Board of Directors' Meeting

8 June 2023

Agenda item		063/23		
Report Title		Bi-Annual Maternity Safe Staffing Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		BAF4, BAF3
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	67, 87
Well Led	√	Our partners		
Consultation Communication		Nursing, Midwifery, AHP and Facilities Group 12.4.23 People and OD Committee 11.5.23		
Executive summary:		• Midwifery staffing is complex; acuity can often change rapidly maintaining safe staffing levels continues to be complex due to increased pressures on the workforce. • The service has seen an improvement in overall staffing position, moving from a position of significant vacancies to a position of no vacancies, in line with Birth Rate Plu. • 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.		
Recommendations for the Board		The Board is asked to: Approve and take assurance from this report, that that there is an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q3/4 of 2022/23 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5		
Appendices:		Appendix 1: Midwifery red flags		

1.0 Introduction

1.1 The aim of this report is to provide assurance to the Board of Directors that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q3/4 of 2022/23 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5 where the following standards are used:

Table 1

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

1.2 The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in October 2022.

2.0 Background

2.1 The previous 2021 Birthrate Plus (BR+) assessment recommended a total clinical whole time equivalent workforce (WTE) requirement of 200.55 registered midwives (RMs) and postnatal (PN) midwifery support workers (MSWs), rising to 205.53 WTE with the rollout of Midwifery Continuity of Carer (MCoC) to 51%.

2.2 The updated 2022 BR+ assessment recommends a WTE of 199.80 RM's & PN MSWs which is in-keeping with the previous assessment however it does not include any uplift for the rollout of MCoC as the National Midwifery team no longer support the use of BR+ for this workforce model.

2.3 Instead, they advise using the MCoC toolkit which has been designed by the National team however it is worth noting that this is not currently available due to undergoing modifications on the advice of BR+ to ensure it is fit for purpose.

2.4 This does mean that there is a risk that the 199.80 WTE mentioned above may increase in the future once the toolkit becomes available, but for the moment, the rollout of MCoC is currently paused in line with guidance from the national team around safe staffing.

3.0 Current Position

3.1 The below table presents the current workforce position for clinical midwives and MSWs

and includes those recruited to but not yet in post. It does not include any specialist midwives, midwifery management roles grade 8a and above, or midwife sonographers. It is also exclusive on any staff on fixed term secondments to support the Maternity Transformation Programme.

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	179.82	182.29	1	+3.47
MSW's Band 3	20.00	17.71		-2.29
Total	199.80	200.61	201.61	+1.21

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

3.2 Although the table above presents a healthy workforce position in terms of recruitment of clinical staff, these figures are impacted by unavailability which is on the rise.

3.3 The below table demonstrates that there has been a steady improvement in the number of staff taking maternity leave over the last 15 months (the lowest rate seen in a number of years) however there is a significant number of staff on long term sickness absence, which combined with the number on maternity leave, is a deficit of 15% of the clinical workforce.

Table 3

	Q4 21/22	Q1 22	Q2 22	Q3 22	Q4 22/23
Maternity leave*	14.92wte	7.44wte	7.33wte	5.78wte	4.87wte
Long term sickness absence**	14.5wte	9.33wte	18.75wte	21.22wte	25.28wte
Total	29.42wte	19.01wte	26.08wte	27.0wte	30.15wte

3.4 It should also be noted that this unavailability is impacting on the day-to-day operational service delivery within the maternity unit and causing the senior leadership team to frequently enact the midwifery escalation policy to support safe staffing.

3.5 Weekly staffing meetings are in place to focus on a two week forward look ahead which provides a further opportunity to identify hot spot areas and action appropriate solutions to maintain safe staffing levels.

3.6 Each month the planned versus actual staffing levels are submitted to the national database and NHS Improvement using the information provided from the Healthroster Allocate rostering system, and reported monthly to the workforce meeting.

3.7 The maternity leadership team have joined both Regional and National working parties/webinars to ensure the most up to date measures are in place to support staff back to work.

3.8 The service also benefits from a recruitment and retention midwife thanks to initial funding from Health Education England (HEE); this post has recently been extended as a commitment to continuing to supporting midwives in practice.

