

Perinatal Assurance Report

**Public Board
26th of March 2026**

Presented for:	Information and Assurance
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Previous Committees:	Perinatal Improvement and Assurance Committee January 2026

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	Governance, Management and Sustainability
Regulatory Impact	Regulation 17: Good governance

Key points	Purpose
1. The report provides Trust Board oversight of perinatal quality and safety aligned with the national Perinatal Quality Oversight Model.	<i>Information and Assurance</i>
2. A detailed assurance report is presented to the members of the Perinatal Improvement and Assurance Committee which has delegated authority from the Trust Board. This report is presented by the Head of Midwifery with supporting context provided. The minutes and a Chairs report from this Committee are received by the Trust Board.	<i>Information and Assurance</i>
3. The postpartum haemorrhage and 3 rd and 4 th degree tear rates show common cause variation on the local data, but both are lower than the national average and MBRRACE peers.	<i>Information and Assurance</i>
4. The rolling extended perinatal mortality rate shows special cause improving variation.	<i>Information and Assurance</i>
5. 2 MOSS signals have been received in the reporting period for LGI. Rapid reviews have been undertaken with no immediate safety issues identified.	<i>Information and Assurance</i>
6. There has been a further reduction of red flags aligned with delays in induction of labour pathway in this reporting period.	<i>Information and Assurance</i>
7. 1:1 care in labour and supernumerary status of the coordinator have been maintained 100%	<i>Information and Assurance</i>
8. Compliance with perinatal specific training requirements is above target across the multidisciplinary team.	<i>Information and Assurance</i>
9. Overall compliance with the Saving Babies Lives care bundle has increased from 90% in Q2 to 96% in Q3. This has been externally validated by the West Yorkshire and Harrogate LMNS.	<i>Information and Assurance</i>
10. There have been no missed opportunities for the administration of steroids, magnesium or antibiotics.	<i>Information and Assurance</i>

11. Review of homebirth services following the national Prevention of Future Deaths (PFD) report has been undertaken. Actions have been developed for gaps identified and will be monitored through governance structures.	<i>Information and Assurance</i>
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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.	Minimal	Moving Towards
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	Moving Towards
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	Moving Away

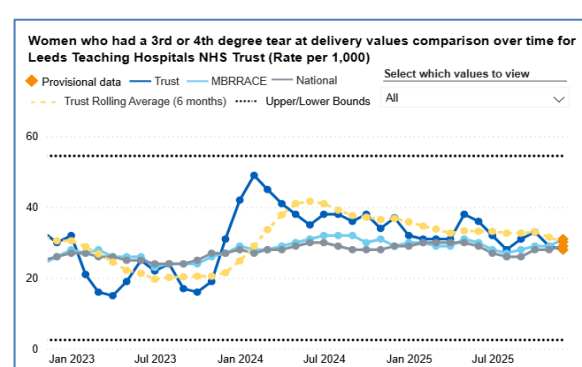
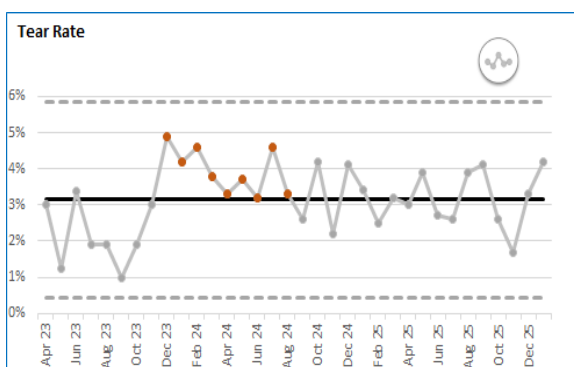
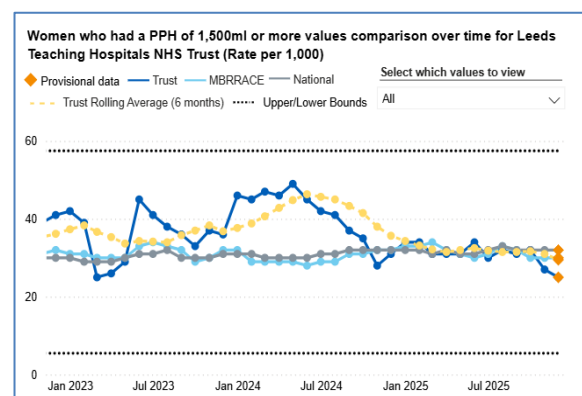
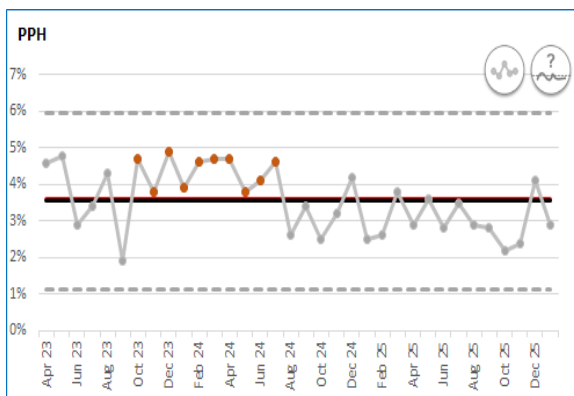
1. Summary

