

**Perinatal Assurance Report  
Public Trust Board**

**30<sup>th</sup> of July 2026**

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| <b>Presented for:</b>       | Information and Assurance                                                                           |
| <b>Presented by:</b>        | Rebecca Musgrave, Head of Midwifery and Nursing                                                     |
| <b>Author:</b>              | Rebecca Musgrave, Head of Midwifery and Nursing                                                     |
| <b>Previous Committees:</b> | Womens Quality Assurance Group July 2026<br>Perinatal Improvement and Assurance Committee July 2026 |

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|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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) |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                               |                                                             |
|-----------------------------------------------|-------------------------------------------------------------|
| <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 May and June 2026. | <i>Information and Assurance</i> |
| 2. There is no special cause variation to clinical outcome metrics.                                                                                                                                                                      | <i>Information and Assurance</i> |
| 3. There were 2 referrals to MNSI in the reporting period and no final reports received. There have been zero regulation 28 notifications received.                                                                                      | <i>Information and Assurance</i> |
| 4. There has been a positive response to nursing and midwifery recruitment, and all vacancy gaps have been appointed to but many of the recruits will not commence in post until Q3 following registration.                              | <i>Information and Assurance</i> |
| 5. Redeployment of midwifery non-clinical, specialist and management teams to support clinical gaps is creating a risk to the capacity available to undertake their primary portfolio and mitigating actions are under review.           | <i>Information and Assurance</i> |
| 6. Work is in progress to extend the fetal assessment services to a 7-day service to support improvements aligned with the saving babies lives care bundle.                                                                              | <i>Information and Assurance</i> |
| 7. Work is ongoing to implement digital solutions to support robust data capture and analysis within the Triage areas to support service developments and improvements.                                                                  | <i>Information and Assurance</i> |

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 8. Progress with year 8 of the maternity incentive scheme is positive, a risk has been identified surrounding external obstetric and neonatal attendance at PMRT reviews. Exploration in progress regarding whether the NHSE improvement advisors meet this criterion. Additional options are also being explored. | <i>Information and Assurance</i> |
| 9. The Ockenden report for Nottingham and the Amos national report have been published in June, a system letter has been received outlining a 10-point immediate action plan which is under 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 |

