

**National  
Maternity and  
Neonatal  
Investigation**

**Oxford University Hospitals  
NHS Foundation Trust**

**Trust Report**

## Note of acknowledgement

We would like to thank the women, birthing people and families who came forward to share their experiences of maternity and neonatal services at Oxford University Hospitals with us. By sharing their experiences, families relived deeply painful and traumatic events in their lives, and we are grateful for them for their preparedness to do so. From the outset we have put the voices of women and families at the heart of this investigation, and that is why our visits to Trusts carried out family evidence panels separate from Trust premises.

We would like to thank staff at the Trust for their time and contributions to the National Maternity and Neonatal Investigation (NMNI) including organising our visits, sharing data and evidence, and for their honesty and openness in interviews and panels.

# Introduction to Oxford University Hospitals NHS Foundation Trust

We visited Oxford University Hospitals (here on referred to as OUH) on the 6 and 7 of November and 5 December 2025. The review considered maternity services at two Trust sites. The John Radcliffe Hospital which delivers hospital-based maternity and neonatal services and the Horton General Hospital where maternity services comprise a standalone Midwifery Led Unit and antenatal services.

The aim of our visit to the Trust was to speak to families about their experiences and understand the experience of staff working there. It was also important for us to view the estate itself, as staff and families reported the impact this could have on services. The Trust visit contributed to our understanding of what is happening in maternity and neonatal services in England.

Each individual Trust report provides a snapshot in time, based on the evidence gathered during our site visit and review. These reports were not intended to replicate the role of the Care Quality Commission (CQC), and they should not be read as equivalent to a formal inspection or rating.

We have used nationally published and validated statistics to help us understand the performance and the context in which services are delivered as part of our site visits to NHS Trusts.

Some Trusts have told us that there are differences between these national data sets and the information they hold locally, or in how they define certain measures.

We recognise that these differences exist. Where a Trust has raised this with us, we have noted this and, for completeness, included both the nationally published data and the Trust's own data or explanation.

## Maternity services

At the time of our visit the Care Quality Commission (CQC) rated maternity services as 'requires improvement' at both the John Radcliffe and Horton General. In June 2026 Oxford Maternity services received a new CQC report that rated the service as 'good' across both sites. We noted that CQC identified seven breaches in regulations in the 'safe' domain for John Radcliffe Hospital. These breaches related to safe care and treatment, clinical spaces, infection prevention control, staffing, and good governance.

An explanation of what the CQC is and what its ratings mean can be found in the Annex 2: Glossary.

## Activity and modes of delivery

Activity:

## National published statistics

- In 2024/25, OUH supported 7,255 births.

### Modes of labour and delivery:

- In February 2026, 43.0% of deliveries were by caesarean section, compared with 38.2% three years earlier in February 2023.
- In February 2026, labour was induced for 17.2% of deliveries, compared with 24.5% three years earlier in February 2023.

## Statistics provided by the Trust

- In 2024/25, OUH supported 7,551 births.

### Modes of labour and delivery:

- In February 2026, 41.9% of deliveries were by caesarean section, compared with 38% three years earlier in February 2023.
- In February 2026, labour was induced for 25.2% of deliveries, compared with 25.0% three years earlier in February 2023.

## Workforce

### National published statistics

As of January 2026, the Trust employed:

- 278.9 full-time equivalent midwives.
- 84.3 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 27.3 which is much higher than the national figure of 23.1 (Oxford is in quintile 5 i.e. the highest 20%).

### Statistics provided by the Trust

As of January 2026, the Trust employed:

- 340.7 full-time equivalent midwives.
- 92.27 full-time equivalent doctors working in obstetrics and gynaecology.

## Neonatal services

At the time of our visit, the Trust's neonatal services were rated 'good' by the CQC in 2014 as part of the Services for Children and Young People. The CQC recently visited the John Radcliffe Hospital to assess their neonatal services in January 2026, and the Trust is currently awaiting publication of its report.

## Unit and care pathway

OUH has a Level 3 Neonatal Intensive Care Unit at the John Radcliffe Hospital, providing care for babies who need the highest level of medical support. It includes advanced breathing support, life and organ support as well as other specialist services. There are 43 Level 3 Neonatal Intensive Care Units across the country.

National published statistics

In 2024, babies were cared for in neonatal units for a total of 12,228 days of care, placing OUH in the top 20% of providers of neonatal care nationally.

Statistics provided by the Trust

1st January 2024 to 31st December 2024 gives a total of 12,704 neonatal care days

## Workforce

In the 12 months ending December 2025, 93.8% of neonatal nursing shifts at John Radcliffe Hospital were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

A full explanation of neonatal staffing guidelines and service specifications can be found in the Annex 2: Glossary.

