Meeting Title	Board of Directors					
Date of the meeting	11 September 2026					
Title	**Ockenden Review, AMOS NMNI and NHS England 10-Point Action Plan**					
Report presented by	Julie Hogg, Group Chief Nurse Danni Burnett, Group Director of Midwifery and Deputy Chief Nurse					
Report written by	Danni Burnett, Group Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for	Decision/Approval		Assurance	X	Update	X
Trust Priorities	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	Perinatal Assurance Committee in Common (PACiC) 2 September 2026					

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

The report provides reasonable assurance that core maternity and neonatal governance, safety and improvement controls are established. It mitigates significant risks by bringing the AMOS, Ockenden and NHS England 10-Point Plan requirements into one assurance framework, with named accountability, evidence standards, milestones and escalation routes. Material residual risks remain in relation to Martha's Rule, joint executive and clinical accountability, workforce deployment and 24/7 resilience, compassionate debriefing, maternity-triage sustainability, estate and capacity, analytical capability and inconsistent experience for women, families and staff. These risks will remain under active oversight through PSIP, PAC, TLT, Quality Committee and quarterly Board reporting, with immediate escalation where required.

Impact Assessment

The proposed assurance approach is expected to have a positive impact on safety, quality, experience, workforce culture and equality. It strengthens listening and escalation routes, Board oversight of maternity triage, workforce and operational risk, compassionate responses when care falls short, and evidence that learning changes practice. No adverse equality impact is anticipated. However, the report recognises continuing variation in access, experience and outcomes, particularly for communities facing deprivation, language barriers, discrimination or other barriers to care. The developing Perinatal Health Equity Partnership, improved demographic and equity reporting, accessible communication and targeted community engagement will be used to shape services, direct improvement action and test whether inequalities are reducing. Any financial, workforce, digital or estate consequences will be developed through the appropriate business-case and governance routes.

Supporting Papers & References

SUPPORTING PAPERS

NHS England 10PP Template – attached

UHL Triage ¼ Service Review – attached

KEY NATIONAL PUBLICATIONS

Ockenden Review into maternity services at Nottingham University Hospitals NHS Trust: final report — published 24 June 2026.

National Maternity and Neonatal Investigation: final report and Trust reports — published 30 June 2026.
NHS England response and Maternity and Neonatal 10-Point Plan — published 1 July 2026.
National Maternity Triage Specification — published July 2026.
Maternity and Neonatal 10-Point Plan assurance process, reporting template and benchmarking tool — published 12 August 2026.

ACRONYMS

Acronym	Meaning	Acronym	Meaning
AMOS	Baroness Amos-led National Maternity and Neonatal Investigation	BSOTS	Birmingham Symptom-Specific Obstetric Triage System
CQC	Care Quality Commission	DART	Deteriorating Adult Response Team
ED	Emergency Department	EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record	FFT	Friends and Family Test
ICB	Integrated Care Board	IPR	Integrated Performance Report
LGH	Leicester General Hospital	LRI	Leicester Royal Infirmary
MAU	Maternity Assessment Unit	MDAU	Maternity Day Assessment Unit
MNVP	Maternity and Neonatal Voices Partnership	NMNI	National Maternity and Neonatal Investigation
PAC	Perinatal Assurance Committee	PEADP	Perinatal Equity and Anti-Discrimination Programme
PREM	Patient-Reported Experience Measure	PSIP	Perinatal Safety Improvement Programme
PSIRF	Patient Safety Incident Response Framework	SPOC	Single Point of Contact
TLT	Trust Leadership Team	UHL	University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

BOARD OF DIRECTORS

11 SEPTEMBER 2026

UHL response to the NUH Ockenden Review, National Maternity & Neonatal Investigation (NMNI) and the NHS Perinatal 10-Point Action Plan

PURPOSE

To provide the Board with an integrated, evidence-based assessment of UHL's response to the AMOS National Maternity and Neonatal Investigation, the Ockenden Review and the NHS England 10-Point Plan. The paper presents the UHL baseline position, incorporates the maternity-triage deep dive, identifies the principal assurance gaps and strategic risks, seeks approval of the baseline return and integrated delivery approach, and sets out the corporate support required to deliver and evidence sustained improvement.

This report is UHL's interim response and baseline stocktake under the NHS England 10-Point Plan assurance process. It sets out the Trust's current assurance position, immediate priorities, residual risks and enabling requirements while the national maternity and neonatal taskforce develops the longer-term action plan. Both the baseline assessment due on 25 September 2026 and the progress update due on 31 December 2026 require formal approval by the Trust Board before submission to NHS England. UHL will continue local delivery at pace and will complete a formal read-across, update its integrated programme and return any material changes in risk, resource or assurance when the national plan is published.

NATIONAL CONTEXT

This is the first report to the UHL Board following publication of the Ockenden Review, the Baroness Amos National Maternity and Neonatal Investigation (NMNI) and the NHS England 10-Point Plan in June 2026. Although developed through different routes, the reports present a consistent national message: maternity and neonatal improvement must be judged by reliable implementation, reduced variation and demonstrable benefit for women, babies, families and staff, not simply by the existence of plans, policies or governance arrangements.

UHL was one of the 12 trusts included in the AMOS investigation, which engaged directly with Trust leaders, system partners, staff and service users. The Trust-specific findings recognised committed leadership, strong governance and extensive improvement activity, while noting that women, families and frontline staff did not yet experience these improvements consistently. Key themes included communication and listening, delays in assessment and triage, workforce and operational pressures, and estate and capacity constraints.

Acknowledgement to staff, women and families. UHL offers its sincere thanks to the women, families, staff and community partners who contributed to the AMOS investigation and spoke with openness and honesty. We are sorry that some women and families did not feel heard, supported or consistently well cared for, and that some staff did not feel their concerns or experiences led to timely change. Their testimony has been essential in helping

us understand both the progress made and the work still required. Although this report presents substantial improvement activity and evidence, we recognise that experience remains inconsistent and that we do not always get things right. We are committed to listening with humility, working in genuine partnership, acting on what we hear and being transparent about what has changed, and what still needs to change to improve care.

UHL has therefore treated the findings as both a national requirement and an opportunity for honest local learning. Our response brings together staff support, continued dialogue and partnership with women and families, alignment with the Perinatal Safety Improvement Programme, and stronger assurance that learning results in sustained frontline change. We also intend to apply the same principles — listening, escalation, triangulation and closed-loop learning — across other departments and higher-risk services, sharing learning between UHL sites and beyond perinatal care.

A **Perinatal Health Equity Partnership** is also being developed to build on established community relationships and bring together women, families, community partners, Maternity and Neonatal Voices Partnership representatives, equity leads and clinical teams. The partnership will provide a visible route for communities to influence service design, improvement priorities and decisions, with clear feedback on how their insight has shaped change. This will support a more consistent approach to co-production, strengthen accountability to the communities UHL serves and help ensure that action is targeted where barriers, inequalities and poor experience are greatest.

EXECUTIVE SUMMARY

UHL's baseline assessment provides reasonable assurance that the core governance, safety and improvement arrangements are established. Of 26 reportable deliverables, 18 are compliant, six partially compliant, two not applicable and none non-compliant. Assurance remains conditional because the six partially compliant areas are not yet fully embedded or consistently supported by evidence of sustainable impact. Board oversight should therefore focus on delivery, variation and the experience of women, babies, families and staff, rather than action completion alone.

Six areas require further action: full implementation of Martha's Rule; formal joint accountability between the Chief Nurse and Medical Director, with consistent clinical leadership participation; full multidisciplinary participation in the Perinatal Equity and Anti-Discrimination Programme; a consolidated review of workforce deployment, capacity and 24/7 resilience; reliable compassionate debriefing and named family contact; and sustained maternity-triage compliance under operational pressure.

The detailed maternity-triage benchmarking provides moderate assurance that the core clinical service is established and functioning, with particular strength in the dedicated 24/7 telephone-triage model. Across both sites, 32 of 82 standards are fully in place, 47 are partially in place, two are not in place and one is not relevant. Full assurance against the National Maternity Triage Specification cannot yet be given because residual gaps remain in the 15-minute assessment standard, timely medical review, patient flow, separation of planned and urgent activity, workforce resilience, partner interfaces, estate and digital infrastructure, service-user measurement, and inequalities data.

RECOMMENDATIONS

The Board is asked to:

- **NOTE** the national shift from assurance that plans exist to evidence that change is embedded, reliable and improving experience and outcomes.
- **ACKNOWLEDGE** UHL's direct involvement as one of the 12 trusts included in the AMOS investigation and the Trust-specific learning arising from that involvement.
- **RECEIVE AND FORMALLY APPROVE** the UHL NHS England 10-Point Plan baseline assessment (18 compliant, six partially compliant, two not applicable and none non-compliant) for submission to NHS England by 25 September 2026.
- **REQUIRE FORMAL BOARD APPROVAL** of the national progress update before its submission to NHS England by 31 December 2026.
- **ENDORSE** the overall judgement of reasonable assurance, with material gaps requiring active oversight.
- **ENDORSE** the proposed oversight route through PSIP, PAC, TLT, Quality Committee and quarterly Board reporting.
- **RECEIVE** the maternity-triage deep dive and note the moderate-assurance position against the detailed National Maternity Triage Specification; **ENDORSE** the seven cross-site priorities in Appendix 3; and **REQUIRE** a single costed, time-bound improvement plan, including formal appraisal of the two interim Tier 2 medical-cover options and return of any investment or Board decisions required.
- **SUPPORT** the workforce, medical leadership, analytical, digital, estates, quality-improvement, communications and programme capacity required for delivery.
- **REQUIRE** quarterly assurance showing movement against each partially compliant deliverable, maternity-triage improvement, risks, mitigations, measurable impact and areas requiring corporate or Board intervention, with immediate escalation of material safety, access, workforce, estate, digital, analytical or delivery risks.
- **ENDORSE** the move to impact-led assurance, including maternity and neonatal metrics in the Integrated Performance Report from the next reporting month, quarterly triangulated reporting of outcomes, experience, workforce, culture and equity, and direct testing with women, families and staff of whether improvement is visible and sustained.

1. INTEGRATED BOARD ASSURANCE POSITION

The completed UHL NHS England baseline assessment supports a judgement of **reasonable assurance**. Of the 26 reportable deliverables, 18 are compliant, six partially compliant, two not applicable and none non-compliant. Core controls and governance arrangements are established; however, assurance remains conditional until the six partially compliant areas are fully implemented, consistently evidenced and demonstrably delivering sustainable improvement. The dashboard below summarises the overall position and the exceptions requiring active oversight; the detailed assessment by action is provided in Appendix 1.

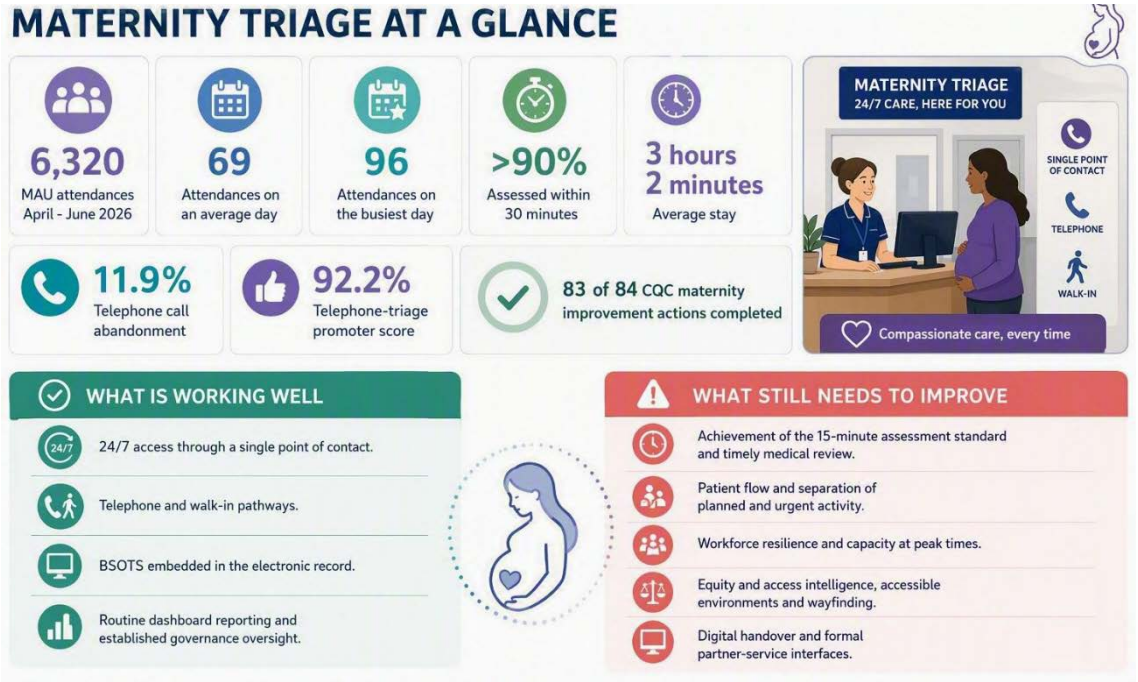
2. PRIORITY ASSURANCE GAPS AND REQUIRED ACTION

The six priority areas below require continued oversight. Detailed milestones and delivery evidence will be managed through the integrated programme tracker and reported by exception.

