

10-Point Plan for Maternity & Neonatal Services

How to Use This Template



The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England is the responsibility of each organisation and trusts must demonstrate compliance with the 10 Point Plan.

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission pro

Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may span more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: <https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

- 1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
- 2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
- 3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
- 4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
- 5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:
Report prepared by:
Report date:
Reporting period covered:

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance				
Action		Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule		1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level		3	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care		2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes		3	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services		7	1	0	1	5
7. Trust review of homebirth services		2	0	0	2	0
8. Responding to incidents, complaints and concerns with humanity and candour		3	0	0	1	2
9. Deliver safe and effective triage in maternity services		3	0	0	3	0
10. Post death care		2	0	0	1	1

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference <i>Please input reference number as listed in 3. Evidence Log tab</i>	Gaps in Assurance <i>Please provide detail of any gaps in assurance</i>	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	EV-34 EV-35 EV-36	Not fully implemented in Maternity	To progress implementation of Martha's Rule in maternity and develop components 2 and 3 decision tree.	Martha's Rule established in Neonates (EV-36), supported by Leeds Inpatient Outreach Nursing Service (LIONS). Not established fully in maternity services - elements 2 and 3 progressing. Working Group with relevant stakeholders established. Existing structures such as e forms on PPM will be utilised. To ensure robust Patient Wellness Assessment materials (element 1) and cross-service as well as service specific escalation pathways are in place for full roll out of Martha's Rule across maternity and neonatal services. NHSE published resources to support implementation 12 August 2026; webinar arranged 22 September 2026. (EV-34, EV-35).
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						

2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01 EV-59	Require the perinatal triangulation and learning (TAL) meeting to be embedded to ensure there is robust analysis Data collection is reviewed monthly, reporting is currently bi-monthly	Formalise monthly MNVP/Cons midwife reporting out of patient experience and feedback - generate evidence of meeting and actions to report into WQAG. Ensure systems in place to support discussion of this at TAL	MNVP and birth reflections report monthly into WQAG where this is discussed and actions taken where necessary. Health equity cons midwife/MNVP/Comms manager meet monthly to review pat ex data and generate actions for teams etc. Currently no formal report out of this meeting. PIAC reporting demonstrates routine review of patient experience, outcomes and clinical audit data, inc MNVP Work Plan & highlight reports, CQC Action Plan, Health Equity & Birth Reflections Quarterly Report, FFT and complaint data (EV-01) Maternity TAL Forum demonstrates quarterly cycle of reviewing the latest available maternity and neonatal clinical audit and patient outcome & experience data (EV-59) - meeting not yet fully embedded
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-02 EV-57	Robust evidence that Board regularly publish a summary report that demonstrates decisions, actions, scrutiny	To ensure summary report published by Board details as required	Pat ex Report provided to the Board bi-monthly via PIAC alongside progress against the Perinatal Improvement Plan. PIAC Chair's Summary report available within the Public Board Papers - tracking of progress and impact delegated to PIAC with escalation to the Board as required. PIAC papers and minutes evidence board-level reporting. scrutiny and oversight of actions (EV-02)
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-03 EV-37	No current mechanism in place to robustly identify variations in outcomes by ethnicity and deprivation. FFT does not detail this information. PREM (patient reported experience measure) will support this when in place.	Implement MATDAT tool across maternity services and continue analysis via National Health Inequalities dashboard (split by Trust to show outcome data, by IMD and ethnicity) Strengthen triangulation of learning via TAL group to inform action planning and targeted, focused work Provide evidence of work planning and enaction via PIAC to Board.	Targetted focus groups with MNVP and Health Equity Team identifies this information which is detailed in the PIAC Paper and Slides and pat ex report (EV-03) The MATDAT SBAR will provide additional evidence of variation by geography, social complexity and vulnerability, and sets out proposed actions to standardise risk assessment and improve equitable access to enhanced care. (EV-37), once implemented (pilot to commence) Use of National and local (PLIC) Health Inequalities Dashboard that shows trust outcome data split by IMD and ethnicity is supportive CSU Health Inequalities dashboard used by Health Equity team to support informaiton provided to PIAC, awaiting PIAC and Board feedback as to efficacy.
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						

