Leeds Teaching Hospitals NHS Trust Perinatal Transformation Programme		Date initiated	
		Date of Update	

Accountability		Responsibility	
Senior Accountable Officers: Chief Medical Officer/Chief Nurse/Chief Operating Officer		Lead	Oversight Group
Lead	**Oversight/governance structure**		
Medical Director – Women's and Children's Director of Operations – Women's and Children's Director of Nursing – Women's and Children's Director of Midwifery	Perinatal Improvement 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 CSU Quality Assurance Group Maternity and Neonatal Improvement Group(s)
Clinical Director, Heads of Midwifery, General Manager – Women's Services Clinical Director, Head of Nursing, General Manager – Children's Hospital	Perinatal Improvement Action Group		

Improvement Plan Aim	Phase 1 The aim of the Perinatal Improvement Plan was 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 The Perinatal Transformation Programme will deliver sustained improvement in the safety, quality and experience of maternity and neonatal care. It will provide a single, accountable framework for addressing regulatory requirements, strengthening safety culture and clinical practice, reducing unwarranted variation and improving outcomes for women, 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 Review of 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 Nottingham Independent Review – 18 immediate and essential actions AMOS National Investigation – 10-point plan Thirlwall Inquiry – recommendations and immediate actions
		CQC Regulation(s)	Regulation 12 Safe care and treatment Regulation 15 Premises and Equipment Regulation 17 good governance Regulation 18 staffing
		NHSE provider licence conditions	Provider licence conditions NHS2(2), (4), (5 B, C, E,F)

Aim	Objective Ref	Objective	Expected outcome	Assurance Mechanism	Executive Lead	Oversight Committee
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	Perinatal Improvement Assurance Committee (PIAC)
	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	PIAC
	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	PIAC

	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	PIAC
	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	PIAC
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	PIAC
	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	PIAC
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	PIAC
	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	PIAC
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	PIAC
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	PIAC
The Trust will complete targeted actions to improve quality standards within the caring domain and areas	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.	Chief Nurse	PIAC

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for improvement noted within the MSSP diagnostic within Maternity and Neonatal Services at Leeds General Infirmary and St James's University Hospital (SJUH).				Patient dignity audits (ward healthcheck). Complaints and PALS report to 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	PIAC
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).	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	PIAC

Status

NS	Not started
O	On track
Off	Off track
C	Complete
R	At risk

Neonatal Services Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
TA1	Agree and implement the future designation and configuration of neonatal services across St James's and LGI, including redesignation of ward J01 as a Local Neonatal Unit, expansion of LGI capacity to 28 cots and reopening of Transitional Care.	Neonatal Matron, J01 Neonatal Clinical Lead	31/10/2027	O	Approved service model and transition plan; BAPM workforce gap analysis and recruitment plan; guidelines and procedures reviewed; estate and equipment risks mitigated; 28 cots operational; Transitional Care reopened; reduction in avoidable transfers between LGI and SJUH.	Head of Nursing, Children's Hospital	
TA2	Agree and implement a sustainable and inclusive neonatal workforce model that meets service requirements, agreed specifications and BAPM standards	Matron, L43 Lead Nurse for Education and Workforce	28/02/2028	R	BAPM workforce gap analysis and approved workforce plan; QIS compliance of at least 70% for eligible staff; statutory and mandatory training of at least 90%; workforce turnover monitored; staff feedback demonstrates improved access to education and support.	Deputy Head of Nursing	
TA3	Undertake a review and develop a strategy to build an inclusive neonatal workforce with equitable access to education, leadership, research and career development, supporting safe, high-quality care.	Matron, L43 Neonatal Clinical Lead	31/12/2027	O	Annual training-needs review across all staff groups; current appraisal and development plan for all staff; equitable access to leadership and research opportunities; approved neonatal research strategy and delivery plan; increasing workforce research capability and participation.	Deputy Head of Nursing	
TA4	Reshape the neonatal working culture and support model around psychological safety, inclusion, wellbeing, shared decision-making and continuous learning.	Matron, L43 Neonatal Consultant (NM)	30/11/2027	O	Integrated staff and family psychological-support model; Shared Decision-Making Council meets at least quarterly; at least 80% of wellbeing actions completed on time; stress-related absence and staff-experience measures monitored.	Deputy Head of Nursing	

