NHS
Lancashire and South Cumbria
Integrated Care Board

Integrated Care Board

Date of meeting	19 March 2025
Title of paper	Maternity & Neonatal Services Update
Presented by	Professor Sarah O'Brien, Chief Nursing Officer
Author	Steph Purcell- Head of Quality & Safety
Agenda item	12
Confidential	No

Executive summary

To provide Board members with an update of Lancashire & South Cumbria Maternity & Neonatal Services. This will be in line with Maternity and Neonatal Single Delivery Plan (NHSE 2023), covering the four themes

- Listening to women and families
- Workforce
- Culture of Safety
- Standards &Structures

Recommendations

For Board member to note the contents of the paper.

Which Strategic Objective/s does the report relate to:		**Tick**
SO1	Improve quality, including safety, clinical outcomes, and patient experience	✓
SO2	To equalise opportunities and clinical outcomes across the area	✓
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	
SO4	Meet financial targets and deliver improved productivity	
SO5	Meet national and locally determined performance standards and targets	✓
SO6	To develop and implement ambitious, deliverable strategies	

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks		✓		Not for the ICB
Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications	✓			For Trust who do not achieve full compliance with 10 safety actions for MIS

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
LMNS Execs Meeting/ LMNS Board	10/1/25 14/2/25	Note the contents and assured of the actions underway.

Conflicts of interest associated with this report				
Not applicable				
Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Professor Sarh O'Brien, Chief Nursing Officer

Integrated Care Board – 19 March 2025

Maternity & Neonatal Services Update

1. Introduction

1.1 The purpose of this paper is to provide Board members with an update of maternity & neonatal services across Lancashire & South Cumbria.

1.2 In line with the NHS England Maternity & Neonatal Single Delivery Plan (March 2023) the report will cover the four themes; Listening to Women & families; Workforce, Culture of Safety, Standards and Structures.

1.3 The Local Maternity & Neonatal System (LMNS), as the maternity arm of the ICB, continue to lead on the oversight and monitoring of quality and safety of services in line with its statutory responsibility.

1.4 The LMNS discharges its statutory responsibilities by undertaking bi-monthly meetings; Quality Assurance Panel and Patient Safety Learning meetings. In addition, an annual comprehensive programme of quality visits for maternity incentive scheme (MIS) and saving babies lives (SBL) is completed.

1.5 A range of data and intelligence is reviewed and analysed as part of the assurance process in relation to maternity and neonatal outcomes, patient experience, workforce and culture.

1.6 Regular assurance reports regarding maternity and neonatal services form part of ICB Quality Committee agenda.

2. Listening to Women & Families

2.1 The Maternity & Neonatal Independent Senior Advocate (MNISA) service has been fully operational since January 2024 working with the pilot sites, Blackpool Teaching Hospitals (BTH) and University Hospital Morecambe Bay Trust (UHMBT).

2.2 The MNISA also began accepting referrals from East Lancashire Hospital Trust (ELHT) in October 2024. Currently not working with Lancashire Teaching Hospital Trust (LTHTr). One of the biggest challenges is the capacity of the single midwife in the service.

2.3 NHS England have confirmed funding of the service will continue till 31st March 2026 in part to complete a national evaluation of the service. Each of the pilots have taken different approaches to the management and service delivery of the MNISA role, the evaluation will recommend future provision.

2.4 The service to date has received 41 referrals, 6 being rejected and signposted to other services due to not meet the MNISA criteria. The families who have

accessed the service were in receipt of maternity/neonatal care services between 2019-2025.

2.5 The 3 top themes reported by women and families referred to the MNISA are; communication, culture and leadership, compassion and support.

2.6 The MNISA role and scope includes access and direct reporting to the Trust Board, Safety Champions and the Quadrumvirate. So timely feedback on the identified learning and any associated recommendations to support improvements can be disseminated.

2.7 The LMNS Board also receive quarterly updates on the MNISA work and the associated system learning and improvements.

2.8 The LMNS has commissioned Healthwatch to undertake quarterly patient experience surveys to understand how the services are engaging with women and families to coproduce personal care plans including the challenges and identify and potential improvements. This will be undertaken with all four services.

2.9 Other improvements enacted as a result include a lady working directly with one unit on personalised care planning. Another unit is currently reviewing their processes in relation to ensuring they keep families updated in investigations, any delays so communication is timely and supportive.

2.10 Across Lancashire & South Cumbria a standard operating procedure was developed with the four services and Maternity & Neonatal Voice Partnerships (MNVPs) to support women and families when there is cross organisational involvement in an investigation. This is to ensure there is lead contact for the family, with clear roles and expectations of the lead trust.