3. MATERNITY TRIAGE: DEEP-DIVE ASSURANCE AND REQUIRED ACTION

The UHL maternity-triage review provides moderate assurance that the core service model is established and functioning, while identifying significant areas where compliance is not yet consistently embedded. The dashboard below summarises current activity and experience

measures; the detailed LRI and LGH 82-standard positions, Board priorities, investment requirements and source-data corrections are provided in Appendix 3.



a) Benchmarking and investment implications:

The detailed LRI and LGH assessments provide a more granular view than the three compliant 10-Point Plan triage deliverables. Both sites have 32 of 82 standards fully in place, 47 partially in place, two not in place and one not relevant. The detailed assessment therefore provides moderate assurance: 24/7 telephone triage and core clinical arrangements are established, but full assurance cannot yet be given because access pathways, workforce capacity, estate and digital infrastructure, service-user measurement, and data and inequalities arrangements are not consistently embedded. These findings do not alter the compliant baseline rating, but they define the cross-site improvement programme required to sustain compliance and progress towards full specification assurance. The site-level evidence, Board priorities, investment position and required dashboard corrections are set out in Appendix 3.

Medical triage cover	Two medical staffing models are proposed for maternity triage. **Option 1** is dedicated Tier 2 medical cover at both sites, 24 hours a day, seven days a week. **Option 2** is dedicated Tier 2 medical cover at both sites during daytime hours, seven days a week, supported by clear overnight consultant and medical-team oversight and escalation arrangements. Both options are intended to support safe and timely clinical decision-making. However, **maintaining medical cover across two sites creates challenges for workforce efficiency and resilience. The longer-term intention is to move to a single-site model, removing the need for dual-site triage staffing and enabling a more efficient, sustainable and clinically robust approach to**

	care delivery. The preferred interim option, implementation requirements, workforce implications and associated costs will require formal clinical, operational and financial appraisal.
Operational evidence	June 2026 performance was 96.6% at LRI and 96.0% at LGH within 30 minutes, but 79.4% and 77.9% respectively within 15 minutes against the 85% target. Activity increased by 5% year on year, from 11,873 to 12,470 attendances in the first six months of 2026. A review of planned postnatal care found that 70% of appointments did not require MAU, supporting redirection to alternative pathways.
Key unresolved dependencies	Priority dependencies include timely medical review; recovery of the 15-minute standard; workforce resilience and a formal competency framework; separation of planned and urgent care; stronger pathways with primary care, EMAS and NHS 111; complete data on delays and outcomes; routine segmentation by ethnicity, deprivation and language; accessible signage and environments; and improved digital handover and capacity oversight. Two interim medical-cover models require appraisal: dedicated Tier 2 cover at both sites 24 hours a day, seven days a week; or dedicated daytime Tier 2 cover at both sites, seven days a week, with clear overnight consultant and medical-team oversight and escalation arrangements. Maintaining cover across two sites creates continuing efficiency and resilience pressures, and the longer-term direction is a single-site model. A dedicated **Midwifery Matron for Maternity Triage** has been established through the repurposing of existing matron portfolios, with no additional financial requirement. Supported by the Head of Nursing, the role will provide consistent cross-site leadership, oversee the improvement programme and apply relevant Emergency Department learning on demand, capacity, initial assessment, escalation, flow, workforce deployment, patient communication and performance oversight, while recognising the distinct clinical requirements of maternity care.
Next assurance point	One SMART tracker will monitor accountable leads, milestones, evidence, residual risk, benefits and validated costs across both sites. Most controllable actions are due between September and December 2026. Monthly exception reporting will support executive programme oversight, with quarterly assurance to PAC and the Board. An interim reassessment will return in February 2027, with final assurance dependent on completion of controllable actions and explicit management of national dependencies, including PREM.

4. ASSURANCE, RISKS AND SUPPORT REQUIREMENTS

UHL will use one integrated assurance framework for AMOS, Ockenden, the 10-Point Plan, PSIP, CQC and related requirements. Each action will identify the national requirement, local baseline, accountable executive, senior responsible owner, milestones, evidence standard, outcome and experience measures, equity impact, risk, mitigation and escalation route. Operational and PSIP forums will oversee delivery; PAC will triangulate and challenge the evidence; TLT and Quality Committee will address corporate dependencies and material risks; and the Board will receive quarterly assurance on impact, variation and unresolved barriers. **Appendix 2** provides a visual summary of the line of sight from point of care to Board, including the escalation triggers and Board assurance tests.

a) From improvement activity to lived impact

Over the last 2 years boards and committees have moved from monitoring action completion to testing impact. Assurance will now focus on what has changed, how we know, who is experiencing the change, where variation remains and what decision or support is required. From the next reporting month, specific maternity and neonatal metrics will be included in the Integrated Performance Report (IPR), supported by quarterly impact reporting that triangulates outcomes, experience, workforce, culture, access and equity.

- **Listen in partnership:** use MNVP, the new Perinatal Health Equity Partnership, complaints, PALS, patient stories, Birth Reflections, community engagement, staff listening, Freedom to Speak Up and local surveys as safety intelligence.
- **Close the loop:** publish clear “What we heard, what we changed, and the difference it made” examples, showing the concern raised, the action taken, the accountable lead, the timescale and the evidence of improvement.
- **Test change directly:** return to women, families and staff after changes are introduced to establish whether the difference is visible and sustained.
- **Triangulate intelligence:** review experience alongside outcomes, incidents, workforce, culture, access and inequalities data, rather than in isolation.
- **Test consistency:** examine variation by site, pathway, shift, ethnicity, deprivation and language so positive averages do not conceal poorer experiences.
- **Strengthen Board evidence:** work with business intelligence to evolve perinatal dashboards to ensure there is a quarterly impact and experience section, with direct examples of feedback leading to change, exception reporting, evidence-confidence ratings and benefits measures for each major action.

The national taskforce action plan remains an external dependency. When published, UHL will complete a formal read-across, confirm any additional requirements, update the integrated tracker and return material changes in risk, resource or assurance to the appropriate committee and Board route.

b) Principal risks and controls

- **Assurance activity displaces improvement delivery:** use one tracker, reduce duplication, prioritise evidence and escalate capacity constraints.

- **Martha's Rule is not consistently visible or embedded:** approve the operating model, communications, training, monitoring and audit of awareness.
- **Medical leadership and joint accountability remain insufficiently formalised:** embed the new assurance and accountability framework for perinatal services, which includes clear roles, responsibilities and expectations.
- **Workforce and specialist-service resilience:** complete the consolidated workforce and deployment review, demand-and-capacity model and investment narrative.
- **Estate and capacity constraints:** agree a prioritised perinatal estate plan, interim mitigations and capital and revenue consequences.
- **Data and analytical capacity:** finalise integrated performance metrics, ownership and demographic segmentation.
- **Improvement is not consistently experienced by families or staff:** triangulate patient and staff voice, complaints, PSIRF themes and direct testing of change.
- **Governance transition creates loss of clarity:** approve the UHL framework, confirm committee routes and monitor transition risks.

Delivery requires coordinated support from executive and medical leadership, operations and business intelligence, People and Organisational Development, estates and capital, digital, communications and engagement, programme governance, and system or regional partners where dependencies cannot be resolved by UHL alone. The approach will also consider how the learning applies across all departments and services, with cross-site learning shared systematically so that relevant improvements are adopted beyond perinatal services.

c) Key Milestones

- **11 September 2026:** formal Trust Board approval of the NHS England 10-Point Plan baseline assessment and integrated assurance report, authorising submission by the national deadline.
- **25 September 2026:** NHS England baseline-submission deadline.
- **September 2026:** finalise the metric set, assurance and accountability framework, communications approach and initial triage actions; establish the Perinatal Health Equity Partnership, confirm its membership and governance route, and agree an initial programme of community-led priorities and measures of impact.
- **6 October 2026:** update on the revised workforce and culture development plans, present the maternity and neonatal estate design and implementation position to TLT.
- **31 December 2026:** submit the national 10-Point Plan progress update following formal Trust Board approval, demonstrating movement from the baseline position.
- **February 2027:** complete a reassessment against the National Maternity Triage Specification, reporting progress against the time-bound cross-site improvement plan, residual risks, benefits and investment or Board decisions required.
- **Quarterly:** integrated Board assurance on progress, risks, evidence and impact.

5. SUMMARY, CONCLUSION AND RECOMMENDATIONS

UHL has established a credible initial response to the AMOS investigation, the Ockenden Review and the NHS England 10-Point Plan. Core governance, safety and improvement controls support a judgement of reasonable assurance, but this remains conditional: six

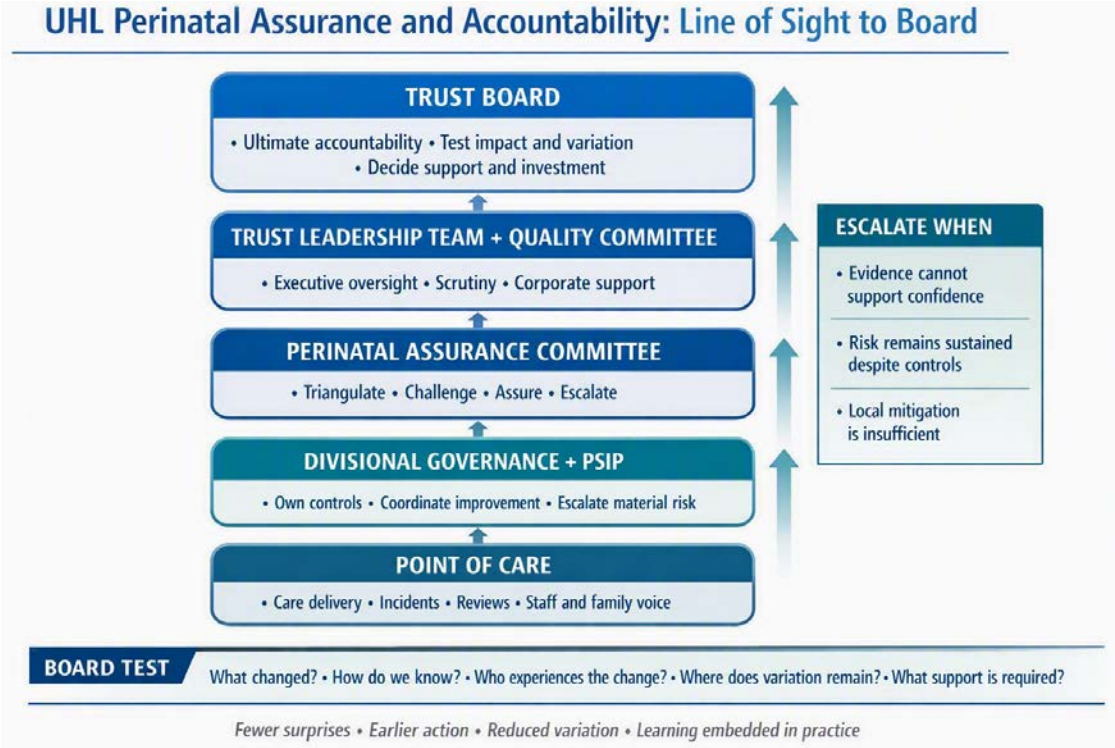
deliverables are partially compliant and both maternity-triage sites remain moderately assured against the detailed specification. Sustained confidence will depend on timely delivery, clear executive and clinical accountability, validated investment requirements, robust evidence and demonstrable improvement in the experiences and outcomes of women, babies, families and staff.