## Experience and outcomes for maternity and neonatal services

In 2025, women's experience of maternity care in a range of maternity care, such as antenatal check-ups, pregnancy, labour and care at home after birth was rated around average. However, women's experience of feeding their baby and post-natal wards was rated below average.

National published statistics

In the 12 months ending October 2024:

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days) of 1.9 per 1,000 live births, much lower than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.5 per 1,000 births, comparable with similar trusts.

Statistics provided by the Trust

- In the 12 months ending October 2024: The stabilised and adjusted neonatal mortality rate was 1.88/1000 births, more than 15% lower than the national average for similar Trusts.

- The stabilised and adjusted stillbirth rate was 3.47/1000 births, just below the national average for Trusts of similar risk level.

A full list of evidence sources that were used to inform this report alongside details on what analytical methods we used can be found in the 'How we gathered and analysed our evidence' section at the end of this report.

## What families told us

The Investigation's engagement strategy has been underpinned by a Families First approach. 'Families First' originated as a key principle of the Hillsborough Independent Panel, and has been adopted in several subsequent investigations, including maternity investigations.

When visiting Oxford University Hospitals NHS Trust, the first thing the Investigation did was to hold family evidence panels in locations separate from the Trust sites. We invited women, birthing people and partners<sup>1</sup> who received care from the Trust to share their experiences at the panels. Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences are situated in the context of the lasting impact of harm and bereavement on their lives and the lives of their loved ones. Families told us that they came forward as they didn't want other families to go through the experiences that they did and they wanted to see long term change.

Alongside the family evidence panels we held on the day of the site visit we also engaged with local family campaign groups: Families Failed by OUH Maternity Services and Keep the Horton General. Families told us about their experiences at OUH and their relationship with the Trust.

We did not set a time limit on when experiences of maternity and neonatal care took place, and families spoke about distressing events that happened across a range of time periods. As a result, some issues raised, such as estates, services or ways of working, may have changed or improved since those experiences took place, but the themes remain important in understanding how families felt and what mattered most to them at the time.

A consistent message from families was that they were not listened to or taken seriously when raising concerns about their own health or their baby's condition. Many described clear warning signs, such as bleeding, reduced movements, or leaking waters. However, they were dismissed and their concerns were not acted upon until the situation became more serious. Families described how healthcare professionals told them not to worry about symptoms, without any examinations being undertaken to provide clinical assurance. One woman described how their knowledge of their own body, based on previous pregnancies, was dismissed.

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<sup>1</sup>This report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services identifies as a woman or mother. Further information on our approach to inclusive language and terminology is provided at Annex: Glossary

*"I had a very clear mental health, perinatal mental health team, signed, approved birth plan for the second time around and the response when I went in for that again 37-week induction, was, "Oh, we don't really have to follow your wishes." It is not wishes, it is a plan because I've experienced harm and my mental health got to a really bad point before. This is a plan to keep me safe, and it's dismissed as like a petty wish list."*

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Some families described how assumptions or stereotypes about their age, race, ethnicity or weight influenced how seriously their concerns were taken. One mother told us that age shaped staff responses:

*"I feel like I was treated as a bit of a young mother, like, you don't really know...we're not really going to take much notice of you."*

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These experiences left families feeling powerless and contributed to a loss of trust in the professionals providing care. Many families described having to persist and advocate strongly for themselves in order to receive safe care.

*"Had I not persisted... this would've been catastrophic."*

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Families repeatedly reported confusing, contradictory, or inadequate communication from staff both during care and afterwards. Some described being given limited information or being presented with changing options for care without explanation or discussion.

*"I was told that I had to have a c-section... then the following week being told, no, no, no, we're now having an induction, without question."*

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In addition to confused messaging, families described receiving different advice from different professionals as a result of a lack of continuity of care and poor communication across teams. This left families unsure about which advice to follow or what was the right decision to make. In busy clinics and wards with multiple staff involved, some families described not knowing who was providing their care, or who was responsible for their safety.

*"Each member of the team gave a completely different perspective... there was no consistency."*

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A lack of clear explanation after previous events affected families' ability to process and recover from their experiences.

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*"I was never told, 'this is what happened to you... this is what you need to be aware of.'*

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Many families described significant staffing pressures, particularly on labour and postnatal wards, and the impact this had on the quality of care they received. This included being left alone during labour or immediately after birth, when unwell or recovering from major procedures. Even basic care was an issue with women and birthing people left without food drink, or pain relief.

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*"I was labouring completely alone...nobody was in that room with me."*

*"I was laying in a bloody bed...nobody put anything on me after my c-section."*

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Several families in five different evidence sessions described conditions that did not meet basic standards of cleanliness. This included the presence of other women's blood and urine in clinical areas and shared bathroom facilities.