2.11 All four services at the March 2025 Quality Assurance Panel will be presenting the latest findings, trends and themes from the CQC Maternity Survey (2025). This will include a coproduced action plan with their allocated MNVP. Ongoing oversight and assurance of progress of the action plan will be undertaken on a 6 -monthly basis by the panel members.

2.12 Positive to report that the Helme Chase (Midwifery Led Birth Unit) service reopened in February 2025 following a 6- month closure whilst an extensive workforce review and consultation and engagement with the local community was undertaken.

3. Workforce

3.1 The LMNS workforce team has collaborated with Trusts to convene a round table discussion on staffing; comparing Birth Rate Plus staffing assessments, funded establishment, actual establishment, and evaluating whether these meet the needs of women and families within Lancashire and South Cumbria.

3.2 The findings were presented at the LMNS Quality Assurance Panel in November 2024. The data from this was utilised by the Trusts to support development of associated business.

3.3 The LMNS workforce tracker, which will be updated quarterly, has been developed to monitor and assess the Perinatal footprint, encompassing midwifery staff, maternity support workers (MSWs), obstetrics, and neonatal staff and will be reported to the LMNS Quality Assurance Panel, LMNS Board and ICB People Committee.

3.4 The objective of the tracker is to fulfil the ICB's responsibility in the assurance around commissioned safe staffing levels and to monitor vacancy rates to support staff retention within the workforce.

3.5 Several strategies have been enacted by the LMNS to support the workforce agenda; establishment of community of practices and workforce education forums to share and learn best practice in relation to recruitment and retention.

3.6 The LMNS have funded a pilot project of nine MSWs to become registered midwives through a registered midwifery degree apprenticeship to build the principle of "growing our own workforce". A full evaluation will be undertaken to measure impact.

3.7 The LMNS has worked collaboratively with ELHT and Burnley College to pilot a specific 'T' Level in Health; specialising in midwifery, to ensure prospective midwifery students have the skills and knowledge to successfully complete a midwifery degree or embark on a career within the midwifery team.

3.8 A positive evaluation and outcome has been presented at the LMNS Board on the previously commissioned project to develop a LMNS wide preceptorship pack and programme of support. Aligning to the national of agenda of retention of newly of qualified midwives (NMC 2020).

4. Culture of Safety

4.1 All four services have completed the SCORE Culture survey as this was a pre-requisite following the quadrumvirate completing the national perinatal cultural leadership training.

4.2 The results and the drafted action plans are reported via the Quality Assurance Panel. The Health Innovation Network has been commissioned to provide support to the quadrumvirate following the survey results.

4.3 LTHTR are due to present their initial results and findings at the Quality Assurance Panel in March 2025

4.3 UHMBT have previously reported the survey results over 5 themes; leadership and governance, well-being, training and development, respect and civility and psychological safety and leadership development.

These themes have now been transferred to an overarching culture improvement plan which included former culture reviews such as the ‘Good Vibes Report’ and ‘Anti-racism Cumbria’

4.5 BTH presented their initial findings and acknowledged the challenges experienced in not having the full quadrumvirate engaged in the national perinatal culture leadership training programme and how this has impacted.

4.6 Three themes evident in relation to staff burnout, improvement readiness and teamworking. Neonatal nursing and medical team indicated to be the happiest workforce from the survey.

4.7 BTH recommended that due to a new Head of Department for Obstetrics, newly appointed interim Head of Midwifery and new leadership for Neonates there will be a relaunch and review of the SCORE survey. The LMNS support this approach.

4.8 ELHT provided a further update on their progress against the SCORE survey action plan. Cultures coaches have been working alongside the quadrumvirate.

4.9 Additional strategies employed to ensure the workforce are continually updated on the progress of the culture programme of work is by key staff from the quadrumvirate engaging in a podcast.

4.10 Following feedback from staff on the postnatal ward at ELHT around the pressures experienced and how this was negatively impacting on flow and discharge the service has created a suite of discharge videos.
The LMNS has requested the service to feedback the learning and impact of this innovative practice at the Quality Assurance Panel in May 2025, potential system learning and adoption.

4.11 The LMNS has convened a working group with clinicians across the four maternity services, midwives, obstetrics, theatres staff to review the processes around LocSIPPS, documentation and recording specifically to the management of postpartum haemorrhage (PPH). This was following two declared Never Events in relation to retained foreign object post procedure.

4.12 The inaugural meeting took place in January 2025, noting variation in practice of documentation and engagement from the services for an agreed system approach for recording on BadgerNet.

4.13 The LMNS Clinical Dashboard is being reviewed on a monthly basis by the Lead Midwife and Lead Obstetrician. This is a standard agenda item at the Quality Assurance Panel.