The maternity-triage review provides moderate assurance: performance against the 30-minute assessment standard is strong, but material risks remain in timely initial assessment and medical review, demand and capacity, flow, workforce resilience, cross-system access, estate and digital infrastructure, service-user measurement, and inequalities data. Delivery of the seven cross-site priorities in Appendix 3 therefore requires coordinated executive oversight, notwithstanding the compliant rating of the three baseline triage deliverables.

APPENDIX 1. UHL 10-POINT PLAN BASELINE SUMMARY

Summary by Action - Baseline	Total	Compliance			
Action		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	0	3
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	1	2
6. Ensuring 24/7 safety and responsiveness of services	7	1	0	1	5
7. Trust review of homebirth services	2	1	0	0	1
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	0	3
10. Post death care	2	0	0	0	2

APPENDIX 2. UHL PERINATAL ASSURANCE AND ACCOUNTABILITY



Appendix 2 illustrates how frontline intelligence, including care delivery, incidents, staff voice and family experience, moves through divisional governance and PSIP to the Perinatal Assurance Committee, executive committees and the Trust Board. It clarifies accountability at each level and the circumstances requiring escalation: where evidence cannot support confidence, risk remains sustained despite controls, or local teams require corporate, system or regional support. The Board uses this line of sight to test impact, variation and the need for further action, support or investment.

APPENDIX 3. MATERNITY TRIAGE SPECIFICATION BENCHMARKING SUMMARY

This appendix provides the site-level position from the National Maternity Triage Specification benchmarking audit at 6 September 2026. It should be read alongside the three compliant NHS England 10-Point Plan triage deliverables: the baseline deliverables remain compliant, but the more detailed 82-standard assessment provides moderate assurance and identifies significant residual gaps requiring coordinated executive oversight.

Site-level assurance position

LRI: **Moderate assurance that the core clinical maternity triage service is established and functioning, particularly the dedicated 24/7 telephone-triage model**. Full assurance cannot yet be given because compliance is not consistently embedded across the wider urgent-care pathway. Principal risks relate to fragmented cross-system access, medical and midwifery capacity, estate and digital limitations, inconsistent service-user measurement, and an underdeveloped data and inequalities framework.

LGH: A **credible operational foundation is in place, with comparatively strong assurance in telephone triage, clinical assessment, equity and urgent-care recognition**. Overall compliance is not yet consistently embedded. Principal constraints are medical workforce capacity, inconsistent system pathways, the physical and digital triage environment, limited use of data for continuous improvement, and variable evidence that service-user feedback changes practice.

Medical triage cover: Two interim models are proposed: dedicated Tier 2 cover at both sites 24 hours a day, seven days a week; or dedicated daytime Tier 2 cover at both sites, seven days a week, supported by clear overnight consultant and medical-team oversight and escalation arrangements. Both support safe and timely decision-making, but dual-site delivery creates workforce-efficiency and resilience pressures. The longer-term intention is a single-site model, subject to formal clinical, operational and financial appraisal.

Improvement priorities

1. Agree a funded workforce plan for additional ST3–5 obstetric registrar posts, with recruitment, rota, acuity and senior-response assurance, alongside a protected minimum midwifery model.
2. Progress LRI MDAU business case / planning and require milestones for operational separation of urgent and scheduled activity.
3. Nominate executive ownership for a single 24/7 access model and secure formal referral, handover and escalation agreements with Primary Care, ED, Gynaecology, EMAS and NHS 111.
4. Approve a maternity triage measurement strategy, named metric owners, data-quality controls, tiered review arrangements and routine analysis by ethnicity, language, deprivation and disability.
5. Prioritise immediate estate and digital risk mitigations, including transfer equipment, clinical-room IT access, diagnostic transport, digital handover boards, centralised monitoring, accessibility work and costed CCTV options.

6. Commission inclusive routine feedback, strengthen concerns and second-review routes, improve wayfinding and waiting-time information, and establish executive oversight of national PREM readiness.
7. Require a single time-bound improvement plan covering every partial or not-in-place standard, with accountable owners, completion dates, evidence requirements, benefits measures and clear escalation routes. Monthly exception reporting should support executive oversight, with quarterly assurance to PAC, TLT and the Board.

Investment, dependencies and source-data corrections

The benchmarking assessments confirm that maternity triage services at LRI and LGH are operationally established, with strengths in telephone triage, governance, urgent-care recognition and core clinical assessment. However, both sites have partially implemented standards requiring investment to achieve full compliance with the proposed Maternity Triage Specification. The most significant requirement is additional obstetric registrar capacity for dedicated Tier 2 support. This requirement is site specific, not shared across the two sites, and must therefore be aggregated. Further quantified requirements relate to estates, digital infrastructure, patient flow, equipment and operational separation of urgent and scheduled activity. The resulting total indicative investment is c. £2.07m. This figure represents the currently quantified investment identified through the benchmarking process. They exclude any future workforce recommendations arising from the Birthrate Plus review, accessibility improvements, training requirements, pathway redesign activity and wider system developments that have not yet been formally costed.

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 Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts 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 recordec 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 process. 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 nati 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 wheth evidence is strong, adequate, limited or not available. Evidence may support 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 evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation: University Hospitals Leicester
Report prepared by: Danni Burnett- Director of Midwifery
Report date: 26/08/2026
Reporting period covered: Q1 2026-2027

Baseline Assessment		
Key Metrics		
Total deliverables		**26**
Compliance	0. Not applicable	2
	1. Non-compliant	0
	2. Partially compliant	6
	3. Compliant	18
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline	Total	Compliance			
Action		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	0	3
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes	**3**	0	0	1	2
6. Ensuring 24/7 safety and responsiveness of services	**7**	1	0	1	5
7. Trust review of homebirth services	**2**	1	0	0	1
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	0	3
10. Post death care	**2**	0	0	0	2

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
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

Report signed off by Trust Board (named Exec): Julie Hogg, Group Chief Nurse

Trust Board sign off date: 02/09/2026

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	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-01, EV-27	UHL has existing Ask Me, DART/MEWS/NEWTT2 and neonatal FiCare escalation routes, but these are not yet an approved, visible Martha's Rule pathway covering all required components, training, communications and usage/outcome monitoring.	Agree the UHL model and implementation plan within 8 weeks; define governance, staff training, family communications, usage data and escalation outcome monitoring.	The Joint Executive briefing identifies Chief Nurse/Medical Director ownership and an immediate decision.
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?	Compliant	EV-02, EV-03, EV-04			
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?	Compliant	EV-05 & EV-06			
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?	Compliant	EV-02, EV-03, EV-04			
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?	Partially compliant	EV-27	Joint Chief Nurse and Medical Director accountability is proposed but still requires formal approval, updated terms of reference, clear reporting lines and named senior responsible owners.	Formalise joint executive accountability within 6 weeks; update terms of reference, reporting lines, escalation routes and named owners for each workstream.	The Joint Executive action plan provides the proposed model but not evidence that it is fully embedded.
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-05 & EV-06	A corporate perinatal medical leadership role is still developing. Current Clinical Director and Deputy Clinical Director attendance at Board is by exception rather than a consistently evidenced arrangement.	Define attendance expectations for clinical leaders; record attendance, challenge and decisions in Board minutes.	
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	EV-07	Leadership onboarding is underway, but full multidisciplinary participation is not yet assured because obstetric vacancies and unresolved backfill/funding constrain medical workforce release.	Agree funded backfill and a proportionate release plan; confirm the named multidisciplinary cohort, attendance and completion evidence.	
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?	Compliant	EV-02, EV-03, EV-04, EV-05, EV-08, EV-09			
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	EV-10, EV-11			
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-12, EV-13, EV-14			
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		Trust does not utilise short-term locums		

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)? *(In line with MIS Year 8)*	Compliant	EV-15, EV-16			
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? *(In line with MIS Year 8)*	Compliant	EV-12, EV-17			
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? *(In line with MIS Year 8)*	Compliant	EV-18			
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-02, EV-05, EV-06, EV-28, EV-29	Board and PAC oversight is evidenced		
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-27, EV-28	A consolidated deployment review is not yet complete. Current evidence identifies consultant capacity gaps and the need to assess demand, flow, specialist cover, education resilience and redeployment impact across both maternity sites.	Complete the time-limited demand, capacity and resource-deployment review; quantify roles and capacity, assess bereavement and infant-feeding resilience, document redeployment impacts, and agree mitigations and investment asks.	The medical workforce capacity analysis as an input, not as a substitute for the full multidisciplinary review.
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?	Compliant	EV-05, EV-06, EV-19			
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?	Not applicable				
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-05,EV-06, EV-20, EV-21,EV-22			
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-03, EV-04, Ev-05, EV-06			
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		Further work to embed compassionate debriefing process, staff training records, a named family contact, or early duty of candour led by a senior manager.	Approve debriefing guidance; collate training and compliance records; evidence named family contacts, senior duty-of-candour timing, family feedback and thematic learning reported through governance.	The Leicester SharePoint search found relevant patient-experience assurance but not sufficient current evidence to close this gap.
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?	Compliant	EV-23, Ev24			
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?	Compliant	EV-02, EV-05, EV-24			
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?	Compliant	EV-24			
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-25			
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	EV-26			

Maternity Triage Service Review

April 2026 - June 2026

Kerry Johnston, Head of Nursing
Sarah Blackwell, Lead Midwife for Quality Improvement

Why the maternity triage service review is required

National requirement, benchmarking approach and intended use

The review translates the NHS 10 Point Plan for maternity services and the July 2026 Maternity Triage Specification into a structured programme of assurance and improvement.

NATIONAL REQUIREMENT

Service review is required as part of the NHS 10 Point Plan for maternity services.

The July 2026 specification sets the expectations against which local triage arrangements should be assessed.

BENCHMARKING TOOL

A standard template has been provided to assess alignment with the Maternity Triage Specification.

It identifies strengths and opportunities and creates a consistent evidence base for improvement planning.

HOW IT SHOULD BE USED

Self-assessment and quality improvement are equally important purposes of the tool.

The review tests effectiveness, safety, accessibility, equity and responsiveness across the service.

Assurance Summary

Board/PAC position against the National Maternity Triage Specification

ASSURANCE ESTABLISHED

24/7 access is established through SPOC, Telephone Triage and open-door MAU pathways.

BSOTS is embedded digitally across both sites with strong 30-minute performance.

Governance is active through SitRep, tactical huddles, the MAU Working Group and PAC.

CQC benchmarking is strong with 83 of 84 triage actions complete.

RESIDUAL RISKS

Initial triage and medical review remain variable during peaks and weekends.

Workforce resilience and competency need stronger evidence and formal closure.

Planned-care separation, partner pathways and discharge communication remain incomplete.

Equity and data intelligence are not yet routine enough to prove outcomes consistently.

ASSURANCE TRAJECTORY

One implementation tracker to consolidate owners, evidence and governance routes.

Most local actions fall due between September and December 2026.

Martha's Rule awareness remains a local action to March 2027; PREM is a national dependency.

An interim reassessment should return to Board/PAC in February 2027; final closure follows completion of controllable actions.

Substantial assurance. The operating model is established, but five consolidated residual-risk themes are evidenced as closed

Site-level specification alignment

Board/PAC position against the National Maternity Triage Specification

Leicester Royal Infirmary		Fully in place	Partially in place	Not in place	Not relevant
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	0%	100%	0%	0%
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	40%	50%	10%	0%
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	60%	20%	0%	20%
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	67%	0%	0%
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	100%	0%	0%	0%
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	40%	40%	20%	0%
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	30%	70%	0%	0%
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	33%	67%	0%	0%
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	60%	40%	0%	0%
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	14%	86%	0%	0%

Leicester General Hospital		Fully in place	Partially in place	Not in place	Not relevant
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Both sites are partially assured

Urgent-care access and infrastructure are strongest; service-user experience and staffing (particularly at LGH) require focused action

PAC (onwards to Trust Board) Recommendations

Three decisions convert the review into accountable risk oversight

1 — ENDORSE

Endorse the judgement: the core model is established; partial assurance remains.

