Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 29 July 2026

TB2026.58a

Title:	**National Maternity and Neonatal Investigation: Progress Against the National Ten-Point Plan and the Local Report**

Status:	**For Discussion**
History:	

Board Lead:	**Chief Nursing Officer / Chief Medical Officer**
Author:	**Yvonne Christley, Chief Nursing Officer**
	Professor Andrew Brent, Chief Medical Officer
Confidential:	**Yes**
Strategic Pillar:	**Patient Care**

Executive Summary

1. This is the first report to the Board on the National Maternity and Neonatal Investigation (NMNI) and the OUH local report, both published-on 30 June 2026.
2. The Trust accepts the findings of the Investigation, including the failings in care that families experienced, and its responsibility to act on them. The Trust apologises to every family affected.
3. The Trust did not wait for publication to act. Feedback from the NMNI team was addressed as it was received during the investigation, and this paper sets out progress against the NMNI recommendations and the actions taken in response to the local findings.
4. The National Ten-Point Plan sets the framework for the response. The ten actions are set out in section 1. A detailed review of the Plan's requirements has been undertaken, and delivery has commenced against all ten. Progress will be reported monthly through the Quality and Performance Committee, and a full account of delivery against every action will come to the Board in November 2026.
5. Three national actions have progressed furthest. Action 1, Martha's Rule, was launched Trust wide on 2 March 2026, with maternity specific pathways in place across obstetric units, midwife led units and homebirth. Action 9, maternity triage: we have delivered training, additional midwifery capacity, three additional triage spaces and a Maternity Triage Learning Programme that started in July 2026. Action 7, the review of homebirth services, is complete and its improvements are being implemented.
6. The local report made findings rather than recommendations. The Trust has reviewed these and developed its own improvement actions in response, organised across six themes. Section 4 reports on each of the six themes.
7. Progress on the local themes is furthest advanced on midwifery staffing, where a line-by-line establishment review is complete and work has commenced to increase the funded establishment, and on listening to service users, families and communities, where the Perinatal Community Partnership Programme has produced the OUH Perinatal Listening and Learning Framework. Work on culture, leadership and staff voice is at an earlier stage.
8. The maternity scan pathway is being revised to comply fully with the standard national antenatal scanning pathway, with a proposed implementation date of 3 August 2026, subject to approval of the plan by the Trust Management Executive on 30 July 2026.
9. The Perinatal Community Partnership Programme has held listening sessions with women and families in their own community settings since April 2026, and the proposed 90 Day Community Informed Improvement Programme is presented for discussion ahead of its formal approval route.

10. The response is delivered as a single programme through the existing Perinatal Improvement Programme and not as a separate plan. Governance, risk, regulatory context and resources are in section 5.
11. The only action (10 Point Plan) with an external deadline before the next Board meeting is the national post death care requirement, due by 31 July 2026. The Board Assurance Statement is presented for approval in a separate paper at this meeting.

Recommendations

12. The Trust Board is asked to:
    - Approve the Trust response to the Investigation as a single programme, delivered through the Perinatal Improvement Programme, and the governance and reporting route set out in section 5; and
    - Note progress against the National Ten-Point Plan in section 3 and the six local report themes in section 4.

Contents

National Maternity and Neonatal Investigation: Progress Against the National Ten-Point Plan and the Local Report

1. Purpose

1.1. The purpose of this paper is to report progress against the National Ten-Point Plan and the six themes of the OUH local Amos report. The Trust response and action plan is in progress, and the paper sets out what has been delivered, what is underway and what is still to begin.

1.2. The ten actions in the National Ten-Point Plan are set out below. Part One follows the same order, so that the Trust Board can read the position on each action in turn.

1) Listening to women and their families by rolling out Martha's Rule.
2) Listening to women and their families through real time outcomes, experience and clinical audit data acted upon at Board level.
3) Dual Board level accountability between medical directors and chief nursing officers for maternity and neonatal care.
4) The Amos into Action staff listening exercise.
5) Addressing inequalities in maternity and neonatal outcomes.
6) Ensuring 24/7 safety and responsiveness of maternity and neonatal services.
7) Review of homebirth services.
8) Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma informed approach.
9) Delivering safe and effective triage in maternity services.
10) Post death care.

