The Shrewsbury and Telford Hospital NHS Trust

# Board of Directors' Meeting
# 9 December 2021

| | | | | |
|---|---|---|---|---|
| **Agenda item** | 301/21 | | | |
| **Report** | 6 Monthly Maternity Staffing Report | | | |
| **Executive Lead** | Director of Nursing | | | |
| | **Link to strategic pillar:** | | **Link to CQC domain:** | |
| | Our patients and community | √ | Safe | √ |
| | Our people | √ | Effective | √ |
| | Our service delivery | √ | Caring | √ |
| | Our partners | | Responsive | √ |
| | Our governance | √ | Well Led | √ |
| | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | √ | BAF204 | |
| | For decision / approval | | **Link to risk register:** | |
| | For review / discussion | | | |
| | For noting | | | |
| | For information | | | |
| | For consent | | | |
| **Presented to:** | Board of Directors | | | |
| **Dependent upon** (if applicable)**:** | | | | |
| **Executive summary:** In order to comply with the requirements of clinical negligence scheme for Trusts (NHSLA, 2021) the following standards are addressed:- | Birthrate Plus (2021) provides an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the maternity at SaTH.<br><br>The report provides an update on the :-<br>• Current clinical midwifery vacancy position in accordance with the Birthrate Plus (2021) report,<br>• Implementation of a 90/10% skill mix in accordance with the Birthrate Plus report and<br>• The impact of recent staffing challenges measured by acuity and maternity safer staffing red flags (NICE, 2015)<br>• The report highlights that despite a challenging year, the service now has improved oversight of staffing vacancies and oversight of safety metrics with a clear plan in place to address these.<br><br>The Board are asked to take assurance from the report | | | |
| **Appendices:** | Appendix One: **Maternity red flag events, NICE (2015)** | | | |
| **Lead Executive:** | | | | |

# Midwifery Staffing Report

## Introduction

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.

Birthrate Plus provides an evidence based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service. This staffing report will focus on the recommendations of the Birthrate Plus Report (2021) and how safer staffing is facilitated by adoption of the recommendations, as outlined in the previous staffing paper presented in July 2021.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

The report also provides an accurate account of the current workforce status and includes an update from work from recommendations within the paper presented in July 2021. In addition, gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. A clear breakdown of Birth Rate Plus or equivalent calculations to demonstrate how the required establishment has been calculated.

In order to comply with the requirements of clinical negligence scheme for Trusts (NHSLA, 2021) the following standards are addressed:-

*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 systematic, evidence-based process to calculate midwifery staffing establishment is complete.*
- *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*
- *All women in active labour receive one-to-one midwifery care*
- *Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.*

## Background/Context

There are two models of maternity care currently in place within the SaTH maternity service. Firstly, there is a traditional model, where midwives provide care in the specific area of the service where care is required. Secondly, there is a continuity of carer model (Better Births,

2016), where small teams of midwives provide care throughout the maternity pathway, antenatal, intrapartum and postnatal, for a defined caseload of women.

A full Birth Rate Plus assessment was completed by the service with a final report shared in February 2021. The Trust is currently working to the previous Birth Rate plus report which was implemented into funded establishment in 2019. Funding has now been agreed for the maternity services to work to the latest Birth Rate plus 2021 recommendations and work has progressed to reset budgets and midwifery templates to reflect this. Once completed this work will also demonstrate accurate fill rates from Health roster.

**Birthrate Plus Report – BR+**

The BR+ (2021) refers to the numbers of both clinical and non-clinical midwives. Non clinical midwives that is those in specialist and managerial roles, with the SaTH maternity service meet the recommendation of BR+. This paper, therefore, will focus on the numbers of midwives required for provision of clinical care.

At the end of October 2021 there were 11.25 wte clinical midwife vacancies against a baseline of 200.55 wte clinical midwives. There are 3.8 wte midwives due to start in November and a further 1.4 wte due to start in December reducing this vacancy further.

**Table 1 - October 2021**

| Funded BR+ (2021) clinical midwives WTE | Contracted WTE clinical midwives | Variance |
|---|---|---|
| 200.55 WTE | 188.30 WTE | *11.25 WTE* |

Work continues to recruit to existing midwife vacancies by rolling advertisements for Band 6 clinical midwives and, midwives specifically to work in continuity carer teams, which may be more attractive to potential recruits. Due to national and regional workforce challenges, all options are being explored to support the midwifery workforce.

One of the findings of B R+ (2021) is that clinical staffing can be adjusted to include a varied skill mix to support the midwifery workforce suggesting that this is a local decision dependent upon the configuration of services. Many maternity services utilise the skills of maternity support workers to support in this way.

Although the role of the maternity support worker has been prevalent for some time, Health Education England (HEE) has provided resources to standardise this role nationally. SaTH has been fortunate to be able to utilise these resources to plan how the introduction of this role to complement the workforce and improve skill mix to optimise care.

Representatives from SaTH have joined regional network groups to ensure we have followed national guidance to introduce the role of the maternity support worker, using national job profile and national competence framework to ensure safe clinical competency is achieved.

