

Perinatal Improvement Assurance Committee Chairs Summary Report

Public Board
30 July 2026

Presented for:	Alert, Advice, and Assurance
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Previous Committees:	9 July 2026

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Learning, Improvement and Innovation Freedom to speak up
<u>Regulatory Impact</u>	Regulation 9: Person-centred care Regulation 12: Safe care and treatment Regulation 16: Receiving and acting on complaints Regulation 19: Fit and proper persons employed Regulation 20: Duty of candour

Key points	Purpose
This report provides a summary of the key highlights from the Perinatal Improvement Assurance Committee meeting and seeks to alert, advice and provide assurance to the Board on the areas discussed.	Alert, Advice and Assurance

<u>Risk Appetite Framework</u>			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Operational Risk	Health & Safety Risk – We will protect the health and wellbeing of our patients and workforce by delivering services in line with or in excess of minimum health & safety laws and guidelines.	Cautious	Operating within
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 outside
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. Introduction

Following its last meeting the Committee has considered significant issues and key areas to highlight to the Board under three key categories Alert, Advice, Assurance (AAA):

- Alert - areas which the Committee wishes to escalate as potential areas of non-compliance, which need addressing urgently, or that it is felt Board should be sighted on.
- Advice - any new areas of monitoring or existing monitoring where an update has been provided to the Committee and there are new developments.
- Assurance - specific areas of assurance received warranting mention to Board.

2. Alert

- The Committee expressed concern regarding the continued delay to implementation of the digital patient monitoring solution intended to support compliance with national maternity triage standards. Members noted that the current reliance on multiple electronic workflows and manual whiteboard processes limited real-time visibility of patient flow, created operational inefficiencies, and increased reliance on resource-intensive manual data collection. Whilst acknowledging that the associated risk remained on the Trust's risk register with enhanced mitigating controls in place, including additional staffing and manual monitoring processes, the Committee sought assurance regarding the effectiveness and long-term sustainability of these arrangements. The Committee noted that implementation remained dependent on the external system supplier completing the required server outage and that the matter had been escalated through Digital and Informatics Technology (DIT) governance. The Committee agreed to alert the Board to this ongoing risk and requested continued oversight until the digital solution had been fully implemented, embedded, and demonstrated to be supporting compliance with national maternity triage standards.
- The Committee remained concerned regarding ongoing operational pressures affecting maternity services, particularly delays within the induction of labour pathway, constraints in antenatal and postnatal bed capacity, and the continued lack of assurance relating to the maternity triage system and associated red flag reporting. Members noted that workforce pressures and estate constraints continued to impact patient flow and that the benefits arising from improvement work, including the Rapid Process Improvement Workshop, were not expected to be fully realised until later in the year. The Committee also sought further assurance regarding the number of outstanding Datix incidents and supported the continued scrutiny of maternity triage and BSOTS through the Integrated Quality Improvement Group, including a proposed deep dive review. The Committee agreed to alert the Board of the need to prioritise improvements to antenatal bed capacity at St James's University Hospital and postnatal capacity across both hospital sites to improve patient flow, reduce delays within the induction of labour pathway, strengthen service resilience, and support the continued delivery of safe, high-quality maternity care

3. Advice

- The Committee noted that, whilst progress against Safety Action B remained satisfactory, continued organisational focus was required to improve Trust mandatory training compliance amongst medical staff, which remained below the required trajectory despite recent improvement. Members noted that the rotational nature of the medical workforce and competing clinical demands continued to affect compliance and welcomed the actions underway to strengthen induction arrangements, improve the portability of mandatory training between organisations, and further embed compliance through appraisal and workforce planning. The Committee also recognised the need to ensure sufficient multidisciplinary faculty and consultant capacity to sustain delivery of the expanding perinatal training programme.
- The Committee expressed its concern regarding the limited time allocated and capacity available to support the MNVP function and the potential impact this could have on meaningful service user engagement, co-production and delivery of improvement activity,

particularly in the context of increased national scrutiny of maternity services and local health inequalities. Members also noted the increase in formal complaints compared with the previous year and emphasised the importance of ensuring sufficient resource to support effective engagement, strengthen understanding of patient experience, and embed learning across maternity and neonatal services. The Committee requested further assurance on the future operating model and capacity of the MNVP to support the delivery of sustained service improvements.

- The Committee noted the refreshed corporate risk on the Corporate Risk Register relating to the regulatory breaches identified following the CQC inspection and agreed to assume primary oversight of the risk on behalf of the Board. Members welcomed the review of the existing controls and mitigating actions and advised the Board that continued Executive oversight, and regular monitoring would be essential to ensure the effective implementation of mitigating actions, demonstrate sustained compliance with regulatory requirements, and support the timely reduction of the Trust's risk exposure.