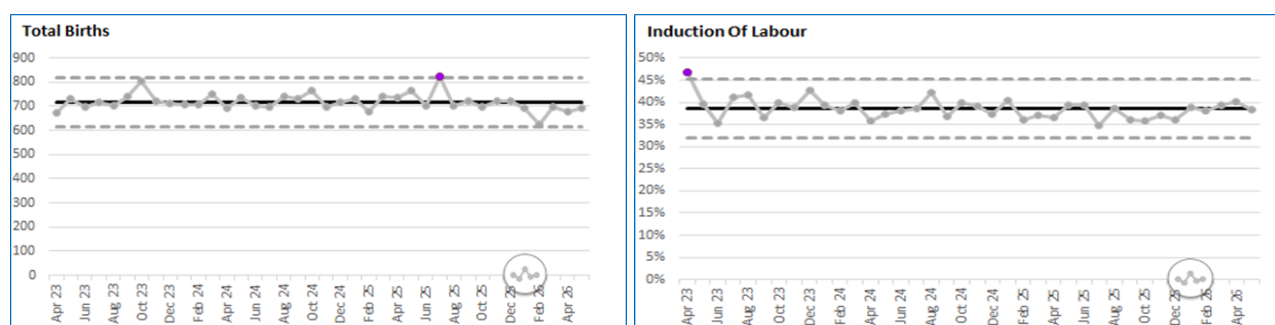
## 1. Summary

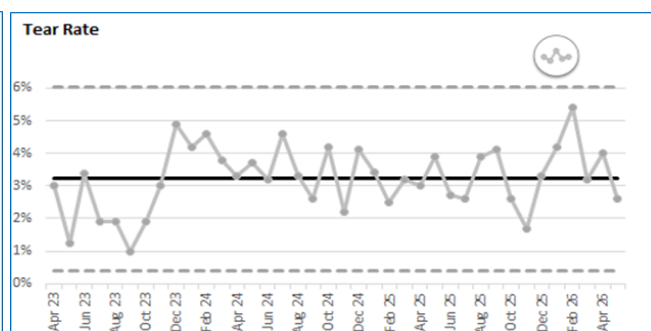
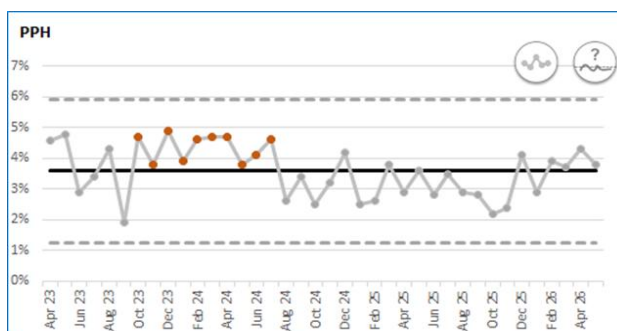
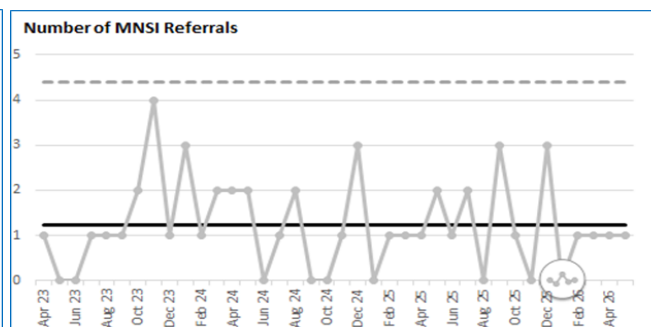
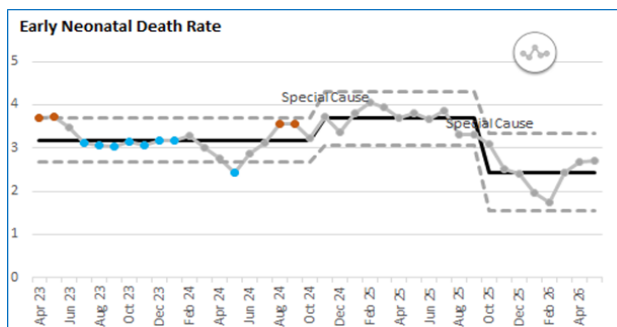
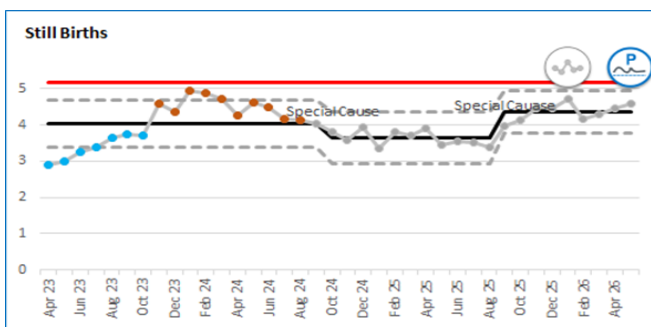
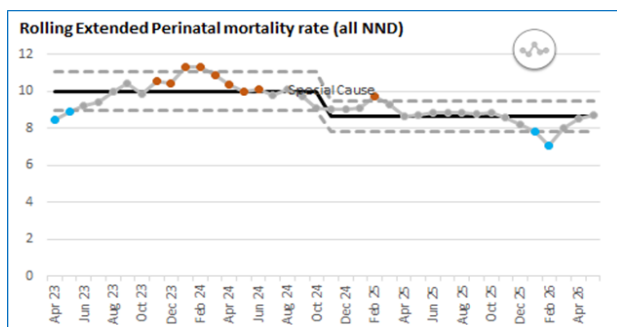
The purpose of this report is to provide the Trust Board of any present or emerging safety concerns or activity to ensure safety with a two-way reflection of “ward to board” insight across the multidisciplinary, multi-professional maternity services team. It is aligned with the principles and requirements set out in the national NHSE Perinatal Quality Oversight Model (PQOM). The reporting period is May and June 2026. To ensure that information has been validated there is a time lag with some data, but where possible the most recent data has been shared.