Recognise established access, BSOTS, Telephone Triage and governance, alongside strong Telephone Triage satisfaction and feedback routes.

Acknowledge five consolidated residual-risk workstreams: timeliness, workforce, flow, communication/voice and equity/data.

2 — APPROVE

Approve one SMART tracker with confirmed accountable leads, dates and evidence thresholds.

Accept the current residual risk while agreed controls are delivered and exceptions escalated.

Use the MAU Working Group, PSIP, PAC and Board routes to oversee R1–R5.

3 — AGREE

Agree routine PAC/IPR reporting on performance, action status, residual risk and exceptions.

Agree that no RAG improves until the stated closure evidence is available.

Agree an interim February 2027 reassessment and a final judgement after controllable actions are complete.

Triage Service Specification

Gap Analysis

See Annex A for further detail

University Hospitals Leicester

Principle 1: Access is established; capacity challenges need attention

Current position and insight across activity, access, pathways and integration

FOUNDATION IN PLACE

24/7 access through SPOC, telephone, walk-in and community referral.

30-minute triage compliance remains high despite periods of escalation.

Core referral and postnatal pathways are established

Standardised guidance, accessible information, interpreter support and escalation/SitRep oversight enable consistent, equitable onward care.

Together, these provide a credible access and governance foundation.

DEMAND IS OUTPACING FLOW

+5% year-on-year footfall — nearly 600 additional attendances.

6,320 attendances in the review quarter; 69 per day and a peak of 96.

Unannounced attendances rose 12 → 35 (+192%).

Diversions affected both sites, with greater impact at LGH and continued pressure on the 15-minute standard.

Capacity pressure is structural, not episodic.

THE RESPONSE

70% of reviewed planned postnatal appointments did not require MAU.

Redirect planned and non-urgent care through Meridian PNC, MDAU and BadgerNet.

Close the amber assurance gaps in partner escalation, capacity oversight and discharge communication.

Build routine equity and access monitoring into the MAU dashboard.

Evidence: slides 8–11 | Annex 1.1–1.10 and 2.6–2.10 | Tracker R3 — Flow & partner pathways

MAU activity: sustained high demand

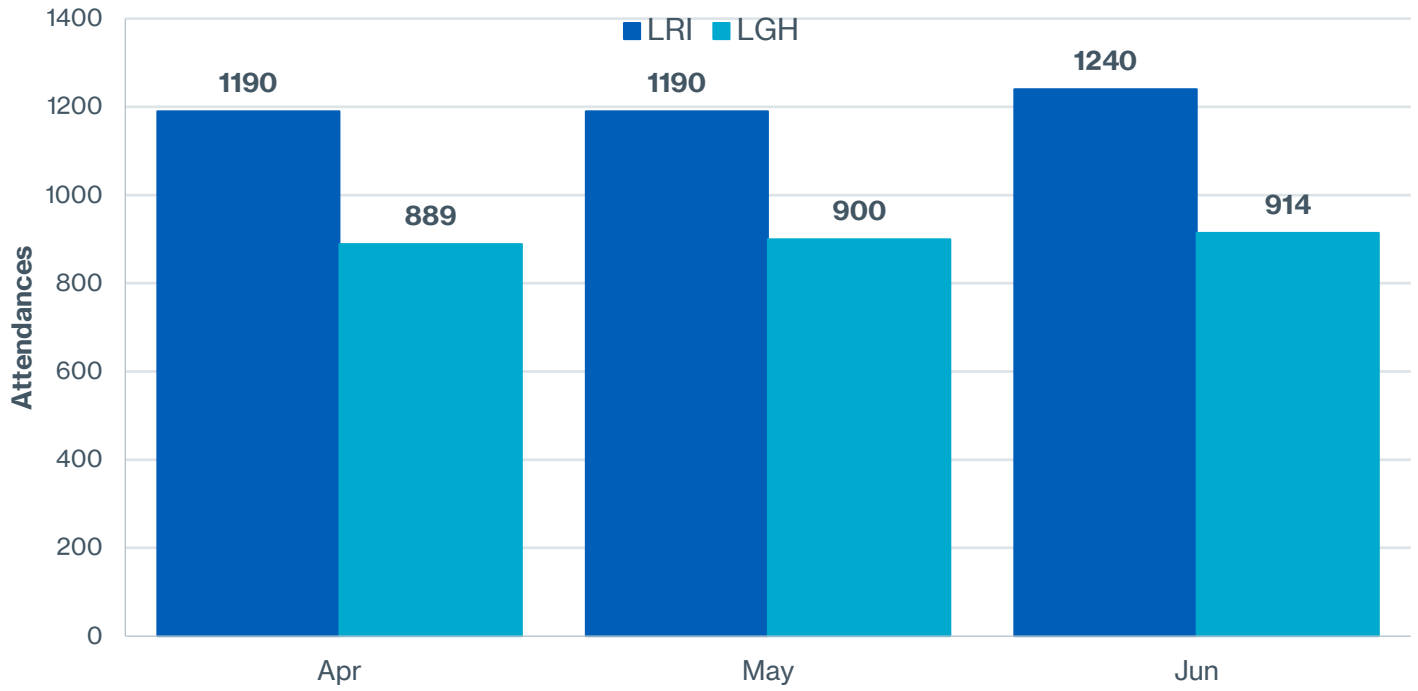
April to June 2026 | LRI and LGH

6,320
attendances
Across both sites

69
average per day
Across the quarter

96
busiest day
19 June 2026

+3.7%
growth Apr to Jun
2,079 to 2,154 attendances

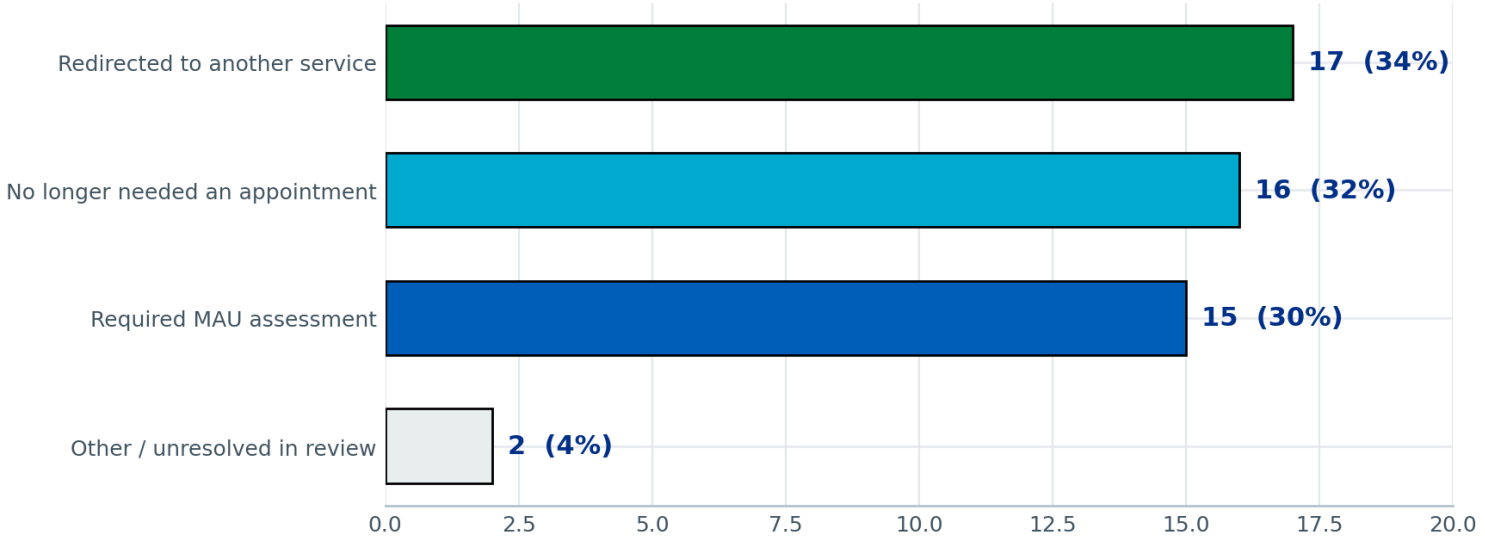


What the data says

- Both sites diverted activity during escalation; LGH was disproportionately affected by 1:1 diversions.
- Diversion frequency reflects 15-minute triage challenges, especially at LGH.
- 30-minute triage compliance remained high, assuring timely clinical assessment for most patients.
- Ethnicity, deprivation and language data are not yet routine; dashboard development and self-discharge deep dives provide interim oversight.

Planned postnatal care: most activity can be moved out of MAU

Review of 50 planned postnatal appointments



70%

did not require MAU

35 of 50 reviewed

30%

required MAU assessment

15 of 50 reviewed

Key insights

- **70% did not need MAU:** 34% were redirected and 32% no longer required an appointment.
- **Only 30% required assessment:** most planned postnatal care can be managed through alternative pathways.
- **Earlier redirection is the opportunity:** 8 of the 15 women seen in MAU arrived before alternatives were arranged.

What we're doing

- Pathways: embed direct booking to Meridian PNC/MDAU and configure two daily BadgerNet slots
- Implementation: brief staff, review the admissions tracker and redirect suitable appointments earlier
- Assurance: repeat the pathway audit, evidence reduced avoidable MAU use and report through Tracker R3.