3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	EV-14	None	None	Chief Nurse and Chief Medical Officer established as accountable officers, which is documented within the PIAC Terms of Reference (EV-14).
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV-04 EV-12 EV-29	Director of Midwifery (DOM) currently vacant and under recruitment. Clinical Director (CD) attends PIAC. CD for neonatal services does not attend	Confirm maternity and neonatal CD and DOM attendance at Board and/or PIAC Newly appointed perinatal DON to attend	PIAC has delegated authority from Trust Board (EV-13) Clinical Director for maternity and HOM (in DOMs absence) have attended PIAC - attendance currently under review (EV-04) ToRs for PIAC show DOM and maternity CD as members (EV-29)- however this is changing and CD will no longer be attending PIAC. Head of Midwifery attends Board to present perinatal improvement plan and MIS progress. This will be presented by DOM when in post.
4. 'Amos into action' staff listening exercise (NHSE Action)						
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant	Chair Summary report awaited from September PIAC	Plans progressing - for Chairs Summary report to Board to evidence	To ensure staff attendance at PEADP programme	Plans are in place to support attendance at PEADP programme
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-05	Report not currently provided to Board that specifically focuses on trends identified by the inequalities dashboard.	Develop reporting mechanism that clearly defines analysis and service response to inequalities data	Pat ex report demonstrates evidence against health inequalities and targeted work around this which is presented to PIAC and evidenced in the Chair's report to Board. PIAC reporting on HI data and subsequent workstreams strengthened from Sept 2026 onwards. PIAC pat ex reports demonstrate review of inequalities
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-06 EV-15	Implementation plan developed, to be approved September 2026.		MCB Implementation Plan drafted. Report and plan to be presented for approval to PIAC in September 2026 (EV-15) PIAC papers evidence oversight of the Maternal Care
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-39	none	none	The Trust is fully compliant with the RCOG standard, with April–June 2026 data demonstrating at least 80% consultant presence in defined acute care situations (EV-39).
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Not applicable	EV-30	n/a	n/a	Not applicable: the Trust does not currently employ any short-term locums (two weeks or less) on tier 2 or 3 obstetric rotas, so a short-term locum database is not required. Longer-term locums have been appointed to substantive posts. A standard operating procedure is in place for the management of short-term locums should they be engaged. (EV-30)

6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? <i>(In line with MIS Year 8)</i>	Compliant	EV-16 EV-17 EV-18	none	none	The neonatal nursing and medical establishment is fully funded against BAPM standards, with workforce oversight through PIAC and daily staffing monitoring through the SitRep process (EV-16, EV-17, EV-18)
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? <i>(In line with MIS Year 8)</i>	Compliant	EV-19 EV-20 EV-21 EV-22 EV-23 EV-24	none	none	The funded midwifery establishment is supported by a current Birthrate Plus review, recommissioned workforce assessment and establishment data, with ongoing oversight through PIAC workforce reporting (EV-19 to EV-24).
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? <i>(In line with MIS Year 8)</i>	Compliant	EV-25 EV-26	none	none	Duty anaesthetist and trained anaesthetic assistant rotas demonstrate 24/7 cover across LGI and SJUH in line with the relevant ACSA standards (EV-25 and EV-26).
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-07 EV-27	none	none	PIAC papers and the bi-annual workforce report provide board oversight of workforce acuity, staffing pressures and clinical risks across maternity and neonatal services, including escalation and mitigating actions to maintain safe and responsive care (EV-07 and EV-27).
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	EV-08 EV-13 EV-28	Internal resource deployment, including redirection of roles to support frontline delivery and staffing investment not reported directly to Board (assurance provided to PIAC, a formal committee of the Board).	Confirm Board review	This function has been delegated to PIAC from Trust Board (EV-13)- the PIAC papers and the bi-annual workforce report evidence consideration of internal resource deployment, redeployment risks and service resilience (EV-08 and EV-28). Redeployment occur on a daily basis to frontline services to meet acute needs. Evidenced in daily matneo sitrep reports
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant	EV-47	Trust Board has not received a specific report on a review of homebirth services. PFD submitted to NHSE 2025 which detailed LHTT review	Outcomes from Homebirth review with clear actions provided to PIAC and Board	Assurance re homebirth services provided to Quality Assurance Committee. Review of Home Birth Service underway and monitored via Perinatal Improvement Plan- work commenced with MIA regarding this and in view of Home Birth Standards Publication. PIAC received SBAR paper in February(EV-47)
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant	EV-60	Action plan to be developed, supported by MIAs.	Action plan to be incorporated into perinatal improvement plan and share with region	A working group has been established, supported by MIAs to manage risks associated with homebirth service. Perinatal Improvement Plan demonstrates on-going actions are described and monitored (EV-60).
8. Responding to incidents, complaints and concerns with humanity and candour						