A detailed report and slide deck is also shared with members of the Perinatal Improvement and Assurance Committee and a summary from this meeting is shared with the Board via the Chairs report.

## 2. Discussion

There are no special cause concerns seen within the Statistical Process Control Charts below. All incidents and investigations are reviewed to identify any themes including workforce availability and any actions identified are implemented and monitored.





## PMRT

There were 14 eligible perinatal deaths notified via NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, by LTHT within the reporting period. These deaths comprised of the following cases: 1 late fetal loss <22 weeks, 5 stillbirths, 5 early neonatal deaths (including one baby transferred to LTHT from an external unit postnatally for specialist neonatal care with all maternity care provided an external unit), 3 late neonatal deaths (including one baby transferred to LTHT from an external unit postnatally for specialist neonatal care with all maternity care provided by the external Trust)

All 14 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. None of the babies met criteria for referral to MNSI.

Of the babies eligible for PMRT review during May and June 2026, 100% of families received information about the PMRT process, and different ways to be able to share their feedback and questions when they feel ready.

LTHT use MBRRACE recommended letter templates and supportive information, which are available in different languages to ensure that parents receive information in a format that

they can understand. The Duty of Candour apology process is also being followed in relevant cases.

There was 1 case graded as a C and 1 as a C and D. This grading reflects that the multidisciplinary team assessing the care consider that there were issues identified that may have made a difference to the outcome/were likely to have made a difference.

LTHT have a reciprocal agreement with other Trusts within West Yorkshire and Harrogate Local Maternity & Neonatal System (LMNS) to provide external reviewer attendance at PMRT review meetings. The requirement is that a minimum of 60% of all eligible cases have relevant external reviewers. During May and June 12 (80%) of the 15 cases reviewed had an external reviewer present (maternity services were unable to secure external attendance for the remaining 3 cases as this was an extra meeting held at short notice). There is ongoing work to ensure that there is consistent external representation from all disciplines at PMRT reviews.

Key themes identified through the PMRT reviews were the presence of severe congenital abnormalities (67.4% of the babies who died), placental issues and extreme prematurity.

Further details of the mortality reviews are included in the Clinical Negligence Scheme for Trusts (CNST) Safety Action C Maternity Incentive Scheme report shared with and presented to the private Trust Board due to the sensitivity and potentially identifiable information.

## **MNSI**

There was 1 referral to MNSI in the reporting period for potential severe brain injury, and 1 maternal death following a transfer from another provider for intensive care facilities with no maternity care provided at LTHT. (There is only 1 referral shown on the SPC chart due to the timing of reporting) The Duty of Candour process is being followed, and the parents/families have received MNSI and NHSR-ENS information in a format that is accessible to them, with a named contact and an offer of an early debrief. There were 0 final reports received from MNSI.

## **MOSS**

The last MOSS signal was received on the 28<sup>th</sup> of April 2026. Neonatal deaths that have contributed to the MOSS system since January 2025 have been reviewed and common themes identified were the presence of significant congenital abnormalities with a high number of babies having an advanced care plan in place antenatally. These have been developed between the multidisciplinary team and parents to support compassionate palliative end-of-life care following birth for babies with known severe congenital abnormalities with limited life expectancy. There is early involvement of the childrens hospices antenatally to provide continuity of care following birth where appropriate. >50% of the babies that died had been referred to LTHT tertiary fetal medicine services from other providers. The NHSE Maternity Improvement Advisors have also supported review of stillbirths. There was no significant key themes related to BMI, smoking status, gestation, fetal monitoring, fetal growth restriction, non-attendance at appointments, diabetes or hypertension management. A higher proportion of families had a deprivation index code of 1-3 and compared to background data there were differential outcomes for those of a Black/Asian ethnicity. A further review has been undertaken to review all stillbirths during 2025 from a public health and health inequalities lens. Addressing disparities requires a more systematic, holistic, and personalised approach to maternity care one that integrates

social determinants alongside clinical risk assessment and care pathway planning and ensures equitable access, engagement, and support for all women, families and birthing people. Actions have been developed in response to the review and include further improvements to PMRT processes to support thematic reviews and scoping and testing the implementation of the Royal College of Midwives (RCM) Maternity Disadvantage Assessment Tool.

