University Hospitals of Leicester NHS Trust

Trust Board Paper I

Meeting title:	Trust Board					
Date of the meeting:	12 November 2026					
Title:	**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:	Karradene Aird, Associate Director of Midwifery Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Which 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	N/A					

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

The report provides reasonable assurance that core perinatal governance, surveillance and improvement controls remain in place. September 2026 and Quarter 2 intelligence indicates a largely unchanged overall safety position, but assurance remains qualified by persistent clinical signals, workforce resilience, capacity and induction-of-labour delays, and inequalities in access and outcomes. Haemorrhage-related returns to theatre, low Apgar scores, severe perineal trauma and emerging preterm-birth variation require continued scrutiny. Oversight of these risks and the response to the Maternity and Neonatal 10 Point Plan, Thirlwall Inquiry, MBRRACE-UK recommendations and other external learning continue through the Executive Perinatal Oversight Group, PSIP, PAC, Trust Leadership Team, Quality Committee and Board.

Impact assessment

The report and the improvement actions it describes are intended to support safety, quality, experience, workforce culture and equity through stronger listening and escalation routes, Board oversight and the combined review of outcome, workforce and experience data. No adverse equality impact is anticipated from those actions; this does not establish that current access, experience or outcomes are equitable. Continuing variation includes interpreter access, communication and consent, postnatal care, induction of labour, discharge planning and immunisation uptake. The response will draw on 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 whether these arrangements are effective.

Appendices

None

Glossary

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

Term or abbreviation	Meaning
ATAIN	Avoidable Term (37 weeks or later) Admission to a neonatal unit

BCG	Bacillus Calmette–Guérin vaccine
BSOTS	Birmingham Symptom-specific Obstetric Triage System
CCTV	Closed-circuit television
CTG	Cardiotocography
EPR	Electronic Patient Record
FFT	Friends and Family Test
IOL	Induction of labour
IPR	Integrated Performance Report
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MDT	Multidisciplinary team
MEWS	Maternity Early Warning Score
MIS	Maternity Incentive Scheme
MNSI	Maternity and Newborn Safety Investigations
MNVP	Maternity and Neonatal Voices Partnership
MOSS	Maternity Outcomes Signal System
One-to-one care in labour	Continuous care from a dedicated midwife during established labour
PAC	Perinatal Assurance Committee
PEP	Perinatal Equity Partnership.
PMRT	Perinatal Mortality Review Tool.
PPH	Postpartum haemorrhage
PSII	Patient Safety Incident Investigation
PSIP	Perinatal Safety Improvement Programme
PSIRF	Patient Safety Incident Response Framework
RSV	Respiratory syncytial virus
SUDIC	Sudden and Unexpected Death in Children.
WTE	Whole-time equivalent

University Hospitals of Leicester NHS Trust

BOARD OF DIRECTORS

12 November 2026

UHL PERINATAL REPORT

PURPOSE OF THE REPORT

This report updates the Board and public on UHL's maternity and neonatal safety, quality, experience, workforce and operational performance. It summarises progress, remaining risks and actions, including the Maternity and Neonatal 10 Point Plan, Thirlwall Inquiry and other external learning, alongside engagement, improvement and recognition activity. It explains how delivery and impact are monitored through Trust governance.

This report combines September 2026 surveillance and performance, reported in the October Integrated Performance Report (IPR), with the July–September Q2 safety report insights. These are complementary views of overlapping periods, not separate successive clinical positions; improvement and national-priority updates are presented separately. Under the Perinatal Assurance and Accountability Framework, reporting comprises monthly IPR metrics, the bi-monthly surveillance scorecard (next due December 2026) and the quarterly PAC Chair's Highlight Report (last presented October 2026). Perinatal IPR measures and assurance methodology continue to develop, with BadgerNet validation ongoing and data-quality assessments awaiting confirmation.

RECOMMENDATION

The Board is asked to:

- **Receive** the report and **note** the current position across perinatal safety, quality, experience, workforce and operational performance;
- **Continue** to seek assurance and be curious through committee and Board oversight: test timely delivery, reliable implementation and sustained improvements in safety, experience and equity. For perinatal IPR measures, seek validated data, consistent definitions and denominators, and robust trend and variation analysis before concluding that change is sustained.

