Appendix 9

Bradford Teaching Hospitals
NHS Foundation Trust

BI-ANNUAL MIDWIFERY STAFFING REPORT, MARCH 2022

Background:

This is the first of the bi-annual midwifery staffing reports for 2022, and follows the September 2021 paper presented to Trust Board. This paper is presented as an appendix to the Nursing and Midwifery staffing report.

In addition to the bi-annual midwifery staffing reports, Trust Board has been appraised of the midwifery workforce position on a monthly basis, as part of the Maternity and Neonatal Services reporting process.

It must be noted that the paper presented in September 2021, was based on the reporting period January to June 2021, and was delayed in reaching Board in order that presentation of the overarching nursing paper and the midwifery paper were synchronised. This explains why the current reporting period includes data for 8 months rather than 6 months.

The September 2021 paper concluded that the services immediate priority was to meet the 2021 Birth Rate Plus report recommendations of a 12.52 whole time equivalent (WTE) increase to the midwifery establishment, required to maintain safe services based on the acuity and risk categorisation of Bradford women and the existing pathways of care.

The second priority was to work towards a further increase of 20 WTE midwives in order to achieve midwifery continuity of carer (MCoC) as a default position for all women.

Board was supportive of the recommendations including the increases to establishment.

The previous bi-annual midwifery staffing reports also include recommendations required to meet the Royal College of Midwives (RCM) Leadership Manifesto, which in turn is an Ockenden 2020 assurance compliance.

Board was again, supportive of the recommendations regarding midwifery leadership.

The reporting period July 2021 to February 2022 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 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 has remained challenging between July 2021 and February 2022. Despite significant financial investment from National Maternity Transformation funding bids, the service has struggled to recruit the required increase to the midwifery workforce establishment. This is a result of a well-publicised, national midwifery shortage, and the pressure on midwifery recruitment as all NHS maternity providers undertake Birth Rate Plus to meet Ockenden compliance, resulting in required increases to the majority of midwifery establishments. This has been noted across the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS), with the majority of our neighbours identifying significant increases to midwifery staffing. This has made, and will continue to make, recruitment extremely challenging during 2022/23, as all organisations are vying for the same cohort of newly qualified and existing midwives.

The maternity service has been pro-active in advertising and recruiting to vacancy attributed to expected annual attrition, in addition to working towards a further increase of 12.52 WTE Despite the offer of innovative, bespoke, midwifery roles, recruitment of experienced midwives has been limited.

As a result of this, the service has increased the number of Maternity Support Workers (MSW) in the clinical areas. This is not intended to replace midwives with non-registrants, but has been an attempt to release midwifery time and provide additional support to women and babies in key areas including infant feeding.

International Midwifery Recruitment is being actively pursued during 2022/23, following a successful funding bid from Health Education England (HEE).

Covid 19:

Midwifery and maternity staff sickness and absence rates have remained high, with the continued requirement for staff to self-isolate due to household contacts, until a negative PCR is confirmed, and an increased number of staff with positive lateral flow results.

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. A proportion of staff continue to respond to incentivised bank rates, but on occasions this has not been sufficient to maintain optimum staffing ratios in all areas.

Safety has been maintained across all areas of the unit by daily redeployment of staff, flexing inpatient beds to preserve safe staffing ratios, use of non-clinical and specialist midwives to support clinical areas. This is managed by the daily Maternity Bed Manager, which has been extended to cover weekend shifts by those willing to pick up bank shifts. The escalation policy is then implemented in situations where activity and acuity is higher than staffing levels can support, diverting, as a last resort, women where appropriate and possible.

Additional measures to improve safe staffing levels in Community Midwifery have also been implemented including the suspension of specialist midwife support roles, suspension of the intrapartum element of some continuity of carer teams, and the temporary pause of the Outstanding Maternity Service programme to release clinical hours.

It must also be noted that this reporting period includes the preparation for Maternity Cerner go live, requiring the release of staff for training which was achieved, but with additional pressure on staffing.

Obstetric theatre

There are no current vacancies within the obstetric theatre agreed establishment. The theatre team currently includes midwives and the service is actively trying to recruit theatre nurses to release the midwives in that team back to the midwifery pool.

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 a full review was commissioned in November 2020, with a report being received in May 2021 A summary of the report and recommendations was presented to Executive Team Meeting in May 2021.

A Birth Rate Plus table top review was completed in early April 22, this review assumed that the case mix of Bradford Teaching Hospitals NHS Foundation Trust had remained but was recalculated to reflect the change in the annual birth rate from 5370 to 5135. The recommendation of 10% non-clinical and management roles has also been incorporated into the desk top tool.

