

Cover page	
Meeting	Public Trust Board
Paper Title	Midwifery Staffing report – July 2019 to December 2019 Inclusive
Date of meeting	6 th February 2020
Date paper was written	26th January 2020
Responsible Director	Executive Director of Nursing, Midwifery and Quality
Author	Director of Midwifery
Executive Summary	
<p>The National Institute for Health and Care Excellence (NICE) published the report Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013).</p> <p>The Maternity Incentive Scheme operated by NHS resolution asks whether the service can demonstrate an effective system of midwifery workforce planning to the required standard. This report provides the detail of the minimum evidential requirements to Trust Board which are required for this standard including:</p> <ul style="list-style-type: none"> • Birthrate plus assessment • Midwife to Birth ratio • Actions to achieve appropriate staffing levels • Red flags • The provision of 1:1 care in labour and a supernumerary coordinator on each Delivery Suite (DS) shift • Details of the specialist midwives employed 	
Previously considered by	Care Group Board 28/01/20

The Board (Committee) is asked to:			
<input type="checkbox"/> Approve	<input checked="" type="checkbox"/> Receive	<input type="checkbox"/> Note	<input type="checkbox"/> Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:

Safe

Effective

Caring

Responsive

Well-led

Link to strategic objective(s)

Select the strategic objective which this paper supports

- PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare
- SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care
- HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities
- LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions
- OUR PEOPLE Creating a great place to work

Link to Board Assurance Framework risk(s)

Number 1204

Equality Impact Assessment

- Stage 1 only (no negative impact identified)
- Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)

Freedom of Information Act (2000) status

- This document is for full publication
- This document includes FOIA exempt information
- This whole document is exempt under the FOIA

Financial assessment

Main Paper

Situation

The maternity service currently operates a hub and spoke model of care. The Obstetric unit is situated at PRH, with a midwifery led unit (MLU) situated within the main hospital. This is currently remote from the OU but a new build is in progress resulting in the Wrekin unit being an alongside MLU.

The Freestanding Midwifery led unit at RSH is currently closed to births whilst essential building work takes place but both antenatal and postnatal clinics operate from there.

In addition there are 3 freestanding midwifery led units; Oswestry, Bridgnorth and Ludlow. Births are currently suspended in all of these units pending a public consultation as to the future of midwifery led services in these units. All of the units provide antenatal and postnatal care.

The service also provides community midwifery care via teams of community midwives linked to each of the MLUs. There are consultant led antenatal clinics (ANC), a triage unit and a day assessment unit (DAU).

The current model of care is a traditional model of team working to provide antenatal and postnatal care with core midwives providing inpatient care on DS and the wards and outpatient care in triage, DAU and ANC.

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers.

Background

NICE published the report Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013). A gap analysis was completed against this and this is currently being reviewed by the Director of Midwifery

Safety action number 5 of the Maternity Incentive Scheme asks:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The required standard for this is detailed below:

- a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
- b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
- c) All women in active labour receive one-to-one midwifery care
- d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

The minimal evidential requirements for this standard are:

The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
- An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.
- Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
- The midwife: birth ratio.
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

The year 2 standard also included information regarding red flags which have been omitted from year 3 but due to the importance of noting and acting upon these they have been reported in this paper.

Assessment

Birthrate Plus assessment

A full Birthrate plus assessment was completed by the service in April 2017. Agreement was reached in April 2019 to recruit to the recommended level of midwives as detailed in the report and the current number of vacancies against this is less than 5 with plans to recruit to these posts. Services which do not have the recommended number of midwives as detailed in a Birthrate plus assessment have an increased risk of a high number of midwifery staffing red flags and times when the DS coordinator cannot be supernumerary. The service has requested that the Birthrate plus assessment is repeated this year as it is now due for reassessment.

Action: Complete Birthrate plus assessment

Midwife to Birth ratio

The monthly midwife to birth ratio is currently calculated using the number of Whole time equivalent midwives employed and the total number of births in month. This is the contracted Midwife to birth ratio. A more accurate midwife to birth ratio is given when using the actual worked ratio which is in use across the West Midlands network for the calculation of monthly midwife to birth ratio. This takes into account those midwives who are not available for work due to sickness or maternity leave whilst adding in the WTE bank shifts completed in each month. This “worked” calculation will show greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. The reporting of the contracted ratio is a useful measure to assess the recruitment and retention of midwives to the service although will show small fluctuations due to this as well as changes in birth numbers each month.

Action: Provide worked midwife to birth ratio each month alongside contracted ratio

Planned versus actual staffing levels

Each month the planned versus actual staffing levels are submit to the national database using the information provided from the Allocate rostering system. The template for the areas was incorrect during this reporting period having not been updated to reflect staffing changes. This has resulted in the data not being accurate in terms of percentage fill rates plus there are some areas which appear to have a very high as well as others with a very low fill rate. The templates have now been changed but not yet reviewed by the Director of Midwifery.

