East Suffolk and North Essex NHS Foundation Trust

Council of Governors

Date of Meeting:	30 September 2026
Report Title:	Implications and recommendations following the Ockenden Review and Baroness Amos Report
Executive/NED Lead:	Catherine Morgan, Chief Nurse
Report author(s):	Amanda Price-Davey, Director of Midwifery

☐ **Approval** ☑ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

This report is presented to the Council of Governors for information and keeps governors updated on the implications of the Ockenden Review, Baroness Amos Report, the NHS England Maternity and Neonatal Services 10 Point Plan and the national maternity triage specification. The Quality and Patient Safety Committee considered the substantive report on 20 August 2026, and some governors attended that meeting.

Since that consideration, the Trust has completed and validated its 10 Point Plan baseline and separate maternity triage benchmarking assessments for Ipswich and Colchester. The Extraordinary Board approved the baseline on 23 September 2026 and received the two triage audits as the Trust baseline before submission to NHS England.

Good assurance can now be given that the benchmarking required at this stage has been completed, the Trust has been transparent about areas requiring further development, and governance arrangements are established to oversee delivery. This does not mean that every newly published requirement is already fully implemented or that the workforce, capacity, estate and data pressures described in the report have been resolved. These matters remain subject to continuing oversight through the Maternity and Neonatal Improvement Board, Quality and Patient Safety Committee and Board. A further Board-approved progress return is required by 31 December 2026.

Action Required of the Council

The Council of Governors is asked to note the report, the good level of assurance following completion of the national baseline and both site-level triage benchmarking assessments, and the arrangements for continuing Board and committee oversight.

1. Background and context

In June 2026, Donna Ockenden published the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust. The review identified sustained failures across

leadership, culture, governance, workforce and clinical practice, together with repeated failures to listen to women and families and to act on known concerns. Many of the themes had been identified in earlier maternity reviews but had not been implemented consistently or sustained.

Baroness Amos subsequently published her Independent Investigation into Maternity and Neonatal Services in England. Although national in scope, the report described familiar and recurring themes: unacceptable variation in care; inequalities in outcomes and experience; insufficient listening to women, families and staff; workforce and leadership pressures; and organisations becoming accustomed to longstanding problems, workarounds and risk. The important implication for Boards is that the absence of a new incident or immediate harm does not in itself mean that a longstanding risk is adequately controlled.

The recommendations from the two reports have not been accepted in full as the national policy response. The newly established National Maternity and Neonatal Taskforce has instead been asked to consider the findings and recommendations together and develop a comprehensive national action plan. Further national direction is expected in December 2026. This means that the final national response remains in development, but providers are not being asked to wait before taking action.

As an interim response, NHS England issued a 10 Point Plan of urgent actions for all maternity and neonatal providers. This paper builds on the report presented to MNIB in July 2026 and incorporates the National Maternity Triage Specification published on 29 July 2026 and the NHS England assurance letter issued on 12 August 2026. It is structured to take the Council of Governors from the national context and requirements, through ESNEFT's strengths and current position, to the areas requiring further attention and prioritisation.

ESNEFT has credible strengths and established improvement activity. Good assurance is offered that the national baseline and both site-level maternity triage benchmarking assessments have been completed and validated, remaining gaps are clearly identified, and there is an established route to delivery. Workforce sustainability, triage, senior obstetric responsiveness, estates and data remain priorities for continuing oversight.

2. What Trusts have been asked to do

Pending the Taskforce's final national action plan, NHS England has asked trusts to focus on ten urgent actions. These cover Martha's Rule; monthly Board review of outcomes and experience; dual Chief Nurse and Chief Medical Officer accountability; staff listening; inequalities and the Maternal Care Bundle; 24/7 safety and responsiveness; homebirth; humane and candid responses to incidents and complaints; maternity triage; and post-death care.

The 12 August assurance letter converts these priorities into a formal assurance process and makes the expectations more explicit:

- a standard national baseline assessment must be submitted to the East of England region by 25 September 2026;
- a progress update must be submitted by 31 December 2026;
- both submissions require Trust Board approval and visible Board ownership, scrutiny and escalation of significant concerns through ICB and regional routes;

- existing evidence will be used wherever possible, including Board and committee papers, dashboards and MIS Year 8 evidence;
- the national maternity triage benchmarking tool, issued by NHS England alongside the assurance materials on 12 August, should be used for the Board-level audit. The audit is expected by the September submission, with full implementation of the specification within 12 months; and
- "Amos into Action" will be a nationally led, NHS-wide staff listening exercise. Trusts are encouraged to support staff participation and consider how local learning will be governed and acted upon. Further details are expected shortly. No return is required for this action within the national assurance template.

