

Trust Board Paper G

Meeting title:	Trust Board					
Date of the meeting:	8 October 2026					
Title:	UHL Perinatal Report					
Report presented by:	Julie Hogg, Chief Nurse and Deputy Chief Executive Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Report written by:	Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

The report provides reasonable assurance that UHL's core perinatal governance, safety and improvement controls are in place and that the August 2026 position remained broadly stable despite sustained operational pressure. Positive indicators include 100% one-to-one care in labour, no Patient Safety Incident Investigations, achievement of all ten Maternity Incentive Scheme safety actions, full-term neonatal admissions at 4.8% against the 6% national comparator, and improvement in smoking at delivery to a provisional 2.5%. Material risks remain in neonatal staffing, maternity medical workforce capacity, induction-of-labour timeliness, ward and neonatal capacity, patient experience, severe postpartum haemorrhage, immunisation uptake and data quality following the EPR transition. These risks, together with delivery of the Maternity and Neonatal 10 Point Plan, the Trust-wide response to the Thirlwall Inquiry and relevant external learning, are under active oversight through the fortnightly Executive Perinatal Oversight Group, PSIP, PAC, Trust Leadership Team, Quality Committee and Board.

Impact assessment

The report supports a positive impact on safety, quality, experience, workforce culture and equity by strengthening listening and escalation routes, Board oversight and the triangulation of outcome, workforce and experience data. No adverse equality impact is anticipated. The report recognises continuing variation in access, experience and outcomes, including interpreter access, communication and consent, postnatal care, induction of labour, discharge planning and immunisation uptake. These issues will be addressed through the Perinatal Health Equity Partnership, MNVP and community engagement, the Your Voice initiative, the patient-experience action plan and improved demographic reporting. The national 10 Point Plan, Thirlwall review and MNSI homebirth learning will provide further tests of the effectiveness of these arrangements.

Appendices

None

Glossary

This table explains the main specialist terms and abbreviations used in the report.

Term or abbreviation	Meaning
Full-term neonatal admission	Admission of a baby born at 37 weeks or later to a neonatal unit.
One-to-one care in labour	Continuous care from a dedicated midwife during established labour.
BCG	Bacillus Calmette–Guérin vaccine, used to protect against tuberculosis.
CTG	Cardiotocography
EPR	Electronic Patient Record
FFT	Friends and Family Test
LGH	Leicester General Hospital
LRI	Leicester Royal Infirmary
MDT	Multidisciplinary team
MIS	Maternity Incentive Scheme
MNSI	Maternity and Newborn Safety Investigations
MNVP	Maternity and Neonatal Voices Partnership
PAC	Perinatal Assurance Committee
PPH	Postpartum haemorrhage
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSIP	Perinatal Safety Improvement Programme
RSV	Respiratory syncytial virus

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

BOARD OF DIRECTORS

8 October 2026

UHL PERINATAL REPORT

PURPOSE OF THE REPORT

This report provides the Board of Directors and the public with an update on the safety, quality, experience, workforce and operational performance of UHL's maternity and neonatal services. It sets out the main areas of progress in this reporting month, the risks that remain and the actions being taken, including UHL's response to the national Maternity and Neonatal 10 Point Plan, the Thirlwall Inquiry and other relevant external learning. It also highlights recent engagement, improvement and recognition activity, and explains how progress and impact will be monitored through the Trust's governance arrangements.

In line with the new Perinatal Assurance and Accountability Framework, Board reporting will follow a coordinated cycle. The Perinatal Assurance Committee Chair's Highlight Report was presented last month, the full Perinatal Surveillance Scorecard will follow next month as part of its bi-monthly reporting schedule, and the Integrated Performance Report (IPR) will continue to include a core set of agreed perinatal metrics each month. This month, the Board is therefore receiving the perinatal report, which provides a high-level view of the surveillance metrics and an update on ongoing, new and emerging areas of focus, including delivery of the Maternity and Neonatal 10 Point Plan and the Trust's response to the Thirlwall Inquiry. The Chair's Highlight Report will continue to be presented quarterly.

RECOMMENDATION

The Board is asked to:

- receive the report and **note** the current position across perinatal safety, quality, experience, workforce and operational performance;
- **note** the key risks that remain and the actions being taken to manage them;
- **endorse** the governance and assurance arrangements for delivery of the Maternity and Neonatal 10 Point Plan and UHL's response to the Thirlwall Inquiry; and
- **continue** to seek assurance on delivery, impact and the timely escalation of risks through the established committee and Board reporting routes.

1. PERINATAL SERVICES SUMMARY

UHL's August 2026 perinatal position was largely stable, with 781 births, 100% one-to-one care in labour, no PSIs, one MNSI referral and four moderate-harm incidents. Smoking at delivery sustained improvement at a provisional 2.5% against the 6% target, breastfeeding initiation was 79.6%, and full-term neonatal admission reduced to 4.8%, below the 6% national comparator. Maternity safe staffing was 92.9%. Areas requiring continued oversight include a reduction in the FFT promoter rate to 85.6%, and neonatal safe staffing at 78.8%. The average

interval from decision for artificial rupture of membranes to completion improved from 39 to 33 hours but remains a material operational and experience pressure.