3.9 The below table presents the specialist midwives currently in post and does not include posts which are not yet recruited to:

Table 4

Specialist Role	WTE	Specialist Role	WTE
Fetal Monitoring Midwives	1.0	Public Health Lead Midwife	1.0
Bereavement Midwives	2.0	Professional Midwifery Advocate Lead Midwife	1.0
Continuity of Carer Lead	1.0	Perinatal Pelvic Health Midwife	0.6
Infant Feeding Lead	0.6	Improving Women's Health Midwife	1.0
Saving Babies Lives Lead	1.0	Lead Education Midwife	1.0
Digital Midwife	1.0	Clinical Practice Educators	2.0
Maternity Mental Health Midwife	0.6	Clinical Practice Facilitators	2.0
Antenatal Screening Midwife	1.0		

4. Workforce Plan

Midwifery has an attrition rate of around 20wte each year in addition to continued long term unavailability made up from a combination of maternity leave and long-term sickness absence. While there is an element of funding available to cover maternity leave in the short term, historically, it has always been difficult for providers to recruit to temporary posts especially in the presence of a national midwifery workforce gap.

4.1 This required SaTH to be proactive from a workforce perspective, agreeing with finance to convert some of the funding from recurring temporary positions to 10wte substantive positions that would attract midwives looking for stability and job security.

4.2 The below table presents the planned recruitment currently in train as part of the workforce plan, the majority of which is either already advertised and in the process of being recruited to or about to be advertised

Table 5

Planned Recruitment	WTE	Additional Info.

International midwives	10.0	Recruitment ongoing, some interviews have been held and offers about to be made
Midwifery apprentice programme	9.0 over next 3 years	3wte commencing training programme in September 2023, 3wte in 2024, 3wte in 2025
Midwifery support worker apprentice programme	6.0	3wte to commence September 2023 uni intake, 3wte to commence Trust programme
Apprentice midwife sonographer	1.0	Rolling programme each year
Equality, diversity and inclusion midwife	1.0	New post, JD being worked up
BFI lead midwife	1.0	14-month secondment funded by the LMNS to support the journey to BFI accreditation
Breastfeeding support midwife	0.6	Post to enhance current support offer
Frenulotomy lead midwife	0.4	Specialist post out to advert, to strengthen current provision
Multiple pregnancy midwife	0.6	Funding for 12month secondment in first instance to improve service provision
Transformation matron role	1.0	Currently paused due to a leadership gap, restarting in May 2023 with 6 months to run

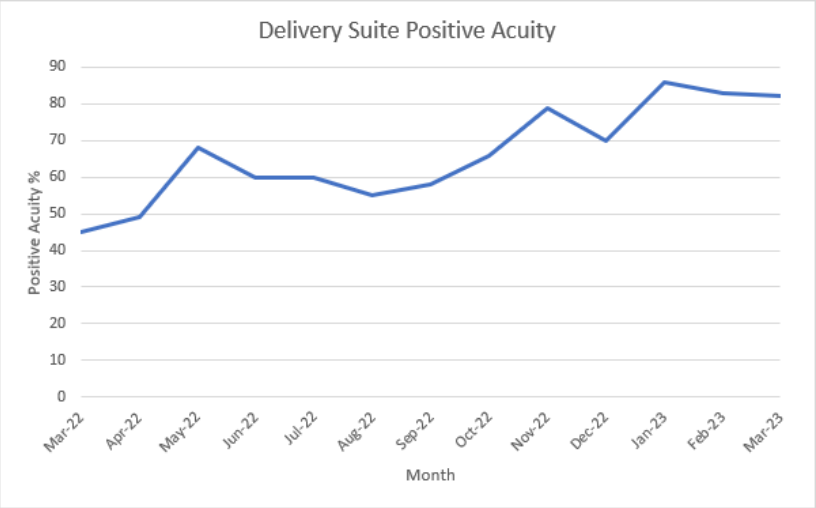
5. Acuity Data

5.1 For the purpose of this report, acuity is referencing intrapartum activity (the number of women being cared for on the delivery suite) and is measured using the BR+ acuity tool. BR+ 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”.