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TA5	Undertake a review and agree actions to improve neonatal staff facilities, wellbeing and workplace culture through systematic use of national and local staff feedback.	Matron, L43	31/03/2028	O	All staff facilities and rest areas reviewed; agreed priority improvements delivered on time; psychologically safe listening reaches roles, sites and shifts; actions co-produced with staff and progress reported quarterly; staff satisfaction and workplace-experience measures improve.	Children's Tri-Team	
TA6	Establish integrated neonatal and perinatal pathways that provide timely access, reduce avoidable delay and transfer, minimise unwarranted variation and improve outcomes and experience for babies and families.	Neonatal Clinical Lead	31/12/2027	O	Capacity, demand and flow reviewed routinely; compliance with escalation pathways monitored; off-pathway escalation recorded; refusals, delays and avoidable transfers reduce; pathway-focused improvement projects reviewed quarterly; urgent theatre transfers and transitions to children's services monitored; family and staff experience reviewed.	Children's Tri-Team	
TA7	Undertake a review of neonatal estate and develop a procedure to provide a safe, sustainable neonatal estate and environment aligned with service need, capacity, demand and infection-prevention requirements.	Neonatal Clinical Lead Matron, J01	30/09/2028	O	All neonatal areas reviewed against relevant Health Building Notes; critical equipment serviced on time; Water Wise practice and training embedded across all areas; estate, equipment and infection-prevention actions reviewed routinely; healthcare-associated infection and Serratia trends monitored.	Children's Tri-Team	
TA8	Complete the Perinatal Equity and Anti-Discrimination Programme - agree a framework to deliver inclusive, person-centred neonatal and perinatal care that responds to each baby's and family's needs, promotes equity, prevents discrimination and supports personalised care.	Neonatal Consultant (AF) Neonatal Consultant (LB)	31/03/2028	O	Participation in the Perinatal Equity and Anti-Discrimination Programme; at least 90% completion of relevant equity, inclusion and family-care training; key information available in accessible formats; identified communication needs met; equity themes and outcomes reviewed quarterly; service-user forum meets at least quarterly.	Deputy Head of Nursing	
TA9	Develop a framework to enable families to be active partners in their baby's care through Family Integrated Care, shared decision-making, practical support, secure access and inclusive research participation, supported by the delivery of Family Integrated Care training.	Neonatal Consultant (AF)	31/12/2028	O	Publication of framework. At least 90% of relevant staff complete Family Integrated Care training; families report confidence in participating in care; secure access operational at agreed entry points; equitable research opportunities offered; all families receive information and support for shared decision-making; meal access, overnight amenities and family feedback reviewed quarterly.	Children's Tri-Team	
TA10	Develop a framework to provide effective neonatal governance related to patient safety incident management, timely escalation, sharing learning, openness and continuous improvement, to investigate and respond to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach, in line with the actions set out in the 10-point plan (NHSE, August 2026).	Neonatal Governance Consultant Neonatal Governance Lead Nurse	31/12/2027	O	Publication of governance framework. Patient safety incidents escalated within 24 hours; at least 95% of reviews completed within the agreed timeframe; family involvement recorded in eligible reviews; at least 90% of learning actions completed on time; complaints performance reviewed monthly; Duty of Candour compliance assured.	Children's Tri-Team	
TA11	Implement Martha's Rule across neonatal services, in line with the actions set out in the 10-point plan (NHSE, August 2026) to improve engagement and communication with families so they can raise concerns and access timely independent clinical review.	Neonatal Governance Lead Nurse Neonatal Matron, L43	31/05/2027	O	Families informed of escalation routes; at least 90% of relevant staff trained; escalations reviewed within agreed timescales; activations audited monthly; discharge feedback demonstrates that families feel able to raise concerns.	Deputy Head of Nursing	
TA12	Undertake a review to strengthen neonatal digital systems and monthly intelligence reporting to identify risks, inequalities and improvement priorities.	Neonatal Consultant (HS)	31/03/2028	NS	Validated dashboard reviewed monthly; BadgerNet available at each bedspace with trained users; documentation quality, system use and implementation risks monitored through governance; measurable improvement in data completeness and accuracy.	Children's Tri-Team	
TA13	Redesign the neonatal workforce and clinical operating model around sustainable 24/7 care, aligning staffing, senior clinical oversight and support services so babies receive safe and responsive care whenever they need it.	Neonatal Matrons	28/02/2028	O	All shifts reviewed against agreed staffing standards; shifts outside BAPM guidance escalated and reported; identified gaps have named mitigation and ownership; performance and risks reviewed monthly.	Deputy Head of Nursing	
TA14	Undertake a review of the post-death care pathway and communicate the revised pathway to all staff, in line with the actions set out in the 10-point plan (NHSE, August	Neonatal Consultants (BL and AL)	30/09/2028	R	Revised post-death care pathway. Communication to staff. Compliance with the agreed post-death pathway; complete identification and transfer records; PMRT reports completed to	Children's Tri-Team	

	2026) to provide dignified, post-death care and compassionate support for bereaved families.				the required standard; learning actions tracked to completion; family feedback and access to bereavement support reviewed.		
TA15	Undertake a review and implement the recommendation and actions set out in the Thirlwall Inquiry report (September 2026) to provide safe neonatal care: • Issue a communication to staff setting out the SUDIC process to confirm that this is applicable for every death (or collapse leading to death) of an infant or child under the age of 18, which would not have been reasonably be expected to occur 24 hours previously by 28 September 2026 • All cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), in line with the guidance and timeframes set by NHSE • Install CCTV cameras focused on storage fridges, cupboards or units in neonatal units by 30 November 2026 • Meet requirements for access, control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use by 31 March 2027 • Identify a designated lead reporter with responsibility for inputting data and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system • Develop a clear process for leaders to respond to concerns raised about the conduct and behaviour of staff when they are raised, including acting on suspicions about deliberate harm. Share protocol with staff setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient, to be published by NHSE by 31 March 2027. • Provide information and support to families and staff	Directors of Children's Services	30/09/2027	R	Local self-assessment completed with risks, actions, owners and evidence of closure; SUDIC pathway understood and accessible; medicines security meets national requirements; safeguarding and escalation training assured; concerns acknowledged, investigated and closed with feedback; mortality, deterioration, incidents, complaints and workforce concerns triangulated monthly; assurance reported through NIAG, PIAG, PIAC and Trust Board.	Trust Board	

Maternity – Culture, Leadership and Inclusion Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
CLI1	Reshape maternity culture around psychological safety, inclusion and shared professional accountability, with leaders modelling agreed behaviours and multidisciplinary teams working cohesively.	Culture Lead, Women's	31/01/2027	O	Agreed behavioural standards and workshop programme; participation and staff feedback; improvement in relevant staff survey and culture indicators.	Clinical Director, Women's Director of Midwifery	
CLI2	Transform the maternity working environment around psychological safety and positive staff experience, using workforce intelligence to identify and address the systemic causes of poor experience.	Culture Lead, Women's	31/01/2028	O	Quarterly psychological safety data; staff survey and multidisciplinary thematic analysis; external trainee feedback; action plan delivery and evidence of sustained improvement.	Clinical Director, Women's Director of Midwifery	
CLI3	Redesign the colleague wellbeing model around identified workforce need, providing accessible and responsive support across maternity services.	Clinical Psychology Team Culture Lead, Women's	31/03/2027	O	Uptake and access data; staff survey feedback; sickness absence trends; resident doctor feedback; evidence that identified gaps are addressed.	Clinical Director, Women's Director of Midwifery	