### **Claims Scorecard**

The claims scorecard has been thematically analysed and triangulated to support learning and recurrence of risks. Next steps include embedding the newly formed triangulation and learning group, rolling out consistent use of the “BRAIN” toll to support informed choice. This is a simple evidence-based decision-making framework that empowers people to confidently ask questions to support their decision making and informed consent. A trauma informed gap analysis has recently been undertaken which triangulated findings from MNVP feedback, CQC survey data, complaints PALS, incidents, obstetric claims and birth reflections feedback. The actions from the review focus on reducing the risk of emotional harm, traumatisation, loss of trust and birth trauma and have been included within the overarching perinatal improvement plan.

### **Regulation 28**

There have been 0 regulation 28 notifications (prevention of future deaths) issued 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. All the improvement workstreams are currently being reviewed by the multidisciplinary leads supported by NHSE improvement advisors and actions updated accordingly.

### **Care bundles and national quality improvements**

The Trust continues to demonstrate strong performance against the British Association of Perinatal Medicine (BAPM) perinatal optimisation standards. There was 1 missed opportunity to administer 2 doses of steroids within 7 days of birth.

Saving Babies’ Lives Q4 audit data has been submitted and externally validated and remains 96% overall. Key risks relate to smoking cessation service sustainability, Fetal Assessment Unit capacity, delivery of smoking cessation outcomes, compliance with reduced fetal movement scanning standards, and implementation of uterine artery Doppler screening. These are monitored through Trust and CSU governance arrangements and will be mitigated through recruitment, service redesign, enhanced oversight, governance escalation, and targeted quality improvement.

The fetal assessment services are being redesigned to support 7-day coverage aligned with the recommendations in the saving babies lives care bundle. This will also create additional capacity to meet service demands. Inextricably linked to this is a review of the required workforce to support the services and sustain resilience.

The multidisciplinary team are reviewing the nationally published maternal care bundle, and a comprehensive plan will be reported to the Trust Board. Initial work is underway to map current implementation across the six maternal care bundle elements, identify evidence requirements, and confirm responsible leads. The immediate priority is to establish a clear implementation plan, supported by quarterly reporting to monitor progress, risks, gaps and escalation requirements. This is not yet supported by a mature quarterly audit dataset, and the immediate focus is therefore on confirming baseline implementation, identifying gaps and agreeing the implementation plan required for March 2027.

### **National roll out of MEWS**

There is a multidisciplinary working group with representation from across key areas of the organisation to support the organisational rollout of the national evidence based modified early warning score for pregnant and postpartum people. A digital solution has been identified and the platform used at an organisational level will be PPM+. Rollout is planned for Q3 and will require large scale education and training. All pregnant or postnatal people (up to 4 weeks) will need to be assessed using this tool regardless of where they are in the organisation, the gestation of their pregnancy or their reason for admission rather than the national NEWS assessment. The parameters and thresholds are quite different between the tools due to the changing physiology during pregnancy and the early postnatal period. A local decision has been made to lower the thresholds for escalation to critical care outreach to optimise the opportunity of prevention of morbidity and mortality through earlier assessment and intervention as required.

### **Women experiencing delays to Induction of labour >6 hrs**

There has been an increase in red flags in this reporting period, 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. A multidisciplinary working group participated in a rapid process improvement workstream in June supported by the organisation's improvement team. This has focused on service improvements in this area, particularly around delays to artificial rupture of membranes but also encompassing the full pathway. Several quality improvement strategies have been identified including introduction of a dedicated induction of labour midwife on each shift, development of a live digital bed state, dedicated postnatal delivery suite midwife and support worker, standardised cross site information sharing, and timely artificial rupture of membranes following admission to delivery suite. This will be evaluated using quality improvement methodology and further interventions introduced as indicated. It is anticipated that significant improvements will be seen when the recently recruited midwives are in post, which will facilitate consistent optimal staffing levels to support continuous flow of women on the induction of labour pathway.