1.3. Several workstreams address both the national plan and the local report. Inequalities, triage, midwifery staffing, listening to women and families, and culture appear in both. To avoid duplication, each is reported once only, in the part where it sits most naturally, and is cross referenced where required. Where the reader is directed to another section, the full position is set out there and is not repeated.

2. Background

2.1. The final report of the National Maternity and Neonatal Investigation (NMNI) and an individual OUH local report were published on 30 June 2026, accompanied by a National Ten-Point Plan for all trusts.

2.2. The local report draws on family evidence panels, staff listening events, interviews and Trust documentation. It describes failings in listening, communication, staffing, estates, culture and the Trust's relationship with families.

2.3. The Trust accepts the findings of the Investigation and apologises to every family affected. Families experienced failings in the care provided, and the Trust takes responsibility both for those failings and for the actions required to address them.

2.4. The response set out in this paper is delivered through the existing Perinatal Improvement Programme and not as a separate plan, so that there is one plan, one set of owners and one reporting route.

2.5. The Trust response and action plan is delivered as a single programme. Part One responds to the National Ten-Point Plan and Part Two to the six themes in the local OUH Amos report.

2.6. Every action has a named executive owner, a measure of success and a delivery date. Delivery is overseen by the Perinatal Assurance Group, with monthly reporting to the Quality and Performance Committee and quarterly reporting to the Trust Board.

3. Part One: Progress Against the National Ten-Point Plan

3.1. The action plan was established on 6 July 2026, and work is in progress against all its actions. Delivery dates run to March 2027, with the first actions, on post death care, due by 31 July 2026. The headings below follow the urgent actions in the NHS England letter of 30 June 2026.

Action 1: Listening to women and their families by rolling out Martha's Rule

3.2. Martha's Rule was launched Trust wide on 2 March 2026 and provides women, families and staff with a direct route to request an urgent review of care. Maternity specific pathways are in place covering obstetric units, midwife led units and homebirth, aligned to the Trust escalation model.

3.3. A maternity specific implementation plan supporting this roll out is in delivery. It embeds awareness of Martha's Rule and operational clarity on how to respond across all maternity services. The plan completes by 31 August 2026. It comprises webinars for all maternity staff between 27 July and 6 August 2026, multidisciplinary team briefings in every maternity area

across both sites and in the community teams, reinforcement training on how to respond to a request for review, guidance for patient safety review chairs, walk rounds to test awareness in clinical areas, and posters and patient information leaflets so that women and families know the route exists.

3.4. Neonatal services were in scope of the Trust wide Martha's Rule launch in March, and the escalation route is live for parents and staff in the neonatal unit. What is not yet in place is the neonatal specific detail and how the route sits alongside existing escalation in the unit. Those arrangements will be confirmed by October 2026.

3.5. An audit of staff awareness, service user awareness, and use of the escalation route will be completed by December 2026. The audit will show whether Martha's Rule is working in practice and is fully embedded.

3.6. In summary, Martha's Rule is live in maternity and neonatal services, and staff and families can use it now. The Trust cannot yet demonstrate that awareness is consistent across all areas and all shifts, or that the route is being used as intended when a concern is raised. The audit referenced above is the point at which the Board can take assurance and will be completed by December 2026.

Action 2: Listening to women and their families through real time outcomes, experience and clinical audit data acted upon at Board level

3.7. A dedicated Perinatal Experience Lead has been recruited and starts in August 2026 to lead this work. The perinatal outcome and experience measures are being designed jointly with families through the Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP), for adoption by October 2026.

3.8. The measure set will report the experience of women from ethnic minority backgrounds separately, supported by the equality, diversity and inclusion midwives and the obstetric equity lead.

3.9. Clinical audits are being refocused and triangulated with local data, and the maternity version of the new OUH Patient Experience Survey is in development.

3.10. The community listening work that feeds this action is reported once, in paragraphs 4.11-4.15, and is not repeated here.

Action 3: Dual Board level accountability between medical directors and chief nursing officers for maternity and neonatal care

3.11. Maternity and neonatal papers are now presented to the Trust Board under the joint leadership of the Chief Nursing Officer and Chief Medical Officer, and the Director of Midwifery and clinical directors attend when maternity or neonatal matters are discussed. The Perinatal Assurance Group provides the assurance mechanism beneath the Board, with both executives, the Director of Midwifery and the clinical leads for obstetrics and neonatology in its core membership. Work is in progress to integrate maternity and neonatology into a Perinatal Directorate, and joint executive accountability for oversight, performance, improvement and escalation will be formalised in the Board and committee terms of reference by September 2026.