4. Assurance

- The Committee received the inaugural report from the Perinatal Improvement Assurance Group (PIAG) and was assured that strengthened Executive oversight and governance arrangements were in place to oversee delivery of the Perinatal Improvement Plan (PIP), including robust assurance through the Evidence Review Panel. Whilst recognising the progress made, the Committee sought further assurance regarding the management of off-track actions, the sustainability and measurable impact of completed improvements, and the risks affecting delivery of the PIP. Members expressed concern regarding revised implementation timescales for a number of improvement actions and requested future reports to provide clearer differentiation between completed actions awaiting assurance and outstanding actions, enhanced reporting on delivery risks, greater visibility of the risk register, and stronger evidence of outcomes and benefits realised. The Committee concluded that PIAG was discharging its responsibilities in accordance with its Terms of Reference but emphasised the importance of maintaining Executive focus on timely delivery and demonstrating sustained improvements in maternity and neonatal services.
- The Committee received an update on the key findings and recommendations arising from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (Nottingham Report) and the Independent Investigation into Maternity and Neonatal Services in England (Baroness Amos Report). The Committee was assured that the recommendations had been reviewed through the Trust's governance arrangements and would inform preparations for the Leeds Maternity and Neonatal Independent Review, implementation of Martha's Rule, compliance with emerging statutory requirements, and alignment of the Perinatal Improvement Plan with national learning. The Committee also noted the strengthened oversight of mortuary arrangements to support the Board Assurance Statement required by NHS England by 31 July 2026, including assurance against the recommendations of the Fuller Report (Phase 2), with follow-up actions to be reported through the Committee. Members welcomed the commitment to undertake an audit of maternity triage within the first three months in line with the National Review of Triage and to receive further assurance on the implementation of these national recommendations and the embedding of learning across Trust services.
- The Committee received the Perinatal Assurance Report and was assured that appropriate governance, quality and safety arrangements remained in place to support delivery of the NHSE Perinatal Quality Oversight Model (PQOM). Members welcomed the positive progress in midwifery and neonatal workforce recruitment following the CQC Section 29A Warning Notice, the development of a multidisciplinary programme to implement the national Maternity Early Warning Score (MEWS), and the achievement of the national 70% Qualified in Specialty (QIS) compliance standard within Neonatal Services. The Committee also noted continued progress in evidencing and assuring Perinatal Improvement Plan actions, positive delivery against the Maternity Incentive Scheme, and robust governance arrangements for

monitoring neonatal mortality through the Perinatal Mortality Review Tool (PMRT), Maternity and Newborn Safety Investigations (MNSI), the Neonatal Operational Delivery Network and internal governance processes. Members further received assurance that labour ward safety indicators, including 1:1 care in labour and supernumerary coordinator compliance, continued to be closely monitored with appropriate mitigations where required, and that no immediate patient safety concerns had been raised through the Safety Champion or Freedom to Speak Up processes.

- The Committee received the Mid-Point Review of Maternity Incentive Scheme (MIS) Year 8 – Safety Action B and was assured that appropriate arrangements were in place to deliver compliance with the national perinatal training and education standards. Members noted that compliance across the required multidisciplinary patient safety training programmes remained on or above trajectory, with the exception of Maternity Support Worker PROMPT training, for which a recovery plan was in place and full compliance was expected by the end of July 2026. The Committee also welcomed the successful introduction of impacted fetal head training, improvements in medical mandatory training compliance, and the continued oversight of training delivery through established governance arrangements. Whilst recognising risks associated with training capacity, venue availability and potential staff redeployment, the Committee was assured that these risks were being actively managed and that delivery of Safety Action B remained on track.
- The Committee received an update on progress against Maternity Incentive Scheme (MIS) Year 8 – Safety Action C and was assured that appropriate governance arrangements were in place to identify, review and embed learning arising from perinatal incidents, mortality reviews and patient safety investigations. Members noted that all qualifying perinatal deaths had been reported through the SPEN process within the required timescales, all families had been involved in the Perinatal Mortality Review Tool (PMRT) process, and appropriate referrals had been made to the Maternity and Newborn Safety Investigations (MNSI) programme where required. The Committee also welcomed the strengthened emphasis on evidencing the impact of learning through triangulation of intelligence from PMRT, MNSI, PSIRF reviews, MOSS alerts, staff and service user feedback, and health inequalities analysis. Members were assured that recurring themes, including clinical deterioration, multidisciplinary communication, CTG safety and delays within the induction of labour pathway, were being incorporated into the Perinatal Improvement Plan and monitored through the developing Governance Triangulation Group to support sustained improvements in patient safety and outcomes.
- The Committee received assurance on implementation of the Saving Babies' Lives Care Bundle (SBLCB) Version 3.2 during Q4 2025/26 and noted an overall compliance rate of 96%, with full compliance achieved for Elements 2, 4 and 6. Members were assured that improvement plans were in place for the remaining elements and that identified risks continued to be actively managed through established governance and quality improvement arrangements. The Committee noted the actions underway to improve smoking cessation support, establish a sustainable seven-day ultrasound service for women presenting with recurrent reduced fetal movements, strengthen ultrasound workforce capacity, and improve compliance with interventions to reduce preterm birth. Members also welcomed the assurance that learning from audits, clinical outcomes, incidents and operational intelligence would be increasingly triangulated through a revised audit methodology, supporting a shift from process-based assurance towards outcome-focused continuous improvement. The Committee approved the revised Saving Babies' Lives Audit Review Paper and was satisfied that the proposed approach would strengthen governance oversight while maintaining appropriate assurance over areas of greatest clinical risk.
- The Committee received the first biannual Perinatal Workforce Report produced in line with the NHS England Year 8 Maternity Incentive Scheme requirements and was assured that appropriate workforce planning, recruitment and governance arrangements were in place to support the delivery of safe perinatal services. Members welcomed the significant progress