5.2 A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite 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 delivery suite 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*”

5.3 The below graph presents the acuity data for Delivery Suite over the last 12 months (March 2022 – March 2023) inclusive:

Graph 1



5.4 As can be seen above, in March 2022, the service was at its lowest safe staffing position, with only 45% positive acuity against a target of 85%. The introduction ofsome immediate actions (such as job planning specialist midwives to work clinically as part of a 80:20 or 60:40 split) saw an initial improvement, however, heading into peak holiday season in addition to a known seasonal peak meant that one offset the other with only minor improvements felt by the service and, by September 2022, we remained below 60% positive acuity.

5.5 Following a successful recruitment campaign in the spring of 2022, the Trust welcomed 26 newly qualified midwives, and 4 experienced midwives into the organisation from September 2022 onwards. These were introduced to the workforce gradually, benefitting from a robust supernumerary period upon appointment and supported by an excellent preceptorship programme that has seen the service retain 100% of our 2021 cohort of newly qualified midwives.

5.6 As it stands currently, we are on course to achieve this retention for the second year running which is testament to the benefits of the education team who truly go above and beyond to ensure our preceptee's receive the right amount of supernumerary status and are supported at every opportunity.

5.7 Additionally, as can be evidenced within table 3, the number of midwives on maternity leave in Q3 2022 also reduced to its lowest level in 12 months which, in conjunction with the number of new starters to the service, meant we were able to see improvements within midwifery staffing levels as evidenced in the above graph.

6.0 Red Flags

6.1 The table below shows the number of red flags in month, followed by the percentage of shifts identified by the tool as red, amber, or green acuity.

Table 6

Month	Red Flags	1 to 1 Care not met	Coordinator Not Supernumerary	Positive (green) Acuity %	Acuity Red %	Acuity Amber %	Acuity Compliance Rate
October 2022	58	0	0	66%	5%	29%	82.8%
November 2022	23	0	0	79%	17%	5%	86.11%
December 2022	46	0	0	70%	19%	11%	90.32%
January 2023	24	0	0	86%	10%	5%	90.32%
February 2023	30	0	0	83%	16%	1%	89.29%
March 2023	25	0	0	82%	14%	4%	90.1%

6.2 In order to meet standards b and c of the CNST MIS safety action 5, the number of times when 1:1 care in labour has not been met is also reported, along with the status of 'coordinator not supernumerary'.

6.3 As can be evidenced from table 6 above, there service was able to maintain 1:1 care in labour for all women 100% of the time and there were no occasions whereby there was a loss of coordinator not supernumerary status as defined within the technical guidance of the CNST MIS.

6.4 The maternity service holds twice daily safety huddles during which all red flags are discussed from across the service areas. Where there is a shortfall, midwives will be rotated from one area to another to support any increase in acuity and facilitate safe care.

6.5 The escalation policy is implemented should any area require more midwifery staffing based on patient numbers and acuity/complexity.

7.0 Midwife to Birth Ratio

There is no national standard midwife to birth ratio however for years, the midwifery world has worked to the well cited ratio of 28 or 29.5 births to every 1wte.

7.1 The most recent BR+ assessment undertaken in 2022 advised an overall ratio for SaTH of 22.2 births to 1wte is based on extensive data from BR+ studies and is calculated from a

detailed assessment for workforce planning purposes. The below table shows the WTE broken down by area:

Table 7

Type of care	WTE
Delivery suite births, all hospital care	29.9 births to 1wte
All hospital births, all hospital care	29.4 births to 1wte
Homebirths	33.1 births to 1wte
Community AN & PN Care, all hospital care	96.8 cases to 1wte
All community care including attrition and safeguarding	91.9 cases to 1wte
Overall ratio for all births	**22.2 births to 1wte**

7.2 The below table represents the midwife to birth ratio for all births which is determined by the number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability through sickness or maternity leave.

Table 8

	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Midwife to Birth Ratio	1:29	1:27	1:26	1:25	1:25	1:25

7.3 The figures in table 8 are above the desired overall ratio of 1.22 detailed above and this is most likely due to the unprecedented amount of staff unavailability detailed in table 3.

8.0 Medical Staffing

8.1 The Trust operates a tier 3 rota system for obstetric medical staffing which means there is 24/7 on-site consultant presence as opposed to a consultant being on-call from home.

8.2 One of the many benefits of a tier 3 rota is that there is no delay out of hours when consultant attendance is required as they are already on site and therefore do not have to mobilise into the maternity unit.