8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-09 EV-49 EV-50 EV-51 EV-58	We are taking the opportunity to further strengthen our existing patient safety and quality assurance arrangements through the development of the next PSIRP and PSIRF Policy, due for publication in April 2027. In parallel, the Patient Safety and Quality Strategy is being refreshed to ensure continued alignment with NHS strategic priorities and the NHS England Quality Strategy. This will enhance the consistency, integration and oversight of our existing systems and provide a stronger framework for demonstrating assurance, learning and continuous improvement.	We are currently developing the next Patient Safety Incident Response Plan (PSIRP) and updating the Patient Safety Incident Response Framework (PSIRF) Policy, with the revised documents planned for publication in April 2027. Alongside this, we are updating the Patient Safety and Quality Strategy to ensure it continues to align with the NHS Long Term Plan/NHS strategic priorities, whilst also reflecting the NHS England Quality Strategy and the evolving national quality and patient safety agenda. As part of this we are conducting public engagement with our patients and the public to understand what matters to them, how they want us to respond and how we address inequalities.	Controls in place: LTHT Patient Safety Incident Response Plan 2024-27 LTHT Patient Safety Incident Response Framework Policy 2024-27 LTHT Quality Accounts published each year by 30 June LTHT Patient Safety and Quality Strategy 2024-27 aligned to NHS Patient Safety Strategy Reporting against Patient Safety and Quality Strategy twice a year to Board level Committee - Quality Assurance Committee Bi Monthly Patient Safety and Shared Learning Report - reported to Board level Committee - Quality Assurance Committee Established escalation process for Perinatal Patient Safety through to weekly Executive Led Quality Review meeting - this includes PMRT outcomes graded C or D, Referrals and reports from MNSI, notifiable incidents for review. Learning from Deaths report Reporting to PIAC - Board level Committee bi annual Feedback to Women and families as per incident reporting and being open policies.
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-10 EV-49 EV-50 EV-51	Following issuing of the Regulation 16 breach related to timeliness of complaint responses and separate improvement plan is being delivered. Part of this is to ensure meaningful, trauma informed conversations.	Embed new triangulation meeting to pull this together. A report will be received by WQAG as this becomes more established. Complaints improvement Plan.	Maternity and Neonates- PIAC reporting evidences thematic review of complaints and concerns, with oversight of learning and associated improvement actions (EV-10). LTHT Quality Accounts published each year by 30 June LTHT Patient Safety and Quality Strategy 2024-27 aligned to NHS Patient Safety Strategy Reporting against Patient Safety and Quality Strategy twice a year to Board level Committee - Quality Assurance Committee Bi Annual Patient Experience Report that flows to Board reported to Board level Committee - Quality Assurance Committee Established escalation process for all complaints that reference Patient Safety through to weekly Executive Led Quality Review meeting Reporting to PIAC - Board level Committee bi annual Feedback to Women and families as per complaints process and through in person complaints meetings.

8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	EV-38 EV-48	Whilst the Trust has in place systems and processes for being open, patient engagement following patient safety or complaint investigation we are aware that we have actions to deliver in relation to ensuring trauma informed feedback, provision of a key contact and timeliness of DoC.	Maternity processes are in place for duty of candour, compassionate debriefing and responding to complaints. Delays in completing these processes are recognised and are being reviewed through the Perinatal Improvement Plan. The Patient Safety Incident Review Education Plan includes a module on Patient Engagement. This will be implemented from 1 April 2027.	The Complaints and PALS SOP provides clear contact, communication, escalation and quality-assurance processes for responding to concerns raised by patients and families (EV-38). The perinatal mortality review SOP provides defined processes for parental feedback, named bereavement contact, compassionate debriefing, communication of review findings and actions, and completion of Duty of Candour requirements (EV-48).
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	EV-11 EV-31 EV-32 EV-33	Further validation of the benchmarking audit tool is required to review all outstanding findings before the audit can be formally approved and reported to the NHSE region. Submission deadline: 25/09/2026	Complete validation of the benchmarking audit tool, review and address all outstanding findings, obtain formal approval, and report the completed audit to the NHSE region by 25/09/2026.	The maternity triage benchmarking audit provides evidence on dedicated staffing, capacity, escalation arrangements, facilities and estates. Assurance remains partial while the audit tool is validated, all outstanding findings are reviewed, and formal approval and reporting to the NHSE region are completed (EV-11 and EV-31–33).
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV-12 EV-40 EV-41 EV-42	Validated routine data are not yet available for key triage measures, including waiting, assessment and review times, activity, delays, outcomes, redeployment and inequalities.	Develop validated routine reporting for triage activity, waiting and review times, delays, outcomes, staffing and inequalities, with findings reviewed through the established governance arrangements.	PIAC reporting and the benchmarking review provide some oversight of triage quality, staffing and capacity; however, robust routine performance and inequalities data are not yet available to demonstrate full board assurance (EV-12 and EV-31-33).
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV-43 EV-44 EV-45	BSOTS implementation is underway, but a formally approved implementation plan, milestones, full training and competency assurance, and validated measures of impact are still required.	Develop and approve a time-bound BSOTS implementation plan, including milestones, staff training and competency assurance, and measures to monitor implementation against national guidance.	BSOTS implementation and service redesign are underway, demonstrating progress towards national guidance. Full assurance requires an approved implementation plan, defined milestones, competency assurance and validated monitoring of impact (EV-31-33). Aiming to implement improvements by Sept 2027.
10. Post death care						

