Regional Midwifery Forum

Minutes of the Meeting Held: Tuesday 9th January 2007

Present:

Name	Unit
Pat McGeown, **Chair**	Perinatal Institute
Jean Lucas	Alexandra Hospital, Redditch
Wendy Burt, Coralie Rogers	Birmingham Womens Hospital
Helen Melville	Good Hope Hospital
Carol Colclough	Keele University
Lesley Adams	Princess Royal Hospital
Anthea Gregory-Page	Royal Shrewsbury Hospital
Amanda Hackett	Russell's Hall Hospital
Verna White	Sandwell General Hospital
Joyce Till	Stafford General Hospital
Pat Bodin	University of Central England
Kerry Gorton	Walsall Manor Hospital
Ann O'Reilly, Isobel McDermott	Walsgrave Hospital
Marcia Edwards	Wolverhampton University
Jill Wright, Kate Morse, Mandy Williams	Perinatal Institute

Apologies:

Name	Unit
Angela McBennett	Birmingham Women's Hospital
Elinor Clarke	Coventry University
Deb Garrett, Dawn Fuller	George Eliot Hospital
Suzanne Wilson	Good Hope Hospital
Amanda Palmer, Jan Pakes	Hereford County Hospital
Val Tristram	Kidderminster Hospital
Anne Mellor	Mid Staffordshire Hospital
Lorraine Smith, Christiane Harrison, Debra Hickman	New Cross Hospital
Cath Mercer	Royal Shrewsbury Hospital
Ruth Gammon	Staffordshire& Shropshire University
Jackie Jenkinson	University Hospital North Staffordshire
Wendy Jones	Warwick Hospital
Tracey Cooper	Worcester Royal Hospital

Minute Taker: Claire Hallahan, Perinatal Institute

Agenda Items

Action Points

1. Introduction

Welcome and individual introductions.

2. Minutes of meeting 12th September 2006

The minutes were agreed as correct.

3. Matters arising

- The HOMs are very supportive of this group. They are currently working together to look at maternity services and are currently focussing on postnatal care management strategy and are still at a strategic level with this so the information has not been shared yet. They would like this group to do some work towards this at a later date and would like us to continue looking at mental health and any other current topics.
- AGP to forward their mental health care pathway to be circulated to the group. **AGP**

Presentations

- **Overview of Reducing Perinatal Mortality Project**

Mandy Williams, Project Midwife for the Reducing Perinatal Mortality (RPM) project, presented an overview of the project.

The project was preceded by the Bellevue Project in 2001 which examined women's experiences of antenatal services. The recommendations from this project were to ensure antenatal services were more flexible and accessible to all and that care should be midwife led.

The project was initiated because Birmingham and the Black Country (BBC) have got the highest Perinatal mortality in the country. The average is 8 in every 1000 but the BBC's is 10.1. The aim is to reduce this by 20% by 2009 by cutting the number of stillbirths caused by IUGR by a third.

A project initiation document was produced by PCT Chief Executives, and then the PCT Accord decided what the targets would be.

The targets for the RPM project are strengthening maternity services and focussing on the 5 key Process Indicators (KPI's):

1. Early booking (prior to 12/40) – the target is 80%
2. Continuity of carer – 75% of antenatal and postnatal visits to be with the named midwife
3. Detection of IUGR – 60% detection antenatally
4. Smoking cessation – reduce to 15% by 2010
5. Breastfeeding initiation – increase rates by 2% every year

Within the KPI's there will also be sub categories to compare, parity, age, ethnic origin and BMI.

The project has been split into three areas

- Maternal Experience Study – a study will be conducted to compare antenatal care of women going through the traditional model of care with the enhanced

model. Quantitative surveys and qualitative semi-structured interviews will explore women's experience of antenatal services, such as relationship with midwife, continuity of carer, choices and information received and smoking cessation support.

- Data collection – this commenced February 2006, 8 trusts are collecting pregnancy data from which reports are generated. This is the first time that this type of data has been collected centrally.
- Confidential case reviews – looking at IUGR stillbirths more than 30 weeks gestation with no fetal abnormality. Since October 2006 there have been 4 panels (16 cases reviewed so far).

