

Leeds Teaching Hospitals NHS Trust Perinatal Improvement Plan				Date initiated	01/10/2025 Approved by Trust Board November 2025
				Date of Update	05/03/2026
Accountability		Responsibility			
Lead	Oversight/governance structure	Lead		Oversight Group	
Chief Medical Officer Chief Nurse (temporary)	Quality Assurance Committee	Deputy Heads of Midwifery Deputy Head of Nursing Matrons – Women's Services and Neonatal Services Clinical Lead – Obstetrics Clinical Lead - Neonates		Children's Hospital Quality Assurance Group Women's Services Quality Assurance Group Weekly Quality Meeting Executive Management team	
Director of Midwifery Medical Directors – Operations Deputy Chief Nurse Directors of Operation Clinical Director, Head of Midwifery, General Manager – Women's Services Clinical Director, Head of Nursing, General Manager – Children's Hospital	Perinatal Assurance Group				
Improvement Plan Aim	Phase 1 The aim of the Perinatal Improvement Plan is to combine all risks, areas for improvement and transferrable learning from inspections, regulatory enforcement and breaches, completion of service level diagnostics and peer reviews into a consolidated plan to drive improvement and mitigate risk. Phase 2 A separate Perinatal Improvement Programme will be developed to enhance the safety and quality of maternity and neonatal care by focusing on a positive culture of safety, improving clinical practices, and reducing variations in outcomes for mothers, babies, and families.		Sources of information	CQC Inspection reports Maternity and Neonatal Services – Published June 2025 MSSP Maternity Improvement Advisor Diagnostic Report – Published May 2025 MSSP EDI Diagnostic – Published September 2025 Neonatal Peer Review outcome and action plan – Published 23 September 2025 NHS Resolution review of year 5 & 6 MIS Declarations Saving Babies Lives V3 NHS Screening Programme letter of concern 11 September 2025 Consideration of National reports/initiatives – MOSS, CQC Maternity improvement Resource (September 2024) Trust data	

Aim	Objective		Expected outcome	Assurance Mechanism	Executive Lead	Oversight Committee
	Ref					
The Trust will deliver actions to achieve compliance with CQC Regulation 12 Safe care and treatment within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	1	Ensure the Trust has consistent and effective systems to mitigate any risks to safe delivery of care and treatment that is reasonably practicable. 12(2)(b)	A reviewed and strengthened governance process which has effective management of the quality and safety of services.	Outcome report of review of governance systems and processes.	Chief Nurse	Quality Assurance Committee
	2	Ensure that where equipment or medicines are supplied by the Trust, there are sufficient quantities of these to ensure the safety of service users and to meet their needs. 12(2)(f)	An effective governance system which creates value and achieves Trust goals by establishing clear structures, roles, and processes for decision-making, accountability, risk management, and reporting.	Increased number of CTGs in circulation. Equipment inventory implemented for track and trace of fetal monitoring equipment. Fetal wellbeing audits.	Chief Medical Officer	Quality Assurance Committee
	3	Ensure the proper and safe management of medicines. 12(2)(g)	An effective process for the safe management of medicines.	Safe management of medicines audit. Annual report from Medicines Safety Officer to QAC.	Chief Medical Officer	Quality Assurance Committee
	4	Ensure the Trust has consistent and effective systems to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. 12(2)(h)	An effective process for the management of healthcare acquired infections.	Infection Prevention and Control Audit. Report on Infection Prevention and Control to IPC Sub-Committee and QAC.	Chief Medical Officer	Quality Assurance Committee
	5	Ensure that where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. 12(2)(l)	An effective process for care planning and transfer of care to ensure the health, safety and welfare of the service users.	Transfer of care checklist audit.	Chief Operating Officer	Finance and Performance Committee
The Trust will deliver actions to achieve compliance with CQC Regulation 15 Premises and Equipment within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	6	Ensure all premises and equipment are clean, secure, suitable, maintained and appropriately located. 15(1)	Effective process for the storage, maintenance and cleaning of equipment and cleaning of premises.	Premises cleaning audit. Report on Infection Prevention and Control to IPC Sub-Committee and QAC.	Chief Medical Officer	Quality Assurance Committee

