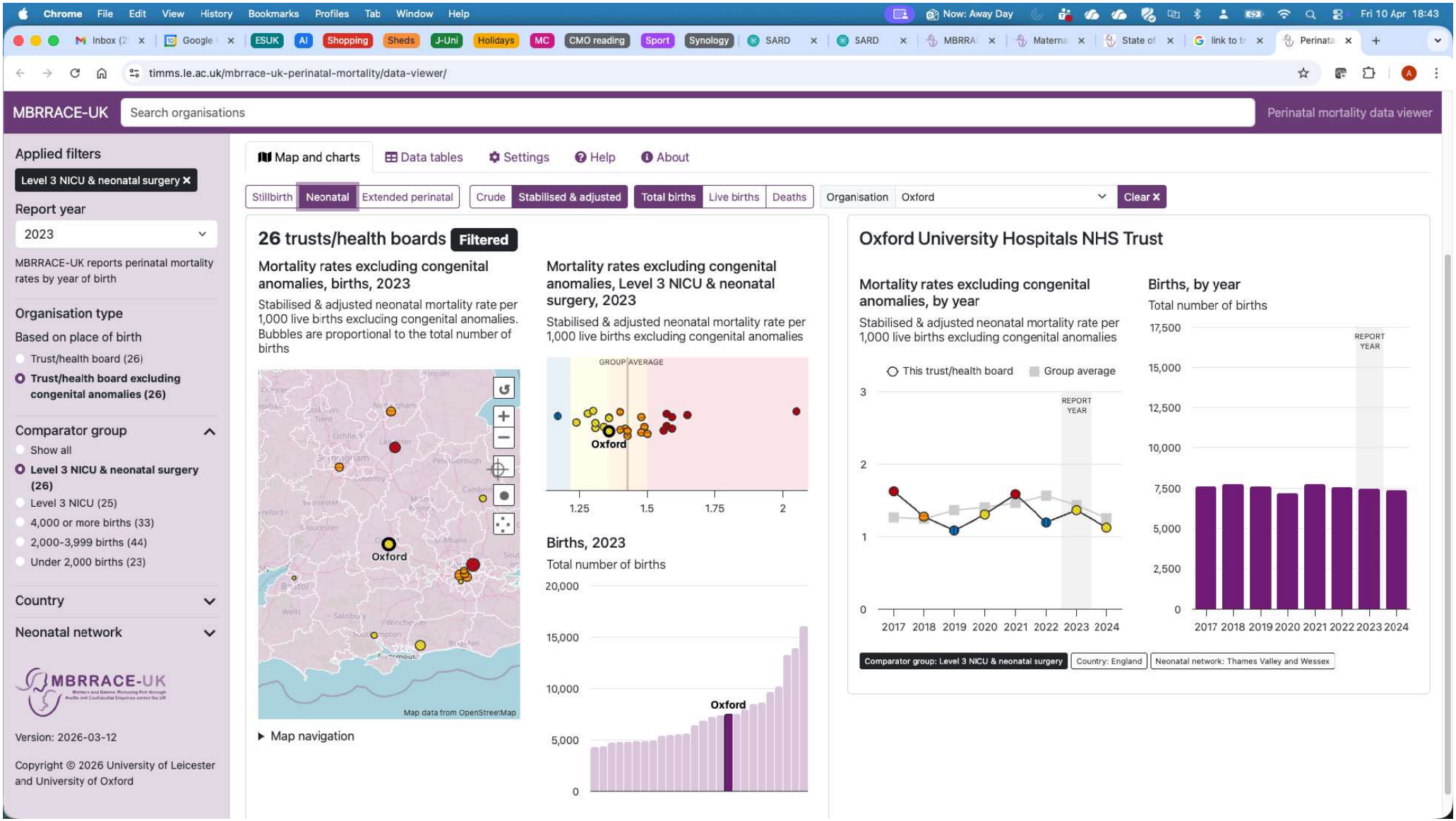
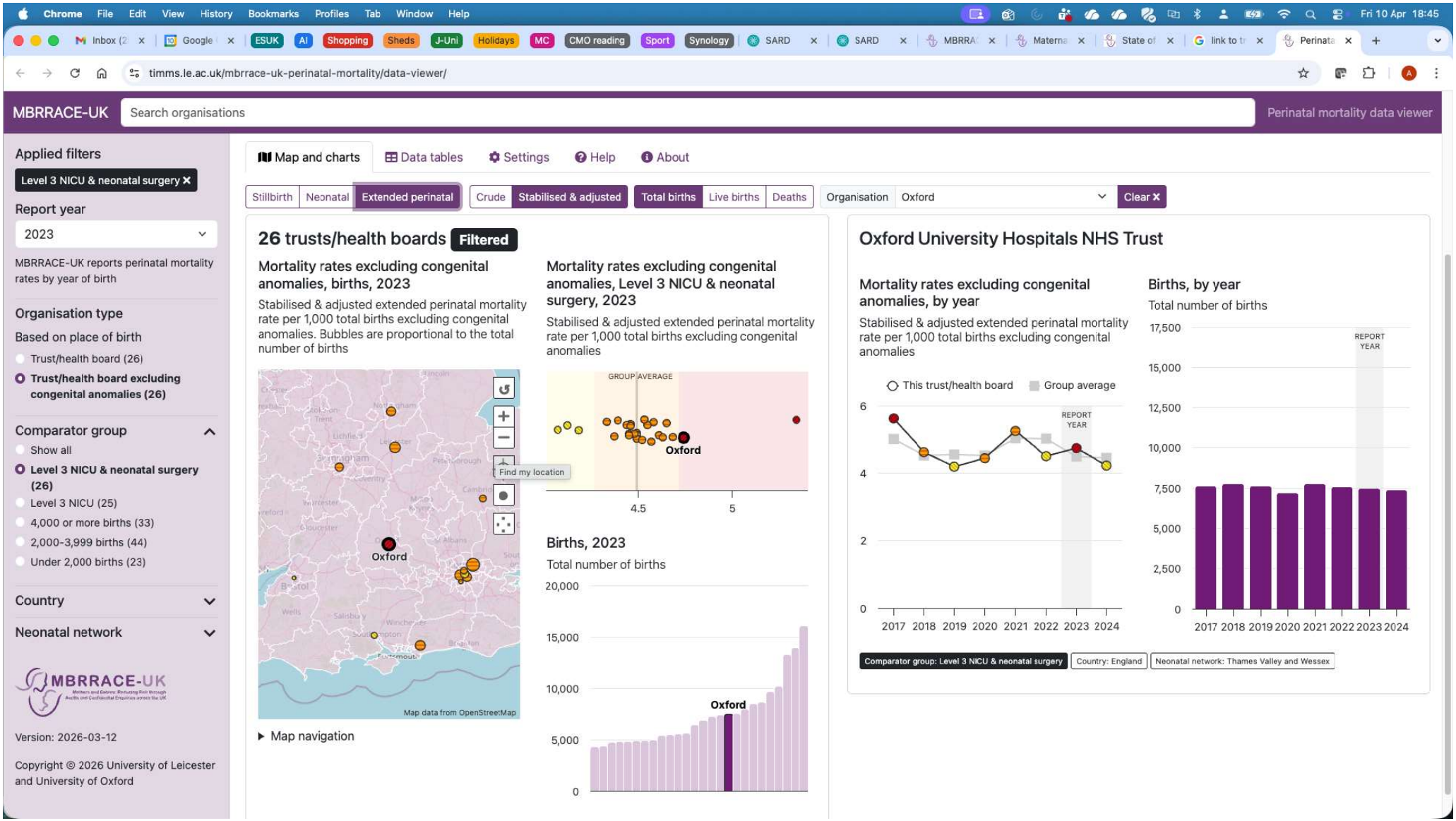


