The Leeds Teaching Hospitals NHS Trust

Leeds Maternity and Neonatal Independent Review

Public Board 26 November 2026

Presented for:	Information and Assurance
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Previous Committees:	None

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

Link to Strategic Objective	Outcomes – being outstanding now and in the future.
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 Regulation 15: Premises and equipment Regulation 17: Good governance Regulation 18: Staffing

Key points:	
• The Leeds Maternity and Neonatal Independent Review was commissioned by the Secretary of State in October 2025 • The Chair of the Independent Review was appointed in March 2026 • The Terms of Reference for the Independent Review were published on 28 September 2026 • Data platform for secure transfer of records has been commissioned by NHSE – training has been provided to Trust team and also to the independent review team. • Staff have continued to be updated on progress through the perinatal briefing meetings.	Information and Assurance

Risk Appetite Framework			
Level 1 Risk	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
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. Summary

The Leeds Maternity and Neonatal Independent Review was commissioned by the Secretary of State in October 2026. The Chair of the Independent Review was appointed in March 2026. The Terms of Reference for the Independent Review were published on 28 September 2026 (appendix).

2. Progress

Preparations for the Leeds Maternity and Neonatal Independent Review are continuing to progress.

The Programme Director has appointed posts to the Trust team, including Programme Manager, Business Support Manager, HR/staff support lead, Communications Manager, Data Analyst, Clinical Psychology lead and a Midwife who will provide direct support to the case review and selection process. Additional support has been recruited to support the CSU with PALS enquiries and complaints. An Information Governance (IG) Co-Ordinator has been appointed to provide support with Freedom of Information (FOI) and Subject Access Requests (SARs). A Consultant Neonatologist and Consultant Obstetrician have been appointed in November to provide clinical advice in the case review and selection process following publication of the ToR.

Meeting with Chair of the Independent Review
Since the last Board meeting on 24 September 2026 a meeting was held with the Chair of the Independent Review and the Board (Teams) on 25 September before the Chair met with families in Leeds on 26 September, and the Terms of Reference published on 28 September 2026.

This provided an opportunity to discuss the findings of the Nottingham independent review and the immediate and essential actions, and how this will inform the approach to the independent review in Leeds. The Chair also outlined the methodology for the Leeds Maternity and Neonatal Independent Review and encouraged the Board to support and enable staff to engage with the Review Team in confidence. The Board were invited to ask questions about the approach to the review, including how families who reported positive experiences of care would be included in the review. The Board discussed the process for overseeing improvements identified during the review and how this would be incorporated into the perinatal improvement plan through the Learning and Improvement Group that would be chaired by the Chief Nursing Officer.

Terms of Reference (ToR)

The ToR for the Leeds Maternity and Neonatal Independent Review were published in the period following the last Board meeting on 28 September 2026 (appendix), commissioned by the Department of Health and Social Care (DHSC). The ToR set out the purpose and objectives of the Independent Review together with the governance arrangements. This includes sharing the key findings with the Trust, DHSC and NHS England on a bi-monthly basis through a learning and improvement process, including escalation in the event of areas of concern being identified relating to patient safety in maternity and neonatal services.

The ToR set out the scope of the review (page 5-6). It will consider maternity and neonatal care from **1 January 2011** up to and including **31 March 2028**, where mothers and babies have suffered severe harm or death whilst under the care of Leeds Teaching Hospitals NHS Trust. The period 1 January 2011 to 31 December 2014 will be on an 'opt in' basis, and from 1 January 2015 will be 'opt out.' If families do not opt out, they will automatically be included in the review. Explicit consent will not be sought from the families for their information to be shared by the Trust with the review team. The final report will be presented to the families, Trust and DHSC (as the commissioners of the review) and will be published on or before **31 March 2029**.

There are eight categories of severe harm or death that the review will look at, these are described in the ToR. The Trust will identify cases for the review based on these categories. The definitions of those cases that are in scope have been reviewed with clinical leads and feedback provided to the Independent Review team via DHSC following a meeting in October. This includes clarification of some of these definitions to confirm the cases that will be provided by the Trust. Cases will be graded following review based on an established methodology to help understand the ways in which care may have impacted on outcomes for the families involved. The grading definitions are set out in the ToR (page 9).

The review will consider the governance and oversight arrangements in place in the Trust to ensure appropriate identification, learning and action related to themes emerging from incidents, complaints, and concerns regarding maternity and neonatal care. This will include post death care of mothers and babies in the mortuary and associated after death care services in all settings in the Trust.

The review will also consider the actions taken by professional regulators in relation to the specific cases being considered, to ascertain if their actions were sufficient to support accountability, any regulatory action or the identification of potential learnings.

DHSC have commissioned specialist psychological support service that is trauma-informed for families engaging with the review. The service will be available for the full duration of the review, including the family feedback and closedown phases.

The review team will liaise with members of staff working in the Trust, this will include current and former staff. The Trust will provide the review team with information to enable them to signpost current and former Trust staff to appropriate and available support mechanisms that are in place to encourage these staff members to voice their perspectives and experiences.

Preparations for the Independent Review

The Programme Director and team have met regularly with representatives from DHSC and NHSE to establish the arrangements for supporting the review, including the transfer of case records (open book). The data platform for secure transfer of records has been commissioned by NHSE; training has been provided to the Trust team and also to the independent review team.