1. PERINATAL SERVICES SUMMARY

UHL's September 2026 perinatal position was largely unchanged overall, but continuing safety signals, capacity constraints and inequalities require Board oversight (see Appendix A for an 'At a Glance' summary). Across 800 births, one-to-one care in labour was maintained at 100%; there were no Patient Safety Incident Investigations, one MNSI referral and 14 moderate-harm incidents. Positive movements included breastfeeding initiation at 82.1%, smoking at delivery at 2.2%, postpartum haemorrhage of 1,500 ml or more at 3.3%, and maternity safe staffing at 93.1% of planned hours. The principal clinical exceptions were full-term neonatal admission at 5.1%, the persistent adverse signal for Apgar scores below 7 at five minutes and increased third- and fourth-degree tears. Capacity constraints continued to affect induction of labour, patient flow and patient experience. Equity review remains focused on late antenatal booking among women of Black ethnicity and women with multiple ethnic backgrounds, and emerging variation in perineal tears and preterm birth among Asian and Asian British women.

2. PERINATAL SURVEILLANCE HIGHLIGHTS

a. Workforce and Culture

Workforce indicators were stable overall in September. Registered midwifery vacancy increased to 4.3% while remaining below the agreed threshold. The midwifery establishment has increased, so fluctuations in the vacancy rate are expected as recruitment progresses; 23.37 whole-time equivalent (WTE) staff have been recruited in recent months. Maternity safe staffing improved to 93.1% of planned hours. Recruitment and development of the graduate pipeline continue to mitigate immediate risk. Sustained recruitment and retention work remains necessary to strengthen the longer-term resilience of neonatal nursing and obstetric and neonatal medical staffing.

The perinatal culture improvement plan is being refreshed, informed by staff feedback, ongoing fact-finding and relevant national recommendations on leadership, speaking up, listening to staff and fostering an open learning culture. This work will align with the developing workforce strategy, with progress and impact monitored through the established governance arrangements.

b. Operational Performance and Flow

Demand on maternity services remained high in September, with available capacity continuing to constrain service delivery. Service disruption persisted, including episodes of suspension and diversion, while bed availability continued to affect admission, transfer and discharge flow. Midwifery red-flag events remained stable and continued to receive oversight through matron validation and acuity review.

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 maintains a 24/7 provision, supported by monthly multidisciplinary review and individualised care planning.

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, with improved initial assessment times but continuing pressure on medical review. Telephone activity was approximately 5,600 calls, with an average response time of 2 minutes 38 seconds. Across 2,162 face-to-face attendances, the average attendance-to-triage time improved to 8 minutes 38 seconds; 82.4% were triaged within 15 minutes and 96.6% within 30 minutes. These initial assessment measures are distinct from the average wait for medical review, which remained 1 hour 47 minutes. Continued focus is required on sustaining timely triage and improving medical review through stronger workforce capacity and patient flow.

Induction of labour (IOL) remained a material operational and experience pressure despite a shorter waiting interval. The average time from the decision to undertake artificial rupture of membranes to completion of the procedure improved from 33 to 28 hours but remained prolonged. Demand also increased with IOL accounting for 35.6% of September births, compared with the previous 12-month average of 31.5%. Maternal requests for caesarean

birth during induction increased to 4.2%. Enhanced oversight and demand-and-capacity management remain priorities, with delays and requests for caesarean birth considered alongside incidents, clinical outcomes, complaints and real-time feedback. Additional capacity and pathway controls remain under review to reduce delay, improve communication and support timely, coordinated and personalised care.

c. Experience and Engagement

Maternity Friends and Family Test response improved to 11.8% in September, although it remained below the 25% target; the promoter rate was broadly unchanged at 85.5%. Experience was strongest in antenatal care at 88.2%, followed by labour and birth at 85.9%, and was lowest on postnatal wards at 79.7%. Thirteen maternity complaints and no neonatal complaints were recorded in the month. Feedback across complaints, Birth Reflections and the Friends and Family Test continued to identify communication, feeling unheard, delays, pain management, consent and personalised care as the principal themes. Automated messaging and community collection routes are increasing participation, while improvement activity is focused on stronger partnership working, timely assessment and clearer escalation routes for women and families.

Neonatal parent and carer feedback for January to September 2026 recorded a Friends and Family score of 96% for recommending the neonatal unit. This provides evidence beyond complaint counts but covers a different period and question from the September maternity measures, so the results are not directly comparable.

The current inclusivity analysis cannot establish that maternity experience is equitable because samples are small and participation is uneven. Positive responses ranged from 88.3% among White respondents to 92.7% among Black respondents, but these percentages do not support a firm comparison between groups. Communication, feeling unheard, staff attitude and dismissed concerns recur across ethnic groups. Although engagement is becoming more ethnically diverse, language barriers and reliance on informal translation remain evident. The findings therefore provide a broadly positive but incomplete picture.

