

BI-ANNUAL MIDWIFERY STAFFING REPORT, SEPTEMBER 2022

Background:

This is the second of the bi-annual midwifery staffing reports for 2022, and follows the March 2022 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.

The March 2022 paper concluded that the services immediate priority was to continue to achieve and sustain the Birth Rate plus figure 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 the further increase to the establishment required to achieve midwifery continuity of carer (MCoC) as a default position for all women.

Trust Board was supportive of the recommendations and agreed to continue to support the long term commitment made in 2021 to fund the establishment required to provide MCoC as a default position

The previous bi-annual midwifery staffing reports included 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 purpose of this report is also to evidence:

- A systematic, evidence-based process to calculate midwifery staffing establishment
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated above
- 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 the reporting periods March to September 2022 amid the continuing backdrop of well-publicised, national midwifery shortages, and the pressure on midwifery recruitment as all NHS maternity providers undertake Birth Rate Plus to meet Ockenden compliance.

The maternity service has been pro-active in having a 'rolling' recruitment process throughout the year, which has resulted in small numbers of band 6 midwives joining the team. This has managed the expected annual attrition rates, but has not impacted on the required increase to the establishment.

The service participated in the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) centralised Newly Qualified Midwife (NQM) recruitment campaign for the second year running. 24 NQM were offered positions at BTHFT, fewer than previous years.

The current cohorts of NQM are those most affected by the Covid-19 pandemic, experiencing disruption to both academic and clinical placements during the last 2 years. As a result of these challenges an increased number are not in a position to join the NMC register in October, with some being delayed until the new year and others as much as a full year. This has significantly impacted on our autumn position, with only 9 midwives in a position to start their midwifery career. This is a very unusual position and means that the current staffing pressures will continue into the New Year.

Recognising the challenges this group have experienced, the service have invested in providing an enhanced offer of pastoral support, to nurture, increase confidence, achieve competence and aid retention, in the form of a Pastoral Support Specialist Midwife and a number of band 6 Legacy Midwives. The Legacy Midwives are experienced midwives at the end of their careers, who will share their wealth of knowledge and experience by working alongside NQM in clinical practice.

Following a successful funding bid from Health Education England (HEE), the service has actively pursued the recruitment of International Midwives during 2022. This has been slow to gain momentum, but in recent weeks we have offered a number of positions to midwives from the Philippines and are optimistic that following completion of OSCES, they will join the midwifery workforce in early 2023.

Sickness and Absence:

Midwifery and maternity staff sickness and absence rates have remained high during this reporting period despite the lifting of restrictions and a move to 'living with Covid.'

Staff remain stressed, tired and have demonstrated reduced resilience post pandemic, which not only affects short term absence, but also the uptake of bank shifts. This was particularly noted over the peak summer months but has improved latterly following the Trust agreement to support 'surge' bank rates.

Mitigation:

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. 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. These decisions have not been made lightly, and the most vulnerable women accessing maternity services at BTHFT have continued to benefit from enhanced antenatal and postnatal care from a known midwife.

It was hoped that the arrival of NQM in October/November would enable intrapartum care to resume in some of the Midwifery Continuity of Carer (MCoC) teams, but this is likely to be delayed until December.

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.

MCoC:

Communication from the National Maternity Transformation team in September, informed that the 2024 target to achieve MCoC as a default position for all women, had been removed. Trusts have been formally asked to focus on achieving safe and sustainable staffing levels as a priority.

The national message is clear that MCoC is still the ambition, and that whilst the target date has been removed, Trusts should continue to assemble the 'building blocks' required to achieve this at such a time it is safe to do so, working with local, regional and national continuity leads to ensure that this is achieved.

This is very much the approach already taken at BTHFT and whilst no new teams are planned, the service continues to prioritise existing teams developed to support women from BAME/vulnerable backgrounds. The removal of a target alleviates a significant recruitment pressure and also enables us to evaluate the existing teams and make improvements/amendments as necessary.

Royal College of Midwives (RCM) Leadership Manifesto:

Following Board approval of the September 2021 Bi-annual Midwifery Staffing paper, the service is pleased to report the first appointment required to strengthen the senior midwifery leadership structure as outlined in the RCM Leadership Manifesto, and as recommended in the Ockenden Report.

A Deputy Associate Director of Midwifery (DADM), Band 8b, will commence in post before the end of the year, meeting the first element of the manifesto.

An Associate Director of Midwifery (ADM), Band 8c, will be advertised in September 2023, to fulfil the manifesto and achieve compliance with the corresponding Ockenden recommendation.

In addition to the senior leadership structure, the RCM manifesto outlined a number of Specialist Midwife roles, of which BTHFT are mainly compliant, with the exception of a Specialist Midwife for Diabetes.

Bradford has a high proportion of women who are diabetic or who develop Gestational Diabetes Mellitus (GDM) during pregnancy. Women who are diabetic or who develop diabetes during pregnancy are at higher risk of having a poor outcome, including increased risk of stillbirth. In an attempt to further reduce the stillbirth rate and improve maternal and neonatal outcomes for women in this cohort, the service strongly believes that the addition of a Specialist Midwife for Diabetes will support this improvement work and provide additional support and surveillance of this group of high risk women.

The service is therefore requesting that Board support the addition of a Specialist Midwife for Diabetes to the structure. This will be achieved by removing a band 6 from the midwifery establishment and will be a small cost pressure funding the difference from band 6 to 7.