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CLI4	Create a transparent maternity speaking-up and learning system in which staff can raise concerns safely, receive timely feedback and see learning translated into changes in safety, culture and service delivery.	Culture Lead, Women's	30/06/2027	O	Quarterly feedback on organisational learning; speaking-up themes and response times; completed actions; evidence that learning is shared and applied.	Clinical Director, Women's Director of Midwifery	
CLI5	Redesign post-event staff support around trauma-informed principles, providing consistent multidisciplinary debrief and psychological support following complex, unexpected or traumatic maternity care.	Clinical Psychology Team Patient Experience Lead	30/09/2027	O	Approved pathway; timely multidisciplinary debrief offer; referral and equity-of-access data; staff and family feedback confirming that support is accessible, compassionate and trauma informed.	Chief Nurse Chief People Officer	
CLI6	Transform perinatal leadership capability and behaviours through a consistent model of competency development, coaching, organisational development and team-effectiveness support aligned to the national framework.	Director Team, Women's and Children's	31/05/2028	O	Leadership competency assessment; agreed development plans; participation and completion data; staff feedback; organisational development and clinical psychology assurance.	Director Team, Women's and Children's	
CLI7	Create a shared perinatal strategic direction through an integrated vision and strategy that aligns maternity and neonatal services around consistently safe, high-quality care for women, babies and families.	Director Team, Women's and Children's	30/04/2027	O	Perinatal vision and strategy approved through Trust governance; delivery plan, benefits and outcome measures monitored through programme governance.	Chief Nurse Chief Medical Officer	
CLI8	Embed independent challenge, external insight and shared learning within the perinatal improvement model, systematically translating recommendations into measurable service change.	Culture Lead, Women's Heads of Midwifery	31/01/2030	O	Network terms of reference and participation; documented challenge and learning; actions tracked to completion; evidence of impact on improvement priorities.	Director Team, Women's and Children's	
CLI9	Redesign how colleague voice shapes maternity and neonatal services, systematically translating staff feedback into improvements in support, working environment and service delivery.	Head of Midwifery Clinical Director, Women's Head of Nursing Clinical Director, Children's	31/10/2027	O	Triangulated colleague feedback; prioritised action plan; progress reported quarterly; improvement in staff experience, support and engagement measures.	Director Team, Women's and Children's	
CLI10	Embed equity and anti-discrimination within the maternity and neonatal operating model through implementation of the national Perinatal Equity and Anti-Discrimination Programme.	Head of Midwifery (Operational)	31/08/2027	O	Relevant staff participation and completion data; agreed local action plan; quarterly progress and outcome reporting; evidence of improved inclusion and reduced inequity.	Chief People Officer	
CLI11	Await NHSE to launch a full, open conversation with NHS staff and leaders to identify how we will implement the Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH) to be implemented across the system.	Head of Midwifery Clinical Director, Women's	TBC	NS	National requirements reviewed through the established triage process; local gap analysis completed; actions, owners and timescales agreed and monitored.	Chief Nurse Chief Medical Officer	
CLI12	Redesign perinatal leadership arrangements around shared accountability and collaborative decision-making, strengthening leadership capability and joint working across maternity and neonatal services.	Directors of Operations – Maternity and Neonates	30/04/2027	O	Leadership memorandum of understanding agreed; perinatal vision and strategy approved; accountabilities and joint ways of working evaluated through governance and staff feedback.	Chief Operating Officer	

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Engagement, Communication and Health Equity							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
EC1	Embed lived experience as a core component of staff education and improvement, enabling service users and the Maternity and Neonatal Voices Partnership to co-design and participate in changes to care.	Head of Midwifery Deputy Head of Nursing, Neonates	31/03/2027	O	Programme of co-designed activity; participation records; service-user feedback; examples of changes made in response to lived experience.	Director of Midwifery	
EC2	Create a reciprocal community-engagement model that systematically converts insight from communities into prioritised improvement and demonstrable outcomes.	Head of Midwifery Deputy Head of Nursing, Neonates	31/12/2026	O	Published engagement programme; participation from underserved communities; triangulated experience report; prioritised actions with owners and dates; quarterly outcome reporting to quality governance.	Chief Nurse	
EC3	Strengthen the strategic influence of service-user voice through a sustainable Maternity and Neonatal Voices Partnership model, providing effective scrutiny, co-production and constructive challenge.	Head of Midwifery	31/12/2026	C	Agreed commissioning and governance arrangements; MNVP participation in key quality and safety forums; evidence that recommendations receive a documented response and are tracked.	Board Maternity Safety Champion	
EC4	Redesign maternity environments and wayfinding around accessibility and inclusion, enabling people to navigate and use maternity services more easily.	Consultant Midwife, Health Equity Communications Manager, Women's	31/03/2027	O	Approved wayfinding and signage plan; accessible patient communications; completed environmental changes; service-user testing and feedback demonstrating improvement.	Head of Midwifery	
EC5	Redesign interpreting and translation support as an integral part of maternity pathways, providing reliable and equitable communication support when it is required.	Consultant Midwife, Health Equity LTHT Patient Experience Team	31/12/2028	O	Triangulated access and experience data; identified gaps recorded and mitigated; staff training and awareness; usage and quality measures; service-user feedback demonstrating improved access.	Head of Midwifery	
EC6	Redesign maternity information around accessibility, inclusion and informed choice, providing consistent information across pregnancy, birth and the postnatal period through appropriate channels.	Consultant Midwife, Health Equity OPAL Team Communications Manager, Women's	31/12/2027	O	Accessible information suite and antenatal education offer; reach and participation data; user feedback; digital engagement measures; periodic content review against accessibility standards.	Head of Midwifery	
EC7	Embed trauma-informed principles as the standard model for communication and engagement with women, families and colleagues.	Communications Manager, Women's	31/03/2027	O	Approved communication and engagement strategy; staff and service-user insight; implementation plan; audit of communication quality; evidence of action in response to feedback.	Corporate Communications Lead	
EC8	Redesign how services listen and respond to women and families in real time, embedding reliable feedback and escalation mechanisms at critical points in care and strengthening the voice of people at greater risk of not being heard.	Deputy Head of Midwifery Neonatal Transformation Lead Nurse	31/12/2027	O	Approved patient-experience plan; real-time feedback reviewed through governance; Martha's Rule and escalation routes implemented; listening prompts embedded in handover and care processes; staff training and three months of audit evidence.	Head of Midwifery Head of Nursing	
EC9	Redesign continuity and personalised care pathways using population and clinical intelligence, identifying women who would benefit from enhanced continuity on the basis of clinical risk and social complexity.	Consultant Midwife / Team Leaders	31/07/2027	O	Enhanced continuity model and cohort criteria agreed; equity impact assessed; implementation monitored; continuity, experience and outcome measures reported through governance.	Head of Midwifery	
EC10	Redesign maternity pathways around trauma-informed care, embedding personalised care, meaningful choice and birth reflection within routine service delivery.	Deputy Clinical Director, Women's Deputy Head of Midwifery	31/12/2028	O	Agreed trauma-informed framework; staff capability and training; pathway audits; access and equity measures; service-user feedback; evidence of improvements arising from review.	Clinical Director, Maternity	