The Trust will deliver actions to achieve compliance with CQC Regulation 17 good governance and provider licence conditions NHS2(2), (4), (5 B, C,E,F) and (6) within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH)..	7	Ensure the Perinatal Services have effective governance systems and processes to assess, monitor and improve the quality and safety of the services.	A reviewed and strengthened governance process which has effective management of the quality and safety of services.	Report to Women's Quality Assurance Group.	Chief Medical Officer	Quality Assurance Committee
	8	Ensure the Perinatal Service has consistent and effective systems to ensure incidents are consistently reported, investigated appropriately and with lessons shared within and across services to prevent recurrence	Positive reporting of patient safety incidents. Procedure for sharing learning across perinatal services that is understood and followed by all staff.	Perinatal report to Women's and Children's Quality Assurance Groups and Quality Assurance Committee.	Chief Medical Officer	Quality Assurance Committee
The Trust will deliver actions to achieve compliance with CQC Regulation 18 staffing and Regulation 12(2)(c) within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	9	Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to be deployed and that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely within Maternity Services.	Staffing rotas that demonstrate there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives to be deployed. Data demonstrates staff have completed mandatory and essential training relevant to their roles.	Daily staffing escalation report (Director of Midwifery). Weekly staffing escalation report to Chief Nurse and Chief Medical Officer. Monthly maternity staffing and skill-mix report. Report on maternity staffing to Women's Quality Assurance Group Quality and Quality Assurance Committee. Reporting on mandatory training compliance to Workforce Committee.	Chief Nurse	Quality Assurance Committee
	10	Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to be deployed and that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely within Neonatal Services.	Staffing rotas that demonstrate there are sufficient numbers of suitably qualified, competent, skilled and experienced neonatal nurses to be deployed. Data demonstrates staff have completed mandatory and essential training relevant to their roles	Daily staffing escalation report (Head of Nursing). Weekly staffing escalation report to Chief Nurse and Chief Medical Officer. Monthly neonatal staffing and skill-mix report. Report on neonatal staffing to Children's Quality Assurance Group Quality and Quality Assurance Committee. Reporting on mandatory training compliance to Workforce Committee.	Chief Nurse	Quality Assurance Committee
The Trust will complete targeted actions to improve quality standards within the safe domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	11	Provision of safe, quality and effective care that protects people from abuse and avoidable harm.	Effective process for the provision of safe perinatal care. Compliance with safety standards set out in Maternity Incentive Scheme (MIS).	Perinatal report to Women's and Children's Quality Assurance Groups and Quality Assurance Committee. Report on MIS evidence/compliance and submission.	Chief Medical Officer	Quality Assurance Committee
The Trust will complete targeted actions to improve quality standards within the effective domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	12	Service provision that achieves good outcomes, helps people maintain quality of life and is based on the best available evidence.	Effective process for monitoring clinical outcomes	Clinical outcomes report to Women's and Children's Quality Assurance Groups and Quality Assurance Committee. Peer review reports.	Chief Medical Officer	Quality Assurance Committee
The Trust will complete targeted actions to improve quality standards within the caring domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	13	Services that involve and treat people with compassion, kindness, dignity and respect.	Effective process for monitoring patient treatment to ensure they are treated with compassion, kindness, dignity and respect.	Reports on Friends and Family Test – satisfaction scores. Annual maternity survey. Annual patient survey. Patient dignity audits (ward healthcheck). Complaints and PALS report to Quality Assurance Committee.	Chief Nurse	Quality Assurance Committee
The Trust will complete targeted actions to improve quality standards within the responsive domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).	14	Service provision that responds to people's needs and provides co-ordinated care and support.	Effective process for responding to patient's needs and providing co-ordinated care.	Ward healthcheck audit – report to Quality Assurance Committee. Local audits (maternity and neonates) to provide assurance re actions identified in the MSSP diagnostic and improvement plan.	Chief Nurse	Quality Assurance Committee
The Trust will complete targeted actions to improve quality standards within the well led domain and areas for improvement noted within the	15	Services that are well led, have shared direction and a positive culture.	Effective leadership and culture for the management and oversight of perinatal services, collaboration between maternity and neonatal services.	Joint perinatal report to Quality Assurance Committee (maternity and neonates).	Chief Medical Officer	Quality Assurance Committee

MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).						
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Status	
O	On track
Off	Off track
C	Complete
E	Evidenced and assured
R	At risk

1. Ensure the Trust has consistent and effective systems do all that is reasonably practicable to mitigate any risks to safe delivery of care and treatment. 12(2)(b)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
1.1 (Mat)	Review current systems and processes from incident reporting through to shared learning across the service to address timely review of incidents, logging of actions and sharing of learning implement.	Deputy Heads of Midwifery Quality, Safety and Learning Team Lead	31/03/2026		O	Evidence of regular review of the live learning log Learning newsletters and Monthly QSL packs Established weekly PRIRFF Established WIRRM Launch of Unit with a memory and learning burst	Head of Midwifery Clinical Director (Women's Services)	30/09/2026
1.2 (Neo)		Lead Nurse for Quality (Children's Hospital) Governance Lead (Neonates)	31/05/2025	31/05/2025	E	Shared learning included within Huddles and Perfect Ward Board. Children's Hospital shared learning intranet developed and in place. Launch of Unit with a memory and learning burst. Documented mechanism to track the effectiveness of implemented preventative actions	Head of Nursing, Children's Hospital	30/09/2025
1.3 (Mat Neo)	Undertake a review of the PMRT process, escalation process, patient debriefs and reporting into the Quality Governance structure and through to Trust Board.	Matrons, Maternity and Neonatal Services. Clinical Leads, Obstetrics and Neonatal	31/12/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Revised PMRT SOP and Terms of Reference PMRT letter templates revised and templates for different languages created. Outcome of LMNS review of PMRT across LMNS Trusts Weekly Perinatal Escalation Report Neonatal PMRT Nurse secondment supported via MIS Discretionary Funding. Role progressing via VCP process.	Head of Midwifery Head of Nursing, Children's Hospital Clinical Directors Women's Services and Children's Hospital.	30/09/2026
1.4 (Mat Neo)	Review current incident review systems and processes to ensure compassionate and regular communication with families during investigations of their care.	Quality, Safety and Learning Team Lead Lead Nurse for Quality (Children's Hospital) Governance Lead (Neonates)	31/12/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	SOP for the engagement with patients and their families during patient safety investigation. Duty of candour compliance Revised working practice for governance nurse when supporting families during patient safety investigations.	Head of Midwifery Head of Nursing, Children's Hospital Clinical Directors Women's Services and Children's Hospital.	30/09/2026
1.5 (Mat)	Implement the Maternity Outcomes Signal System (MOSS) to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM).	CSU Tri Team, Women's Services supported by the Maternity Improvement Advisors	31/01/2026		C	Developed SOP to support Moss framework Leadership team have attended webinars Completed process when signal received. Report on implementation and outcomes to Women's Quality Assurance Group and Quality Assurance Committee.	Director of Midwifery Medical Director of Operations Direct of Operations	30/09/2026
1.6 (Mat)	Review the recommendations in the CQC Maternity Improvement Resource, summary of maternity inspections (September 2024), focusing on the 4 key themes: triage, incidents, leadership and culture and health equity – to incorporate into improvement plan.	Head of Midwifery	31/03/2026		O	Report on the review of CQC Maternity Improvement Resource, safety actions incorporated into perinatal improvement plan.	Director of Midwifery	30/09/2026
1.7 (Mat Neo)	Review the processes for the management of deteriorating patients and training and support for	Clinical lead – maternity and neonates	31/03/2026		O	Report of review to Women's Quality Assurance Group and Quality Assurance Committee.	Clinical Director	30/09/2026

