

**Perinatal Assurance Report  
Public Board**

**28 May 2026**

<b>Presented for:</b>	Information and Assurance
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<b>Previous Committees:</b>	Womens Quality Assurance Group Perinatal Improvement and Assurance Committee.

<b>Freedom of Information Act (FOIA) Exemption</b>	<input type="checkbox"/> <b>YES</b> (restricted from the FOIA) <input checked="" type="checkbox"/> <b>NO</b> (available to the public under the FOIA)
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<b>Link to Strategic Objective</b>	Focus on care quality, effectiveness and patient experience
<b>Link to Provider Capability Assessment</b>	Quality of care
<b>Link to CQC Well-led Statement</b>	Governance, Management and Sustainability
<b>Regulatory Impact</b>	Regulation 17: Good governance

<b>Key points</b>	<b>Purpose</b>
1. The report provides the Trust Board with high level oversight of the quality and safety of the perinatal services aligned with the national NHSE Perinatal Quality Oversight Model (PQOM). The reporting period is March and April 2026.	<i>Information and Assurance</i>
2. The Perinatal Improvement and Assurance Committee, a designated subcommittee of the Trust Board have reviewed the detailed perinatal assurance report and associated appendices aligned with the Perinatal Quality Oversight Model prior to flow to Trust Board.	<i>Information and Assurance</i>
3. There is a separate report shared at private Trust Board based on Safety Action C of the Maternity (Perinatal) Incentive Scheme.	<i>Information and Assurance</i>
4. The extended perinatal mortality report does not show any special cause concern.	<i>Information and Assurance</i>
5. A level 2 Maternity Outcomes Signal System (MOSS) has been received and a critical safety check undertaken with external reviewers as per the national and local guidance. There was no immediate safety concerns identified during the review.	<i>Information and Assurance</i>

Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Operating within
Operational Risk	Choose an item.	Choose an item	Choose an item.
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Operating within
Financial Risk	Choose an item.	Choose an item	Choose an item.
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Operating outside

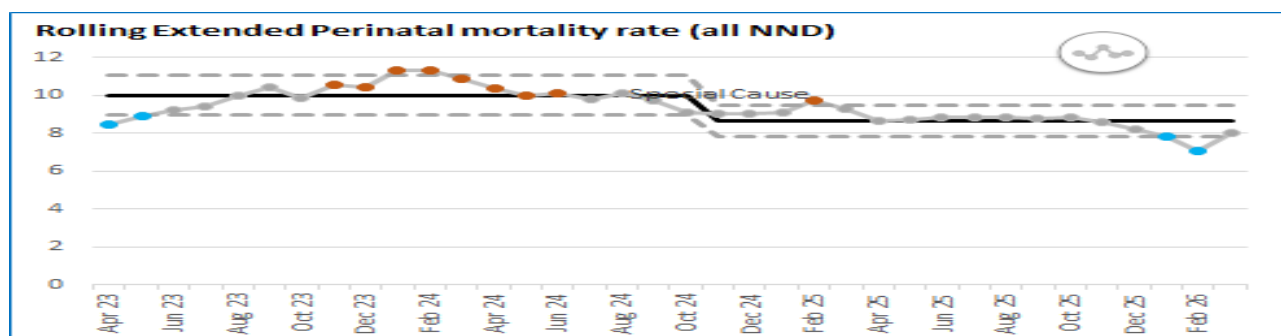
## 1. Summary

This report provides the Trust Board with information and assurance to support oversight of the quality and safety of the perinatal services aligned with the principles and requirements set out in the national NHSE Perinatal Quality Oversight Model (PQOM). The reporting period is March and April 2026. Further detail associated with all elements of the Perinatal Quality Oversight Model is shared with the Perinatal Improvement and Assurance Committee prior to flow to Trust Board with opportunity for curiosity and discussion with all members of the perinatal leadership team.

## 2. Discussion

The clinical quality and outcome measures remain stable with no special cause concerns seen.

The Statistical Process Control (SPC) chart below shows the extended perinatal mortality rate. There is no special cause concern highlighted.



### PMRT

All eligible perinatal deaths have been notified via NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, by LTHT within the reporting period. All babies were reported to MBRRACE-UK within 7 working days, and all neonatal deaths reported to MBRRACE and the Child Death Overview Panel (CDOP) within 2 working days.

**MNSI**

There was one referral to MNSI, and one final report received from MNSI with 2 safety recommendations. The recommendations have been reviewed by the multidisciplinary team and actions developed which will be monitored through the governance structures and any unmitigated risks escalated.

**MOSS**

A level 2 Maternity Outcomes Signal System (MOSS) has been received within the reporting period and a critical safety check undertaken with external representation as per the nationally agreed process. No immediate safety risks were identified from this review.

**Claims Scorecard**

The claims scorecard has been thematically analysed and triangulated to support learning and recurrence of risks. Claims are predominantly rooted in system and process issues rather than attributed to individual errors. Triangulated data has been reviewed by the perinatal triangulation and learning group to identify strategies to improve outcomes and reduce risks.

**Regulation 28**

There have been zero regulation 28 notifications (prevention of future deaths) in this reporting period.

**Maternity Safety Support Programme**

The perinatal services continue to work with the NHSE improvement advisors to support ongoing improvements. Progress is continuously monitored through internal and external governance structures.

**Care bundles and national quality improvements**

The Trust continues to demonstrate strong performance against the British Association of Perinatal Medicine (BAPM) perinatal optimisation standards.

