Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

FOR PUBLICATION

DERBY CITY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

April 2023

Report of Derby and Derbyshire Integrated Care Board

Overview of Maternity Services in Derbyshire (Following the Ockenden Report)

1. Purpose

This paper provides an overview of maternity services in Derbyshire and information on the governance, assurance and safety of maternity services locally.

2. Information and Analysis

2.1. Definitions

Definitions for terms used in this paper are:

- **Maternal mortality/death –** is the death of a woman during or up to 6 weeks (42 days) after the end of a pregnancy (whether the pregnancy ended in termination, miscarriage or a birth or was an ectopic pregnancy).
- **Neonatal mortality/death** – is the death of a live born baby within the first 28 days of life.
- **Perinatal mortality/ death** – is both stillbirths and neonatal deaths.
- **Preterm birth -** babies born alive before 37 weeks of pregnancy.
- **Stillbirth –** when a baby is born dead after 24 weeks of pregnancy.

2.2. National policy

Maternity care oversight, assurance and transformation is informed by the following national reports:

- **Better Births, the report of the National Maternity Review** (2016) sets out a vision to help achieve better and safer outcomes for families. The recommendations were to make care more personalised; improve shared decision making for families and provide a supported, high performing workforce who work across boundaries. The Maternity Transformation programme addressed the Better Births recommendations

- **NHS Long Term Plan (2019)** – focuses on action to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- **The Saving Babies Lives Care Bundle Version 2 (2019)** – provides detailed information on how to reduce perinatal death and pre-term birth. This brings together five elements of care that are widely recognised as evidence based and/or best practice:
  - Element 1: Smoking in Pregnancy
  - Element 2: Fetal Growth Restriction
  - Element 3: Reduced fetal movements
  - Element 4: Effective fetal monitoring in labour
  - Element 5: Preterm Birth
- **Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) –** this provides financial reward to Trusts for achieving ten recommended safety actions and meeting strict criteria for monitoring and assurance. The safety actions are Perinatal Mortality Reviews, Maternity Services dataset, avoiding term admissions to the neonatal unit and transitional care, clinical workforce, midwifery workforce, Saving Babies Lives Care Bundle, Maternity Voice Partnerships, multidisciplinary training, safety champions and digital strategy.
- **The Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust** (2020) provided 7 Immediate and Essential Actions (IEAs) for Trusts to review and implement:
  - Enhanced safety
  - Listening to women and families
  - Staff training and working together
  - Managing complex pregnancy
  - Risk assessment throughout pregnancy
  - Monitoring fetal wellbeing
  - Informed Consent
- **The Final Report of the Ockenden review** (2022) – identified an additional 15 Immediate and Essential Actions (IEAs) for Trusts.
- **The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE) reports** provide guidance on national indicators and causes of maternal and neonatal mortality used to identify areas for improvement locally and nationally.
- **The Reading the Signals: Maternity and Neonatal services in East Kent** report (2022) Following an investigation into 2 hospitals this report makes four key action areas:
  - Key Action Area 1: Monitoring safety performance – finding signals among noise
  - Key Action Area 2: Standards of clinical behaviour – technical care is not enough
  - Key Action Area 3: Flawed teamworking – pulling in different directions
  - Key Action Area 4: Organisational behaviour – looking good while doing badly

2.3. LMNS Governance, Oversight and Assurance

The Local Maternity and Neonatal System (LMNS) is the collective term for clinicians, managers, service users, Local Authorities, NHS providers and commissioners who come together to plan, deliver and evaluate maternity services within the Joined Up Care Derbyshire Integrated Care System (ICS) to meet the needs of pregnant people, babies and families. The LMNS was established in 2016 and is the maternity arm of the ICS. The role of the Derbyshire LMNS has developed into one of supporting transformation and having oversight and assurance of the safety of maternity services and the LMNS Board provides governance for these areas and transformation.

