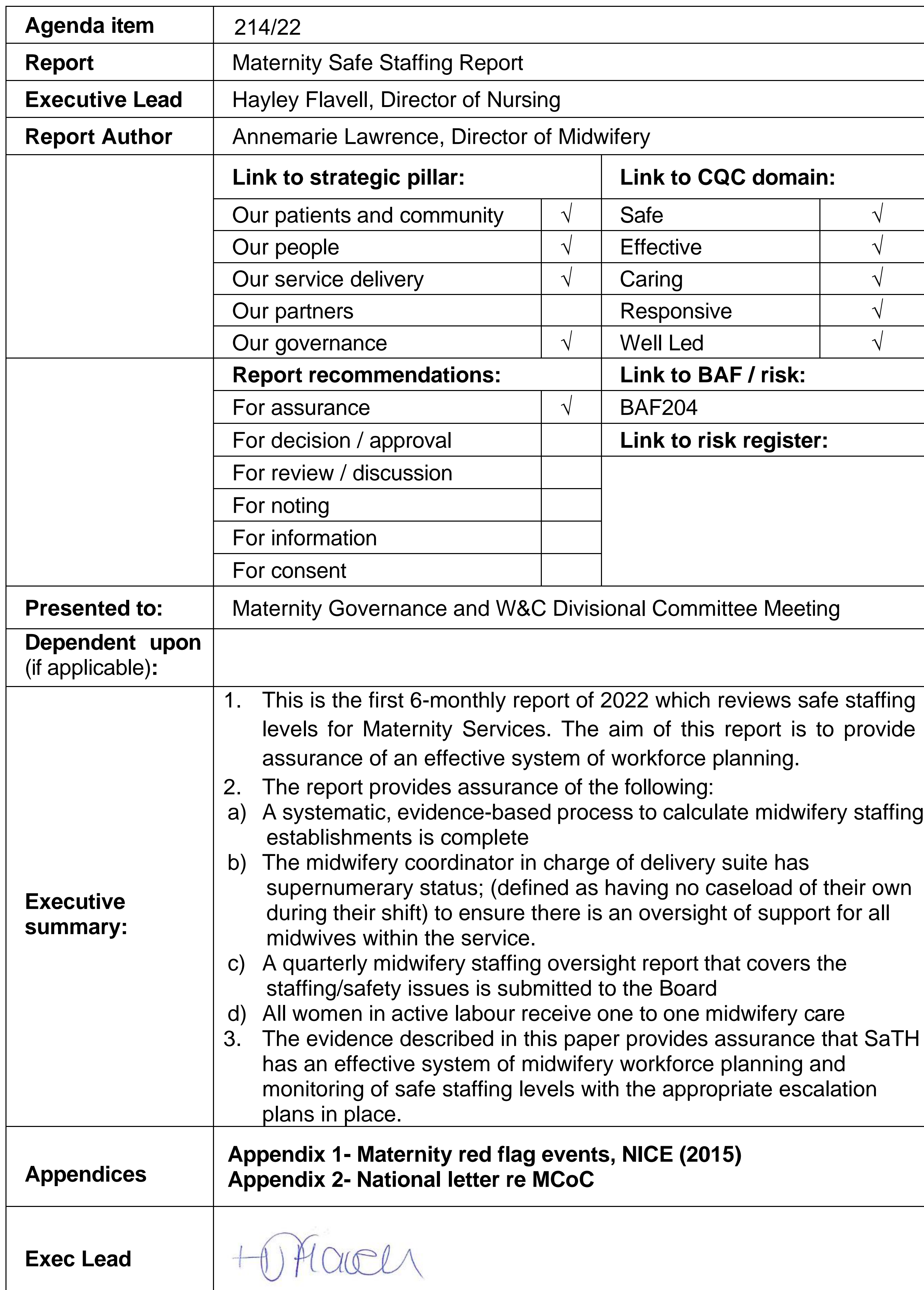
Board of Directors' Meeting
10 November 2022