Figure 4: MBRRACE stabilised and adjusted extended perinatal mortality rate for Oxford, 2023 (Excluding congenital abnormalities)



4. **Engagement with Families and Campaign Representatives**: The Trust is committed to meaningful and sustained engagement with families and representative groups who have shared their experiences of maternity care. We recognise the importance of listening to a wide range of voices to inform service improvement and ensure that care is responsive, inclusive, and compassionate.

   We regularly meet with families as part of our incident investigation and complaints processes. For all serious maternity incidents, including perinatal deaths, families are invited to participate in the review process. OUH's family involvement rate in maternity investigations is approximately 90%, which exceeds the national average.

   Beyond individual case engagement, the Trust has taken steps to broaden its dialogue with the wider maternity service user community. In December 2025, we hosted a Maternity Listening Event, open to all service users, where families, advocacy groups, and staff came together to share experiences and perspectives. Feedback from this event has been collated and is actively shaping our improvement priorities.

   As part of our broader engagement efforts, the Trust is enhancing its approach to working in partnership with service users, including bereaved families. We are committed to ensuring that individuals have a clear and consistent voice in shaping maternity care at every level of service design and delivery. Our focus remains on delivering inclusive, transparent, and responsive services that reflect the experiences and needs of those who use them. To support this, a series of local listening and engagement events will begin across Oxfordshire in May 2026. These sessions will offer further opportunities for families and communities to engage directly with maternity services, share their experiences, and contribute to ongoing service development.