10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-53 EV-55	none	none	The Public Board considered and approved the Board Assurance Statement on 30 July 2026 for submission to NHS England by the 31 July 2026 deadline. The statement confirms Board review of the applicable Fuller recommendations, executive safeguarding oversight, mortuary governance arrangements and a timetable for the Premises Assurance Model (EV-53 and EV-55).
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	EV-53 EV-54 EV-56	Full compliance has not yet been demonstrated against all applicable Fuller Inquiry recommendations: 11 of 20 are fully compliant, seven partially compliant and two non-compliant.	Deliver and monitor the Care of the Deceased Improvement Plan through the weekly task and finish group, Quality and Safety Assurance Group and Quality Assurance Committee. Complete the historic HTA-reportable incident review and declaration, finalise the Premises Assurance Model submission, implement routine mortuary-to-Board reporting and close the outstanding Fuller, security, resilience and estate actions, with periodic assurance to the Trust Board.	The Board received a comprehensive post-death care assurance update on 30 July 2026 and delegated ongoing oversight of the improvement plan to the Quality Assurance Committee. The Fuller assessment provides partial assurance: 11 of 20 applicable recommendations are fully compliant, seven partially compliant and two non-compliant. A single improvement plan (delegated authority to QAC) assigns owners, target dates and governance routes for the outstanding actions, including routine reporting, security controls, operational resilience and estate requirements (EV-53, EV-54 and EV-56).



baseline assessment. Where a deliverable has already been reported as achieved in the baseline here any progress updates are required.

ty risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms

[illegible]