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		Consultant Midwife, Health Equity					

Maternity – Estates and Equipment Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
EE1	Reconfigure the maternity and neonatal service model across LGI and St James's, aligning capacity, estate, workforce and transition arrangements to the future configuration of services, with effective controls for risks arising during transition.	Director of Operations Women's and Children's	TBC	NS	Approved options appraisal and decision record; capacity and demand analysis; estate and workforce impact assessment; funded implementation plan; risks and interim controls recorded and monitored through maternity and neonatal governance.	Chief Operating Officer	

Maternity – Pathway Redesign and Quality Improvement Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
PR1	Redesign the induction-of-labour pathway as an integrated, equitable and transparently managed model of care, providing real-time visibility of women awaiting induction across settings and reducing avoidable delay and risk.	Delivery Suite Consultant Lead Antenatal and Postnatal Consultant Lead Maternity Team Leader	31/08/2027	O	Approved pathway and operating model; visibility system implemented; safety-check audit; waiting-time, delay and outcome measures; exception reporting to Women's Quality Assurance Group and PIAC.	Clinical Director, Women's	
PR2	Redesign maternity triage around a standardised, evidence-based model of clinical prioritisation, ensuring women are assessed and responded to according to clinical need and national performance standards.	Lead Clinician, Obstetrics Antenatal and Postnatal Matron, SJUH	31/03/2027	O	Approved triage tool and pathway; staff training; audit of assessment and prioritisation; performance against agreed response standards; incidents, delays and user experience reviewed through governance.	Clinical Director, Women's	
PR3	Redesign the elective caesarean service model around capacity and demand, aligning workforce and theatre resources to create a safe and sustainable service that meets Maternity Incentive Scheme requirements.	Lead Clinician, Obstetrics Intrapartum Matron, SJUH Consultant Anaesthetist	31/12/2027	O	Capacity and demand review; agreed workforce and theatre model; compliance with relevant standards; cancellation, delay and outcome measures; formal assurance to quality governance.	Clinical Director, Women's	
PR4	Redesign the recognition and response model for maternal and fetal deterioration, integrating Enhanced Maternal Care and the national Maternity Early Warning Score with reliable escalation and clinical response.	Anaesthetic Consultant Consultant Obstetrician and Obstetric Lead for MMN Acute Medical Consultant and Obstetric Physician	31/12/2027	NS	Approved pathways and escalation standards; staff training and competency; audit of recognition, escalation and response; review of delayed escalation, harm and transfer events; exception reporting through quality governance.	Clinical Director, Women's	

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		Intrapartum Matron, LGI					
PR5	Create an independent escalation route for women and families through implementation of Martha's Rule across maternity and neonatal services, enabling concerns to receive timely clinical review.	Lead Clinician, Obstetrics Anaesthetic Consultant Neonatal Clinical Lead	30/06/2027	O	Implementation plan completed; families informed of escalation routes; staff training; response-time and activation audit; themes and outcomes reported through operational and quality governance.	Clinical Director, Women's	
PR6	Embed the national maternal care bundle as the standard model of maternity care, creating reliable and sustained delivery of each required element and improving maternal outcomes.	Maternity Incentive Scheme Programme Manager	31/3/2027	O	Approved implementation plan; compliance dashboard; risk and exception reporting; bi-monthly progress report to PIAC; evidence of impact on maternal outcomes.	Clinical Director, Women's	
PR7	Redesign the perinatal bereavement pathway around equitable, compassionate and clinically effective care, providing consistent support to families following loss.	Rainbow Clinic Lead Antenatal Clinic Matron	TBC	O	Approved pathway; timely access to bereavement and follow-up support; staff training; PMRT and learning-action compliance; family feedback and equity-of-access review.	Clinical Director, Women's	
PR8	Redesign the obstetric ultrasound service around capacity, demand and workforce need, providing sustainable and equitable access to timely ultrasound.	Outpatients and Fetal Assessment Unit Consultant Lead Sonography Lead General Manager, Women's Antenatal Clinic Matron	TBC	O	Capacity and demand plan; waiting-time and access data; cancelled and delayed scan profile; workforce plan; incident and outcome review; assurance through maternity governance.	Clinical Director, Women's	
PR9	Embed a consistent quality-improvement operating model across maternity services, enabling teams to test change, measure outcomes and translate improvement activity into demonstrable and sustained benefits.	KPO Lead	30/04/2027	O	Agreed methodology and governance; staff capability and coaching; portfolio of active projects; outcome and balancing measures; benefits and learning reported quarterly.	Clinical Director, Women's	
PR10	Redesign allocation to the Lotus Team, where safe and sustainable, to enable earlier access to continuity and relationship-based care for women planning homebirth or midwife-led intrapartum care.	Lotus Team Lead	31/03/2027	O	Pathway review and eligibility criteria; workforce and capacity assessment; continuity, safety, outcome and experience measures; implementation monitored through maternity governance.	Head of Midwifery	