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*"... when I was in the [geographical location] in labour and I was in a room where the only way to go to the bathroom was to sort of go down a corridor, and at least two toilets that I went to, sort of in between contractions and sort of really struggling to get to them, each one just covered in other people's blood."*

*"But for me, the breakdown of the hygiene issues, the blood along the floors, the blood in the toilets, the blood along my own body with wipe marks from surgery that they actively left there "*

*"In the delivery suite at the Hospital there was blood splattering on the wall and on the ceiling". I wasn't under any illusion that this was going to be a lovely holiday, but it really really was poor, and I just felt unhygienic..."*

*"I believe they want to do a check of your fluid balance, so you have to pee in a pan. Well, you go to the toilet and there's someone else's pan of pee still on the toilet because no one's going to collect it to weigh it to see how much there is. It's disgusting."*

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On our visit we observed a toilet in the maternity unit at John Radcliffe that had blood over it. We also heard about problems with cleanliness in the NICU at John Radcliffe.

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*"Other times, we walked into the NICU and see blood dripping down from the side of her cot, where they had forgotten to clean up after taking bloods. Plastic bits were also left inside her cot."*

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When we reflected these findings to the Trust they responded in the following way.

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*"The Trust apologises unreservedly for the experience described. The observation of a soiled toilet falls well below the standards the Trust expects and that women and families deserve. The Trust takes this seriously."*

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Families recognised that staff were often under significant pressure but described feeling like a nuisance or a burden when seeking basic care. Families recognised that for staff this was their day-to-day job but wanted some recognition that, for them, this was one of the most important and potentially difficult days of their lives.

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*"You feel like a massive inconvenience, when actually, that's what their service is. They're the people that they're dealing with every day, and yet, you're just kind of getting scoffed at and, "Oh god, another one."*

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The Keep the Horton General group told us that they felt the closure of the obstetric maternity unit at Horton was a factor behind some of the delays in receiving care and increased staff pressures because all patients requiring obstetric care needed to go to the John Radcliffe rather than care being split across two sites. This investigation did not carry out an exercise to verify whether this assertion was correct.

Another recurring theme was the lack of consistent support following harm or loss. While bereavement teams were often praised, supportive care was not consistently experienced by families across other parts of the service.

Families described a sharp contrast between compassionate, individualised care provided by specialist teams and the broader system, where support was limited or fragmented. In particular, families described a reduction in support once they left hospital, with follow up care difficult to get or absent altogether. Others described long term impacts on their mental health, relationships, and confidence in future pregnancies, often without adequate ongoing support.

*"I was traumatised. So every talk about birth...I think even now, this is 5 years ago, every talk about birth would make me upset"*

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Underlying many testimonies is a strong belief that harm was preventable. Families repeatedly stressed to us the following concerns: missed warning signs, failure to act on known risks, and repetition of the same mistakes time and time again, affecting different families. Many linked this to a culture where decisions were made without consultation with families.

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*"All of us have preventable issues that we didn't have to go through, and it's all because of a statistic that they seem to feel like is the right thing to do. Funnily enough, nobody else does."*

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### **When care went well**

We also heard about staff members who took the time to listen, explain situations clearly and noticed what mattered to women, birthing people and their families.

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*"It was incredible...was so nice, she was like, "I can tell that you're a bit terrified, we'll do a walk down so that you can see -- you're imagining what's going to happen" which was really helpful."*

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For families 'small acts' of compassion went a long way and left a lasting impression, such as asking if a partner was okay, or trying to improve their comfort during labour.

## What we saw and heard at Oxford University Hospitals

During our visit, we spent three days at OUH, visiting both the John Radcliffe and Horton General Hospital, including a full walkaround of all areas where maternity and neonatal care are delivered. The visit included an obstetrician, midwife and public health consultant.

The community served by OUH includes more women aged at 35 or over, but fewer women living in the most deprived areas, who are obese or smoke in early pregnancy, or who have had a previous caesarean section compared with national averages.

Whilst health inequalities are not widely prevalent compared to national averages, there are pockets of deprivation, as well as recent migrants and asylum seekers, particularly in Banbury. This means that more targeted interventions are needed to ensure that certain groups of people do not become isolated or invisible.

Families told us about not being listened to at OUH and felt that the Hospital prioritised doing things the 'Oxford Way' over their care preferences. However, we also heard women who had positive experiences and spoke highly of individual midwives and services such as the midwife led unit 'The Spires'.

During our visit we considered the Trust's practice in relation to antenatal ultrasound scanning. The guidance provided by NICE in regard to antenatal ultrasound scans recommends that for an uncomplicated, singleton pregnancy two scans are performed:

- A dating scan between 11-14 weeks to determine gestational age, detect multiple pregnancies and estimate the date delivery is due.
- An anomaly scan between 18-20 weeks to screen for specific conditions and structural anomalies in the baby.