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 10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

We have a current establishment of 245.62 of which 19 are 'Additional Senior Management and Specialist Midwives' which is 7.70% (including ward manager non-clinical time). This falls below the recommended percentage.

Table 1

	BIRTHRATE PLUS 2022 WTE Bands 3 to 8	**VARIANCE** Feb 22 position of midwifery vacancy
Current funded position	279.77	-34.15
Core Services and with Continuity Teams at 29%	253.35	-7.73
Core Services and with Continuity Teams at 35%	255.52	-9.9
Core Services and with Continuity Teams at 51%	263.49	-17.87
Core Services and with Continuity Teams at 100%	272.30	-26.68

Following the recent publication of the 2nd Ockenden report into failings at Shrewsbury and Telford, there has been increased debate and discussion regarding the continued national maternity transformation plans for midwifery continuity of carer (MCoC) to be the default position for all women.

The message from National Maternity leaders is clear that MCoC should not be considered until safe staffing levels are achieved. However, achieving MCoC as a default position remains the overarching ambition. The Maternity Service at BTHFT has adopted this position over the last 6-12 months and at the current time has no intention to progress any new continuity teams or pathways.

Instead, the priority is to achieve the 253.35 WTE Birth Rate + have assessed as required to provide safe staffing levels based on existing MCoC pathways and models of care. The current vacancy against this figure is -7.73 WTE which will increase with usual attrition rates between now and newly qualified midwife appointments in October.

The second priority for 2022/23 will then be to recruit a further 2.17 WTE required to achieve 35% MCoC in addition to safe staffing, gradually working towards the number required to achieve 51% MCoC.

Consideration as to whether 100% MCoC is a realistic and safe goal will take place in 2023/24.

It is felt that this incremental approach is realistic and more achievable in the current midwifery staffing shortage

Trust Board is asked to continue to support the long term commitment made in 2021 to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE. The table top calculation for this paper, based on a decreased birthrate is 272.30 WTE, but it must be noted that if the birthrate increases or decreases further in 2022 this figure may change again.

Midwife to Birth ratio:

Based on the current agreed establishments of 248.09 WTE midwives, we aim for a midwife to birth ratio of 1:20.1. 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 eight month period is as follows (Table 2):

July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022
1:23.8	1:23.9	1:23.8	1:23.7	1:23.1	1:22.8	1:22.3	1:22.5

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 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. 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:

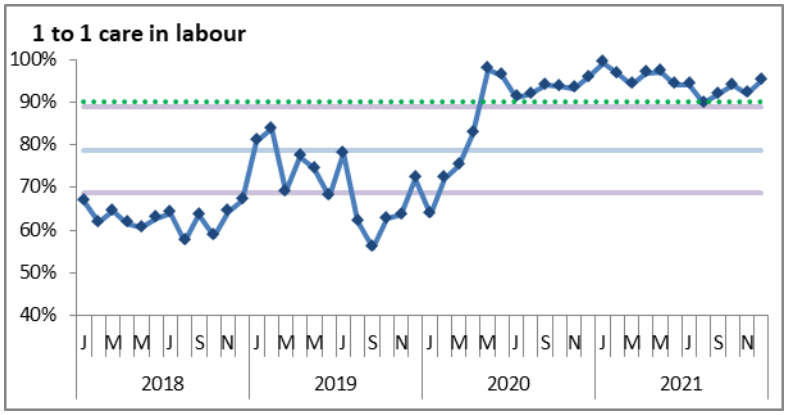
- 1 x Supernumerary Band 7 co-ordinator.
- 7 x Midwives including an additional Band 7 per shift.
- 1 x Obstetric Theatre practitioner. (This may be a theatre nurse or midwife).

There have been 6 reported Red Flag cases of failure to achieve supernumerary labour ward co-ordinator status, recorded on Safe Care during the 6 months July 2021 to February 2022 suggesting that supernumerary status is achieved consistently almost 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 July 2021 to December 2021. January and February data is not available in this format, but has remained over 90%.

Table 3



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 since April 2020. The service considers this to be a significant achievement given the staffing challenges experienced during the pandemic. One to one care is monitored monthly on the maternity dashboard and exception reported to Regulation Committee if the rate is below 90%.

The change from Medway to Maternity Cerner EPR is anticipated to result in some data quality issues regarding the reporting of 1:1 care in labour. This is due to a lack of mandatary fields in Cerner and an ability to leave the field blank. The service is in the process of recruiting Data Quality midwives who will monitor this as part of their wider role.

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.

