CHAIR'S KEY ISSUES

ESCALATING TO QPS BOARD

East Suffolk and North Essex NHS Foundation Trust

ORIGINATING BOARD / COMMITTEE / TASK & FINISH GROUP AND DATE:	Maternity & Neonatal Improvement Board – 24 September 2026
CHAIR:	Catherine Morgan, Deputy Chair of MNIB, & Maternity Safety Champion
LEAD EXECUTIVE DIRECTOR:	Catherine Morgan, Chief Nurse

Agenda Item	Details of Issue	Approval Escalation Alert Assurance Information
Matters Arising	The Maternity & Neonatal Improvement Board received assurance on a number of areas of continued progress, including improvements in Saving Babies' Lives compliance, neonatal quality indicators, training compliance and the Trust's response to the immediate requirements arising from the Thirlwall report. The Board also noted the significant programme of quality improvement activity underway across maternity and neonatal services, with continued focus on strengthening patient safety, workforce resilience and the experience of women, babies and families. However, a number of challenges continue to require close oversight. These include maternity triage and induction delays, data quality and reliability, the workforce and financial implications of the National Maternity 10 Point Plan, and substantial gaps against the 2025 BAPM neonatal medical workforce standards. The Board also identified an emerging ethnicity-related disparity in postpartum haemorrhage outcomes requiring further investigation and engagement. These issues will remain under active review, with clearer exception-based reporting, defined actions and strengthened assurance on the impact of improvement activity.	Information
Assurance Report	**Maternity triage and induction of labour** The Board noted that further assurance is required regarding timely triage assessment, medical review and induction of labour delays. Doctor-review documentation remains a particular concern at Ipswich, while induction delays were reported as more frequent and prolonged at Colchester. There are also limitations in the reliability of Epic reporting and inconsistencies in datasets and denominators, which currently affect the Board's ability to assess performance and trends confidently.	Assurance

	Demand on maternity triage is significantly higher than the national assumption used for workforce planning, with approximately six attendances per pregnancy locally compared with around three nationally. Future reporting will focus on a small number of high-impact interventions and provide clearer triangulation between delays, patient harm and clinical outcomes. **National Maternity 10 Point Plan – significant workforce, estates and funding implications** The Trust was compliant with 19 of 26 requirements at the point of benchmarking. Indicative implementation costs for maternity triage alone were estimated at just under £3m for Ipswich and £4m for Colchester. Workforce and funding represent the principal risks, with implementation potentially requiring approximately 12 additional registrars, alongside further midwifery/neonatal workforce and estates investment. The Board highlighted that the required workforce and estates changes cannot realistically be delivered immediately without national funding and a phased implementation approach. **Neonatal medical workforce – BAPM standards** Neither Colchester nor Ipswich currently meets the 2025 BAPM medical workforce standards across the rota tiers. The most significant risk relates to Tier 2/middle-grade overnight cover, with a single registrar currently covering neonatal and paediatric services, including HDU, ED activity, high-risk deliveries and sick neonates, against a BAPM requirement for two registrars overnight. A phased three-year workforce expansion has been proposed requiring 5 additional Tier 1 doctors, 8 Tier 2 doctors and 4 consultants. Current care is considered safe but relies significantly upon staff goodwill and unscheduled flexibility. The issue has already been escalated to Trust Board, and MNIB endorsed progression of the workforce proposal through business planning and business-case development. **Neonatal capacity and ODN cot-base review** July and August saw significant staffing and acuity pressures. The Trust continues to await a definitive outcome from the ODN cot-base review, which is important to future workforce and service planning. The matter will be raised regionally to seek greater clarity on the timetable.	Alert Alert Assurance

	Emerging inequality in postpartum haemorrhage outcomes The maternity equalities dashboard has identified an emerging disparity in PPH affecting Black/Black British women. The Board agreed that further case review and triangulation with incidents, harm, risk assessment and reasonable adjustments is required. An in-person roundtable involving clinicians, communities, VCSE partners and service users is also being considered.	Assurance
	Positive assurance The Board received assurance that immediate actions arising from the Thirlwall report are being progressed in accordance with national guidance, including work relating to safeguarding, Freedom to Speak Up, SUDIC processes and cameras around cots. Neonatal QIS nursing compliance remains above 75% on both sites; ROP screening timeliness at Colchester has improved following introduction of a dedicated ophthalmologist; no further Enterobacter-positive cases have been identified since 16 June; and specialist ROP treatment has successfully been provided locally at Colchester, avoiding transfer to Addenbrooke's. MNIB Minutes 24 September 2026 … MNIB Minutes 24 September 2026 … Saving Babies' Lives compliance has improved from 88% to 93%, CNST training compliance was achieved at the July checkpoint, and all perinatal death actions were reported as complete. MNIB Minutes 24 September 2026 …	Assurance
	Other matters to note The Board identified maternity-related social-media discussion as an emerging source of "soft intelligence", particularly women comparing Colchester and Ipswich when deciding where to give birth. A more proactive organisational approach to understanding these conversations and providing evidence-based information will be explored. MNIB Minutes 24 September 2026 … The Board also noted changes to its leadership: Mike Gogarty will take over as Chair following Freda Bhatti's resignation, and Alex Duffety will join as a Maternity Safety Champion.	

Escalation	Support/decision required by reporting committee to resolve an issue within its remit	**Alert**	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require future action/decision
Assurance	Evidence or information to demonstrate that appropriate action is being taken within a reporting committee's remit	**Information**	No action required. Reporting to update on discussion within a reporting committee's remit