

Meeting Title	Workforce Committee		
Date	29.01.20	Agenda item	W.1.20.10

BI-ANNUAL MIDWIFERY STAFFING REVIEW

Presented by	Karen Dawber, Chief Nurse		
Author	Sara Hollins, Head of Midwifery		
Lead Director	Karen Dawber, Chief Nurse		
Purpose of the paper	To provide Trust Board with the actions and assurance prior to self-certification to complete the Maternity Incentive Scheme (CNST) year 3.		
Key control	Yes		
Action required	For decision		
Previously discussed at/informed by			
Previously approved at:	Committee/Group	Date	
	Senior Leadership Team (SLT) – S.1(1).20.14	07.01.20	
Key Options, Issues and Risks			
<p>In line with the National Quality Board recommendations (2016) and to evidence compliance with the NHS Resolution Maternity Incentive Scheme (CNST), safety action 5, we are required to review Midwifery staffing on a 6 monthly basis, demonstrating that a systematic, evidence-based process to calculate midwifery staffing establishment has been used, and that the maternity unit meets the recognised best practice in assessing and deploying its workforce.</p> <p>In addition this is the first opportunity to review midwifery staffing following the unannounced CQC inspection in November 2019, and to address the comments and concerns raised.</p>			
Analysis			
<p>The document follows best practice and provides a comprehensive review of midwifery staffing including the Maternity Incentive Scheme (MIS) minimum evidential requirements for Trust Board.</p>			
Recommendation			
<ul style="list-style-type: none">• SLT/Workforce Committee is asked to note the report and the assurance this provides.• SLT/Workforce Committee is asked to consider the request to increase the midwifery establishment by 5.22 WTE to enable an additional intrapartum midwife per shift.• Birth Rate Plus Midwifery Staffing tool to be re-commissioned in summer 2020.• Audit to assess the consistency of which the one to one care in labour definition is applied (March 2020).• Further work to address sickness and absence in collaboration with the Royal College of Midwives and the Human Resource department.• Continue to recruit over establishment by 6.33 WTE to cover maternity leave.			

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				G		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
<input checked="" type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework
<input type="checkbox"/> Code of Governance	<input checked="" type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Safety	

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NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 PURPOSE/ AIM

The purpose of the report is to provide the Workforce Committee with the first of the bi-annual midwifery staffing reports for 2020. In addition this is the first opportunity to review midwifery staffing following the unannounced CQC inspection in November 2019, and to address the comments and concerns raised.

It is also to demonstrate that a systematic, evidence-based process to calculate midwifery staffing establishment has been used, and that the maternity unit meets the recognised best practice in assessing and deploying its workforce.

2 BACKGROUND/CONTEXT

The NICE 2015, Safe Midwifery Staffing for Maternity Settings guidance, and the National Quality Board guidance (2016) recommends that midwifery staffing levels are reviewed every 6 months as a minimum. This report follows the bi-annual midwifery staffing report presented to the Workforce Committee in July 2019, and as an appendix in the Chief Nurse's overarching Nursing and Midwifery Staffing Report.

This report is also required to demonstrate compliance with Safety Action 5 of the Maternity Incentive Scheme (CNST) standards, which requires a bi-annual report to be presented to the Trust Board demonstrating an effective system of workforce planning.

3 PROPOSAL

Workforce Committee is asked to note and consider the recommendations and confirm that the report meets the required standard to assure compliance against Safety Action 5.

4 BENCHMARKING IMPLICATIONS

In gathering the evidence and supporting information a number of sources, both internal and external, have been used.

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5 RISK ASSESSMENT

A number of risk assessments relating to midwifery staffing and the provision of one to one care in labour accompany this report.

6 RECOMMENDATIONS

- SLT/Workforce Committee is asked to note the report and the assurance this provides.
- SLT/Workforce Committee is asked to consider the request to increase the midwifery establishment by 5.22 WTE to enable an additional intrapartum midwife per shift.
- Birth Rate Plus Midwifery Staffing tool to be re-commissioned in summer 2020, noting the caveat that it does not take into account the continuity of carer pathways.
- Audit to assess the consistency of which the one to one care in labour definition is applied (March 2020).
- Further work to address sickness and absence in collaboration with the Royal College of Midwives and the Human Resource department.
- Continue to recruit over establishment by 6.33 WTE to cover maternity leave.

7 Appendices

1. Bi-Annual Midwifery Staffing Report, January 2020.

Attachments:

1. Risk assessment for midwifery staffing.
2. Risk assessment for one to one care in labour.
3. Midwifery funded establishment and roster configuration.
4. Heat Map 6 month trend.

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Appendix 1

Bi-annual Midwifery Staffing Report, January 2020

1. Background

This is the first of the bi-annual midwifery staffing reports for 2020, and follows the July 2019 paper presented to the Workforce Committee (W.7.19.12). In addition this is the first opportunity to review midwifery staffing following the unannounced CQC inspection in November 2019, and to address the comments and concerns raised.

The July 2019 paper concluded that the midwifery establishment reported met the needs of the service and recommended an establishment increase of 1 WTE band 7 to support the role of a specialist midwife post for women with vulnerabilities including substance misuse and perinatal mental health issues. This recommendation was agreed by the Workforce Committee.

The previous report highlighted challenges in meeting the March 2020 Continuity of Carer figure of 35% and consistently achieving 1:1 care in labour.

The purpose of this report is also to evidence:

- A systematic, evidence-based process to calculate midwifery staffing establishment and that the maternity unit meets the recognised best practice in assessing and deploying its workforce.

This report provides the minimum evidential requirement for the Trust Board to meet Maternity Incentive Scheme (MIS) safety action 5.

The review uses a methodology of professional judgement, Birth Rate Plus / birth to midwife ratios and a review of red flag and incident data.

2. Current Midwifery staffing position

Midwifery staffing has been a significant challenge during the last six months for a number of reasons, including:

- A continuous high volume of maternity leave.
- High levels of short term sickness.
- Anticipated attrition plus resignations and retirements leading to a higher than normal vacancy rate in late summer.

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- Opening of new areas including the Induction of Labour Suite, which did not require an increase to establishment, but impacts on the ability to redeploy staff throughout the unit due to the need to maintain safe staffing levels in all clinical areas.

A risk assessment for the current midwifery staffing position has been included in attachment 1.

2.1 Successes

Despite the challenges identified above there have also been significant successes in relation to midwifery staffing. The graph below (figure 1) demonstrates the stepped increase to the funded establishment over the last 2 years against the contracted WTE. The November 2019 position for contracted staff is significantly improved and reflects the 21 newly qualified midwives (NQM) who joined the service in October 2019. The full effect of the NQM will be appreciated in January 2020, as they gain confidence and competence as practitioners at the start of their midwifery careers.

Note the contracted is higher than funded in recognition of maternity leave and attrition rates (i.e. planned over recruitment).