ESNEFT has completed and validated its baseline assessment against the national 10 Point Plan. The Extraordinary Board approved the completed baseline on 23 September 2026 and received the separate Ipswich and Colchester maternity triage benchmarking assessments as the Trust baseline before submission to NHS England. Relevant improvement activity is underway across all ten areas, supported by an evidence and action log and established governance arrangements.

3. Key strengths

Strength	Evidence and significance
Established governance and improvement infrastructure	MNIB provides multidisciplinary oversight; PSIRF is embedded; bi-monthly safety reporting supports learning; the Trust has existing routes through QPS and Board and can align the national return with MIS Year 8 evidence.
Women and families increasingly involved	MNVP involvement is established, including participation in PMRT, co-production of information and contribution to mandatory training. Birth Reflections, FFT and complaints learning provide further routes for insight.
Established 24/7 maternity triage and use of BSOTS	ESNEFT provides 24/7 maternity triage across both acute sites and uses the Birmingham Symptom-specific Obstetric Triage System (BSOTS) to support consistent assessment, prioritisation and escalation according to clinical urgency. Dedicated maternity triage telephone lines are in place on both sites, with the Ipswich service introduced in early 2025. The Advanced Midwifery Practitioner (AMP) model is contributing to improved triage performance on the Colchester site and has received positive regional feedback; a further AMP is supporting antenatal capacity at Ipswich. These arrangements provide a strong clinical foundation on which to build the Trust's response to the national specification.
Band 7 frontline leadership development	The Leading Labour Ward programme has been evaluated across two cohorts. All nine NHS Healthcare Leadership Model capabilities improved and eight showed statistically significant improvement. The greatest gains were Sharing the Vision (+1.31), Developing Capability (+0.98) and Connecting our Service (+0.95). Across both cohorts, self-efficacy increased by 20% and work engagement by 30%, both statistically significant. Resilience increased by 11%, although this was not statistically significant. The repeatability across cohorts supports confidence that the programme is strengthening leadership capacity rather than producing isolated benefit.

Strength	Evidence and significance
Maternal Care Bundle mobilisation	Clinical leads and task-and-finish groups are in place across all five elements, providing a structure for delivery towards full implementation by March 2027.
Post-death care assurance	The Trust completed the required Board-level review, with the Board Assurance Statement signed by the Chief Executive and Trust Chair on 30 July 2026. Within maternity, specialist bereavement provision and established links with PMRT and wider governance provide a foundation on which to develop a more resilient cross-site, seven-day service.
Sustained investment in maternity workforce	The Trust has invested additional resources in maternity services over the past five years in response to increasing acuity and complexity. This has included increasing midwifery capacity, strengthening the 24/7 senior midwifery leadership model by building a second Band 7 role on each acute site into the staffing templates, and investing in obstetric workforce and leadership arrangements. This provides a stronger platform for the next phase of workforce development.

3.1 Sustaining the Band 7 leadership strength

The evaluation supports the programme as a patient-safety and workforce intervention, not simply a development course. Stronger ability to share direction, develop colleagues, connect services and hold to account is directly relevant to the leadership failures described in national maternity reviews. The programme also provides a cohort of leaders who can act as culture and improvement champions across both sites.

The evaluation nevertheless identifies what is required to convert learning into sustained service impact:

- greater transparency and Band 7 involvement in service decision-making;
- protected management time and support to develop and retain midwifery talent;
- continued meaningful dialogue with senior leaders and structured collective reflection;
- use of delegates as culture champions and leaders of improvement;
- extension of just and inclusive culture development to senior leaders, with consistent use of Equality Impact Assessments; and
- continued organisational development support, empowering line management and consistent reinforcement of expected leadership behaviours.

4. What more needs to be done: priorities for focus

Priority	Why it matters	Assurance focus / governance route
1. Evidence-based 10 Point Plan assurance	Current ratings have not all been validated and several lines lack a RAG. Green status without evidence may overstate assurance.	QPS should receive assurance that the evidence has been validated, material gaps and resource implications have been identified, and unresolved risks are visible before Trust Board approval.

