The Royal Wolverhampton
NHS Trust

Midwifery Report
January 2018

Agenda Item No: 9.3

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	January 2018
Title:	Midwifery Report
Executive Summary:	**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 2017/18. **2. Better births – Improving outcomes of Maternity Services in England.** Local Maternity Systems have formed across England and are working collaboratively on the proposals within the report to make maternity services safer and more personal for women. The BCLMS Transformation plan – Ambitions and Commitments 2017 -2020 has been written and endorsed by NHS England (NHSE) which outlines vision, ambition, and priorities as part of the 5 year forward plan. **3. Safer maternity Care. The National Maternity safety Strategy – Progress and next steps.** A progress report has been published in November 2017 by the DoH and sets out additional measures to drive improvement further in terms of improving the rigour and quality of investigations into Term still births, neonatal and maternal deaths and serious brain injury. **4. Professional Midwifery Advocate (PMA) Role** The Professional Midwifery Advocate (PMA) role will be responsible for taking forward the new non-statutory model of clinical supervision. This will be employer led.
Action Requested:	To receive and note the report
Report of:	Tracy Palmer, Head of Midwifery and Gynaecology
For the attention of the Board. • **Alert** • **Assure** • **Advise**	To advise the Board with a progress update on the key programmes of work for Maternity services in line with the national ambition and safety strategy plans outlined within the National Maternity review: Better Births – Improving outcomes of Maternity services in England (2016). • Midwifery staffing and birth ratio. • Better births recommendations – Improving outcomes of Maternity Services in England

	• Safer Maternity care – The national Safety strategy – progress and next steps. • Professional Midwifery Advocate (PMA) role.
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality. 2. Proactively seek opportunities to develop our services
Resource Implications:	Workforce.
Public or Private: **(with reasons if private)**	Public
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* *Safer Maternity Care (2017) The National Maternity Safety Strategy – Progress and next steps. Department of Health.* *Implementing Better Births: Continuity of Carer Five year Forward View (2017). DoH.* *Black Country Local Maternity Transformation Plan 2017-2020 (EMBED DOC)* *Each Baby Counts (2015) RCOG* *NHS early resolution and Redress (2017) NHS Resolution.*
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

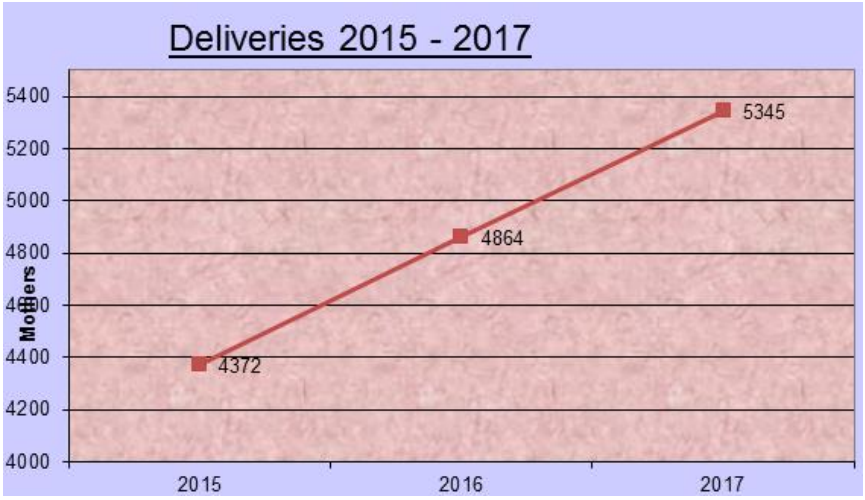
1.1 Birth to Midwife ratio remained at 1:31/32 over the last 12 months.

The Chief Nursing Officer and Medical Director have agreed to a Formal Birth rate + assessment which is presently in progress. This is being funded by the division. This assessment will enable a review based on acuity and 'models' of care, such as a Birth Centre/Midwife Led Service, together with a detailed breakdown of staff per area and model of care.

Data collection for 3 months will provide a reliable and valid case mix along with other intrapartum and ward activity.

In December 2017 funded midwifery vacancies have been appointed into. However as birth rates have increased over and above RWT's 5000 commissioned birth rates – Midwife to birth ratio remain at 1:31.

1.2 Annual birth rate



1.3 In September 2017 the Chief executive wrote to Clinical Commissioning groups (CCG's) within the Black Country to raise concerns regarding the increase in booking activity and birth rates at RWT. Discussions have also taken place within the BCLMS, Maternity network and with NHS England (NHSE) in terms of how RWT could manage activity and provide capacity for extra births.

