Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Perinatal Quality Surveillance Summary Report – April and May 2025**
Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee (MCGC) 09/06/2025** **Maternity and Neonatal Governance Operational Delivery Committee June 2025**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The report provides a summary and overview of the perinatal quality surveillance at Oxford University Hospitals, based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 7 safety actions. The report covers the April 2025 and May 2025 reporting period.
2. **Perinatal Deaths Review**: The report summarises 4 perinatal deaths that were reviewed in April and May; using the Perinatal Mortality Review Tool (PMRT).
3. **Patient Safety Incidents**: In maternity, there were 217 safety incidents reported in April 2025, 63 of which were moderate harm or above. There were 218 safety incidents reported in May 2025, 48 of which were moderate harm or above. In Neonates, there were 82 safety incidents reported in April 2025, 1 of which was moderate harm. There were 64 safety incidents reported in May 2025, 1 of which was moderate harm.
4. **Avoiding Term Admissions**: Unplanned admissions to the neonatal unit were 4.8% and 3.1% respectively in April and May remaining below the national target of 6%. The primary reason for admission and diagnosis on discharge is respiratory distress in the neonate.
5. **Training compliance:** Training compliance for newborn life support remains at above 90% for midwives, neonatal/paediatric consultants, junior neonatal doctors (who attend births) and ANNP's apart from Neonatal nurses' compliance is currently at 89%. A collaborative action plan has been developed to meet the >90% standard. The anaesthetic group attending PROMPT is at 89% (improvement from previous month). Foetal monitoring training for consultant obstetricians has increased to 92% from 88%.
6. **Delivery Suite Care**: There were no occasions in April or May when 1:1 care in labour was not provided. There were no occasions when the Delivery Suite coordinator was not supernumerary for the shift.
7. **Maternity and Perinatal Incentive Scheme (MPIS):** Year 7 of the MPIS was published on the 02 April 2025. This is currently being reviewed and meetings set up for this year to monitor compliance against the safety actions.
8. **Service Users' Feedback**: In April the service received 123 responses (23.5% of our delivery rate) from the Friends and family test (FFT) and 102 responses (16% of our delivery rate) in May. There has been several positive responses and areas identified that require further improvement. The service recognises that further work is required to encourage an improvement to our response rate and will be working with our teams to increase this uptake. We are advertising now within the community and promoting completion from the initial booking appointment. Neonates have now been set up on the Friends and Family Test (FFT) survey.
9. **Staff Feedback**: The Safety Champions Walk-around was conducted on the 16 April 2025 and which included the Transitional Care Unit (TCU) on Level 5 and the

Neonatal Unit (NNU). Weekly safety walkabouts in line with the Trust Care Assurance framework were conducted by the senior leadership team during this period. Staff continue to have access to the Say on the Day devices to rate their shift experiences this is now being managed by the PMA/Wellbeing lead for Maternity. The results of the annual staff survey have been shared with the matrons. *Growing Stronger Together* sessions with staff are underway to co-produce an action plan.

Recommendations

10. The Trust Board is asked to:

- Receive and note the contents of the Perinatal Quality Surveillance Model Report.

Contents

Perinatal Quality Surveillance Summary Report – April and May 2025

1. Purpose

1.1. The report provides an overview of the perinatal quality surveillance Oxford University Hospitals, based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 7 safety actions.

1.2. The report covers the data from April and May 2025.The Trust is required to provide a Perinatal Quality Surveillance Monitoring report to the Berkshire West, Oxfordshire, Buckinghamshire (BOB) Local Maternity and Neonatal Services (LMNS) for perinatal quality oversight.

1.3. The monthly data on which this paper is based is presented within the maternity quality report at the Maternity Clinical Governance Committee (MCGC) meetings.