The LMNS is required to support the Trusts to achieve full compliance with national report recommendations and gain assurance of progress with full reporting to the local LMNS Board. This supports the expectation within the national Perinatal Quality Surveillance Model that LMNS's have both an assurance role and supportive role to each trust. Onward exception reporting by system and to region will be undertaken through the monthly NHS Midlands Regional Perinatal Quality Group (RPQG) meeting, which forms the regional layer of governance.

Derbyshire LMNS has a monthly Perinatal Quality and Safety Group (PQSG) where Trusts provide an update on their current position against national recommendations and guidance. An update on current perinatal mortality rates and any patient safety incidents is provided to monitor against national indicators. If required deep dives are requested along with completed audits to provide evidence of safe care. The Perinatal Safety Forum (a subgroup of the PQSG) provides an opportunity to discuss progress and action plans and escalate areas of concern to PQSG.

The development of reporting templates to align with the Trusts reporting is in progress to provide a clear, consistent picture of maternity services across Derbyshire.

2.4. Derbyshire Maternity Service Provision

Maternity services within Derbyshire consist of two acute Trusts, Chesterfield Royal Hospital Foundation Trust (CRH) and University Hospitals of Derby and Burton Foundation Trust (UHDB). UHDB has two sites providing maternity care: Royal Derby Hospital (RDH) and Queens Hospital Burton (QHB). Prior to COVID a standalone birth unit was available at Samuel Johnson Hospital for residents in the south of the county, however this was temporarily suspended due to staffing pressures. Currently, the home birth service at UHDB is suspended until September 2023 when it is anticipated workforce numbers will improve following the recruitment of internationally qualified and newly qualified midwives. All sites have Neonatal Units, Consultant Led Care and Midwifery Led Care Units providing care for approximately 11,500 people per year and families.

CRH has approximately 3500 births per year and covers North Derbyshire and Chesterfield primarily. RDH has approximately 6000 births per year and covers Southern Derbyshire and Derby City. Both hospitals provide care to residents of the High Peak. QHB covers South Derbyshire and Burton and therefore extends into Staffordshire. Derbyshire County residents have a choice of place of birth, including home and may access services at the hospitals discussed or may attend Nottinghamshire, Staffordshire, or Greater Manchester Trusts. This

is reciprocated where residents of the counties listed may choose maternity care within Derbyshire.

2.5. Stillbirth and neonatal death rates

The current stillbirth and neonatal deaths rates for CRH and UHDB compared to the national ONS (2021), and MBRRACE (2022 rate based on 2020 data) rates are given in Table 1.

Table 1: Stillbirth and neonatal death rates for Derbyshire Trusts compared to national data

	Derbyshire		National	
	CRH (Feb 23)	UHDB (Feb 23)	Office of National Statistics (ONS, 2022)	MBRRACE (2022 based on 2020 data)
Stillbirth rate / 1000 total births	1.77*	4.55*	4.2	3.33
Neonatal death rates / 1000 live births	0.35*	2.22*	2.7	1.53

* 12 month rolling average

UHDB stillbirth has been increasing steadily and is now above national rates. This has been discussed monthly in the LMNS meetings to maintain oversight. The higher complexity of cases seen at UHDB in the fetal medicine unit may explain to a degree why the rate is higher than the CRH rate, as many of the cases relate to prematurity or fetal abnormalities.

A review of a small number of stillbirths and neonatal deaths which included midwives, obstetricians, neonatologists, and NHS England (NHSE) took place on January 31st with initial findings of no themes or safety concerns. This review is to be repeated using a more comprehensive and robust assurance tool with more cases, to understand why the stillbirth rate is rising and ensure that the initial findings of no themes or safety concerns is an accurate reflection of perinatal mortality at UHDB. The LMNS will be a member of the review team providing oversight with the review expected to be completed within six months. During this time the LMNS Board will continue to maintain oversight on the progress of the review.

In addition, the Healthcare Safety Investigation Branch (HSIB) which conducts independent investigations, undertook a thematic review of seven patient cases in its maternity services that occurred between January 2021 and March 2022, commissioned by NHS Derby and Derbyshire ICB following a request from UHDB's maternity department. The report was published in February 2023. There were no immediate safety concerns however UHDB had five recommendations to implement, with ten actions for consideration to improve safety. The immediate recommendations are being implemented and have been reported through the LMNS Board. There has been agreement form the UHDB Trust Board to invest in strengthening the governance team and family liaison and steps have been taken to commission a compassionate leadership course to address staff culture.