2. PERINATAL SURVEILLANCE HIGHLIGHTS

a. Workforce and Culture

Workforce performance remained mixed in August. Registered midwifery vacancy was 3.4%, with 92.9% of planned maternity staffing hours achieved. Neonatal nursing vacancy was 10.1%, and safe staffing was achieved on 78.8% of shifts; tier 1 and tier 2 neonatal medical staffing were 98% and 90% respectively. Non-registered midwifery vacancy increased to 10.7%, while sickness was highest in LGH midwifery at 9.8% and LRI neonatal services at 12.1%. The maternity medical workforce remains a material structural risk, with five consultant vacancies and programmed-activity gaps affecting sustainable senior cover, planned care and specialist services. Recruitment continues and the BirthRate Plus[®] assessment is underway (due to report early Q3).

Safety Champion walkarounds and wider listening activity continue to indicate growing staff engagement and openness. Of the actions arising from 2026 activity, 67 have been completed and 9 remain open. Staff pulse checks continue to centre on medical staffing, maternity and neonatal capacity, facilities and involvement in service change. These themes are being addressed through leadership visibility, restorative and organisational development work, Freedom to Speak Up routes and the newly launched Your Voice initiative, with feedback triangulated alongside safety, workforce, quality and patient-experience information

b. Operational Performance and Flow

Operational pressure included five site specific suspensions, ten diversions, one homebirth suspension and seven midwifery-led unit suspensions.

UHL's homebirth service recorded 38 bookings and 19 homebirths in August, with five intrapartum transfers, two babies born before arrival and 17 multidisciplinary care plans. The service remains mature with 24/7 provision, monthly multidisciplinary review, individualised care planning and positive outcomes. Further standardisation is required in MDT terms of reference, ambulance communication, digital and offline documentation, competency expectations and formal legal oversight.

The UHL Perinatal Pelvic Health Service remains a strong, largely compliant multidisciplinary model, with rising referrals, low waiting times and positive NHS England assurance.

Maternity triage remained busy in August. Telephone activity was 5,615 calls and the average response time was 2 minutes 35 seconds. Face-to-face performance improved to 82.3% triaged within 15 minutes and 97.6% within 30 minutes, with an average attendance-to-triage time of 8 minutes 55 seconds. Medical review remained pressured, with an average wait of 1 hour 45 minutes.

Induction of labour remains a material operational and experience risk. Induction accounted for 34.4% of births in August, compared with a previous 12-month average of 31.1%. The average interval from the decision to undertake artificial rupture of membranes to completion

improved from 39 to 33 hours, but remains prolonged and reflects sustained demand, bed and workforce constraints and competing clinical priorities.

Maternal request for caesarean birth during induction reduced from 4.5% to 2.7%. Additional bed capacity continues to be used on the adjoining ward at Leicester General Hospital while options are explored to maintain and expand capacity. The pathway requires continued enhanced oversight, stronger demand-and-capacity management and triangulation of delays with incidents, clinical outcomes, complaints and real-time feedback.

c. Experience and Engagement

Maternity FFT response improved from 9.7% to 11.0% in August; however, the promoter rate reduced from 90.4% to 85.6%. Antenatal and postnatal feedback remained mixed, with recurring themes across complaints and Birth Reflections relating to communication, information sharing, delays, discharge, compassion, pain management and not feeling listened to. Data-quality issues within FFT categorisation are being corrected, and automated text messaging, community collection routes and the co-produced patient-experience action plan are being progressed.

Interpreter use improved from 20% to 52% following deployment of mobile video-interpreting equipment, but consistent access has not yet been demonstrated. The developing Perinatal Health Equity Partnership, MNVP and community partners will provide a clearer route for women and families to shape service design and improvement, including targeted work on postnatal care, communication and consent, induction of labour and discharge planning.

d. Quality and Outcomes

Clinical quality indicators remained predominantly within common-cause variation. In August, no Patient Safety Incident Investigations were raised, one referral to Maternity and Newborn Safety Investigations and four moderate-harm incidents. The principal learning themes remain communication, handover, fetal surveillance, documentation and timely escalation; these continue to inform targeted improvement and assurance activity.

Clinical outcomes. Severe postpartum haemorrhage increased from 1.9% in July to 3.8% in August and requires continued surveillance and review. The proportion of babies with an Apgar score below 7 at five minutes was 1.8%. Severe perineal trauma improved from 4.5% to 2.7%, although sustained reduction remains a priority. Full-term neonatal admission also improved to 4.8%, below the 6% national comparator, while breastfeeding initiation was 79.6%.

Multidisciplinary clinical simulation training compliance was 91% and newborn life support compliance was 93%. Maintaining and improving compliance remains an important control for reliable emergency response and consistent multidisciplinary practice.

Immunisation uptake was 43.9% for RSV, 77.1% for pertussis and 47.5% for BCG. RSV uptake continues to improve; however, further progress is required across all three programmes. Recovery actions include stronger call-and-recall processes, improved access and documentation, greater use of opportunistic vaccination and increased resilience within

the BCG workforce. Progress will continue to be monitored through the established performance and governance routes.