Maternity – Quality, Safety and Governance Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
QSG1	Redesign the end-to-end maternity patient-safety learning system, connecting timely incident reporting, proportionate review, action delivery, shared learning and evaluation of impact within the Trust PSIRP.	Governance and Quality Lead, Women's Lead Clinician, Obstetrics	31/03/2027	O	Incident timeliness and quality measures; live learning and action log; overdue-action profile; learning communications; evidence that changes in practice are evaluated and recurring themes reduce.	Head of Midwifery (Governance and Risk) Deputy Clinical Director, Women's	
QSG2	Embed family involvement as an integral part of patient-safety investigation, providing compassionate, timely and regular communication throughout the investigation journey.	Governance and Quality Lead, Women's Deputy Clinical Director, Women's	31/12/2027	O	Approved family-engagement procedure; documented family involvement; Duty of Candour compliance; timeliness and quality audit; family feedback and evidence that learning is shared.	Head of Midwifery (Governance and Risk) Clinical Director, Women's Head of Nursing, Children's	

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QSG3	Embed Saving Babies' Lives Care Bundle version 3 as the standard model of maternity safety practice, achieving and sustaining compliance across all required elements.	Programme Manager for Maternity Improvement	31/01/2028	O	Element-level compliance and exception reporting; NHS England peer review; perinatal assurance report; action plans for gaps; outcome trends monitored through quality governance.	Clinical Director, Women's	
QSG4	Redesign the Women's Services complaints and PALS pathway around compassionate response, learning and resolution, supported by sufficient capacity to provide a timely and effective service.	Head of Midwifery (Governance and Risk)	31/12/2027	O	Approved procedure; response timeliness and overdue profile; themes and learning; actions arising from birth-trauma review; experience feedback and assurance through Women's Quality Assurance Group.	Chief Nurse	
QSG5	Create a single integrated perinatal quality and safety governance model, connecting accountability, intelligence, escalation and assurance from specialty and CSU governance through to the Quality Assurance Committee and Trust Board.	Governance Lead Clinician, Maternity Neonatal Governance Lead	31/12/2027	O	Approved framework and governance map; complete reporting cycle; triangulated quality dashboard; documented escalation and response; periodic effectiveness review.	Clinical Director, Maternity	
QSG6	Redesign the maternity clinical-governance operating model around clear portfolios, accountability and cross-cover, creating a resilient governance function.	Head of Midwifery (Governance and Risk) Governance and Quality Lead, Women's	31/01/2027	O	Approved structure and role profiles; job plans; portfolio map; cross-cover arrangements; workload and resilience review; evidence of timely governance delivery.	Governance and Quality Lead, Women's	
QSG7	Create a standardised maternity quality and safety intelligence model that integrates risk, performance, outcomes, experience and improvement and enables escalation by exception.	Governance and Quality Lead, Women's	31/08/2026	C	Approved reporting template and schedule; complete and timely reports; staff training; quality review of reporting; evidence that escalations receive a recorded response.	Head of Midwifery (Governance and Risk)	
QSG8	Redesign priority maternity processes to remove avoidable risk, delay, duplication and unwarranted variation, creating safer, more reliable and efficient pathways through measurable quality improvement.	Governance and Quality Lead	31/12/2027	O	Agreed priority list; completed process maps; identified risks and waste; tested improvements; outcome measures and learning reported through governance.	Programme leadership	
QSG9	Create an integrated maternity risk, performance and assurance system that identifies emerging concerns early and provides clear accountability, escalation and resolution from service level to Trust Board.	Deputy Clinical Director, Women's	30/06/2027	O	Approved governance map and terms of reference; clear reporting and escalation routes; attendance and decision records; annual effectiveness review.	Chief Nurse	
QSG10	Redesign Board-level maternity safety oversight around frontline and service-user intelligence, enabling concerns to be identified early, challenged effectively, escalated promptly and tracked through to resolution.	Deputy Chief Nurse	30/04/2027	O	Role expectations and work programme agreed; engagement activity and walkarounds; issues escalated and tracked; assurance report to the Quality Assurance Committee and Board.	Chief Nurse	04/09/2026
QSG11	Maintain and assure an effective pathway for women who do not attend antenatal appointments, including timely follow-up, safeguarding escalation and mitigation of access inequalities.	Consultant Midwife, Health Equity	31/12/2025	C	Approved antenatal guideline; audit of follow-up and escalation; safeguarding and equity review; assurance to Women's Quality Assurance Group.	Director of Maternity	
QSG12	Sustain safe medicines management across maternity services in line with the Trust Medicines Code, with reliable controls for storage, access, administration and escalation of non-compliance.	Matrons, Women's Services	31/12/2025	C	Daily checks and scheduled audit; central action tracking; assurance visits; monthly compliance reporting to medicines governance; persistent non-compliance escalated through clinical governance.	Head of Midwifery	
QSG13	Sustain infection-prevention and control standards through clear staff responsibilities, regular briefing and standardised audit of hand hygiene, uniform and equipment-cleanliness controls.	Deputy Head of Midwifery	30/03/2026	C	Briefing and completion records; weekly IPC audit; ward-level compliance metrics; action plans for gaps; recurring themes and infection trends reviewed through governance.	Head of Midwifery	
QSG14	Ensure subject access requests are completed accurately, lawfully and within required timescales, with appropriate support for staff and no avoidable backlog or information-governance risk.	General Manager, Women's Services	30/04/2026	C	Approved process and responsibilities; request log; timeliness and backlog measures; information-governance compliance; staff support arrangements and exception reporting.	Clinical Director, Women's	