The October Perinatal Safety Improvement Programme (PSIP) Board highlighted implementation priorities relevant to these themes: embedding the new Interpreting and Translation Service processes, developing accessible information about the maternity assessment and triage pathway, and using weekly senior-led patient walk-arounds to obtain feedback and address concerns in real time.

Current analysis does not stratify experience by deprivation, so it cannot show whether socioeconomic disadvantage compounds variation associated with ethnicity or language. The next step is to improve denominators and data completeness, routinely analyse experience by ethnicity and deprivation and, where numbers permit, examine their intersection with language.

d. Quality and Outcomes

September's IPR shows variation in neonatal and perinatal outcomes, including fewer neonatal unit admissions and stillbirths, alongside an increase in neonatal deaths. Behind

each of these figures is a baby and family, and the increase in neonatal deaths will be subject to appropriate review and oversight to ensure that any learning is identified and acted upon. The IPR records improved 30-minute triage, initial assessment times and the decision-to-artificial-rupture-of-membranes interval, while 15-minute triage remained below the 90% target. Postpartum haemorrhage and third- and fourth-degree tears are reported as case counts in the IPR and as rates below. Monthly exceptions require active review alongside clinical surveillance, which indicates that most quality indicators remain within common-cause variation. September recorded no commissioned Patient Safety Incident Investigations, one accepted MNSI referral and 14 moderate-harm incidents; these measures do not provide assurance in isolation. Section 5 summarises the July–September Q2 safety and learning review, providing quarterly context rather than a separate later position.

Postpartum haemorrhage of 1,500 ml or more reduced from 3.8% to 3.3%, while breastfeeding initiation improved to 82.1%. Perineal trauma (third- and fourth-degree tears) increased to 4.3% but remained within expected variation, and focused prevention work continues. The rate of babies with an Apgar score below 7 at five minutes reduced slightly but remained above target and continued to show special-cause variation, requiring ongoing review of agreed actions and outcomes. Full-term neonatal admission increased to 5.1%, while remaining below the 6% national comparator. September recorded a preterm birth rate of 70 per 1,000 live singleton births, above the national rate of 59, with early intelligence indicating a higher rate among Asian and Asian British women; a detailed review of preterm births and neonatal admissions is ongoing, with findings to be reported to the Perinatal Assurance Committee (PAC).

Multidisciplinary clinical simulation training compliance improved to 95%, while newborn life support compliance remained at 93%. The Maternity Incentive Scheme Safety Action 8 midpoint was achieved in line with national guidance. Focus remains on maintaining compliance, sustaining term-neonatal-admission and obstetric anal sphincter injury improvement work.

Immunisation uptake improved to 48.3% for RSV, 82.1% for pertussis and 58.7% for BCG. Further progress is required, particularly for RSV and BCG. Uptake and variation will continue to be monitored through established governance.

3. NATIONAL PRIORITIES AND EXTERNAL LEARNING

a. Maternity and Neonatal 10 Point Plan

NHS England Midlands has completed its regional review of UHL's baseline assessment against the Maternity and Neonatal 10 Point Plan. The review covered 26 deliverables and reported 13 as compliant, 12 as partially compliant and 1 not applicable. The regional assessment has provided greater alignment between the Trust and regional assessment across 19 deliverables. Positive assurance was recognised in Board reporting, workforce oversight, homebirth and complaints governance, consultant presence and maternity triage. The Trust considers that much of the supporting evidence is already available. The next submission will therefore focus on presenting and mapping that evidence more clearly against the assessment criteria, alongside engagement with the regional team to clarify how the evidence demonstrates the required assurance and where further evidence or action is

needed. The next assessment submission (due 31 December 2026) will focus on evidence for inequalities, neonatal establishment, 24/7 trained anaesthetic-assistant cover, post-death-care assurance and the mortuary review, while maintaining assurance on short-term locum controls. Community engagement through the inaugural Perinatal Equity Partnership meeting supports this work; priorities and the approach to demonstrating its impact are set out in Section 4. A workforce strategy meeting brought together all specialties to begin the three-year perinatal workforce programme, looking beyond headline vacancy figures at skill mix, education, retention, leadership, senior decision-making and resilience across the whole week.

Work is underway to understand demand, identify capacity constraints and pinpoint where women wait or pathways slow down. Several walkarounds have been undertaken to examine estates concerns raised by staff, observe the care environment and discuss practical issues with the teams working in it. This approach will inform the assessment of priorities and potential changes rather than relying solely on written requests.