The Shrewsbury and Telford Hospital NHS Trust



Agenda item	214/22			
Report	Maternity Safe Staffing Report			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Annemarie Lawrence, Director of Midwifery			
	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:	Maternity Governance and W&C Divisional Committee Meeting			
Dependent upon (if applicable)**:**				
Executive summary:	1. This is the first 6-monthly report of 2022 which reviews safe staffing levels for Maternity Services. The aim of this report is to provide assurance of an effective system of workforce planning. 2. The report provides assurance of the following: a) A systematic, evidence-based process to calculate midwifery staffing establishments is complete b) The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service. c) A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board d) All women in active labour receive one to one midwifery care 3. The evidence described in this paper provides assurance that SaTH has an effective system of midwifery workforce planning and monitoring of safe staffing levels with the appropriate escalation plans in place.			
Appendices	**Appendix 1- Maternity red flag events, NICE (2015)** **Appendix 2- National letter re MCoC**			
Exec Lead	H Flavell			

Midwifery Safe Staffing Report for Q1/2 of 2022

1.0 Purpose

The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels from April to October 2022. This is a requirement of the NHSLA Maternity Incentive Scheme for safety action 5 (NHSLA, 2021).

The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in July 2022. In addition, gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. A clear breakdown of BirthRate Plus or equivalent calculations to demonstrate how the required establishment has been calculated is also included.

2.0 Background

The NHSLA Maternity Incentive Scheme requires that the SaTH demonstrates an effective system of midwifery workforce planning to the required standard using the following standards prescribed within safety action 5 of the MIS:

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care
d	A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board

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 clinical activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation for times of high demand or low staffing numbers.

BirthRate Plus is a proven evidence-based methodology for calculating midwifery staffing requirements and is based on the case mix for women and babies accessing the service. This staffing report will include data from the 2021 BirthRate Plus Report however a further assessment using the methodology has been carried out in Q2 and a new report is awaited in the next few weeks. This paper builds upon the previous staffing paper presented in July 2022.

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 (Appendix 1). These red flags are triangulated with the Trust's incident reporting system Datix and assurance is gained from there being no link to patient harm.

3.0 Current position

The below table presents the current workforce position for clinical midwives, midwifery support workers and includes specialist midwives on fixed term secondments to support the

Maternity Transformation Programme.

Table 1

	Establishment*	In post	Vacancy
Midwives Bands 5-7	181.85	179.28	-2.57
MSW's Band 3	23.54	17.40	-6.14
Specialist Midwives Bands 6-8	22.05	24.28**	+2.23
Total	227.44	220.96	-6.48

** Does not include management roles 8a and above, or midwife sonographers*

*** Includes fixed term secondments to support the Maternity Transformation Programme*

Table 2 presents the same data within columns 2&3 of table 1, however also includes an update on positions that have been recruited to but are not yet in post. The vacancy position within column 5 of table 2 is an over recruitment to compensate for attrition rates and unavailability.

Table 2

	Establishment	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	181.85	179.28	11.0	+8.43*
MSW's Band 3	23.54	17.40	6.0	-0.14
Total	205.39	196.68	16.0	+7.29

**Over recruitment to compensate for attrition rates and cover unavailability; majority of the workforce available from Autumn 2022*

In October, the 6 MSW apprentices who completed their university accredited course in September 2022 are due to commence formally in post which will see this staff group at establishment for the first time since the introduction of the MSW role to the workforce in 2021.