PMcG added that some areas have moved their antenatal services from GP surgeries to children's centres, to enhance the service within the community. Where this has happened, it has worked well and there are more children's centres planned. It allows women more opportunity to see their midwife and the midwives have got a permanent base with all of the equipment they need. Stoke has also started to do this.

Future work

- Reduce health inequalities: To reduce health inequalities by 10% by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy
- Reduce mortality rates (cancer, heart disease and stroke and related diseases)
- Reduce adult smoking rates
- Reduce teenage pregnancies
- Infant Mortality: Smoking during pregnancy
- Infant Mortality: Breastfeeding initiation rates

MW showed the group a sample report, consisting of the results of 3 trusts data, so that the group could see what can be achieved from collecting pregnancy data. The reports show whether each Trust is on target for the KPI's; a sub-group analysis of 'at risk groups' (e.g. ethnic groups, age, BMI etc) were also highlighted in order for Trusts to recognise areas to target. The reports can be generated for each Trust, each PCT and in the future each ward.

A discussion followed about continuity of carer and how it is defined when a lot of midwives are part time, job share or work as a buddy. PMcG said after a lot of discussion it was decided that each person is classed individually and that this was the midwife that the woman should see. PMcG said that the figure is achievable but realises it will take time and will need to be accomplished a step at a time.

- **Northwick Park – Report of Maternal Deaths**

Kate Morse gave an overview of the findings of the Northwick Park Report.

There were 10 maternal deaths, within 42 days of delivery, between April 2002 – April 2005 at Northwick Park Hospital. This number of maternal deaths was significantly higher than at trusts with a similar birth rate. During this time the birth rate at Northwick Park had increased due to the closure of a nearby

2002 – 3 maternal deaths (in a 2 week period)
2003 – 4 maternal deaths
2004 – 2 maternal deaths
2005 – 1 maternal death

KM presented 2 of the cases and the group discussed the management of each case.

Case 1

- Primigravida
- Cause of death: intracerebral haemorrhage.

Case 2

- Multigravida – 4 previous pregnancies, one live child
- Cause of death: Haemorrhage

Both cases were classified as direct deaths meaning a death resulting from obstetric complications of the pregnant state from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

The Healthcare Commission findings were:

- Poor record keeping
- Failure to communicate between departments
- Statements were not obtained from all of the staff involved
- Statements incomplete, unsigned and not dated
- Equipment failure or lack of equipment
- Failure to record blood results in the clinical case notes
- Failure by staff to detect and communicate abnormal blood test results appropriately
- A failure to initiate early investigation and treatment.
- Failure to recognise when progress in labour deviates from the normal course expected
- Delays in seeking medical advice
- Lack of clear management plans for women whose pregnancy is classified as high risk
- There was an excessive reliance on the use of locum and agency staff, who did not always receive the necessary guidance or support.
- Deficiencies in the management structures also contributed to the poor quality of care the women received
- Initially the midwives received little professional support from the supervisors of midwives
- Concerns about the low numbers of staff and how this may impact on the safety of patients

Group discussion

The general feeling of the group was that there were obvious shortfalls in the care the women received. Treatment should have been initiated earlier in the first case and other options should have been considered earlier in the second case. The group felt if the management had been different both deaths could have been prevented.

Within one local unit they have a multi disciplinary meeting as a result of a maternal death.

Due to the shortages of blood products, many units are moving towards using cell savage machines. Walsgrave have recently purchased one and using it in high risk cases in their maternity department and said that anyone who wishes to see the machine is welcome to visit the unit. Contact either Ann O'Reilly or Isobel McDermott.

4. Topics for discussion

- Fit for Practice in the Genetic Era – Ruth Gammon
- NSF Delivery Plan
- Common Assessment Framework for Child Protection – Ann O'Reilly
- Coventry's NRF Risk Assessment Tool – Ann O'Reilly
- Discuss further cases from the Northwick Park Report

5. Any Other Business

LA asked if any other unit had protocols/guidelines for using a birthing pool for labour and delivery for women wishing to have VBAC. WB said that BWH would have something that she could forward on and also suggested contacting New Cross.

6. Date and Time of next meeting

- Tuesday 6th March 2007 at **1pm** (lunch available from 12.30pm)
  Venue: The Perinatal Institute, Crystal Court, Birmingham