2.6. Ockenden - Derby and Derbyshire position

The Immediate and Essential Actions from The Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (Ockenden, 2020) report produced seven Immediate and Essential Actions (IEA's) for all Trusts to consider their position against and implement to improve maternity services. These are:

1. Enhanced safety
2. Listening to women and families
3. Staff training and working together
4. Managing complex pregnancy
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed Consent

Workforce and Guidelines

Within each of the seven actions were separate questions for the Trusts to consider and implement the recommendations where gaps were identified. The release of the report occurred as the country went into the COVID pandemic which presented implications for the implementation of some of the recommendations. Initially the Trusts self-assessed their position against the IEAs, however there was a national ask that the NHSE Regional Perinatal Teams visit all maternity services in 2022 to gain assurance for progress in completing the initial 7 IEAs. All 21 Trusts in the Midlands region were assessed by the regional team as having reduced compliance from their self-assessed position of March 2022. There were no Trusts that achieved full compliance.

The assessed compliance by the NHSE Midlands Perinatal team equated to 39% at each Trust, with some actions missing across all 7 IEA's and workforce. The tables below demonstrate the areas requiring further actions to meet compliance.

2.6.1. Chesterfield Royal Hospital NHS Foundation Trust

Table 1: CRH Ockenden 7 IEA's compliance in September 2022

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety	Green	Yellow	Green	Yellow	Green	Green	Green	Green
2) Listening to women and families	N/A (Grey)	N/A (Grey)	Green	Yellow	Green	Green	Green	Green
3) Staff training and working together	Green	Green	Green	Grey	Yellow	Green	Green	Black
4) Managing complex pregnancy	Yellow	Green	Yellow	Yellow	Yellow	Yellow	Black	Black
5) Risk assessment throughout pregnancy	Yellow	Yellow	Yellow	Yellow	Black	Black	Black	Black
6) Monitoring fetal well-being	Green	Yellow	Yellow	Yellow	Yellow	Black	Black	Black
7) Informed consent	Yellow	Yellow	Yellow	Yellow	Green	Yellow	Black	Black
Workforce Planning	Yellow	Yellow	Yellow	Yellow	Black	Black	Black	Black
Guidelines	Yellow	Black	Black	Black	Black	Black	Black	Black

Key: Green full compliance; Yellow partial compliance with the action or evidence not available; Black/Grey NA

Enhanced Safety and Listening to Women and Families – To meet full compliance for both IEA's perinatal mortality reviews should include an external specialist. CRH and UHDB have a reciprocal agreement in place to review the cases and meet the outstanding action.
Staff training and working together – A minimum of 90% of each maternity unit staff group should attend inhouse multidisciplinary training. Currently CRH have trained 85% of

midwives and 88% of obstetricians. Targets have been met for maternity support workers and anaesthetists.
Managing complex pregnancy – Maternal Medicine Networks have been developed to support Trusts providing care for women with complex pregnancies. The pathway for referral needs to be developed. Specialist Consultant leads are required for each case. Saving Babies Lives compliance is required to achieve all of the actions for IEA 4, 5 and 6 and is currently 70% at CRH (assessed January 2023).
Risk assessment throughout pregnancy – Evidence of a risk assessment being completed, along with a discussion on place of birth and birth choices is required. Work is ongoing to improve compliance.
Monitoring Fetal Wellbeing – A fetal monitoring lead midwife and lead obstetrician have been identified by the Trust to ensure that fetal monitoring education is up to date and any incidents involving fetal monitoring are investigated by the leads.
Informed Consent – Information needs to be available in different formats to meet the needs of the women with the website being clear and informative, and evidence to ensure that women are involved in care choices is required. A revised website is currently in development
Workforce Planning and Guidelines – Workforce plans should be shared regularly with the Trust and LMNS Boards and ensure that workforce meets the recommendations from the Birthrate plus tool commissioned by Trusts. A Consultant Midwife post is being recruited to. Guidelines need to be up to date and represent current NICE guidance. A process is in place to meet this requirement.

