

**Independent Review of Maternity Services at Nottingham University Hospitals NHS
Trust**

Independent Investigation into Maternity and Neonatal Services in England

Public Board 30 July 2026

Presented for:	Information and Assurance
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Previous Committees:	Perinatal Improvement Assurance Committee 9 July 2026

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Outcomes – being outstanding now and in the future.
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Learning, Improvement and Innovation
Regulatory Impact	Regulation 12: Safe care and treatment Regulation 15: Premises and equipment Regulation 17: Good governance Regulation 18: Staffing

Key points:	
The following reports were published in June 2026: - Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (24 June 2026) - Independent Investigation into Maternity and Neonatal Services in England (30 June 2026) The reports have been reviewed with executive directors at the Improvement Steering Group, with senior leaders on 1 July 2026 and Perinatal Improvement Assurance Committee on 9 July 2026.	Information and Assurance

Risk Appetite Framework			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Operating outside

1. Summary

The following reports were published in June 2026:

- Independent Review of Maternity Services and Nottingham University Hospitals NHS Trust (24 June 2026)
- Independent Investigation into Maternity and Neonatal Services in England (30 June 2026)

The reports have been reviewed with executive directors at the Improvement Steering Group, with senior leaders on 1 July 2026 and at Perinatal Improvement Assurance Committee on 9 July 2026.

2. Finding and Recommendations – Quality and Performance Implications

Independent Review of Maternity Services and Nottingham University Hospitals NHS Trust (24 June 2026)

The Nottingham Review was commissioned in June 2022 to consider the provision of maternity and neonatal care at Nottingham University Hospitals Trust (NUH) between 2012 and 2025. From 2010 the Trust's maternity and neonatal services were increasingly scrutinised due to concerns related to governance, leadership, and organisational culture. These issues were identified through a combination of internal reporting, regulatory activity and staff feedback. A signature case informed the review together with a large number of other cases over the course of the review and led to a wide-range of recommendations for improvement for the trust, NMC, GMC, Human Tissue Authority and CQC.

Whilst the report is focused on failings in care and where improvements are required there are positive messages in the report.

In the summary statement the Chair highlights that

“in most circumstances, clinicians are committed to providing safe, compassionate and high-quality care. Equally, families rarely seek to attribute blame to individuals when care has been delivered in good faith. What matters most to parents and their families is that, when harm does occur, the truth is told, that accountability occurs, and that meaningful learning is identified and acted upon. In this way, such, sometimes life changing harm, can be transformed into opportunities for improvement, helping to reduce the likelihood of similar experiences being repeated for others”.

There are 8 key headings for the **Immediate and Essential Actions** to be taken following publication of this Report.

1. Listening to Women and Families
2. Workforce Planning and Safe Staffing
3. Training and Multi-Professional Learning
4. Risk Assessment Throughout Pregnancy
5. Incident Investigation and Family Involvement
6. Governance and Board Accountability
7. Culture, Teamwork and Psychological Safety
8. Mothers Who Have Died and Post Death Care

In response to publication of the report, there were key announcements regarding changes that will be implemented in response to the Nottingham review:

- **Martha's Rule will be extended to all maternity settings in England**, so parents can request a rapid review if a baby or mother's condition is deteriorating and they are concerned this is not being responded to.
- A new **duty of candour and assistance** will apply to the independent maternity and neonatal reviews in Leeds and Sussex. This is part of the Hillsborough Law, the name commonly used for **the Public Office (Accountability) Bill**, which is currently going through Parliament. This means that NHS staff who are asked to provide evidence to the reviews would be legally required to co-operate fully, share relevant information openly and honestly, and support the reviews to establish the facts.
- **New measures and checks in hospital mortuaries.** The Human Tissue Authority (HTA) will require trusts to review internal records from 2015 to 2026 as part of an assurance exercise regarding incident reporting. This will be confirmed in a letter from NHS setting out the actions trusts will be required to take. A **Board Assurance Statement** will be submitted to NHSE by **31 July 2026** setting out the arrangements for oversight of mortuary care and the recommendations in the Fuller report (Phase 2) that was published in July 2025.