3.1. Unavailability

In addition to the current vacancy position, the speciality is also dealing with a significant amount of unavailability which has increased in Q2 and is made up of the following:

Table 3

	Q4 21/22	Q1 22	Q2 22
Maternity leave*	14.92wte	7.44wte	7.33wte
Long term sickness absence**	14.5wte	9.33wte	18.75wte
Total	29.42wte	19.01wte	26.08wte

*Midwives only
**including covid absence

As can be seen above in table 3, the unavailability rate has increased significantly in Q2 due to an increase in long term sickness absence however this is likely due to the introduction of new divisional HR surgeries to support sickness management and a confidence that sickness

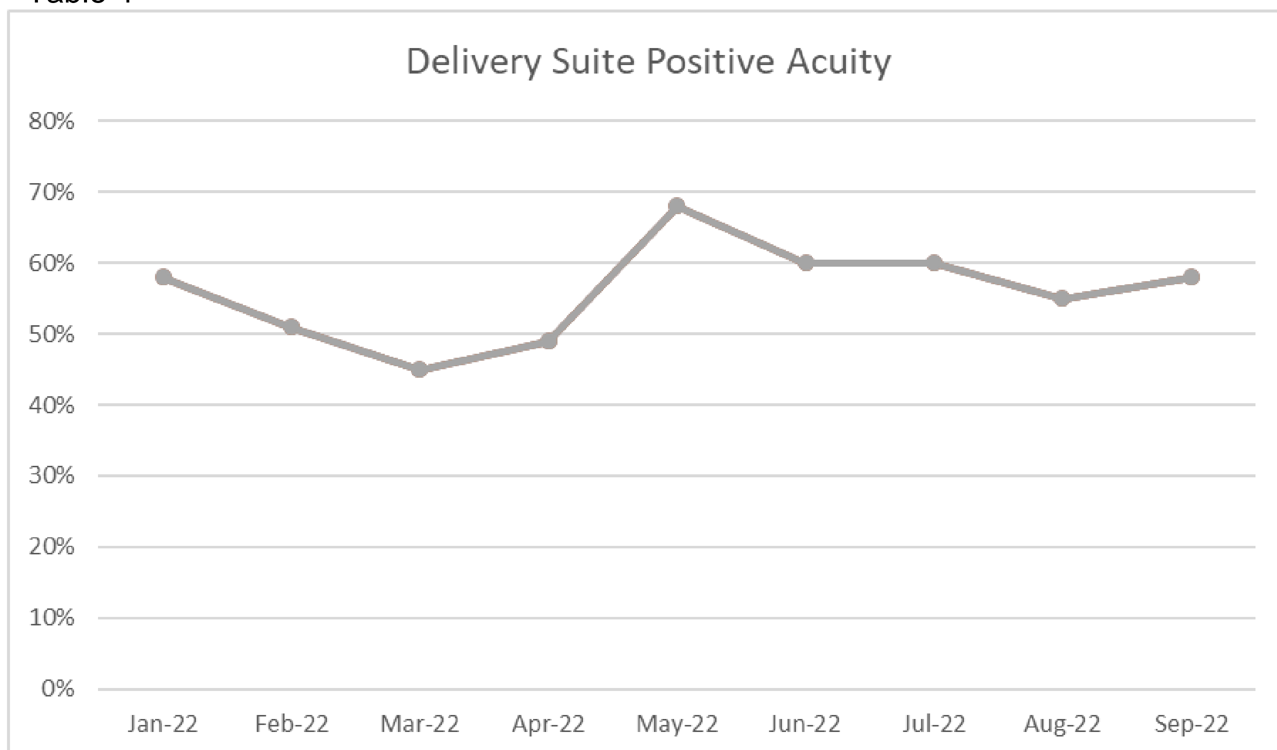
is now being reported and managed correctly.

As a service, Maternity also has a higher-than-average number of staff on maternity leave, year on year. These posts are usually advertised as temporary positions to enable backfill, however they have historically been difficult to recruit into due not being substantial positions. Given that the service can evidence such a high rate of maternity leave, the decision has been made as part of our workforce plan to convert a portion of the temporary vacancies into permanent positions, resulting in an additional 10wte substantial posts.