2.6.2. University Hospitals of Derby and Burton NHS Foundation Trust

Table 1: UHDB Ockenden 7 IEA's compliance in August 2022

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety	Green	Yellow	Green	Yellow	Green	Green	Green	Green
2) Listening to women and families	N/A (Grey)	N/A (Grey)	Green	Yellow	Green	Yellow	Yellow	Green
3) Staff training and working together	Green	Yellow	Green	Grey	Yellow	Yellow	Green	Black
4) Managing complex pregnancy	Green	Yellow	Yellow	Yellow	Yellow	Green	Black	Black
5) Risk assessment throughout pregnancy	Yellow	Yellow	Yellow	Yellow	Black	Black	Black	Black
6) Monitoring fetal well-being	Green	Yellow	Yellow	Yellow	Yellow	Black	Black	Black
7) Informed consent	Green	Green	Yellow	Yellow	Yellow	Green	Black	Black
Workforce Planning	Yellow	Green	Yellow	Yellow	Black	Black	Black	Black
Guidelines	Yellow	Black	Black	Black	Black	Black	Black	Black

Key: Green full compliance; Yellow partial compliance with the action or evidence not available; Black/Grey NA

Enhanced Safety – Perinatal mortality reviews should include an external specialist. UHDB and CRH have a reciprocal agreement to review cases and meet this outstanding action.
Listening to women and families – Coproduction of services with service users' needs to be evidenced and links with the safety champions need to be strengthened. UHDB have been working more closely with the Derbyshire Maternity and Neonatal Voices to achieve this.
Staff training and working together – A minimum of 90% of each maternity unit staff group should attend inhouse multidisciplinary training. Currently UHDB have trained 100% of midwives and anaesthetists but only 72% of obstetricians and 80% maternity support workers. Twice daily Consultant ward rounds must be implemented 7 days a week

Managing complex pregnancy –Specialist Consultant leads are required for each complex pregnancy and a completed audit is required for evidence. Saving Babies Lives compliance is required to achieve all of the actions for IEA 4, 5 and 6 and has recently been assessed as 37% compliance.
Risk assessment throughout pregnancy – Evidence of a risk assessment being completed along with a discussion on place of birth and birth choices is required. Audit evidence needs to be improved to meet compliance.
Monitoring Fetal Wellbeing – A Fetal monitoring lead midwife and lead Obstetrician are required within the Trust to ensure that fetal monitoring education is up to date and any incidents involving fetal monitoring are investigated by the leads. The business case presented to UHDB Trust Board acknowledged this and will be addressed.
Informed Consent – Evidence is required to show that women are involved in decision making processes and that decisions are respected. Information needs to be available in different formats to meet the needs of the women. The website needs to be clear and informative and links with Derbyshire Maternity and Neonatal Voices needs to be improved.
Workforce Planning and Guidelines – Clinical workforce plans should be shared regularly with the Trust and LMNS Boards. A Consultant Midwife post job description is in development. Guidelines must be evidence based and a process in place to review them as part of a continual improvement process

The Trusts have provided further and more recent evidence for review by the LMNS in April 2023. Following this an updated compliance report will be shared with the Trusts and with the Midlands Perinatal team by May 2023. It is anticipated that both Trusts will be able to demonstrate an improved compliance.

Both Trusts have areas to action that are similar including:

- specialist roles within maternity being involved in perinatal mortality reviews,
- evidencing the involvement of women in their care choices,
- training and workforce development
- the full implementation of the requirements for Saving Babies Lives Care Bundle version 2.

Due to the reporting mechanisms in place, the LMNS is assured that, the quality and safety of maternity services is monitored and that the reported reduced compliance is predominantly in relation to audit and provision of evidence which is being progressed by both Trusts.