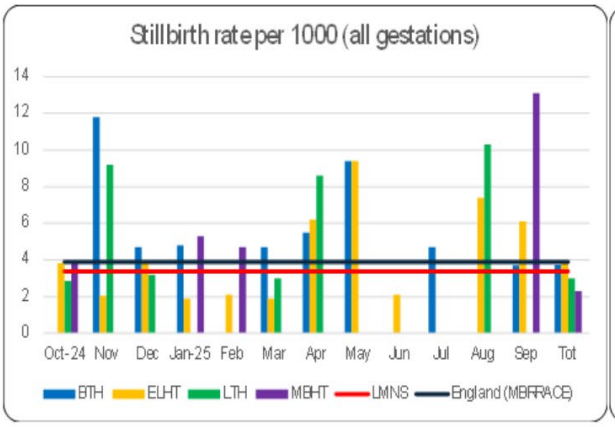

fig 1

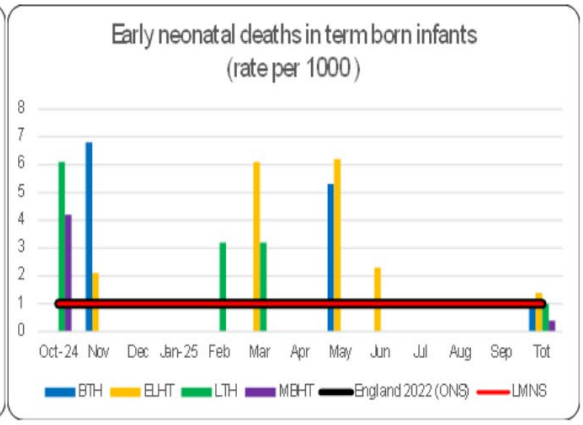

fig 2

4.14 Local data demonstrates that the stillbirth rate (fig 1) for babies of all gestations (from 24 weeks) across Lancashire and South Cumbria is 3.4 per 1000 births, which is below the England rate of 3.9/1000.

4.15 The graphs show the month by month variation in overall rate, however these remain low actual numbers and included babies who were all preterm or had significant fetal abnormalities.

4.16 All pregnancies, resulting in stillbirth are reviewed using the perinatal mortality review tool (PMRT), including those of extreme prematurity and known complexities, and all term stillbirths are referred to Maternity & Newborn Safety Investigation (MNSI) for an independent investigation.

4.17 The second chart shows the rates of early neonatal death (birth to 7 days) for babies born at full term (37 weeks onwards). This data also shows that the maternity providers in L&SC perform around the national rate. This rate however, is based on all birth settings. ELHT has a higher ENND rate than other providers in the LMNS but when compared to similar Trusts, ie larger services with level 3 NICU the rate is lower.

4.18 As with stillbirths these numbers remain low and all early neonatal deaths at term are reviewed using the PMRT and those meeting certain criteria referred for full investigation by MNSI, with concerns, learning and positive feedback fully escalated through the local and ICB patient safety governance structures

4.19 All four services in Lancashire & South Cumbria are below the national 6% target of term admissions to neonatal intensive care (NICU). L&SC system are currently 4.8 %.

4.20 During 2024 there were four babies less than 27 weeks being born in the wrong place (outside a level 3 NICU) all four cases occurred at BTH. A joint review by both maternity and neonates is undertaken to identify any learning and conclude if the case was avoidable or unavoidable.

4.21 To note in 3 out of the 4 cases the women presented in established labour therefore no time to transfer out safely. One case, the trust attempted a timely

transfer out to a level 3 NICU however there were no beds available in the North West region to accept an in-utero transfer.

4.22 Across L&SC a total of 5 maternal deaths sadly occurred in 2024. All the cases were referred and accepted for independent investigation by MNSI. Two of the cases were early pregnancies(<6 weeks) and had not yet booked with maternity services, with a case of a non-engagement with antenatal services. Once the investigations have been completed the findings and any identified learning will be shared at the LMNS Patient Safety Learning Group.

4.23 The Maternal Medicine Network (MMN) completed a North-West maternal death review (2019-2023). The findings and associated recommendations have been shared across the LMNS and the wider ICB. As a result, the LMNS is convening a maternal death working group to ensure key clinicians and services have a dedicated forum to work collaboratively to address the MMN recommendations for improvements. The first meeting will take place on 24th March 2025 .

5. Standards and Structures.

5.1 At the January 2025 LMNS Quality Assurance Panel all four maternity services provided assurances and confirmation they are fully compliant with the recommendations from the National Patient Safety Alert for risk of Oxytocin overdose. To note the deadline 31st March 2025.

5.2 NICE in November 2024 redacted its guidance for the use of Fetal Pillows however the Royal College of Obstetrics & Gynaecology recommendations are still in place.