3.12. Until the terms of reference are changed in September 2026, joint accountability operates in practice but is not yet documented.

Action 4: The Amos into Action staff listening exercise

3.13. The national programme, which will be externally facilitated, was announced in July 2026. OUH is planning staff release and backfill arrangements so that every staff group and shift pattern can participate. The coordination lead will be confirmed by August 2026.

3.14. The Trust has engaged community midwives directly in reviewing the on-call model, working alongside the NHS England Maternity Improvement Advisors between March and May 2026, and dedicated listening events for all staff groups begin in August 2026, ahead of the national programme commencing. The schedule of further local events will be confirmed in August 2026.

Action 5: Addressing inequalities in maternity and neonatal outcomes

3.15. This action and the local Amos report theme on equity in care and experience are one programme. The national commitments are set out here. The local findings and the Trust response to them are in paragraphs 4.16-4.20 and are not repeated here.

3.16. The Trust has established dedicated equity roles, including the equality, diversity and inclusion midwives and the obstetric equity lead, to improve the experience and outcomes of women and families who face the greatest inequalities in care.

3.17. A maternity and neonatal inequalities measure set is being co-designed with women and families and will be incorporated into Trust Board reporting from December 2026. It will include measures of safety, clinical outcomes and

experience, stratified by ethnicity and deprivation where possible, so that the Board can identify unwarranted variation, monitor progress and hold services to account for reducing inequalities. Reporting arrangements, escalation thresholds and executive accountability will be in place by October 2026.

3.18. The Trust is planning staff release and backfill so that the full multidisciplinary team can participate in the national Perinatal Equity and Anti-discrimination Programme, available to all trusts by the end of 2026, and so that its learning is translated into local improvement.

3.19. The Maternal Care Bundle is being implemented through a dedicated multidisciplinary programme, complete by March 2027. The programme is focused on reducing variation in care, improving safety and narrowing inequalities in outcomes, with progress and evidence of impact reported quarterly to the public Trust Board from July 2026.

Action 6: Ensuring 24/7 safety and responsiveness of maternity and neonatal services

3.20. Medical staffing has been strengthened to provide overnight cover. Six registrar posts have been approved, with recruitment in its final stages. Consultant obstetricians are providing registrar level cover where required to maintain safety during the recruitment period. From August 2026 an additional resident doctor will provide overnight support in the maternity assessment unit, increasing assessment capacity and supporting timely clinical review.

3.21. Recruitment to the six registrar posts completes by September 2026. Until the posts are filled, consultant obstetricians provide registrar level cover. The Trust monitors the effect of that arrangement on consultant hours and on planned activity and reports it through the Perinatal Assurance Group.

The Trust maintains a fully funded neonatal medical establishment aligned to British Association of Perinatal Medicine (BAPM) standards. The consultant rota is fully BAPM compliant, and a business case converting three locum consultant posts to substantive appointments was approved in July 2026. The resident rota is not yet compliant, reflecting a small number of vacancies. Newly appointed doctors are commencing in post, and the service will be fully established, with a compliant resident rota, by October 2026.

Action 7: Review of homebirth services

3.22. A review of the homebirth service was completed in March 2026 and shared with NHS England Southeast. The review considered safety, quality, workforce capability, governance arrangements, clinical outcomes, service

user experience and the longer-term sustainability of the service. Findings and recommendations have informed a programme of improvements designed to strengthen assurance, governance and the safe delivery of care across all homebirth pathways.

3.23. Actions taken in response to recommendations and feedback received from NHS England Southeast will be finalised by September 2026. This will provide a clear record of assurance that identified risks have been assessed, recommendations have been addressed, appropriate mitigations are in place, and arrangements exist for ongoing monitoring of the safety, quality and sustainability of the homebirth service.

Action 8: Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma informed approach

3.24. The Trust has established daily incident review, rapid review meetings and routine oversight of complaints and patient experience. These identify harm and prompt a response. They also test whether women and families are treated with compassion, openness and respect. The maternity and neonatal clinical psychologists lead the work to embed a trauma informed approach across both services. They support staff to recognise the impact of adverse experiences and to respond to concerns in a way that is person centred, timely and respectful.