MAU footprint increased by 5% year on year

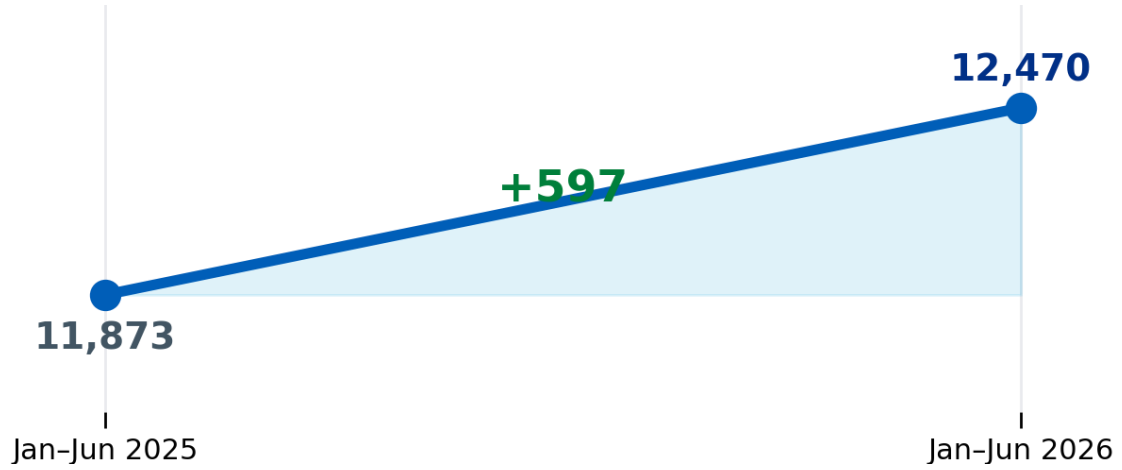
January to June comparison

11,873
Jan to Jun 2025

12,470
Jan to Jun 2026

+597
additional attendances

+5.0%
year-on-year growth



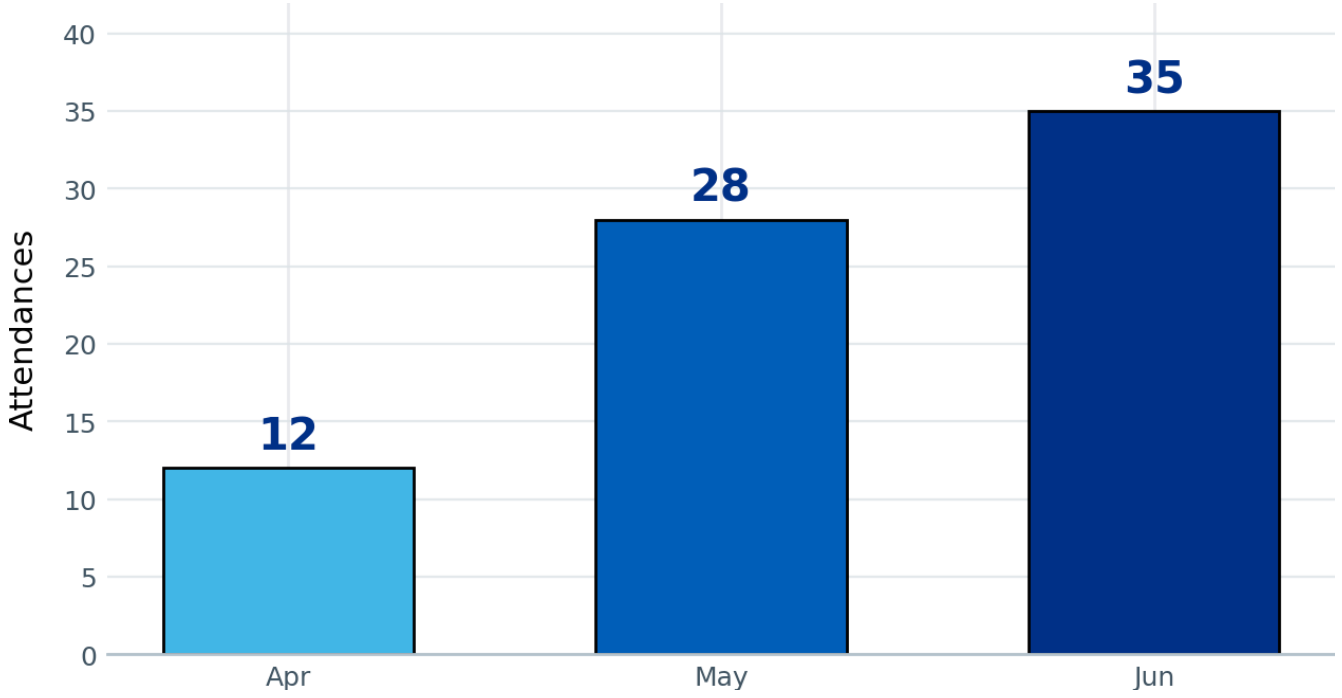
The service handled nearly 600 more attendances in the first half of 2026.

The increase supports continued focus on flow, alternative pathways and timely medical review.

Capacity pressure is structural

Unannounced attendances rose sharply

April to June 2026



12

April

35

June

+192%

increase from April to June

Open access is a safety control. The residual risk is insufficient capacity and pathway discipline to absorb rising unannounced demand without diversion or delayed initial triage. Record diversion frequency, duration and site impact through Tracker R3.

Maternity triage performance at a glance

April to June 2026 | evidence: triage slide 16; self-discharge 18; TT 21–24; flow 28

6,320
MAU attendances

>90%
triaged within 30 mins

3h 02m
average ward stay

~80%
discharged home

11.9%
call abandonment

92.2%
TT promoter score

83 / 84
CQC actions complete

23h 50m
longest stay

WHAT THE DATA SHOWS

- **Reduced Fetal Movements** is the leading presenting concern at both sites, indicating women are aware to call
- **Case volume** differences across LRI and LGH
- **Service role** mixed urgent and reassurance needs confirm MAU as the front door.

OPERATIONAL FOCUS

- **Timeliness —** recover the 15-minute standard and reduce medical-review delay.
- **Pathways —** route planned care away from urgent MAU capacity.
- **Intelligence —** strengthen equity, discharge and pathway reporting.

Principle 2: Urgent-care model established; pathway integration needs assurance

Current position and insight across urgent access, prioritisation and system pathways

URGENT-CARE MODEL IN PLACE

BSOTS rapid assessment is embedded digitally across both MAU sites.

24/7 open access is maintained without appointment or prior referral.

5 of 10 requirements are green; waiting-time communication and system links remain amber.

FFT and walkarounds support a culture that validates women's concerns.

PATHWAY ALLOCATION IS MIXED

Only 50% of 34 audited cases were appropriate for BSOTS/MAU.

23.5% were better managed elsewhere through MDAU, GP, neonatal or ultrasound pathways.

Site defaults and incomplete categorisation reduce confidence in reporting.

Avoidable routing adds pressure to urgent-care capacity.

THE RESPONSE

Reinforce referral criteria and route planned activity away from MAU.

Improve EPR location and BSOTS recording then repeat the audit.

Strengthen signage and waiting-time communication across both sites.

Formalise partner escalation and handover by September 2026.

Urgent access is established; stronger pathway allocation, data quality and system integration are needed to complete assurance.

Evidence: slides 13–18 | Annex 2.6–2.10 | Tracker R1 — Timeliness & medical review; R3 — Flow & pathways

Principle 3: Prioritisation works; timeliness and competency remain incomplete

Current position and insight across BSOTS assessment, ongoing care and medical review

CLINICAL PRIORITISATION WORKS

BSOTS is used across both sites with high-acuity cases prioritised and escalated.

30-minute performance remains strong for the majority of women.

Ongoing midwifery care has improved across green, yellow and orange pathways.

BadgerNet now provides complete real-time attendance data.

SPEED & REVIEW REMAIN VARIABLE

15-minute performance remains below 85% particularly at LGH.

Most delay occurs between 15 and 30 minutes rather than beyond 30 minutes.

Medical review is the key bottleneck during peaks, weekends and shared cover.

Self-discharge review found prolonged waits and inconsistent follow-up documentation.

THE RESPONSE

Complete the RCOG gap analysis and maintain BSOTS audit.

Deliver the formal competency framework by December 2026.

Report a 15-minute recovery trajectory with named ownership and site-level data.

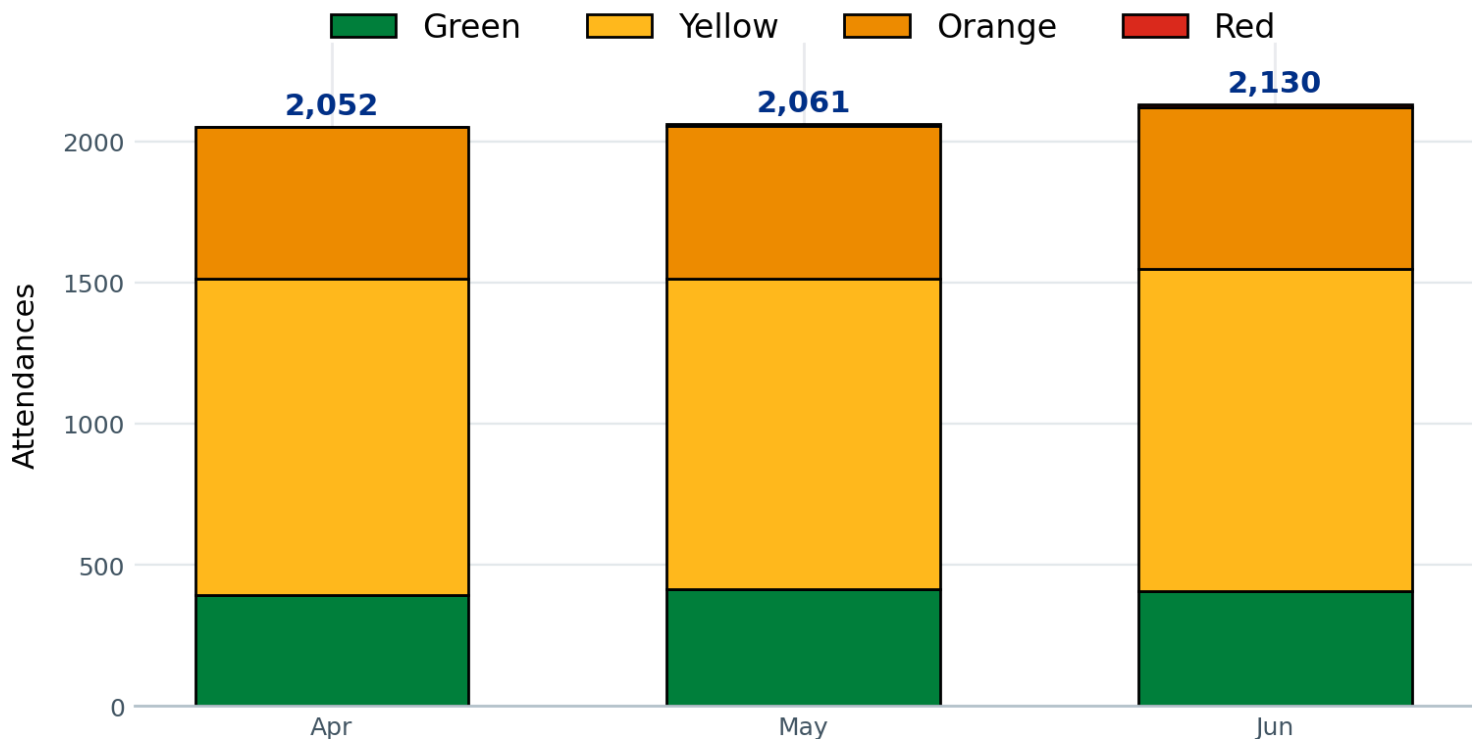
Manage medical-review capacity through the Principle 8 workforce plan.

Evidence: slides 15–18 and 28 | Annex 3.1–3.4 | Tracker R1 — Timeliness & medical review; R2 — Workforce

Clinical prioritisation is effective; full assurance depends on faster initial triage, formal competency evidence and more reliable medical review

BSOTS acuity: moderate-risk workload dominates

April to June 2026



80%

yellow + orange

Moderate-risk workload

19

red attendances

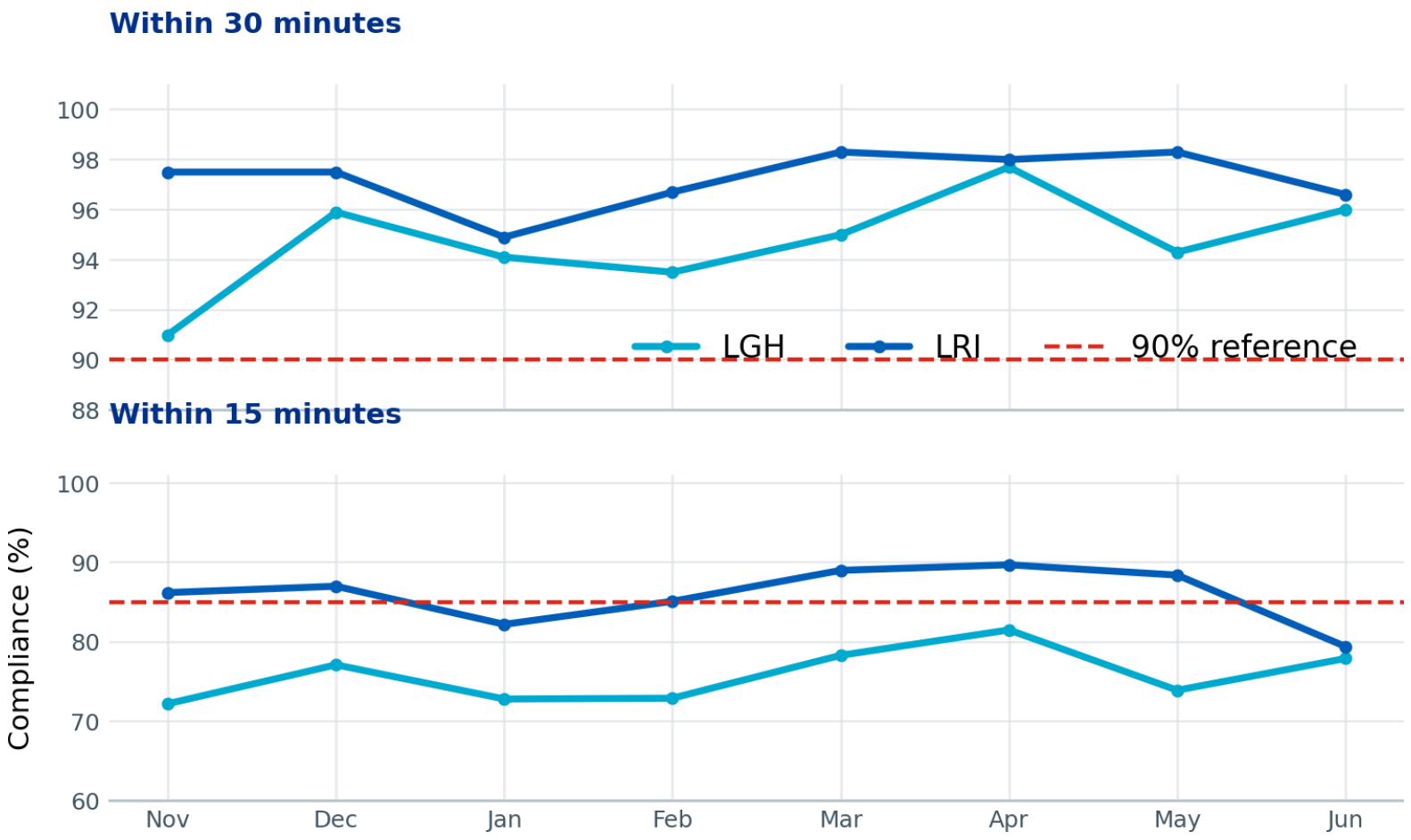
Across the three months

Operational implication

High volumes of yellow and orange cases require timely review and consume significant clinical capacity, even when immediately life-threatening presentations remain uncommon.