Priority	Why it matters	Assurance focus / governance route
2. Sustainable midwifery workforce and staff resilience	The Birthrate Plus review will provide an updated assessment of the midwifery workforce required across the maternity pathway. Current funded staffing templates may not provide sufficient uplift or headroom for all staff to undertake mandatory CNST training while maintaining clinical cover. Resulting gaps are filled predominantly through bank shifts worked by substantive staff. This supports continuity and limits agency use but can reduce resilience and may contribute to fatigue and sickness absence.	QPS should receive assurance on the quality and safety implications of the Birthrate Plus findings and the adequacy of funded uplift. Any proposed changes to establishment, templates or recruitment should be considered through established workforce, financial and business-planning processes, taking account of affordability and preceptorship capacity.
3. Maternity triage	The national specification requires triage staffing to be based on local attendance, demand, peak times and acuity rather than birth numbers alone. Applying this approach for the first time may identify additional midwifery and obstetric requirements. The first baseline data on medical review within BSOTS timeframes are expected this month, although data-quality issues remain. Current medical staffing arrangements may not consistently provide the level of dedicated medical capacity anticipated by the national triage specification, particularly at Ipswich and during evenings and overnight. The emerging BSOTS baseline will help quantify the position and inform any required service response.	QPS should receive assurance that the national audit has assessed activity, attendance, acuity and BSOTS timeliness separately for each site; that material midwifery, medical, estate and data gaps are identified; and that any proposed changes to the AMP or medical workforce model are routed through the appropriate Trust planning and approval processes.

Priority	Why it matters	Assurance focus / governance route
4. Obstetric workforce and 24/7 responsiveness	There is no nationally agreed workforce modelling methodology for obstetrics and gynaecology. Local experience indicates increasing pressure at consultant and registrar level from additional antenatal and caesarean lists, increasing complexity and the combined demands of obstetrics and gynaecology. Out of hours, one registrar covers each site; electively, increased gynaecology referrals and waiting lists also affect obstetric capacity.	QPS should receive assurance that obstetric and gynaecology demand, acuity, rota resilience and response times are being assessed and that any material risks are managed through established workforce, financial and risk governance. The Trust should continue to seek a nationally standardised obstetric and gynaecology workforce modelling methodology.
5. Wider multidisciplinary cover	24/7 safety also depends on anaesthetic, neonatal, theatre, support and specialist roles.	Provide assurance that anaesthetic, neonatal, theatre, support and specialist capacity is included within the 24/7 service assessment, with material gaps managed through joint Chief Nurse and Chief Medical Officer accountability and established governance routes.
6. Maternity estates and infrastructure resilience	The Tower provides a current local example of the Amos concern that longstanding constraints and repeated workarounds can become normalised. Electrical supply incidents affecting the Ipswich obstetric operating room occurred during significant obstetric events. Immediate controls reduced risk, but ageing infrastructure, limited alternative obstetric theatre capacity and transfer dependencies create continuing vulnerability.	Continue management through established operational, estates and risk governance. Maintain executive and Board-visible assurance on interim controls, residual maternity safety risk and progress towards a sustainable resolution.
7. Experience, equity and listening	The national ask is for monthly public Board review of outcomes and experience and clear action on inequalities.	QPS should receive assurance that Board reporting includes consistent experience, clinical audit and inequalities measures; demonstrates the impact of action; and reflects co-design with MNVP and underserved communities.

Priority	Why it matters	Assurance focus / governance route
8. Elective caesarean capacity	Rising caesarean birth rates and a larger surgical pathway are placing sustained pressure on bed and theatre capacity. Short-notice confirmation of surgery and repeated fasting for some women awaiting elective or non-urgent caesarean birth have become recurrent features of the current pathway. This affects experience, dignity, flow and the reliability of planned care and should not become normalised.	Maintain QPS visibility of the quality, safety and experience risks associated with elective caesarean capacity. The service requirements and any resource implications should be assessed and progressed through established operational, financial and business-planning arrangements.
9. Maternity bereavement service resilience	The current team structure does not yet provide sufficient cross-site resilience to ensure consistently robust seven-day specialist bereavement provision across Ipswich and Colchester.	Conclude the workforce consultation and, subject to its outcome and the appropriate approval processes, implement a cross-site model that supports resilient seven-day provision, including cover for leave, sickness and periods of increased demand.

5. Workforce implications

5.1 Midwifery establishment and Birthrate Plus

ESNEFT currently has an established workforce of approximately 275 WTE midwives across Ipswich, Colchester and community services. The Birthrate Plus review is underway and is due to report to the Trust in late October or early November 2026. It will provide an updated assessment of the midwifery workforce required across the maternity pathway, taking account of activity, acuity, complexity and service configuration. Until the review is complete, the scale and nature of any workforce gap cannot be confirmed.

