

## **BI-ANNUAL MIDWIFERY STAFFING REPORT, SEPTEMBER 2021**

### **Background:**

This is the second of the bi-annual midwifery staffing reports for 2021, and follows the January 2021 paper presented to Trust Board. This paper is presented as an appendix to the Nursing and Midwifery staffing report and includes the Birth Rate Plus Workforce Report and Recommendations as an appendix, following completion of the Birth Rate Plus midwifery workforce review, undertaken between November 2020 and January 2021.

The January 2021 paper concluded that the midwifery establishment reported, met the needs of the service based on the 2017 Birth Rate Plus report and subsequent Birth Rate Plus 'table top' reviews, and did not recommend any increase to the agreed funded establishment. However, the report was presented with the caveat that an up to date Birth Rate Plus review was being undertaken at the time, and that professional judgement predicted that an increase to the establishment would undoubtedly be a key recommendation.

The reporting period January to June 2021 includes the continued management and impact of the global pandemic, Covid-19 on the maternity service. The revised Maternity Incentive Scheme (MIS) year 3, Safety action 5, specifically asked that the impact of Covid-19 on midwifery staffing levels was considered as part of the bi-annual midwifery staffing report. Although the recently published, MIS, Year 4, safety action 5, does not request this information, narrative has been included due to the continued pressures of the ongoing pandemic.

The purpose of this report is also to evidence:

- A systematic, evidence-based process to calculate midwifery staffing establishment
- The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
- All women in active labour receive one-to-one midwifery care

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.

## **Current Midwifery staffing position and challenges:**

The Midwifery staffing position between January and June 2021 has deteriorated towards the latter end of the reporting period. This in part was due to the annual drop in attrition during the summer months, when annual leave is at a premium and the service awaits the commencement of newly qualified midwives (NQM). Following the removal of the national restrictions of lockdown, the staffing position was directly compounded further by short term sickness and absence due to Covid-19 related issues, including an increase in the number of staff acquiring Covid from household members who have returned to 'normal routines', self-isolation whilst awaiting PCR results of household members and a moderate number of staff who remain on long term sick leave as a consequence of long Covid. The continued recommendation that pregnant women over 28 weeks gestation should not be patient facing, and a number of staff who are clinically vulnerable and remain non-patient facing, has also contributed to staffing pressures. In addition, there are a number of midwifery staff who are diagnosed with 'long Covid' and remain absent from the work place.

It must also be acknowledged that staff are stressed, tired and have reduced resilience as a result of the continued pandemic, which not only affects short term absence, but also the uptake of bank shifts. However, it must also be noted that the midwifery and support staff in maternity have responded positively to the incentivised TNR rates during late summer.

Birth Rate Plus was completed during this reporting period and the recommendation was that the service requires an increase to the establishment of 32.2 WTE midwives to achieve continuity of carer as a default pathway for all women.

It must be stressed that whilst this is our ultimate goal, and has been supported by funding from the National Maternity Staffing bid, Birth Rate Plus identified that in order to maintain a safe service on the current pathways and models of care, an increase of 12.54 WTE midwives is required. This is the immediate recruitment priority.

The service is expecting approximately 20 WTE newly qualified midwives to commence their careers at BTHFT in October 2021. In addition to this there are a further 5 band 6 midwives joining the team in the next few months.

The service was successful in achieving funding for 32.2 WTE midwives, and following the first recruitment drive described above there are a further 23 WTE midwives yet to be recruited to achieve the recommended increase to the establishment.

Further band 5 and 6 interviews will take place in September and adverts for midwives with a special interest in diabetes, perinatal mental health and smoking cessation, are due to be released imminently.

The Director of Midwifery is also considering other recruitment strategies including International Recruitment and return to practice placements.

Obstetric theatre

There are no current vacancies within the obstetric theatre agreed establishment. A band 6 theatre lead is now in post to provide leadership in this area.

### **Calculation of midwifery staffing establishment:**

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

- Birth Rate + 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 including mitigation to cover shortfalls.

