The Leeds Teaching Hospitals NHS Trust

# PERINATAL IMPROVEMENT ASSURANCE COMMITTEE
## Chair's Summary Report

**Public Board**
**26 November 2026**

| | |
|---|---|
| **Presented to:** | Alert, advise and assurance |
| **Presented by:** | Simon Le Clerc, Non-Executive Director, Chair of the Perinatal Improvement Assurance Committee |
| **Author:** | Simon Le Clerc, Non-Executive Director<br>Wisdom Echefula, Senior Corporate Governance Officer |
| **List of meeting dates:** | 12 November 2026 |

| | |
|---|---|
| **Freedom of Information Act (FOIA) Exemption** | ☐**YES** (restricted from the FOIA) ☒**NO** (available to the public under the FOIA) |

| | |
|---|---|
| **Link to Strategic Objective** | Improvement & Innovation – ensuring we are at the forefront of health improvement, innovation and research. |
| **Link to Provider Capability Assessment** | Quality of care |
| **Link to CQC Well-led Statement** | Learning, Improvement and Innovation |
| **Regulatory Impact** | Regulation 12: Safe care and treatment |

| **Key points** | **Purpose** |
|---|---|
| 1. 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, advise, assure |

**Risk Appetite Framework**

| **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, Advise, Assurance (AAA):

- Alert - areas that 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.
- Advise - on 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 alerts the Trust Board to the formal non-compliance with national PMRT guidance arising from the Trust's inability to evidence the use of active-practice external reviewers in perinatal mortality reviews. This is a national issue and has been escalated to NHS England. The Trust is currently exploring reciprocal options with Guy's and St Thomas's NHS Foundation Trust.

- The Committee alerts the Trust Board to the significant deterioration in Saving Babies Lives Care Bundle implementation, particularly the high-risk position regarding reduced fetal movements (Element 3), inadequate scanning capacity and the two month delay in establishing a sustainable seven-day Fetal Assessment Unit (FAU).

## 3. Advise

- The Committee received its first triple A style report from the Chair of Perinatal Improvement Action Group (PIAG), with reflections of future content and style of this report to the Committee moving forward.

- The Board is advised of the ongoing elective caesarean section capacity constraints and the unsustainability of current interim arrangements, with ongoing mitigations to maintain safe service provision pending the TERG-approved workforce expansion and mobilisation of the recruitment of new additional staff for the establishment of the sixth and seventh theatre lists in January and April 2027, respectively.

- The Committee advises that the CQC Section 29A Warning Notice has expired, with no active enforcement action against the Trust, and that improvements in maternity workforce capacity were ongoing through funded establishment uplifts and an active recruitment programme, with residual staffing gaps being managed through interim workforce arrangements pending completion of recruitment by January 2027.

- The ongoing monitoring and assurance of the Trust's implementation of the Thirlwall Inquiry recommendations will transition to the Quality Assurance Committee to provide continued oversight of delivery and compliance.

- While targeted improvement actions are underway to address maternity and gynaecology patient experience concerns, sustained improvement was yet to be evidenced, particularly in relation to waiting times, delays in clinical reviews and communication with service users, requiring continued oversight and triangulation of patient feedback with clinical quality and safety measures.

- The Committee noted the significant maternity health inequalities identified across ethnicity and socio-economic deprivation, and the need to embed targeted, measurable health equity interventions within the PTP, with ongoing assurance demonstrating their impact on reducing disparities in access, clinical outcomes and patient experience.

- The Committee's Terms of Reference and annual workplan have been reviewed to align with the outcome of the NHS Alliance review. Further alignment to the corresponding amendments to the PIAG governance arrangements to ensure consistency, clear accountability and avoid duplication, will be reported to the Committee in January 2027, ahead of submission to the Board for ratification by January 2027.

**4. Assure**

- The Committee approved the PTP and its proposed delivery and governance framework, providing assurance that a structured approach was in place to prioritise, monitor and oversee delivery of the 120 improvement actions, with regulatory requirements and patient safety taking precedence. The Board are presented with this at agenda item 10.2 for approval.

- The Committee approved the Perinatal Cultural Improvement Plan, providing assurance that a structured and actively monitored approach was in place to address maternity and neonatal culture concerns, including incivility, professional relationships and psychological safety, with immediate mitigating actions and established governance oversight supporting progress towards MIS Year 8 compliance.

- The Committee received assurance that the comprehensive retrospective audit of 859 mortuary incidents, undertaken in response to national directives following the Fuller Inquiry and Ockenden Report, had been completed, with the Human Tissue Authority confirming that all identified cases were formally closed with no further action required. The Committee was substantially assured of the robustness of the review, the effectiveness of governance and regulatory oversight, and the ongoing implementation of identified service improvements through the Quality Assurance Committee.

- The Committee received assurance that perinatal quality and safety risks were subject to established operational surveillance, escalation and executive oversight arrangements aligned with the NHSE Perinatal Quality Oversight Model (PQOM), with immediate mitigations in place to manage workforce and capacity pressures while longer-term improvement actions progressed.

- The Committee endorsed the updated assessment of the NHSE 10-point plan, noting progress against the required actions and that Board-level accountability and governance arrangements were established, with outstanding regulatory evidence requirements and residual gaps incorporated into the PTP for continued monitoring. The Committee noted that green internal ratings remained subject to final evidence verification, ahead of Trust Board review on 26 November 2026 and submission to NHSE by 31 December 2026.

- The Committee received assurance that the Trust had made significant progress against the immediate NHSE requirements arising from the Thirlwall Inquiry and remained on track to meet nationally mandated timescales, with outstanding actions subject to continued oversight and delivery through the Trust-wide implementation arrangements. The full report has been shared for information and progress update with the Board.

- The Committee received assurance that the concerns identified during the NHSE Regional Maternity Services Visit had been reviewed, risk-assessed and incorporated into the PTP, with the Perinatal Directorate Quad Team and clinical leadership actively overseeing and implementing mitigating actions, notwithstanding some residual gaps in assurance.

**5. Risk**

The Committee reviewed the significant risks relating to reduced fetal movement scanning delays under SBL Element 3, with next-working-day ultrasound performance at 17.84% and

scanning within two working days declining to 76.53%. The Committee requested escalation of the scanning capacity risk to the Risk Management Committee.

The Committee also highlighted the need to strengthen oversight of MIS compliance as a key strategic control on the Corporate Risk Register, ensuring that identified gaps in controls, regulatory requirements and standardised data cut-off parameters are appropriately reflected and monitored to support sustained compliance and regulatory assurance.

## 6. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

## 7. 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.