The findings will need to be assessed against the funded establishment, staff in post, deployment, absence, training requirements and use of additional staffing. The detailed workforce implications and required next steps are set out in priority 2 above.

5.2 Obstetric workforce

The implications of the national reviews are multidisciplinary. The 10 Point Plan requires parity between obstetric, midwifery, neonatal and operational leadership, consistent Medical Director engagement and appropriate clinical director attendance. It also requires explicit assurance on medical capacity and responsiveness, particularly within maternity triage and out of hours.

There is no nationally agreed workforce modelling methodology for obstetrics and gynaecology, making consistent benchmarking difficult. Local service experience indicates increasing pressure at consultant and registrar level rather than a quantified workforce deficit. Additional antenatal and caesarean lists are required regularly across both sites; out of hours, increasing complexity must be managed alongside gynaecology; and elective obstetric capacity is affected by increasing gynaecology referrals and waiting lists. For example, introduction of the gynaecology hot week at Ipswich has had a material impact on antenatal clinic capacity.

Within maternity triage, the first data showing the proportion of medical reviews completed within BSOTS timeframes are expected this month. Data quality is still being refined, but the information will provide an initial baseline. Current medical staffing arrangements may not consistently provide the level of dedicated medical capacity anticipated by the national specification, particularly at Ipswich and during evenings and overnight. The emerging baseline will help quantify the position and inform any required service response. Any proposed workforce changes should be considered through the appropriate Trust planning and approval processes.

6. Maternity triage: principal service priority

The National Maternity Triage Specification defines triage as the safety-critical emergency front door for urgent and unscheduled maternity care. Trust Boards are expected to have the same visibility and accountability for maternity triage as for other urgent and emergency care. Organisations must audit current provision, complete a gap analysis and implementation plan within three months of publication, report through a public Trust Board, share progress with the NHS England region and fully implement the specification within 12 months. A significant change is that workforce requirements should be assessed using local attendance, demand, peak times and acuity, rather than birth numbers alone. This may reveal different staffing requirements between the two sites.

The national maternity triage benchmarking tool has now been completed separately for Ipswich and Colchester and received by the Extraordinary Board on 23 September 2026 as the Trust baseline. The completed audits provide a stronger site-level evidence base and identify the actions required to progress towards full implementation of the national specification. Initial BSOTS medical-review compliance data are expected this month and will provide a baseline, subject to further data-quality validation. The AMP model is reported to be contributing positively to triage performance and provides a potential workforce-development and retention pathway. Its future service role and any resource implications should be considered through established Trust approval processes.

National expectation	Current issue requiring assurance
Access 24/7 from early pregnancy to six weeks postnatal	Confirm locally agreed pathways and responsibilities between maternity triage, early pregnancy services, gynaecology, ED and primary care, including coordinated referral and handover so women access the appropriate service for their gestation and clinical need.
Initial assessment within 15 minutes	Agree consistent definitions, staffing and Epic reporting to demonstrate compliance and identify delay-related outcomes.
Dedicated 24/7 telephone triage, not diverted to labour ward	Assess call volumes, unanswered/abandoned calls, peak demand, staffing and escalation.
Dedicated staffing structurally independent of labour ward	Model protected midwifery and support staffing using local attendances, calls, peak times and acuity rather than birth numbers alone; assess the position separately for Ipswich and Colchester; and treat redeployment as a formal escalation event.
Timely senior medical decision-making	Validate and report the emerging baseline for medical review within BSOTS timeframes. Assess whether current capacity consistently supports timely review at Ipswich and during evenings and overnight, and use the findings to identify any required service response through established governance.

National expectation	Current issue requiring assurance
Advanced Midwifery Practitioner model	Evaluate the contribution of the AMP model to quality, performance, antenatal capacity, workforce development and retention. Define the future service requirement and route any workforce or resource implications through established Trust planning and approval processes.
Fit-for-purpose urgent-care estate	Assess visibility, privacy, capacity, infection prevention, accessibility, separation from scheduled activity and proximity/transfer to delivery suite on both sites.
Equity, experience and co-design	Use demographic and experience data; involve MNVP and underserved groups in audit, information and redesign.
Routine Board-visible measurement	Develop reporting for calls, attendances, waiting and review times, redeployment, reattendance, disposition, outcomes, incidents, complaints, inequalities and improvement impact.