3.25. Quarterly thematic learning reports commence in August 2026, bringing together intelligence from incidents, complaints, patient experience, safety investigations, Duty of Candour processes and family testimony to identify themes and track the impact of improvement actions. A Board level review of the openness, humanity and candour of responses to families, informed directly by family experience, will be incorporated into public Trust Board reporting by January 2027, examining whether concerns are listened to, families are meaningfully involved and learning leads to change.

Action 9: Delivering safe and effective triage in maternity services

3.26. Maternity triage is an established priority within the Perinatal Improvement Programme, with delivery monitored through the Perinatal Assurance Group. A Board level audit began in June 2026, and a gap analysis against the National Maternity Triage Specification, published in July 2026, will be completed by October 2026. The findings and the improvement plan will be reported through the public Trust Board and shared with NHS England Southeast, with full implementation of the specification by June 2027.

3.27. Improvements have already been made to triage capacity and responsiveness. All staff delivering telephone triage have completed the required training, an additional midwife has been added to the triage

workforce, and midwifery staffing has been strengthened to provide additional support at peak demand. A review of the Maternity Assessment Unit footprint has led to additional triage space being refurbished, improving flow, privacy and assessment capacity, and upgraded iPads and triage software enable midwives to complete assessments, risk stratification and documentation more efficiently.

3.28. The Trust has designed and developed a Maternity Triage Learning Programme, which commenced in July 2026. As part of the programme, information on how and when to access triage will be co-designed with women and families, supporting equitable access to care. Safety, waiting times, time to clinical assessment, patient flow, workforce and patient experience measures are routinely monitored as part of the programme.

3.29. The estates work in the Maternity Assessment Unit that supports this action is reported in paragraphs 4.21-4.24, and the co-design of triage information with women and families is reported in paragraph 4.14.

Action 10: Post death care

3.30. The national System letter on post death care was circulated on 30 June 2026, requiring submission of a Board Assurance Statement by 31 July 2026 and asking Trust's to review their position against the Fuller Inquiry's 29 recommendations.

3.31. The Board Assurance Statement is presented for approval in a dedicated paper at this meeting, and the Board is referred to that paper for the full assurance position. The paper records that four of the five assurance domains are confirmed.

3.32. The self-assessment against the Fuller Inquiry recommendations shows 23 recommendations met, three not applicable and three requiring further action, with the principal area for action being the incorporation of the safeguarding of people after death into formal guidance, training and policy. An action plan, with executive ownership and milestones against each recommendation, will be reviewed through the Quality and Performance Committee from August 2026.

4. Part Two: Progress Against the Local Amos Report Themes

4.1. The local report's findings are addressed through six themed workstreams. Every finding has been mapped to an action with an executive senior responsible officer, a service lead, a measure of success and a delivery date, and no finding has been left without a response.

4.2. Each of the six themes is reported below. Several of the actions that answer these themes are reported in Part One.

The OUH Antenatal Scanning Pathway

4.3. The Investigation raised concerns about the universal 36-week scan offered to all women under the OUH antenatal scanning pathway, and the potential impact of this on the Trust's capacity to deliver scans to women in whom a scan is indicated after 36 weeks.

4.4. In response the Trust has revised the OUH antenatal scanning pathway to comply fully with the standard national scanning pathway, while retaining the universal 36-week scan OUH already offers. The revised pathway increases growth scan monitoring. Women with a risk factor indicating that their baby may not grow as expected will be offered growth scans continuing beyond 36 weeks, irrespective of a normal 20-week uterine artery Doppler and a normal 36-week scan. The Trust will continue to offer a scan at 39 weeks where a baby is measuring below the 10th centile at the 36-week scan.

4.5. Revised Growth Scan and Anomaly Scan guidelines were ratified at an extraordinary Maternity Document Review Group on 22 July 2026 and have been forwarded to the ICB and NHS England. An Antenatal Scanning Pathway Task and Finish Group, supported by the Chief Medical Officer and Chief Nursing Officer, meets daily to oversee safe implementation, with a proposed start date of 3 August 2026.

4.6. The Trust has also commissioned a full independent external review of the OUH antenatal scanning pathway in its entirety. The review will be conducted by independent expert clinical reviewers with no prior involvement and will cover the evidence base, alignment with national guidance, the impact on capacity for indicated scans, and outcomes including equity stratified results.

