AIMS views on the 10 Point Plan announced following the June 2026 Ockenden and Amos Reports

We have set out our comments against the 10 Point Plan set out in Sir James Mackey's letter following the publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England, dated July 1 2026.

	Theme	What this means	Detail	Implementation notes	AIMS comments
M1	**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.	Yes, it's important to get this in place. It could be helpful in various ways, and it's important that Maternity is included in such cross-nhs initiatives, unless there is a good reason not to be. Time will tell just how it has been effective. This rollout was discussed recently at NHS England's Maternity and Neonatal Stakeholder Council. In previous correspondence with them, AIMS has found the team running this initiative communicative and on the ball. But nb: this is listening to women and families on just one (albeit hugely important) issue of concern - that of deterioration. ***Are we satisfied that we have a well-publicised and monitored route for escalation and resolution for women and families in the case of other concerns?***
M2	**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**	2.1 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.		We particularly applaud the notion of transparency here in terms of what is reported to the Board around patient outcomes and experience data, and that it must be to the Public Board. Too often we find that important issues are hidden from public view because the detail lies in papers not included in the publicly accessible board information (for example, if having been 'dealt with' in a committee of the Board). How often are Trust Boards expected to meet? This suggests monthly: is this currently the case for all? When will the Patient-Reported Experience Measure (PREM) be available? Will stakeholders be consulted on the final draft version? It is hard to understand why this suggests only selected PREM elements until we have seen it. Is there a common framework for patient experience collection, analysis and reporting, to ensure that this is done to a high-standard within every

		2.2 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.	provider? For various reasons, we also assume that MNVP work will supplement a robust in-house approach. Can we be assured of that point? It will probably be useful for you to define 'minority groups' in this context. To date, a helpful framework here has been CORE20+5, which gives local flexibility within the national ask. Most importantly, we consider that M1 and M2 fail to capture the more nuanced requirement to listen to women ((who are the rights-holders in maternity care - not their families) as a crucial element of ongoing safe, personalised and equitable maternity care. And just listening in itself is not enough, of course: crucially, it requires the creation of a space in which women will speak up, where trust and confidence has been established. Such upstream information-sharing is essential, not least in order to try to avoid the potential catastrophes that are provided for, for example, through the adoption of the downstream Martha's law. We look forward to further consideration of how to embed this element of upstream safety critical listening as the Comprehensive Reform Plan is developed: we see no obvious way of ensuring this other than via a full pathway community-based midwifery continuity of carer model of care. The call for reinvigorating clinical audits is welcome. NHS England may not be aware, however, that this is a particularly difficult area in terms of accessibility and transparency, and we would welcome some assurance being given on this.
M3	**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.		This is an interesting approach. It is not clear how this builds upon and improves the current (and in our view flawed) system of leadership and accountability that sits (a) in the current Board structure, as well as (b) below that via the four or more leaders, known as the Quad (generally including the Director or Head of Midwifery, the Clinical Director/Director for Obstetrics, the Neonatal Clinical Lead and an operational/management representative, although this team of 4 has been expanded in some areas). A simple exhortation for there to be parity between members of the senior leadership Quad is not sufficient, by the way, although we appreciate the sentiment. A more sophisticated analysis of power is necessary, and this would begin by naming the problem that lies behind this statement.. Maybe this overall approach suffices for now, but we would welcome assurance that this is part of an ongoing improvement discussion. For example, we would be keen to see a template for discussion that develops a single point of accountability for maternity and neonatal services. We recognise that this is complex territory, given the traditional cross-hospital Board roles of clinical director and director of nursing. It might be that a sunset clause approach could be used to good effect here, to offer a temporary boost to this clinical service area in terms of offering that single point for maternity and neonatal, akin to the 'subject matter expert' suggested in the Ockenden Report. It also seems to us that further consideration should also be given to the role of the non-executive board-level maternity safety champion. How has this been working in practice?