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QSG15	Ensure freedom-of-information requests are completed accurately, consistently and within statutory timescales, minimising backlog, reputational risk and avoidable demand on clinical teams.	Quality, Safety and Learning Team Lead General Manager, Women's Services	30/04/2026	C	Approved process and responsibilities; request log; timeliness and backlog measures; quality review; staff support arrangements and exception reporting.	Clinical Director, Women's	

Maternity – Workforce and Education Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
WE1	Redesign out-of-hours maternity operational leadership around continuous senior oversight, integrating senior midwifery on-call support with a 24/7 Patient Flow Co-ordinator function to strengthen escalation and flow.	Head of Midwifery (Operational)	31/12/2026	O	Approved out-of-hours escalation arrangements within the Maternity Escalation Policy; complete on-call and Patient Flow Co-ordinator rotas; escalation logs reviewed for timeliness, response and recurring themes.	Director of Midwifery Medical Director – Operations	
WE2	Transform the perinatal workforce model around future service need, aligning capacity, capability, leadership and succession arrangements to sustain safe services over the next three years.	Head of Midwifery (Operational) Clinical Director, Women's Head of Nursing, Children's Lead Clinician, Neonates	31/03/2027	O	Strategy approved through relevant governance; supporting workforce plan and milestones agreed; communication and engagement evidenced; delivery, risks and benefits monitored through workforce and programme governance.	Chief Nurse Chief Medical Officer Director of Midwifery	
WE3	Redesign the maternity medical workforce model around current and future service need, aligning capacity, skills, senior cover and job plans to provide sustainable and safe medical staffing.	Clinical Director, Women's	31/08/2028	O	Approved medical workforce review; capacity, demand and job-plan analysis; future workforce model and implementation milestones; progress and risks reported through medical workforce governance.	Deputy Chief Medical Officer (Workforce)	
WE4	Review consultant roles, responsibilities, job plans and escalation arrangements to provide clear accountability and an effective senior response to operational and clinical risk.	Clinical Director, Women's	31/03/2026	C	Completed role and responsibility review; revised job plans where required; escalation-response effectiveness, incident themes and staff feedback reviewed through an established monthly reporting cycle.	Deputy Chief Medical Officer (Workforce)	
WE5	Redesign ward-leadership capacity to protect leadership time for quality, safety, workforce and improvement, enabling ward leaders to exercise effective ownership of service improvement.	Deputy Head of Midwifery	31/01/2027	O	Protected-time requirement agreed and reflected in rosters; utilisation and exceptions reviewed monthly; delivery of ward-level objectives and improvement actions monitored through governance.	Tri-Team, Women's Services	
WE6	Redesign executive midwifery leadership arrangements around clear and stable accountability, establishing an appropriately scoped and substantively appointed Director of Midwifery role.	Deputy Chief Nurse	30/11/2026	O	Approved leadership-structure review; role scope and reporting arrangements agreed; substantive recruitment completed or supported by a time-bound recruitment plan; transition risks monitored.	Chief Nurse	
WE7	Maintain maternity roster fill rates by implementing the approved approach to proactive recruitment against the recurrent maternity-leave requirement.	Head of Midwifery (Operational)	31/01/2025	C	Trust Board decision and supporting paper; recruitment establishment confirmed; vacancy, leave and fill-rate reporting demonstrates sustained impact on clinical rosters.	Chief Nurse	
WE8	Ensure labour-ward establishments and roster templates provide sufficient additional midwifery capacity when elective caesarean lists are operating, reducing avoidable cancellation and escalation.	Head of Midwifery (Operational)	31/01/2027	C	Approved establishment and roster templates; staffing compliance on elective-list days; cancellation, delay and escalation data monitored through operational governance.	Chief Nurse	
WE9	Agree and maintain an appropriate staffing uplift within the midwifery establishment, informed by Birthrate Plus, workforce risk and service requirements.	Head of Midwifery (Operational)	12/01/2026	C	Approved Trust Board paper and decision; establishment uplift documented; workforce indicators, roster fill, temporary staffing and safety outcomes monitored.	Chief Nurse	

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WE10	Redesign remote-working arrangements around the operational and escalation needs of maternity services, ensuring critical support remains safe, timely and reliable.	Head of Midwifery	30/11/2026	O	Approved review and revised arrangements where required; response-time and availability standards defined; exceptions and impact on critical escalation monitored through workforce governance.	Chief People Officer	
WE11	Redesign professional support for midwives around a sustainable Professional Midwifery Advocate model, providing equitable access to restorative clinical supervision and professional advocacy to strengthen wellbeing, practice and quality of care.	Workforce Transformation Matron	30/11/2029	O	Gap analysis completed; revised strategy approved; dedicated time and support evidenced; access, activity and impact monitored through quarterly and annual PMA reporting.	Head of Midwifery (Operational)	
WE12	Ensure fetal-monitoring clinical leadership capacity meets Saving Babies' Lives Care Bundle version 3 requirements, including one programmed activity per site.	Deputy Clinical Director, Women's	31/12/2025	C	Consultant job plans evidence the required programmed activity at each site; role delivery and impact monitored through fetal-monitoring and maternity governance.	Clinical Director, Women's	
WE13	Redesign site-based midwifery leadership around visible accountability and sufficient leadership capacity, enabling leaders to address quality, safety and workforce priorities effectively.	Head of Midwifery (Operational)	31/01/2027	O	Approved leadership structure with site-specific roles; funded establishment and recruitment plan; visible-leadership schedule; staff feedback and delivery impact monitored through CSU governance.	Director of Midwifery Medical Director – Operations	