The HTA carried out an inspection of the mortuary at LGI and St James's in April 2026, the final report was published June 2026. Three major and one minor shortfall were found against standards for traceability processes and premises, facilities and equipment.

There are specific themes running through the report that will support the preparations for the Leeds Maternity and Neonatal Independent Review. These messages were shared with senior leaders on 1 July when the report and recommendations were discussed:

- Patient safety incidents – reporting, grading, escalation and investigation – oversight of improvement plans
- Operating within the Patient Safety Incident Response Framework (PSIRF)
- Understanding of the trusts Patient Safety Incident Response Plan (PSIRP)
- Handling complaints – timeliness, learning, thematic analysis, alignment to improvement plans
- Application of Duty of Candour (Regulation 20)
- Involvement of families, keeping them informed – timeliness, open, honest, transparent

There are a number of other themes that are highlighted in the report that were shared with senior leaders:

- Recognition and response to deterioration, including escalation
- Communication with families – listening to concerns and acting on these, written communications that are sensitive and clear
- Communication and support for patients and families whose first language is not English, including interpreters (reference to reliance on family members)
- Staffing and the impact on patient safety
- Psychological safety for staff in the workplace
- Freedom to speak up
- Documentation and risk assessment (including telephone risk assessment and triage)
- Informed consent – documentation
- Adoption of national guidelines and best practice
- Learning from clinical audit findings
- Governance teams – resources and support

- Continuity of care – sharing information across organisations

Independent Investigation into Maternity and Neonatal Services in England (30 June 2026)

The national investigation was led by Baroness Amos. Twelve trusts were included. The investigation team listened to 450 families, received 10,500 responses to a Public Call for Evidence, 9,000 staff engaged with the review through surveys, trust visits and interviews. The report summarised the conclusions:

- Women are not being listened to, heard or believed, with serious consequences for safety and quality of care, resulting in avoidable harm, trauma and loss of confidence in themselves and in the system.
- Racism and discrimination are embedded throughout the maternity and neonatal system, with unacceptable impact on safety, equity and quality of care, and staff wellbeing.
- Service design and planning is slow to respond to safety and demand and is not equipped to meet the changing needs of women, babies and families - including the changing profile of women giving birth and the increase in medical interventions during births.
- The system is fragmented and care is inconsistent – antenatal, birth and labour, neonatal and postnatal services are not joined up.

The report confirmed that the National Maternity and Neonatal Taskforce, chaired by the Secretary of State for Health and Social Care, will develop and oversee a new national action plan in response to Baroness Amos's findings.

The report sets out eight recommendations to redesign the maternity and neonatal system and deliver fundamental change:

1. The creation of a statutory national Maternity and Neonatal Commissioner to drive the urgent, systemwide change identified by the Investigation and provide leadership for a redesigned maternity and neonatal system, through the Health Bill currently before Parliament
2. Systematically listening to the voices of women and families
3. Improving how the system responds when something goes wrong, including providing a sincere apology and learning lessons
4. Creating a modern service framework which sets out national standards to consistently achieve high quality maternity and neonatal care
5. Tackling racism, discrimination and inequality
6. Improving system governance and accountability structures and regulatory oversight
7. Improving culture and teamworking, and strengthening leadership at all levels of the system and across professions
8. Delivering estates and digital systems that are fit for modern maternity and neonatal care.