5. **Actions and Remedial Measures:** Following the January HOSC meeting, the Trust promptly corrected and updated the maternity report after being alerted to an inaccuracy. To ensure future accuracy, we have strengthened our internal sign-off procedures, incorporating additional clinical and analytical review. For your records, an updated report is included as Appendix 1.

6. **Additional Context for the Committee:** The Trust Board maintain close and ongoing oversight of maternity services. A comprehensive Quarterly Perinatal Mortality Report is presented at public Board meetings, offering detailed analysis of perinatal outcomes, emerging trends, contributory factors, and learning from case reviews. This reporting structure enables the Board to monitor safety, evaluate performance, and ensure accountability for the quality of care provided. Non-Executive Directors play an active role in scrutinising the

report and holding the organisation to account for delivering safe and effective maternity services.

In summary, the Trust acknowledges the concerns raised and regrets the reporting error. The report has been corrected, and internal processes have been strengthened to prevent future inaccuracies. The Trust welcomes the Committee's continued scrutiny and is committed to open and constructive dialogue. If there is any further information the Committee would find helpful, the Trust would be pleased to provide it.

Yours sincerely

Simon Crowther
Interim Chief Executive Officer

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**

Contents

Oxford University Hospitals NHS Foundation Trust Maternity Service Update Report

1. Introduction

1.1. This report updates on maternity services at Oxford University Hospitals NHS Foundation Trust (OUH), covering recent developments, key outcomes, and safety improvements. It addresses the Health Overview and Scrutiny Committee's (HOSC) request for information on birth outcomes, safety actions, and external reviews, including the October 2025 CQC visit, and the national maternity investigation led by Baroness Amos.

1.2. The terms "mothers" and "women" are used inclusively for all birthing individuals.

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

Birth Injuries

2.1. 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

2.2. 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%).

2.3. 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	3rd or 4th 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 NMPA 2023		**3.41%**	**3.29%**

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

2.4. 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.

2.5. 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.

2.6. 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

2.7. 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).

2.8. 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	7389	3.66% (271)	0.08% (6)
2025	7218	3.85% (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.

2.9. As indicated in the table 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.

2.10. 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

2.11. 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.

2.12. 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 May 2025, MBRRACE-UK published the Perinatal Mortality Surveillance Report for UK perinatal deaths in 2023.

2.13. As illustrated in figure 1 below, the MBRRACE data from 2023 (the latest to be analysed) shows that the OUH stillbirth rate to be 3.6 per 1000 births or 0.36%. This is the highest among similar trusts, compared to the group average of 3.42 per 1000. To note the Trust with the lowest rate in 2023, had a rate of 3.31 per 1000 births.

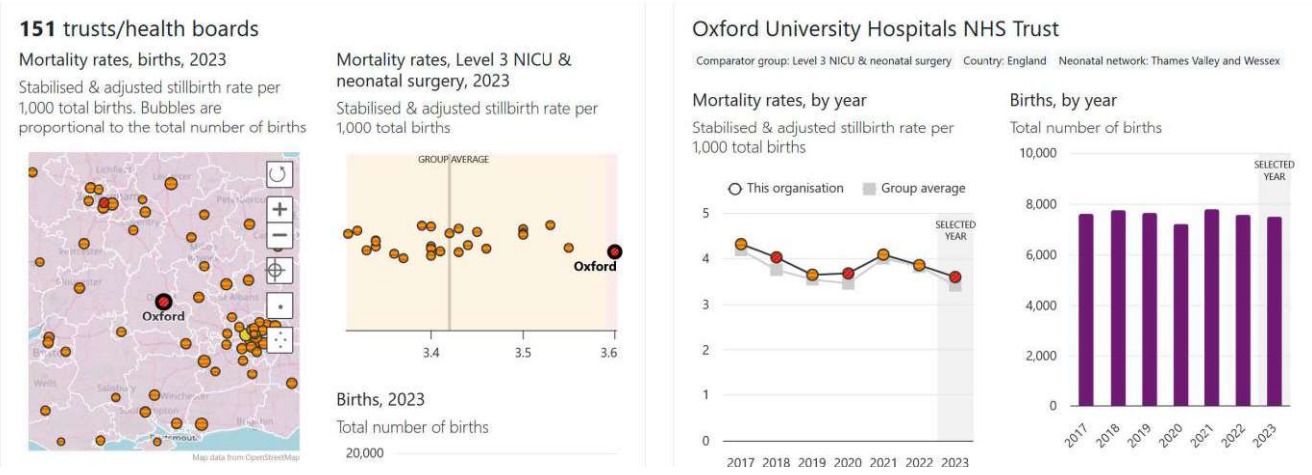


Figure 1: MBRRACE data from 2023

2.14. To access the specific perinatal mortality rates for Oxford, you can visit the MBRRACE-UK website.

Maternal Mortality

2.15. 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 a year following the end of the pregnancy.

