The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	30 January 2017
Title:	**Midwifery Report**
Executive Summary:	This report covers the following key issues: • Midwifery staffing and birth ratio. • Better births recommendations – Improving outcomes of Maternity Services in England • National Maternal and Neonatal Health Safety Collaborative • National Maternity training bid **1. <u>Midwifery staffing and birth ratio.</u>** The report provides an overview of Midwifery staffing to birth ratio at RWT. The report also provides an update on the annual and predicated birth rates for 2016/17. **2. <u>Better births – Improving outcomes of Maternity Services in England.</u>** This report was published in March 2016 and was conducted by Baroness Julia Cumberlegde who acted as independent chair for the review. The national maternity review was asked to review international evidence and make recommendations on safe and efficient models of maternity services including Midwifery led Units (MLU). Seven key recommendations for action were identified within the report and outlined below. **3. <u>National Maternal and Neonatal Health Safety Collaborative</u>** The collaborative was announced by the Department of Health in October 2016. DH's ambition is to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030 **4. <u>National maternity Safety Training Bid</u>** In November 2015, the Secretary of State for Health, Jeremy Hunt MP, announced a new national ambition to reduce the rate of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies in England by 20% by 2020 and 50% by 2030, to ensure England is one of the safest places in the world to have a baby
Action Requested:	To note the report
Report of:	Tracy Palmer, Head of Midwifery

Author: **Contact Details:**	Tel 01902 695162 tracypalmer@nhs.net
Links to Trust Strategic Objectives	
Resource Implications:	Revenue: Capital: Workforce: Funding Source:
Risks: BAF/ TRR **(describe risk and current risk score)**	
Public or Private: **(with reasons if private)**	Public
References: **(e.g. from/to other committees)**	
Appendices/ References/ Background Reading	National Maternity review (2016) Better Births - *Improving outcomes of Maternity services in England. NHS England* *www.improvement.nhs.uk*
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny
Background Details:	**1. Midwifery staffing and birth ratio** 1.1 Birth to Midwife ratio remains stable at between 1:30. – 1:31. A ratio of 1:30 was agreed at The Local Supervisory Authority and regional Heads of Midwifery group. Midwifery recruitment has taken place and offers of appointments made to ensure that Midwifery staffing establishments continue to remain within these ratio's, funding from the Walsall business case to support the extra agreed 500 births have been assigned to budgets to support recruitment. . 1.2 Annual birth rate

2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
4097	3967	4129	4121	4479	4900

1.3 A service model between Wolverhampton and Walsall Healthcare Trust was agreed in March 2016 in order to support Walsall Healthcare Trust's plan to cap births. RWT agreed to take 500 births to support this plan. Transfer of births from Walsall Healthcare trust to Wolverhampton commenced on the 21st of March 2016 and ceased end of August 2016 when 500 transfers were confirmed. The process was managed well without any major concerns.

1.4 RWT is monitoring new bookings from the designated Willenhall

GP's monthly and Walsall births are reported and monitored via the Maternity Dashboard.

1. 5 Forecasts for birth rates have indicated that Annual birth rates for RWT will equate to approximately 4900 births by end March 2017.

1.5 Midwifery staffing / birth ratio are also being monitored closely and active Midwifery recruitment is under way to sustain the 1:30 midwife to birth ratio.

2. Better births – Improving outcomes of Maternity Services in England Key recommendations.

2.1 RWT Maternity service has devised an action plan to incorporate the 7 key recommendations from the report and is working collaboratively with Maternity Units and Commissioners within the Black county called Local maternity Systems (LMS's) to develop and implement a local vision for improved services and outcomes based on the principals outlined in Better Births. LMS's will align with Sustainability and Transformation Plans (STP's) footprints for Maternity services.

2.2 Key recommendations from National maternity Review.

- Personalised care – centred on the woman her baby and family based on needs and their decisions where unbiased information and genuine choice is given
- Continuity of carer - to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
- Safer care – professionals working together across boundaries to ensure rapid referral to ensure right care in the right place. Focus on leadership for a safety culture within and across organisations; investigation honestly and learning when things go wrong.
- Better postnatal and perinatal mental health care. To address historic underfunding and provision in these two vital areas.
- Multi- professional working – breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- Working across boundaries - to provide and commission maternity services to support personalisation, safety choice with access to specialist care when needed.
- A payment system – that fairly and adequately compensates for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

3. National Maternal and Neonatal Health Safety Collaborative

3.1 The collaborative was announced by the Department of Health in October 2016. DH's ambition is to reduce the rates of

maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. All trusts and independent providers in England offering maternity services are asked to make measurable improvements in safety outcomes for women, their babies and families by exchanging ideas and best practice through this three-year quality improvement programme.

3.2 The collaborative supports the aims of the Better Births (2016) maternity review and the Maternity Transformation Programme. It is led by NHS Improvement, working with commissioners, providers, the patient safety collaborative, maternal and neonatal networks and other system partners.

3.3 The collaborative will help all maternity care providers and commissioners to improve clinical practices, reduce unwarranted variation and report on how they are contributing to achieving the national ambition. It will build local capability in quality improvement and provide structured support for local teams to assess their service and develop innovative plans for measurable improvements.

3.4 The collaborative will officially launch on 28 February 2017. RWT will be informed if our application to be included in the first wave has been successful by end of January 2017

3.5 The collaborative will be fundamental to developing a national learning system and a culture of continuous quality improvement for maternity and neonatal services.

4.National Maternity Safety Training Bid

4.1 In November 16, the Secretary of State for Health, Jeremy Hunt MP, announced a new national ambition to reduce the rate of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies in England by 20% by 2020 and 50% by 2030, to ensure England is one of the safest places in the world to have a baby.

4.2 The ambition is part of a wider government aim to reduce all avoidable harm by 50% and save 6,000 lives by 2017. It will form a key part of the work of the patient safety campaign, Sign up to Safety.

4.3 *Better Births, Improving outcomes of maternity services in England* (2016) highlights the need for multi-professional working, breaking down barriers between midwives, obstetricians and other health professionals to deliver world-class safe, personalised care for women and their babies.

4.4 As part of the ambition to halve maternal and perinatal mortality and intrapartum brain injuries, the Department of Health has identified a training fund for NHS maternity services to be administered through Health Education England (HEE).

4.5 RWT was successful in securing £40K to fund training for multi professional teams across Maternity and Neonates.

4.6 Focus for use of the training fund will centre on Human factors training, Obstetric Simulation training (ObSIM), Obstetric emergency skills drills within the community setting, multidisciplinary Cardiotocograph (CTG) training and Neonatal life support (NLS) training.