Additionally, the attrition rate for registered midwives increased in Q2 with the service losing almost 10wte, some due to being accepted onto the health visitor conversion programme (which last recruited pre-covid), while others sought employment closer to home due to the rising costs of fuel/travel.

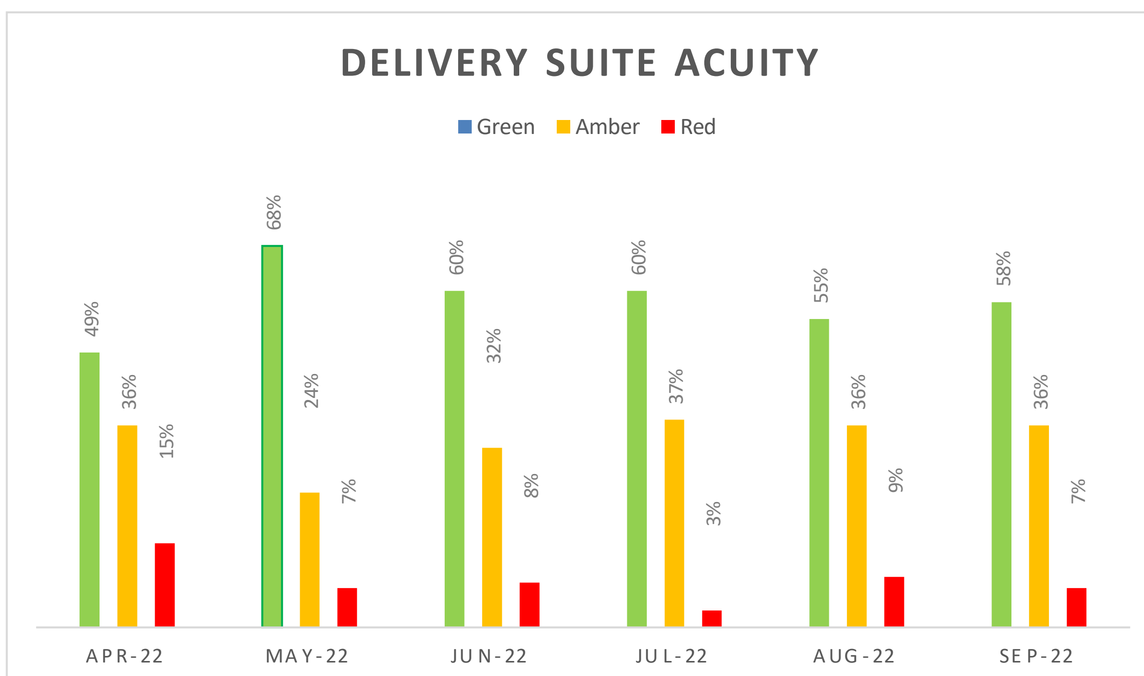
3.2. Acuity Data

Table 4



As can be seen in the graph above, at the beginning of the year there was a steady decline in safe staffing over a number of months due to the significant vacancy rate and the sheer volume of unavailability the service was dealing with. This had started to improve in April and May following action by the senior leadership team which introduced job planning for specialist midwives as part of a 60:40 or 80:20 split, however due to a number of staff retiring in Q1 and an attrition rate of circa 10wte in Q2, this positive increase then tailed off and further action was required to ensure safe staffing.

Graph 1



The above graph evidences the staffing position over the last 6 months. The green bar demonstrates the number of times the maternity unit has had the correct number of staff for the number of patients and the complexity of their health needs. The amber bar evidences the percentage of shifts that are short staffed by up to 2 midwives, with the red bar evidencing the percentage of shifts that are over 2 midwives short.
Following a number of controls being introduced in the early part of the year, the service saw an increase in positive acuity, which then levelled out over the summer period in tandem with seasonal variation. The dip in positive acuity in the month of August correlated with the busiest month for births since October 2021.
It is reassuring to note that while the positive acuity remains steady, the red acuity position has reduced in line with the controls introduced and evidences the escalation policy is working well.

