The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	July 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 • Moving towards a new model of midwifery supervision **1. Midwifery staffing and birth ratio.** The report provides an overview of Midwifery staffing to birth ratio at RWT. The report also provides an update on the annual birth rates for 2016/17. **2. Better births – Improving outcomes of Maternity Services in England.** This report was published in March 2016 and was conducted by Baroness Julia Cumberlege 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 and are being taken forward as part of the Black Country Local Maternity system (BCLMS) and is a task group charged with overseeing the Better Birth agenda for the Black County Maternity Sustainability and Transformation Plans (STP) **3. National Maternal and Neonatal Health Safety Collaborative** 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. The Royal Wolverhampton NHS Trust joined the first wave of the collaborative in February 2017. **4. Moving towards a new model of Midwifery Supervision** There are a number of significant reports which have impacted on the statutory function of Supervision of Midwives and on Maternity Services which include; 'Midwifery supervision and regulation recommendations for change' (PHSO 2013), and 'Midwifery regulation in the United Kingdom' (The Kings fund 2015) The key principals identified within the reports were accepted by the Nursing and Midwifery Council (NMC) and agreed by the Secretary of State. They are:

	• Midwifery supervision and regulation should be separated • The NMC should be in direct control of regulatory activity. The regulatory function of the Local supervisory Authority (LSA) and Supervisor of Midwives role ceased on March 31st 2017. The England Supervision Taskforce was formed by NHS England (NHSE) and the England CNO in January 2016 and has been responsible for developing the new model of midwifery supervision in England.
Action Requested:	To note the report
Report of:	Tracy Palmer, Head of Midwifery and Gynaecology
Author: **Contact Details:**	Tel: 01902 695162 Email: tracypalmer@nhs.net
Links to Trust Strategic Objectives	
Resource Implications:	
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* *https:/www.england.nhs.uk/ourwork/futurenhs/mat-transformation/midwifery-task-force/* *http://ww.kingsfund.org.uk/projects/midwifery-regulation-unitedkingdom*
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

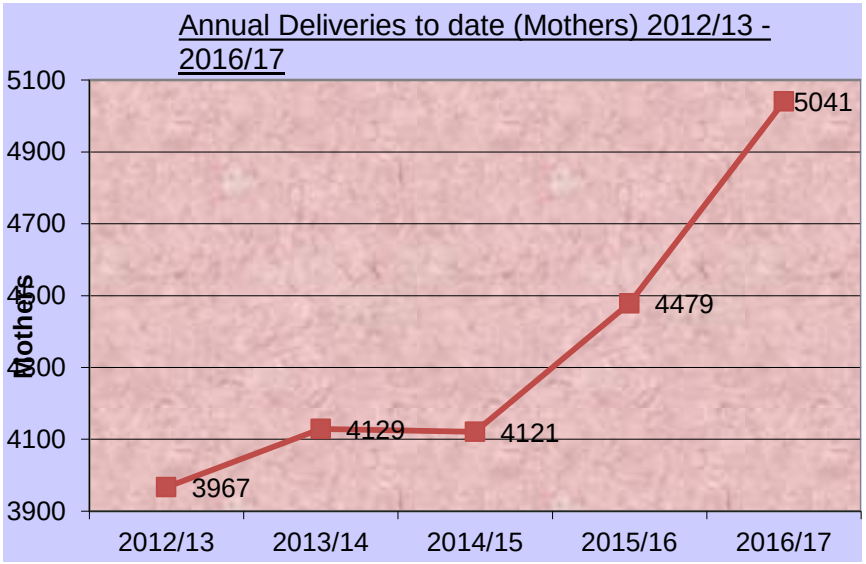
Background Details:

1. Midwifery staffing and birth ratio

1.1 Birth to Midwife ratio remains at 1:31 over the last 12 months. A ratio of 1:30 was agreed by 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.

Despite proactive recruitment it has been a challenge to meet the 1:30 ratio over the last 12 months due to a number of Midwives retiring or moving Trusts for promotion. However in July 2017 8.2 WTE Midwives were recruited and posts offered to fill vacancies. Therefore once staff are in post Midwifery establishments will be staffed adequately to meet the 1:30 birth to Midwife ratio's for 5000 births.

1.2 Annual birth rate



1.3 A service model between Wolverhampton and Walsall Healthcare Trust was agreed in March 2016. RWT continues to support this service model; sustained booking numbers continue to book with RWT from the 6 designated Willenhall General Practices (GP's).

1.4 RWT continues to monitor new bookings from the designated Willenhall GP's and bookings from 'other' GP's outside of Wolverhampton borders monthly and booking numbers are reported and monitored via the Maternity Dashboard.