M4	'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).		This feels like a sensible next step but does rather beg the question of whether there should be a service-user listening exercise too. What is the thinking on that?
M5	**Addressing inequalities in maternity and neonatal outcomes.**	5.1 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. 5.2. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital 5.3 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.	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.	We welcome the news that this rollout should be achieved ahead of schedule, against October 2025 plans. We look forward to seeing key feedback arising from the implementation and evaluation work done to date.
M6	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			AIMS finds it extremely disappointing that this even needs saying, and therein lies, perhaps a key issue: why don't all Boards see themselves as accountable for all this? We think this speaks to the plethora of initiatives that seek to 'support' local maternity services. With the best possible intentions, have we effectively created the conditions for Boards NOT to function well when it comes to maternity and neonatal services? Why should they, when so many other parts of the system are seemingly taking the lead? This is a warning we must heed as the Comprehensive Reform Plan is developed. It also reflects poorly on the role of commissioners. It would be interesting to know how often Commissioners have raised concerns that their local maternity service is not delivering high-quality services? The role for commissioners described in this action seems curiously narrow. Given the current gap in the ability to see obvious ideas for

		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.			strengthening frontline service provision on the part of Boards, we very much welcome the instruction to Boards to redeploy staff to the frontline where service provision needs strengthening - we have long noticed a 'creep' of staff away from the front line, in a myriad of roles. Sometimes specialist roles, away from the front line, must be filled by healthcare professionals, but it is certainly not the case that all should be. This is another area where thinking differently is key, and we'd be keen to see a national overview on how this instruction works out in practice. Similarly, we are concerned about the skill loss across the whole staff team where roles are assigned to specialists. Rather than specialist midwives performing 'specialist roles', for example, we would like to see them becoming 'subject experts' with a remit of ensuring that all midwives have the up-to-date knowledge and skills required for their roles. In this, we will encounter the problem that everyone has their favourite specialist role, that they would wish to protect. We would also flag up barriers to effective working in the form of contractual arrangements that Trusts may have made with staff. As we have previously noted, all staff contracts should be drawn up with the needs of service users in mind, and be well-aligned with the direction of policy which is for a more flexible midwifery workforce, to ensure that we 'staff the woman' and not 'the building'.
M7	**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.	It is a matter of great concern to AIMS that some/many (do we know?) services - on various grounds - are refusing to support women who choose to labour and birth at home. This must stop. We call for transparency around the Trust's individual reviews on this matter - we know that some have avoided scrutiny by not discussing the matter as expected at their Public Board, or by implying that this is instead a matter for the LMNS. In our experience, this latter approach heralds a whole new level of lack of transparency/ lack of opportunities for scrutiny. We suggest that Regional Offices report publicly on this issue, to follow up the November 2025 call to action.. We note that there is no timescale around NHS-E's current work on standards/a framework for care when women decline recommended care. Our sense (we have a representative on the working group) is that this work has not been scoped, planned, and developed in an ideal manner, and we look forward to its rapid move to the open consultation stage with an improved methodology and without compromise in the quality of the work.
M8	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.	Again, it is extremely disappointing to AIMS that this needs to be said. We also note that though humanity, candour and a trauma-informed approach are essential, Trust Boards also need to ensure that they provide resolution for the woman or family, and that corrective actions are implemented and monitored effectively. We expect the suggested blueprint to be concise, and ideally be compiled by and draw on resources produced beyond the maternity team, as this is not a maternity specific issue and they have maternity-specific work enough. We will be very interested to see what Trust Boards need to be told on this issue.

					We note that there are no timescales around this work, but we would hope that service users see an immediate improvement on this measure immediately.
M9	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	Again, we are in a poor place indeed when Trust Boards need to be told that attending appropriately to women and families who reach out for support is part of their remit. We look forward to reviewing the forthcoming NHS-England guidance, which we trust will be evidence-based and explicitly respectful of women's legal and human rights. We are wary of talk of women's 'preferences' when what is actually being talked about is women's decisions about their needs and about their care. We suggest that the Trust audit should include looking at the impact of earlier/later assessment and earlier/later admission to hospital/birth centre on outcomes, in order to inform future guidance.

	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.			The work of AIMS relates to improvements in maternity services and NHS post death care is outside our remit.