This report provides the Trust Board with oversight of perinatal quality and safety aligned with the national Perinatal Quality Oversight Model. The reporting period is January and February 2026. To ensure that there is opportunity for robust in-service discussion and validation of data there is a time lag across the reporting. Where possible the February 2026 data will be shared but for some areas the most recent local validated data will be January 2026.

A detailed report is received by and presented to members of the Perinatal Improvement and Assurance Committee (PIAC) by the Head of Midwifery with supporting context. The Committee has delegated authority from the Trust Board and the minutes of the meeting and a Chairs report flow to Trust Board.

2. Discussion

Clinical quality and outcome measures remain stable with no special cause concerns seen. The SPC charts below detail local data, additionally data from the national maternity dashboard is provided to provide context of the LTHT performance benchmarked nationally and with MBRRACE peers. The most recent national available data is December 2025. The Post Partum Haemorrhage data shows a Trust rate of 25 per 1,000, an MBRRACE rate of 30 per 1,000 and a national rate of 32 per 1,000. The 3rd and 4th degree tear shows a Trust rate of 28 per 1,000, MBRRACE rate of 31 per 1,000 and a national rate of 29 per 1,000.



Perinatal Morbidity and Mortality

The January and February perinatal mortality review tool (PMRT) report has been shared with the Trust Board to provide assurance that every eligible perinatal death has been reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) via the MBRRACE-UK Reporting Tool and that the defined standards have been met. The Board have also received a copy of the actions in progress to support learning identified during the reviews.

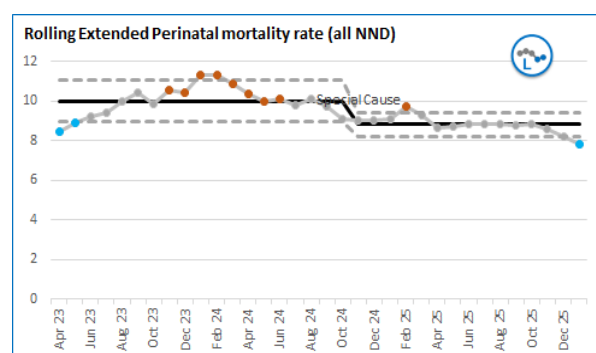
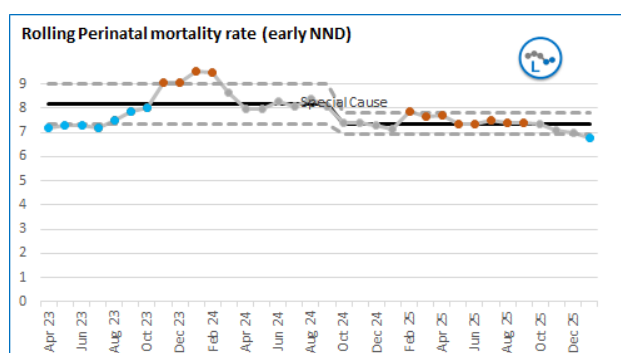
All perinatal deaths continue to have a multidisciplinary review including external peer reviewers using the nationally recognised PMRT tool and are graded accordingly. The outputs from the PMRT review and any associated risks are shared through governance mechanisms including the weekly Trust quality review meeting which is attended by key executive and quality and safety teams.

There have been 2 referrals to MNSI during the reporting period and 2 final reports received, 1 with 2 safety recommendation and the other with no safety recommendations. A multidisciplinary review has been undertaken to review themes and develop actions. The actions identified are tracked through internal governance mechanisms.

There has been 0 regulation 28 (prevention of future deaths) issued by HM Coroner.

The perinatal mortality SPC charts are provided below and show special cause improving variation. To support understanding, (MBRRACE-UK), definitions related to perinatal mortality are summarised below:

- A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks.
- A neonatal death is a baby born during the pregnancy who lives, even briefly and dies within 4 weeks of being born.
- An early neonatal death is a baby who dies before 7 completed days after birth.
- Extended perinatal deaths refers to all stillbirths and neonatal deaths.