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, July 2021 to February 2022, there were 9 diverts, 5 partial diverts and a further 12 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. This has prompted a further categorisation of 'partial divert' to be added to the reporting process. It is anticipated that in the subsequent midwifery staffing paper, the incidence of a full unit divert will be rare, and that the reporting captures the more accurate position which is that the unit rarely 'closes' to all admissions.

Unfortunately, there is no consistent regional or national data available to act as a comparator and indicate whether or not BTHFT is an outlier in this area. It must also be noted that whilst unit escalation policies across the LMS and the region are becoming standardised, units have very different ways of addressing capacity and staffing issues which makes it even more challenging to benchmark the BTHFT position.

For example, neighbouring units with more than 1 site rarely divert to other organisations, but frequently divert between their own units. Other organisations do not divert services as an acute response, but divert women to other units for elective procedures such as induction of labour. This is not captured as a unit divert.

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. The escalation policy is in the final ratification processes and has been brought in line with LMS and Regional policies and reflects OPEL principles. The amended policy is expected to be roll out after EPR go-live.

The service has also included escalation of the need to divert services to the Executive Director on Call, to enable oversight, support and challenge at executive level.

Table 4 is a monthly break down of the diverts/partial diverts/attempted diverts during the reporting period.

MONTH	DIVERTS	ATTEMPTED DIVERTS	PARTIAL DIVERTS
JULY	2	1	0
AUGUST	4	4	0
SEPTEMBER	1	3	0
OCTOBER	0	2	0
NOVEMBER	1	0	0
DECEMBER	1	1	2
JANUARY	0	0	2
FEBRUARY	0	1	1
TOTALS	9	12	5

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

Incidents associated with midwifery staffing are reported via Datix and are investigated by the maternity Quality and Safety team. In the eight month time period July 2021 to February 2022 there were 49 reported incidents where ‘staff’ or ‘staffing’ were mentioned in the narrative.

All incidents were reported as low or 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 49 reported Datix include 36 relating to the 26 unit ‘diverts/attempted/partial 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 and are included in the daily Maternity SitRep submission to the Regional Chief Midwifery Officer Team.

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 814 Red Flag incidents recorded on Safe Care, July 2021 to February 2022. This is a significant increase and demonstrates that midwives have embedded the concept of red flag reporting into daily practice. Appendix 1 provides a breakdown of the red flags raised by area and category.

Key points:

- 104 of the 814 red flags relate to registered midwife (RM) short fall of less than 2 RM* per shift plus a further 247 red flags reporting an RM short fall. This has come as no surprise given the increase in short term sickness and absence driven by Covid. The service will check that this is not a duplication of reporting.
- 132 red flags were due to delay in medical review which is outside the scope of midwifery staffing and this paper. These are escalated to the Clinical Director.
- 37 episodes of a failure to provide 1:1 care in labour for any period of time. This is a relatively low number and is consistent with the previously reported 1:1 care in labour rates of >90%.

*It must be noted that clinical areas are never left with less than 2 RM's and that staff are redeployed from other areas to maintain minimum safe staffing levels.

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. For the purpose of this paper, a table top Birth Rate + exercise has been conducted and due to a drop in birth rate the required number of midwives has dropped slightly. The caveat is that this is likely to change again in 2022/23.

The ongoing priority is to continue to manage vacancy and recruit to the calculated establishment required to achieve safe staffing based on existing MCoC models and pathways of care. The next priority is then to incrementally increase the midwifery workforce to introduce more MCoC teams with the ultimate ambition of achieving MCoC as a default position for all women. This approach is in line with National Maternity Transformation recommendations. Achieving the number required to achieve 100% continuity of carer will be a bigger challenge, and recruitment plans include international recruitment and how we make a midwifery career at BTHFT the organisation of choice. This is included in the recruitment and retention action plan, appendix 2.

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

The report continues to evidence a sustained, embedded 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 and shift leaders, has continued to improve and is now embedded within the culture of the unit.

The Covid-19 pandemic has impacted on midwifery staffing levels to varying degrees during the reporting period July to February 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 continue to support the long term commitment made in 2021.
- Birth Rate plus most recent table top exercise shows this to be a decrease of 7.47 WTE to 272.30 WTE required to achieve MCoC is a default position for all women.

- Taking the safety concerns raised in the Ockenden reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to support the services proposal that the first priority is managing vacancy and recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care at 35%. This is an establishment of 255.52 WTE, moving towards 51% MCoC by November 2022 with an establishment of 263.49 WTE.

Appendices:

10- Red Flag report July 2021 to February 2022

11- Recruitment and retention action plan – maternity incentive scheme