3.3. Red Flags

Table 5

Month	Number of red flags	1:1 care not met	Coordinator not supernumerary	Positive (green) acuity %	Acuity red %	Acuity amber %	Acuity compliance rate
April 2022	79	0	3	49%	15%	36%	91%
May 2022	40	1	3	68%	7%	24%	89%
June 2022	60	1	1	60%	8%	32%	89%
July 2022	49	0	0	60%	3%	37%	85%
August 2022	66	1	3	55%	9%	36%	87%
September 2022	52	0	5	58%	7%	36%	86%

The above table evidences the red flag data, in addition to a breakdown of the acuity data for Q1 and Q2 of 2022. In the earlier part of Q1, several control measures were introduced to

improve the staffing position whilst recognising the vacancy/unavailability rate. This improved somewhat until August 2022 when there was a reduction in positive acuity due to a seasonal increase in birth activity in month which in turn increased the number of red flags in month. All episodes of 1:1 care in labour not met is reviewed by the senior leadership team and occur very briefly while initiating the escalation policy. Similarly, all occasions of coordinator not supernumerary are also reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite.

Midwifery staffing levels are proactively reviewed weekly as part of a 10-day forecast to determine planned staffing versus agreed establishment for each clinical area, including on-calls. Furthermore, a twice daily staffing huddle takes place which reviews the actual midwifery and support staffing and acuity levels to ensure a fast response with mitigating actions to address any highlighted staffing shortfalls.

Actions are taken in line with the Escalation Policy to mitigate the risk to patient safety. This includes staff movement between areas, supernumerary staff within the numbers in addition to utilising the on-call team for short periods and sourcing additional staff at short notice.

Assurance can be gained from the compliance rate for completion of the tool as it remains above 85% which is in accordance with the agreement of the Midlands Regional Directors of Midwifery.

3.4. Midwife: Birth Ratio

The below table presents the midwife to birth ratio which is determined by the number of births divided by the number of staff available each month. Based on the establishment, the mean midwife to birth ratio at SaTH should be around 1:26 each month however the current figures are being impacted by the increase in unavailability, in addition to the increase in births during August 2022 which saw the highest number of births in month since October 2021.

Table 6

	July 2022	August 2022	September 2022
Midwife to Birth Ratio	1:29	1:30	1:29

Once the new cohort of midwives are out of their period of supernumerary status, this should improve the midwife to birth ratio.

4.0 Mitigation

In order to support the workforce during this time of high unavailability and vacancy rates, the following measures have been introduced:

- All specialist midwives have been job planned to work clinically which supports their clinical credibility in addition to the day-to-day workforce. Once the service is fully established, this clinical component will continue due to the positive feedback received, but will revert back to supernumerary status.
- The 7-day manager of the day rota is working well which, in conjunction with the on-call divisional manager equates to managerial support being available to the clinical teams 24/7.
- Bank shifts remain incentivised to 150% for midwives to encourage pick up - this will continue until the new band 5 cohort of registered midwives are out of their supernumerary period.

- Midwifery Continuity of Carer remains suspended in line with the immediate and essential actions of the final Ockenden report. Further rollout will not take place until the service can support safe staffing on all shifts, and there is evidence that this is a sustained position. The building blocks for MCoC will continue to be embedded in preparation for moving towards full implementation of the model in the future.
- Wrekin MLU is now fully open, providing additional birth options for women.
- Representatives of SaTH have joined both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff back to work.
- 100% of our 2021 B5 midwives remain in post which is testament to the commitment of the preceptorship midwife and the education team in supporting and ensuring a robust preceptorship package of support is in place.
- Confirmation of secured funding for International Midwife recruitment with SaTH committed to supporting 10wte into the workforce in 2023 – these posts will be recruited to over the coming months and will add some much-needed diversity to our current workforce.
- Ward managers all work clinically as part of their working week.
- Updated escalation policy in place in line with Midlands OPEL Framework.
- The maternity team continue to actively recruit new staff.
- The introduction of several B7 leadership positions into maternity triage which will enable improved escalation.
- The service is currently working with HEE to introduce a Midwifery Apprentice Programme to SaTH as part of longer-term workforce plans.