NICE makes a further statement in relation to monitoring routine intrauterine growth,

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*"Do not routinely offer ultrasound scans after 28 weeks for uncomplicated singleton pregnancies"*

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Apart from the two scans identified NICE recommends that further scans are only offered if there is concern about intrauterine growth identified through fundal height measurements that take place as part of routine antenatal appointments.

The protocol at OUH is to offer all women ultrasound scans at 36 weeks as part of the Oxford Growth Restriction Identification Programme (OxGRIP). Accordingly, the protocol and practice at OUH departs from NICE guidance by offering all women and birthing people an ultrasound scan at 36 weeks.

The Investigations Expert Advisors were concerned that departing from NICE guidance in the way the OxGRIP programme does, impacts on its capacity to deliver scans to those women who have a clinical justification for requiring a scan as set out in NICE guidance. Indeed, during a family panel we were informed that despite a woman having a clinical indication for an ultrasound scan after 36 weeks due to midwifery concerns over her symphysis fundal height, she was informed that due to the use of the OxGRIP pathway this would not be provided by the Trust.

In addition, we are concerned regarding the information provided to women about OxGRIP. The OxGRIP protocol, and information provided to women booking at the trust are unclear on the extent to which OxGRIP incorporates NICE antenatal guidance regarding monitoring of symphysis fundal height during pregnancy, or the offer of ultrasound scans when clinically indicated. We are aware that NHS England has recently undertaken a review of OUH maternity and that this review includes an examination of OxGRIP. The Trust has informed the Investigation that the Health Research Authority has also undertaken a formal review of the programme.

When speaking to the executive team we heard about the breakdown in the relationship between the Trust and local family groups. They told us they wanted to fix this relationship and speak to the family groups but acknowledged they weren't getting it right. During our visit there was a news article criticising the Trust following an investigation into the harm caused to families using maternity services in Oxford

During our visit we met staff who were committed to their jobs and wanted to provide women and families with the best care they could. This was against a backdrop of daily challenges that staff were facing, including a lack of midwifery and medical staffing, and delivering care in estates that were not fit for purpose. The resident medical cover "out of hours" i.e. overnight was 2 junior resident doctors (or equivalents) and 2 senior residents (or equivalents) and a single anaesthetist (at resident level). These doctors were supported in both disciplines by non-resident consultant cover. The doctors are responsible for covering obstetrics and gynaecology in a large tertiary hospital with 8,500 births per year.

To place this in context, if there are two obstetric theatre cases simultaneously taking place (which could not occur without either requesting anaesthetic cover from elsewhere in the hospital or for the non-resident consultant to attend from home), or an obstetric theatre case and an emergency gynaecology case then there are no free staff to cover the wards, maternity triage or emergency gynaecology admissions. In the view of the investigation team, this was not an appropriate staffing model for a unit of this size. This was supported by evidence heard from staff who described long waits for medical reviews on triage out of hours and a lack of cover for patients on the wards. We also witnessed the distress this situation caused resident doctors.

The John Radcliffe Hospital's women centre was first opened in 1972. The maternity and neonatal units sit across multiple floors, so women and babies have to be moved between floors during their stay at the Hospital. We saw delivery suites that didn't have

windows, that were cold, small and cramped and had pillars in the middle of them affecting where equipment could be placed.

Due to health and safety concerns related to fire dampeners, only two immobile women or birthing people are allowed on the postnatal floor at any one time, meaning that following a caesarean section women could not move to the postnatal ward straight away if there were already immobile women there. This led to women being kept in a recovery area that felt like a holding bay, created blockages throughout the system and made it difficult to preserve the privacy and dignity of women, as we saw on our visit. If women weren't discharged or regaining mobility in the postnatal ward quickly enough, this increased the pressures in the recovery area, creating a backlog for the delivery suite and triage.

The Trust informed us that they had commenced "an active and substantially funded remediation programme directly targeting the specific issues described..." stating that they had invested £1.5million in maternity estates at John Radcliffe since 2023. They also stated that a further phase of work was planned for the financial year 2026/27. However, the Trust accepted that the programme of works carried out had not yet resolved the underlying capacity constraints previously described.

Neonatal estates at John Radcliffe Hospital are also cramped. The ICU is spacious and had an orderly unit despite the large amount of equipment needed to care for babies in the unit. However, the HDU and LDU are very cramped and there is limited space for families to spend time at their babies' cot side.

Staff across the sites also told us about shift patterns and staffing models that are long, demanding and at times feel unsafe. This is echoed across different grades and professions.

At the Horton General, the unit is small and well contained. It has two birthing rooms and offers local community services. The site was clean and uncluttered when we visited. We met with the Keep the Horton Group as part of our engagement work to hear about their experiences with the Trust and concerns they have about the closure of the obstetric maternity unit at Horton General.