3. NATIONAL PRIORITIES AND EXTERNAL LEARNING

a. Maternity and Neonatal 10 Point Plan

UHL has completed its initial baseline assessment against the national Maternity and Neonatal 10 Point Plan. The assessment is being used to consolidate existing improvement programmes, identify evidence gaps and confirm accountable leads, milestones and escalation routes. Particular focus is being given to maternity triage, workforce, leadership and culture, listening to women, families and staff, inequalities, data quality, learning from incidents and complaints, and the estate and capacity required to deliver safe care. Delivery will be overseen through the established perinatal governance structure (Fortnightly Executive Perinatal Oversight Group and the Perinatal Assurance Committee), with material risks escalated to the Trust Leadership Team, Quality Committee and Board. A further progress update will be provided in line with the national reporting timetable.

b. Thirlwall Inquiry

Following publication of the Thirlwall Inquiry report, UHL has commenced a structured Trust-wide review of the recommendations and their implications for neonatal, maternity, children's and wider corporate services. Initial work is focused on safeguarding, recognition of unusual patterns, mortality and outcome surveillance, speaking up, escalation of concerns, family voice, medicines governance, leadership response and Board accountability. Existing controls and evidence are being mapped, immediate actions identified and a coordinated governance route established. A fuller gap analysis and implementation plan will return through the appropriate assurance committees and to the Board as the national response develops.

c. MNSI learning from intrapartum care provided at home

We are reviewing the recently published MNSI [learning from investigations where intrapartum care has been provided at home](#). PAC has previously received assurance on the work undertaken to strengthen UHL's homebirth service, including individualised care planning, multidisciplinary review and oversight of transfers and outcomes. The new national learning provides a further opportunity to test and strengthen these arrangements, with particular focus on selection and informed choice, escalation and transfer, ambulance communication, emergency preparedness, equipment and medicines, multidisciplinary learning, documentation and digital resilience, and workforce competence. Any additional actions will be incorporated into the existing homebirth improvement plan and reported through perinatal governance, with PAC receiving a further assurance update once the review is complete.

4. ENGAGEMENT, IMPROVEMENT AND RECOGNITION

Your Voice. The [Your Voice](#) initiative has been launched to strengthen how staff experience, ideas and concerns inform improvement. Feedback will be considered alongside safety, quality, workforce and patient-experience intelligence, with themes, actions and evidence of

change reported through established governance routes. This will complement existing Safety Champion walkarounds, leadership visibility and Freedom to Speak Up arrangements.

Preterm prevention service recognition. The specialist preterm prevention service was represented at the House of Lords following recognition by the Cavell Trust. The visit provided an opportunity to share the contribution of our specialist midwives, supported by the obstetric consultant lead, to improving care for women and babies. Preterm birth rates are reducing, while demand continues to rise, including regional referrals for cerclage procedures. The recognition reflects the team's compassionate, specialist and responsive care and the impact of sustained multidisciplinary improvement.

Martha's Rule full implementation remains on track for March 2027 with campaigns already insitu aligned to 'Ask Me'. Work is underway to implement a new approved approach, patient communication resources and review of the NerveCentre Patient Wellness Questionnaire, with progress coordinated through the Trust implementation group.

5. ADDITIONAL PERINATAL HIGHLIGHTS

Quarter 1 Perinatal Safety Report: The Q1 2026/27 perinatal safety position remained stable, providing reasonable assurance that established governance, surveillance and learning arrangements are effective. Across 2,388 births, 709 incidents were reported, of which 98% resulted in no or minor harm. One Patient Safety Incident Investigation was commissioned, and three cases were referred to MNSI, with two accepted for external review. Triangulation across incidents, complaints, mortality reviews, claims and external investigations identified no emerging deterioration or recurring system-wide safety concern.

Key learning remains consistent across fetal surveillance, CTG interpretation, escalation, documentation, communication and pathway reliability. Fourteen moderate-harm incidents were reviewed, with targeted actions established for obstetric haemorrhage, perineal trauma, referral compliance, neonatal safety and the reliability of clinical documentation. The final MNSI report identified one safety recommendation and one safety prompt, with interim controls and longer-term digital solutions being progressed to improve standardisation and visibility of risk.

Patient experience remains an area requiring continued oversight. Forty-four complaints were received, primarily relating to communication, informed decision-making, care coordination and pathway delays. Although complaint volumes increased, there was no corresponding increase in harm.

Five PSIRF priorities have been agreed focusing on deterioration and transfer, capacity-related harm, delays in diagnosis or treatment, failure to act on results and time-critical medication delays.

As we approach [Baby Loss Awareness Week](#), from 9 to 15 October, we take time to remember every baby who has died and to acknowledge the enduring impact of loss on parents, families and loved ones. We know that no two experiences are the same, and we are committed to providing compassionate care, listening to families' experiences and ensuring that support is available when it is needed most. Through this commitment, we continue to strengthen the bereavement care we provide and honour the trust that families place in us during profoundly difficult times.