	staff in the early recognition and management of deterioration in mothers and babies.					Safety checks audits aligned to the PIER approach to identify adherence with the approach, any areas of good practice and areas for improvement. Specific audits of MEWS/ NEWTT2 completion and escalation. Monitoring of escalation and response times. Patient feedback/ experience		
1.8 (Mat)	Review the process for the identification, escalation and response to deterioration in fetal wellbeing to support staff in the early recognition of deterioration, reduce harm and improve outcomes. Implement PIER (Prevention, Identification, Escalation and Response).	Clinical lead – maternity	31/03/2026		O	Report of review to Women's Quality Assurance Group and Quality Assurance Committee. Safety checks audits aligned to the PIER approach to identify compliance with the approach, any areas of good practice and areas for improvement. Specific audits of fetal well-being monitoring aligned to identification and escalation of clinical risk.	Clinical Director	30/09/2026
1.9 (Mat)	Review the approach to induction of labour to ensure this is standardised to support midwives and clinicians to safely manage induction of labour to improve outcomes and experience. Utilise the birthrate plus acuity app to develop a central place to monitor data. Participate in the NHSE Programme to establish a process where all women awaiting Induction of Labour (IOL) are visible regardless of environment.	Clinical lead - maternity	31/03/2026		O	Report of review to Women's Quality Assurance Group and Quality Assurance Committee. Safety checks audits aligned to identify compliance with the approach, to identify any areas of good practice and areas for improvement. Monitoring of performance data and audits aligned to the elements in the NHSE pilot.	Clinical Director	30/09/2026
1.10 (Mat)	Review the approach (SOP) to assessing and triaging women, implement a standardised tool to support midwives and clinicians to safely and effectively assess women when they attend with clinical concerns.	Clinical lead - maternity	31/03/2026		O	Report of review to Women's Quality Assurance Group and Quality Assurance Committee.	Clinical Director	30/09/2026

2. Ensure that where equipment or medicines are supplied by the Trust, there are sufficient quantities of these to ensure the safety of service users and to meet their needs. 12(2)(f)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
2.1 (Mat)	Procure additional CTG machines and distribute these across the service.	General Manager, Women's Services	31/12/2025	30/09/2025	C	All additional CTG machines purchased and operational.	Director of Operations	31/03/2026
2.2 (Mat)	Develop and implement a CTG asset inventory and process of escalation.	Fetal Monitoring Midwife Team	31/12/2025		C	System to track equipment implemented and staff trained. All instances of CTG not being available recorded on Datix.	General Manager, Women's Services	31/03/2026

3 Ensure the proper and safe management of medicines. 12(2)(g)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
3.1 (Mat)	Implement a joint action plan with Medicines Management following review of all elements of the medication storage, to improve medicines safety.	Matrons, Women's Services	01/09/2025	01/09/2025	C	Medicine Safety Audits and Checks: Daily checklists and audits are systematically carried out to ensure the safe storage, handling, and administration of medicines.	Deputy Heads of Midwifery	30/09/2026
3.1 (Neo)		Neonatal Matrons, Children's Hospital	01/09/2025	01/09/2025	C	Findings from assurance visits will be shared with ward managers at the time of visit, with any required actions logged and tracked centrally. Monthly compliance reports	Deputy Head of Nursing	31/12/2025

						will be reviewed by the Medicines Governance Group, and persistent issues escalated through clinical governance structures		
3.2 (Neo)	Embed a process to provide assurance that medicines management standards are being maintained and managed in line with the Medicines Code to improve medicines safety.	Matrons, Women's Services	31/12/2025	31/12/2025	C	Evidence of assurance reviews and reporting of findings including, where applicable, actions to address non-compliance through Speciality Forum. Neonatal – RPIW week with Medicines Management completed, Assurance visits from MMPS team with completed action plans, weekly medication audit of medication practice and storage, reconfiguration of medication rooms and implementation of the Medicine Storage and Security – Staff Responsibilities document.	Deputy Heads of Midwifery	31/03/2026
3.2 (Neo)		Neonatal Matrons, Children's Hospital	31/12/2025		C		Deputy Head of Nursing	31/03/2026