## What staff told us

The executive team described working in a very challenging context, with intense public and media scrutiny, increasing demand for maternity care, workforce pressures, and limitations in estate and data systems. A recurring theme during our visit was the capacity pressures experienced by maternity and neonatal services. The Trust cares for a high number of families across a large area, with some women having extremely complex medical needs.

The pressures are leading to blockages across the system, with women spending longer periods of time on the post-natal ward after birth and delivery due to more complex after birth needs. Meaning that fewer patients are discharged quickly. Blockages on the post-natal ward leads to delay in women and birthing people being moved from the delivery suite and recovery area into the post-natal ward.

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*"It's that domino effect, isn't it?... we get to the state where we are kind of bed blocked in all directions when the level five postnatal ward that's got 42 beds is full. Then you've got no patient flow at all and your backlog of inductions are queuing up."*

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The estates at the John Radcliffe are contributing to this problem and the blockages in patient movement.

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*"The building isn't really fit for purpose. We are restricted with the number of immobile patients that we can have because of the fire exit strategies. So that means that the recovery pathway down on level two where delivery suite and theatres are, particularly for the elective c-sections of which there are numerous. It means that we could only have two enhanced recovery patients go up to the ward at any one point because of the lifts and the evacuation processes involved."*

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As we saw at other trusts, the rise in caesarean sections and inductions are also causing delays for families and pressures for staff. Many staff told us about these pressures.

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*"So our average delay time for an induction from waiting like being classed as ready for delivery suite is about 30 hours. So massive, massive amount of time."*

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The Trust told us that their own audited data for the thirteen months from May 2025 to May 2026 indicated that delays approaching 30 (26) hours were recorded in September

2025. However, they stated that this was a period of unusually increased activity in terms of births and not representative of performance across the period, as the average across the 13 months was 13 hours. We note that the most recent CQC report<sup>2</sup> published in June 2026, identified that between April to October 2025 there were 206 delays that exceeded 24 hours.

Staff also told us that if there are back-to-back caesarean sections in multiple theatres simultaneously which can leave insufficient staff to safely cover the rest of the unit, especially overnight. When we shared these findings with the Trust, it provided data indicating that the need for more than one overnight emergency theatre occurred 22% of the total nights during 2025. The Trust acknowledged that this demand can place pressure on overnight staffing.

We heard from both midwifery and medical staff that as a result of the whole system being under pressure there are delays for women awaiting induction. This causes stress and anxiety especially if a patient was told that an induction had to be done by a certain point in their pregnancy due to health risks increasing.

Across the system we heard that the constraints of the building limited how the increasing capacity demands can be met. The maternity assessment unit is being extended but due to physical space constraints further extension options are limited.

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*“One of the things that we're challenged by is an old estate, it's a building that's 50 years old, it's cramped in terms of size because you imagine over the last 50 years, activity's grown very significantly, but it's also limited in terms of what we can do.”*

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Staff told us about the impact of estate challenges including families having to walk down corridors after birth to use toilets and showers, poor temperature control, layouts that do not provide dignity and privacy to patients and limited spaces for families to spend time together.

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*“Working in a building that's so old that you cannot sustain an even temperature throughout the building... it's far too hot in the summer... it's freezing... in the winter.”*

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In addition to challenges related to capacity and estates, staff also raised work patterns. As we saw across other trusts we visited, staff noted a misalignment between what the staffing tools used indicated were safe-staffing levels and what felt safe when delivering care to women and families.

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<sup>2</sup> <https://www.cqc.org.uk/location/RTH08/reports/LAP-01891/maternity>

*"So, what happens is they fill it in when they've got time so it looks like oh this is lovely because look at all of your green column but that's because the times they don't fill it in is because it's they're too busy to fill it in."*

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Community midwives told us that in addition to carrying out community and home-based care they could be drafted in to cover staffing gaps at the John Radcliffe. Whilst the staff understood the need for additional staffing cover, they often had to do this after working a long community shift of their own. We heard how being called onto wards can feel relentless and unsettling as they are being asked to work in settings with unfamiliar processes, sometimes arriving in the middle of busy shifts. In response to our findings the Trust informed us that escalations such as bringing community midwives to John Radcliffe hospital only happen in exceptional circumstances to ensure that patient needs are met. The Trust also informed us that they are undertaking workforce planning to reduce reliance on short notice escalation.

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*"We're called in because it's gone bonkers and it's not our familiar area. So we are half the time having to ask people what to do. We're not providing the same service that the delivery suite midwives can do because they know it like the back of their hands."*

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At staff panels staff members, across grades and job roles, were distressed and emotional, describing regular shifts where they felt both midwifery and medical staffing levels were not safe and there were not enough people to deliver the care that was needed for women and babies. Staff told us that they felt they often got through a shift "by the skin of our teeth" rather than because staffing levels were appropriate for the amount of work needed.

