

**Perinatal Assurance Report
Trust Board**

24 September 2026

Presented for:	Information and Assurance
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Previous Committees:	Women's Quality and Governance Group Perinatal Improvement and Assurance Committee

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

Key points	Purpose
1. The report provides the 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 July 2026.	<i>Information and Assurance</i>
2. There are separate Maternity (Perinatal) Incentive Scheme reports shared with the Board based on Safety Action A – a review of the elective capacity, Safety Action B – Perinatal training Compliance Report, Safety Action C - Learning from reviews and investigations (Inclusive of PMRT)	<i>Information and Assurance</i>
3. The service cannot declare compliance against safety action C, 'learning from reviews and investigations' in terms of compliance with the PMRT element. There is a requirement of a minimum of 60% of deaths reviewed, having external peer attendance. The input from the Maternity Improvement Advisors does not meet this requirement. Though this support has now been identified, there are insufficient eligible reviews remaining within the reporting period to achieve the 60% threshold. The service have taken advice from NHS Resolution/MIS colleagues to understand whether there are any actions that can be taken to improve compliance within timeframe.	<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. There was 1 referral to MNSI in the reporting period and no final reports received. There have been no regulation 28 notifications received and no	<i>Information and Assurance</i>

MOSS signals in the reporting period, however a MOSS signal was received in September.	
6. There is a separate report detailing the LTHT Review of National NHSE Triage Tool, and Implementation Plan.	<i>Information and Assurance</i>
7. Following the Ockenden report for Nottingham and the Amos national report, NHSE have published an urgent 10-point plan for immediate action plan. LTHT's position against this is partially assured.	<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 Trust Board with information 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 July 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.

To demonstrate alignment with the information being provided and risks being managed on the CSU's risk register, reference is made throughout this report.

2. Discussion

PMRT

There were 7 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: three stillbirths, two early neonatal deaths (including one termination of pregnancy), one late neonatal death (a baby transferred to LTHT from an external unit postnatally for specialist neonatal care with all maternity care provided by the external Trust) and one termination of pregnancy (>24 weeks gestation).

All 7 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. One of the babies met criteria for referral to MNSI.

There were 10 eligible cases reviewed using the PMRT in July and none of the cases were graded C or D. 100% of the families received information about the PMRT process, and were offered different ways to be able to share their feedback and questions with support.

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 Board.

MNSI

In July, there was 1 referral to MNSI for a baby, and no final reports received from MNSI.

MOSS

A MOSS signal was not received during the reporting period (July), however an alert was received on the 3 September. A rapid review of the case that triggered the MOSS signal was undertaken on 10 September. Following the MOSS signal, a critical safety check return was submitted to NHSE within timeframe on the 15 September. The outcome of the critical safety check recognised that the service still have improvement actions needed around patient safety.

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 and continuing to focus on actions from the trauma informed care gap analysis which will be monitored through our perinatal improvement plan pathway redesign workstream

Regulation 28

There have been no regulation 28 notifications (prevention of future deaths) in this reporting period.

Risk Register and Risk management

New risks onto the Risk Register for July include triage services having digital ability (K2) to support accurate signposting of service users (ID11958), impact on bereavement care due to the use of portable equipment as rooms not currently equipped with piped oxygen, VTUs (ID11976), non-compliance of MIS year 8 PMRT external peer reviews (ID11979), the transference of samples from community to the acute site for testing (ID11972) and repair work required to theatre ceiling light (ID11950)

The Risk Register and processes around managing risk in the service is currently under review, with support from MIAs and the corporate team.

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. The maternity Governance Structure, TOR and agendas are all currently being reviewed by the corporate team, with involvement from MIAs.

Care bundles and national quality and safety improvements

The Trust continues to demonstrate strong performance against the British Association of Perinatal Medicine (BAPM) perinatal optimisation standards. Overall, Q1 findings indicate

good performance and continued improvement across the majority of optimisation measures, with missed opportunities limited to antenatal corticosteroid administration and ongoing work focused on understanding variation between sites and sharing learning to further improve compliance. The preterm MDT now meet with the neonates team in a quarterly perinatal optimisation MDT meeting where they discuss shared learning and review cases and NNAP data together.

Saving Babies' Lives Q1 2026/27 audit data has been collated and internally validated and remains 96% implemented 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 (Risk Register ID10482) and mitigated through recruitment, service redesign, enhanced oversight, governance escalation, and targeted quality improvement.

The service has reviewed the nationally published maternal care bundle, and an implementation plan will be presented to Trust Board in November to meet the programme's expected compliance by March 2027. The six elements of the care bundle will be supported by quarterly reporting to monitor progress, risks, gaps and escalation requirements.

Following the publication of Baroness Amos's independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, the chief executive, chief nursing officer, and medical director for NHS England published a 10 Point Plan of urgent actions for maternity and neonatal services. A baseline assessment of LTHT's position against this will be presented to Trust Board in September, followed by a progress update by 31 December 2026.

Maternity (Perinatal) Incentive Scheme

The Year 8 Maternity (Perinatal) Incentive Scheme published on the 31st of March provides an 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.

The service cannot declare compliance against safety action C, 'learning from reviews and investigations'. For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the MDT review. The input from the Maternity Improvement Advisors does not meet this requirement. Though external clinical review support has now been identified for LTHT, there are insufficient eligible reviews remaining within the reporting period to achieve the 60% threshold. (Risk Register ID11979) The service have taken advice from NHS Resolution/MIS colleagues to understand whether there are any actions that can be taken to improve compliance within timeframe.