It is therefore proposed that the clinical maternity workforce will consist of band 5 and 6 clinical midwives, supported by band 5 neonatal nurses and maternity support workers within the postnatal area. In addition, band 3 maternity support workers will support care in the community area. In line with BR+ and the RCM (2016) there is no role for a maternity support worker in intrapartum care or inpatient antenatal care.

**Table 2**

| Funded BR+ clinical midwives WTE | Number of wte clinical midwives required following implementation of 90/10% skill mix split | 10% skill mix, that is, band 3 and non-midwives above band 3. |
|---|---|---|
| 200.55 WTE | 184.22WTE | 20.05 WTE |

Whilst recognising that the 90/10% skill mix is not yet implemented, based on October 2021 data, it is envisaged there could be a potential over establishment of the midwifery clinical workforce of 4.08 WTE. If an over establishment materialises it will provide the workforce with a degree of resilience over the next few months whilst the skill mix is implemented in full and new roles are embedded. During the period of transition planned leavers will be working their notice period and so the potential over establishment may not materialise in full.

Options proposed by BR+ are that 11.6 WTE maternity support workers are utilised within the postnatal inpatient area, with the remaining 8.45 WTE across the community areas. In this respect, work has been done in collaboration with neonatal colleagues to strengthen the transitional care service which is situated within the postnatal ward area. This work has recommended that we the skill mix of neonatal nurses to develop our transitional care service. See table below.

**Table 3**

| Area | WTE skill mix breakdown in accordance with BR+ | Total WTE |
|---|---|---|
| Postnatal ward | 11.6 WTE to include local decision of 5.8 WTE maternity support workers and 5.8 WTE band 5 neonatal nurses. | |
| Community services | 8.45 WTE | =20.05 WTE |

The launch date for introduction of the band 3 role is 15th November 2021. There will then be a transitional period, whilst working towards full implementation of the 90/10% skill mix from the previous workforce model.

To provide further assurance regarding safety of the maternity service data has been collected from the last three months to provide oversight of the impact of recent staffing challenges. The following staffing metrics have been reviewed

**Maternity Safer Staffing Red Flag Events 2021**

**Table 4**

| Month | August 21 | Sept 21 | Oct 21 |
|---|---|---|---|
| Red flags from Acuity Tool | 67 | 63 | 61 |
| Red flag events reported via datix | 29 | 22 | 20 |

A maternity red flag (NICE, 2015) event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the area of care should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. (See appendix 1)

The number of red flags reported on the maternity dashboard have increased significantly over the last 3 months, which is reflective of staffing challenges. This increase has necessitated a review of the critical red flags to gain a greater understanding of data highlighted on the maternity dashboard.

Red flags are currently reported via the Birth Rate plus acuity intrapartum tool every four hours on delivery suite and 3 times daily on inpatient wards. There is oversight of the presenting red flags, reported via the acuity tool, at twice daily maternity safety huddles. Senior midwives direct staffing resource to areas of higher need and to prioritise one to one care in labour. In addition to reporting of red flags via the acuity tool, datix requires the highlighting of red flags in any incident reported relating to maternity staffing enabling a triangulation of data.

Numbers of red flags, reported via the acuity tool have historically been reported monthly via the maternity dashboard. Recent discussions at governance meetings have highlighted a limited understanding of the number of women impacted by red flag, highlighting the need to undertake an in depth review.

On review, of the 61 red flag events in October and due to four hourly reporting, it was clear that multiple reports had been submitted for individual women. Hence, 44 red flag events related to 20 women who were affected by a delay of more than 8 hours for artificial rupture of membranes (ARM)/augmentation. In mitigation, however, as the women are maternity inpatients during the delay there is ongoing monitoring of maternal and fetal wellbeing. If there are any issues arising care then care would be reprioritised. Decision making and prioritisation of care involves the multidisciplinary team, which provides assurance that any delay has not put them at additional risk of harm.

## Provision of one to one care of women in labour

**Table 5**

| Month | August 21 | Sept 21 | Oct 21 |
|---|---|---|---|
| Data taken from MIS | 99.3% | 98.7% | 99.7% |
| Number of occasions where one to one care has not been provided, reported via datix reported. | 3 | 0 | 1 |

Provision of one-to-one care for women in labour is a maternity safer staffing standard and inability to adhere to this standard is a red flag (NICE, 2015). Provision of one to one care of women in labour is reported on the maternity dashboard monthly. Compliance of this standard is prioritised to maintain safety and care for women in labour.

## Shift co-ordinator not able to maintain supernumerary status

**Table6**

| Month | August 21 | Sept 21 | Oct 21 |
|---|---|---|---|
| Number of occasions recorded via BR+ acuity too where co-ordinators reported not being able to maintain supernumerary status | 4 | 3 | 6 |
| Numbers datix incident reports where co-ordinators reported not being able to maintain supernumerary status | 1 | 0 | 1 |

Safer Staffing Standards for Delivery Suite (RCOG, 2007) states that services should organise their delivery suite staffing to enable supernumerary status for the delivery suite coordinators to enable capacity to maintain oversight of delivery suite activity and be available to support other members of staff providing care for women.