MOSS

The MOSS system has been established by NHS England in response to the East Kent report into maternity services "Reading the signals". Its aim is to identify safety concerns within perinatal services to enable action to be taken in a timely manner. The system tracks the number of term intrapartum still births and neonatal deaths up to 28 days within a

perinatal service. When the number of “events” exceed what is expected an alert ‘signal’ is sent to the Trust and “critical safety check” must be completed by the Trust. 2 signals have been received within the reporting period, rapid reviews were undertaken and no immediate safety concerns identified, and further reviews will be undertaken through the PMRT process. The reporting processes have been followed as per the guidance.

Claims Scorecard

The 2025 claims scorecard has been received, reviewed and triangulated with incident, complaint and learning data and next steps identified to support improvements and presented at PIAC with an opportunity for discussion. The triangulation of the scorecard data is reviewed quarterly through internal governance processes.

Workforce

The neonatal nursing and medical workforce 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.

A birthrate plus (BR+) assessment was undertaken in 2024 to review the midwifery staffing requirement to support safe care. The clinical budgeted establishment aligns with the recommendations and has been further enhanced by Trust Board support to backfill 75% of the maternity leave. The nonclinical specialist and management cohort of the midwifery workforce has received significant investment and will align with the birthrate plus recommendations imminently.

Following successful recruitment, the early career midwives that joined the service between September 2025 and January 2026 have completed their supernumerary period and continue to be supported to transition to registered midwives through the enhanced preceptorship model in place. There is active recruitment in progress to close the vacancy gap and backfill the maternity leave. In the interim safety is maintained using bank and agency and redeployment across the service as indicated.

The Trust continue to support Maternity Support Workers to access the midwifery apprenticeship degree programme and have individuals completing the programme in January 2027 and others commencing in September 2026. This model supports career development of support workers, facilitates aspirations to increase workforce representation of our local demographic and is anticipated over time to reduce the primary reason for attrition which is relocation.

Key Performance Indicators of 1:1 care in labour and supernumerary status of the coordinator as per the MIS definition have been maintained. The midwife birth ratio is 1:24. There has been a further reduction of 45 red flags from the previous reporting period. Red flags are primarily related to delays on the induction of labour pathway and directly correlate with increased/decreased acuity and workforce availability.

A medical workforce report has been developed by the Clinical Director and is under review by the executive team to support the current and future medical workforce model.

The Board level and maternity and neonatal safety champions have undertaken walkarounds across the service to support floor to Board escalation, the detail has been

presented to the members of the Perinatal Improvement and Assurance Committee and actions identified. There was no immediate safety concerns escalated.

Regular perinatal engagement sessions and walkarounds continue by the leadership teams supported by executive colleagues which is positively received by the wider workforce. The Freedom to Speak Up (FTSU) Guardians and champions are also available to support escalation.

A consultant obstetrician is leading on the connection project which is a culture change programme for Leeds maternity services that aims to improve quality, safety and wellbeing by strengthening the human connections at the heart of maternity care. The framework responds directly to the themes identified by the 2024 CQC reports and the 2025 Maternity Safety Support Programme diagnostic assessment. An independent diagnostic is also being commissioned from the psychological safety institute to identify what is working well and any areas for improvement. The leadership team are engaging with the Regional NHSE team to deliver some further specific culture improvement activity.

Training

The perinatal training databases are continually updated and the data used to inform the training reports. Compliance with perinatal specific training requirements is above target across the multidisciplinary team.

Nursing and midwifery compliance with wider job essential training is above target. Medical leads are supporting improvements to achieve targets for doctors. The compliance for obstetrics and gynaecology doctors is 73% and 85% for neonatal medical staff.

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 by May 2026.

Service user engagement and experience

A summary of the 2025 CQC maternity survey has been shared with safety champions and the Perinatal Improvement and Assurance Committee. The leadership team and the Chair of the Maternity and Neonatal Services Partnership (MNVP) are co-producing an action plan in response to the survey findings which will be presented to the Safety Champions and the Local Maternity and Neonatal System, these groups will monitor outputs and report to PIAC. Whilst improvement actions will span across the entire pathway, postnatal care will be an area of concentrated focus as this is highlighted through multiple sources as an area requiring service improvement.

Friends and Family (FFT) Response Rate

- Birth Response rate: 28% (95.24 % positive rating)
- Antenatal- Response rate: 15% (94.25% positive rating)
- Postnatal - 22% Response rate (89.03% positive rating)
- Community postnatal – 13% response rate (88.51% positive rating)
- LGI Neonatal Unit Response rate: 56% (100 % positive rating)
- SJUH Neonatal Unit- Response rate: 41% (93.33% positive rating)
- Transitional Care: 54% Response rate (100% positive rating)

There was a total of 15 complaints received during January and February (13 for maternity and 2 for neonatal services). The maternity themes related to communication, general dissatisfaction across the maternity pathway and having unanswered questions related to pregnancy and birth. The neonatal themes centred around communication, care and accommodation environment. The perinatal team are working with service users to respond to concerns raised and supporting local resolution meetings where desired. Thematic analysis will be undertaken as part of the improvement plan and actions will be monitored via the Trust improvement plan.