The Trust has completed a review of the ToR and provided a response to the DHSC and review team, focusing on the definitions of those cases in scope to clarify the case selection criteria and this has been progressed. Work is ongoing at the Trust to prepare the first 'open book' of cases, based on the scope of the review, in readiness for opt-out letters to be sent to families. Once received, families will have 28 days to respond to the opt-out letters, as set out in the ToR, before case reviews commence. This will be progressed when the Information Sharing Agreement (ISA) has been finalised and signed by all stakeholders.

The Programme Director and team met with DHSC and representatives from the review team, including lead midwives, consultant obstetrician and consultant neonatologist on 12 November 2026 to establish key contacts, discuss and agree the next steps of the review.

A communication has been sent to families who asked to be included in the review following publication of the ToR at the end of September. Contact details for the independent review have been shared together with link to the ToR on the Gov.UK website. The Trust has shared the e-mail contact to forward the details to the independent review team so this will be managed directly and maintain the independence of the review.

Information Sharing Agreement
The ToR state that all records and data relating to the review will be processed according to the information sharing agreements. The review will have information management and privacy policies that will set out the approach the review takes to managing information that complies with information legislation.

The DRAFT Information Sharing Agreement (ISA) was received on 10 November 2026; this has been reviewed by the Trust's Information Governance (data protection) lead and initial feedback provided to DHSC on 12 November 2026. This was further reviewed with DHSC on 19 November 2026 and will be signed by both parties (review team and the Trust) when this has been finalised.

Data Protection Impact Assessment
The Data Protection Impact Assessment (DPIA) is being completed in conjunction with IG leads, with a covering statement from the Chief Medical Officer. This will be completed and presented to Perinatal Improvement Assurance Committee (PIAC) when the ISA has been finalised and signed by stakeholders.

Staff briefing
Staff have continued to be updated on progress through the perinatal briefing meetings. Open face-to-face meetings were held with staff on 17 and 20 November 2026, providing opportunity to ask questions about the Independent Review and meet the team who will be leading and co-ordinating the response.

10-point plan
NHSE published a set of urgent actions in response to the recommendations in both the national maternity report (Amos) and Nottingham report (Ockenden). The 10-point plan

was published on 30 June 2026. These urgent actions will inform the Leeds Maternity and Neonatal Independent Review and will report into the National Maternity and Neonatal Taskforce to inform the development of the national action plan, that is set to be published in December 2026. A further update on progress against the 10-point plan is to be submitted to NHSE on 31 December 2026, following review at PIAC and Board in November (item 10.6).

Thirlwall Inquiry
The Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 was published on 15 September 2026. Whilst there are specific recommendations for neonatal services, there are also wider lessons that have been shared with senior leaders in all CSUs. This will also inform the lines of enquiry for the Leeds Maternity and Neonatal Review, in line with the Nottingham and Amos reviews.

A letter was received from NHSE on 21 September 2026 summarising the priority recommendations in the report and a commitment to a series of immediate actions whilst the recommendations of the Inquiry are considered in full, including the safe storage and handling of insulin, investigating deaths through the SUDIC process, safeguarding and bereavement care pathway. These immediate actions were discussed at September Board and also at the Quality Improvement Group (QIG) with NHSE on 14 October 2026 and senior leaders on 21 October 2026. A report on progress against the actions will be presented to Board in November (item 10.7).

Your voice conversation
The Trust has fully engaged with the Your Voice conversation, a national consultation that was launched by NHSE from 12 October – 2 November 2026, inviting people to share their experiences to shape future improvements in maternity and neonatal services. This will also inform the National Action Plan that is set to be published in December 2026.

Progress regarding the Leeds Maternity and Neonatal Independent Review is reviewed with Executive Directors at the weekly Improvement Steering Group and continues to be discussed with NHSE and partners at the Quality Improvement Group (QIG), including oversight of the perinatal improvement plan that was developed in response to the findings and recommendations in the CQC inspection reports and MSSP diagnostic reports.

3. Financial Implications

There are financial implications of the Leeds Maternity and Neonatal Independent Review. Funding has been provided by NHSE to establish the infrastructure and resources required to support the Trust's response and management of the logistics of the review.

4. Risk

Perinatal Improvement Assurance Committee provides oversight of the Trust's patient safety and outcomes risk related to maternity and neonatal care. 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) 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.

The risk is referenced in the Corporate Risk Register CRRE1 – breaches of Regulations – maternity and neonatal services.

5. Communication and Involvement

The reports have been discussed with senior leaders and key messages shared with staff across the trust.

6. Impact on Equality and Health Inequalities

The themes related to health inequalities are described in specific chapters of the reports, the findings and recommendations related to this will be incorporated into the perinatal improvement plan.

7. Publication Under Freedom of Information Act

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

8. Recommendation

Trust Board is asked to:
Receive the update and assurance on progress regarding the preparations for the Leeds Maternity and Neonatal Independent Review following publication of the ToR on 28 September 2026.

Supporting Information

Appendix 1 Terms of Reference Leeds Maternity and Neonatal Independent Review (28 September 2026)

Craig Brigg
Programme Director

November 2026