1.5 Midwifery led Births born in The Midwifery Led Unit average at 19.5 % over the last year. This is an extremely positive number of births and has supported management of capacity on Central delivery suite. 3 extra birth rooms on Delivery suite and recently 4 extra post natal beds located on the MLU have also been essential to facilitate the extra activity and capacity demands.

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

2.1 RWT 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 The purpose of the BCLMS is to provide place-based planning and leadership to enable local maternal and neonatal services to become safer, more personalised, kinder, more professional and family friendly.

2.3 The BCLMS membership includes all providers involved in the delivery of maternity and neonatal care. Senior clinicians, commissioners, operational managers, and primary care working across Wolverhampton, Walsall, Dudley and Sandwell and West Birmingham.

2.4 One of 3 The task groups within the BCLMS will be charged with overseeing the *Better Births* agenda for the Black Country STP.

2.5 The work of the *Better Births* task group will:

- Be reflective of the national agenda for maternity services specific to *Better Births.*
- Standardise pathways to support women to make informed choices.
- Agree consistent pathways, pathways and consistent data sets to ensure continuity of maternity services across the Black Country.
- Ensure best practice arrangements for birth agenda, improving maternity safety outcomes across the Black Country. (This work aligns itself with the work with the Maternal and Neonatal Health safety collaborative.)
- Strategic leadership to embed the 'normalisation' agenda; increasing the number of births within midwifery led care.
- Determine workforce needs and workforce baselines to support understanding of future work force requirements.

2.6 Inaugural meeting took place in March 2017 and meetings continue monthly.

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 was officially launched 28th February 2017.

3.5 RWT was officially informed that our application was successful and that we are included in the first pioneering wave for this three year programme.

3.6 Following on from the launch event the programme ambition and scale of sequence is:

<u>National learning set – Year 1</u>

- 3 X 3 day learning meetings for improvement leads
- 6-8 weekly unit visit by central programme lead
- National event March 2017 to share learning and progress from wave 1 organisation.

<u>Year 2 – wave 2 Trusts</u>

- National learning set
- Regional meetings to include LMS's
- 6-8 weekly unit visits by central programme team
- National event – share learning and progress from wave 1 and 2 organisations.

<u>Year 3 – wave 3 Trusts</u>

- National learning set
- Regional meetings to include LMS's
- 6-8 weekly unit visits by central programme team
- National event – share learning and progress from all organisations.

3.7 RWT quality improvement programme is to *'Reduce the number of Term admissions to Neonatal Unit with Arterial cord PH of <7.05 or venous PH <7.1 by 50% by 2019'* The three improvement leads form RWT attended the first of 3 day learning sets in Leeds May 2017. The Central Programme team visit is scheduled for July 2017.

4.0 Moving to a New Model of Midwifery supervision.

4.1 The NMC as a health care professional regulator should have

direct responsibility and accountability solely for the core functions of regulation. Legislation pertaining to the NMC has been revised to reflect this. The additional layer of regulation for Midwives and the extended role for the NMC ended on March 31st 2017.

4.2 The conclusions of the PHSO (2013) referred to the merits of midwifery supervision in the support it provided for midwives and therefore there was no requirement to remove the non-regulatory aspects of midwifery supervision.

4.3 Review of the non-regulatory aspects of midwifery supervision has been undertaken within evidence based context to develop a new model of supervision within the midwifery profession.

4.4 The model that has been piloted and tested in 7 sites and is called A-EQUIP – Advocating and educating for Quality Improvement.

4.5 The A- EQUIP Model

- Three distinct functions; restorative, personal action for quality improvement and education and development.
- The model aims to support the Midwife through a process of clinical supervision.
- Enhances quality of care and supports preparedness for appraisal and revalidation.

4.6 The Professional Midwifery Advocate (PMA). This is a new role that replaces the supervisor of midwives. To undertake the role the midwife must successfully complete a PMA preparation programme provided by Health Education Institutes (HEI).

4.7 Plan for RWT is to appoint 1 PMA initially in a seconded role to 'test out' process, impact and outcomes of the new model. With a review after 10 months to evaluate the value of A-EQUIP and how this aligns with the professional employer led model.

	4.8 The PMA will also be responsible for overseeing the non-regulatory duties of Midwifery supervision for example complex birth planning, advocacy for women and the birth reflections service. 4.9 The new model of midwifery supervision is fundamentally important part of the wider Maternity Transformation programme (Better Births 2016) and is a key part of work stream five – *Transforming the Workforce.* 5.0 All supervisory investigations (n) 4 were completed before the deadline 31st March 2017 for RWT. There were no outstanding actions from any of the investigations. All relevant documentation was archived and sent on to the LSA as directed by the Local Supervisory Authority Midwifery Officer (LSAMO) within timescales in order for these documents to be forwarded to Nursing and Midwifery Council (NMC) to be archived.