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*"It's not fair. We need to be sufficiently staffed to support our staff and to support our own wellbeing. We can't care for others if we can't care for ourselves. There's times that it feels really unsafe."*

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Unsafe staffing was also spoken about in relation to overnight shifts where, if caesarean sections were taking place, there were no doctors to assess patients in triage or if complications occurred in the post-natal ward.

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*"Every single one of my colleagues who I've asked for feedback from has comments about overnight staffing in terms of workload."*

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We were told that the continual scrutiny that OUH was under was affecting staff morale, and that some staff felt “beaten down” by the media scrutiny. Staff described feeling ashamed and said they had to hide what their jobs were in fear of online hate.

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*“I feel terrified to come to work... you know... So it is that whole dynamic of it feels impossible to have a solution to this system where it's so broken.”*

*“I mean I was filling up my car today with my hoodie on that says Hospital A on my way to work. I took my hoodie off and put a longer coat on because what used to be something that I used to be really proud of now makes me feel quite ashamed to say that I'm like a sorry that I'm a midwife.”*

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Some staff also said that they had no right of reply against these criticisms and couldn't put their points of view. This left staff feeling powerless and without a voice whilst dealing with “normal” work pressures. Staff also described worrying about future patients and their willingness to visit the Hospital if they had concerns or worries, given the media scrutiny.

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*“We want to make improvements. We want to get it out there that we're a good unit but what do we do to change that attitude out in social media? We don't have a voice on social media and that's really hard.”*

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Senior Trust executives described the many changes that had taken place in patient safety and some expressed concern that a focus on the historic issues did not fully reflect the situation as it currently was. In addition, one consultant told us:

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*“But we have changed, and we are changing, and we are adapting, and we are trying to deliver on our promises.”*

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Improvements in patient safety oversight and governance measures were described to us. We also heard about multi-disciplinary teams that were working well together and addressing some very difficult issues with their most disadvantaged communities. We heard from some staff members about the level of stress junior staff were exposed to and who said there was a lack of support from senior staff. One said that it was only when CQC visited that senior staff were visible:

*"The CQC came, we had managers coming out of every cupboard checking files. Yet before that, we don't see anybody."*

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We heard from senior staff about the pressures they were under trying to deliver services and trying to manage high levels of reporting requirements, audits, complex IT systems and ensuring that staff are recruited to a safe level. Senior leaders also described that whilst clinical working relationships were positive and they felt able to raise concerns about patients to clinicians, there were tensions around governance processes and management systems. We also heard that teams did not acknowledge the pressure that others were under.

*"I think there's a lack of understanding about what we do and the pressures that we are under operationally... I also think there's an unwillingness there sometimes to understand."*

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We interviewed senior leaders at the Trust and spoke about the levels of distress that we had witnessed from frontline staff, particularly in relation to staffing levels. There appeared to be limited understanding of the concerns staff had regarding patient safety. Leaders explained staff distress as arising from increased media scrutiny and CQC inspections.

We heard about long standing cultural issues that existed amongst professionals in maternity. A senior leader at the Trust acknowledged that tensions existed in relation to hierarchies and power relationships within the consultant body.

*"So we are aware of a range of tensions. They're mostly, I think tensions which could be racial as well as about gender. So we had a couple of pieces of cultural work done, getting people outside interviewing and getting a sense of what's there. One in maternity and one in neonatal from memory. They, I think tend to come down more on the favour on the side of this being a product of hierarchies and power relationships, rather than specifically around misogyny. But historically most of the leaders have been male. Not entirely, but most. So I'm aware a bit of stuff there."*

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They described the power dynamics in OUH as a resistance to letting go of professional power. A senior leader gave an example of how these power relationships manifest in patient relationships citing the example in maternity services where there was a reluctance to accept the 2011 NICE guidelines for caesarean sections on maternal request when they first started working at the Trust in 2019.

*"...perhaps I can talk you through my impression of the elective caesarean section bits. Because I think what it evidences headline is a resistance to letting go of professional power."*

*" So I think the resistance that I saw...in 2019 to elective caesarean sections, maternal request sections, I should say, was primarily driven by it feeling like an affront to professional expertise."*

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We heard from clinical staff about the dominant culture in the Trust described as the "Oxford way".

*"Anything that is done in [Oxford] by [Oxford] that potentially isn't done anywhere else in the world is the [Oxford] Way. It is the best. Woe betide you if you challenge it."*

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This was described to the investigation team in the following way.

*"...but it is a sort of clique type question. I think that we have begun to loosen that clique..."*

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We also heard how the changes that had taken place in clinical leadership that had improved the culture.

*"I think the current leadership is more open than the previous leadership. I do think we are in a better place..."*

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There is evidence of a willingness to ignore national guidelines based on evidence in favour of what Oxford clinicians think is the better way and a culture among medical staff that presented itself as united on particular issues, despite the reality being different.

We spoke with a number of former and present staff who raised concerns about cultural issues relating to misogyny, racism and bullying.