7. Completed baseline position against the 10 Point Plan

Action	Current position	Assurance focus / where addressed
1. Martha's Rule	Leads identified; engagement with Critical Care underway.	Confirm the implementation model, escalation route, communications and training.
2. Outcomes and experience at public Board	Outcomes reported; MNVP, PMRT and co-production established.	Experience, clinical audit and inequalities reporting are addressed under priority 7.
3. Dual Board accountability	Named executive accountability and DoM attendance as required.	Maintain consistent Chief Nurse/Chief Medical Officer ownership and relevant clinical director attendance.
4. Amos into Action	Local lead and some listening activity.	Support the nationally led exercise and agree governance and feedback arrangements for local learning.
5. Inequalities and Maternal Care Bundle	Leads and task-and-finish groups in place.	Inequalities reporting is addressed under priority 7; Maternal Care Bundle delivery remains under established oversight.
6. 24/7 safety and responsiveness	Birthrate Plus is underway; local obstetric and multidisciplinary capacity pressures are identified.	Midwifery, obstetric, triage, surgical-capacity and multidisciplinary requirements are addressed under priorities 2–5 and 8, with resource implications routed through established Trust processes.
7. Homebirth review	Local overview reports benchmarking and monitoring.	Confirm the final evidence, Board reporting and impact of improvement actions.

Action	Current position	Assurance focus / where addressed
8. Humanity, candour and trauma-informed response	PSIRF reporting and trauma-informed training established.	Demonstrate the impact of learning from incidents, complaints, claims, staff and family feedback.
9. Safe maternity triage	24/7 triage, BSOTS and dedicated phone lines are established; AMP support is reported to be contributing positively and medical-review baseline data are emerging.	Use the completed site-level audits to address the acuity-based workforce, medical response, AMP service model, estate, equity and data requirements under priority 3 and section 6. Any resource implications will follow established Trust approval routes.
10. Post-death care	The Board Assurance Statement was signed by the Chief Executive and Trust Chair on 30 July 2026.	Continue oversight of outstanding corporate post-death care actions. Maternity bereavement workforce resilience is addressed under priority 9.

8. Governance and next steps

Date / milestone	Required action
20 August 2026	QPS scrutiny of strengths, priorities, concerns and national requirements.
23 September 2026	Extraordinary Board approved the completed 10 Point Plan baseline and received the Ipswich and Colchester triage benchmarking assessments as the Trust baseline before regional submission.
By 29 October 2026	Complete triage gap analysis and implementation plan and report publicly, reflecting three months from publication of the specification.
Late October / early November 2026	Receive the Birthrate Plus report, assess any workforce implications and route these through the appropriate workforce, financial and governance processes, with relevant quality and safety assurance reported to QPS.
31 December 2026	Submit Trust Board-approved national progress update.
By 29 July 2027	Full implementation of the national maternity triage specification expected.
Ongoing	Detailed delivery monitoring through MNIB. QPS receives assurance on quality and safety themes and material risks through established reporting routes, without duplicating MNIB oversight. Trust Board retains approval of national returns and visibility of significant risks; ICB/regional escalation is used where concerns or support needs are identified.

9. Conclusion

The Ockenden Review and Baroness Amos Report reinforce priorities already recognised within ESNEFT and provide an opportunity to build on established strengths. The evaluated Band 7 leadership programme is particularly important evidence that the service is investing in the frontline leadership, confidence and engagement required for sustainable cultural and safety improvement.

Established governance, service-user involvement, PSIRF arrangements, Maternal Care Bundle mobilisation and completion of post-death care assurance provide a credible platform.

The reports also require clear acknowledgement of where further strengthening is needed. The most significant issues are sustainable midwifery and obstetric workforce capacity, dependence on substantive staff working additional bank hours, acuity-based staffing and timely medical review within maternity triage, elective caesarean capacity, triage estate and data, infrastructure resilience and the need to translate the completed baseline into sustained, evidence-based delivery. Good assurance can now be given that the national baseline and both site-level triage benchmarking assessments have been completed and validated, with transparent identification of remaining gaps and established governance for delivery. This does not mean that all requirements are fully implemented; workforce, triage, surgical capacity and estates implications remain subject to continuing oversight and action.

Detailed delivery will continue to be monitored through MNIB, with assurance on principal quality and safety implications and material risks reported through QPS and the Board. The Council of Governors is receiving this report for information and is not being asked to duplicate those oversight arrangements or approve the national returns.