4. Ensure the Trust has consistent and effective systems to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. 12(2)(h)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
4.1 (Mat)	Conduct team briefings led by Ward Managers focusing on IPC practice and responsibilities.	Matrons, Women's Services	31/12/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Audit of completion rates	Deputy Heads of Midwifery	31/03/2026
4.2 (Mat)	Monitor compliance with hand hygiene, uniform, and "I am clean" sticker use to be checked weekly using a standardised IPC audit tool.	Matrons, Women's Services	31/12/2025		C	Compliance with IPC audit tool Ward metrics Monitored as part of the weekly matron's assurance checks and reviewed in matrons meeting. To complete an audit and report to evidence and assure.	Deputy Heads of Midwifery	31/03/2026
4.3 (Neo)	Establish and maintain decluttering logs on each unit ensuring estates receive monthly reports on waste storage issues for action.	Neonatal Matrons, Children's Hospital	31/12/2025		C	Decluttering logs Escalation to Estates Established a new off unit storage area for equipment. Implemented a surgical stock rotation process on L43 Audit of stock and clutter incorporated into Matron Assurance Visits and Quality Team Reflective Walks.	Deputy Head of Nursing, Children's Hospital	31/03/2026
4.4 (Neo)	Create check and challenge stations at entrances to each unit to ensure all families and visitors are following IPC guidance.	Neonatal Matrons, Children's Hospital	31/12/2025		C	Compliance of unannounced spot checks reported in weekly IPC huddles. Recurring issues will be tracked and escalated through the IPC governance framework Check and challenge incorporated into ward clerk work station due to proximity to entrance. Implementation of Water Wise programme works commencing January 2026 will include revised check and challenge process once completed, estimated April 2026.	Deputy Head of Nursing, Children's Hospital	31/03/2026
4.5 (Neo)	Fully integrate a hand hygiene audit process into both the daily and monthly Matron Assurance frameworks across all clinical areas. Use this mechanism to provide real-time feedback and identify non-compliance trends, aiming for ≥95% hand hygiene compliance by November 2025.	Neonatal Matrons, Children's Hospital	30/11/2025		C	monthly dashboards and include hand hygiene as a standing discussion item in clinical governance meetings. Hand Hygiene audit incorporated into the monthly matron assurance template, weekly hand hygiene audits performed during neonatal IPC audits, peer hand hygiene audit monthly performed monthly by a ward leader from another ward, ad hoc hand hygiene audits supported by the Trust IPC team. Discussed at monthly IPC meeting, to be added to gov meeting quarterly.	Deputy Head of Nursing, Children's Hospital	30/04/2026

5. Ensure that where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. 12(2)(i)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date

5.1 (Neo)	Implement a daily multidisciplinary review process for all neonatal transfers (incoming, outgoing, and within-unit level of care changes), ensuring full compliance with the Transfer SOP and neonatal unit criteria.	Neonatal Matrons, Children's Hospital Neonatal Clinical Lead	01/07/2025	01/07/2025	C	Audit compliance weekly for the first 3 months, then monthly, with documented actions taken where deviations occur. Track trends and improvements through quarterly governance reports to ensure sustained alignment with safety and quality standards. Monthly HRG report for SJUH submitted to Weekly Quality Meeting and CQC. (update Jan 25 now submitted monthly). Transfer SOP	Children's Hospital Tri Team	31/01/2026
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6. Ensure all premises and equipment are clean, secure, suitable, maintained and appropriately located. 15(1)								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
6.1 (Mat)	Update the Maternity theatres estate risk, mitigation and controls and complete a monthly review.	General Manager, Women's Services	30/06/2025	30/06/2025	E	Review of updated risk, mitigations and controls.	Director of Operations	30/11/2025
6.2 (Neo)	Complete a comprehensive, independent assessment of the neonatal unit premises aligned with national best practice guidelines (e.g., BAPM, NHS Estates).	Neonatal Matrons, Children's Hospital Neonatal Clinical Lead	31/01/2026		C	Premises Gap Analysis Report	Clinical Director General Manager Children's Hospital	30/04/2026
6.3 (Neo)	Conduct a unit-wide audit of all cot-side resuscitation equipment to ensure 100% compliance with Resuscitation Council UK standards. Re-audit quarterly and track findings in the unit's governance reports.	Neonatal Clinical Lead	31/01/2026 Amended on 02/01/2026 – new target date of 31/04/2026		O	Audit of all cot-side resuscitation equipment completed with Resuscitation Team. Procurement of NeoPuffs using MIS funding to improve space utilisation.		30/04/2026
6.4 (Neo)	Implement and embed a Standard Operating Procedure (SOP) for Estates Evacuation.	Clinical Lead, Neonates Estates and Facilities	30/09/2025	30/09/2025	C	Estates Evacuation SOP actively in use hospital-wide, including within our Neonatal Unit.	General Manager, Children's Hospital	31/12/2025
6.5 (Neo)	Complete all estate related jobs identified by CQC during inspection.	Neonatal Clinical Lead	30/06/2025	30/06/2025	C	100% of estates jobs logged and completed.	General Manager, Children's Hospital	30/11/2025
6.6 (Neo)	Implement a system to ensure all equipment is readily available, safe, and correctly stored, through comprehensive inventory, checks and storage including empowering staff through education on equipment management protocols.	Neonatal Matrons, Children's Hospital Neonatal Clinical Lead	31/12/2025		C	Equipment inventory New off unit storage facility secured, and equipment moved to new area. Band 7 portfolio established for equipment management with dedicated non-clinical time (23 hours per month) Equipment inventory completed Gap analysis presented to Children's Tri team and procurement engaged to address shortfalls. Incubators and Neopuffs on order SOP for decontamination of cardiac echo machine implemented Working group established for equipment management and monitoring following staff engagement.	General Manager, Children's Hospital	31/03/2026
6.7 (Mat) (Neo)	Review the safe storage of clinical waste and promote good storage and disposal practices.	Matrons, Women's Services and Children's Hospital	04/07/2025	04/07/2025	C	Review of Clinical Waste corridor storage with Estates and Facilities and Trust wide communication issued. Daily spot checks completed by Team leaders.	Deputy Heads of Midwifery	31/12/2025
6.8 (Mat)	Complete all estates related issues identified during the MSSP Diagnostic (CCTV and intercom, removal of Perspex barriers).	Deputy Chief Nurse	20/03/2025	20/03/2025	C	CCTV and intercom repaired and operational at Antenatal Delivery Unit and MAC LGI All Perspex barriers removed at SJUH and LGI	Director of Midwifery	20/06/2025