Initial triage: strong within 30 minutes, variation within 15

Complete BadgerNet data | November 2025 to June 2026



96.0% / 96.6%

June within 30 mins

LGH / LRI

77.9% / 79.4%

June within 15 mins

LGH / LRI | target 85%

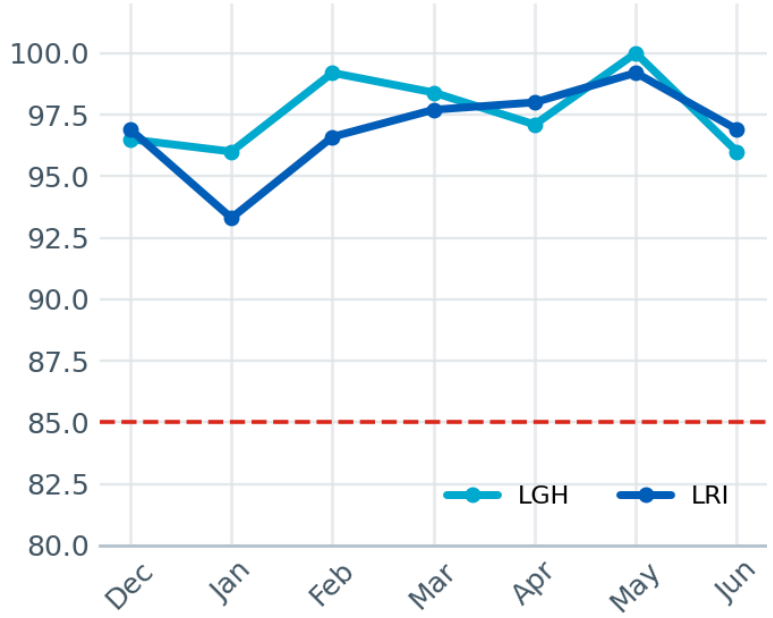
Key message

Most delay sits between 15 and 30 minutes. Recover earlier initial assessment while sustaining 30-minute performance. A named site trajectory and quantified medical-review baseline are still required for closure.

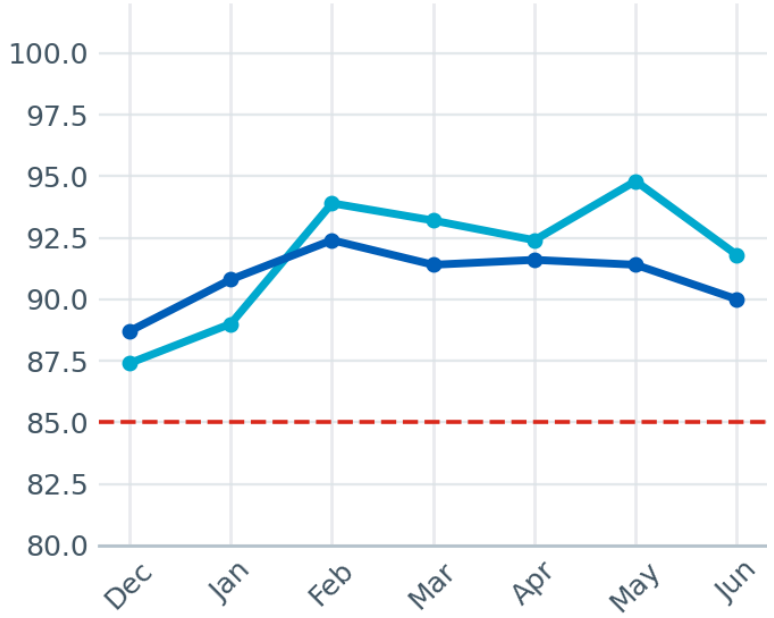
Ongoing midwifery care: improvement sustained above target

December 2025 to June 2026 | 85% national target

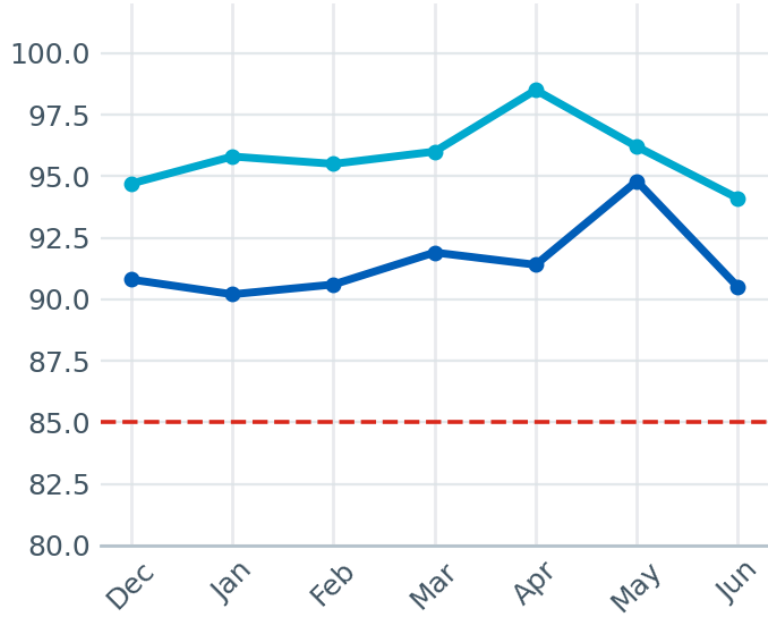
Within 4 hours



Within 1 hour



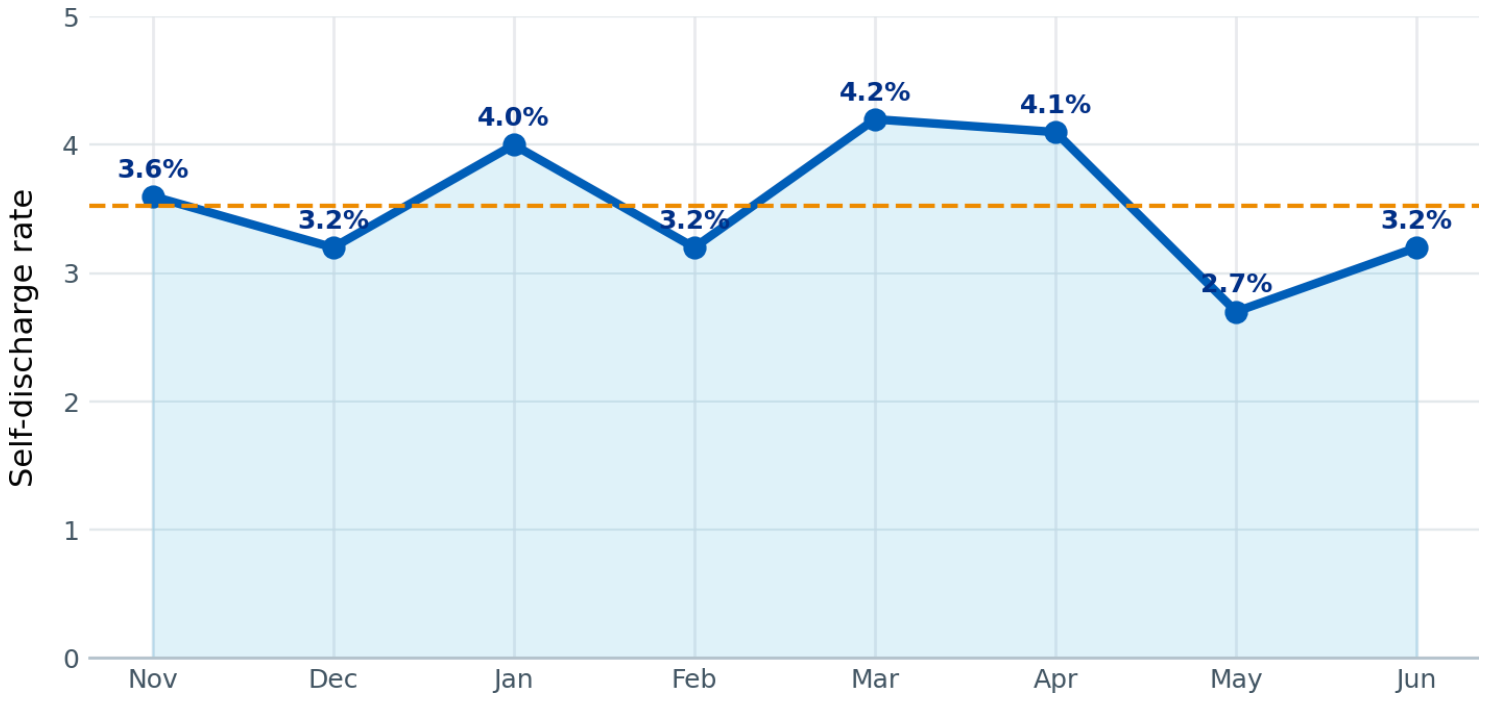
Within 15 minutes



Both sites remained above the 85% target across all three measures throughout the complete-data period.

Self-discharge remained broadly stable

November 2025 to June 2026



3.2%

June 2026

3h 07m

average stay

MAU overall: 3h 09m

9h 48m

longest stay

MODERATE ASSURANCE

57 episodes were reviewed. Average stay was 3h 07m versus 3h 09m overall; most women were assessed and safety-netted.

WHAT IT MEANS

Self-discharge is multifactorial—not solely wait-related. The cohort was broad, with higher-deprivation areas well represented.

PRIORITY ACTION

Monitor trends; record reasons, follow-up and communication needs; report long-wait bands and causes; escalate earlier when waits are prolonged.

Principle 4: Information is available; accessibility and discharge need evidence

Current position and insight across access information, interpretation and safety-netting

MULTIPLE ROUTES ARE IN PLACE

Guidance is available through BadgerNotes, Health for Under 5s, antenatal education and digital channels.

Interpreter support is available 24/7 and family members are not relied upon.

2 of 5 requirements are green; accessible formats and discharge processes remain amber.

BSOTS information and QR codes help explain access and waiting processes.

ASSURANCE IS ABOUT UNDERSTANDING

Accessible formats are not yet complete including the easy-read MAU leaflet.

Personalised discharge fields have not yet been audited for consistent completion.

Coordinated handover is not fully evidenced across onward pathways.

Channel availability alone does not prove comprehension or safe re-attendance.

THE RESPONSE

Complete the accessibility review and easy-read leaflet by September 2026.

Define the discharge audit sample and closure threshold; audit understanding, safety-netting, handover and follow-up by November 2026.

Report interpreter access and usage and test whether women understand next steps and when to re-attend.

Evidence: Annex 1.9 and 4.1–4.5 | Tracker R4 — Communication & voice

Until accessibility, understanding and handover reliability are evidenced, there remains a risk of delayed re-attendance, missed follow-up or fragmented onward care.

Principle 5: Telephone Triage is mature; quality exceptions need action

Current position and insight across access, safety, quality and sustainability

A MATURE 24/7 SERVICE

24/7 dedicated Telephone Triage operates alongside protected open-door face-to-face assessment.

2m 06s average answer wait demonstrates responsive access.

Effective risk stratification: 65% admitted onward; 30% required no onward admission.

Strong experience and core quality: 92.2% promoter score and 100% compliance for clinical action and safety-netting.