1.4. Provide an overview of compliance in relation to MPIS Year 7.

2. Perinatal Deaths

2.1. The table below summarises the total number of deaths by type and gestation reported through maternity services.

2.2. There was 1 perinatal death in April and 5 in May 2025.

Month		Apr' 25	May '25
Total Number of Deaths		**1**	**5**
Type of Mortality	Antepartum Stillbirths	0	4
	Intrapartum Stillbirths	0	0
	Neonatal Deaths	1	1
Gestational Age	<24 weeks	0	1
	24-27 weeks	0	0
	28 - 31 weeks	0	3
	32 - 36 weeks	0	0
	37-41 weeks	1	1
	≥ 42 weeks	0	0
Number of Cases reviewed using PMRT		3	1
External Panel Member	Occasions present	3	0

3. Findings from Perinatal Deaths Reviews

3.1. In April, three cases were reviewed using the Perinatal Mortality Review Tool (PMRT), and one case was reviewed in May (see table 1). Care was evaluated using categories A, B, C, and D; two grades were assigned during the review process—one for care provided up to the point of death of the baby and another for care following the birth of the baby. Category definitions are provided in appendix 1.

3.2. Case 1 - Graded a B as following the death of the baby as a Kleihauer test had been sent to the laboratory (lab) but not processed: a review of the process has taken place, and the lab are aware to run any requests relating to intrauterine fetal death must be processed.

3.3. Case 2 – Graded as a C following a discussion regarding the recommended induction of labour timing, which was in line with our clinical guidance but may have made a difference to the outcome, considering the accumulation of risk factors. The care has been referred to MNSI and PSII.

3.4. Case 3 - graded A/A as there were no issues identified with the care.

3.5. Case 4 - Graded a B due to the cardiac abnormality not being identified at the anomaly scan at Stoke, discussions are to be held with Stoke over the quality of images to determine if this was indeed missed during the ultrasound procedure. The care following was graded an A.

Ulysses No: or MBRRACE	Case	IUD - Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following the death of her baby
Case 1	Intrauterine death (IUD) 25+2 attended Maternity Assessment Unit (MAU)as Community Midwife unable to auscultate the fetal heat.	A	B
Case 2	39+2 diagnosed on admission to MAU. Referred to Maternity Neonatal Safety Investigation (MNSI).	C	B
Case 3	IUD 36+5 diagnosed on the antenatal ward. Under the Fetal Medicine Unit (FMU), 1st CTG on admission met criteria and there was a plan for a repeat Cardiotocograph (CTG) 4 hours later. Repeat CTG – unable to detect fetal heart.	A	A
Case 4	P0 booked at Stoke. Referred to OUH for oligohydramnios at 20 weeks. Found to be Pre-Rupture of Membranes (PROM) and have a major cardiac abnormality. IUD at 25+5	B	A

Table 1: Reviews in April and May 2025

4. MNSI Referrals

4.1. In April, there was one referral to MNSI. Staff have received support from the Professional Midwifery Advocate (PMA) team. A baby was born via a category 1 emergency caesarean section for fetal distress after presenting to the Maternity Assessment Unit (MAU) in early labour. The baby was subsequently therapeutically cooled. Sadly, the baby was moved to a comfort care pathway and passed away. A rapid review was completed. Learning in relation to having the right level of neonatal support in attendance at the birth was identified and has been shared with the delivery suite teams.

4.2. In May 2025, three cases were reported. All three cases were of suspected hypoxic-ischaemic encephalopathy (HIE) and were subsequently therapeutically cooled. All three MRIs showed no evidence of hypoxia. The first two cases occurred within days of each other, and the third occurred at the end of May. The latter case has not yet been referred formally to MNSI as the parents have not yet given consent. A thematic review is underway to identify any common themes

4.3. We did not receive any final reports from MNSI in April or May 2025.

5. Patient Safety

5.1. The Trust adopted a standardised approach from October 2021, automatically grading Postpartum Haemorrhage (PPH) of more than 1.5 litres and Obstetric Anal Sphincter Injury (OASI) incidents as moderate harm to ensure thorough investigation and learning. In maternity there were 66 moderate and above harm incidents reported in April 2025 and 48 in May 2025. We had a lower proportion of moderate harm Ulysses in May 2025 (22%), compared to our average. Of the PPH and OASI cases reviewed during this period all cases were graded A or B.

5.2. In Neonates there was 1 moderate harm incident reported in April 2025 and 1 in May 2025. A surgical incident is currently under review by the paediatric surgical team. Joint learning identified that OUH neonatal sepsis guideline has a built-in safer threshold than the national guidance, however this nuance needs greater transparency/team education to ensure wider awareness and adherence.

