

NORTHAMPTONSHIRE LMNS NEWSLETTER

A QUARTERLY NEWSLETTER FROM YOUR MATERNITY AND NEONATAL SYSTEM

Welcome to the first edition of Northamptonshire LMNG Newsletter!

WHO WE ARE

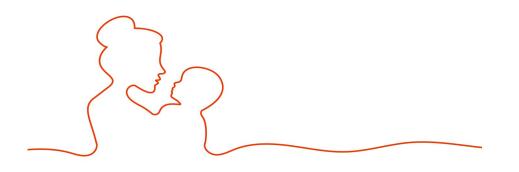
Local Maternity and Neonatal Systems or LMNSs were created in 2016 following the recommendations made in the Better Births report.

Northamptonshire Local Maternity and Neonatal System (LMNS) are here to support maternity service teams and service users across Northamptonshire. We are working to improve safety, develop our choice and personalisation services whilst transforming our digital offering.

WHAT DO WE DO?

We bring together commissioners, providers and service users to develop and implement a locally owned plan to deliver the recommendations of the Better Births Initiative. We are being overseen by a board that consist of midwives, provider staff, consultants, NHS England, Northamptonshire Integrated Board (NICB), University of Northamptonshire (UON) Public Health and Maternity and Neonatal Voices Partnership (MNVP)

MNVP is a working group made up of women, birthing people and families and is supported by local Integrated Care Board (ICB) and maternity services from our hospital trusts. The MNVP is an independent forum which has been set up to listen to and speak for service users who have accessed local maternity and neonatal services and want to capture what was good/bad what can be improved/ what works well.



INSIDE THIS ISSUE

Who we are
What to expect
Shared Learning



WHAT TO EXPECT

In our regular issues we want to share with you:

- Updates from our projects such as:
 - * Pelvic Health
 - * Continuity of Carer
 - * Smoking Prevention
- * Feedback from our MNVP
- Celebrate our Successes
- Spread the learning



We are asking for your comments and contributions towards the shape and contents of this newsletter

Please send your comments, ideas and updates from your workstreams you want to share with the colleagues to:

Anna.Chlubek1@nhs.net







SHARED LEARNING

Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients. We use a variety of processes to review incidents, such as SI investigations, PMRT processes, and regional and national reports.

Some of the learning identified within Northamptonshire maternity services settings during Q4 2022/2023 provides us with the following system wide guidance:

- Consider aspirin for women who have previously delivered an SGA baby, as per SBLCBv2 guidance.
- Record a partogram for women in labour with a known IUD after 24 weeks of pregnancy
- Review the pregnancy risk assessment at each contact during pregnancy and the intrapartum episode to ensure an overview of all relevant changes is maintained.
- Follow clinical guidelines based on national best practice standards
- Communicate effectively with colleagues in the wider MDT team and refer for specialist advice as appropriate
- Use CTG monitoring 'fresh eyes' review processes to help identify and escalate abnormal CTGs.
- Support women and birthing people to make informed choices by giving transparent unbiased information about risks and benefits in individualised cases.
- Provide information in a format that is understood by the receiver (either written or oral) and use interpreter services when required.



Follow this link for a report into the importance of educating families around safe sleeping practices

https://sway.office.com/ jxLkzbwlWQFv47ap?ref=Link&loc=play



In November 2022, MBRRACE produced their most recent report into the learning from maternal deaths and morbidity during 2018-2020. Follow this link for the lay summary report

https://www.npeu.ox.ac.uk/assets/downloads/mbrraceuk/reports/maternal-report-2022/MBRRACE-UK Maternal Report 2022 - Lay Summary v10.pdf