7. Ensure the Perinatal Services have effective governance systems and processes to assess, monitor and improve the quality and safety of the services.								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date

7.1 (Neo)	Conduct a leadership capability baseline assessment to develop targeted leadership development programs and establish a structured oversight and audit framework for senior nurses.	Neonatal Matrons, Children's Hospital Neonatal Clinical Lead	31/03/2026		O	Completed baseline assessment. Leadership development programme Base line review from peer leadership (assessed as strong leadership).	Tri Team, Children's Hospital	30/06/2026
7.2 (Mat)	Review and strengthen the Perinatal Leadership Team within the Women's Service Unit to create site specific leadership role, out of hours escalation and increased visibility.	Tri Team, Women's Services	31/12/2025		C	Revised structure showing site specific roles. Out of hours escalation process Increased visible leadership at both sites with schedule shared with CSU weekly.	Director of Midwifery Medical Director - Operations	31/03/2026
7.3 (Mat) (Neo)	Review the governance structure, reporting and escalation within the maternity and neonatal services, including the ToR and membership of the Perinatal Assurance Group.	Director of Quality Head of Quality Governance	31/12/2025		C	Revised structure and ToR for Perinatal Assurance Group	Chief Nurse	30/04/2026
7.4 (Mat)	Conduct open civility culture workshops focused on psychological safety and learning from incidents and patient experience.	Women's CSU Tri Team	31/03/2026		O	Schedule and agenda of workshops Feedback from staff	Director of Midwifery Medical Director - Operations	30/04/2026
7.5 (Mat)	Promote the Freedom to Speak Up Guardian, champions and routes of escalating concerns anonymously. Implement anonymous reporting mechanisms (e.g., Speak Up Guardians).	Women's CSU Tri Team	31/03/2026		O	Publicly share positive examples of improvements made due to staff feedback. Develop culture improvement KPIs within leadership performance metrics.	Director of Midwifery Medical Director - Operations	30/04/2026

8. Ensure the Perinatal Service has consistent and effective systems to ensure incidents are consistently reported, investigated appropriately and with lessons shared within and across services to prevent recurrence								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
9.1 (Mat)	Quality, Safety and Learning Team to share immediate learning and feedback from incident reviews through a monthly pack of quality, safety and learning information to be delivered to all areas.	Quality, Safety and Learning Lead, Women's Services	01/10/2025	01/10/2025	C	QSL Monthly Pack Audit of staff awareness of the pack	CSU Tri Team, Women's Services	31/01/2026
9.2 (Mat)	Develop and implement a weekly Perinatal Escalation Report to provide Executive level oversight of patient safety incidents within the Perinatal pathway.	Patient Safety and Quality Managers Governance Leads – Maternity and Neonatal Services	01/10/2025	01/10/2025	C	Weekly Perinatal Escalation Report Weekly Quality Review Meeting Minutes	Chief Nurse Chief Medical Officer	31/01/2026

9. Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed (Regulation 18) and that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12(2)(c)) within Maternity Services								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
9.1 (Mat)	Implement twice daily huddles (including attendance from Neonatal Service) and weekly staffing sitrep to mitigate any gaps for the week and week ahead. In addition to further use of bank and agency staff to mitigate short term risk.	Head of Midwifery Director of Midwifery	30/11/2025	01/09/2025	C	Staffing report to CQC as agreed. Weekly staffing sitrep	Chief Nurse	30/04/2026
9.2 (Mat)	Complete a workforce report for midwifery staffing and develop a workforce operational plan to achieve Birthrate plus recommendations and implement a quarterly workforce review.	Head of Midwifery Director of Midwifery	31/01/2026		Off	Completed workforce paper. Completed workforce operational plan. Report to Quality Assurance Committee	Chief Nurse	30/04/2026
9.3 (Mat)	Complete a full review of clinical education, review of skills and implementation of competency framework for all areas.	Head of Midwifery Director of Midwifery	31/01/2026		C	Complete review of clinical education with recommendations	Chief Nurse	30/04/2026
9.4 (Mat)	Complete a review of the Medical Workforce and produce a report outlining current staffing and future needs by November 2025, with implementation milestones defined through to March 2026.	Clinical Lead, Women's Services CSU	30/11/2025 Amended on 02/01/2026 – new target		C	Completed Medical Workforce paper	Clinical Director Deputy Chief Medical Officer (Workforce)	31/01/2026