in substantive nursing and midwifery recruitment, noting that vacancy gaps had been addressed through successful recruitment, with newly appointed staff expected to commence during Q3 following professional registration and preceptorship. The Committee also received assurance that workforce establishments remained aligned with Birthrate Plus recommendations for midwifery and BAPM standards for neonatal services, that consultant obstetric presence continued to meet Royal College standards, and that no concerns had been identified regarding obstetric anaesthetic staffing. Members noted the positive neonatal workforce position, ongoing recruitment to obstetric posts, and confirmation that existing workforce mitigations would remain in place until substantive staff were in post. The Committee further noted that a review of the obstetric workforce would be undertaken during 2027 to ensure capacity remained aligned with future service demand and expansion.

- The Committee approved the Maternity Incentive Scheme (MIS) Governance and Assurance Framework and was assured that it provided a robust and transparent governance structure for the delivery, monitoring, evidence review, risk escalation and final declaration of the Scheme. Members noted that the framework established clear assurance mechanisms, including routine progress monitoring, evidence review through the Perinatal Evidence Approval Panel, Committee oversight, senior leadership review and system-level assurance through the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB). The Committee welcomed the framework's emphasis on evidence-based and auditable decision-making, the timely identification and escalation of delivery risks and areas of non-compliance, and the collaborative development of the framework with external assurance support. Members also noted the commitment to review the Women's CSU risk register, maintain alignment with the Perinatal Improvement Plan, and continue embedding assurance through wider LMNS and ICB governance arrangements, with a further update to be provided on the future regional governance model.
- The Committee received the Service User Experience Report and was assured that robust arrangements were in place to capture, triangulate and respond to feedback from women, families and the Leeds Maternity and Neonatal Voices Partnership (MNVP). Members noted that intelligence from a range of sources, including the 2025 CQC Maternity Survey, 15 Steps walkarounds, Safety Champions, patient feedback, complaints and experience surveys, was informing quality improvement and the development of an overarching Service User Experience Improvement Plan. The Committee welcomed the progress made against the 33 CQC improvement actions, the incorporation of longer-term actions within the MNVP Annual Work Plan, and the strengthened governance arrangements to ensure operational ownership of patient experience, dissemination of learning and greater involvement of women and families in service improvement. Members also recognised the importance of further analysing health inequalities and demographic trends to ensure that the experiences of vulnerable communities continued to inform service development.

5. Risk review

The Committee highlighted the continued delay to implementation of the digital maternity triage solution and ongoing maternity capacity pressures, including delays within the induction of labour pathway and constraints in antenatal and postnatal bed capacity, as significant risks. Members noted that reliance on manual processes continued to limit real-time oversight of maternity triage and that capacity pressures were affecting patient flow and service resilience. The Committee noted that both risks would be escalated to the Risk Management Committee for enhanced oversight and assurance.

The Committee also provides oversight of the Trust's patient safety and outcomes risk, and the Corporate Risk Register CRRE1 – CQC Registration – breaches of Regulation(s) – Maternity and Neonatal services. The Trust is currently operating within the risk appetite for the level 1 risk (clinical risk) and is operating outside the risk appetite for the level 2 risk category (patient safety and outcomes) set by the Board as a consequence of the findings from the CQC inspections of maternity and neonatal services and well-led.

6. Recommendation

The Board are asked to receive and note the content of this report and be assured that the Perinatal Improvement Assurance Committee continues to fulfil its assurance function as delegated from the Board and as defined within its Terms of Reference.