

- To:
- NHS trust and ICB:
 - chief executives
 - chairs
 - chief nursing officers
 - medical directors
 - chief operating officers

NHS England
Wellington House
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30 June 2026

- cc.
- NHS England region
 - regional chairs
 - regional directors
 - medical directors
 - chief nursing officers
 - chief midwifery officers
 - regional obstetricians

Dear colleagues,

Publication of Baroness Amos' independent investigation into maternity and neonatal services in England

Thank you for joining today's event and contributing to our conversation about maternity and neonatal services. I don't think anyone who attended today could have been anything other than deeply moved by what we heard and discussed.

This is a moment in our history that requires our collective leadership to act with real urgency in addressing the failings and harm experienced by women, babies and families and improve maternity and neonatal care.

None of this is going to be easy, but we all agreed today that this must be a turning point for maternity and neonatal services in the NHS. Women, babies, and families deserve better, as do our colleagues working in these services.

As set out during the event today, we have created a 10 Point Plan for maternity and neonatal services (see Annex 1), taking those elements from [Baroness Amos' national](#)

[investigation](#) and Donna [Ockenden's recent review](#) that we must focus on delivering now. This is a set of urgent actions in response to the recommendations in both reports that we are asking trusts and the wider system to prioritise.

These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December. Further information and a reporting template will be shared soon.

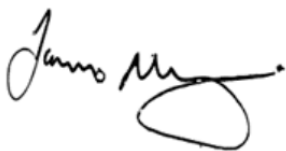
In response to the Amos report, the government has also announced NHS England will make £10.6 million available in 2026/27 to support the recruitment of newly qualified midwives, helping them enter and remain in the NHS while strengthening frontline maternity capacity. See Annex 2 for further information.

The government also announced the creation of the UK's first ever Maternity and Neonatal Commissioner, providing an independent voice to strengthen focus on safety, experience, equity and accountability for women, babies and families. Alongside this, an additional £41 million will be invested to improve the safety and quality of the maternity and neonatal estate, supporting better environments for those using and working in maternity and neonatal services.

As we heard today, this must be a turning point for the NHS. Trusts and systems have already prioritised improving maternity and neonatal care, and progress has been made through the commitment and hard work of staff. We cannot allow failures in care to persist and be followed by reviews that continuously highlight the same themes.

Thank you for your leadership as we respond and move forward together with urgency to deliver lasting change for women, babies and families, and rebuild trust and confidence in maternity and neonatal care.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'James Mackey', with a stylized flourish at the end.

Sir James Mackey
Chief Executive Officer

Annex 1

Urgent Actions

Action	Description
Listening to women and their families by rolling out Martha's Rule	Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27. Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings. Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.
Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal

	parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards. As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings. The aim is to support this approach through national webinars.
Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	All trusts must 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. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.
‘Amos into action’ staff listening exercise	Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national

	conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).
Addressing inequalities in maternity and neonatal outcomes	We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.
Ensuring 24/7 safety and responsiveness of maternity and neonatal services	All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in

	bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.
Trusts to review their homebirth services	Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services. Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team. NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.
Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour.

	We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.
Deliver safe and effective triage in maternity services (already committed by Government)	All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.

Post death care (already committed by Government)	All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding 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. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

ANNEX 2

Support for the recruitment of newly qualified midwives

The government has invested in expanding midwifery training, resulting in a strong pipeline of newly qualified candidates. Maternity services have also undertaken significant work to recruit, support and retain newly qualified midwives, including through preceptorship and flexible workforce models. There is now an opportunity to maximise the benefit of this investment by ensuring newly qualified midwives are able to enter employment promptly and contribute to increasing frontline capacity.

National offer for 2026/27

NHS England will make £10.6 million available in 2026/27 to enable the recruitment of newly qualified midwives. £9 million of this funding will be recurrent and incorporated into provider baselines from 2027/28 to support ongoing workforce growth and service stability.

The funding is intended to support providers to create additional temporary Band 5 midwifery roles, over and above planned recruitment. It should support recruitment ahead of future turnover and, where appropriate, enable temporary recruitment above establishment to increase clinical capacity and support safe staffing.

As in 2025/26, providers should explore the temporary uplift and utilisation of vacant maternity support worker roles to enable the creation of additional Band 5 midwifery posts, providing a structured route for newly qualified midwives to transition into substantive employment as vacancies arise.

Funding must be used to deliver additional employment opportunities and should not be used to fund posts already planned within existing workforce plans or budgets.

NHS England regional teams will work with systems and providers to support delivery and ensure the offer reflects local workforce needs.

Expectations of systems and providers

Providers should continue to strengthen early career support, including high-quality preceptorship, supervision and pastoral support, to improve retention and support early career development. This investment should also inform longer-term workforce planning, supporting sustainable growth in midwifery capacity.

Organisations should work in partnership with staff side representatives and maintain clear communication with students and graduates to support confidence in NHS employment pathways.

Implementation, monitoring and assurance

Funding will be distributed through existing mechanisms, with further detail to follow. Regional teams will work directly with systems and providers to support implementation and ensure funding is applied effectively.

A national monitoring and assurance approach will track delivery and impact, focusing on evidence of additional employment opportunities, increases in frontline workforce capacity and improvements in newly qualified midwife employment outcomes.

Progress will be monitored through established workforce reporting arrangements and used to inform future workforce planning and policy development.

Next steps

Further operational guidance, including allocation details and reporting requirements, will follow shortly.

Organisations are asked to begin early planning and engagement locally to ensure rapid mobilisation following publication of Baroness Amos' investigation report.
