Description

All Systems Ready: The Amos Review

As with any National Maternity and Neonatal report, I recommend that you read the contents in full. Take your time. It isn't always easy, but it is essential. In this short letter, I summarise the essence of the review to prompt your own reading and consideration.

Published in June 2026, the Independent Investigation into Maternity and Neonatal Services in England, chaired by Baroness Valerie Amos, aimed to understand why avoidable harm persists despite repeated maternity reviews and recommendations. The goal is to develop one national set of actions to improve safety and quality, reduce inequalities, strengthen accountability and ensure the voices of women, babies and families shape maternity and neonatal care.

Review approach

It is important to note that the review was deliberately a rapid ten-month, system-level investigation, not a review of individual clinical cases. However, the rapid investigation placed childbearing women, people and families at its centre. It heard directly from more than 450 families, received over 10,500 public responses, visited 12 NHS units representing different populations and service models, and gathered evidence from more than 9,000 maternity and neonatal staff. National organisations, professional bodies, advocacy groups and system leaders also contributed, alongside analysis of previous recommendations and international health-system comparisons.[1]

Core findings and actions

- Services are not consistently designed or resourced to provide safe, equitable, compassionate and high-quality care.
- Women, people and families are not always heard, with racism, discrimination and inequalities continuing to affect experiences and outcomes.
- Workforce pressures, insufficient training, poor multidisciplinary team cultures and inconsistent leadership undermine safety and compassionate care.
- Fragmented services, inadequate estates and digital systems create additional risks.
- Repeated recommendations have not reliably translated into sustained change, often because implementation is insufficiently prioritised, resourced or evaluated.
- System reform is needed, including a statutory Maternity and Neonatal Commissioner and national Modern Service Framework.
- Maternity triage requires immediate attention, including dedicated staffing, timely assessment, senior escalation and organisational oversight.

The overarching ambition of the review and ongoing work is to create a learning maternity and neonatal system built around safety, listening, equity, accountability and compassion.

Dr Anna Byrom, CEO, All4Maternity

Reference

1. Independent Investigation into Maternity and Neonatal Services in England: Final Report and Recommendations. National Maternity and Neonatal Investigation. https://www.matneoinv. org.uk/wp-content/uploads/2026/06/WEBSITE_ NMNI-Final-Report-and-Recommendations.pdf. Published June 30, 2026.

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