

Meeting Title	Quality Academy		
Date	28.04.21	Agenda item	QA.

MATERNITY SERVICES UPDATE – MARCH 2021

Presented by	Karen Dawber, Chief Nurse	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Quality Academy/Board with a monthly update on progress with the Maternity Improvement Plan, including Care Quality Commission (CQC) Action Plan, monthly stillbirth position and continuity of carer	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For decision	
Previously discussed at/ informed by	Details of any consultation	
Previously approved at:	Committee/Group	Date
Key Options, Issues and Risks		
<p>The Maternity Service was rated as ‘Required Improvement’ following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an ‘Outstanding’ service.</p> <p>Following Executive approval, the service have embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.</p> <p>Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors/Quality Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and ‘halve it’ trajectory.</p> <p>The monthly maternity services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity services.</p>		
Analysis		
<p>The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The updated action plan reflects progress and the position during February and March. The ‘must, should, could’ do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete.</p> <p>The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Service Programme continues to attract engagement from staff with progress evident in all 5 work streams during March.</p>		

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Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Deputy Chief Medical Officer and Chief Nurse. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

The Board/Quality Academy is asked to note the progress of the Maternity Services Action plan.

Board/Quality Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

The service requests that the Board/Quality Academy notes the narrative on the February maternity dashboard and notes that the March data is not available due to the timing of the paper submission, and will be provided at the next monthly update. However, the March stillbirth position is included within this report.

Board/Quality Academy is asked to acknowledge that there was no Serious Incidents (SI) declared in March.

The service requests that the Board/Quality Academy note the progress of the Outstanding Maternity Programme during March.

The Board/Quality Academy is also asked to note the progress made with the Continuity of Carer action pathways.

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Risk assessment																						
Strategic Objective	Appetite (G)																					
	Avoid	Minimal	Cautious	Open	Seek	Mature																
To provide outstanding care for patients			g																			
To deliver our financial plan and key performance targets			g																			
To be in the top 20% of NHS employers					g																	
To be a continually learning organisation				g																		
To collaborate effectively with local and regional partners					g																	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant																	
Explanation of variance from Board of Directors Agreed General risk appetite (G)	Risk (*)																					
<table border="1"> <thead> <tr> <th>Benchmarking implications (see section 4 for details)</th> <th>Yes</th> <th>No</th> <th>N/A</th> </tr> </thead> <tbody> <tr> <td>Is there Model Hospital data relevant to the content of this paper?</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Is there any other national benchmarking data relevant to the content of this paper?</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>							Benchmarking implications (see section 4 for details)	Yes	No	N/A	Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Performance implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) <input checked="" type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS Improvement Effective Use of Resources:

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Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the CQC Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity services.

2 BACKGROUND/CONTEXT

Ongoing Impact of Covid-19 pandemic on Maternity Services:

The service has responded to the pandemic in line with local, regional and national recommendations/directives, and has adapted the provision of maternity services to ensure that women, babies and staff are protected whilst maintaining safe, responsive maternity care.

The service is fully compliant with NHSE request that woman are supported to have a support person of their choice with them at every stage of the pregnancy and birth journey.

The surveillance of women who are Covid positive in the community setting continues, ensuring that pregnant women from BAME and vulnerable communities are monitored and any deterioration in condition is rapidly identified and acted upon.

During March there were 0 women, who experienced significant Covid 19 symptoms and required intensive or enhanced care. There were no babies with symptoms of Covid during this time. We do not, to protect our women and staff, move staff from maternity services to the acute main site.

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020. The report looked at maternal and neonatal harms

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occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services.

Following sign off by Executive Team Meeting (ETM) on 8 February, the service submitted a completed assurance template to the Regional Midwifery Officer on 10 February, ahead of the 15 February deadline. The service was able to demonstrate a high level of compliance with the 7 recommendations, and a statement of commitment to support the implementation of recommendations awaiting further national guidance and information.