A detailed stocktake against national expectations is underway for triage services. This has identified established arrangements, including 24/7 access and BSOTS, alongside areas requiring further work: timely assessment, medical review, patient flow, workforce resilience and communication with women while they wait.

The updated assessment and triage benchmarking will be presented to the Trust Board on 10 December 2026, ahead of the regional submission on 31 December 2026.

b. Thirlwall Inquiry

The immediate time-dependent Thirlwall action is neonatal insulin security. CCTV coverage of neonatal insulin storage areas is required by 30 November 2026, with recordings retained for at least 28 days; full compliance with access-control and storage requirements is required by 31 March 2027. Following the initial Trust-wide review of the report and learning, key stakeholders have met to update priorities and further develop the implementation plan. Its five immediate areas remain Board review and assurance, including professional curiosity and speaking up; application of the Sudden and Unexpected Death in Children (SUDIC) process; implementation of the National Bereavement Care Pathway for stillbirth and neonatal death; secure access to and storage of insulin; and safeguarding training, escalation routes and Board assurance. Progress, risks and actions will be monitored through the established assurance arrangements.

c. MBRRACE-UK 2026

The MBRRACE-UK 2026 Maternal Report highlights continuing national priorities in maternity care, particularly sepsis, capacity and the recognition of deterioration. Its findings are consistent with several areas already prioritised locally. The report specifically recommends rapid access to antibiotics for suspected sepsis, review of capacity to meet increasing demand and consistent use of maternity early warning scores.

Rapid access to antibiotics is already a focus of UHL's maternity sepsis improvement work, alongside demand-and-capacity work for planned care. The Maternity Early Warning Score

(MEWS) is due to go live across maternity services on 9 November 2026, ahead of Trust-wide implementation in quarter 4. MEWS is intended to strengthen recognition, escalation and response to maternal deterioration and supports the agreed Patient Safety Incident Response Framework priorities: deterioration and transfer, delays in diagnosis or treatment, failure to act on results and time-critical medication delays. Implementation will be supported by staff education, clear escalation pathways and monitoring of compliance, incidents and clinical outcomes. Assurance will test reliable use in practice and evidence of earlier intervention and safer care, rather than implementation alone.

The remaining recommendations will now be reviewed in detail against current practice, existing improvement plans and available evidence. Where appropriate, findings will be triangulated with incidents, complaints, mortality reviews, workforce and capacity information, clinical outcomes and staff and patient experience to test whether existing controls are effective and whether any further action is required. PAC will receive an update setting out the outcome of this review, any identified gaps, agreed actions, accountable leads and the evidence that will be used to demonstrate impact and sustained improvement.

4. ENGAGEMENT, IMPROVEMENT AND RECOGNITION

Perinatal Equity Partnership (PEP): The inaugural meeting provided a forum for community engagement on differences in access, experience and outcomes. The partnership, Maternity and Neonatal Voices Partnership and community partners enable women and families to shape service design and improvement. Current priorities include a directory of services and governance arrangements. Future updates will show the themes raised, actions agreed and evidence that co-production has influenced service change.

Meet the Expert Event: More than 150 women, birthing people, partners and family members registered for UHL's fourth maternity Meet the Expert event, held at the African Caribbean Centre on 23 September. Taking the event into the community enabled families to speak directly with maternity teams and partner organisations and access trusted advice on birth choices, infant feeding, vaccinations, pelvic health and wellbeing. Feedback was overwhelmingly positive: attendees valued the accessible setting, face-to-face discussion and opportunity to make informed decisions about their care. This feedback supports community-based engagement as an approach to partnership with local families.

5. ADDITIONAL PERINATAL HIGHLIGHTS

The **Quarter 2 Perinatal Safety Report** (July to September 2026) indicates no widespread deterioration or new system-level risk. Across 2,360 births, 723 incidents were reported; 97.2% resulted in no or minor harm and 20 were graded moderate harm. Duty of Candour compliance remained at 100%, with no severe-harm or death incidents recorded through Datix and no Q2 MOSS alerts. Eight haemorrhage-related returns to theatre remain the principal active signal, with review focused on risk assessment, escalation, the haemorrhage bundle and debriefs. MNSI learning reinforces fetal surveillance, cumulative risk, escalation, communication and informed choice. PMRT reviewed 21 cases during this reporting period, distinct from Datix classifications, without recurring organisational failure or deteriorating mortality outcomes identified; further learning may emerge. Respiratory morbidity, documentation and thermoregulation remain improvement priorities.