The Final Report of the Ockenden review (2022) provided 15 new recommendations, building on the initial 7. National guidance is due to be released on March 31st, 2023, to provide a Single Delivery Plan to incorporate all of the standards and recommendations from the national reports for maternity services. The LMNS will work with the Trusts to establish robust reporting mechanisms to provide the required level of assurance for the Integrated Care System and service users.

2.7. Saving Babies Lives Care Bundle (v2) (SBLCB) – current position

For CRH the reported compliance in January 2023 was 70%, which had increased from 17% in February 2022. Full compliance has been met with Element 1: Reducing Smoking in Pregnancy and Element 3: Management of Reduced Fetal Movements. The Midlands

Regional Perinatal Team is supporting CRH to achieve full compliance of SBLCB through bimonthly assessments of available evidence.

UHDB completed the optional regional assessment tool and received their first feedback on compliance in February 2023. Their assessed position was 37% compliance. They will be reassessed in May 2023, with an expectation that this will improve with the availability of more evidence from audits for assurance.

Saving Babies Lives Version 3 is expected in 2023 and will build on the Version 2 currently being implemented.

2.8. Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) – current position

Both Trusts reported partial compliance with the safety actions in February 2023 due in part to the impact of COVID on staff attendance on multidisciplinary training and workforce pressures affecting implementation of the actions. Saving Babies Lives Care Bundle compliance is also a requirement and as neither Trust has full compliance with all elements, they did not meet that safety standard. UHDB reported compliance with two of the ten actions and CRH with four. The LMNS will be sighted on the action plans to achieve compliance and by improving the availability of evidence.

2.9. Quality Improvement in Maternity Services – current position

In Derbyshire the following changes have been implemented as part of the Maternity Transformation Programme addressing the Better Births recommendations:

- a maternal mental health service to support women who do not meet the criteria for the perinatal mental health team.
- the practice of personalised care using and embedding personalised care and support plans.
- Midwifery Continuity of Carer to support women throughout their pregnancy journey to improve outcomes for the most disadvantaged.
- an NHS Tobacco Dependency pathway for pregnant smokers to improve outcomes for babies and families.
- the development of the workforce across maternity and neonatal services.
- the implementation of multidisciplinary training to improve skills and patient safety.
- the development of a meeting structure to allow shared learning across teams and organisations within the LMNS.

The following areas of clinical care that have been reviewed and changes made following LMNS scrutiny are:

- **Third and fourth degree perineal tears** (which can occur following a vaginal birth). CRH were reporting numbers which were higher than the national average. Through working with the Trust, and the introduction of quality improvement measures this

has now reduced, and the Trust is no longer an outlier. UHDB are also using the same care pathway and have remained within the national average.

- **Postpartum haemorrhage (PPH) or Major Obstetric Haemorrhage** (which is excessive bleeding following a birth). A national quality improvement measure is in phase one of implementation to improve outcomes for mothers. At UHDB, the pathway has been introduced to ensure PPH is managed with correct escalation, expertise, and monitoring to provide timely and appropriate treatment. This is currently under review locally as a quality improvement project. CRH are implementing measures to meet the national recommendations and will be part of a research project from October 2023. Both Trusts are actively involved in the national working group. Management of major obstetric haemorrhage, which is bleeding over 1500mls, was identified in the HSIB report and in a related coroner's case heard in February 2023. The LMNS Board will maintain oversight of postpartum haemorrhage through monthly review of cases and through monitoring of the implementation of the recommendations made for UHDB in the HSIB report. It is recognised that the report should be used for shared learning and therefore CRH will be included in the reviews for assurance.

- **Induction of labour –** (this may be indicated if there are concerns over fetal or maternal wellbeing or in a pregnancy which is more than 40 weeks gestation to reduce the risk of morbidity or mortality). Nationally, numbers are rising due to the increasing complexity of pregnancies. Regionally, a pathway has been developed to assist Trusts in correctly assessing the need for an induction of labour and to ensure that there is consistency in the offer of care across the Midlands. The impact of this will be monitored through the LMNS. Derbyshire Maternity and Neonatal Voices, who represent service users, have completed a survey on experiences of induction of labour and the reports are in the process of being shared and reviewed by UHDB and CRH.