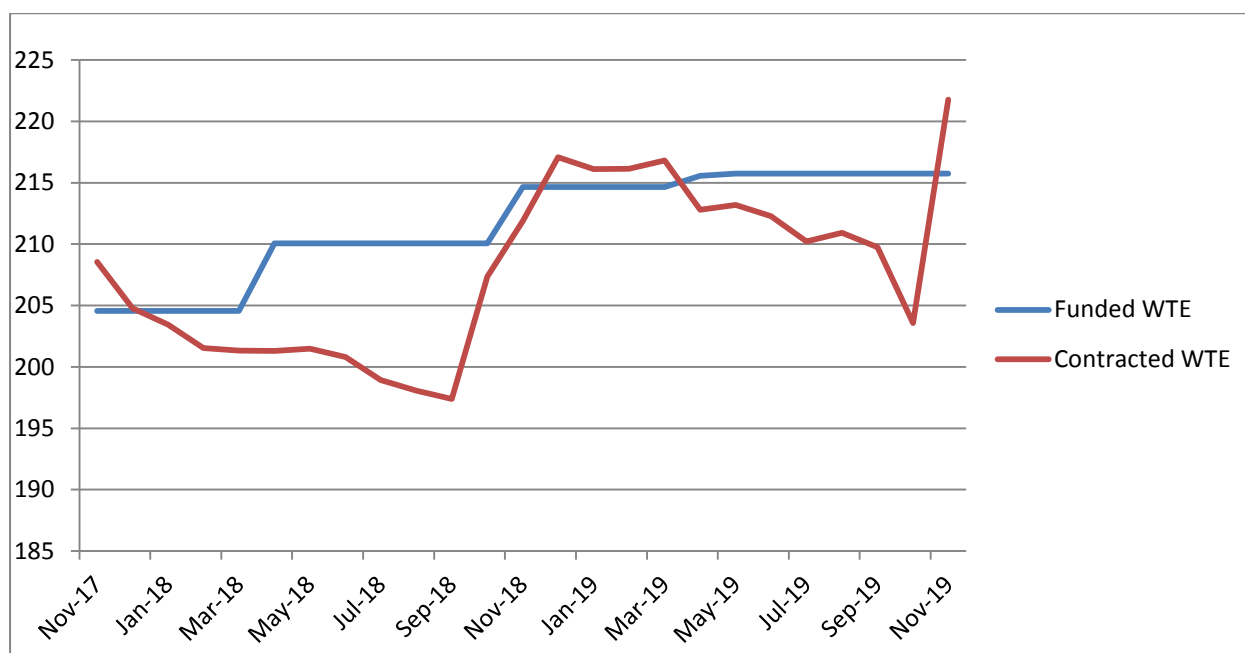


Figure 1: Contracted staff against establishment November 2017 – November 2019.

The appointment of a Specialist Midwife for Perinatal Mental Health and Complex Care Needs in November 2019 was a much welcomed addition to the specialist midwifery team. The post holder will provide expert advice and support to midwives and co-ordinate the care of women with complex needs. In addition to this, the post holder will support the Associate Director of Midwifery with delivering the local, regional and strategic perinatal mental health agenda.

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The opening of the Induction of Labour Suite in April 2019 has provided a designated area in which to cohort women undergoing induction of labour. This has improved the clinical management of this group of women in addition to ensuring a better service user experience. The Induction Suite has 8 beds and requires a minimum safe staffing level of 1:4. Whilst this has not required an increase to the midwifery establishment as these are the same women looked after in a different way, it does impact on the ability to redeploy midwives to other areas in response to staffing/activity challenges, as staff for this area are ring fenced. This has impacted on the ability to deliver one to one care in labour. However, we feel it is safer to maintain the IOL suite in direct response to previous clinical incidents, rather than increase the one to one care in labour rate. This option maintains safe care in all areas. There is no evidence of any harm in response to this mitigating action.

There are no current vacancies within the obstetric theatre team, which provides 24/7 emergency theatre cover to the Labour Ward and reduces the frequency of midwives needing to scrub in theatre at the expense of providing one to one care in labour. The service has identified the need for an obstetric theatre team leader (band 6) and this will be recruited to in early 2020.

2.2 Calculation of midwifery staffing establishment

The tools utilised to calculate the required establishment for the birth rate include:

- Birth Rate Plus tool methodology.
- Midwife to Birth ratio.
- Planned versus actual midwifery staffing levels.
- Supernumerary co-ordinator status and 1:1 care in labour data taken from Medway and SafeCare.
- Red flag incidents associated with midwifery staffing.

2.2.1 Birth Rate Plus tool methodology

Birth Rate Plus exists as the only recognised tool to calculate midwifery staffing levels, and was initially commissioned in May 2017, with a report being received mid-2018. Following the January 2019 decision to not re-commission the tool in full, we have applied the Birth Rate Plus methodology to calculate the required establishment against the 2018/19 activity of 5,364 births.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 22% for annual, sick & study leave allowance, 10% for travel in community and 1% for the PMA model.

Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % midwife increase is

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applied to Categories III (20%); IV (30% & V (40%). The 2017 study demonstrated that 25% of births were in the lower risk categories (1&2) with 21% in the moderate (3) category and 54% in the high categories (4&5). Overall, the case mix is significantly different to the 2014 Birth Rate Plus study, when 34% of births were in the lower risk categories compared with just 25% in 2017. Whilst acknowledging that the tool has not been completed in full since 2017, there is no indication based on professional judgement, to suggest that the acuity of Bradford women has reduced.

The overall clinical establishment for total of 5364 births with Birth Rate Plus recommended overall ratio for all births 1:24 is summarised as follows:

TOTAL CLINICAL WTE (incl. 1% midwifery PMA) 223.5 wte

A skill mix adjustment of 90/10% has been applied to the clinical total wte of **223.5 wte** (excluding PMA) this equates to 22.35 wte competent and qualified support staff. Therefore 201.15 WTE Registered Midwives are required to meet the recommended standard.

Birth Rate Plus recommends that

The total clinical establishments for both services do not include the following roles:

- Head of Midwifery & Matrons 4
- Supernumerary Labour Ward Coordinator 5.22
- Practice Development role. 1
- Clinical Governance roles 3
- Information/Maternity system role. N/A
- Additional hours for antenatal screening over & above clinical 0.5
- Coordination for such work as Safeguarding Children. 2

Comparison of Birthrate Plus® staffing totals with Current Funded Establishment based on above dataset

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles; skill mix adjustment of the clinical staffing between midwives and competent and qualified support staff can be applied. The table below (table 1) outlines the comparison of Birth rate Plus® results with current funded establishments based on above data and results.

2.2.2 Comparison of Maternity Staffing

The current midwifery establishment (end of December 2019) for bands 5-7 is 208.3 WTE, with no current vacancies and 51.79 WTE support staff with a current vacancy of 5.13 WTE.