National Quality Improvements

The overall compliance with saving babies lives care bundle is 96% for Q3, this is an increase from 90% in Q2. Performance with the care bundle is externally validated by the LMNS. It has been fed back that the evidence submitted is of a high quality and there is evidence of incremental and sustained improvements. The two areas of focus are supporting a 7-day ultrasound scanning service and increasing compliance with very brief smoking advice.

The service continues to monitor compliance with BAPM optimisation metrics and there have been no missed opportunities for steroids, magnesium or antibiotics. All metrics for all cases are reviewed by the multidisciplinary team to identify opportunities for improvement. Recurrent themes where compliance isn't 100% are associated with either spontaneous labour, a need to expedite the birth for fetal wellbeing, or requirements for resuscitation at birth.

A maternal care bundle was published by NHSE in January 2026. [NHS England » The Maternal Care Bundle](#) The care bundle sets best practice standards across 5 areas of clinical care based on the findings of MBRRACE-UK data. The aim is to reduce morbidity and mortality and reduce inequalities in these adverse outcomes. The elements of focus are:

- Venous Thromboembolism
- Prehospital and acute care
- Epilepsy in pregnancy
- Maternal mental health
- Obstetric Haemorrhage

Following the publication, a local benchmarking tool has been developed whilst awaiting a national benchmarking tool to complement the bundle. A multidisciplinary working group has been set up and has met to support a review of all elements and identification of any gaps. On completion of the review a report will be developed and presented to the Board. The approach will require collaboration with internal and external stakeholders including primary care to optimise maternal wellbeing and reduce the risk of maternal morbidity and mortality.

NHS England issued a letter on 26 November 2025 requesting an urgent review of all Trust homebirth services following the Prevention of Future Deaths (PFD) report. The letter highlights critical concerns across operational delivery, care planning and risk assessment, and governance and oversight. Trusts were required to ensure that their homebirth services remain safe, high-quality, and subject to robust governance and undertake a review of 3 key areas: operational running of the service, care planning and risk assessment and governance and oversight. A working group has been established to review the findings and recommendations.

The midwives supporting homebirths within Leeds are trained in newborn life support and out of hospital emergency training. Their primary role is that of an intrapartum midwife who has significant knowledge, skills and experience of caring for birthing people across the entire intrapartum pathway with varying levels of complexity, comorbidities and existing and evolving risks during labour and birth. 2 midwives provide care and support during a homebirth. They are familiar with and responsive to emergency situations for both the birthing person and baby. Processes are in place to provide regular updates to the delivery suite coordinator and seek advice and guidance from midwifery and obstetric colleagues if indicated. There is a multidisciplinary clinic pathway to support birthing people who make an informed decision to choose an alternative pathway that sits outside of local guidance.

Following the review areas of focus to optimise safety identified are:

- Review and revision of local standard Operating Procedure to ensure alignment with national recommendations.
- The addition of homebirth equipment checks to mykitcheck to ensure digital record of checks.
- A review of all birth choices pathways.
- Review of patient information leaflet to include freebirth information.
- Exploration of digital record keeping for homebirths (the intrapartum element of the Electronic Record System is not available in the community setting).

Maternity (Perinatal) Incentive Scheme

The Trust Board declaration form for year 7 of the Maternity Incentive Scheme has been submitted to NHS Resolution within the required timeframe and the outcome of the submission is awaited. A high-level letter has been received by the Trust regarding the principles of year 8 and the full guidance is anticipated to be published before the beginning of April. In the interim evidence continues to be collated as per year 7 requirements.

3. Quality and Performance Implications

See main discussion

4. Financial Implications

Not applicable

5. Risk

There are no new risks to escalate from this paper.

6. Communication and Involvement

There is ongoing communication with the public and staff regarding the perinatal services

7. Improving Health Equity

Health Equity is inextricably linked to perinatal care; the service has a Health Equity team led by a Consultant Midwife. The team work with the wider team to identify opportunities to support service improvements and outcomes.

8. 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 26th of March 2026.

9. Recommendation

The Trust Board are asked to receive this summary paper note the contents and be assured that members of the Perinatal Improvement and Assurance Committee have reviewed all elements of the national Perinatal Quality Oversight Model and had opportunity to explore data further through check and challenge and this is reflected in the papers, minutes and Chairs report from the Committee.

10. Supporting Information

The following papers make up this report:

1. None