A national portal through which to provide the supporting evidence has yet to be opened, but is expected in April 2021.

The service also provided the Regional Midwifery Officer with the confirmation that the full Birth Rate Plus acuity tool was commissioned in November 2020, with a draft report expected in March 2021.

Maternity Action Plan and CQC rating

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention.

The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. A number of recommendations will require significant time to complete, as they are intrinsically linked to major maternity transformation plans. For example, the action relating to closely monitoring infection risks in obstetric theatre will be categorised as 'ongoing' until the completion of the planned theatre rebuild which is approximately 6 weeks behind schedule. On-going surveillance of all women who have had a caesarean birth remains in place as part of the risk mitigation until the work is complete.

The action plan is reviewed 4-6 weekly by the Associate Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife. The majority of actions are making progress in line with target dates. However, a small number of actions have been impacted by working arrangements due to the pandemic as described.

A separate governance tab has been added to the overarching action plan; to evidence the actions required to demonstrate the CQC 'must do' that the Trust must improve governance and oversight of risk in maternity services.

The action plan was updated in March and significant progress has been made. All of the 'Should Do' recommendations are now complete. Of the 15 'Must Do's' 13 are either 'complete and closed' or 'complete with ongoing monitoring'. The 2 ongoing actions relate to 'Fresh Eyes' audit and staffing incidents. Significant work has already been undertaken. However, further improvement work is in progress.

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Stillbirth position

There were 2 reported stillbirths in March. Both women were booked and received antenatal care at Leeds Teaching Hospitals. Both were unbooked, acute admissions to BTHFT where intrauterine death was diagnosed and intrapartum care provided. Unfortunately, because the births occurred at BTHFT they will be represented in our statistics although we had no involvement or influence in the care prior to the acute admissions.

Table 1 is the summary of cases occurring in March.

Gestation	Summary	Outcome
25+5	G2 P1. Complex medical history including haematology condition booked in Leeds. Presented as an acute emergency pre-alert from YAS with a massive antepartum haemorrhage. Cat 1 LSCS performed. Baby stillborn. Significant Post-Partum Haemorrhage. Notable practice regarding the management of this major obstetric haemorrhage from all of the MDT involved in her care.	Leeds Teaching Hospitals informed. No further investigation by BTHFT
37	. A 19 year old lady in her first pregnancy who had received intermittent care in Leeds attended with an intrauterine death at 37 weeks gestation. She referred her care to Bradford at 36 weeks and reasonable attempts were made to book her urgently for AN care by the community team. Sadly she attended 6 days after referral with an intrauterine death.	Leeds Teaching Hospitals informed. No further investigations at BTHFT

Table 2 is the running total of stillbirths in 2021, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

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Table 2:

Stillbirths 2021			Expected deaths within total number	Further detailed investigation
Month	Number of baby's	Running total	Butterfly baby's	Number of cases
January	0	0	0	0
February	1	1	0	Yes - level 1
March	2	3	0	0

Ongoing actions to address the stillbirth rate

The Service continues to work towards full implementation of the Saving Babies' Lives Care Bundle, Version 2 and the improved identification and management of small for gestational age babies through the Outstanding Maternity Service (OMS) programme transformational work stream.

The revised fetal growth guideline including management of small for gestational age babies has been widely reviewed and commented on. Roll out of the guidance commenced 1 February 2021.

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring treatment for HIE in March.

Serious Incidents (SIs)

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were 0 maternity SI's declared in March.

There are 2 ongoing SI investigations, 1 declared in November completed to interim report and 1 declared in July which has been completed to final report.

Date of Incident	Brief Description	Immediate Findings	Finalised Key Issues
November 2020	A lady in her third pregnancy who is a type 2 diabetic requiring metformin booked her antenatal	Failure to utilise interpreting services appropriately. 72 hour review	Investigation still in progress. Completed to interim report stage.