Equity intelligence highlights later booking and higher smoking prevalence in more deprived groups, emerging variation in preterm birth and severe perineal trauma among Asian women, and higher smoking prevalence and stillbirth rates among teenage mothers. National Perinatal Equity data (December 2025) shows higher UHL preterm birth rates than nationally, alongside comparatively positive early-booking and severe postpartum haemorrhage measures. Local intelligence indicates that the ethnic case mix of MNSI referrals did not appear disproportionate to the maternity population. Small numbers and differing populations and reporting periods limit interpretation and do not establish causation. These findings require continued review of equitable access and outcomes, with residual risks remaining visible until sustained benefit is demonstrated.[1]

[1] Data quality and interpretation. September surveillance figures are the best available data at the time of reporting. The underlying scorecard uses Badgernet data following the transition to the new Electronic Patient Record, and validation is ongoing; figures may therefore be subject to minor revision. Individual monthly movements do not, on their own, demonstrate sustained improvement or deterioration. Assurance depends on validated definitions, comparable reporting periods and the interpretation of trends alongside incidents, mortality reviews, workforce information and patient and staff feedback.

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Appendix A

AT A GLANCE Key measures – September 2026

800	100%	93.1%	82.1%	3.3%	5.1%
Births in September	One-to-one care in labour	Maternity planned staffing hours achieved	Breastfeeding initiation	PPH ≥1,500 ml	Full-term neonatal admissions (ATAIN)

September figures remain subject to validation following work to improve utilisation of BadgerNet and NerveCentre intelligence.

Monthly movement alone does not demonstrate sustained improvement.

POSITIVE MOVEMENT
Encouraging progress in key areas

- PPH ≥1,500 ml reduced from **3.8% to 3.3%**
- Average attendance-to-triage time **8 minutes 38 seconds**
  82.4% within 15 minutes
  96.6% within 30 minutes
- **95%** multidisciplinary simulation training
- **Active and successful recruitment campaigns**
- RSV, pertussis and **BCG** immunisation uptake **improved**

Positive movement, not yet sustained improvement.

WHERE SCRUTINY REMAINS
Areas requiring continued focus

- Low Apgar scores remain an adverse special-cause signal
- Third- and fourth-degree tears increased to **4.3%** (increase compared to previous month)
- Preterm birth **70 per 1,000** (compared with national rate of 59) – continued surveillance and analysis
- Average triage medical review wait **1 hour 47 minutes**
- Induction of labour accounted for **35.6%** of births
- Decision to artificial rupture of membranes interval **28 hours**
- **Eight** haemorrhage-related returns to theatre in Q2

These risks require continued oversight and targeted action.

WORKFORCE & CAPACITY
Ongoing challenges and improvement

- Midwifery vacancy rate **4.3%**
- Neonatal Nursing Vacancy **7.06%**
- Neonatal medical staffing **98% Tier 1 | 90% Tier 2**
- Obstetric staffing shortfalls affecting care reduced to **3.9%**
- Capacity continues to affect induction, admission, transfer, discharge and patient experience.

EXPERIENCE & EQUITY
Listening to women, families and communities

85.5%	79.7%	96%
Maternity promoter rate (FFT)	Positive experience on postnatal wards	Neonatal recommendation score*

*Covers January to September 2026 and is not directly comparable with maternity data.

Strongest maternity experience: **Antenatal care 88.2%**
Lowest experience: Postnatal wards **79.7%**
Key themes: communication, feeling unheard, delays, pain management, consent and personalised care.

Equity focus
Access | Experience | Outcomes

- Late antenatal booking and language barriers
- Communication, consent and use of informal translation
- Continued surveillance and analysis of variation in preterm birth and severe perineal trauma.

Current samples are too small and uneven to conclude that experience is equitable. Improved ethnicity, deprivation and language data are required.

NATIONAL LEARNING → LOCAL ACTION
Implementing and responding to national priorities

Maternity and Neonatal 10 Point Plan
13 compliant | 12 partially compliant
0 non-compliant
Next assessment submission: **31 December 2026**
Priority evidence areas:
- Inequalities
- Neonatal establishment
- Anaesthetic-assistant cover
- Post-death care and mortuary assurance
- Locum controls

Thirlwall Inquiry
Immediate focus:
- Neonatal insulin security
- CCTV coverage (required by 30 Nov 2026)
- SUDIC processes
- Bereavement care
- Safeguarding, escalation and speaking up
- Board assurance and professional curiosity

Full access-control and storage compliance: **31 March 2027**

MBRRACE-UK
Local priorities:
- Rapid access to antibiotics for suspected sepsis
- Capacity review
- Consistent use of MEWS
- Testing implementation through outcomes, not simply completion