5.3. Avoiding Term Admissions to the Neonatal Unit (ATAIN): Unplanned admissions to the neonatal unit were 4.8% and 3.1% respectively in April and May remaining below the national target of 6%. The primary reason for admission and diagnosis on discharge is respiratory distress in the neonate.

5.4. The quality improvement red hat project went live on the 27 January 2025 and is ran until 30 April 2025. An initial review has been completed looking

at missed neonatal observations since implementation of the project, findings suggest there may be increased reporting where the presence or absence of a red hat is prompting a check as to whether observations are required. Overall numbers are low (an increase from 6 to 8 incidents). Further data collection is planned for the next two months to examine compliance and timeliness of neonatal observations since implementation and to examine whether this relates to subsequent admissions to SCBU. This will be presented to the next ATAIN quarterly meetings.

6. Maternity Mandatory Training Attendance

6.1. Training weeks that include PROMPT, fetal monitoring training, OxMUD and neonatal life support continue, and compliance is above the target of 90% for staff groups apart from the anaesthetic group attending PROMPT which is at 89**%** (improvement from previous month). Fetal monitoring training for consultant obstetricians has increased to 92% (from 88**%**).

6.2. At the end of March 2025, training compliance for newborn life support is above the target of 90% for neonatal/paediatric consultants, junior neonatal doctors (who attend births) and ANNP's. For neonatal nurses, compliance is 89%.

7. Minimum Staffing

7.1. There were no occasions in April or May when 1:1 care in labour was not provided for women and birthing people in established labour and there were no occasions when the Delivery Suite Co-ordinator was not working in a supernumerary capacity during the shift.

7.2. The midwife to birth ration was 1:23.40 in April and 1:25.51 in May.

7.3. In April, on-call Midwifery staff provided 78.5 hours, a notable decrease from March. In May, on-call hours rose to 159, particularly for daytime community teams.

7.4. Neonatal Workforce: The team is progressing toward meeting BAPM medical staffing standards. After TME approved increased staffing on 28 November, two locum consultants have been appointed. By July 2025, 12-hour weekend resident cover will be in place. Six additional registrars were recruited; three are already supporting night shifts, with the remaining three starting by the end of quarter 2.

7.5. Neonatal Nursing Workforce: Successful rolling recruitment programme for Band 5 and Band 6 Nurses, reducing vacancy rates to 1.07WTE and 3.24WTE, respectively. A full review of establishment and service requirements is underway to ensure efficiency in neonates. The focus

remains on supporting Qualify in Specialty (QIS with the aim of being fully compliant by 2027.

7.6. The Trust monitors compliance with regards to consultant attendance for clinical situations listed in the RCOG workforce document 'roles and responsibilities of the consultant providing acute clinical care in obstetrics and gynaecology,' via exception reporting. No episodes have been reported where a consultant did not attend in person in April or May.

7.7. A resident consultant is present on site every day from 08:00 until 21:30, providing consistent senior clinical oversight and immediate support for complex or acute situations throughout the day and into the evening totaling 109hrs per week.

8. Maternity (Perinatal) Incentive Scheme (MPIS)

8.1. The Trust has received confirmation from NHS Resolutions that they have passed all 10 Safety Actions for year 6 of the MPIS.

8.2. Year 7 of the Maternity and Perinatal Incentive Scheme (MPIS) was published on the 02 April 2025.

8.3. Monthly meetings occur with all key stakeholders and plans are in place to meet requirements in line with necessary time frames (see appendix 2 for an overview of the Safety Actions). Potential areas of concern arise from the following safety actions:

8.4. Safety Action 1: "External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage". This is an MBRRACE requirement and has been updated in year 7. This is being discussed with the LMNS and key stakeholders.

8.5. Safety Action 4: An action plan is in place to meet the neonatal workforce requirements and is anticipated to be compliant by September.

8.5.1. Safety Action 7: The Maternity and Neonatal Voices Partnership (MNVP) lead to be a quorate member of trust governance, quality and safety meetings at speciality/divisional/directorate level. The post has been appointed into in June 2025 and awaiting further information in relation to start date.

9. Service Users Feedback

9.1. The service has implemented a Triangulation and Learning Committee (TALC) which includes complaints, service user feedback, safety themes,

legal/claims, patient experience and operational representation. The aim of the committee is to triangulate feedback data from the multiple sources and develop and execute actions to address themes in a timely and systematic way.