QUALITY EXCEPTIONS MATTER

Call-quality exceptions remain: three-point ID 62%, name given 19%, and plan agreement 86%.

6% had no onward pathway recorded, despite a 2-point improvement.

Abandonment is 11.9%, improving by 2.1 percentage points.

Call-to-outcome linkage is incomplete, limiting evidence of impact on avoidable MAU attendance.

THE RESPONSE

Audit open access and urgency documentation to confirm attendance is never restricted.

Close identification, introduction and shared-planning gaps through targeted feedback and audit.

Define an abandonment threshold and safety response; link calls to MAU attendance, re-contact and outcomes.

Align staffing to peaks and complete the SPOC workforce model.

Evidence: slides 21–24 | Annex 5.1–5.8 | Tracker R2 — Workforce; R5 — Equity & data

Telephone Triage is responsive and valued; assurance remains partial until audit gaps close and abandonment, re-contact and outcome impact are evidenced.

Telephone Triage is responsive and effective; targeted quality gaps remain

High-level synthesis of access, demand impact and call quality

2m 06s

average answer wait

3m 25s

average call duration

11.9%

abandonment rate

2.1 percentage-point reduction from last report

24 / 7

service cover

CURRENT POSITION

24/7 dedicated access operates alongside open-door face-to-face assessment.

Telephone advice never replaces assessment; urgent concerns trigger immediate attendance.

Netcall recording, EPR and trained staff support safe, consistent care.

WHAT THIS MEANS

Effective front door: reassures or redirects women while escalating those needing MAU assessment.

Open access protects safety: attendance is not restricted to manage workload.

Pre-arrival information and oversight support flow and urgent capacity.

PRIORITY ACTIONS

Audit open access: confirm attendance is never restricted and urgency/timing are recorded.

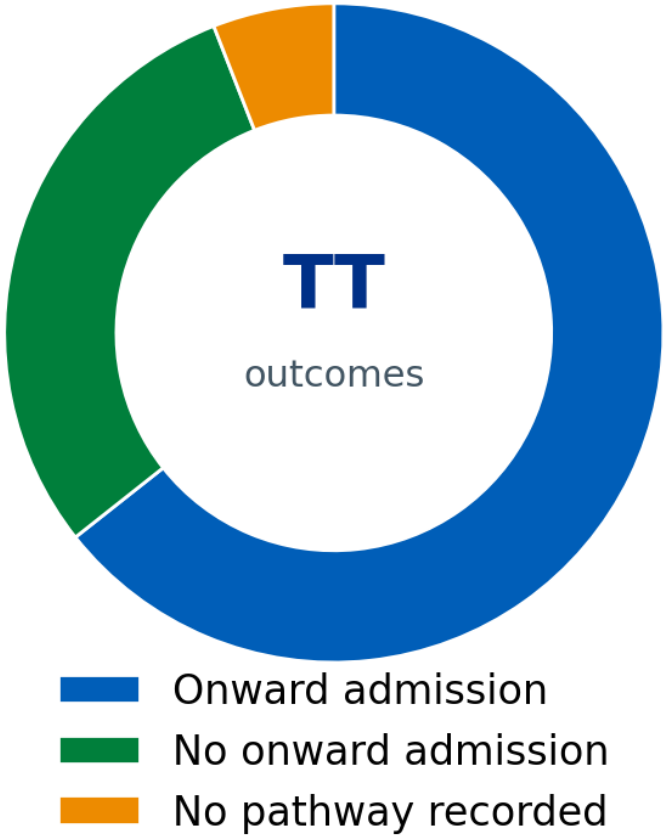
Close call-quality gaps: three-point ID 62%; name given 19%; plan agreement 86%.

Analyse abandonment and link outcomes to demand, staffing and MAU attendance.

Telephone Triage is delivering responsive, safe access; the next assurance step is to close specific audit gaps and evidence its impact on MAU demand.

Telephone triage outcomes: effective front-door decision-making

Reported onward pathway categories



65%

onward admission

30%

no onward admission

6%

no onward pathway recorded

Percentages are rounded and may not total 100%; “not recorded” improved by 2 percentage points from the last Board report.

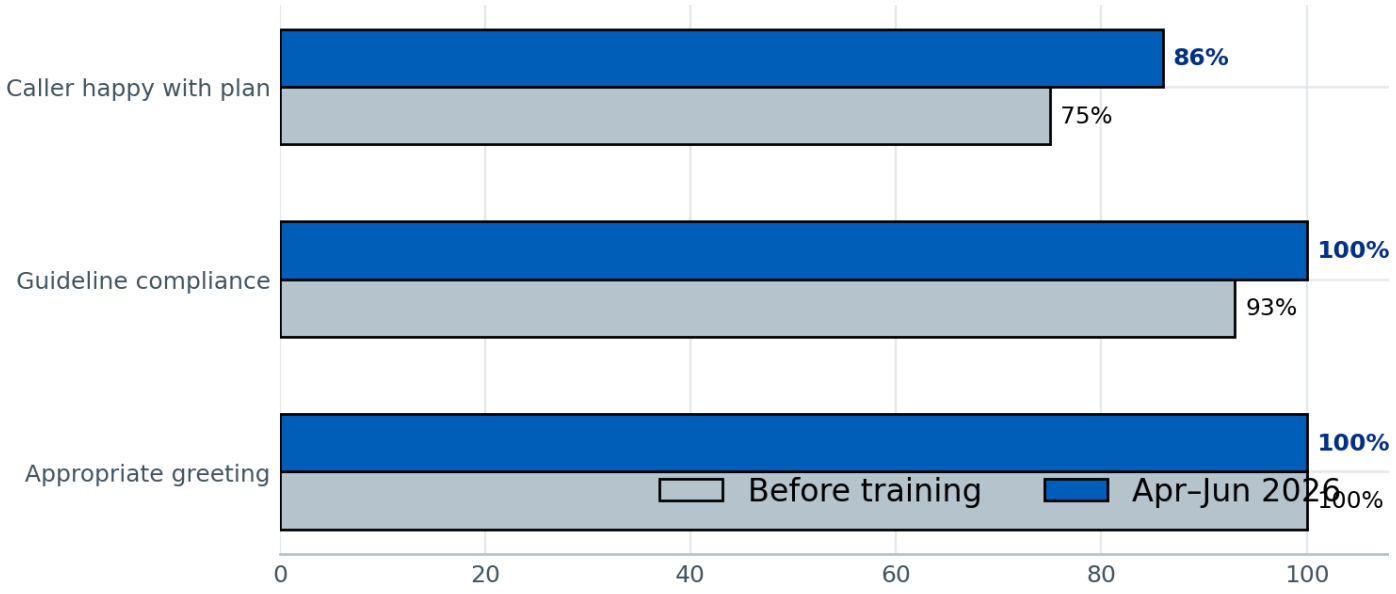
Interpretation

Telephone triage identifies women needing face-to-face assessment while supporting reassurance and alternative pathways.

Outcome recording, and linkage to re-contact and clinical outcome, remains the principal assurance gap.

Telephone triage call quality improved after training

Audit results | before training vs April to June 2026



Remaining quality gaps

62%

3-point ID

19%

name given

86%

caller happy with plan

Maintain the gains in clinical action, tone and safety-netting while targeting reliable identification, introductions and shared planning.

Telephone triage experience is strongly positive

Patient feedback and safety indicators

92.2%

promoter score

129 responses

83%

selected urgent advice

7.8%

neutral or poor

4%

used an interpreter

All reported a positive experience

Patient voice

“Phone line was answered quickly, I was listened to and the midwife rang me back quickly.”

Principle 6: Listening is embedded; closing the feedback loop remains incomplete

Current position and insight across experience, complaints, escalation and co-production

LISTENING IS EMBEDDED

Feedback is gathered through multiple routes, including FFT, SPOC, complaints, MNVP and walkarounds.

Insight is triangulated across quantitative results and lived experience, including Message to Matron and 15 Steps.

131 MAU surveys show improvement to 70% at LRI and 85% at LGH by June.

MNVP attends the MAU Working Group monthly, supporting co-production and decision-making.

THE LOOP IS NOT YET CLOSED

Seven complaints involved MAU and centred on review delays, beds and communication.

Waiting-time awareness remains weaker than "felt listened to" scores.

Survey response rate, representativeness and demographic coverage are not yet shown.

Martha's Rule remains a local red action; PREM is an external dependency; "you said, we did, impact" is not yet evidenced.

THE RESPONSE

Co-produce improvements with MNVP and publish monthly accessible updates for women and staff.

Show two "you said, we did, impact" examples with owners, dates and outcome measures.

Embed Martha's Rule awareness by March 2027.

Adopt the national PREM when it becomes available, using local feedback in the interim.

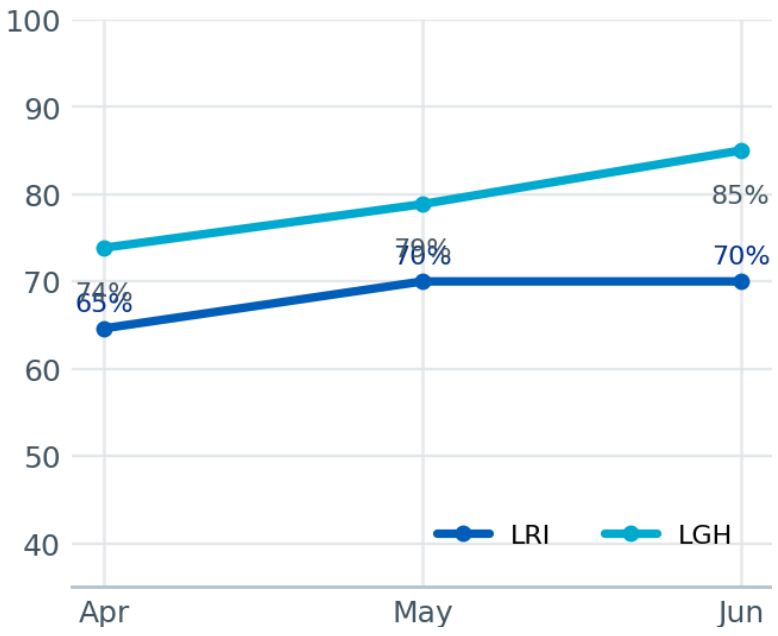
Evidence: slide 26 | Annex 6.1–6.7 | Tracker R4 — Communication & voice; R5 — Equity & data

Feedback routes are strong; fuller assurance requires visible service changes, stronger waiting-time communication and escalation awareness.

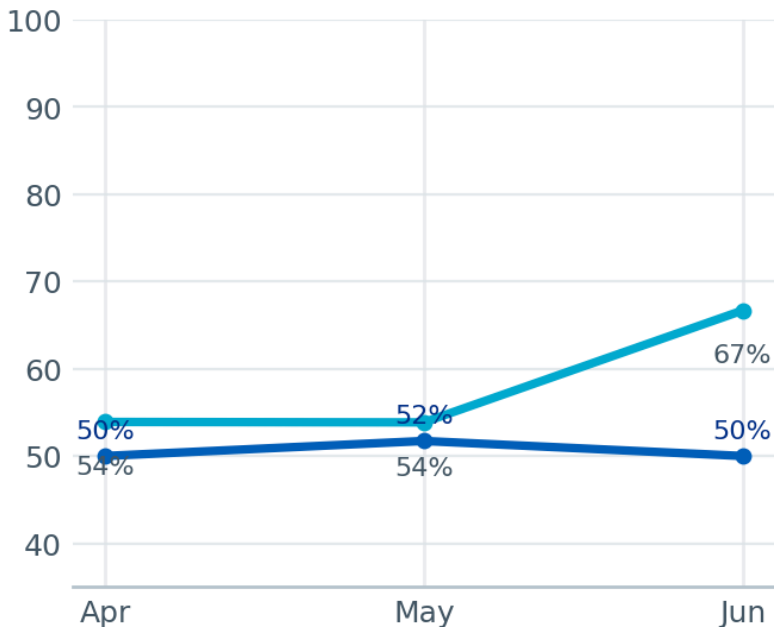
Experience improved, but communication about waits remains weaker

Friends and Family Test | April to June 2026

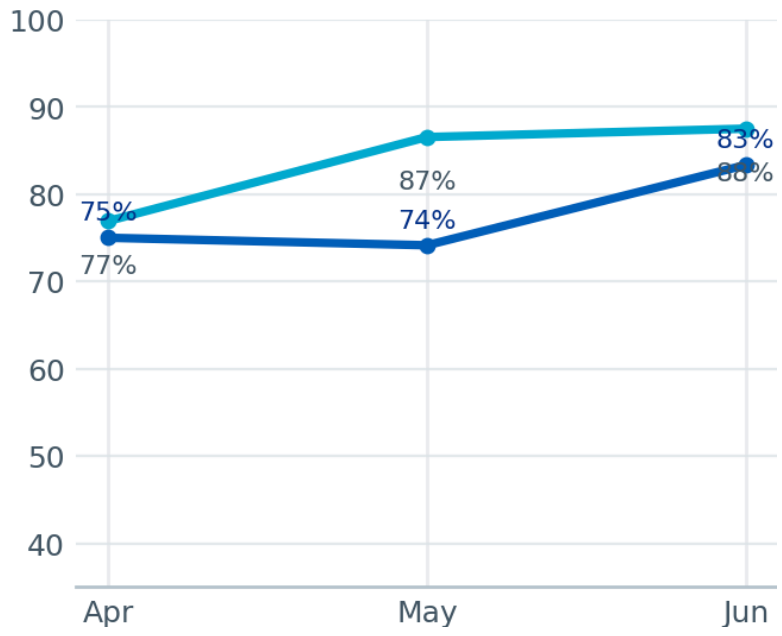
Overall experience



Aware of triage / waits



Felt listened to



Board focus: sustain gains in listening and overall experience, while making expected waits and updates more visible and consistent.

