General Risk Assessment Form

1. Risk Location

SDU: Singleton

Site: Sing/NPH

Ward/ Dept: Maternity services

Speciality: Maternity

2. Title: Phase 4 : Reinstatement of intrapartum service in Swansea Bay Health Board. Comparison of different birth environments to aid the safest de-escalation programme.

3. Risk in Brief (A brief description of the risk, enter facts not opinions. Do not enter the names of people)

Currently intrapartum service provision has been centralised to Singleton Hospital due to maternity staffing unavailability driven largely by the effects of COVID 19.

Home birth and birth in the Free Standing Birth Centre (NPBC) are suspended as part of stage 3 of the RCOG/RCM (Appendix 1) professional guidance to prioritise safe care for the many and maximise use of all available resource.

Closure of these services has enabled control of staffing shortages and the effects of shortages on patient care and safety within the acute setting, but has created other risk that is currently held and reported on including.

1) Break down of pathways leading women to the safest birth area based on individual assessment.
2) Increase in unsuitable women birthing on the obstetric unit (See score-card data embedded).
3) Increase in rates of unnecessary birth related intervention linked to inappropriate birth setting, Increase in acuity linked to this intervention, including caesarean section, forceps, episiotomy and blood transfusion (Birthplace 2011).
4) Negative impact on women's birth experience (NICE,2017).
5) Restricted choice in birth place model.
6) Theoretical increase in women choosing to Freebirth or BBA (RCM,2020).
7) Midwives displaced out of preferred areas of work.
8) Health Board reputation- failure to provide safe evidence based birth place options (NICE,2017) .

Maternity%20Score card%20information

4. Number of people exposed to the Risk

400-500 women and babies per year.

Approximately 25 midwives

5. Summary of Controls in place

- Midwifery led care criteria for intrapartum care (WG 2017)
- All Wales Clinical Pathway for Normal Labour (WG 2020)
- SOP for The Bay Birth Unit to maintain at least 1 midwifery led area 24/7, this includes pathways for accessing care (telephone triage)- Place of Assessment in labour- Midwifery skill set specific to the area- staffing, escalation and reporting expectations.
- Communication with community midwives ref birthing options.
- Communication with women via social media around current birthing options.
- Review of Datix and investigation if the Bay Birth unit is unmanned for any period. (1 Datix received to date, in the 1st week of restricted service tis was a process issue that SOP has addressed).
- Centralised process for coordination of community teams phones to ensure care access pathways are uninterrupted.
- Reinstatement of management time for the lead midwife for the bay birth unit to manage rosters with the community manager.
- Availability of virtual tour of the Bay Birth Unit to support women's experience.
- Virtual 36/40 appointment with community midwife to support information giving, identification of women on a midwifery led pathway and signposting to midwifery led setting for birth.
- Free birth Guideline available on WISDOM (SBUHB 2020).

6. Risk Type

Short and long term health consequence of increased medical intervention during birth. Organisational reputation.

Risk Cause

Change in deliverable service due to midwifery staffing unavailability of >30%

* Please use Appendix 5 of the Risk Management Strategy & Policy to complete sections 7 – 9

7. Likelihood of Hazards and Risks causing harm/damage

1 Rare	2 Unlikely	3 Possible	4 Probable	5 Expected
				5

8. Consequence/severity of outcome should hazard(s) come to fruition

1 Negligible	2 Minor	3 Moderate	4 Major	5 Critical
			4	

9. Current Risk Rating

Likelihood Rating	5	x	Conse Rating	4	=	R Number	20	g

10. Actions Required to Reduce the Risk

As staffing levels stabilise and are maintained at levels less than 30%, stage 4 of the RCOG/RCM – professional guidance should be implemented and where appropriate modified to reinstate the full intrapartum service as soon as is safe to. This will control and reduce unnecessary risk.

With staffing unavailability projected to be 20-30% by the 19th of December (due to the on boarding of newly recruited band 6 midwives and new band 5's/graduates).

The reinstatement of full services at the FMU (NPBC) should be prioritised with rosters and support plans in place to facilitate this transition. Reopening the FMU should be proitsised over reopening home birth services due to;

1. The model in NPBC will support more births per day/month versus home births. It is expected that if NPBC remained closed but home birth reopened then most of the women who would have birthed in NPBC will choose home birth. Increasing homebirths from approximately 12 per month to 30-35 births per month. Predicted increase to community workload would be approximately 18-25 extra births a month. This has a resource impact due to the presence of a 2nd midwife for homebirths, births planned in NPBC could be facilitated at 3:3 compared with 3:1 in home birth (Including NPBC coordinator). Community services are the staffing group most consistently affected by staff unavailability currently reporting rates of around 36%.

2. Birthplace study 2011/ NICE 2014 suggests FMU's have the low rates of intervention and improved outcomes, compared to alongside Midwifery Units and Obstetric Units, for both multiparous and nulliparous with no increased chance of adverse neonatal outcome (homebirth carry's small increase in adverse outcome for nulliparous (Birthplace,2011)). FMU births also carry and reduced chance of transfer, compared to homebirth (NICE,2017) for nulliparous women during labour/birth minimising the impact of intrapartum maternity transfers on WAST resources and services. Opening the FMU gives maximum benefit to the many whereas homebirth service would only provide particular benefit to Multiparous.

3. On a monthly basis more women choose to birth in NPBC suggesting preference in this model of care.

4. Much of the CHC report was around closure of NPBC- signifying its importance in the community.

5. Presently there is inequity in care access with all intrapartum service sitting in Singleton. Reinstatement of NPBC addresses some of that inequity.

6. The fragility of rosters will be less in FMU model which will be easier to control from sickness versus managing a whole community roster and service provision.

Once staffing unavailability is sustained at > 20% all intrapartum service should resume including home birth which will further reduce risk in the intrapartum service offered by SBUHB.

11. By Whom	Target Date
Senior midwifery leadership team Community managers NPBC core midwives	19/12/21

12. Target Risk Rating following Completion of Actions

Likelihood Rating	2	x	Consequence Rating	4	=	Risk Rating Number	8

13. Conclusions/Additional Information/ Time Scales

The risk assessment undertaken has enabled risks related to available birth setting to be minimised.

14. Date Assessment Escalated	Who was the risk escalated to and why
02/11/21	<redacted s40(2)>

15. Assessors

Name(s)	Signature(s)	Position(s)
<redacted s40(2)>	<redacted s40(2)>	<redacted s40(2)>

Date of Assessment	Review Date
02/11/21	30/12/21

Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic

Information for healthcare professionals

Version 1.3: Published Friday 10 July 2020

Table of changes

1.1	17.4.20	1.1: Added the following elements into data to be considered at each stage: independent midwives, staff requirements to maintain essential antenatal and postnatal care, consideration of local geography and demographics.
1.1	17.4.20	3: Reference made to NHS England guidance on the reconfiguration of intrapartum care services. Recommended co-production of local plans with service user groups
1.1	17.4.20	Throughout: Revised throughout to ensure compatible with NHS England guidance on reconfiguration of intrapartum care services.
1.2	22.5.20	1: Statement added: 'When reorganising services, units should be particularly cognisant of emerging evidence that black, Asian and minority ethnic group (BAME) individuals are at particular risk of developing severe and life-threatening COVID-19. There is extensive evidence on the inequality of experience and outcomes for BAME women during pregnancy in the UK. Particular consideration should be given to the experience of women of BAME background and women living with multiple deprivation, when evaluating the potential or actual impact of any service change.'
1.2	22.5.20	1.1: Inclusion of 'Number of midwives needing to self-isolate or who are 'shielded' but who are able to provide virtual or non-patient-facing care' among the staff groups.
1.2	22.5.20	3: Further detail added on the basis for making decisions around closing some birth settings.
1.2	22.5.20	Throughout: Small changes to clarify document.
1.3	10.7.20	0: Added a note on the implementation of this guidance to clarify that the guidance was intended for the peak of the pandemic and that services should return to normal practice as soon as the local risk of transmission and prevalence allows.

A note on the implementation of this guidance

RCOG guidance on suggested maternity service modifications during the COVID-19 pandemic has been developed to reduce the risk of nosocomial transmission of SARS-CoV-2, particularly to individuals who are most at risk of the severe effects of COVID-19, and to manage the impacts of acute changes within the NHS as a result of the pandemic (e.g. cancellation of elective services and staff shortages). The advice within this guidance was intended for implementation at the peak of the pandemic, when the risk was highest.

Whilst the national risk of SARS-CoV-2 infection is falling in both the UK community and in healthcare settings, maternity services are advised to reflect on their local risk and return to providing clinical care as recommended by pre-existing local and national guidance (e.g. NICE antenatal care schedule, screening including for gestational diabetes) as soon as it is safe to do so. This may include maintenance of local initiatives commenced during the pandemic which have demonstrated an improvement in the quality and experience of care received by women.

A flexible approach is necessary to respond to fluctuations in risk from local or national COVID-19 prevalence and implications of local or national public health policy.

1. Introduction and background

Pregnant women and newborn babies continue to require safe and personalised care during the current COVID-19 pandemic. They represent a unique population, the majority are healthy, experiencing a life event that, brings physical, emotional, psychological and social needs. Women and newborn babies, as far as possible during the pandemic, require access to quality midwifery care, multidisciplinary services and to additional care for complications and emergencies if needed.

When staff and services are under extreme stress there is a real risk of increasing avoidable harm, including an increased risk of infection, morbidity, mortality and reductions in the overall quality of care. Safety, quality and preventing avoidable harm must be key priorities in decision-making. Continuation of as near normal care for women should be supported, as it is recognised to prevent poor outcomes.

When reorganising services, units should be particularly cognisant of emerging evidence that black, Asian and minority ethnic group (BAME) individuals are at particular risk of developing severe and life-threatening COVID-19. There is extensive evidence on the inequality of experience and outcomes for BAME women during pregnancy in the UK. Particular consideration should be given to the experience of women of BAME background and of women living with multiple deprivation, when evaluating the potential or actual impact of any service change. Further detail on the supporting evidence for this is available in the RCOG guidance on coronavirus in pregnancy.

1.1 Provision of midwife-led birth settings

With reference to the current COVID-19 pandemic, the International Confederation of Midwives recommends that in countries where the health systems can support homebirth, healthy women experiencing a low-risk pregnancy may benefit from giving birth at home or in midwife-led units rather than in a hospital where there may be many COVID-19 patients, if there is the ability to provide appropriate midwifery support and appropriate emergency equipment and transfer.[1]

This guidance has been developed to support maternity service leads in decision making about midwife-led birth settings during the coronavirus pandemic and it was informed by a rapid review conducted by the RCM
Professorial Advisory Group.[2]

This guidance recommends a staged approach in responding to emerging issues with staff absence and other service pressures during the pandemic. Decisions about when to implement each stage will need to be made at a local level based on current local data:

- Sickness rate among midwifery staff (midwives, maternity support workers and senior student midwives)
- Number of midwives needing to self-isolate or who are 'shielded' but who are able to provide virtual or non-patient-facing care
- Available additional, temporary midwifery staffing (including independent midwives, additional midwives from the NMC emergency register, those previously in non-clinical roles or year three student midwives)
- Skill mix of available midwifery staffing – including level of seniority and experience in provision of community-based care
- Availability of ambulances and trained paramedic staff, to provide emergency transfer
- Consideration of staff requirements to ensure continued provision of essential antenatal and postnatal care
- Consideration of local geography and demographics which may impact on ability to continue a full range of services

1.2 Benefits and safety of midwife-led birth settings

The positive impact of midwife-led birth settings are well documented, including reductions in the need for a range of medical interventions.[3,4,5] These positive impacts remain of significant importance to prevent avoidable harm, and availability of midwife-led care settings for birth should therefore be continued as far as is possible during the pandemic.

There is considerable evidence to support the safety of homebirth for healthy women when supported by qualified midwives practicing within a supportive network. Findings from the Birthplace study confirm that, for women having their first baby the likelihood of requiring transfer from home to the obstetric unit in labour or immediately after birth is 45% and from a midwife-led unit is 36% – 40%. The transfer rate is much lower at 10% for women having their second (or third or fourth) baby.[4] Transfers reported in the study were mostly for non-emergency reasons such as slow progress in labour and maternal request for pain relief.[4] No increased risks of perinatal or neonatal adverse outcomes for planned homebirths were identified in the largest metaanalysis of 500,000 mother-baby dyads.[6]

2. P rinciples for equitable, safe, effective, quality maternal and newborn care in a pandemic

The following principles are critical during the COVID-19 pandemic. They were developed by the RCM's COVID-19 Professorial Advisory Group, drawing on evidence of essential components of quality care and incorporating the latest information from the World Health Organisation and the International Confederation of Midwives on COVID-19. These principles should underpin maternity care for every woman and baby, every time.

Care providers must:[2]

- Continue to provide evidence-based, equitable, safe, compassionate and respectful care for physical and mental health, wherever and whenever care takes place, by remote access if necessary
- Protect the human rights of women and newborn babies
- Ensure strict hygiene measures and social distancing when possible
- Follow national guidance on use of personal protective equipment (PPE)
- Ensure birth companionship

- Prevent unnecessary interventions
- Not separate a woman from her newborn baby(s) unless absolutely necessary
- Promote and support breastfeeding
- Protect and support staff, including their mental health needs

3. Midwifery services reorganisation during the COVID-19 pandemic

Service leads will wish to make decisions about reorganisation of their services, including the need to centralise due to staffing and other service pressures, on the best available evidence.

There is very little evidence available to support changes in configuration of services, and particularly changes to a more centralised services, during the COVID-19 pandemic. Emerging evidence from European settings supports continuing to strengthen community services in order to enable social distancing and minimise spread in healthcare settings.[7] The importance of deployment of outreach services, community clinics, and home care rather than the centralisation of services has been identified.[7,8,9] It may be of benefit for midwifery services to keep community midwifery staffing as separate as possible from hospital midwifery staffing to reduce the risk of transmission between staff.[8,9] The International Confederation of Midwives (ICM) has based their current recommendations for maternity care during COVID-19 on supporting community birth for healthy women and newborn babies in view of reducing spread of infection.[1] NHS England clinical guidance[10] on temporary reorganisation of intrapartum care during the pandemic states that freestanding midwifery units and homebirths help to keep women out of hospital and reduce the pressure on hospital services.

However, it is recognised that safety in birth remote from hospital settings requires the availability of skilled experienced midwifery staffing and paramedic ambulance transfer facilities. Where these are not available, it may be necessary to modify available services, seeking at all times to maximise the provision of a safe and positive birth experience to all women.

The phased approach described below identifies the need to have a flexible approach to service provision – stepping up into a more centralised service as the impact of the pandemic on staffing and ambulance services reaches its peak, while seeking to maintain or step back down the provision of midwifery led and community based care settings when staffing and ambulance provision allows. Decisions about offering birth place options for women in a particular area are best made in a way that demonstrates recognition that any reduction in birthplace options is temporary and will be continually reassessed throughout the timeline of the pandemic.

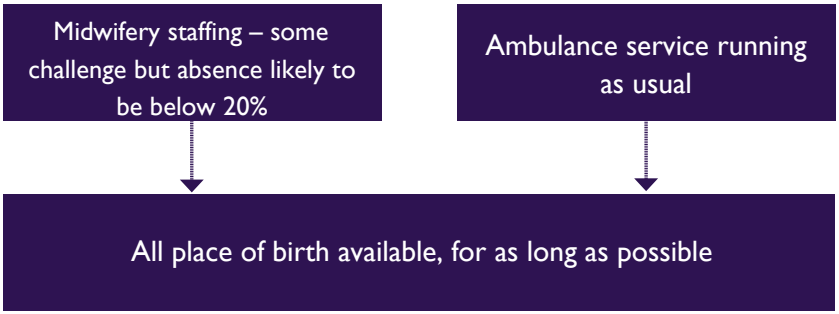
The decision to suspend homebirth services in some parts of the UK during the pandemic has created significant levels of concern and anxiety for some women planning to give birth at home and has led to some challenge.[11]

Midwifery service leads will need to use judgement and guidance to seek to provide safe, high quality maternity services during the pandemic for the women in their care and this will, on occasion, require making difficult judgement calls about what services can be safely provided. The rights of women to choose their preferred place of birth will need to be balanced against the rights of all women to receive a safe level of midwifery care.[12] Where a service lead is making a decision about temporary suspension of some services, including homebirth, as a result of the pandemic, they should inform their Trust Board or NHS Board and commissioner and seek advice from their local legal department. Principle 6 of the NHS Constitution identifies that the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. As the NHS is funded by public money, this principle highlights the importance of using this funding fairly in a way that benefits everyone the NHS serves. The NHS seeks to maximise benefits within the constraints of limited resources. It is important to work and communicate effectively with service users and their families. Input into planning and changes to services should be sought from local user groups, including Maternity Voices Partnerships (MVPs) and Maternity Services Liaison Committees (MSLCs). The presence of existing relationships will enable this to be done rapidly; where possible, plans and communications should be co-produced. Maternity service leads should ensure that clear information is provided to all women booked to give birth in their service about current service configuration, this should be updated regularly through the service website, social media and through the MSLCs and MVPs.

3.1 Phase one: preparation and restoration

In the preparation and restoration phase, midwifery care should be provided as normal as far as possible, with all birth settings including home, freestanding and alongside midwife led units, and obstetric units running as usual, for as long as possible. Birth in midwife-led settings is recommended for low-risk women, as per NICE guidance on place of birth.[5]

The percentages set out below are aimed to provide a helpful rule of thumb rather than a definitive rule, to be contextualised for local need. The impact of staffing absence will vary according to the size of the team and other key factors such as rurality.



Women should be advised, through local trust or board websites, other official communications and online forums, including local service user forums, that the provision of care may need to be adapted as the situation changes, with communications co-produced with local MVPs/MSLCs.

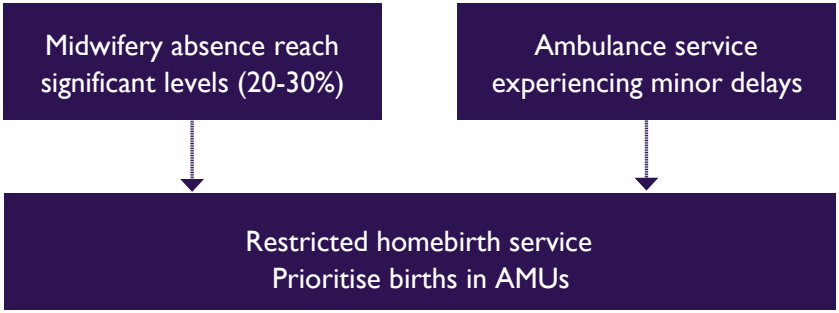
Prior to triggering phase two, the following should be considered:

- Review the number of midwives routinely sent to homebirths. Current policy in most areas across the UK is for two midwives to attend all homebirths. Consideration may be given to adaptation of these policies to include senior student midwives, returning registered non-clinical midwives, returning recently retired midwives or appropriately prepared maternity support workers to attend as the second member of the team for low-risk home births.

- Community midwifery teams and freestanding midwifery units within the same trust/health board should plan to integrate their systems with all-inclusive rotas so to maximise the spread of resources and maintain the full range of maternity settings for as long as sustainable staffing allows.

3.2 Phase two

The second phase is triggered if the midwifery absence is exacerbated by the pandemic. This may be above 20% or if a reduction in skill mix creates a shortage of experienced midwives. The impact of the percentage of staff shortages will vary according to the location of the care; a smaller proportion of midwifery absence may have a greater impact in a very rural area, for example. Local geography and demographics should therefore also shape decision making when moving from one phase to another.