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	care with the midwife over the telephone. The woman's husband was used to interpret and information about her diabetes was not established by the midwife. The woman was treated as low risk throughout her pregnancy despite significantly raised SFH measurements. At 39+1 week's gestation an IUD was diagnosed.	revealed the lack of a robust follow up process for women who failed to attend glucose tolerance testing appointments.	
July 2020	5 weeks Postnatal woman with complex medical and mental health issues, commit suicide at home shortly after being discharged from AED.		Final report completed but not yet shared

There was no SIs declared in March. However, a Level 1 investigation was declared relating to the care of a 38 year old woman in her second pregnancy who attended with likely essential hypertension superimposed by pre-eclampsia and a diagnosis of a 23 week intrauterine death. There was an assumption of 'white coat syndrome' at her booking appointment. She was reviewed at 19 weeks gestation however this was a non-face to face and hence there was a missed opportunity to have a blood pressure assessment. This was a change in service provision due to Covid-19 pandemic.

Despite the low likelihood that management of hypertension earlier or early administration of aspirin antenatally would have changed the outcome; there are significant gaps in risk assessment of the pregnant woman.

Since this sad case, with the exception of the initial booking appointment, all antenatal appointments have resumed as face to face consultations.

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HSIB Cases

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's. There were no cases meeting the HSIB referral criteria in March.

Maternity Unit Diverts

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

Moving forwards, maternity unit diverts will be included on the dashboard to demonstrate both the trend and to provide transparency.

There were 6 unit diverts declared in March, 2 occurring on the same day. The primary reason for divert was the acuity and volume of women in the intrapartum areas, compromised further by short term staffing issues on a number of occasions. Prior to all diverts, staff were redeployed to other clinical areas where possible, additional ward rounds took place on the inpatient wards to reconsider discharges. During daytime diverts, specialist midwives and matrons were utilised to assist with flow.

The senior midwifery leadership team met in March to review the current escalation policy and to agree how diverts are to be reviewed. The OMS programme team will also be supporting a QI piece of work to support the review.

Birth Rate Plus is now complete to draft report stage and the service is currently analysing the findings and staffing recommendations.

MONTH	NUMBER OF DIVERTS	RUNNING TOTAL
JANUARY	1	1
FEBRUARY	0	1
MARCH	6	7

Continuity of Carer Action plan

The Specialist Midwife for Continuity of Carer Pathways produces a monthly highlight report shared with the LMS and the Chief Nurse, in her capacity as Board Level Safety Champion. The report presented in January, relates to activity and progress during February which includes:

- On-calls continue to be suspended for Acorn team due to multiple sickness and a member of staff leaving the trust. They have continued to provide antenatal and

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postnatal CoC to the caseload; 2 new members have joined the team and CoC lead continues to support 1 day per week.

- Amber team to be fully staffed from March with a midwife new to the Trust.
- Willow team working well and the team are enjoying providing full CoC to the women. Occasionally missing births, the team have been doing some work to raise awareness; reminding MAC and LW to inform them when a woman presents, educating the women and adding alerts to electronic records.
- Funding has been approved for the Clover 'clone' team "Heather" which is anticipated to commence this summer.
- The previous loss/palliative care CoC team have started to recruit women to the team with 3 midwives being released 1 day per week initially. The team are planning the model and engaging with service users and the wider MDT in developing the service.
- CoC lead post has been temporarily extended by 3 months.

TOTAL % booked for CoC = 27% BAME % = 28%

Maternity Theatres

Building work commenced in January, immediately revealing a technical issue of sub-main distribution cables that need to be diverted prior to the project continuing. This essential work was completed in March.

The Maternity Theatre Project Board continues to meet on a monthly basis, and any anticipated delays/challenges will be escalated at that meeting.

Mitigation of the current maternity theatre has continued throughout the pandemic, including the use of the Public Health England, surgical site infection surveillance tool, for all women who have had a caesarean birth. Weekly Datix reporting of the frequency of theatre 2 usage is well embedded and consistent.