The national investigation report acknowledges that due to the scale and scope these actions will take time to implement. However, there are a set of actions that require rapid implementation, which will make a significant difference to the experience of women and families and the ability of staff to provide care. The report recognises that NHSE are developing a national maternity triage specification, to set out what good maternity triage services look like. This is highlighted as a key safety intervention and makes recommendations for this to be expedited and to ensure that the national maternity triage specification includes the following actions as a minimum:

- Dedicated midwife resource to be available to answer calls and provide timely advice. For telephone triage services, staff must offer a face-to-face appointment if women remain concerned.
- Appropriate clinical capacity and escalation pathways to maintain patient flow to be available at all times of day and night and at weekends. This will include access to a senior clinical decision maker.
- Clear board oversight to be in place within trusts about the operation of the triage service, including regular reviews of waiting times, performance and implementation of actions to improve the service where identified.
- Ensure units have sufficient antenatal bed capacity to admit women for support in early labour.
- Within 12 months, an evidence-based tool to be mandated as the national triage standard across all NHS maternity units, with compliance monitored through regional and national maternity safety oversight.
- All maternity units to have dedicated triage staffing structurally independent of labour ward midwifery numbers. Redeployment from triage to labour ward to be formally classified as an escalation event requiring documentation and review. Triage midwives to be sufficiently trained in rapid assessment.
- National training pathway for midwives working in triage to be developed, enabling advanced practice, with clear competency frameworks and governance.
- Triage performance data (including time to initial assessment, review times, redeployment frequency, and outcome data for women who experienced delays) to be collected, reported, and published at trust, regional, and national level quarterly, as a board-level patient safety indicator.

In the interim, all trusts will be required to complete a board-level audit within the next three months (end of September 2026) of current triage provision, taking account of the points highlighted and with particular attention given to staffing, including medical staffing at appropriate seniority 24 hours a day, 7 days a week. The results of this audit will be reported to regions and DHSC/NHSE.

In response NHSE have published a 10-point plan to be implemented in the first 100 days, following a national meeting with Chief Executives, Chief Medical Officers and Chief Nurses on 30 June 2026:

1. Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27
2. Implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data
3. Establish clear joint accountability at board level for maternity and neonatal services, with Medical Directors and Chief Nurses holding shared responsibility for oversight, performance and improvement
4. 'Amos into action' staff listening exercise to be launched by NHSE
5. National rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026
6. Review staffing to ensure 24/7 availability and responsiveness across key workforce groups
7. Review the safety and quality of homebirth services
8. Review how trusts respond to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour
9. Deliver safe and effective triage in maternity services

10. Post death care – respond to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years.

The trust will work in conjunction with maternity and neonatal leaders to implement the actions, these will be reviewed and incorporated into the perinatal improvement plan and progress will be reported to PIAC, for assurance.

3. Financial Implications

There are recommendations in the report related to staffing, estate and infrastructure that will have financial implications both locally and nationally. This will be reviewed with maternity and neonatal leaders in conjunction with executive directors.

4. Risk

Perinatal Improvement Assurance Committee provides oversight of the Trust's patient safety and outcomes risk. The Trust is currently operating within the risk appetite for the level 1 risk (clinical risk), it is operating outside the risk appetite for the level 2 risk category (patient safety and outcomes) set by the Board as a consequence of the findings from the CQC inspections of maternity and neonatal services and well-led, the breaches in Regulations included in the report and the Section 29A Warning Notice that was issued under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk is referenced in the Corporate Risk Register CRRE1 – breache(s) of Regulations – maternity and neonatal services.

5. Communication and Involvement

The reports have been discussed with senior leaders and key messages shared with staff across the trust.

6. Impact on Equality and Health Inequalities

The themes related to health inequalities are described in specific chapters of the reports, the findings and recommendations related to this will be incorporated into the perinatal improvement plan.

7. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

8. Recommendation

Trust Board is asked to:

- Receive the reports published in June 2026 and note the findings and recommendations and the actions the trust is required to take.
- Be assured regarding the trust's response to the findings and recommendations in the reports, which will be reviewed in conjunction with maternity and neonatal leaders and incorporated into the perinatal improvement plan and progress reported to PIAC.

Supporting Information

Appendix 1 Independent Review of Maternity Services and Nottingham University
Hospitals NHS Trust (24 June 2026)

Appendix 2 Independent Investigation into Maternity and Neonatal Services in England (30
June 2026)

Appendix 3 NHSE letter 26 June 2026 – post-death care and mortuary oversight

Appendix 4 NHSE letter 30 June 2026 – 10 Point Plan (100 days)

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21 July 2026