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 April 22 and repeated in October 2022. This review assumed that the case mix of Bradford Teaching Hospitals NHS Foundation Trust had remained unchanged 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 24.3 are 'Additional Senior Management and Specialist Midwives' which is 9.8 % (including ward manager non-clinical time). This now meets the recommendation following the move to having more non-clinical time for ward managers a change of model aimed at better contributing to the Quality and Safety agenda.

Table 1

	BIRTHRATE PLUS 2022 WTE Bands 3 to 8	VARIANCE September 22 position of midwifery vacancy
Current funded position	279.77	-36.42
Core Services and with Continuity Teams at 29%	253.35	-10.00
Core Services and with Continuity Teams at 35%	255.52	-12.17
Core Services and with Continuity Teams at 51%	263.49	-20.14
Core Services and with Continuity Teams at 100%	272.30	-28.95

As discussed previously, although the target date for achieving MCoC has been removed, 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 12 months and at the current time has no intention to progress any new continuity teams or pathways, but will continue to focus on women and birthing people from our most vulnerable populations.

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 -10 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.

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 and again in March 2022, 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 six month period is as follows (Table 2):

Mar 2022	April 2022	May	June 2022	July 2022	Aug 2022
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		20022			
1:22.3	1:23.7	1:23.6	1:23.5	1:23.9	1:24.3

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 a Birth: Midwife based on the previous agreed establishment of midwives recommended by Birth Rate Plus but differs from the skills mixed numbers in the Birthrate Plus tool (as per Table 1).

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 were 0 reported Red Flag cases of failure to achieve supernumerary labour ward co-ordinator status, recorded on Safe Care during the 6 months March to September 2022.

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 Cerner Maternity.

Table 3

	March	April	May	June	July	Aug	Sept
Received 1:1 Care Overall	95%	92%	94%	98%	92%	93%	85%
No	18	28	20	8	29	24	58
No Labour	55	48	58	44	44	73	59
Yes	351	316	317	316	343	345	343

Despite the ongoing staffing challenges, the service has continued to sustain 1:1 care in labour rates above 90% with the exception of September, which is extremely positive.

The service is not able to fully explain the reason for the drop in September as an isolated month, although it is noted that there was an increased number of babies born in areas outside of the Labour Ward and Birth Centre, such as MAC/Induction Suite/Antenatal Ward than other months. The service will monitor the monthly percentage for October onwards, and will reintroduce validation at source by the Labour Ward Co-ordinator team if the position falls 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.

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, March to September 2022, there were 0 full diverts, 10 partial diverts and a further 5 occasions where the need to divert was declared but the unit remained open due to neighbouring organisations being unable to accept admissions.

Partial diverts are declared when women, usually those requiring intrapartum care, are diverted to another unit, whilst BTHFT maternity continue to triage and see women with other clinical issues such as reduced fetal movements. Partial diverts also include incidences where neighbouring units can initially accept women and then become unable to accept further, meaning that BTHFT then receive all admissions.

A total of 18 women were diverted to other units for care, some of whom returned to continue care at BTHFT after the event.

There were 5 occasions where the need to divert services was declared but neighbouring units were unable to accept. On these occasions the services continued to triage and admit Bradford women. It must be stressed that there are no reported incidences of harms caused

to women and babies during these times, but this affected the ability to provide one to one care in labour and the quality of care provided to mothers and babies.

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 updated maternity escalation policy was ratified in September and has been brought in line with LMS and Regional policies and reflects OPEL principles.

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

Table 4:

MONTH	DIVERTS	ATTEMPTED DIVERTS	PARTIAL DIVERTS
MARCH	0	0	1
APRIL	0	2	3
MAY	0	1	1
JUNE	0	0	0
JULY	0	1	3
AUGUST	0	1	1
SEPTEMBER	0	0	1
TOTALS	0	5	10

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 and March 2022 papers 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 March to September 2022 there were 25 reported incidents where 'staff' or 'staffing' were mentioned in the narrative.

All incidents were reviewed 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 25 reported Datix include 17 relating to the 15 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 672 Red Flag incidents recorded on Safe Care, 1 March 2022 to 30 September 2022. Appendix 1 provides a breakdown of the red flags raised by area and category.

Key points:

- 49 of the 672 red flags relate to registered midwife (RM) short fall of less than 2 RM* per shift plus a further 217 red flags reporting an RM short fall. This continues to reflect the ongoing staffing challenges. It is possible that there is a small amount of 'double counting' and recording of staffing short falls in the 2 different columns, which will be reviewed by the Matron team.
- 98 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.
- 26 episodes of a failure to provide 1:1 care in labour for any period of time. However, this is inconsistent with the actual number of women reported on Cerner who didn't receive 1:1 care overall.
- *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 remains unchanged due to a static birth rate. The full Birth Rate + review will be recommissioned in late 2023/24 as part of the 3 yearly review cycles.

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 ambitions, a recommendation which remains unchanged except for the removal of a target date for achieving.

The service remains committed to proactive recruitment including International Midwives and reinforcing the systems and processes in place to retain staff through preceptorship and pastoral care.

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% with the exception of September. This will be monitored and any deterioration of position will be investigated.

The collection of Red Flag incidents on Safe Care, inputted by the labour ward co-ordinators and shift leaders, is now embedded within the culture of the unit.

Recommendations:

- Taking the safety concerns highlighted in the Ockenden reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to continue 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%.
- Trust Board is asked to continue to support the long term commitment made in 2021 and again in March 2022, 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 service requests that Board support the addition of a Specialist Midwife for Diabetes to the structure. This will be achieved by removing a band 6 from the midwifery establishment and will be a small cost pressure funding the difference from band 6 to 7.

Appendices:

1.1 Red Flag report March 2022 to September 2022