### **Homebirths**

Facilitation of homebirths continues to be monitored via the maternity services dashboard. This includes the number of women choosing homebirth as place of birth, the number of women transferred to hospital for maternal or fetal indications during either the intrapartum or postnatal elements of care and the number of women requested to attend hospital due to insufficient staffing levels to support a homebirth. During the last 6 months, the percentage of planned home births at the start of labour has ranged between 0.43% and 1.12%. Additional midwifery resource is required to support homebirth in comparison to the hospital setting and vacancy gaps and midwifery absence can negatively impact the ability to support

this service. During the last 6 months, the percentage of home births that have been suspended due to insufficient staffing has ranged between 28.57% and 71.43%. Supporting choice of place of birth is a priority for the service and it is anticipated that the number of suspensions will decrease as the staffing levels increase over the coming months.

## **Triage**

There is a multidisciplinary working group reviewing the recently published Triage recommendations and benchmarking local provision. An area of focus is associated with ensuring robust data entry within an electronic platform that supports real time data, a visual dashboard and the ability to readily extract meaningful data to inform audits and service improvements. Currently a significant amount of data is manually inputted, which is time consuming, and a digital solution would be preferable and more reliable.

## **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 positive response to nursing recruitment following agreement to uplift the staffing across all areas and all vacancy gaps recruited to but many recruits not commencing until Q3. There are currently 8.94 WTE gaps for the registered nursing workforce aligned with the current establishments but all have been appointed to.

There has been a positive response 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. There is currently a deficit of 18 WTE from the Birthrate plus recommendations and 33 WTE gap following the revised budget to increase the unavailability uplift. All posts have been appointed to and there will be redeployment back into the clinical service following a temporary enhanced preceptorship model implemented last year, but 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. Where gaps remain or are exacerbated by increased sickness, non-clinical, specialist and management midwives are being redeployed to fill the gaps, however this creates a risk to the capacity for delivery of their primary portfolio.

A workforce paper has been developed which articulates a need for an additional 16 obstetric consultants, this year 6 new posts plus making 3 WTE locum posts substantive is being prioritised. Recruitment plans are in progress with a view to further phased recruitment over the next 2 years. There is also ongoing work to increase the number of resident doctors, there is currently a 5.7 WTE tier 2 and 4 WTE tier 1 gap. Gaps for the resident doctors are being mitigated through.

- Enhanced pay
- Actively seeking locums
- Biweekly review of gaps by Clinical Director and rota leads
- Development of a new rota pattern

Key performance indicators of 1:1 care in labour and supernumerary status of the coordinator have been monitored throughout the reporting period. On the 26th of May there is 1 red flag reported where there was a delay in transferring a woman from the antenatal ward to delivery suite for 1:1 care. This was mitigated by redeploying a midwife from another area. There was a further red flag raised on the 30th of May for inability to provide 1:1 care

in labour, scoping had commenced to divert maternity services but didn't need to be progressed as the acuity improved and this was mitigated. There was 1 red flag raised in May for the coordinator not being supernumerary. However, the coordinator was supernumerary at the start of the shift, this episode was for a short period and did not involve the coordinator providing 1:1 care in labour

Acuity continues to be monitored across the inpatient areas of the maternity services via the live birthrate plus tool. The antenatal and postnatal areas continue to experience sustained pressure and a mismatch between the acuity and available workforce. A further Birthrate Plus assessment is due to be undertaken later this year and will assess whether an increase in staff is required to support increasing complexity and acuity.

## **Training**

Training compliance aligned with the core competency framework meets or exceeds the trajectories across the perinatal service for fetal monitoring, PROMPT (emergency skills and drills) and neonatal resuscitation training except for Maternity Support Workers who are currently 89% compliant against a target of 90% for PROMPT training. However, the individuals that are non-compliant are booked on training in July 2026 with 1 booked in September due to annual leave and no training available in August.

The mid-point review of training has been undertaken in alignment with the requirements of year 8 of the Maternity Incentive Scheme with a comprehensive training paper presented to the Perinatal Improvement and Assurance Committee.

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.