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BR Plus Total Clinical wte	223.5	The total clinical wte for hospital & community calculated using Birthrate Plus methodology
BR Plus Total Skill Mix Adjustment at 90% (inc. 1% for PMA)	201.15	90% of total as midwives – bands 5 to 7 including PMA
Current funded clinical wte (bands 5 – 7)	194.26	The current funded midwifery wte includes Sp Mw clinical contribution but excludes non-clinical midwifery roles
Difference between BR Plus wte & current funded midwifery wte	6.89	The variance between BR Plus clinical wte & funded wte based on midwifery staffing
BR Plus Total Skill Mix Adjustment for 10%	22.35	10% of total as support staff who contribute to the clinical total in postnatal care and who can replace midwife hours
Current Funded Support roles (Band 3)	22.35	The Current funded support wte for the postnatal aspect of care
Difference between BR Plus Support roles to include in comparative total	0	Variance between BR Plus Clinical wte & Current Funded wte based on support roles for the PN aspect of care
Overall Difference between BR Plus wte compared with clinical wte - bands 3 to 7	6.89	The actual difference between BR Plus clinical wte & current funded wte combining midwives & appropriately trained support staff

Table 1

A further breakdown of the midwifery staffing establishment is shown in attachment 3.

The tool suggests that an increase to the current establishment of 6.89 WTE midwives is required. However, in addition to the funded midwifery establishment the service is also funded for 6.18 WTE theatre practitioners to provide 24/7 obstetric theatre cover. The provision of 24/7 theatre cover prevents midwives from being ‘pulled’ from providing intrapartum care to scrub for emergency theatre cases. The current establishment plus the addition of the theatre practitioners, should in principle meet the overall Birth Rate Plus recommendation. However, this report also describes the challenges achieving one to one care in labour, highlighted as an area of concern during the recent CQC inspection. The service recommendation is that an additional 5.22 WTE midwives are recruited to the Birth Centre, providing 1 extra midwife per shift to increase the ability to provide one to one care in labour.

The service also suggests that repeating the full Birth Rate Plus tool should be given careful consideration to confirm that the table top methodology and the recommendations of the 2017 review are still relevant. The limitations to the tool are that it has not been updated to

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include the service requirements for the provision of continuity of carer pathways, therefore, this should be taken into account when repeating it. There is no alternative midwifery staffing acuity tools available at present.

2.2.3 Midwife to Birth ratio

The midwife to birth ratio is calculated as *the number of total births per Whole Time Equivalent (WTE) clinical midwife in this reporting period, this excludes Head of Midwifery, Matrons and the two non-clinical risk and governance midwives*. This calculation is standard across the region and is what was previously reported into the regional dashboard.

The annual births for 2018/2019 were 5364.

Calculation example:

In September 2019 there were 199.88 clinical midwives (Band 7 30.48 WTE, Band 6 145.48 WTE and Band 5 23.92).

$$\frac{5364}{199.88} = 26.8 \text{ therefore ratio } 26.8 \text{ births per } 1\text{WTE RM } 1:26.8$$

Based on the agreed establishments of 204.78 WTE midwives, we aim for a midwife to birth ratio of 1:26.2. However, professional judgement would suggest that an additional 5.22 WTE midwives are required moving to a midwife to birth ratio of 1:25.5.

Please note, the figures below include all staff (including maternity leave and long term sickness and absence) and an agreed over establishment to balance this.

A review of the previous six month period is as follows (Table 2):

Jun 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19
1:26.6	1:26.8	1:26.9	1:26.8	1:25.6	1:25.4	1:25.6

Table 2

The ratio is calculated on the number of midwives employed and does not account for any monthly variations in staffing due to sickness and absence.

2.2.4 Planned versus Actual midwifery staffing levels

Details of planned and actual midwifery staffing levels are available to view on the monthly 'Heat map' data produced by the Chief Nurse team (See attachment 4). Data is reviewed at the monthly Chief Nurse Quality meetings and during confirm and challenge and establishment reviews.

2.3 Supernumerary labour ward co-ordinator status and the provision of one to one care in labour

In March 2019, labour ward co-ordinators commenced 4 hourly acuity data collection, demonstrating compliance with the 100% supernumerary status described in safety action 5

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of the Maternity Incentive Scheme, and evidencing the frequency of which one to one care in labour is achieved. This data was used to calculate the provision of one to one care in labour. However, inconsistencies with populating the 4 hourly score card has resulted in unreliable data, prompting a return to using the individual midwife assessment of the provision of one to one care in labour completed on the Medway maternity information system. It is anticipated that Medway, cross referenced with red flag reporting on Safe Care, should provide a more reliable position moving forward.

2.3.1 Supernumerary labour ward co-ordinator status

The labour ward staffing model is as follows:

1 x Supernumerary Band 7 co-ordinator.

7 x Midwives including an additional Band 7 per shift.

1 x Obstetric Theatre practitioner. (This may be a theatre nurse or midwife).

Since the last bi-annual Midwifery staffing paper was presented to the Workforce Committee, there has been an increased frequency of the inability to roster a second Band 7 midwife on every labour ward shift. This in part, has been due to long term sickness within the co-ordinator group, mitigated by stopping the planned rotation of a co-ordinator into the Birth Centre to improve relationships and culture between the two areas.

A combination of a number of Band 7 co-ordinators reducing their contracted hours to 30-34.5 from 37.5, and the increased demand to support PROMPT faculty from within this group, has been identified as a contributory factor in covering the roster. Further action to mitigate this risk has been taken, and an additional 18 month fixed term post is currently being recruited to.

Despite the challenges covering the roster with a second Band 7, there has only been one recorded red flag incident on Safe Care, of the labour ward co-ordinator not achieving supernumerary status, for the total duration of one hour. It is acknowledged that reporting of Safe Care red flags has only been in place since November 2019, but prior to this was reported on Datix. There are no Datix reports between June and November 2019 suggesting that supernumerary status has been compromised. This indicates that supernumerary labour ward co-ordinator status is achieved almost 100% of the time.

2.3.2 Provision of one to one care in active labour and mitigation to cover any shortfalls

Table 3 below, demonstrates one to one care in labour rates taken from Medway for women giving birth on the labour ward and the birth centre between June and November 2019.

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Month	Labour Ward	Birth Centre	Total
June	68%	64%	67%
July	78%	77%	78%
August	62%	69%	64%
September	56%	65%	57%
October	63%	69%	64%
November	65%	64%	64%

Table 3

Consistently achieving one to one care for >90% of women in established labour is a key challenge for the service.

The contributory factors are:

- Increased staff sickness resulting in the need to redeploy midwives from other areas to maintain safe staffing levels on Labour Ward. This particularly impacts on the Birth Centre, who historically achieved high levels of one to one care, as they increasingly close beds from 7 to 5 and work with 2 rather than 3 midwives.
- Labour Ward Co-ordinators achieve almost 100% supernumerary status and do not act as the main care giver for women in labour, even when intrapartum activity is high. The rationale for this is to ensure that there is a focus on acuity and activity by a senior practitioner at all times, to maintain the safety of all women on the unit.
- Admission of women for induction of labour is not routinely delayed due to Labour Ward activity; therefore we often have more women than midwives on the labour ward. This is safer than delaying ongoing induction of labour and we have had no clinical harm as a result of this. However, prior to the induction of labour suite and close monitoring of women requiring induction of labour, in 2016/17 we did see harm as a result of delays.
- Current Labour Ward environment does not have an area to cohort women who require increased observation/care but are not in labour.
- Possibility that there is an inconsistent application of the one to one care in labour definition.
- As a unit we do not cohort postnatal women on the labour ward, if there are delays in beds becoming available on the wards. Women remain with the delivery midwife to preserve continuity and safety.