During October the reasons for the delivery suite coordinator not being able to maintain supernumerary status is explained as follows: -

- 1: 1 care in labour was not provided to 3 patients for a very limited time while staff were redeployed to assist from other areas. This was appropriately escalated and managed with no impact on outcome. 3 of the red flags for the co-ordinator being unable to maintain supernumerary status are during these episodes.

- On 2 other occasions the co-ordinator were not supernumerary for brief periods as they were caring for PN patients and one other occasion for an induction of requiring that was considered an immediate priority. In all cases the necessary clinical actions had been taken to maintain safety and the situation had been escalated to the managers

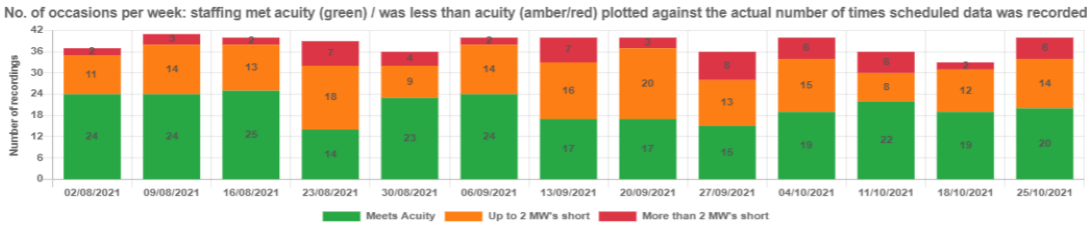
There is an expectation that the coordinator would escalate not being able to maintain supernumerary status to the manager on call if it was anticipated that this would be for a prolonged period which does not have a plan to resolve the situation in place. In summary, the co-coordinators were using their supernumerary status to support and provide indirect care.

A further measure of safe staffing is utilised within SaTH and consists of BR+ acuity tool in all inpatient areas to measure safe staffing levels and advises co-ordinators when care needs of women and babies are unable to be met with current staffing levels in any particular area. This tool informs our escalation policy and supports oversight and scrutiny of staffing levels.

Data from all areas is shared twice daily acuity tools in all areas at senior management safety huddles to inform flexible deployment of staff when required to maintain safety across the unit and is also presented monthly on the dashboard from Delivery suite only to provide oversight and monitoring of safety in wider forums for scrutiny.

In addition to highlighting maternity safer staffing red flags on the maternity dashboard, monthly, Birth Rate Plus acuity tool data is presented. See 13 week report below. This is taken from Delivery Suite data alone currently.

2.0




**Overall during the data period for weeks commencing 02/08/2021**

| | |
|---|---|
| % of recordings where staffing level more than 2 MW's short | 10.6% |
| % of recordings where staffing level is up to 2 MW's short | 32.4% |
| % of recordings where staffing level meets acuity | 48.2% |
| Data collected for the period covered by this summary provides | 91.2% compliance |

It is important to recognise that this is a measure of Delivery Suite acuity only, at this time. Further assessment of the acuity within all inpatient areas is carried out at twice daily senior management team Safety Huddles, which are captured on proforma along with actions taken to mitigate risk across all areas.

- The table above highlights percentage of times the ward area is in positive acuity and when amber and red acuity is registering and alerting actions to be taken to maintain safety levels.
- There is an escalation policy for staff to use in the event of staffing short falls

## Conclusion

As discussed earlier, midwifery safe staffing is complex due to its ability to rapidly change based on care needs and complexities of maternity cases and more recently due to national pandemic challenges over the past year, with staff isolations and increased pressures on the workforce.

A full Birth Rate plus report (2021) was commissioned and findings shared with Trust Board via an earlier staffing paper in July 2021.This second staffing paper, demonstrates significant progress from the earlier paper with a clearer workforce position and a plan, as recommended, to apply the use of the 90/10% skill mix. This will complement the current workforce, whilst strengthening overall vacancy position to reach the recommended workforce establishment early in 2022.

It is anticipated that there will be improved acuity levels in all areas across the service and in turn numbers of red flags generated will be reduced.

Finally, this the paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.

With clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety is a priority for the service.

In addition to this monthly monitoring internally and externally via the perinatal Quality Surveillance group and other Board level meetings trends, areas of concerns can be identified and enacted upon.

The report highlights that despite a challenging year, the service now has improved oversight of staffing vacancies and oversight of safety metrics with a clear plan in place to address these. It also has a clear workforce plan that utilises a more diverse skill mix, which will enhance care provision and strengthen the clinical workforce.

## Reference list

*Better Births a five year forward view for Maternity care https://www.england.nhs.uk/wpcontent/uploads/2016/02/national-maternity-review-report.pdf*

*Safe Midwifery Staffing for Maternity Settings NICE 2015 NG4 www.nice.org.uk/guidance/ng4*

*Royal College of Midwives 2016 Guidance on implementing the NICE safe staffing guideline on Midwifery staffing in maternity settings*

Maternity Incentive Scheme- year Four. NHSLA (2021) NHS resolution**.**

*RCOG 2007 Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour (RCOG 2007)*

**Appendix 1**

**Maternity red flag events, NICE (2015)**

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally