Quality Impact Assessment - Transitional Model

Scheme Name	Transitional Model

	Brief description of Scheme	Accountable Lead	Clinician completing QIA	Impact on Quality (consider Patient Safety, Clinical Effectiveness and Patient Experience)				If Risk Score Above 9
				Describe Impact on Quality/Risk	C	L	Risk Score	Full Assessment Required
1	Remove all birthing and postnatal in-patient stays from Oswestry, Ludlow & Bridgnorth MLU's. Operate only as community base plus homebirths. (As Market Drayton/Whitchurch) - retaining day services - It is proposed that in order to mitigate risks, provide safe care to our mothers-to-be and support staff during this time; the inpatient and overnight provision is suspended in three of our smaller MLU's with the least birth activity (Ludlow, Bridgnorth and Oswestry) for a minimum period of 3 months (beginning 1st July 2017). The MLU buildings will function as a day community based service rather than an over-night inpatient service. This will mean that all community antenatal and postnatal care will continue to be provided either within the unit during the day or in the community, however, women will not (during this period) be able to give birth in these units or be transferred to them for their postnatal care. For care in labour (intrapartum) all women will be offered birth in either RSH or PRH MLU's or the Consultant Unit. In some areas, women may wish to give birth outside of our County, for example, either at Wrexham, Hereford or another unit of their choosing. Women, will however, still be able to receive all of their community postnatal care from their local unit, either at the unit (during the day) or at their home. Additionally women can still choose to have a home birth and this will continue to be facilitated in line with their current choices. This model is proposed to commence on the 1st July 2017 lasting for a period of 3-6 months to allow for consolidation of staff, provide certainty for womend and staff during this period and await the outcome of the CCG Led MLU Reveiw (first draft due end September 2017).	Deirdre Fowler	Sarah Jamieson/Anthea Gregory-Page	**RISK OF INCREASE IN BBA'S OR PRECIPITATE BIRTHS -** No facility for ad hoc callers or precipitate births; therefore planned and robust communication will be required to manage maternal expectation and risks. In addition the home birth service will be maintained, this will allow individual risk assessment of each woman and for those concerned that an incresed journey time will increase their risk of a BBA, will have the option of choosing a home birth. (BBA - born before arrival). On average we can expect to see 3.2 births from all three units generated per week during this time - our current BBA rate is 0.5% - we may see an increase in this, however, with robust communication, a home birth service and also the fact that during the day the unit is staffed, this will minimise this risk to approximately 0.02%.	4	1	4	**N**
				REMOVAL OF POSTNATAL STAY - Removal of postnatal stays and intrapartum care. Currently approximately 10% of women who give birth in Shropshire use these services for postnatal care. However, just 3.9% (16/17 data) use the services in the 3 smaller MLU's for intrapartum care. Postnatally our length of stay in Shropshire is longer than the national average for both low and high risk births. For example our length of stay for caesarean sections is approximately 2.5 days, whereas nationally this figure is 1.5 days. Use of these units for postnatal stays means that often women in these units recieve one to one care throughout their stay from a midwife whereas the consultant unit high risk postnatal ward have 3 midwives to 23 women and babies (at full capacity). Therefore the risk for the service as a whole is taken in to account when calculating this risk score.	2	3	6	**N**

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			COMMUNITY OBJECTION AND CAMPAIGN - Local community objection to reduction in choice and local services. There is an on-going campaign to maintain the services at the 3 smaller MLU's in their current state. This creates regular poor press for the Trust and also impacts on staff via social media. This risk score takes in to account Trust reputation. Mitigation will involve user and staff involvement in key decision making, continuing updates to staff and users throughout the transitional period and open discussions and forums with key stakeholders. Full details of the communication and co-production plans, along with media plans are contained within the Transitional Model Paper.	3	5	15	**Y**
			POSSIBLE INCREASE IN COMMUNITY WORK - Possibility of increased community work due to reduced inpatient provision. However, Birthrate Plus (April 2017) has demonstrated that to staff the activity, we need less staff than the current template provides - during this transitional model, we will not reduce staff below those proposed by Birthrate Plus - in essence this means that the staffing would actually allow a team approach and could also include the intrapartum and postnatal care, however, as this inolves a change to the current model this cannot be considered until the completion of the CCG MLU review. Therefore this risk is minimal due to the allowance of Birthrate Plus staffing (meaning that with no intrapartum or inpatient activity the workload should fit easily within the allowed template.	2	3	6	**N**
			STAFF MORALE - Staff morale may be reduced in Oswestry, Bridgnorth, Ludlow due to changing working pattern and increased on calls. Potential for increased sickness absence. Whilst this is a risk, staff communication and involvement will be increased significantly, all staff, whether working in an MLU or not will be given the opportunity to state their preferences and where possible within service needs these wishes will be accomodated. In addition, we will suspend our forthcoming rotation (Due October 2017) to further stablisise and consolidate the workforce. Staff directly affected have been communicated to openly and will all will have the opportunity to comment on their preferences for work place, they have already expressed a preference for knowing their workplace and not being allocated on an ad-hoc basis and this has been facilitated.	3	3	9	**N**