9.2. After launching the updated Friends and Family Test (FFT) via Microsoft Teams QR code in February, Maternity services received 123 responses in April and 101 in May.

9.3. In April the service received 123 responses (23.5% of our delivery rate). There were: 109 positive responses, 11 negative / neutral and 3 failed to commit to a response. The positive themes were that midwives and staff have been described as personable, good communication, welcoming, helpful and caring. A relative commented on how impressed they were with interpreter availability. There was one clear theme that required improvement in relation to communication around discharge especially if their baby is in the neonatal unit (NNU).

9.4. A mind map will be introduced on the postnatal ward to visually outline the time of available services and indicate the approximate times when each type of care can be accessed. Upon admission, staff will personalise each person's care by circling what they require before discharge, ensuring service users know when to expect support for feeding, medical checks, and other routine care steps. This tool will help clarify the schedule for these services, so parents and families are informed about the timing of their care throughout their stay.

9.5. In May the service received 102 FFT responses (16% of our delivery rate). There were 90% good/very, good and 10% poor/very, poor. The service recognises that further work is required to encourage an improvement to our response rate and will be working with our teams to increase this update. We are advertising now within the community and promoting completion from the initial booking appointment. 33% of the positive themes were focused on the care, attention and support from the postnatal ward. We have also seen good communication/attentive staff on the labour ward. There were reports of excellent immunisation and BCG service – reassuring staff and there was a feeling of time and support to inform decisions. Length of stay on MAU prior to discharge whilst waiting for results was an area that was identified as requiring improvement. Work is underway within the Triage quality improvement project to enhance communication when delays in receiving results extend discharge times.

9.6. On review of ethnicity of the responses received in April from the FFT, 78% were completed by white British compared to 22% completed from all other ethnicities. In May, 52.5% of responses received were from white British, 10% were from white -any other white background, 9% preferred not to say

and 27% were from other ethnicities. There is an action to support further response from all of our communities; Support the introduction of this FFT being more accessible within the community to focus on completing the FFT at their initial booking appointment and further focused touch point at 28-week appointment and Postnatal home visit. Optimising the opportunity to use the interpreting services. Posters and leaflets have been put up within each clinic space with a QR code encouraging access to the QR code during other community visits.

9.7. The 'Say on the Day' devices stationed in the Maternity Ultrasound Departments confirmed 205 responses in May with 99% positive feedback. Comments centred around excellent communication, kindness and compassion.

9.8. The Newborn Care Unit is collaborating with the Thames Valley and Wessex Neonatal Network to implement a Neonatal Family Experience Feedback Survey. The Friends and Family Test (FFT) has been established for neonatal care, with the initial report expected at the end of June.

10. Feedback from Staff Engagement Sessions and the Safety Champions

10.1. On the 16 April, the Safety Champions Walk-around was conducted by Sharon Andrews, Head of Midwifery, Claire Litchfield, Maternity Clinical Governance Manager and Dr. Amit Gupta, Neonatal Unit (NNU) Clinical Lead. Their journey included the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU).

10.2. Staff have recognised challenges related to the Maternity estate and logistics of setting up the unit. There is an understanding that these issues require long-term solutions and measures have been implemented to address them.

10.3. Service users, particularly parents of babies cared for in both the neonatal unit and the TCU, shared inspiring feedback about their experiences. They highlighted the seamless care provided, especially when attending for baby intravenous (IV) antibiotics, describing how the setup allowed them to remain with their baby in the TCU and accompany them together for treatment. Their comments reflected appreciation for the attentive and cohesive approach of the team.

10.4. The feedback from service users about their experiences in the TCU and Level 5 postnatal ward was overwhelmingly positive. Two service users, who had been inpatients for 5 and 10 days respectively, provided excellent feedback. They praised the timely pain relief, responsive staff, clean and tidy environment, and most importantly, the kind and compassionate

behaviours consistently displayed by the staff caring for them. All service users they spoke to had received support with infant feeding and gave positive feedback about the morning feeding sessions held on the ward. There were some suggestions made to improve this service, such as having 'infant feeding specialists' more readily available, which they will certainly consider.