8.3 From a rota perspective, the below table shows the number of medical staff supporting each tier of the rota currently:

Table 9

Rota Tier	**No. of Medical Staff**
Tier 1 (ST1-ST3)	13
Tier 2 (ST4-ST8)	16
Tier 3 (Consultant)	19

8.4 In respect of the tier 1 and 2 rota, there have been no rota gaps in the last 6 months for either which is encouraging however there are gaps currently within the tier 3 rota which has required the use of agency locums.

8.5 The speciality have a comprehensive locum induction package that sets out the requirements for all locums to undertake both PROMPT and fetal monitoring training prior to working clinically to reduce the risks to patient safety that are known to be linked to staff unfamiliar to the working environment/multidisciplinary team.

8.6 While the speciality only have 1 agency locum currently, due to ongoing rota gaps within the tier 3 rota, there are plans to go out to advert for 2 locum consultants as the service recognises that the various gaps are currently being filled by existing staff as internal locums which is not sustainable in the long term.

8.7 Additionally, it is worth noting that the provision of obstetric care is always prioritised given that this is the acute service, however this does mean that there are often gaps within the gynaecology service as elective care is cancelled to release capacity to support obstetrics.

8.8 The knock-on effect of this on the gynaecology service is that the numbers of patients waiting for elective procedures continues to increase leading to a dip in referral to treatment (RTT) performance for this speciality area.

9.0 Midwifery Continuity of Carer

9.1 MCoC at SaTH remains paused in line with both the recommendations on safe staffing from the Ockenden Report, and the National letter published in September 2022.

9.2 The letter advised that any Trust that was unable to 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.

9.3 As the Trust continues to improve its staffing provision, there will be an expectation from the LMNS, regional and national teams to review our position in terms of restarting MCoC as a model of care. However, although our vacancy position has improved significantly, we continue to have a very high unavailability which must be taken into consideration before any alterations are made to current service provision.

9.4 This unavailability rate will need to improve significantly, and we will need to evidence a sustained safer staffing position before any changes are made.

9.5 In the meantime, we are committed to implementing the building blocks of MCoC as this will ensure we have laid solid foundations that are safe to build upon.

10.0 Pre-registration Midwifery Programme

10.1 In the Autumn of 2020, concerns were raised regarding the quality of midwifery training at SaTH and following several visits by the HEE team over the spring and summer of 2021, the service was placed onto HEE's Quality Improvement Register, Intensive Support Framework (ISF) at level 2.

10.2 Following a comprehensive action plan, the service was followed up in December 2021 and although there were no new significant concerns raised, it was acknowledged that staffing pressures within the department was impacting on student experience.

10.3 With the introduction of a new leadership team in early 2022, the service began to develop a number of new workstreams which enabled improvements in many areas and staffing levels continued to rise throughout the autumn of 2022.

10.4 In January 2023, HEE undertook a further quality intervention visit which identified that overall students reported a significantly improved experience whilst undertaking their practical placements at SaTH, with the HEE panel acknowledging that the actions implemented by the Trust to address previous concerns were translating into positive feedback being shared by Pre-registration Midwifery students.

10.5 The entire cohort of students were interviewed along with a number of practice educations and practice supervisors and the visiting panel reported that 100% of those interviewed said they would recommend SaTH as both a place to learn and a place to work.

10.6 As a result of this, based on the overall positive findings and the key areas of improvement identified, the panel recommended that SaTH was reduced from ISF Category 2 to ISF Category 1, and the concern was removed from the HEE Quality Improvement Register.

11. Conclusion

11.1 Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels continues to be complex due to increased pressures on the workforce as a result of the Ockenden Report and other National Maternity reviews.

11.2 Despite these challenges, the service has seen an improvement in our overall staffing position, moving from a position of significant vacancies to a position of no vacancies which is due to a forward-thinking workforce plan that has enabled us to become proactive rather than reactive and actively plan for a known attrition rate.

11.3 Due to the improvements being made at every level as a result of the MTP and our commitment to the delivery of national drivers known to impact on patient safety such as the Saving Babies Lives Care Bundle and the CNST MIS, safety continues to improve as we

evidence that these elements are embedded into everyday practice.

11.4 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.

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.