3. Alternative Options Considered

3.1 Alternative options are not applicable for this paper

4. Implications

4.1. The implementation of recommendations to improve safety is important, however other measures are also used to provide assurance on maternal and neonatal clinical care safety. Local data is compared to national averages to ensure Derbyshire are not outliers for any clinical measures and quality improvement initiatives used where necessary.

4.2. A national response is awaited following the publication of Reading the Signals: Maternity and Neonatal services in East Kent in October 2022, along with the recommendations for the Final Ockenden 15 IEA's, to determine the implication for the LMNS.

4.3. NHSE has provided specific funding to implement the Ockenden recommendations and investment has been made into staffing and Perinatal Mortality Review Tool investigations. Midwifery Continuity of Carer was a significant factor in meeting some of the requirements and helping to reduce health inequalities, however staffing has affected recruitment and progression with this model of care delivery. CRH has one team in place and plan to develop another team in Q3 2023. UHDB has two teams currently.

4.4. Workforce pressures have been significant since 2020. A workforce plan is in place and recruitment is on a rolling basis. Gaps in senior management has impacted on the speed at which actions are implemented to meet the recommendations. Interim measures have been employed to improve governance however this is a longer-term problem, where there is not currently a solution in place.

4.5. Data collection, audit and evidence are significant factors in providing assurance both within the LMNS and for external reporting. The IT systems used require updating to keep up with the extensive data required. A maternity digital strategy has been developed through the Trust to allow investment and improve data collection and reporting. The LMNS has oversight of the Trusts dashboard monthly which allows scrutiny, shared learning and comparison between CRH and UHDB and national data, to establish outlier status. This information is also available through the Maternity Services Dataset which is a national reporting requirement.

5. Consultation

5.1 Derbyshire Maternity and Neonatal Voices (DMNV) are invited to the LMNS Board meetings and the Perinatal Quality and Safety Forum to ensure that there is an open and honest approach from maternity services. Service user feedback is presented and discussed to highlight areas for coproduction. Both Trusts have participated in a "15 steps" review of maternity services. The Trusts have received their reports, following the visits in 2022, with improvements recommended around four separate themes: welcoming and informative; safe and clean; friendly and personal and organised and calm to improve the patient and family user experience of the maternity service. A further review at RDH took place in February 2023 to determine the experience of families from the deaf community and included Definitely Women to provide feedback. The action plans will be shared with the LMNS and DMNV to provide assurance that changes have been implemented.

6. Background Papers

The NHS Long Term Plan (2019) - NHS Long Term Plan » The NHS Long Term Plan

The Saving Babies Lives Care Bundle Version 2 (2019) - NHS England » Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality

Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) Maternity incentive scheme - NHS Resolution

The Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (2020) Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust - GOV.UK (www.gov.uk)

The Final Report of the Ockenden review (2022) - OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)

The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE) reports - MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)

Better Births, the report of the National Maternity Review (2016) - NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care

National Perinatal Quality Surveillance Model - NHS England » Implementing a revised perinatal quality surveillance model

Reading the Signals: Maternity and Neonatal services in East Kent report (2022) - Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)

15 Steps for Maternity Royal Derby Hospital and Queens Hospital Burton, July 2022

15 Steps for Maternity visit to UHC

15 Steps for Maternity Chesterfield Royal Hospital, November 2022

CRH 15 Steps November 2022.pdf

7. Appendices

7.1 Appendix 1 – Implications.

This is not appropriate for this report.

8. Recommendation

That the Committee:

- Reviews the contents of the report and notes the actions taken to provide governance and assurance against the national maternity service recommendations and reports ensuring that Derbyshire maternity services are safe.

Report Author:

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Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

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March 2023

Appendix 1

<u>Implications</u>

Financial

1.1 N/A

Legal

2.1 N/A

Human Resources

3.1 N/A

Information Technology

4.1 N/A

Equalities Impact

5.1N/A

Corporate objectives and priorities for change

6.1N/A

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)