4.7. Revised information for women and families has been developed and will be signed off through OMNVP before publication. Staff training and communications are being delivered through the Task and Finish Group.

Midwifery Staffing

4.8. The report cited staff distress about shifts that felt unsafe, and acuity records showing green when the shift did not feel safe. The Trust accepts these findings. A digital Birthrate Plus tool has been implemented and now records staffing pressure and acuity in real time. All inpatient areas will be covered by the end of July 2026, with compliance audited.

4.9. A line-by-line establishment review has been completed and a new validated Birthrate Plus report was received in June 2026. Work has commenced to increase the funded establishment. The service is currently over established against its funded position, so the immediate midwifery workforce risk is mitigated while that work is completed. A business case is in preparation, and recruitment planning is running alongside it so that posts can be advertised as soon as the funded establishment is agreed.

4.10. A third hospital based on-call started in July 2026 and is the first step in removing reliance on community staff. The Trust is working with community midwives to minimise the on-call requirement. The community on-call standard operating procedure was updated and amended in June 2026 to set an interim maximum number of hours. A designated-on call roster is live, supported by daily huddles and a monthly audit of hours used.

Listening to Service Users, Families and Communities

4.11. The report found that women were not listened to, that warning signs were dismissed, and that advice given to women was confusing and contradictory. The Trust accepts those findings. In response, the Perinatal Community Partnership Programme was established with service users, families, communities and staff. It strengthens how the Trust listens to, learns from and works alongside them.

4.12. Between April and June 2026 teams held listening sessions in community settings, including East Oxford, Blackbird Leys and Florence Park. Sessions were translated so that conversations were accessible to women from Black, Asian and minority ethnic communities. What people told the Trust mirrors what families told the Investigation: key issues were communication, continuity of care, cultural safety, language barriers, and the need to feel listened to, respected and involved.

4.13. In July 2026 the Trust completed three further listening sessions with 20 women, spanning pregnancy and the postnatal period, from diverse communities across Oxfordshire. This work was supported by interviews in the maternity assessment unit, partnership conversations with local community organisations, and a staff workshop.

4.14. The programme has produced the OUH Perinatal Listening and Learning Framework. Its first improvement programme is co-designing triage information with people who have recent experience of the service, through the Maternity Triage Learning Programme. Their feedback is already improving information, care and the environment in the maternity assessment unit. Everyone who contributes will be told what changed because of what they said.

4.15. A 90 Day Community Informed Improvement Programme is underway to consolidate this work and extend it to other maternity improvement activities. It concludes in October 2026. Oversight is through the Perinatal Assurance Group and the Quality and Performance Committee.

Equity in Care and Experience

4.16. The national commitments on inequalities are in paragraphs 3.15-3.19 and are not repeated here.

4.17. The Investigation found that women from ethnic minority backgrounds experienced worse care at OUH. It found that women's pain, distress and knowledge of their own bodies were not consistently taken seriously, and that concerns were more readily dismissed where a woman was from a minority background or did not speak English as a first language.

4.18. In response, a programme of improvement will be fully developed by September 2026. Clinical guidelines and decision tools will be reviewed for embedded bias, with priority areas identified by September 2026 and the first review completed by January 2027. Outcomes and experience will be stratified by ethnicity so that disparities remain visible rather than lost in aggregate figures. Baseline data will be published by January 2027. Where a disparity is identified, the Trust will name the gap, the action to close it, and the date by which it will close.

4.19. Language access will be treated as a safety issue, with interpreting need recorded and professional interpreting available at every point of care by January 2027.

4.20. A programme plan with confirmed timescales will be completed by September 2026.

Estates

4.21. **Changes service users, families and communities can already see are in place**: Cleaning of shared facilities has been enhanced with frequently checked rounds. The observation area has been subdivided to create a dedicated recovery area with clear lines of sight, staffed by two registered recovery practitioners in addition to a dedicated midwife.

4.22. **Estates improvements to the Maternity Assessment Unit**: The Investigation and the Trust's own listening work both identified the environment in the Maternity Assessment Unit (MAU) as a source of distress. Women described waiting in cramped and public spaces, with no privacy for conversations about their care.