*"...some people feel it [is]very difficult to speak up about their racist and discriminatory experiences because they fear, and that was exactly what was happening here, that -- you know, and it was actually -- how this got flagged to me..."*

*"I'm not convinced it's really cracked the misogyny element..."*

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*"Listening to the experience of some of our black staff colleagues of their maternity services it has identified a channel of communication and feedback that we have not used as well as we should.."*

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From a whistleblower we were provided with an example of what they considered harm which occurred to a woman who had a complex condition. The harm occurred as a result of a delay arising from a disagreement between two consultants regarding when action should take place. We were told that an investigation into this matter was delayed for many months and that the Trust chose to have the issue investigated by an individual who did not have the required expertise to comment on the complex condition. We were advised that the investigation did identify poor relationships between medical staff.

We shared a draft of our report with the Trust, and they wanted it to be made clear that we had not previously put this case to them and that they had not had the opportunity to verify it against their own records.

We were also told that although the majority of staff worked as a team there was a history of poor relationships between some medical staff.

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*"I feel very strongly and very passionately about the department ..., and I believe that 95 per cent of the staff are completely amazing and working really hard and dedicated to the women and have the women at the absolute centre of their care."*

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We were told that the prevailing culture at Oxford is difficult to challenge and that if someone speaks up, they are subject to micro level criticisms and that medical staff had left the Trust because of this treatment.

The NMNI team requested a tranche of documents from each Trust that we visited, including Freedom to Speak Up reports. For Oxford there were 17 Freedom to Speak Up reports between Spring 2024 and Autumn 2025 relating to maternity and neonatal services. These covered issues such as poor professional relationships between staff, patient safety concerns and bullying or harassing behaviour.

At the Horton General the staff faced different challenges to the John Radcliffe. The capacity is lower and the type of work is different with fewer challenges with capacity issues. The Horton General staff generally spoke positively about the Horton General and the leaders that oversaw the midwife led unit there, describing it as having a supportive local team culture.

*"I mean all my babies were born here I'm really proud to work for the Unit and work with the team. I think we do good care."*

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Staff at the Horton General also spoke about local pockets of deprivation in Banbury which affected the women and families they served. We were told about interventions that were in place locally such as the Saplings Group which is a support system for women over 18 with additional social care needs. It is run by local midwives with wider support from across the Trust.

We spoke to one consultant who was responsible for a specialist clinic that originally focused on women and girls with Female Genital Mutilation but has since expanded its scope beyond that to support asylum seekers, refugees, and others. They spoke about their long-standing commitment to addressing health inequalities in these communities.

*"FGM used to be sort of the key to get the door open to come into the service. What I now have is the scope to see asylum seekers, refugees, undocumented migrant women, so -- and most of my work is with black, Asian and ethnically minoritised women."*

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We heard from some staff who trained at the Trust and had remained there for a long time because they enjoyed working at the Trust.

*"I couldn't imagine working anywhere else."*

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## What this means for families and services in Oxford University Hospitals

OUH is responsible for delivering maternity and neonatal care to a large geographic area resulting in high levels of service users. The Level 3 NICU on site means that additional complex NICU cases are transferred in from neighbouring areas adding to that pressure.

The Trust is constrained in how it copes with high numbers of service users because of the estate at the John Radcliffe, which is old and not fit for purpose. The condition of the estate at John Radcliffe directly affects patients' experiences and the ease with which staff can transfer patients between services.

Capacity pressures across the service are affecting staff's day-to-day experiences at the Trust. Staff described working unsustainable shift patterns where night-time cover is stretched thinly and community midwives are under pressure, particularly when they are called upon to provide on-call cover.

We were told by the Trust that they recognise that community midwives experience genuine pressure during high demand periods, particularly where community midwives are called upon to provide on-call cover. The Trust provided the Investigation team with data from August to October 2025 that showed utilisation of available on-call hours ranging from 11 to 55 percent. We do not consider this data undermines the community midwives' genuine concerns expressed to the Investigation regarding the safety of women and babies through these arrangements. We are concerned that staffing patterns at Oxford are putting staff in unsafe situations where the care they can give is compromised. Women and birthing people are at risk if staffing levels are stretched to the point of burnout.

Whilst relationships between staff groups are described positively in terms of how they support each other in clinical situations, some staff feel unsupported by senior clinical leaders. In panels, front line staff were emotional about the pressures they were under and the unsafe situations they felt they were working in.

The executive team acknowledged that staff were under pressure, but we did not consider that they fully understood the cause of the distress staff were experiencing. We noted that the executive team ascribed staff distress to external matters including the hostile profile the Trust currently has in the media and the pressures from the recent CQC inspection. However, although we heard that both of these issues did impact on staff, we saw and heard about the distress staff experience from internal operational challenges they encounter as they attempt to deliver consistently safe care to women and babies. We found that the senior leadership team had limited insight into how these operational challenges impacted on the distress staff experienced.