			date of 30/03/2026					
9.5 (Mat)	Finalise and embed the medical escalation process in alignment with BSOTS (Birmingham Specific Obstetric Triage System), ensuring 100% MAC rostering compliance.	Clinical Lead, Women's Services CSU	30/11/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Medical Escalation Process aligned to BSOTS 100% compliance with BSOTS evidenced within MIS	Clinical Director Deputy Chief Medical Officer (Workforce)	28/02/2026
9.6 (Mat)	Conduct a full review of consultant roles and responsibilities and introduce a monthly reporting cycle on escalation response effectiveness, incident trends, and staff feedback.	Clinical Lead, Women's Services CSU	30/11/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Completed review of consultant roles and responsibilities Review of job plans Established monthly reporting cycle	Clinical Director Deputy Chief Medical Officer (Workforce)	28/02/2026
9.7 (Mat)	Complete a risk assessment regarding safe staffing requirements and impact on the services ability to prioritise training.	Head of Midwifery Clinical lead - maternity	31/12/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Completed risk assessment outlining mitigation and controls.	Chief People Officer	31/03/2026
9.8 (Mat)	Complete a full-service wide review of training and training needs analysis developed for all staff groups aligned to workforce priorities and strategy.	Women's CSU Tri Team	31/12/2025 Amended on 02/01/2026 – new target date of 30/03/2026		O	Training needs analysis	Chief People Officer	31/03/2026
9.9 (Mat)	Review the support provided to newly qualified midwives, including the programme of induction and preceptorship to enable them to carry out their roles.	Head of Midwifery	31/12/2025	01/11/2025	C	Report to Women's Quality Assurance Group on the review of support provided to newly qualified midwives. Monitoring of 24/7 support to newly qualified midwives	Director of Midwifery	31/03/2026
9.10 (Mat)	Review the current Professional Midwifery Advocate (PMA) role and service, including dedicated time and support to undertake the role. Develop and embed a PMA strategy to address the findings of the review and implement recommendations.	Head of Midwifery	31/01/2026		OFF	Completed PMA review – assurance recommendations have been implemented.	Director of Midwifery	30/04/2026
9.11 (Mat)) (Neo)	Establish a programme of clinical visits and listening events for staff (midwifery and neonates) to engage them in service developments and improvements	Head of Midwifery Head of Nursing (neonates)	31/01/2026		C	Programme of visits and listening events – maternity and neonates	Chief Nurse	30/04/2026

10. Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed (Regulation 18) and that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12(2)(c)) within Neonatal Services

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
10.1 (Neo)	Ensure all medical rotas (Tier 1, Tier 2, and Consultant) are reviewed against the British Association of Perinatal Medicine (BAPM) standards, thereby optimizing staffing levels, enhancing patient safety, and contributing to the overall objectives of the Quality Improvement System (QIS) action plan.	Neonatal Clinical Lead	30/11/2025		C	All posts recruited to – rota BAPM compliant – both sites covered 24/7 by separate consultants	Clinical Director, Children's Hospital	31/03/2026
10.2 (Neo)	Develop SOP for escalation and management of gaps on medical rotas	Neonatal Clinical Lead	30/11/2025		C	SOP for escalation and management of gaps on medical rotas developed and implemented.	Clinical Director, Children's Hospital	28/02/2026

10.3 (Neo)	Undertake a workforce review of Allied Health Professional (AHP) staffing levels at SJUH and LGI. Develop and implement a targeted recruitment and retention plan, including use of bank and agency support where needed, to ensure safe and effective service delivery.	CSU Tri Team, Children's Hospital	31/10/2025		C	Undertaken a workforce review and business case submitted. Recruited to Ockenden funding for AHP's Retention plan and targeted recruitment defined within business case and components that are non finance dependent implemented. Awaiting timeline for progression of business case. Suggest addition of a new action to track progress of business case.	Medical Director - Operations	31/01/2026
10.4 (Neo)	Review the Qualified in Speciality action plan to ensure year on year improvement of qualified neonatal staff.	Neonatal Matrons	31/03/2026		C	Reviewed plan. Staged training plan towards achieving QIS target	CSU Tri Team, Children's Hospital	30/09/2026
10.5 (Neo)	Audit the frequency and impact of registered nurse redeployment to and from the neonatal unit, with a focus on its effect on safety and neonatal capacity.	Deputy Head of Nursing, Children's CSU	30/11/2025 Amended to new target date 28/02/2026		C	Monitor patient safety incidents related to provision of mutual aid and impact on local staffing in the neonatal unit(s). Monthly review of staff re-deployment both to the neonatal unit and from the neonatal unit in place and triangulation with incident reporting.	CSU Tri Team, Children's Hospital	31/03/2026
10.6 (Mat)	Identify and implement protected time for Ward Leaders to enable delivery of key objectives.	Deputy Heads of Midwifery	31/12/2025		C	Compliance will be monitored through monthly workforce reporting	CSU Tri Team, Women's Services	31/03/2026

11. The Trust will complete targeted actions to improve quality standards within the safe domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
11.1 (Mat)	Review the process for the monitoring and escalation of mandatory and priority training.	Women's CSU Tri Team	31/03/2026		O	Evidence of compliance being monitored through Quality Assurance Groups. Report to Workforce Management Group and Workforce Committee	Chief People Officer	30/06/2026
11.1 (Neo)		CSU Tri Team, Children's Hospital	31/03/2026		O			30/06/2026
11.2 (Mat) (Neo)	Develop a process for the completion, oversight and reporting of the Maternity Incentive Scheme (MIS) to improve compliance with the safety actions and work towards full compliance.	Director of Midwifery Clinical Director, Women's Services	31/01/2026		C	MIS Lead appointed. Perinatal Assurance Reporting to Quality Assurance Committee. MIS session presented by NHS Resolution	Chief Medical Officer	30/06/2026
11.3 (Mat) (Neo)	Implement a process for oversight of MIS discretionary funding (year 7).	General Manager – maternity Associate Director of Finance	31/12/2025		C	Report to Finance and Performance Committee	Director of Finance	31/03/2026
11.4 (Mat) (Neo)	Develop a programme to implement the principles of Trauma Informed Care in Perinatal Services, with support from MIAs and leads at NHS England.	TBC	30/06/2026		O	Project plan for the implementation of Trauma Informed Care	Chief Medical Officer	30/09/2026

12. The Trust will complete targeted actions to improve quality standards within the effective domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
12.1 (Mat) (Neo)	Commission an independent review of MBRRACE perinatal mortality data based on the terms of reference developed by the Maternity and Neonatal Voices Partners and a family that has used our services ensuring a trauma informed approach.	Clinical Director	30/06/2026		O	Completed review presented at Quality Assurance Committee	Chief Medical Officer	30/09/2026
12.2 (Mat) (Neo)	Conduct a review of Trust neonatal mortality and antenatal pathways to ensure alignment with SBL v3 requirements.	Clinical Lead, Obstetrics and Neonates	31/12/2025 Amended on 02/01/2026		O	NHS England Peer Review Perinatal Assurance Report Alan Fenton identified as Lead for the review.	Clinical Director	31/03/2026

			to new target date 30/04/2026			TOR for review at Perinatal Improvement Assurance Committee in January 2026.		
12.3 (Mat)	Review relevant policies to ensure guidance is available for staff for patients that do not attend antenatal appointments.	Deputy Heads of Midwifery	31/12/2025		C	Antenatal Guideline which includes a section on DNA in all areas of maternity services. Report to Quality Assurance Group, Women's	Director of Midwifery	31/03/2026
12.4 (Mat)	Develop an action plan in response to a letter of concern from the NHS England Antenatal Screening Programme.	General Manager, Women's Services	31/12/2025		C	Report to Clinical Effectiveness and Outcomes Group. Action plan developed and shared at CEOG Actions and progress reviewed by NHSE who are assured re progress. MIA undertaking review of full screening pathway to support any further work.	Chief Medical Officer	31/03/2026
12.5 (Mat)	Review the trust current compliance with the Royal College of Obstetrician Good Practice guidance related to the Birmingham Symptom-specific Obstetric Triage System.	Clinical Lead, Obstetrics	31/03/2026 Amended on 02/01/2026 to new target date 30/03/2026		O	Report on compliance to Women's Quality Assurance Group and Quality Assurance Committee	Clinical Director	30/06/2026

13. The Trust will complete targeted actions to improve quality standards within the caring domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
13.1 (Mat)	Complete a review of the current complaint processes and pathways within Women's Services.	Director of Midwifery	31/12/2025 Amended on 02/01/2026 to new target date 30/06/2026		O	Complaints and PALS SOP approved July WQAG. Review of impact of birth traumas on patient experience and the person's perception of their labour (included in PSIRP) – implementation of recommendations.	Chief Nurse	31/03/2026
13.2 (Mat Neo)	Work with service user representatives and Maternity and Neonatal Voices Partners (MNVP) to co-design and participate in staff training, simulation, and QI initiatives, including Through My Eyes events.	Head of Midwifery Deputy Head of Nursing (neonates)	31/12/2025		C	Schedule of events and participation Service User feedback	Director of Midwifery	31/03/2026
13.3 (Mat Neo)	Work with service user representatives and Maternity and Neonatal Voices Partners (MNVP) to co-design a programme of listening events with women and families who use maternity and neonatal services	Head of Midwifery Deputy Head of Nursing (neonates)	31/01/2026		C	Programme of listening events Report to Quality Assurance Committee The service correlates information on people's experience from complaints, compliments, friends and families, compassion audits and MNVP feedback to identify themes and trends and uses this as an opportunity to improve.	Chief Nurse	30/06/2026
13.4 (Mat)	Ensure the MNVP is a core member of Women's Quality Assurance Group, Maternity and Neonatal Safety Champions meetings and included in key midwifery recruitment to ensure the patients voice is represented.	Head of Midwifery	31/12/2025	31/12/2025	C	MNVP core member of WQAG, Maternity Safety Champions	Board Maternity Safety Champion	31/03/2026
13.5 (Mat) (Neo)	Review and update the Trust's Handbook for Bereaved Parents, co-produced with service users with relevant lived experience.	Bereavement Midwives Neonatal Matrons	31/03/2026		O	Updated handbook for Bereaved Parents Bereavement checklist and resources in place. SOP for families taking babies home, including hospice liaison, cuddle cot governance, and police notification guidance	Head of Midwifery	30/06/2026
13.6 (Mat)	Review the role of the Board Maternity Safety Champion.	Deputy Chief Nurse	31/01/2026		C	Report to Quality Assurance Committee and Board	Chief Nurse	30/04/2026

14. The Trust will complete targeted actions to improve quality standards within the responsive domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
14.1 (Mat)	Review the availability and effectiveness of cell salvage for Maternity Theatres at LGI.	Quality, Safety and Learning Team lead	31/03/2026		C	Additional cell salvage equipment purchased by T&A Risk added to the risk register. Staff advised to report all incidents related to cell salvage availability. Cell salvage a standard agenda item on Maternity and Neonatal Safety Champions agenda	General Manager, Women's Services	30/06/2026
14.2 (Neo)	Neonatal clinical and management leads to continue to work with the Neonatal Operational Delivery Network (ODN) to agree cot designation, in conjunction with Specialist Commissioners. Implement the recommendations set out in the neonatal peer review report (published October 2025).	Neonatal Matrons, Children's Hospital Neonatal Clinical Lead	30/06/2026		O	Weekly report of HRG level care days being provided at SJUH, reported monthly to CQC. Documented discussions with Neonatal ODN and NHS England Specialised Commissioning. Compare current commissioned capacity against demand, patient flow trends, and projected requirements. Draft evidence-based recommendations for cot numbers, designations, and configuration and incorporate recommendations into the formal options appraisal for neonatal care at LTHT. ODN have agreed	Clinical Director, General Manager, Children's Hospital	30/09/2026
14.3 (Mat) (Neo)	Review the future service configuration at LGI and St James's locations for maternity and neonates following the Secretary of State announcement about new hospital buildings, including the risk controls and mitigations.	General Manager – maternity and neonates Director of Operations	31/03/2026 Amended to new target date 30/06/2026		O	Risk controls and mitigating actions – maternity and neonatal risk registers	Chief Operating Officer	30/09/2026
14.4 (Mat) (Neo)	The Trust Communications and Estates teams to bring the unique identity and wayfinding standard for maternity areas to the same standard as The Children's Hospital.	Communication Leads	30/06/2026		O	Improved Wayfinding Signage at LGI / SJUH to ensure consistency across city. Installed welcoming and inclusive wall vinyls.	Associate Director of Communications	30/09/2026