Existing mitigation in place includes completion of the amber escalation documentation, when there are concerns that staffing levels are insufficient to provide safe care to the

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number of women on the labour ward. Failure to achieve one to one care in labour has been included as a trigger to consider escalation in the updated escalation guideline.

One to one care for women in active labour is often not achieved due to the competing need to provide one to one care to high acuity, sick women who are not in labour. The designs for the planned maternity theatre rebuild include a 4 bedded area which will provide the ability to cohort women who have a clinical need to be on Labour Ward, but who do not require one to one care or are in labour. Building work is due to commence in spring 2020.

Birth Centre staff are frequently used to cover staffing shortfalls in other areas. Three midwives plus one maternity support worker is the current requirement for every shift, however the birth centre is generally the first area from where staff are redeployed to support other clinical areas. When the birth centre is taken down to two midwives, two rooms are closed; however this significantly affects the opportunity to provide one to one care if more than two women are in established labour.

The one to one care in labour definition was re-launched in December 2019, in an attempt to encourage all midwives caring for women in labour to use a consistent definition. This has been communicated at safety huddles and handovers. An audit of intrapartum notes will be undertaken in March 2020, to assess whether the definition has been embedded in practice.

Of note, there have been no complaints from women reporting that they felt they were left alone during labour or at a time when they were concerned during the last 6 months. Equally, there has been no indication that failure to provide one to one care in labour is a contributory factor in clinical incidents relating to Labour Ward. This supports the theory that one to one care is provided more frequently than midwives are recording. A risk assessment on the provision of one to one care in labour has been undertaken and is included as attachment 2.

2.4 Maternity Unit 'Closures'

There have been 18 occasions between June and November 2019, when the unit has declared the need to divert women to neighbouring organisations in order to maintain safety across the unit. 11 of the 18 occasions cited staffing issues as one of the contributory factors, demonstrating good application of the amber risk assessment tool and that Labour Ward co-ordinators are responsive to the issues which potentially compromise the safety of mothers and babies on the unit.

Of the 18 reported closures, there were 10 occasions when there was no requirement to divert women, and 2 occasions when other units were unable to accept. A total of 23 women were diverted to neighbouring organisations for assessment and/or intrapartum care on the remaining 6 occasions.

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3 Number of red flag incidents

The Maternity Incentive Scheme standard is that Trust Boards are sighted on the number of red flag incidents associated with midwifery staffing, reported in a consecutive six month time period within the last 12 months.

Incidents associated with midwifery staffing are reported via Datix and are investigated by the maternity risk and governance team. In the six month time period June 2019 and November 2019, there were 51 Datix reported incidents relating to midwifery staffing, 32 relating to unit escalation/closures and a proportion of these do not specify midwifery staffing as a contributory factor. All incidents were reported as no harm, and describe an inability to provide a level of care to the expected standard rather than physical harm or poor outcomes for mothers and babies. An inability to provide one to one care in labour due to midwifery staffing levels is most frequently reported by the Birth Centre.

During this reporting period there was 1 occasion when a woman was delayed in receiving an epidural for pain relief during labour. From November 2019, delay in epidural is recorded as a red flag incident rather than a Datix report, as it is a measure of quality rather than harm.

There have been no incidents requiring a level one investigation or serious incident (SI) report where midwifery staffing is directly cited as a causative or contributory factor, during the same time period.

In March 2019, labour ward co-ordinators commenced the 4 hourly acuity scorecard collections, and a number of red flag incidents were agreed as quality indicators. This method of collection was initially well received. However, inconsistencies with the quality and frequency of data collected by the co-ordinators were noted after 6 months, and it was agreed that this was not a user friendly or robust process. From 1st November 2019, red flag triggers are collected on the electronic SafeCare staffing and acuity tool including:

Labour Ward and Bradford Birth Centre:

- Failure to provide 1:1 care in labour.
- Number of women waiting >30 minutes for epidural.

Maternity Assessment Centre (MAC):

- Delay in transfer from MAC to Labour Ward.
- Delay in medical review.

For implementation in 2020, are red flags for the antenatal/postnatal inpatient wards including:

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- Number of women waiting augmentation/induction of labour for >12 hours.
- Delay in transfer from inpatient ward to Labour Ward.

Due to the timing of the bi-monthly midwifery staffing report, red flag data collected on Safe Care is only available for November and December 2019 as follows:

3.1 Red Flags Analysis-Maternity 1.10.19-20.12.19 (12 weeks)

3.1.1 Red Flags recorded

A 12 week look back has been completed (table 4 and figure 2) to view the use of red flags and further provide insight for teams of how the system can assist in recognising, reporting and viewing key safety indicators and actions to promote service safety and learning as part of positive safety culture building.

Area	Number of Red Flags	Week reported	Red Flag
Birth Centre	1	2	Delay in Epidural
Labour Ward	14	1, 5, 6, 7 2 3 9 2,3,4,5,6,7,9	Delay in Epidural Delay of >30 minutes for pain relief LW co-ordinator not supernumerary Shortfall in RN or RM Unable to provide 1:1 care in labour (see screen shot below)
MAC	2	6 12	Delay in Medical Review Delay in transfer to LW
Obstetric theatres	1	2	Shortfall in RN or RM

Table 4

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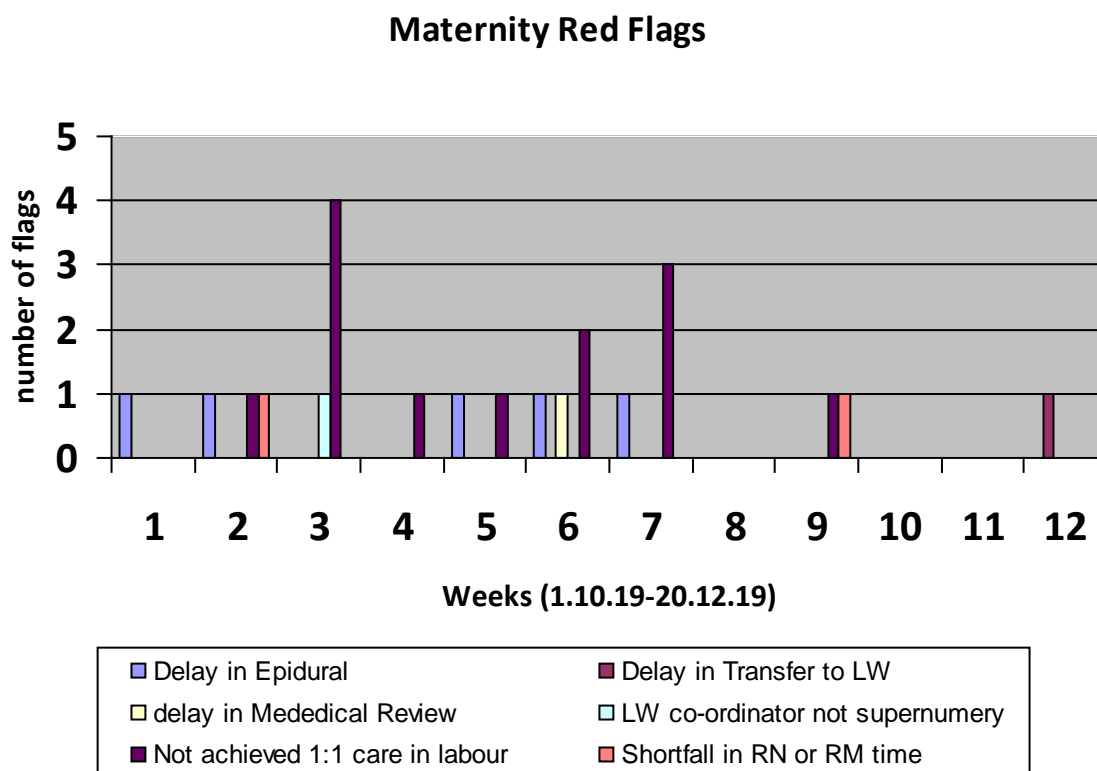


Figure 2

The service acknowledges that there are only 18 recorded red flag incidents in the 12 weeks since the tool has been implemented, making analysis of the themes and trends emerging difficult. To ensure that the system is embedded in practice, the service will review the populated data on a weekly basis initially until confident that all red flags are captured.

4 Challenges

4.1 Delivering Continuity of Carer

The national mandated target for women booked on a Continuity of Carer pathway in March 2020 is 35% and is not anticipated to be achieved despite progress being made during 2019 and further teams planned for 2020. All teams created so far are from within the current midwifery establishment and involve the same midwives caring for the same groups of women in a different way, with the exception of the Clover Team which is funded through the Big Lottery Fund. The pathways in place do not impact on the overall ability to safely staff the unit, although the Clover Team is protected from any redeployment during escalation due to the funding arrangements.

Continuity of Carer teams currently in place:

- Clover Personalised Midwifery case loading team (Funded by Better Start Bradford).

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-
- Home Birth team.
 - Gold Star (HIV)/Bradford Butterfly Pathway.
 - Teens.

The teams above have achieved 7.7% of women booked on a Continuity of Carer pathway in the last 6 months, against a target of 20%.

The following are further teams who have formed in the last month or are due to commence in early 2020, and who are anticipated to generate 16.5% against the 35% target.

- Willow Team (Birth Centre model).
- Acorn (Vulnerable women).
- Multiples.

A service redesign is essential to deliver the 35% and subsequent 51% and will have significant implications for the midwifery workforce, as well as a likely financial implication providing the evidence based community caseload model of 1:36 against the current caseload of around 1:90-100. A paper will be presented to the Workforce Committee in Quarter 4 describing the anticipated impact of the proposed continuity of carer plans on the midwifery workforce.

4.2 Sickness and Absence

The graph below (figure 3) demonstrates the long and short term sickness rates for the last 12 months. The November 2019 position for long term sickness has significantly improved following the return to work of a number of staff, 1 resignation due to ongoing health issues and a retirement. However, short term sickness rates peaked in November 2019, with a number of staff expected to fall into the long term sickness category during the next reporting period.

Actions taken to improve sickness and absence during the last 6 months include strengthening the reporting process. All staff now report sickness/absence into the 'Hot Desk' phone, which is held by a Band 7 midwife. Staff now expect to be asked a series of questions including, reason for absence and expected date of return. If staff chose not to disclose this information, they are informed that they will be contacted by the relevant line manager during the next working day for support and advice.

The service is confident that long term sickness and absence is appropriately and consistently managed by the matrons. However, it has been identified that further action is required around the management of staff with a persistent high Bradford Factor score, and that staff who demonstrate recurrent patterns of absence require closer monitoring and target setting.

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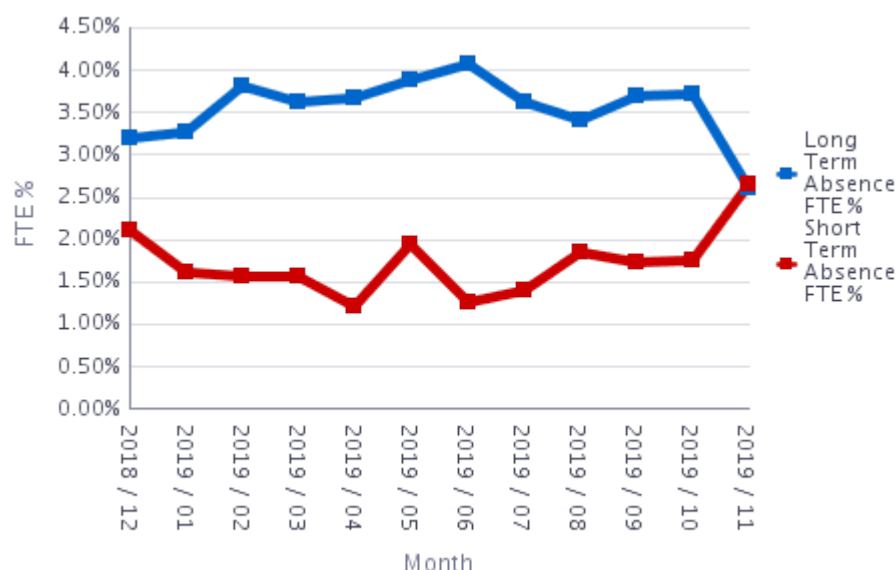


Figure 3

The table below (table 5) describes the top 3 reasons for absence for the year to date.

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S98 Other known causes - not elsewhere classified	81	93	2,506	26.1
S10 Anxiety/stress/depression/other psychiatric illnesses	41	46	2,108	22.0
S99 Unknown causes / Not specified	81	91	808	8.4

Table 5

Other known causes and unknown causes not specified as the main reasons for absence, makes targeted improvement work a challenge. The central reporting process and follow up by a line manager, described earlier, is intended to support the identification of specific causes of sickness and absence but is not having the desired effect.

A focussed piece of work with support from occupational health and human resource colleagues is urgently requested in the New Year. The Royal College of Midwives regional representative has already been approached for support with understanding the issues of its members and the wider workforce at Bradford.

5 Conclusion

The service believes that this report meets the Maternity Incentive Scheme required standard to demonstrate an effective system of midwifery workforce planning.

Applying the Birth Rate Plus methodology, supported by evidence from reported staffing incidents and data from SafeCare, has confirmed that the current midwifery establishment meets the needs of the service, with the exception of one to one care in labour. Furthermore, the continuing cycle of increased sickness and absence levels has had a significant impact

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on the ability to safely staff all areas of the maternity unit on a shift by shift basis, resulting in an increased frequency of maternity unit diverts/closures during the last 6 months. The inability to consistently achieve one to one care in labour has been identified as a significant concern by the CQC. The service recommendation therefore, is for an increase to the midwifery establishment of 5.22 WTE, which will enable an increase of one midwife per shift across the intrapartum floor.

Despite the staffing challenges, there have not been any complaints or clinical incidents where staffing has been identified as a contributory factor.

The collection of 'red flag' incidents on Safe Care commenced in November 2019 and whilst it is recognised to be working well, the service will closely monitor until assured that this system is embedded in daily practice and that incidents are robustly captured.

Additionally, it is anticipated that maternity leave will continue at current rates therefore to maintain staffing levels, we should over recruit by an additional 6.33 WTE.

6 Recommendations

- SLT / Workforce Committee is asked to note the report and the assurance this provides.
- SLT/Workforce Committee is asked to consider the request to increase the midwifery establishment by 5.22 WTE to enable an additional intrapartum midwife per shift.
- Birth Rate Plus Midwifery Staffing tool to be re-commissioned in summer 2020, noting the caveat that it does not take account of continuity of carer pathways.
- Audit to assess the consistency of which the one to one care in labour definition is applied (March 2020).
- Further work to address sickness and absence in collaboration with the Royal College of Midwives and the Human Resource department.
- Continue to recruit over establishment by 6.33 WTE to cover maternity leave.

Attached:

- Attachment 1: Risk assessment for midwifery staffing.
- Attachment 2: Risk assessment for one to one care in labour.
- Attachment 3: Midwifery Funded Establishment and Roster Configuration.
- Attachment 4: Heat Map 6 month trend.

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Attachment 1: Risk Assessment Template

Risk assessment number	3404 Version 3	Conducted by	C Stott Governance & Risk Lead Midwife S Hollins Head of Midwifery	Date	30.12.19					
Brief description of job/activity/objective being assessed		Maternity staffing issues due to long and short term sickness levels								
Site	Bradford Royal Infirmary	Location	Maternity Unit							
Step 1: Identify the hazards (Using bullet points write down here the potential hazards)										
Minimal staffing levels within all areas of the maternity services not achieved due to long and short term sickness levels.										
Source		Category								
Step 2: Decide who might be harmed and how (For each hazard you need to be clear about who might be harmed; it doesn't mean listing everyone by name, but rather identifying groups of people e.g. patients, nursing staff, porters, secretaries etc. and how they may be harmed)										
This could impact on: Patient safety and quality of care Ability to provide 1 to 1 care to all labouring women Possible closure of beds and services. Patients may require divert for care at another Trust Staff job satisfaction Maternity unit reputation										
Step 3: Evaluate the risk and decide on the existing precautions and decide if there is a need for further precautions. (Having spotted the hazards, you then have to decide what to do about them. Listing existing control measures here or note where the information can be found e.g. existing policies, procedures, work etc.)										
Existing control measures			Risk matrix							
Sickness policy Escalation policy Requests for Bank staff TNR and Agency			Impact /	Catastrophic	5	5	10	15	20	25
			Major	4	4	8	12	16	20	

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<p>Hot desk midwife Monday to Friday office hours to support risk assessments and staff movement On call senior midwife rota covers all unsocial hours. Senior midwifery management team Chief nurse team</p> <p>5.9.19 - Discussed at maternity core group. Risk remains the same. Sickness continues to be managed as per the sickness policy. 19 WTE midwives starting in October 2019. Maternity Sickness rates: April 5.23% YTD 4.95% May 6.69% YTD 5.16% June 6.57% YTD 5.43% July 7.25% YTD 5.80% Guidelines for sickness management have been sent to staff and managers Continuous risk assessment of the service. Redeployment of staff to ensure staff and patient safety maintained. Consider closure of beds and services to staff acute areas ie: Labour ward. Hot desk updates, staff encouraged to rely on senior on call midwife for help and support Staff letter to all to inform them of actions taking place to try and improve situation. Review sickness levels Review establishment figures/change list</p> <p>30.12.19 – Midwifery staffing at full establishment. Current sickness rates: November 2019 overall sickness rate 5.26% Short term sickness 2.66% Long term sickness 2.6% Existing control measures continue</p>								Moderate	3	3	6	9	12	15
								Low	2	2	4	6	8	10
								Negligible	1	1	2	3	4	5
Risk rating taking into account existing controls			Risk = Table 2 - Likelihood x Table 3 - Impact											
Likelihood	5	X	Impact	2	=	Risk rating	10							

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Rationale							
Target risk rating							
Likelihood	3	X	Impact	2	=	Risk rating	6
Rationale							

	Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain
	Table 2 – Likelihood / Probability				

Table 2 – Likelihood / Probability				
1	Extremely Unlikely	Less than 20%	Once every two years or more	Rare / Low
2	Unlikely	20% to 39%	Once a year	Unlikely / Low to Medium
3	Possible	40% to 59%	Once a Month	Possible / Medium
4	Likely	60% to 79%	Once a Week	Likely / Medium to High
5	Almost Certain	80% or more	Once a Day or more	Almost Certain / High

Table 3 – Impact / Severity			
1	Negligible	No / Minor Injury / Minimal loss / No time off work	Low
2	Low	Minor Injury / Some loss / 7 or Less days off / Some Damage	Low to Medium
3	Moderate	Injury / 7 or more days off / Damage / Loss / RIDDOR Incident	Medium
4	Major	Long term injury / irreversible injury / serious damage or loss / RIDDOR Incident	Medium to High
5	Catastrophic	One or more fatalities / irreversible injury / substantial damage or loss / RIDDOR Incident	High


Step 5: Risk reduction action plan <i>(Please list here what additional control measures are needed to reduce the risk to an acceptable level. You only need to complete this section when additional control measures are required)</i>				
Risk assessment number		Brief description		Date
Additional control measures required to reduce the risk to the lowest possible level:		Action owner/designation	Timescale	
Recruitment of 19 WTE midwives		S Hollins	complete	
Continue to manage staff as per the sickness policy		Maternity Matrons	Ongoing	
Produce and circulate guidelines for the management of sickness for staff and managers		A Hardaker	Complete	
Meeting with Regional RCM rep and Trust Human Resources department and		S Hollins	Feb 2020	

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Occupational Health for support					
Review compliance with attendance management policy to ensure that all staff with a high Bradford Factor are managed appropriately with effective monitoring and target setting.		S Hollins		February 2020	
Residual risk					
Anticipated residual risk rating <i>(Re-score your assessment based on the proposed additional control measures being implemented. This proposed / anticipated residual risk score will provide an indication of the potential / anticipated risk reduction that is likely)</i>				Date added to risk register*	
				31/05/2019	
				Date submitted to Risk.Assessments@bthft.nhs.uk Date initial review required	
Likelihood	3	X	Impact	2	= Residual risk rating 6
Decision to accept residual risk					
Designation				Name	

Risk reduction action guide							
Risk Rating			Action Level	*Risk register	Action time scale	Remedial Action Owner	Decision to Accept Risk
Green	Low	1 to 3	Observations	No	12 months or more	Ward / Department Manager	Ward / Departmental Management
Yellow	Moderate	4 to 6	Recommendations / Continuous Improvement	Yes	6 to 12 months	Care Group / Department Manager	Departmental Management
Orange	High	8 to 12	Further Additional Controls / Process, Task, Activity Review / Escalation	Yes	2 weeks to 6 months	Divisional Manager	Divisional Management
Red	Extreme	15 to 25	Major Review / Escalation / Prohibit	Yes	Immediate to 2 weeks	Executive Director	Executive Director via IG&R /Board

Attachment 2: Risk Assessment Template

Risk assessment number	V1	Conducted by	C Stott S Hollins	Date	30.12.19					
Brief description of job/activity/objective being assessed		Delivery of 1 to 1 care in labour								
Site	BRI	Location	Labour Ward							
Step 1: Identify the hazards (Using bullet points write down here the potential hazards)										
<p>There is a risk to quality of care in labour due to 1 to 1 care not being achieved.</p> <p>1 to 1 care rates during 2019 were 63-83%</p>										
Source		Category								
Step 2: Decide who might be harmed and how (For each hazard you need to be clear about who might be harmed; it doesn't mean listing everyone by name, but rather identifying groups of people e.g. patients, nursing staff, porters, secretaries etc. and how they may be harmed)										
<ul style="list-style-type: none"> Quality of Patient care could be compromised for both women and babies Women in established labour should have one-to-one care and support from an assigned midwife as this will increase the likelihood of the woman having a 'normal' vaginal birth without interventions, and will contribute to reducing both the length of labour and the number of operative deliveries (NICE, 2017, Intrapartum care). There is a reputational risk as women may choose to birth elsewhere Job satisfaction may be effected if a good standard of care is being provided. 										
Step 3: Evaluate the risk and decide on the existing precautions and decide if there is a need for further precautions. (Having spotted the hazards, you then have to decide what to do about them. Listing existing control measures here or note where the information can be found e.g. existing policies, procedures, work etc.)										
Existing control measures			Risk matrix							
<ul style="list-style-type: none"> Patient outcomes and experience is being monitored – There has not been 				Catastrophic	5	5	10	15	20	25

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<p>an increase in complaints or incidents where by 1 to 1 care is a contributory factor.</p> <ul style="list-style-type: none"> Red flag data is being collated and monitored on safe care – 6 red flags reported for delay in epidural and 7 for inability to provide 1 to 1 care in the last 8 weeks. Escalation policy is initiated when 1 to 1 care is not being achieved. Supernumerary status for labour ward coordinators is protected to provide support on the unit. The risk of protecting this has been deemed greater than the risk of not delivering 1 to 1 care. 24 hour Maternity assessment center Induction of labour suite Introduction and ongoing implementation of continuity of care models Dedicated theatre team 24 hours Hot desk midwife to support maintenance of safe staffing in clinical areas 							
Risk rating taking into account existing controls							
Likelihood	5	X	Impact	2	=	Risk rating	10
Rationale							
Target risk rating							
Likelihood	2	X	Impact	2	=	Risk rating	4
Rationale							

	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5
Risk = Table 2 - Likelihood x Table 3 - Impact			1	2	3	4	5
			Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain
			Table 2 – Likelihood / Probability				

Table 2 – Likelihood / Probability				
1	Extremely Unlikely	Less than 20%	Once every two years or more	Rare / Low
2	Unlikely	20% to 39%	Once a year	Unlikely / Low to Medium

Table 3 – Impact / Severity			
1	Negligible	No / Minor Injury / Minimal loss / No time off work	Low
2	Low	Minor Injury / Some loss / 7 or Less days off / Some Damage	Low to Medium

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3	Possible	40% to 59%	Once a Month	Possible / Medium	3	Moderate	Injury / 7 or more days off / Damage / Loss / RIDDOR Incident	Medium
4	Likely	60% to 79%	Once a Week	Likely / Medium to High	4	Major	Long term injury / irreversible injury / serious damage or loss / RIDDOR Incident	Medium to High
5	Almost Certain	80% or more	Once a Day or more	Almost Certain / High	5	Catastrophic	One or more fatalities / irreversible injury / substantial damage or loss / RIDDOR Incident	High

Step 5: Risk reduction action plan <i>(Please list here what additional control measures are needed to reduce the risk to an acceptable level. You only need to complete this section when additional control measures are required)</i>									
Risk assessment number		Brief description						Date	
Additional control measures required to reduce the risk to the lowest possible level:					Action owner/designation			Timescale	
To provide education to increase red flag reporting on safe care					Matrons			January 2020	
Re-launch 1 to 1 care in labour definition					C Stott			January 2020	
Audit of birth records to support accurate reporting of 1 to 1 care in labour					C Stott			April 2020	
Review red flag data on a weekly basis					Matrons			On going	
6 monthly staffing review submitted to board which recommends an increase in establishment of 1 midwife per shift (5.22 WTE) in the intrapartum areas					S Hollins			January 2020	
Residual risk									
Anticipated residual risk rating <i>(Re-score your assessment based on the proposed additional control measures being implemented. This proposed / anticipated residual risk score will provide an indication of the potential / anticipated risk reduction that is likely)</i>					Date added to risk register*				
					Date submitted to Risk.Assessments@bthft.nhs.uk				
					Date initial review required				
Likelihood	2	X	Impact	2	=	Residual risk rating		4	
Decision to accept residual risk									
Designation								Name	

Risk reduction action guide						
Risk Rating	Action Level		*Risk register	Action time scale	Remedial Action Owner	Decision to Accept Risk
Green	Low	1 to 3	Observations	No	12 months or more	Ward / Department
						Ward / Departmental

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						Manager	Management
Yellow	Moderate	4 to 6	Recommendations / Continuous Improvement	Yes	6 to 12 months	Care Group / Department Manager	Departmental Management
Orange	High	8 to 12	Further Additional Controls / Process, Task, Activity Review / Escalation	Yes	2 weeks to 6 months	Divisional Manager	Divisional Management
Red	Extreme	15 to 25	Major Review / Escalation / Prohibit	Yes	Immediate to 2 weeks	Executive Director	Executive Director via IG&R /Board

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Attachment 3: Midwifery funded establishment and roster configuration

Midwifery funded establishment and roster configuration 24 hour services			
Staff groups	Funded establishment	Numbers Day shift 08.00-20.30	Numbers Night Shift 20.00-08.30
Labour Ward			
Midwives Supernumerary Coordinator	5.22 Band 7	1	1
Midwives	6.63 WTE Band 7 31.32 WTE Band 5/6 Midwives	1 Band 7 6 Band 5/6	1 Band 7 6 Band 5/6
Midwifery care support staff (Band 2 and 3)	11.41 WTE (including elective theatre cover)	2	2
Labour Ward Theatres			
Midwives	2.49 WTE band 5/6	2 x Mon – Friday 8am – 4pm	0
Scrub (a combination of registered nurses and midwives)	7.66	2 x Mon – Friday 8am – 4pm 4pm – 8pm x 1 Saturday and Sunday x 1	1
Contributions to Non Labour Ward activity (PROMPT NIPE)			
Midwives	2.21	Ad hoc	
Total	66.97 WTE	14 (11)	11