Maternity – Antenatal and Newborn Screening Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
A1	Redesign antenatal and newborn screening around an end-to-end tracked pathway, using reliable cohort oversight and failsafe mechanisms to ensure eligible women receive all required screening within national timescales.	Screening Programme Team	28/02/2027	O	Coverage, completeness and timeliness KPIs; missed-screen and exception profile; corrective actions; quarterly assurance through the Screening Oversight Group.	Screening Matron	
A2	Create an integrated Radiology and Screening operating model with shared oversight and accountability for equitable delivery of the antenatal and newborn screening programme.	General Managers, Radiology and Women's Services	31/01/2027	O	Agreed governance and operating arrangements; equitable access and re-offer rates; reduction in missed appointments; clear wayfinding and accessible information; exception reporting through screening governance.	Screening Matron and Radiology Lead	
A3	Redesign the antenatal and newborn screening failsafe system around active cohort surveillance, ensuring missed, incomplete or delayed screening is identified and corrected promptly.	Screening Quad Team	31/12/2026	O	Approved procedures; complete cohort tracking; staff training; timeliness of corrective action; audit of missed screens and sustained compliance.	Antenatal and Newborn Screening Co-ordinator Screening Matron	
A4	Align screening incident reporting, review, escalation and learning with national guidance and Trust patient-safety processes.	Quality, Safety and Learning Team Screening Team	30/04/2026	C	Incident reporting quality and timeliness; national reporting compliance; action and learning logs; monthly screening assurance report to Women's Quality Assurance Group.	Screening Matron and Radiology Lead	
A5	Redesign the screening workforce model around safe and continuous programme delivery, providing sustainable establishment and resilient failsafe capacity.	Screening Quad Team	31/01/2027	O	Approved establishment and recruitment plan; vacancies and absence monitored; critical functions covered; service continuity and KPI performance maintained.	Screening Matron	
A6	Achieve sustained compliance with national antenatal and newborn screening standards by independently validating local controls, closing identified gaps and demonstrating reliable programme assurance.	Screening Quad Team	31/03/2026	C	External review and walkthroughs completed; recommendations tracked; NHS England participation in quarterly oversight; evidence of sustained improvement.	Screening Matron and Radiology Lead	
A7	Redefine the boundaries of the antenatal and newborn screening programme, transferring non-screening clinical pathways to clearly accountable services and protecting screening capacity and governance.	Screening Quad Team	31/01/2027	O	Scope and ownership agreed; revised pathways approved; safe transfer completed; impact on screening capacity and performance assessed.	Clinical Lead Screening Matron	
A8	Redesign infectious-disease and sickle-cell and thalassaemia screening around reliable end-to-end failsafe controls, preventing missed or incomplete screening.	Screening Quad Team	31/01/2027	O	Complete cohort tracking; programme KPIs reviewed monthly and quarterly; missed-screen and corrective-action audit; sustained compliance evidenced.	Screening Matron Antenatal and Newborn Screening Co-ordinator	

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A9	Redesign the results pathway following miscarriage around timeliness, compassion and reliability, ensuring women receive appropriate communication and follow-up.	Screening Quad Team	31/01/2027	O	Approved pathway and standards; timeliness and completion KPIs; communication and follow-up audit; experience feedback; assurance through screening governance.	Antenatal and Newborn Screening Co-ordinator Screening Matron	
A10	Redesign screening information around accessibility and informed choice, providing nationally approved information in formats and languages that meet the needs of women and families.	Consultant Midwife, Health Equity Communications Manager, Maternity	31/01/2027	O	Accessible digital information available; reach and usage measures; service-user feedback; MNVP review; assurance through the Patient Experience Forum.	Screening Matron	