15. The Trust will complete targeted actions to improve quality standards within the well led domain and areas for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).								
Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method and measures of assurance	Responsibility for monitoring/ oversight	Planned review date
15.1 (Mat)	Establish a leadership programme for the senior midwifery team to support ongoing development and succession planning	Director of Midwifery	31/03/2026		O	Structured professional development pathways and mentoring will be developed	Chief Nurse	30/06/2026
15.2 (Mat)	Review and strengthen the Perinatal Leadership Team within the Women's Clinical Service Unit to create site specific leadership role and increase visibility.	Director of Midwifery	31/12/2025	31/12/2025	C	Revised structure – including additional Deputy HoM, Additional Matron, Deputy CD and additional senior roles funding the MIS discretionary funding.	Chief Nurse	31/03/2026
15.3 (Mat) (Neo)	Undertake a review of the maternity and neonatal management arrangements (CSUs) to establish a fully integrated perinatal pathway and service.	Director of Operations (maternity and neonates)	31/03/2026		O	Report of perinatal pathway and management review.	Chief Operating Officer	30/09/2026
15.4 (Mat) (Neo)	Schedule a session facilitated by NHS Resolution on completion, reporting and declaration of the Maternity Incentive Scheme.	Head of Quality Governance	31/01/2026		C	Session scheduled with key team members. Session slides	Chief Nurse Chief Medical Officer	30/04/2026
15.5 (Mat) (Neo)	Review the requirements of MIS and current reporting mechanisms to ensure compliance with safety action 9 (Board assurance on maternity and neonatal, safety and quality issues).	Director of Midwifery	31/12/2025	31/12/2025	C	Report to Women's Quality Assurance Group and Quality Assurance Committee	Chief Nurse	30/04/2026
15.6 (Mat) (Neo)	Through appraisals liaise with KPO to incorporate Leeds improvement Method training into personal development plans	Head of Midwifery	30/06/2026		O	Increase in numbers of CSU trained staff. Increase in the number of QI projects within the CSU	General Manager, Women's services	30/09/2026

	supported by funding from the MIS discretionary fund.							
15.7 (Neo)	Complete a service review, needs assessment, resource planning and implementation plan to optimise the psychological support available to the neonatal team by reviewing current services and redesigning deployment of the 1.352 WTE Children's Hospital Psychologists for maximum impact.	Principal Clinical Psychologist	31/12/2025 Amended on 04/01/2026 to new target date 30/04/2026		O	Report to Children's Hospital Quality Assurance Group, which details a sustainable, evidence-based deployment model for the Children's Hospital Psychologists that demonstrably improves neonatal team wellbeing, reduces stress-related absenteeism, and enhances overall team performance.	General Manager, Children's Hospital	31/03/2026
15.8 (Mat)	Review Director of Midwifery portfolio, focus on maternity and neonates and how this is aligned to the Chief Nurse team.	Deputy Chief Nurse	30/11/2025	01/11/2025	C	Leadership structure review – report.	Chief Nurse	30/06/2026
15.9 (Mat)	Review the maternity governance framework, including the routes of assurances from specialty/CSU to QAC and Board.	Governance lead clinician (maternity)	31/01/2026		O	Report to Women's Quality Assurance Group and Quality Assurance Committee	Clinical Director (maternity)	30/06/2026
15.10 (Mat) (Neo)	Review the findings and recommendations in the MSSP Equity, Diversity and Inclusion (EDI) diagnostic report to ensure the principles of EDI are embedded to promote safe, respectful and culturally responsive care for all families. Focus on: - Improving ethnicity/language/race data completeness - Real-time multilingual service user feedback - Safety culture and anti-racism training - Maternity and neonatal Advisory Panel with service users - Expand Continuity of Carer for Core20PLUS5 groups - Embed EDI into maternity and neonatal governance framework, including patient safety incident reviews. - Embed inclusive leadership competencies into senior roles.	Head of Midwifery Head of Nursing (children's) Deputy Director of HR	31/03/2026		O	Report to Workforce Committee and Quality Assurance Committee Implementation of actions in response to EDI review.	Chief People Officer	30/09/2026
15.11 (Mat)	Review the current process for the receipt, data capture and completion of subject access requests including consideration of use of roles approved through MIS funding to support the data capture and also process of staff support for those named in or providing information.	Quality, Safety and Learning Team lead. General Manager – Women's Services	31/01/2026		OFF			
15.12 (Mat)	Review the current process for the receipt, assessment and completion of freedom of information requests including consideration of use of roles approved through MIS funding and where necessary psychological support for staff.	Quality, Safety and Learning Team lead General Manager – Women's Services	31/01/2026		OFF			
Trust wide action related to improving well led quality standards is included in the LTH Improvement Plan.								