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Midwifery funded establishment and roster configuration 24 hour services			
Staff groups	Funded establishment	Numbers Day shift 08.00-20.30	Numbers Night Shift 20.00-08.30
Birth centre			
Midwives	2.92 WTE Band 7 midwives 15.5 WTE Band 5/6 Midwives	3	3
Midwifery care support staff (Band 2 and 3)	5.48 WTE Band 2/3	1	1
Total	23.9	4	4
Maternity Assessment Centre			
Midwives	1 WTE Band 7 12.5 WTE Band 5/6	2 Early shift 3 Late shift	2
Midwifery care support staff (Band 2 and 3)	5.44 WTE Band 2/3	1	1
Total	18.94	3 Early 4 late	3
M3 – Includes Induction of Labour Suite			
Midwives	1 WTE Band 7 26.5 WTE Band 5/6 (including IOL Suite staffing)	6	4
Midwifery care support staff (Band 2 and 3)	5.22 WTE Band 2/3	1	1
Total	32.72	7	5
M4			
Midwives	1 WTE Band 7 16 WTE Band 5/6	4	2

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Midwifery care support staff (Band 2 and 3)	13.05 WTE Band 2/3	3	2
Total	30.05	7	4

Other services

Funded establishment	Provision
Community Midwifery	
2 WTE Band 7 45.5 WTE Band 5/6 6.46 WTE Midwifery care support staff Band 3	Community Midwifery Services covers a wide geographic patch. The service is managed by 2 WTE Community Clinical Midwifery Managers.
Total: 53.96	
Antenatal Clinic and Antenatal Day Unit	
0.8 WTE Band 7 11.28 WTE Band 5/6 3.56 WTE Midwifery care support staff Band 2/3	Antenatal Clinics - provide a service for those women requiring consultant obstetric opinion. This area is supported by midwives based in ANC and ANDU.
Total: 15.64	
Specialist Midwives	
Band 6/7	Risk and Governance Midwife Specialist Midwife for Quality Midwifery Practice Specialist Midwife for Professional Development Specialist Midwife for Bereavement Specialist Midwife for Antenatal and Newborn Screening Specialist Midwife for Safeguarding Associate Specialist Midwife for Safeguarding Specialist Midwife for Teenage Pregnancy Specialist Midwife for Infant Feeding Specialist Midwife for Continuity of Care Specialist Midwife for Perinatal Mental Health
Total: 10.72	

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Attachment 4: Maternity Heat Map June 2019 to November 2019

		Patient feedback			Harms								Absence and Turnover		Staffing								Ward Accreditation Score
					Falls with harm			Pressure Ulcers			Infection control				Day		Night		Care Hours Per Patient Day (CHPPD)				
Ward	Month	Compliments	Complaints	FFT recommended	No harm	Low	Moderate	Category 2	Category 3	Category 4	MRSA	C.Diff	Cumulative % Abs Rate (FTE)	LTR FTE %	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
M3	Jun-19	0	0	100	0	0	0	0	0	0	0	0	11.1	16.1	76.2	41.1	83.4	90.1	726	4	0.9	4.8	Aug-18
	Jul-19	0	0	100	0	0	0	0	0	0	0	0	11.1	16.3	83.7	101.7	75.6	116	579	5.2	1.9	7	Aug-18
	Aug-19	0	0	100	0	0	0	0	0	0	0	0	19.5	16.4	68.4	95.6	72.6	92.6	598	4.4	1.2	5.6	Aug-18
	Sep-19	0	0	97	0	0	0	0	0	0	0	0	13.5	16.7	75.4	79.8	70.9	98.7	599	4.4	1.1	5.5	Aug-18
	Oct-19	0	0	92	0	0	0	0	0	0	0	0	14.7	17.1	67.1	90.2	72.7	93.9	542	4.8	1.3	6.1	Oct-19
	Nov-19	0	0	100	0	0	0	0	0	0	0	0	16.3	8.3	76.9	86.9	76.6	101.9	623	4.4	1.1	5.5	Oct-19
M4	Jun-19	0	1	94	0	0	0	0	0	0	0	0	7.1	18.4	84.9	97.4	95.2	103.2	1009	1.9	1.4	3.3	Aug-18
	Jul-19	0	0	92	0	0	0	0	0	0	0	0	7.1	10.6	94.3	106.8	87.4	101.6	440	4.6	3.8	8.4	Aug-18
	Aug-19	0	0	88	0	0	0	0	0	0	0	0	6	10.4	90.6	92.8	88.8	97.9	495	4	3.6	7.6	Aug-18
	Sep-19	0	0	98	1	0	0	0	0	0	0	0	2.7	3.9	94	94	85.2	101.6	457	4.2	3.8	8	Aug-18
	Oct-19	0	0	97	0	0	0	0	0	0	0	0	3	3.9	100	90.8	100.1	100.1	457	4.7	3.8	8.5	Aug-18

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	Nov-19	0	0	93	0	0	0	0	0	0	0	0	2.9	3.8	97.9	84.5	108.3	101.7	457	4.7	3.6	8.3	Aug-18
BC	Jun-19	0	0	100	0	0	0	0	0	0	0	0	7.6	19.2	86.1	91.9	85.4	100.3	73	25	10.2	35.1	Jun-18
	Jul-19	0	0	100	0	0	0	0	0	0	0	0	6.4	18.7	96.7	85	83.7	91	91	21.9	7.4	29.2	Jun-18
	Aug-19	0	0	100	0	0	0	0	0	0	0	0	12.8	18.3	86.6	87.3	77.7	90.6	99	18.3	6.6	24.9	Jun-18
	Sep-19	0	0	98	0	0	0	0	0	0	0	0	5.4	17.6	75.3	104.6	73.6	95.1	88	18.1	8.2	26.3	Jun-18
	Oct-19	0	0	100	0	0	0	0	0	0	0	0	5	10.8	78.5	103.5	80.1	94.1	103	16.9	7	23.9	Jun-18
	Nov-19	0	0	100	0	0	0	0	0	0	0	0	4.8	10.6	86	85.1	69.1	87.1	91	18.3	7.1	25.4	Jun-18
LW	Jun-19	0	1	100	0	0	0	0	0	0	0	0	6.3	10.2	92.1	-	100.2	-	325	12.6	0	12.6	Jun-18
	Jul-19	0	0	100	0	0	0	0	0	0	0	0	6.6	10.2	84.8	-	87.3	-	274	13.8	0	13.8	Jun-18
	Aug-19	2	0	100	0	0	0	0	0	0	0	0	9.8	13.5	102.2	-	93.9	-	330	12.8	0	12.8	Jun-18
	Sep-19	0	0	100	0	0	0	0	0	0	0	0	4.4	10.7	98	-	99.1	-	325	12.7	0	12.7	Jun-18
	Oct-19	0	0	100	0	0	0	0	0	0	0	0	5	10.8	98.5	-	95.7	-	292	14.5	0	14.5	Oct-19
	Nov-19	0	0	98	0	0	0	0	0	0	0	0	4.8	10.6	104.2	-	104.3	-	300	14.6	0.1	14.6	Oct-19