1.2 In October 2017 the CEO formally wrote to CCG's providers and NHSE to inform that RWT would not be able to facilitate additional bookings / births over the commissioned 5000 in order to maintain safety, quality and Midwifery birth ratio standards. This took effect from November 2017. This data is being monitored and the maternity service has observed a minor decrease in bookings thus far.

1.4 Booking and birth rate data is being monitored closely within the Directorate with a formal review of projected birth rates planned in early spring.

1.5 The service model between Wolverhampton and Walsall Healthcare Trust was agreed in March 2016. RWT continues to support this service model.

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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. .

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 has been reviewed recently to ensure correct representation at The strategic oversight board and LMS implementation committee and to strengthen governance structure and function.

2.4 The BCLMS Transformation Plan has been written and endorsed by NHSE.

2.5 Key priorities within the transformation plan have been identified as :

- To tackle perinatal and infant mortality – in line with the DoH ambition to halve stillbirth rates, neonatal and maternal deaths and brain injuries by 2030. This work aligns itself with the work with the Maternal and Neonatal Health safety collaborative of which RWT are involved in the first wave 2017/18.

- Implementing Better Births: Continuity of carer (DoH 2017) - agree within the LMS on the service model most appropriate for BC providers. Ensure consistent pathways, pathways and data sets to ensure continuity of maternity services across the Black Country.

- HoM is presently undertaking a review of Community Midwifery services to inform future service model for RWT re: Continuity of Carer.

- Shared learning for serious untoward incidents (SUI) within the LMS.

- To continue to strengthen community inclusion by engaging with women and families as part of the Maternity

Voices partnership (MVP) across the LMS.

- Determine workforce needs and workforce baselines to support understanding of future work force requirements.

3. Safer Maternity Care – The national Maternity safety Strategy – progress and Next steps.

3.1 In 2015 The Department of Health (DoH) set a challenging ambition 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.

3.2 A progress report *Safer Maternity Care* (2017) has been published in November 2017 by the DoH and sets out additional measures to drive improvement further. The National ambition timescales has been re-set to halve rates (as above) by 2025 as opposed to 2030.

3.3 As part of this ambition The Department of Health announced the launch of the National Maternal and Neonatal Health Safety Collaborative in October 2016 lead by NHSE.

3.4 RWT joined the collaborative in March 2017 as one of 45 Trusts involved in the first wave 2017/18. The focus centres on quality improvement and provides structured support for teams to develop plans for measurable improvements. RWT have had their improvement project signed of by NHSI and are working towards implementation.

3.5 Saving Babies lives Care Bundle (NHSE 2016) is designed to tackle perinatal mortality with focus on surveillance. RWT are working towards improvement activities across all 4 elements of the care bundle.

1. Reduce Smoking
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of fetal movements
4. effective fetal monitoring during labour

3.6 Immunisation against Flu and pertussis. RWT joined the pilot from Public Health England (PHE) in 16/17. Programme is well established and will continue into 18/19 with good uptake from mothers to be for Flu 87.3% and Pertussis 87%.

3.7 Maternity Safety Training Fund – RWT secured bid of 40K in 2016. Funding is being spent on multidisciplinary training and will support programmes of work to deliver Better Births ambition.

3.8 Perinatal and Mental Health bid for funding – still awaiting call for bids for NHSE transformation funding to provide specialist perinatal mental health service across the Black Country. RWT involved in pilot perinatal mental health advisory clinics in

January 2018.

3.9 Rapid Resolution and Redress. NHS Resolution (2017). Each Baby Counts RCOG (2015). RWT reporting in line with both programmes.

3.9.1 Maternity units are awaiting direction from the DoH regarding their plans in terms of the proposed new way in which Term Stillbirths will be investigated. The DoH have announced in their report *Safer Maternity Care* (2017) that together with NHSE, NHSI and the new Healthcare safety Investigation Branch (NSIB) that they intend to publish by Q2 2018 information and guidance on the standards for maternity investigations to deliver Morecambe Bay and Better Birth recommendations.

4.0 Professional midwifery Advocate (PMA) role update.

4.1 The NMC as a health care professional regulator now has direct responsibility and accountability solely for the core functions of midwifery regulation.

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). RWT has 2 fully trained PMA's newly appointed into a seconded post.

4.7 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.

4.8 Head of Midwifery will provide a progress report once role has established at Trust Board in July 2018.