Table 1 - Fill rates for Delivery Suite and Wrekin midwifery Led unit

	Fill Rates DS Midwife (RM)		Fill rates DS Women's Services assistant (WSA)		Fill Rates Wrekin RM		Fill rates Wrekin WSA	
	Day	Night	Day	Night	Day	Night	Day	Night
Jul	120	96	114	95	130	107	103	120
Aug	127.5	113.5	100.8	94.3	30.9	99.3	74	95.7
Sep	115.3	113.4	106.9	103	88.7	95.1	85.9	90
Oct	114.2	117.9	108.2	94.6	95.9	96.7	87.2	87.2
Nov	127.5	115.2	98.2	105.1	109.2	106.2	103.2	105
Dec	120.8	112.6	85.9	99.7	107.6	93.8	103.9	87.1

Table 2 - Fill rates for antenatal ward and postnatal ward

	Fill Rates AN ward RM		Fill rates AN ward WSA		Fill Rates PN ward RM		Fill rates PN ward WSA	
	Day	Night	Day	Night	Day	Night	Day	Night
Jul	123	93	148	192	128	130	99	107
Aug	75.3	149.7	34.3	186.2	146.9	102.7	132.6	104.6
Sep	130.9	149.6	67.4	190.8	138.6	105.4	132.9	100.2
Oct	140	159.2	51.3	198.9	157.3	107.1	128.6	99
Nov	72.8	162.3	31.8	229.5	161.4	119.9	128.7	103.4
Dec	127.2	161.8	48.3	192.9	159.5	131	124.2	138.5

Action: Monitoring and reporting of fill rates each month

Action: Staffing review

Action: Review of staffing template

Intrapartum Acuity

The maternity service implemented the use of the Birthrate intrapartum acuity tool in 2017. This was initially using an excel based programme. From September 2018 the service introduced the web based App. The data is inputted into the system every 4 hours by the Delivery Suite coordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate defines acuity as “the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency”

A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on DS at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the DS at the time. In addition the tool collects data such as red flags which are defined as a “**warning sign that something may be wrong with midwifery staffing**” (NICE 2015). SaTH has adopted the red flags detailed in the NICE report plus added some local indicators (Appendix 1) and an example of the data collection tool for one day and also the staffing versus workload chart which is produced as a result of the data collection can be reviewed in appendix 2 & 3 respectively.

The Royal College of Midwives in discussion with Heads of Midwifery has suggested that a target of 85% staffing meeting acuity should be set but that this can be reviewed and set locally depending upon the type of maternity service. In addition there should be a compliance with data recording of at least 85% in order to have confidence in the results.

During the reporting period the service did not achieve 85% positive acuity in any month. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short.

Current compliance with the data recording is poor for the scheduled times of reporting (3am 7am, 11am 3pm, 7pm and 11pm). However, data is also recorded ad hoc which together with the scheduled recordings has been used to provide the information below. In addition the actions taken by the coordinator when there is negative acuity is not always recorded meaning that they may take action to redeploy staff during times of high acuity but it is not possible to always evidence this is happening.

Action: Meeting planned with Coordinators to review use of acuity tool.

Action: Review of staffing to ensure correct numbers of midwives are available to work in delivery suite matched to acuity levels

Action: Review of the escalation policy to ensure that it adequately supports the movement of staff around the unit during periods of high acuity.

Red flags

In total there were 166 red flags recorded during this 6 month reporting period. The majority of these related to delays in the induction of labour process (66%). All delays will be incident reported via the Datix system and care reviewed to assess impact.

Action: Review of the Induction of labour pathway especially the process for prioritisation at times of high activity

1:1 care in established labour

1:1 care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour)” (NICE 2015). During this

reporting period there were 11 occasions when 1:1 care was recorded as not being provided.

Action: All cases where 1:1 care in labour has not been provided will be reviewed to assess impact and outcome including the 11 occasions noted in this report. This will be triangulated with the acuity and implementation of the escalation policy.

Supernumerary status of the coordinator

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 25 occasions during the reporting period.

Action : Review of the Escalation policy to ensure that it supports the supernumerary status of the coordinator and clearly defines the actions to take to mitigate in times of high activity / acuity.

Specialist Midwives

The service has a wide range of specialist midwifery posts as detailed below:

- Digital
- Bereavement
- Infant feeding
- Risk / governance
- Education
- Safeguarding
- Antenatal and Newborn Screening
- Guidelines

Table 3 – Acuity, red flag data and midwife to birth ratio – July 2019 –December 2019 inclusive

Month	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Midwife to birth ratio (contracted)	Acuity % Positive	Red %	Amber %	Acuity Recorded
Jul	36	3	6	1:28	72	5	23	168
Aug	21	1	3	1:28	74	4	22	162
Sept	46	3	5	1:27	65	11	24	156
Oct	12	0	0	1:25	73	3	24	156
Nov	14	3	4	1:23	72	6	22	141
Dec	37	1	7	Awaited	64	8	28	151

Recommendation

The Board is requested to note the findings of this report. An action plan has been developed to address the issues raised in this report.

Given these issues it is suggested that the Board receive a quarterly update rather than a bi-annual report. The metrics will be included on the maternity dashboard which will also provide additional monthly overview at the Maternity Oversight Committee.

Appendix 1

Midwifery staffing red flags

Red flags

- Delayed or cancelled time critical activity
- Emergency LSCS/instrumental delivery requires more staff than are available
- No available Delivery Suite beds
- Delay in providing pain relief > 30 mins
- Delay between presentation and triage
- Delay of more than 8 hours for ARM/augmentation
- Delay commencing PROM IOL
- Co-ordinator not supernumerary
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour

Appendix 2

Mon 30/12/2019

Time	Cat I	Cat II	Cat III	Cat IV	Cat V	Cat A2	PN Readmission	Cat PD1	Cat PD2	Cat PN	Cat A1	Cat X	MWs & Coordinator	Total no. of women in acuity	Acuity	
03:00		1	2	1						2	2		7	8	0.80	Info
07:00		1	1	1							4		7	7	1.50	Info
11:00			3		2						2		7	7	-0.40	Info
15:00			3		1						2		7	6	1.00	Info
19:00		1	3	1		1					1		8	7	0.60	Info
23:00			2	2							3	2	8	9	1.00	Info

T 01/01/2020

Appendix 3