Maternity Dashboard

Appendix 1 contains the maternity dashboard including February data.

The metrics reported on the February dashboard continue to demonstrate consistently positive outcomes. There are currently no areas of significant concern to report.

- The home birth rate exceeded 2.5%. This is a huge achievement and the team continue to go from strength to strength.
- Breastfeeding initiation rate improved again in February and was greater than 70%.

Due to the timing of this paper, the March maternity dashboard has not yet been updated and will be provided in the next monthly update to Regulation Committee/Board.

Outstanding Maternity Service Programme

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

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The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit For The Future.
- Investing In Our Workforce.

Progress during March:

Programme Governance

- QI training roll out ongoing.
- Dashboard creation is underway.
- Public facing communication – Telegraph and Argus article.
- Quality Academy presentation.

The Women's Journey

- Meacc Pathway completed, launched and in use (Enhanced Maternal Care).
- Fetal Growth Pathway completed, alongside training for new guidance in progress.
- Ambulatory Care Pathways commenced starting with Reduced Fetal Movements review.
- BSOTS Implementation commenced (Birmingham Symptom Specific Obstetric Triage System).

Investing In Our Workforce

- Labour Ward handover VRE sessions have been completed with MDT representation.
- 3 substantive consultant posts have been approved by the Board.
- Birth rate plus draft report has been discussed.
- Staff survey focus group has been established with OD.

A Building Fit For The Future

- Labour Ward First 15 Steps completed.
- Welcome sign in top 5 languages being developed.
-

Moving to Digital

- "The Perfect Clinic Room" in process of being established – equipment ordered.
- Obstetric Website development underway.
- MSW and Midwife secondments to work with the Cerner Project have been appointed.
- Current State Review underway for Cerner Project.
- Linking Learning and Quality Through Our Information.
- Staff survey has been distributed to understand how staff use the lessons learned.
- Guideline templates have been shared with the MVP.
- Ward to board process review in progress linking with Trust.

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Maternity Cerner

The Maternity Cerner project continues at pace. The inaugural project board met in March and the team are receiving weekly progress updates including:

- Current State reviews completed successfully, with positive feedback received from participants.
- Fetalink kick-off planned 13 April.
- Future State reviews in planning for week commencing 19 April.
- Workshop planning underway.

NHSI Maternity Safety Support Programme

The organisation received notification from NHSI in July 2020, that maternity services at BTHFT had been entered onto the Maternity Safety Support Programme, triggered by the CQC 'requires improvement' rating.

The programme was paused due to Covid-19, but has now formally recommenced with notification received on 23 November 2020.

The first support visit took place virtually on 15 December. The service shared a presentation outlining the journey and progress made during the 12 months following the CQC visit, including the immediate response to the Ockenden Report.

The service is now in the 'diagnostic' phase of the support programme and 2 site visits took place in February, including attendance at the Women's Core Governance Group meeting. Verbal feedback was extremely positive.

No further updates or issues were raised during March. Further site visit planned for 21 April when the service will ask when we can expect formal feedback and what to expect as next steps in the process.

3 PROPOSAL

The service proposes that the Maternity Action Plan, stillbirth rate, and continuity of carer continue to be presented on a monthly basis, until sustained improvement is noted in these key areas and the 2019/20 Maternity CQC action plan is complete.

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

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5 RISK ASSESSMENT

Stillbirths and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

6 RECOMMENDATIONS

The Board/Quality Academy is asked to note the progress of the Maternity Services Action plan.

Board/Quality Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

The service requests that the Board/Quality Academy notes the narrative on the February maternity dashboard and notes that the March data is not available due to the timing of the paper submission, and will be provided at the next monthly update. However, the March stillbirth position is included within this report.

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7 Appendices

1. Maternity Improvement Plan - Appendix 1.
2. Maternity Dashboard - Appendix 2.