The midwifery leadership team are working closely with the lead midwife for education for the University of Leeds to understand any potential delays to undergraduate students completing the midwifery programme and taking actions to optimise opportunities to support timely completion.

## **Activity**

There is ongoing work to model the service requirements to support elective section births. Further resources are required to meet demand, and a full capacity and workforce plan is being developed and will be reported to the Trust Board in due course.

The perinatal services continue to operate under sustained pressure, and this is reflected in the daily OPEL scores. However there has been a significant improvement to the OPEL status of the neonatal unit at SJUH which has been at OPEL 1 for a significant proportion of the reporting period.

## **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. Themes and feedback are summarised below:

- Staffing – high acuity, feeling pressured, low morale, need to optimise skill mix to support the complexity of Leeds maternity services

- Environment – Facilities for neonatal parents who are “rooming in” prior to discharge, progress with procurement of additional ventilators.
- Communication and engagement- need to consider ways to celebrate innovation and good practice. Families were very positive about the care received through neonatal services; there were no families available to talk to from maternity services.

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.

### **Service user experience**

Friends and Family Feedback (FFT) across maternity services remained consistently positive, with over 90% positive responses in antenatal and intrapartum care with a reduction to 87.5% for the postnatal pathway. Areas of focus are:

1. Antenatal: Improve communication about waiting times and ensure clear explanations of outcomes and care plans.
2. Intrapartum: Maintain the strong compassionate care culture while strengthening communication during delays and escalation.
3. Postnatal: Prioritise staffing, pain relief responsiveness and discharge flow.

Neonatal Friends and Family Test feedback was overwhelmingly positive across all areas, with 100% positive feedback. Families described exceptional standards of care, support and experience.

A separate detailed patient experience paper has been developed and presented to the Perinatal Improvement and Assurance Committee with the coproduced maternity survey CQC action plan.

### **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.

Early progress is positive, leads identified, reporting routes in place and evidence mapping underway. The MIS Governance paper has been approved through Women’s and Children’s quality groups and is being presented to PIAC as a separate agenda item. Safety Action C3 compliance risk identified: PMRT external MDT attendance may not consistently include obstetric/neonatal medical reviewers. An action has been taken to review PMRT attendance against the 60% requirement and confirm whether Maternity Incentive Advisor attendance meets external specialty reviewer criteria. Agree process to secure appropriate external obstetric/neonatal attendance where required.

### **Nottingham Ockenden report and Amos report**

Donna Ockenden published the Nottingham independent inquiry report on the 24<sup>th</sup> of June. The report highlights key issues with leadership, governance and culture. The report is being reviewed locally, and the team will work with local regional and national colleagues to respond to the recommendations. The Baroness Amos report was published on the 30<sup>th</sup> of June and sets out a robust package of 8 recommendations aimed at delivering long term and systemic and cultural transformation in maternity and neonatal care. There is a national taskforce in place that will be supporting local teams with the transformation required.

### **3. Financial Implications**

The expansion of the fetal assessment service will have financial implications which will be discussed through the appropriate processes.

### **4. Risks**

- Due to current gaps in the clinical midwifery workforce, bank and agency staff are being utilised to fill the gaps, remaining gaps which are exacerbated by sickness and absence are filled through redeployment of non-clinical, specialist and management teams. Whilst this supports mitigation of clinical risk, an unintended consequence is reduced capacity of these team members to undertake their primary portfolio and ensure timely governance and process tasks are undertaken.
- Absence of a live dashboard and digital data collection tool to support optimal monitoring, auditing and evaluation of Triage services.
- Fetal assessment services being able to meet demand and provide timely scanning aligned with the saving babies lives care bundle.

### **Communication and Involvement**

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

### **5. 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.

### **6. 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 30<sup>th</sup> of July 2026.

### **7. 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.

Review whether there is any wider organisational support available to ensure consistent timely governance processes until the clinical staffing gaps have been filled.

Continue to support from a digital perspective in implementing a solution to support triage data collection and dashboards.

Support the review of the expansion of the fetal assessment services to ensure timely scans as per the saving babies lives recommendations.

**8. Supporting Information**

None.