5.0 Midwifery Continuity of Carer

This paper is presented exclusive of the staffing resource required for MCoC in view of the current pause in rollout following the Immediate and Essential Actions of the final Ockenden Report. That said, the requirement to move towards full implementation of MCoC as the default model of care is still present albeit without any targets in line with the National letter published in September 2022 – see appendix 2.

6.0 Conclusion

Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels has become more complex recently due to national pandemic challenges and staff isolation, in addition to increased pressures on the workforce as a result of the Ockenden Report and other National Maternity reviews.

A further BR+ assessment has been completed in Q2 and although it is disappointing that the report was not available at the time of compiling this paper, the service will ensure an updated position is available as soon as practically possible following the sharing of the report.

It is anticipated that there will be improvement in the acuity levels across the service from October 2022 due to the gradual introduction of 22 newly qualified B5 midwives who have begun to take up their substantive posts at SaTH. These midwives will commence a robust and comprehensive preceptorship programme, which has received excellent feedback from 2021's cohort of newly qualified midwives, of which 100% have remained in employment following completion of their preceptorship.

Finally, this 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 a 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 remains the priority for the service.

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.

7.0 Actions Required of The Board of Directors

The Board of Directors are requested to

- Receive this report
- Decide if any if any further actions and/or information are required

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.

Appendix 2

Midwifery Continuity of Carer Letter - NHS England

Classification: Official

Publication reference: PR2011

To:
- Trust chief nurses
- Trust directors of midwifery
- Trust COO
- Trust CEO
- Trust medical directors
- Trust clinical directors for obstetrics

cc.
- Regional directors
- Regional chief nurses
- Regional medical directors
- Regional chief midwives
- ICB chief nurses
- LMNS Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2022

Dear colleagues

Midwifery Continuity of Carer

We are writing to you to set out essential and immediate changes to the national maternity programme in the light of the continued workforce challenges that maternity services face. There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.

Over the past two years staff have had to work in ways that they never imagined, in difficult circumstances and we know that maternity services are experiencing stress and strain. The top priority for maternity and neonatal services must continue to be ensuring that the right workforce is in place to serve women and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. We hope this will enable your services to improve in line with the evidence, at a pace that is right.

We know trusts have submitted their MCoC plans and will have considered safe staffing levels in submitting their plans. Thank you for your work on these and your efforts to implement MCoC to date

We expect you to continue to review your staffing in the context of Donna Ockenden's final report. Your local LMNS, regional and national colleagues are here to support you with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

As we have said previously:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

Approved educational institutions (AEI's) educating pre-registration midwifery students will continue the implementation of the future midwifery standards of the NMC. It is expected that midwifery students will be taught the MCoC model, alongside other approaches to safe, high-quality care for women. The NMC has written to education providers to confirm that this remains a requirement of registration and to suggest how this can be achieved when students are placed in those organisations that are not able to fully implement MCoC at this time. Where this is the case, students will still benefit from practice supervisors and assessors being able to explain and discuss the concept and we would ask for your support to encourage this to happen.

With the advice of the independent working group established after the final Ockenden report, we will publish a national delivery plan for maternity services this winter which will bring together actions for maternity services, including next steps for improving continuity across all professional groups.

Yours sincerely,

Dame Ruth May
Chief Nursing Officer,
England

Prof Jacqueline Dunkley-Bent OBE
Chief Midwifery Officer
National Maternity Safety Champion
NHS England

Dr Matthew Jolly
National Clinical Director for Maternity and Women's Health
National Maternity Safety Champion
NHS England