Midwives practising in the community should have their workload reviewed and where possible the provision of antenatal and postnatal care rationalised, in line with RCM/RCOG guidance.[13] This will include increasing the provision of virtual rather than face-to-face appointments where appropriate. Virtual appointments may be provided by midwives required to self-isolate or 'shield' but who are well enough to work, if appropriate home working technology is able to be provided.

In some NHS trusts/ health boards there are multiple midwife-led units. To ensure viability it may be necessary to reduce the number of freestanding midwife-led units providing care, and to prioritise alongside over freestanding midwife-led units to reduce the workload of the ambulance service, especially if delays in response time start to be experienced.

Consider the following points to enable decision making about rationalising place of birth options for women:

- Scale-up the number of midwife-led rooms in the maternity unit to ensure women who prefer or are eligible for midwifery-led care can receive it.

- Utilise midwifery staff more flexibly between different areas, to support women's choice of place of birth, while maintaining a safe level of safe level of antenatal and postnatal care. [13]

- Provide virtual midwifery support and assessment to enable longer stays at home in early labour, where this is appropriate.

- Offer homebirth only to low-risk multiparous women and offer low-risk primiparous women option of alongside midwife-led unit birth, to reduce need for intrapartum transfers.

- Encourage early discharge from midwife-led units to free up intrapartum capacity.
- Ensure communication with ambulance service is in place and category 1 calls only are requested of them.

- Use dedicated services for non-emergency transfers (including private or army ambulances or dedicated private taxi.)

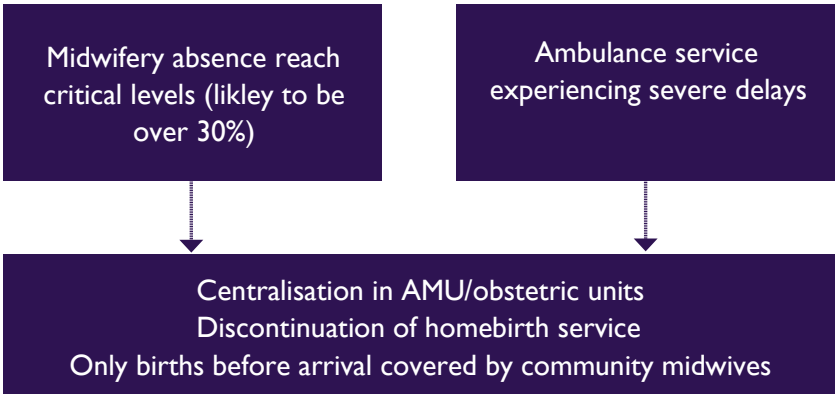
During phase two, women should be made aware of plans for centralisation if phase three is triggered, through individual contact with women booked for birth at home or in a midwife-led setting; trust and board websites; other official communications and online forums, including local service user forums. Communications should be co-produced with local MVPs/MSLCs.

3.3 Phase three

Phase three should be triggered once the midwifery absence reaches a critical point (likely to be over 30%) or once the ambulance service is unable to support category 1 emergency calls without severe delays. If the safety of homebirth cannot be assured and midwifery staffing does not allow safe staffing of all places of birth, centralisation is recommended.

Anticipation is recommended so local trusts/health boards should have protocols and standard operating procedures in place and be able to trigger phase three smoothly and safely.

Alongside midwife-led units will be the only midwife-led settings available to women, as well as allocated midwife-led rooms on obstetric units in those NHS trusts/health boards lacking an alongside midwife-led unit.



3.4 Phase four: de-escalation or restoration

It is essential that the changes recommended by this guidance are reviewed regularly and de-escalated according to the availability of midwifery staff and safe transfer.

3.4.1 Table: process for de-escalation or restoration

Midwifery absence critical (e.g. over 30%)	Midwifery absence significant (e.g. 20- 30%)	Midwifery absence - nearing normal levels (e.g. below 20%)
Centralisation in alongside midwife-led and obstetric units	• Reinstate restricted homebirth service • Reinstate freestanding midwifery led units • All-inclusive rota for community and midwifery-led unit midwives	• Reinstate homebirth service for all women • Reinstate all options for place of birth

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THE ROYAL COLLEGE OF MIDWIVES

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