NHS
North East and North Cumbria

National Maternity Investigations

Board Update

North East and North Cumbria ICB

Background and Context

- Ockenden Review (Nottingham):
  - Largest maternity review in NHS history covering 2012-2025.
  - Evidence from 2,500 families and 800 current or former staff.
  - Reviewed the full care pathway, governance, leadership, maternal deaths and organisational culture.
  - Sets Immediate and Essential Actions (IEAs) and wider system learning to improve maternity and neonatal safety nationally.

- National Maternity and Neonatal Investigation (Amos) Review
  - Reviewed services across 12 NHS trusts and gathered evidence from women, families, staff and national stakeholders to identify systemic issues affecting care nationally.
  - Sets eight national recommendations.

Key Themes from Ockenden and Amos

Theme	Board Relevance
Listening to Women and Families	Women's voices must inform service improvement
Health inequalities	Reduce variation in outcomes and experiences
Culture and safety	Earlier identification and escalation of concerns
Governance and accountability	Robust oversight and assurance mechanisms
Sustained improvement	Demonstrate measurable improvement over time

Key Learning from national reviews
National investigations have consistently found that previously identified learning has not (always) been embedded into practice.

Implication for NENC:
Assurance processes must both identify concerns and ensure measurable and sustained improvement.

NHSE 10-point plan for maternity and neonatal services

1. Listening to women and their families by rolling out Martha's Rule
2. 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
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care
4. '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
7. Trusts to review their homebirth services
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach
9. Deliver safe and effective triage in maternity services
10. Post death care

Listening to Women and Families

Aim: Women and families actively influence how maternity and neonatal services are designed, improved and monitored.

What have we done?

- Funded Maternity and Neonatal Voices Partnerships across all maternity services.
- Embedded service-user representation in LMNS governance.
- Include lived experience within staff training.
- Participated in the independent advocacy pilot.

What do we need to do?

- Support the roll out of Martha's rule.
- Further strengthen service user voices especially harder to hear voices, locally and nationally.
- Review homes births in line with new national guidance
- Demonstrate how real time service user feedback is heard and actioned.
- Ensure service user voice is an integral part of commissioning/contracting with providers

Reducing Health Inequalities

Aim: Reduce variation in maternal and neonatal outcomes, improve access for all, support culturally competent and personalised care.

What have we done?

- Five-year Equity and Equality Action Plan
- Identified top 5 languages for NENC and supported translation of leaflets
- Supported ‘Cultural Curiosity’ training across all trusts
- Maternity Migrant Care Pathway implemented
- Developed and launched personalised care toolkit.
- **What we need to do?**
- Strengthen system assurance to show how inequalities data is being used to target improvement.
- Support trusts and MNVPs to attend the Perinatal Equality and Anti Discrimination Programme in September 2026
- Work with Neighbourhood Health commissioners.
- Ensure reducing health inequalities is an integral part of commissioning/contracting with providers

Safety, Culture and Governance

Aim: Safe, equitable and personalised care, delivered within services that are accountable for improving outcomes and experiences.

What we have done?

- Quarterly LMNS safety dashboard helps to monitor variation and emerging risks.
- Learning from incidents shared across providers.
- Improvement plans monitored through governance structures.
- Escalation and support processes for providers where risks identified.
- Executive oversight and leadership by ICB Chief Nursing Officer and Chief Medical Officer.

What we need to do?

- Strengthen board level reporting and triangulation of data, including clinical audits.
- Strengthen patient safety culture to ensure when concerns are identified, action is taken and improvements are sustained.
- Ensure implementation of national maternity bundles, evidence based triage, MOSS alerts
- Establish governance arrangements to ensure recommendations from national reports and overarching action plans are monitored and delivered.