5.3 The Regional Team requested all North-West providers to remove from use. At the LMNS Quality Assurance Panel in January 2025 all services were required to provide an updated position.

5.4 Three of the services (UHMBT, BTH, LTHTr) advised they are currently still using as awaiting the updated position statement from NICE which is due to be published in April 2025. ELHT is not using as all key clinicians have been trained in the manual dis-impaction of the fetal head.

5.5 The programme of quality assurance visit for the Year 6 Maternity Incentive Scheme (MIS) has now been completed with LMNS sign off. Each service had four quarterly visits to review evidence and progress of compliance against the 10 safety actions.

5.6 All four services achieved the required targets in achieving compliance with saving babies lives care bundle (SBL) Version 3.

5.7 UHMBT and LTHTr are declaring full compliance with all 10 MIS safety actions.

5.8 ELHT have achieved compliance with 9 out of the 10 safety actions. Safety Action 1 (Perinatal Mortality Review (PMRT)) was not signed off due to the trust not meeting the 2 -monthly timeline in completing the factual accuracy questions for 2 cases. Assurance has been sought regarding the review process and fail safe process in place to ensure this does occur again.

5.9 BTH achieved compliance with 7 of the 10 safety actions. Non- compliance for safety action 1 (PMRT), safety action 4 (clinical workforce) and safety action 9 (Board Assurance).

5.10 To note for safety action 4 specifically the assurance around the engagement and employment of short and long- term locums marked improvements evident with audits and SOPs now in place.

5.11 The LMNS has previously shared SOP, reports and processes to support the BTH service in the safety actions to ensure robust evidence is able to be systematically collated. However, the LMNS acknowledges the gaps in key leadership roles across the quadrumvirate which has negatively impacted on the MIS Year 6 progress.

5.12 For the MIS Year 6 scheme BTH have demonstrated improvement from the Year 5 scheme where they achieved 6 out of 10.

5.13 Two services remain on the national Maternity Safety Support Programme (MSSP) following their CQC inspection of maternity services.

5.14 UHMBT MSSP meeting on the 6th May 2025 is expected to focus on decisions for the service to exit of the programme.

5.15 In order to ensure there is ongoing oversight and assurance of the sustainability of improvement and safety, the service has established a Maternity & Neonatal Improvement Group. The first meeting took place in February 2025. The meeting is chaired by the Director of Midwifery with an agreed terms of reference. The LMNS is a key member of the group.

5.16 BTH next MSSP review and reset meeting is due to take place on the 28th May 2025. The service has an agreed exit criteria and an associated action plan in place. The LMNS will be in attendance to input and support discussions.

5.17 The LMNS will be commencing with a programme of assurance visits with the maternity services in line with the NHSE Maternity & Neonatal Single Delivery Plan (March 2023). A terms of reference for the visits have been agreed with the services, the Regional Maternity team and the Neonatal Operational Delivery Network.

5.18 These visits will be in addition to the MIS quarterly visits and where possible the visits will be undertaken jointly with the Regional Maternity Team and the Neonatal Operational Delivery Network.

5.19 Maternity services on the MSSP will not have any additional assurance visits undertaken by the LMNS whilst on the programme but agreement that when a service exits a LMNS assurance visit will be undertaken within 4 months.

5.20 ELHT assurance visit is booked in for the 30th April 2025, with planning underway to secure a date with LTHTr.

5.21 As part of the assurance process with the Regional Maternity Team, the LMNS is required to provide evidence of the trust and LMNS deliverables as part of the Maternity & Neonatal Single Delivery Plan (March 2023). The LMNS meets with the Regional Maternity Team on a quarterly basis.

6. Conclusions

6.1 The LMNS continues to undertake a comprehensive programme of oversight and monitoring of services in order to be assured of the quality and safety of maternity and neonatal services.

6.2 In order to be effective is discharging duties the LMNS works collaboratively with key stakeholders; Neonatal ODN, Regional Maternity Team, MNSI, Maternal Medicine Network, Healthwatch and the MNVPs.

6.3 Whist services are on the national MSSP which is led by the national and Regional Teams, the LMNS as a key and valued partner contribute and engaged in assurance visits and meetings to support the decision making.

6.4 There is monthly oversight of maternity and neonatal outcomes and embedded forums for the maternity and neonatal services and key clinicians to review and share learning from a range of intelligence including patient safety incidents.

6.5 The LMNS has commenced with a robust programme in the oversight and monitoring of maternity staffing including obstetrics with agreed reporting structures and routes of escalate both into ICB Quality Committee and the ICB People Board.

7. Recommendations

The Board is requested to note the contents of the report.

Steph Purcell

28 February 2025