Evidence Log - Supporting Evidence Submission



The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	2.1	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 2.1	PIAC reporting demonstrates routine review of patient experience, outcomes and clinical audit data.	Strong
EV-02	2.2	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 2.2	PIAC papers and minutes evidence board-level reporting, scrutiny and oversight of actions.	Strong
EV-03	2.3	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 2.3	PIAC reporting identifies inequalities and variation, with actions informed by available insight.	Strong
EV-04	3.2	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 3.2	PIAC records evidence senior maternity and neonatal leaders contributing to governance discussions.	Strong
EV-05	5.2	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 5.2	PIAC reporting demonstrates review of inequalities data and oversight of resulting actions.	Strong
EV-06	5.3	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 5.3	PIAC papers evidence oversight of the Maternal Care Bundle implementation plan.	Strong
EV-07	6.6	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 6.6	PIAC reporting demonstrates board oversight of workforce pressures, acuity and escalation.	Strong
EV-08	6.7	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 6.7	PIAC papers evidence review of resource deployment, redeployment risks and service resilience.	Strong
EV-09	8.1	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 8.1	PIAC reporting demonstrates PSIRF governance, escalation and oversight of learning and actions.	Strong
EV-10	8.2	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 8.2	PIAC reporting evidences thematic review of complaints, learning and improvement actions.	Strong
EV-11	9.1	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 9.1	PIAC papers evidence board oversight of maternity triage audit, staffing and capacity.	Strong
EV-12	9.2	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 9.2	PIAC reporting demonstrates oversight of triage quality, performance, delays and outcomes.	Strong
EV-13	3.2	Board Minute	Trust Board Extract of Minutes	November 2025	Trust Board Administrator	10 Point Plan 3.2	Minute shows delegated authority of Trust Board to PIAC for MIS	Adequate
EV-14	3.1	PIAC ToRs	Trust Standing Orders inc ToRs	January 2026	Trust Board Administrator	10 Point Plan 3.1	The Trust Board has established joint accountability for maternity and neonatal services through the Chief Medical Officer, Chief Nurse and PIAC.	Strong
EV-15	5.3	MCB Plan & Report	MCB Implementation Plan & Board Improvement	September 2026	Programme Manager - Maternity Improvement	10 Point Plan 5.3	The draft Maternal Care Bundle implementation plan and accompanying PIAC report provide preliminary assurance that implementation is being planned and governed.	Limited
EV-16	6.3	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 6.3	The neonatal service is fully funded to bapm standards for medical and nursing and reported through established governance meeting	Strong
EV-17	6.3	Workforce Report	PIAC Bi-Annual Workforce Report	July 2026	CSU Tri-Team	10 Point Plan 6.3	The neonatal service is fully funded to bapm standards for medical and nursing and reported through established governance meeting	Strong
EV-18	6.3	Sample of SttRep	PIAC Bi-Annual Workforce Report SttRep	August 2026	CSU Tri-Team	10 Point Plan 6.3	Demonstrates that neonatal staffing levels are monitored and reported daily, providing timely oversight of the workforce position and enabling any staffing shortfalls, associated risks and required actions to be identified and escalated through the established operational and governance arrangements.	Strong
EV-19	6.4	Birthe+ review Report and slides	Birthe+ review Report and slides	August 2026	CSU Tri-Team	10 Point Plan 6.4	The Birthe+ Plus review report and slides provide the baseline assessment for the funded midwifery establishment and demonstrate that workforce planning has been reviewed against Birthe+ Plus methodology within the required timeframe.	Strong
EV-20	6.4	Birthe+ Quote for workforce planning & PO	Birthe+ Quote for workforce planning & PO	August 2026	CSU Tri-Team	10 Point Plan 6.4	The Birthe+ Plus quote and purchase order evidence demonstrate that workforce planning support has been commissioned to inform establishment planning and ensure the Trust has appropriate evidence to support compliance.	Strong
EV-21	6.4	Clinical Contracted Registered Midwives	Clinical Contracted Registered Midwives	August 2026	CSU Tri-Team	10 Point Plan 6.4	The clinical contracted registered midwives evidence provides the current funded clinical midwifery establishment, enabling comparison against the Birthe+ Plus baseline and supporting assurance that establishment levels are monitored.	Strong
EV-22	6.4	Non-clinical specialist & Management midwives	Non-clinical specialist & Management midwives	August 2026	CSU Tri-Team	10 Point Plan 6.4	The non-clinical specialist and management midwives evidence identifies additional midwifery roles that support the overall establishment and provides transparency on how specialist, leadership and management capacity is included within workforce planning.	Adequate
EV-23	6.4	Workforce Report	PIAC Bi-Annual Workforce Report	July 2026	CSU Tri-Team	10 Point Plan 6.4	The PIAC bi-annual workforce report provides governance oversight of the midwifery establishment, including workforce position, risks, progress against workforce planning actions and escalation through the Trust's assurance route.	Strong
EV-24	6.4	Board Report & Minutes	PIAC papers, slides & minutes	January to July 2026	Trust Board Administrator CSU Tri-Team	10 Point Plan 6.4	The PIAC bi-monthly reports, slides and minutes evidence ongoing review and scrutiny of the midwifery workforce position during the reporting period, demonstrating that workforce establishment, risks and associated actions are monitored through the established governance process.	Strong
EV-25	6.5	Duty anaesthetist rota	Sample of rota	August 2026	Lead Anaesthetist	10 Point Plan 6.5	The duty anaesthetist rotas for SJUH and LGI provide evidence that obstetric anaesthetic cover is identified across both hospital sites, demonstrating arrangements for a duty anaesthetist to be available 24/7 in line with ACSA standard 1.7.2.1.	Strong
EV-26	6.5	Anaesthetic assistant rota	Sample of rota	August 2026	Lead Anaesthetist	10 Point Plan 6.5	The anaesthetic assistant rotas for LGI and SJUH provide evidence that trained anaesthetic assistant cover is planned and available across both hospital sites, demonstrating arrangements to meet the requirement for 24/7 assistant availability in line with ACSA standard 1.3.1.2.	Strong
EV-27	6.6	Workforce Report	PIAC Bi-Annual Workforce Report	July 2026	CSU Tri-Team	10 Point Plan 6.6	The PIAC bi-annual workforce report provides assurance that workforce acuity, staffing pressures and associated clinical risks across maternity and neonatal services are reviewed through the Trust's governance arrangements. It evidences oversight of capacity, escalation and mitigating actions to support a safe and responsive service.	Strong
EV-28	6.7	Workforce Report	PIAC Bi-Annual Workforce Report	July 2026	CSU Tri-Team	10 Point Plan 6.7	The PIAC bi-annual workforce report provides assurance that internal resource deployment across maternity and neonatal services is reviewed through established governance arrangements. It evidences consideration of workforce pressures, redeployment risks, specialist-role resilience and mitigating actions required to maintain safe frontline service delivery.	Strong
EV-29	3.2	PIAC ToRs	Trust Standing Orders inc ToRs	January 2026	Trust Board Administrator	10 Point Plan 3.2	The PIAC Terms of Reference demonstrate that senior maternity and neonatal leaders, including the Directors of Midwifery and relevant Clinical Directors, are expected to attend and contribute to committee discussions when maternity and neonatal matters are considered, supporting effective board-level oversight and accountability.	Strong
EV-30	6.2	SOP for Locums	Procedure	August 2026	CSU Tri-Team	10 Point Plan 6.2	The Medical Locum Staffing SOP provides assurance that agency and locum doctors are subject to standard pre-employment checks, clinical review and approval, verification of relevant competencies and a documented induction before commencing work. It also defines supervision and escalation arrangements, supporting the safe deployment and governance of short- and longer-term medical locums.	Adequate