10.5. Additionally, they asked service users if they had observed the new 'teaming' setup, where nurses, midwives, and support workers collaborate in smaller teams to facilitate continuity of care while releasing time to care. The feedback was very positive, with observations on how nice it was to have familiar staff looking after them and how responsive the staff had been to their needs. Service users also commented on the fluidity of visiting with the new 24 hour set up, although had not experienced a partner staying over themselves but understood that this option was available.

10.6. Service users who shared their experiences of the TCU and Level 5 postnatal ward gave glowing feedback. Two individuals, who had been inpatients for five and ten days respectively, highlighted the promptness of pain relief, the attentiveness of staff, the cleanliness of the facilities, and above all, the kindness and compassion shown throughout their stay. Every service user remarked that they had received support with infant feeding and spoke positively about the morning feeding sessions on the ward. Some offered suggestions to further enhance the service, such as increasing access to 'infant feeding specialists,' an idea that will be explored further.

10.7. Service users were also asked about their impressions of the new 'teaming' model, where nurses, midwives, and support staff work together in smaller groups to improve continuity and increase time available for patient care. The feedback was very encouraging and included; people appreciated seeing familiar faces and felt that staff were highly responsive to their needs. They also commented favorably on the new 24-hour visiting policy, noting the flexibility it provides, even if they themselves had not had partners stay overnight but valued the option being available.

11. Conclusion

11.1. The report outlines the implementation of the Perinatal Quality Surveillance Model (PQSM) in alignment with the Ockenden report's recommendations and the Year 7 safety actions of the Maternity Perinatal Incentive Scheme (MPIS).

11.2. It details the number and types of perinatal deaths documented within the Trust, followed by a summary of the reviews conducted via the Perinatal Mortality Review Tool (PMRT).

11.3. The report also summarises prominent themes and actions derived from these reviews and incidents.

11.4. Additionally, the report indicates the percentage of term admissions to the Neonatal Unit (NNU) and includes an appended action plan.

12. Recommendations

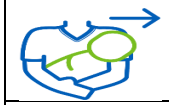
12.1. The Trust Board is asked to:

- Receive and note the contents of the Perinatal Quality Surveillance Model Report.

Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

- A – The review group concluded that there were no issues with care identified.
- B – The review group identified care issues which they considered would have made no difference to the outcome.
- C – The review group identified care issues which they considered may have made a difference to the outcome.
- D – The review group identified care issues which they considered were likely to have made a difference to the outcome.

Appendix 2: Maternity (Perinatal) Incentive Scheme Overview

Safety Action	Description	RAG rating	Comment
1 	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard		Q4 PMRT report was sent to board in May. Ongoing discussions with NHSR surrounding MNVP attendance at PMRT On track to meet increased requirements for completed reviews and external reviewer attendance.
2 	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		No issues identified July is MSDS reporting month. Currently meeting requirements.
3 	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?		TCU requirements met Plan to continue the Red Hat QI project in line with MPIS Year 7 requirements.
4 	Can you demonstrate an effective system of clinical workforce planning to the required standard?		Audits to be registered on Ulysses. Neonatal medical workforce on risk register and is on track with the previous action plan to recruit trainees by September 2025. Concerns escalated with compliance of neonatal nursing workforce due to changes to establishment
5 	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Birth Rate plus (BR+) review scheduled for the end of the calendar year. This will certify requirements of a systematic evidence-based process to calculate midwifery staffing establishment. Current BR+ review still within necessary time frame to meet compliance requirements. Bi-annual reports to Trust Board. Supernumerary status of Delivery Suite coordinator and 1:1 care in labour reported as part of the Maternity Performance Dashboard and the Perinatal Quality Surveillance Model (PQSM) report.

6 	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		Q4 reports awaiting review by LMNS. An update to Saving Babies Lives Care bundle version 3.2 was released at the end of April. The changes have been shared with the relevant leads of each element.
7 	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		MNVP lead recruited in June. Risk remains whilst training and onboarding in progress – LMNS aware of concerns surrounding compliance with this element.
8 	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?		Current training year continues until July. Plans insitu for the training year that starts in September. Improvement plan in place for neonatal nurse
9 	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		No anticipated concerns
10. 	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025		No anticipated concerns