2.16. 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, one in 2023 and two in 2024. The two more recent deaths in 2024 were oncology related (metastatic colorectal cancer and acute myeloid leukaemia). 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.

3. Birth Trauma and Birth Reflections Service

3.1. 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.

3.2. 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.

3.3. 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

3.4. 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.

3.5. 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.

4. CQC Inspection 2025 National Maternity and Neonatal Investigation

4.1. 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.

4.2. 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 the 6th and 7th November and returned on 5th 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.

5. Tackling Inequalities in Maternity Care

5.1. OUH is actively tackling maternal and perinatal health inequalities through community led, practical initiatives that improve access, experience and outcomes for those at greatest risk. Through Equal Start Oxford launched in early 2023 with local midwifery teams, maternity advocates address non-health needs (immigration, welfare, housing and food insecurity), provide interpreting, and run drop-ins that have particularly benefited the East Timorese community; the model will expand to high need areas in Didcot and Banbury later this year. A core ESO component is the Maternity Health Justice Partnership, including a joint obstetric midwife clinic for vulnerable women. In response to rising numbers of dispersed asylum seekers in Section 95 hotel accommodation, OUH has established a monthly joint clinic at the Oxford Witney Hotel and at the Horton Hospital,

supported by an Asylum Welcome caseworker to overcome barriers such as language, navigation of NHS services and transport.

5.2. Between June 2023 and August 2025, OUH implemented a comprehensive equity programme addressing ethnic disparities, sociodemographic vulnerability, language needs and screening inequality, alongside strengthened staff training and community engagement. Translated antenatal classes and tours reached 79 women in two languages (June 2023–March 2025) and 22 women in three languages (April–August 2025).

5.3. While significant progress has been made, OUH remains focused on removing barriers to access and raising awareness of available services to ensure equitable care for every mother and baby in Oxfordshire.

6. Perinatal Improvement Programme

6.1. 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.

6.2. 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.

6.3. 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.

7. Workforce and Staff Support

7.1. 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.

7.2. 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.

7.3. 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.

7.4. 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.

7.5. 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.

7.6. 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.

7.7. 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.

7.8. 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.

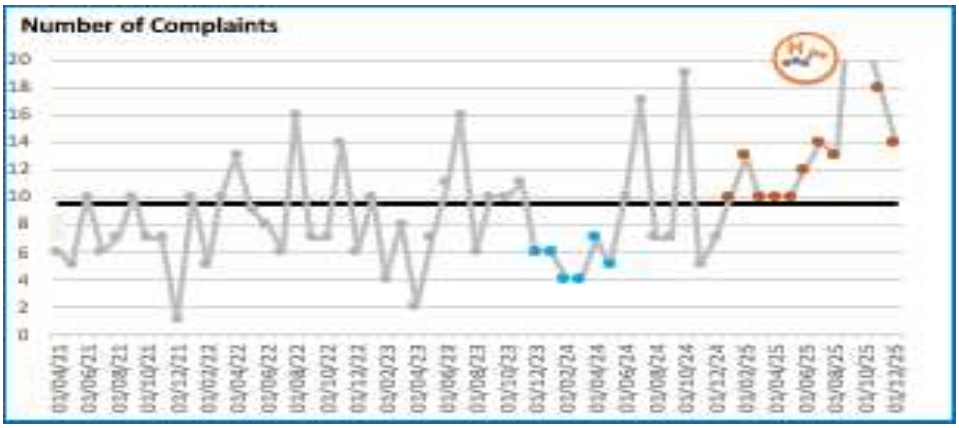
7.9. In January 2026, a new series of wellbeing workshops was launched, covering key topics such as 'Living with Anxiety', 'Finding Purpose', and 'Introduction to Mindfulness'. These sessions are designed to equip staff with practical tools to manage stress and support emotional wellbeing.

8. Patient Experience

8.1. 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

8.2. 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.



8.3. 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.

8.4. 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

8.5. 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.

8.6. 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.

8.7. 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

8.8. 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.

8.9. 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.

8.10. 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.

8.11. Learnings 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.

8.12. 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.

8.13. 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.

9. Conclusion

9.1. This report provides an overview and update on OUH 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. 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.