The accompanying papers from safety actions A, B and C demonstrate compliance and progress against these elements of the scheme.

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.

The maternity service will welcome 35.2wte newly qualified midwives from Q3, who following a period of induction are expected to be in the numbers from Q4 onwards. (Risk Register ID8916 and ID11164) The service is currently out to advert for 8.0wte band 6 midwives and a further 6.0wte early career midwives have been requested via NHSE funding, the outcome of which is pending. The budgeted establishments are aligned with the Birthrate Plus recommendations. In the interim bank and agency midwives are being used to support gaps and mitigate risks.

In accordance with MIS requirements, a further Birthrate Plus review has been commissioned. Planning will commence December 2026, with the report expected in April 2027.

Acuity continues to be monitored across the inpatient areas of the maternity services via the live birthrate plus tool. Key performance indicators of 1:1 care in labour and supernumerary status of the coordinator have been monitored throughout the reporting period. Supernumerary status remains 100%. In July, there was 1 red flag which was not recorded when 1:1 care in labour was not achieved during a full site diversion; the issue was quickly resolved and did not result in adverse outcome.

During the reporting period, there was a significant increase in delays of induction of labour from 67 in June to 108 – this is likely to be due to staffing levels and an increase in acute admissions. It had previously been recognised that the induction of labour pathway required review and following the introduction of a series of measures following the RPIW work, subsequent figures are improved. (Risk Register ID11428)

Obstetric consultant workforce plans are progressing, with 2 of the 9 agreed posts for this year appointed in to and further interviews in place. 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. (Risk Register ID11327 and ID10461)

Activity

Perinatal services continue to operate under sustained pressure, and this is reflected in the daily OPEL scores throughout July with 72% reporting at OPEL 3-4; there was one episode of OPEL 4 necessitating a whole system divert.

There have been challenges in July on the NNU at the LGI with an average capacity of 107%, which impacts the number of pathway refusals and transfers. Mitigations have been initiated including the redeployment of nurses and a business case is to be implemented in September which will support an increase in capacity.

The capacity element of Safety Action A of year 8 of the Maternity Incentive Scheme requires the Trust to undertake an annual demand and capacity mapping exercise for planned caesarean birth covering the complete pathway: preoperative assessment, planned operating lists and theatre availability, anaesthetic and perioperative support, recovery, and transfer to an appropriate postnatal bed. A separate report details the review, however key points include a 40% increase of elective caesarean activity since 2020/21. There is also

increased maternity case complexity and an unreliable, unsustainable model in place to support this increase; a business case is therefore under review.

National maternity reviews identify maternity triage as a safety-critical front door where delays, inconsistent assessment, failures to listen or escalate, and poor continuity of information can contribute to avoidable harm. The 2026 Ockenden report and the Amos review collectively emphasise compassionate listening, reliable urgent assessment and escalation, staffing and capacity aligned to demand and acuity, integrated pathways, and active use of performance, incident and outcome data. A review has been undertaken to assess whether LTHT's triage model is clinically safe, compassionate, equitable, adequately resourced and supported by escalation arrangements that respond to both clinical need and operational pressure (Risk Register ID11862).

Core services and safety controls are in place, but consistent, measurable compliance is not yet fully evidenced; validated data and measurement are not consistently sufficient to demonstrate the 15-minute standard and pathway metrics. This is due to digital systems not currently having the capability to support audit requirements. A solution is in progress which will support service improvement and ability to provide assurance of standards.

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

Overall, perinatal mandatory training compliance is on trajectory across the multidisciplinary team. Challenges have been identified across the medical workforce and actions are in place to improve compliance. The mid-point review of training has been undertaken in alignment with the requirements of year 8 of the Maternity Incentive Scheme and the detail can be seen in the training report provided.

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 voice and experience

The service continues to strengthen and embed health equity and trauma-informed care across maternity provision, with a particular focus on reducing inequalities, improving access and engagement, providing personalised care, and ensuring that women and families with additional needs receive appropriate, compassionate and responsive support throughout their maternity journey. Following review, there is evidence that the Leeds MNVP model is aligned with NHS England national MNVP guidance, though there are challenges around resource to fulfil all requirements of future expectations.

The MNVP has continued to share survey feedback focusing on experiences with MAC, the antenatal day unit, and BSOTS system, actions from which are captured on the overarching patient experience plan.

FFT feedback is predominantly positive, particularly for birth care at L45 and antenatal care at L44. Women consistently describe staff as compassionate, professional, reassuring and attentive. However, the findings should be interpreted cautiously: recorded response rates range from 16% to 29%, with no response-rate data for L44 or J04.

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.

3. Financial Implications

Some of the business planning and safety actions will require financial investment. The team will await further information regarding financial support for staffing and estate from the centre.

4. Risk

Perinatal Improvement Assurance Committee and Trust Board provides oversight of the patient safety and outcomes risk and regulatory risk related to maternity and neonatal services. The Trust is currently operating within the risk appetite for the level 1 risk (clinical risk), it is operating outside the risk appetite for the level 2 risk category (patient safety and outcomes and regulatory risk) set by the Board as a consequence of the findings from the CQC inspections of maternity and neonatal services and well-led, the breaches in Regulations included in the report and the Section 29A Warning Notice that was issued under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 will be made available to the public on 24th September 2026.

8. Recommendation

The 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.

Provide support as required to facilitate the organisational rollout of the national MEWS tool.

9. Supporting Information

Accompanying papers, as supplied