Maternity – Community Services Workstream							
Ref	**Improvement action**	**Responsible owner**	**Target date**	**Status**	**Key evidence and assurance**	**Accountable owner**	**Planned review date**
C1	Redesign community clinical equipment supply around timely and reliable access, creating a resilient system that prevents or rapidly resolves stock gaps and supply delays.	Community Administration Team	30/12/2026	O	Approved ordering process; order-to-delivery times monitored; delays and stock gaps escalated; improvement demonstrated through monthly exception reporting.	Community Matron	
C2	Redesign the community lone-working safety model around reliable personal-safety technology, clear escalation and consistent staff practice to reduce risk to community staff.	Health and Safety Team Community Leadership Team	31/01/2028	O	Devices issued to eligible staff; training and usage compliance monitored; lone-worker procedure audited; incidents and response effectiveness reviewed.	Head of Midwifery	
C3	Embed a consistent lone-working safety model across community maternity services, integrating risk controls, staff identification and reliable escalation arrangements.	Community Midwifery Team Leaders	30/06/2027	O	Annual risk assessment completed; audit confirms identification cards, training and escalation arrangements are in place; exceptions tracked to resolution.	Community Matron	
C4	Redesign the community maternity operating model around demand and continuity, balancing capacity and caseloads to provide sustainable seven-day cover and improved team-level continuity for women.	Community Matron	31/10/2027	O	Workforce and caseload review completed; agreed seven-day operating model; workload, continuity, access and workforce indicators monitored through quality and workforce governance.	Head of Midwifery	
C5	Reconfigure community maternity teams around continuity, resilience and effective roster management, implementing the preferred team structure following appraisal of alternative models.	Community Matron	31/03/2027	O	Options for four to six clusters or five to six larger teams appraised; preferred model approved; implementation plan agreed; continuity, roster and staff-experience measures monitored.	Head of Midwifery	
C6	Redesign the community maternity estate around a sustainable long-term accommodation model that supports safe and reliable service delivery.	General Manager, Women's Corporate Planning Manager	To be confirmed	O	Accommodation requirements defined; options appraisal completed; preferred solution and funding route agreed; implementation risks and interim controls monitored.	General Manager, Women's	
C7	Transition community maternity services from short-term accommodation arrangements to a more stable estate model, reducing reliance on short-term leases and improving service stability.	Community Operational Team Estates and Facilities Team	31/11/2026	O	Lease portfolio reviewed; risks, costs and service impact assessed; longer-term accommodation plan approved and monitored.	General Manager, Women's	
C8	Redesign operational support for community maternity services, transferring estate, venue and clinical-space functions away from inappropriate reliance on clinical staff and into dedicated operational support.	Operational Management Team	31/01/2032	O	Operational support requirement and responsibilities agreed; resource and governance arrangements implemented; issues, response times and impact on clinical capacity monitored.	General Manager, Women's	
C9	Develop and progress the business case for Hillside as a sustainable community-midwifery base.	Community Operational Team	31/10/2026	C	Business case completed and submitted through CSU and Trust governance; decision, funding requirements and implementation actions recorded.	General Manager, Women's	
C10	Create a consistent community maternity estate standard across all locations, ensuring clinical environments meet service, accessibility, estate and infection-prevention requirements.	Community Operational Team	31/03/2028	O	Complete estate and infection-prevention review; standardised risk assessment; action plan with owners and dates; unresolved gaps supported by interim controls and escalated through operational governance.	General Manager, Women's	

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C11	Embed a distributed community clinical-leadership model through specialist champion roles, building team capability in infant feeding, infection prevention, culture, bereavement and perinatal mental health.	Community Team Leaders	31/03/2027	O	Role descriptions and coverage agreed; champions trained; activity and contribution to team capability, compliance and governance evidenced.	Community Matron	
C12	Redesign caseload cover around a buddy model, strengthening continuity for women while providing structured support to early-career midwives.	Community Team Leaders	31/03/2027	O	Model scoped and piloted; continuity, workload, safety and service-user feedback reviewed; early-career support evaluated; decision on wider implementation recorded.	Community Matron	
C13	Reshape specialist and reduced-caseload community provision around demonstrable value, using outcomes, benefits, equity and sustainability to inform future service and commissioning decisions.	Specialist Team Leads	31/03/2027	O	Consistent evaluation completed for each team; activity, outcomes, equity, workforce, cost and service-user experience reviewed; recommendations approved through governance.	Head of Midwifery	
C14	Redesign community rostering around demand and seven-day service delivery, aligning staffing patterns with activity and providing reliable weekend cover.	Rostering Lead Community Matrons	31/03/2027	O	Demand-based roster review completed; weekend staffing model agreed; roster compliance, fill rates, workload and service performance monitored.	Head of Midwifery	
C15	Redesign community leadership capacity around the operating needs of the service, establishing appropriate cluster-level Band 7 leadership and an effective clinical-managerial balance for Band 6 deputies.	Community Matron	31/03/2027	O	Leadership-capacity review completed; proposed model, benefits and resource implications agreed; implementation and impact monitored through workforce governance.	Head of Midwifery	
C16	Redesign the community matron portfolio around dedicated community-service leadership, providing sufficient capacity for oversight of services, staff and delivery priorities.	Senior Midwifery Leadership Team	31/11/2026	O	Portfolio and capacity review completed; revised responsibilities and reporting arrangements agreed; effectiveness assessed through delivery, staff feedback and governance performance.	Head of Midwifery	
C17	Redesign daily community work allocation and co-ordination, enabling clusters to manage activity safely and efficiently with clear accountability.	Community Team Leaders	31/10/2027	O	Current-state process mapped; risks, duplication and delays identified; redesigned process tested and implemented; productivity, workload and staff feedback reviewed.	Community Matron	
C18	Redesign administrative support around seven-day community maternity delivery, aligning administrative capacity and responsibilities with the needs of the clinical service.	Community Operational Team	31/03/2027	O	Administrative demand and capacity review completed; options and resource implications agreed; response times, workload and impact on clinical capacity monitored.	General Manager, Women's	
C19	Redesign the community neonatal jaundice pathway around transcutaneous bilirubin measurement as the first-line assessment, reserving serum testing for clinical indication.	Community Team Leads	31/07/2026	Off	Approved pathway and staff training; access to calibrated equipment; audit of pathway compliance; reduction in avoidable serum bilirubin testing; delays, incidents and outcomes monitored through governance.	Head of Midwifery	
C20	Create an integrated and standardised pathway model for specialist and reduced-caseload community teams, defining consistent referral, eligibility, escalation and handover arrangements while responding to differing population needs.	Community Governance Team	31/01/2027	O	Approved procedures and guidance; referral, eligibility, escalation and handover requirements defined; staff awareness and pathway compliance audited; equity and outcomes monitored.	Head of Midwifery	
C21	Create a community patient-safety learning system that connects incident review, thematic learning and improvement, ensuring learning is shared and actions translate into demonstrable change.	Community Team Leads	31/12/2026	O	Incident timeliness and quality audit; open and overdue profile; thematic reporting; learning communications; completed action plans and evidence of impact reviewed through governance.	Community Matron	
C22	Embed risk management as an integral part of the community operating model, connecting identification, scoring, ownership, review, escalation and closure through a single consistent process.	Governance Lead	30/09/2026	C	Approved risk-management process; complete and current community risk register; regular leadership review; overdue controls and escalations reported through governance.	Head of Midwifery	

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