Saving Babies' Lives Q4 audit data has been submitted and is undergoing validation, it is anticipated that current performance levels will be sustained at 96%.

The multidisciplinary team are reviewing the nationally published maternal care bundle, and a comprehensive plan will be reported to the Trust Board.

**Workforce**

The neonatal nursing and medical workforce establishments are compliant with the British Association of Perinatal Medicine (BAPM) standards and there is ongoing work to increase the Allied Health Provision across the service.

There has been a positive response to midwifery recruitment to support the closure of the clinical and non-clinical, specialist and management gaps. The budgeted establishments are aligned with the Birthrate Plus recommendations. Some of the recruited midwives won't commence in post until Q3 following graduation. In the interim bank and agency midwives are being used to support gaps and mitigate risks.

To support career development and representation of our local demographic within the workforce, midwifery support workers have been facilitated to undertake the midwifery apprenticeship programme. It is anticipated that supporting this route to midwifery registration will positively impact attrition due to relocation.

Key performance indicators of 1:1 care in labour and supernumerary status of the coordinator have been maintained in the reporting period. There was 1 red flag raised on BR+ acuity tool in April for inability to provide 1:1 care, however further review has highlighted that this was mitigated through redeployment of a midwife and diversion of services. Red flags continue to be primarily associated with delays in the induction of labour pathway, most noticeably the interval between the decision for Artificial Rupture of Membranes and the procedure being performed. There is a multidisciplinary working group focusing on service improvements in this area and a rapid process improvement workshop planned to support this work in June.

A medical workforce report for obstetrics has been developed, and recruitment plans are in the pipeline to support initial expansion of this staff group in 2026/27 with a further review planned to support the longer-term ambition. This relates to the consultant and resident workforce.

### **Capacity**

A capacity and demand review of the elective caesarean pathway is being undertaken to identify if further service developments and workforce requirements are required to support this pathway, the findings of the review will be reported to the Trust Board.

### **Staff Feedback**

The Board level and frontline safety champions and MNVP chair, have undertaken safety champion walkarounds and meetings and are using the intelligence gained to support service improvements. There have been no immediate safety concerns identified through the scheduled meetings and walkarounds or escalated to the safety champions at any other time. The CSU has several freedom to speak up champions (FTSU) and there is an FTSU guardian in the organisation. There have been no safety escalations via this route.

### **Training**

Perinatal mandatory training compliance is generally strong and on trajectory across midwifery, nursing and consultant groups, targeted improvements are in place for some medical and trainee staff, actions in place will support improved trajectories imminently. There will be a mid-point review of training in July 2026 in alignment with the requirements of year 8 of the Maternity Incentive Scheme.

The neonatal service is working to meet the national standards for Qualified in Specialty (QIS) training, increasing both training places and course frequency and is on track to meet national compliance.

### **Service user experience**

Friends and Family Feedback (FFT) across maternity services remained consistently positive, with over 90% positive responses in antenatal, intrapartum and postnatal pathways. Women and families consistently praised staff kindness, compassion, professionalism and reassurance, reporting high confidence in clinical safety and feeling listened to and treated with dignity. Multidisciplinary teamwork was particularly valued during labour, birth and

emergencies. Areas of focus for improvements include improving communication, management during delays, consistent feeding support and ensuring timely pain relief.

Neonatal Friends and Family Test feedback was overwhelmingly positive across all areas, with very high response rates and positivity levels exceeding 96%, including 100% positive feedback in some services. Families consistently described exceptional standards of care, highlighting staff compassion, attentiveness, communication and emotional support. Parents reported feeling reassured, well supported and confident in the clinical care provided, with services described as skilled, family-centred and compassionate. Identified improvement themes were limited and primarily related to consistency of advice, facilities, and practical support for partners and breastfeeding mothers within Transitional Care.

Service user feedback has been triangulated across CQC findings, Friends and Family Test data, complaints and birth reflections, with clear, service-user-led priorities identified. A comprehensive action plan is in place to address communication, continuity, pain management, feeding and postnatal support, with ongoing monitoring through established governance arrangements.

### **Maternity (Perinatal) Incentive Scheme**

The Year 8 Maternity (Perinatal) Incentive Scheme published on the 31<sup>st</sup> of March provides a simplified, outcomes-focused framework of six core safety actions, strengthening Trust Board oversight and accountability for workforce capacity, multidisciplinary training and competence, learning from incidents, service-user voice and equity, delivery of evidence-based care bundles, and overall governance, culture and leadership to assure safe and effective maternity and neonatal care. Progress with the incentive scheme will be monitored via the Perinatal Improvement and Assurance Committee with escalation of any risks and oversight continuously reported to the Trust Board.

### **3. Financial Implications**

There are no new financial implications

### **4. Risk**

There are no new risks or changes to the risk appetite.

### **5. Communication and Involvement**

There is ongoing communication with perinatal teams and the public regarding the perinatal services.

### **6. Impact on Equality & Health Inequalities**

Health equity is inextricably linked to perinatal experiences and outcomes and is a key driver in service delivery and improvements.

### **7. Publication Under Freedom of Information Act**

This paper is currently exempt from publication under Section 22 of the Freedom of Information Act 2000 but will be made available to the public on 28<sup>th</sup> of May 2026.

### **8. Recommendation**

The Trust Board are asked to note the contents of the report and demonstrate curiosity in exploring the content, be assured of the systems and processes in place to demonstrate alignment with the NHSE Perinatal Quality Oversight Model.

### **9. Supporting Information**

None