Principle 7: Estate is broadly compliant; two exceptions remain

Current position and insight across environment, accessibility and digital support

9 OF 11 REQUIREMENTS ARE GREEN

MAU is operationally separated from planned/day assessment activity, supported by MDAU policy and referral guidance, helping protect focus on urgent and unscheduled care.

BSOTS Health Checks cover both sites and support assurance on layout and oversight.

Dedicated initial-triage space enables prompt, private assessment.

Diagnostics, reception and handover arrangements support timely care, visibility and escalation.

TWO EXCEPTIONS REMAIN

Accessibility and signage require site-level confirmation.

Accessible WCs and quiet/private areas need evidence through walkarounds.

Digital handover boards are not yet fully implemented.

Length of stay is an operational-flow measure rather than an estates measure.

THE RESPONSE

Complete dated LRI and LGH estates walkarounds by September 2026.

Close signage, accessible WC and quiet/private-space actions with site-level and photographic evidence.

Implement and test BadgerNet handover boards by December 2026.

Continue monitoring privacy, comfort and flow through feedback and environmental review.

The physical environment is broadly assured; accessibility evidence and digital handover are the remaining closure points.

Evidence: Annex 7.1–7.11 | Tracker R3 — Flow & partner pathways; digital/estate actions monitored separately

LRI MAU FEEDBACK

ESTATES / OPS

- Larger Unit - outgrown area for the amount of women through the service
- Comfy Seating Areas
- Bigger Waiting Area
- Better Couches that are able to be used for Emergency Transfers
- Recliner Chairs
- Quiet Room
- Childrens Room / Space
- Discharge Areas
- MDAU at Both Sites
- POD Machine for Bloods
- Bigger Triage Room and away from ongoing care
- Parking Permits / Emergency Parking Space for MAU
- Natural Light / Air Conditioning
- Allocated MAU beds on A/N Wards

STAFFING

- x3 Midwifes on Long Day at Both Sites
- x2 Midwifes and Twilight Midwife 7 till 12 on the Night Shift
- x2 MCA Long Day
- Band 7 Lead Midwife on all shifts to Triage and support Midwifer-Led Discharges
- Medical Staffing Consultant
- Senior Reg; on all shifts for MAU
- Reg
- 8-8 Not shared with Wards
- All Medical staff trained on TV Scans and Dopplers

USER EXPERIENCE

- Vending Machines for Drinks / Food
- Charging Banks
- Patient Journey on TV
- Face-to-face in-house Translators

EQUIPMENT / DIGITAL

- Digital Translation / iPad on Wheels
- More Sonicaids on Wheels
- Computers in all rooms
- Pharmacy Machine for TTOs
- Interactive Whiteboard for patients updated by BadgerNet
- Additional Scan Machine in Assessment Room

MAU flow: most women go home, but the tail of delay is significant

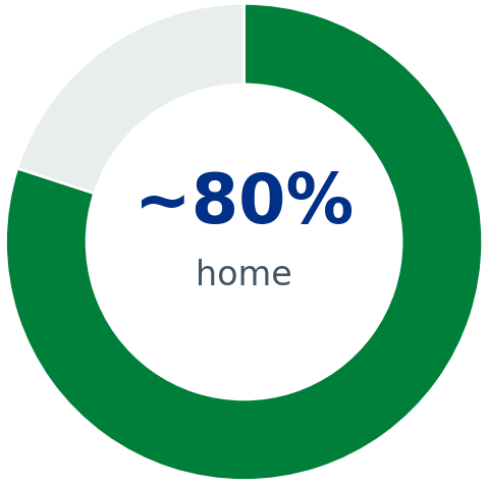
April to June 2026 | Nervecentre data

3h 02m
average ward stay

23h 50m
longest stay

~80%
discharged home

~20%
other onward pathways



The assurance and the risk

Average flow is acceptable for most women, but the 23h 50m maximum indicates a material long-wait tail. Review long waits by medical review, bed and decision-making cause, with harm and escalation outcomes reported through Tracker R1/R2.

Resolve the long-wait tail

Principle 8: Core staffing is established; resilience and review capacity remain vulnerable

Current position and insight across establishment, competency and medical review

CORE ARRANGEMENTS ARE IN PLACE

MAU staffing has increased following the BirthRate Plus establishment review.

24-hour cover is strengthened from August 2026 by additional MAU registrar and junior-doctor capacity, although cover remains shared.

Two Advanced Midwifery Practitioners are due to qualify in September 2026.

4 of 12 requirements are green; eight are amber.

OPERATIONAL FRAGILITY REMAINS

Vacancies remain in midwifery, support and ward-clerk roles.

Seven Datix incidents cited staffing pressure and one TT redeployment was recorded.

Medical-review and bed delays affect flow: April–June average stay was 3h 01m, with a 23h 50m maximum.

BSOTS and telephone-triage training are in place, but the competency framework and compliance evidence remain incomplete.

THE RESPONSE

Use the final BirthRate Plus report to make a documented capacity decision; final report expected Q3.

Complete a site/shift workforce baseline covering establishment, vacancies, fill, sickness and redeployment.

Confirm training compliance and implement the role-based competency framework by December 2026.

Act on the weekend workload audit and strengthen medical-review capacity.

Evidence: Annex 8.1–8.12 | Tracker R2 — Workforce & competency; R1 — Timeliness & medical review

The establishment provides a core service; full assurance requires a confirmed capacity decision, quantified resilience, competency compliance and timely medical review.

Principle 9: Inclusive access is established; equity-outcome assurance is incomplete

Current position and insight across accessibility, population intelligence and lived experience

INCLUSIVE SUPPORT IS IN PLACE

24/7 interpreter support and open access reduce barriers; empathy, anti-racism, EDI and human-factors training support culturally safe care.

The Inclusivity Dashboard provides a developing view of the local population.

MNVP and community engagement bring lived experience into improvement work.

3 of 5 requirements are green; routine inequality intelligence remains amber.

Evidence: Annex 9.1–9.5 and 10.6 | Tracker R5 — Equity & data

OUTCOME INTELLIGENCE IS LIMITED

Demographic and outcome data are not yet integrated routinely into triage oversight.

Repeat-caller counts lack denominators and cannot demonstrate inequity on their own.

Self-discharge analysis identifies themes but not population-adjusted outcome differences.

Current evidence supports inclusion more strongly than equitable outcomes.

THE RESPONSE

Define a minimum equity dataset covering access, waits, repeat contact, self-discharge and outcomes.

Use denominators and outcome comparisons before drawing conclusions.

Link lived experience to a targeted action and measure its effect.

Use Principle 10 to provide the data infrastructure and reporting cadence.

Inclusive access measures are credible; routine, denominator-based equity and outcome reporting is needed to complete assurance

Principle 10: Data coverage is broad; routine Board-level assurance is incomplete

Current position and insight across measurement, governance and improvement action

A BROAD DATA ECOSYSTEM

BSOTS captures activity, waits, acuity and review with supporting MAU and SPOC data.

PSIRF/MNSI, Datix and PAC/PSIP governance provide established safety and improvement oversight.

Anonymous, multilingual FFT and patient-facing updates support transparency and show how feedback improves care.

THREE ASSURANCE GAPS

Outstanding measurement-strategy fields are not yet fully defined.

Formal Board/PAC reporting cadence is not yet embedded.

Demographic variables are not routinely reported with triage outcomes.

Repeated evidence across principles weakens clarity over data ownership.

THE RESPONSE

Create one metric dictionary: definition, source, completeness, period, owner and reporting frequency.

Create a metric gap log showing manual/automated method and delivery date.

Embed a standard PAC report for performance, equity, risks, thresholds and action status.

Convert every priority into Tracker R1–R5 with evidence required for closure.

Evidence: Annex 10.1–10.7 | Tracker R1–R5 — common definitions, thresholds and Board reporting

Data available and reviewed; stronger definitions, demographic reporting and Board-level accountability are needed to prove improvement.

Key Priorities & Next Steps

2026/27 Improvement Priorities & Next Steps

DELIVERY OUTCOME

Convert identified gaps into measurable improvement—with named leads, deadlines and evidence of impact.

The MAU Working Group owns the SMART plan and reports delivery evidence through Tracker R1–R5.

DELIVERY PRIORITIES

- **Results checking —** standard flow, twice-daily review and audit of the 08:00 medical review.
- **Discharge and follow-up —** finalise the self-discharge SOP; embed midwifery-led criteria and follow-up.
- **Planned care —** use PDSA pathways to reduce avoidable MAU attendance.
- **Intelligence —** strengthen dashboard equity measures and the SMART FFT/MNVP feedback loop.
- **Resilience —** build Matron capacity and track SPOC workforce and delivery milestones.

EVIDENCE OF IMPACT

- **Communication —** clear information at arrival and during unavoidable waits.
- **Flow —** fewer avoidable attendances through stronger planned-care pathways.
- **Reliability —** results checked; safe discharge and self-discharge follow-up completed.
- **Learning —** monthly equity, flow and experience reporting, including MNVP “you said, we did, impact”.

Board Assurance Tracker (Residual Risk)

Five consolidated workstreams; accountable leads must confirm ownership and closure evidence before any RAG improves.

Residual-risk workstream	Action / control required	Accountable lead (confirm)	By	Evidence required to close / governance
R1 Medical staffing & review timeliness	Peak/weekend medical capacity is not evidenced, contributing to delayed review and prolonged stays. Confirm the required rota model and senior decision-maker.	MAU Matron / Obstetric Lead	Sep 2026	Site-level review times + weekend demand analysis + approved rota decision + sustained improvement to agreed thresholds; MAU Working Group → PAC.
R2 Workforce & competency	Decide BirthRate Plus capacity; report resilience metrics; implement role-based competency.	Head of Midwifery / Education Lead	Dec 2026	Approved establishment + workforce baseline + competency compliance; Workforce / PSIP → PAC.
R3 Flow & partner pathways	Redirect planned care; formalise partner escalation, handover and operational separation.	MAU Matron / Operational Lead	Oct 2026	Repeat audit shows reduced avoidable MAU use + agreed partner pathways; MAU Working Group → PAC.
R4 Communication & voice	Audit discharge understanding and handover; show feedback-to-change; embed Martha's Rule.	MAU Matron / Patient Experience Lead	Mar 2027	Discharge/handover audit + two impact examples + awareness evidence; Experience governance → PAC.
R5 Equity & data	Implement denominator-based equity reporting, metric definitions and a standard Board/PAC report.	Data Lead / EDI Lead	Sep 2026	Outcome-linked dashboard + metric dictionary + reporting cadence; PAC → Board.

Return to Board/PAC in February 2027 for an interim reassessment; final assurance follows completion of controllable actions and explicit treatment of external dependencies.