### **Birth Rate + tool methodology:**

Birth Rate + exists as the only recognised tool to calculate midwifery staffing levels, and was commissioned in November 2020, with a report being received in May 2021 (Appendix 2a). A summary of the report and recommendations was presented to Executive Team Meeting in May 2021. Following the successful National Maternity Funding bid, the Birth Rate Plus recommendation paper has been revised and is attached as appendix 2b.

The Birth Rate Plus recommended increases to the existing midwifery workforce of 247.56 WTE are displayed in table 1. The minimum increase required to provide a safe service based on the existing pathways and models of care is 12.54 WTE. This increase will enable the service to increase the night time staffing levels on the 2 maternity inpatient wards, which was identified as an area of concern by the Maternity Support Programme team. The increase of 5.22 WTE across both wards has been added to the roster line as bank shifts in the interim, until the new starters are in post and the ward establishments can be formally uplifted.

To achieve continuity of carer pathways for all women as a default position, an increase of 32.21 WTE is required.

Table 1:

	<b>Birth Rate Plus Bands 3-8 WTE</b>	<b>Current      Funded WTE Bands 3-8</b>	<b>Variance</b>
<b>Core Services and with Continuity    Teams at 29%</b>	260.10	247.56	-12.54
<b>Core Services and with Continuity    Teams at 100%</b>	279.77	247.56	-32.21

Year 4 of the Maternity incentive Scheme requires the bi-annual staffing review to include the percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

We have a current (not including Ockenden uplift) establishment of 247.56 of which 23.64 are 'Additional Senior Management and Specialist Midwives' which is 9.50% (including ward manager non-clinical time).

The National Maternity Funding bid will enable the recruitment of 32.2 WTE midwives, achieving the Birth Rate Plus recommendations to achieve 100% continuity of carer. If we are unable to recruit the full amount by the end of the 2021/22 financial year, the funds will be returned unspent. The service asks that Trust Board will commit to funding the Birth Rate Plus recommended increase to establishment. Evidence of this commitment is required as part of the Ockenden assurance process.

If this occurs, the priority will be to ensure that the recommended increase of 12.54 WTE is achieved, in order to maintain a safe service in core areas and deliver up to 29% continuity of carer pathways.

Table 2 demonstrates the anticipated staffing position following the appointment of newly qualified midwives (NQM) in October 2021, and the additional recruitment needed to meet the Birth Rate Plus recommendations.

Table 2:

	Establishment	Vacancy	October position
Current establishment	247.56	10.47	+8.89
BR+ recommendation to maintain safe services on current pathways and models of care	260.10	23.01	-3.65
BR+ recommendation to achieve 100% continuity pathways	279.77	42.68	-23.32

As already mentioned, the immediate recruitment priority is to increase the establishment by 12.54 WTE in order to maintain safe services based on existing pathways and models of care. The 19.36 WTE NQM expected to commence in post in October 2021, leaves a variation of -3.65 WTE. With additional recruitment plans the service has a high level of confidence that the variance will be achieved, and until then this is a tolerable risk which will be managed within the existing escalation and flow processes.

However, it must also be acknowledged that in order to roll out the training and 'go-live' for CERNER maternity EPR, 7 WTE are required to release midwives to learn how to use the system.

There is less confidence that the additional 23.32 WTE required to achieve continuity of carer as a default position for all women, will be achieved during financial year 2021/22. An updated position, mitigation and further recruitment plans, will be shared in the January 2022 bi-annual midwifery staffing report.

#### **Midwife to Birth ratio:**

Based on the current agreed establishments of 247.56 WTE midwives, we aim for 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 3):

Jan 2021	Feb 2021	March 2021	April 2021	May 2021	June 2021
1:24.1	1:24.2	1:24.3	1:23.0	1:23.7	1:23.5

Table 3

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. Please note that this ratio is based on the previous agreed establishment, not on the increased establishment recommended by Birth Rate Plus.

### **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. Collection of this data was suspended nationally during Covid. Where staffing levels fall below planned, mitigation includes the redeployment of staff, including specialist midwives, to cover shortfalls. Beds are also reduced if necessary to maintain safe staffing levels. If these actions are insufficient, the maternity escalation policy is triggered and unit 'divert' declared.

### **Supernumerary labour ward co-ordinator status and the provision of one to one care in labour:**

#### **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).

There have been no reported cases of failure to achieve supernumerary labour ward co-ordinator status, through Datix and similarly no 'Red Flags' recorded on Safe Care during the 6 months January to June 2021 suggesting that supernumerary status is achieved consistently 100% of the time.

### **Provision of one to one care in active labour and mitigation to cover any shortfalls:**

Table 3 below, demonstrates the monthly one to one care in labour rates taken from Medway and validated by the labour ward co-ordinators from January to June 2021.

Table 3

MONTH	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
<b>TOTAL</b>	98%	96%	93%	97%	96%	93%

Consistently achieving one to one care for >90% of women in established labour has been a key challenge for the service, and was highlighted as a concern during the November 2019

CQC inspection. As the table above demonstrates, there has been a continued, sustained improvement in the rates achieved during the last 6 months. One to one care is monitored monthly on the maternity dashboard and exception reported to Regulation Committee if the rate is below 90%.

### **Maternity Unit 'Closures'**

The CQC were concerned by the number of maternity unit closures reported in the 12 months prior to the November 2019 inspection. The NHSE/I Maternity Support Programme team also identified the number of units diverts as an area requiring further attention.

Historically, Bradford maternity services rarely 'closed' to admissions, instead managing increased workload and acuity of complex women at the expense of providing one to one care in labour and potential compromise of safety, which generated concern during the 2016 Maternity Quality Summit. The service has worked hard over the last 3 to 4 years to change the culture around unit escalation, and was disappointed with the CQC assessment that the number of closures reported was excessive.

The decision to divert maternity services is often complex, multifactorial and never taken lightly. Whilst midwifery staffing levels do trigger a need to divert on some occasions, this is never the single root cause and is usually combined with increased admissions to the intrapartum areas and high levels of acuity and complexity.

In the reporting period, January to June 2021, there were 9 diverts and a further 2 occasions where the need to divert was declared but the unit remained open due to neighbouring organisations being unable to accept admissions. It must also be stated that of the 9 diverts reported there were a number of occasions where women requiring intrapartum care were diverted to other services but some women requiring antenatal care and assessment but not intrapartum care were continued to be seen at BTHFT.

Unfortunately, there is no regional or national data available to act as a comparator and indicate whether or not BTHFT is an outlier in this area.

However, due to concerns escalated by the Regional Heads and Directors of Midwifery regarding the staffing challenges as a direct result of the ongoing pressures of Covid-19, the Regional Chief Midwifery Officer initiated a daily (Monday to Friday) maternity sitrep in August, which includes information regarding unit divert status. This has not been collated as yet, but should provide a more accurate picture of diverts occurring across the region.

The Director of Midwifery and senior midwifery leadership team, have reflected on the concerns raised by the CQC and Maternity Support Programme team and have reviewed the escalation process. During 'office hours' there has been a stepped change in how the service utilises non-clinical midwifery staff to support clinical areas, which has prevented diverts on numerous occasions. It must be noted that this does impact on the individual work load of the specialist midwives, but the priority is the provision of safe staffing levels and clinical care.

Table 4 is a monthly break down of the diverts/attempted diverts.

MONTH	NUMBER OF DIVERTS	NUMBER OF ATTEMPTED DIVERTS	RUNNING TOTAL
JANUARY	1	0	1
FEBRUARY	0	0	1
MARCH	6	0	7
APRIL	1	0	8
MAY	0	1	8
JUNE	1	1	9

#### **Number of red flag incidents:**

The Maternity Incentive Scheme, Year 4, safety action 5 has been revised and the recommendation is now that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.

The January 2021 paper reported an improvement in the culture and recording of red flag incidents, particularly within the labour ward setting. This has continued during the current reporting period.

The midwifery matrons have also worked intensively with other clinical areas within the maternity service, to resolve access and permissions issues and embed the positive culture further. This is not reflected in this reporting period, but early indications are that data beyond June 2021 suggests that other areas are now routinely reporting red flags relevant to their areas, which will be included in the January 2022 bi-annual paper.

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 January to June 2021 there were 34 reported incidents where 'staff' or 'staffing' were mentioned in the narrative.

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. The 34 reported Datix includes the 11 unit 'diverts/attempted diverts' already described and the majority of other Datix describe the occasions where staff were redeployed to enhance safety in a variety of clinical areas.



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

Red Flag incidents are reviewed daily (Monday to Friday) by the midwifery matrons. From September, red flag reports will be included as a standing agenda item at the monthly CBU Business meeting with any concerns reported to Women's Core Governance group by exception.

### **Agreed Red Flags:**

Labour Ward and Bradford Birth Centre:

- Failure to provide 1:1 care in labour.
- Number of women waiting >30 minutes for epidural.
- Failure to achieve supernumerary labour ward co-ordinator status.

Maternity Assessment Centre (MAC):

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

Antenatal/Postnatal inpatient wards:

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

Community midwifery and antenatal clinic do not currently use Safe Care due to their outpatient/session based working with high variance in cover and activity requirements.

There were 39 Red Flag incidents recorded on Safe Care, January to June 2021.

- 18 shortfall RM time
- 12 unable to provide 1:1 care in labour
- 6 delay in transfer
- 2 delay in clinical review
- 1 delayed/cancelled critical activity

### **Conclusion:**

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

The completion of the 2020/21 Birth Rate Plus acuity tool and subsequent report provided in April 2021, has enabled the service to have an up to date calculation of the midwifery establishment required to provide a safe service based on existing pathways and models of care, and the establishment required to achieve continuity of carer as a default position for all women. The timing of the report informed the national maternity funding bid, and the service received funding for 32.2 WTE midwives as a result of the information provided.

The immediate priority is to recruit the initial 12.54 WTE required to maintain a safe service, 5.22 WTE of which will be used to uplift the inpatient night time ward staffing levels. There is a high level of confidence that sufficient midwives will be recruited to enable this before the end of the 2021/22 financial year.

Achieving the remaining 23.32 WTE required to achieve 100% continuity of carer will be a bigger challenge, and recruitment plans include international recruitment and how we can attract return to practice midwives and develop the midwife apprentice role. Progress on this will be included in the January bi-annual paper.

The supernumerary status of labour ward co-ordinators is fiercely protected and is consistently 100%.

The report continues to evidence a sustained improvement in the monthly one to one care in labour rates of >90%.

The collection of Red Flag incidents on Safe Care, inputted by the labour ward co-ordinators, has continued to improve. The January 2022 paper will evidence the work undertaken in this reporting period to embed the culture and reporting of red flags in other clinical areas within maternity. .

The Covid-19 pandemic has impacted on midwifery staffing levels to varying degrees during the reporting period January to June. However, this has never been to a critical point and has been managed using the established amber escalation process. The service believes that the Executive decision not to redeploy the midwifery workforce to other areas of the organisation has had a positive impact on maintaining safe midwifery staffing levels throughout the pandemic.

### **Recommendations:**

- Trust Board is asked to note that Birth Rate Plus recommended that the minimum increase to the midwifery establishment required to provide a safe service based on the existing pathways and models of care is 12.54 WTE.
- Trust Board is asked to note that Birth Rate Plus recommended that to achieve continuity of carer pathways for all women as a default position, an increase of 32.21 WTE is required.

- The service asks that Trust Board will commit to funding the Birth Rate Plus recommended increase to establishment. Evidence of this commitment is required as part of the Ockenden assurance process.
- Trust Board is asked to note that an increase of 5.22 WTE across both inpatient wards has been added to the roster line as bank shifts in the interim, until the new starters are in post and the ward establishments can be formally uplifted. This is to improve night time staffing levels in response to NHSI/E.

Appendices:

- Appendix 2a: The Bradford Teaching Hospitals\_Birthrate Plus Final Report\_29.04.2021
- Appendix 2b : Birth Rate Plus Midwifery Workforce Report and Recommendations Update Following National Funding Bid, August 2021