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				INSUFFICIENT STAFF TO RELOCATE TO HIGH RISK AREAS - Risk that relocation of midwives and support workers (WSA) is not enough to cover the shortfall of staff within the consultant unit and the two larger MLU's. To mitigate this risk all staff will be moved according to the greatest need in terms of vacancy levels within each unit. In addition to this a recruitment drive will be undertaken and continue throughout the transitional period. There is also an agreement to over-recruit in the short term, knowing that future vacancies are inevitable. In addition, the Care Group has agreed a defined preceptorship programme for our newly qualified midwives to enable us to recruit to the same number of newly qualifed midwives each year, again taking in to account, succession planning and future workforce restrictions (i.e. retirements, reduction in numbers of students, inabilty to recruit overseas potential).	3	2	6	**N**
				LOCAL COMMUNITY AND POLITIAL OBJECTION - Local community and political objection to a perceived loss of and or reduction of services. Challenge to gain CCG, HealthWatch, Monitor, Maternity Engagement Group, political leaders, NHSI/NHSE aproval. This risk score takes in to account Trust reputation. Mitigation will involve user and staff involvement in key decision making, continuing updates to staff and users throughout the transitional period and open discussions and forums with key stakeholders. Full details of the communication and co-production plans, along with media plans are contained within the Transitional Model Paper.	3	5	15	**Y**
3				**LIMITATION OF CHOICE -** Limitation of choice for women (women will still have choice of a home birth, however, the perception will be a reduction in choice due to removal of the intrapartum and postnatal facility during this transition period. This will impact upon approximately 3.2 women per week across all 3 units. This equates to approximately 3.3% of our served popultation. This risk score reflects the numbers affected. Choice of type of birth will not be affected, only location.	4	1	4	**N**
4				**INCREASED COMMUNITY VISITS -** may be required leading to increased numbers of MW, associated costs - cars, fuel, phones, kit. This risk score reflects the balance of risk, there may well be an increased cost, however, this is balanced by the need to ensure safety for the whole population of women using our services. The financial risk is very minimal as staff will be relocated and in doing so we will reduce some of the overtime and the excess hours. The risk for staffing is already explained in 9.	2	2	4	**N**
5				**INCREASED HOME BIRTHS -** Possibility of increased requests for homebirths (however unlikely as not seen when model used short term in the past or at MD/ Whitchurch). 2 X RM's on-call for 5 weeks for 1 woman.	1	4	4	**N**
6				**INCREASED CALLS/VISITS -** to other areas for e.g. SROM checks, breastfeeding advice, reduced FM. Etc - See 14.	2	2	4	**N**

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8				**INCREASED TRAVELLING TIME FOR WOMEN IN LABOUR**, this may result in a baby being born before arrival (BBA) See 1.	4	1	4	**N**
12				**POTENTIAL FOR INCREASED ACTIVITY** in consultant unit leading to pressure and risk in high risk birthing area, see 13. Assuming that all births are relocated to either the PRH consultant unit or the PRH Wrekin MLU or RSH MLU, this will equate to approximately 1 extra birth per week per unit. Given that all women may choose to give birth on the consultant unit, this would equeate to an extra 3 births per week, currently the average births per week for the consultant unit are 81, therefore this equates to a percentage increase of 3.7%.	2	3	6	**N**

KEY	0	1	2	3	4	5
Consequence	No Consequence	Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood	Will Not Occur	Rare	Unlikely	Possible	Likely	Almost Certain

All proposed schemes must be assessed for their potential effect on patient care

The above form should be completed in conjunction with the clinical lead

The impacts section must be completed by a clinician

The form should be signed/dated by mgr/clinical lead

Person Completing Initial Assessment Sarah Jamieson/Anthea Gregory-Page

Lead Clinician for Initial Assessment Sarah Jamieson