4.23. The Trust has refurbished the MAU and created three additional triage spaces, increasing capacity and reducing the time women wait before

assessment. Further work is planned to improve the waiting area and patient flow in the MAU. This work is being taken forward with input from women who have recent experience of the service, through the Maternity Triage Learning Programme described in paragraph 4.14.

4.24. **Delivery suite facilities**: The Trust is working up plans to provide ensuite facilities in delivery suite rooms. Scoping work has started to establish what is achievable in each room, together with the design, phasing and capital requirement. The Trust cannot yet commit to ensuite facilities in every room, and the plans will confirm what can be delivered. The scoping work reports by September 2026.

Culture, Leadership and Staff Voice

4.25. The Investigation found a culture in which staff did not feel able to raise concerns, and in which professional relationships were strained. It found OUH staff in significant distress and found that leaders' understanding of its causes fell short. Work on this theme is at an earlier stage and will develop over the coming weeks, and the Trust will report more detailed progress through the Perinatal Assurance Group and the Quality and Performance Committee.

4.26. A culture and leadership review is being commissioned as the entry point to this work. Its purpose is to understand the conditions in which staff and leaders have been working, and to identify what needs to change so that the service can improve. It will be conducted by reviewers with no prior involvement with OUH maternity services. Terms of reference will cover professional relationships between teams, the experience of staff who have raised concerns, and the support and conditions available to clinical and operational leaders. Terms of reference and a reporting date are being finalised.

4.27. Work is underway to increase Freedom to Speak Up capacity in maternity and neonatal services, through additional Guardian time and a wider network of trained champions. Concerns raised, themes and outcomes will be reported to the Perinatal Assurance Group monthly and to the Board quarterly. The Trust is strengthening how it closes the loop with people who speak up, so that they know what changed.

4.28. Trust led staff listening events begin in August 2026, running across all shifts, at both hospital sites and in community settings, and facilitated so that staff can speak freely. Dedicated sessions are offered to groups whose voice the Investigation found was least heard, including internationally educated staff, resident doctors, students, bank staff and maternity support workers.

4.29. A Perinatal Staff Psychological Support Programme, led by consultant clinical psychologists, has been implemented and is underway across maternity and neonatal services. Shaped by structured engagement with staff in May 2026, it provides a tiered model of support. It includes one to one psychological intervention, clinical supervision and check ins for senior leaders and for the professional midwifery advocate and professional nurse advocate teams, ongoing reflective practice for matrons and ward managers, and six trauma informed workshops spanning every staff group in the service, from clinical teams to consultants and senior leaders. Additional provision for neonatal staff is being established. Take up is monitored by staff group and site, and access does not require line manager approval.

4.30. Staff survey and pulse survey results, concerns raised through Freedom to Speak Up with themes and outcomes, behavioural concerns and how they were resolved, turnover, vacancy and sickness absence, exit interview themes, and take up of psychological support are all reported and monitored. Progress on culture is tracked against measurable indicators rather than described in general terms. This is an active programme of work for both maternity and neonatal services, forming part of the Perinatal Improvement Programme, which reports to the Perinatal Assurance Group.

5. Governance, Risk and Resources

5.1. The actions in Part One and Part Two are held in one action plan with one set of owners. There is no separate NMNI plan. The programme forms a core part of the already established Perinatal Improvement Programme.

5.2. Delivery reports monthly to the Perinatal Assurance Group, which holds delivery to account and escalates slippage, and from there to the Quality and Performance Committee with exception reporting on anything off track. The Trust Board receives a quarterly report and a full account of delivery against every action in November 2026.

5.3. The financial and workforce implications of the plan are being worked through and will be brought through the Business Planning Group.

6. Conclusion

6.1. Delivery has commenced against all ten national actions, with named owners and dates. Martha's Rule, maternity triage and the homebirth review have progressed furthest. The position on each action is in section 3.

6.2. The six local themes each have an owner, a measure of success and a delivery date. The position on each is in section 4.

6.3. This is one programme, delivered through the Perinatal Improvement Programme and reported through the Perinatal Assurance Group to the Quality and Performance Committee and the Trust Board.

7. Recommendations

7.1. The Trust Board is asked to:

- Approve the Trust response to the Investigation as a single programme, delivered through the Perinatal Improvement Programme, and the governance and reporting route set out in section 5; and
- Note progress against the National Ten-Point Plan in section 3 and the six local report themes in section 4.