Relationships between the Trust and many families remains fractured. Whilst the Trust told us they are trying to bridge the gap with families, we remain concerned that the

evidence we have heard from some families who have recently given birth at the Trust is that they are still being dismissed, and staff are not listening to them.

# How we gathered and analysed our evidence

## How we gathered evidence

The evidence in this report was gathered through multiple sources. These included:

- Trust documents and data reviewed:
  - Quality Committee (or equivalent) minutes
  - Finance Committee minutes
  - All maternity and neonatal performance and service data that goes to the Trust Board
  - Any CQC warning notices or other formal or informal actions related to maternity and neonatal services
  - Complaint documentation relating to maternity and neonatal services
  - Any Freedom of Information requests received by Trusts in relation to maternity and neonatal services
  - Patient Safety Incident Investigations Reports (PSII) related to maternity and neonatal services
  - Patient Safety Incident Response Plan
  - Maternity and Newborn Safety Investigation (MNSI) data
  - Maternity Safety Support Programme (MSSP) documentation reports
  - ICB performance reports
  - NHS Resolution reports and activity
  - Improvement strategies for Maternity and Neonatal Services
  - Maternity and Neonatal risk register
  - Staff disciplinary data
  - Freedom to speak up occurrences
  - Prevention of Future Death Reports
- Two family evidence panels with women, birthing people and families
- Interviews with 10 women, birthing people and families
- Four listening events across different staff groups and grades
- Interviews with 16 members of staff

- 38 additional pieces of information were sent to the Investigation email address which were submitted as evidence for Oxford University Hospital NHS Foundation Trust.

The family evidence panels were supported in the recruitment and promotion of them, by the Maternity and Neonatal Voices Partnership (MNVP) leads for Oxford and through engaging with local campaign groups.

Through these listening events, we engaged directly with women and birthing people, fathers and partners, and families from a wide variety of backgrounds, including those from marginalised communities and deprived groups. Our approach was intentionally inclusive, aiming to capture the perspectives of seldom heard voices and ensure their experiences were reflected within our findings. During the panel events, participants shared personal stories and expressed their views about the care they received at the Trust.

These candid discussions provided valuable insights into both positive experiences and areas where improvements are needed, highlighting the diversity of needs and expectations amongst the community.

The listening events with staff were structured so that staff prioritised the issues for discussion based on those they experienced as most important to giving high-quality, safe and compassionate care.

Interviews with senior leaders in maternity and in the Trust were structured around a set of questions developed to gather information about key issues and requirements if care is to be high-quality care. For example:

- How do maternity and neonatal services level governance meetings report to the board to highlight any concerns, issues or good practice?
- What would you say now are the main barriers to giving safe and compassionate care? On the flip side of that, what would you say if you were to speak to another trust who were in the 'struggling' or 'requires improvement' CQC report landscape now, what would you say to them?
- During the site visit, we heard about the amount of work carried out to meet the needs of the local population, which is often quite complex. Can you tell us about how that impacts your service?
- How are the needs of different groups of women considered? Do you provide any support or training to deliver culturally sensitive care?
- We want to understand how the board supports the Trust to listen to women, families and staff. What processes are in place to hold the Trust to account on this?

- What is your view of where the organisation is at, in terms of maturity, in terms of PSIRF and its aim of involving patients and families and listening to them more as part of investigations?
- How would you describe incident investigations on the maternity and neonatal unit? Are wider system issues considered or is the focus on individuals and blame? How are staff supported during incident investigations?

The interviews were recorded and transcribed. The interview transcripts were sent to interviewees to check for factual accuracy and add any additional elements they may have omitted on the day.

## How we analysed the evidence gathered

Trust documents and data received from the Trust were reviewed by the Investigation team to triangulate evidence and review governance structures.

The listening events with women, birthing people and families, and those held with staff, were recorded in order to ensure evidence was accurately captured word by word and not misrepresented. Individual interview and panel interview transcripts were analysed through a mixture of AI use and human analysts. Analysts developed a specific AI programme for the analytical work that focused on qualitative data analysis. The analytical steps taken were:

- Analysts gave the AI tool information about the aims of the Investigation and the analytical approach. Analysts reviewed the tool's contextual understanding of this.
- The AI tool identified clear topics across the evidence and signposted where this was found across the evidence including suggested quotes. This was checked for accuracy by analysts.
- The AI tool coded the full dataset and organised these codes into suggested themes. Analysts reviewed and refined the themes to ensure they were accurate, clear and firmly grounded in the accounts of women and birthing people, families and staff.
- The final analysis was handed over to the Investigation team to feed into this local trust report and inform the themes and recommendations in the national report.

# **National Maternity and Neonatal Investigation**