Evidence: examples



This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform. Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance. **Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.
	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Analytical reports
Action 2	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	- Board report and minutes - Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	- Board ToR - Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	- Job plans - Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	- Board report - Quarterly MIS thematic report - Equity dashboard reports - Core20PLUS reporting - Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	- Maternal Care Bundle implementation plans. - Board Report - MIS return
Action 6	6.1	Is the trust complying with the RCOG 'Roles and Responsibilities of the Consultant providing acute care' standard? In line with MIS Year 8 is there a minimum 80% consultant presence in defined acute care situations?	- Workforce plan - Biannual workforce papers - Staff experience survey - Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (x2 weeks) working on tier 2/3 obstetric rota? (In line with MIS Year 8)	Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	- Workforce plan - Biannual workforce papers - BAPM workforce standards compliance - Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	- BR+ review and workforce plan - Biannual workforce papers - Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	- Workforce plan - Biannual workforce papers - Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	- Board report and minutes - Biannual workforce papers - Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	- Board report and minutes - Biannual workforce papers - Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	- Board report and minutes - A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services - PSIRF implementation within Maternity and Neonatal Services, governance and review processes. - Process for sharing outcomes and learning from PSIRF reviews with women and families. - Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	- Board report and minutes - Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. - Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	- Board report and minutes - Debrief guidance - Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	Assurance statement
	10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	- Board Report - Review report

10-Point Plan: Our Progress

Maternity & Neonatal Services | Baseline position for ward and department teams | September 2026

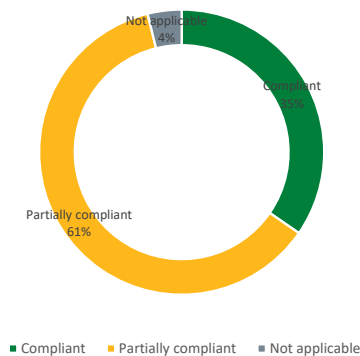
26
DELIVERABLES
REVIEWED

9
COMPLIANT

16
IN PROGRESS

0
NON-COMPLIANT

CURRENT COMPLIANCE STATUS



WHERE WE ARE NOW

- 25 applicable deliverables assessed
- 9 are fully compliant
- 16 have credible plans and evidence but further work remains
- 1 deliverable is not applicable
- 0 deliverables are currently rated non-compliant

Our focus is to convert established plans into consistently embedded practice and auditable Board assurance.

WHAT IS WORKING WELL

- ✓ Joint executive accountability is established
- ✓ Core 24/7 workforce and anaesthetic standards are met
- ✓ PSIRF governance and thematic complaints review are embedded
- ✓ Board assurance for post-death care was completed
- ✓ Evidence and governance routes are established across most actions

OUR NEXT PRIORITIES

- Complete Martha's Rule implementation in maternity
- Embed monthly triangulation of experience, outcomes and audit
- Strengthen inequalities analysis and evidence of resulting action
- Complete homebirth review actions and regional assurance
- Finalise triage audit, routine performance data and BSOTS plan
- Deliver outstanding post-death care improvement actions

Progress reflects the current Trust baseline assessment and will continue to be updated through established governance routes.