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# Maternity and Neonatal 10 Point Plan assurance process

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To:

- NHS trust:
  - chief executives
  - chairs
  - chief nursing officers
  - medical directors
  - chief operating officer
  - communications directors

cc:

- Integrated care board (ICB):
  - chief executives
  - chief nursing officers
  - medical directors
- NHS England:
  - regional directors

- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

Dear colleagues,

## **Maternity and Neonatal 10 Point Plan assurance process**

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the assurance process and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.

The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with Maternity Incentive Scheme (MIS) Year 8 (<https://resolution.nhs.uk/2026/03/31/maternity-perinatal-incentive-scheme-year-8-supporting-safer-care-through-evaluation-and-evolution/>), enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the standardised national reporting template (<https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/>) to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, 'Amos into action' will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out in his letter (<https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>), this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a maternity triage benchmarking tool (<https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/>) to support implementation of the national maternity triage specification (<https://www.england.nhs.uk/publication/national-maternity-triage-specification/>). You can find the full detail in the appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,

**Duncan Burton** Chief Nursing Officer for England  
**Professor Frankie Swords** National Medical Director

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## **Appendix: Maternity and Neonatal 10 Point Plan – support available**

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the [Model Board Report](https://future.nhs.uk/LocalTransformationHub/view?objectID=63614480) (<https://future.nhs.uk/LocalTransformationHub/view?objectID=63614480>) (login required) to support their reporting process.

Support will be available to help trusts and systems implement the 10 point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided below. For any queries relating to the reporting template, please contact [england.maternitytransformation@nhs.net](mailto:england.maternitytransformation@nhs.net) (<mailto:england.maternitytransformation@nhs.net>).

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## **Martha's Rule**

Trusts should follow the implementation and reporting processes outlined by the [Martha's Rule](https://www.england.nhs.uk/patient-safety/marthas-rule/) (<https://www.england.nhs.uk/patient-safety/marthas-rule/>), national team in NHS England. A webinar is scheduled for **Wednesday 12 August, 3pm to 4:30pm** to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication.

The session will provide key information to support local implementation, including:

- an overview of the three components of Martha's Rule
- the national implementation approach
- learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings
- the implementation support, resources and tools available to local teams.

The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team.

The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email [england.psimprovement@nhs.net](mailto:england.psimprovement@nhs.net) (<mailto:england.psimprovement@nhs.net>)

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## **Maternity and Neonatal 10 Point Plan supporting webinar series**

The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in **August**.

The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on:

1. Listen to women and their families using real-time and transparently reported outcomes and experience, **Monday 17 August 2026, 11:30am to midday**
2. Clinical audit, **Wednesday 19 August 2026, 3:30pm to 4:00pm**
3. Ensuring 24/7 safety and responsiveness of services, **Wednesday 19 August 2026, 11:30am to midday**
4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, **Thursday 20 August 2026, midday to 12:30pm**

Further information will be shared soon.

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## **Amos into Action staff listening exercise**

This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services.

Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.

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## Safe and effective maternity triage

The [triage benchmarking tool](https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/) (<https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/>) has been shared by NHS England to support implementation of the [maternity triage specification](https://www.england.nhs.uk/publication/national-maternity-triage-specification/) (<https://www.england.nhs.uk/publication/national-maternity-triage-specification/>).

Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.

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## Post death care

Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: [NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry](https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/) (<https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/>).

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