

BI-ANNUAL MIDWIFERY STAFFING REPORT, MARCH 2023

APPENDIX 3

Background:

This is the first of the bi-annual midwifery staffing reports for 2023, and follows the September 2022 paper presented to People Academy and Trust Board in November 2023.

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

The September 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.

The September 2022 report also requested that Board support the addition of a Specialist Midwife for Diabetes to the structure, to improve outcomes for the high proportion of diabetic pregnant people.

Trust Board was supportive of the recommendations and again agreed to continue to support the long term commitment first made in 2021, to fund the establishment required to provide MCoC as a default position and to add the Specialist Midwife for Diabetes to the structure.

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. Please note that at the time of this report, the year 5 scheme has not been published and the report is based on year 4 standards.

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 September to February 2023 amid the continuing backdrop of well-publicised, national midwifery shortages.

The current vacancy rate for safe staffing is -9.8 WTE and -28.8 WTE for MCoC. This is a slightly deteriorated position compared to the same time in other years, which normally reflects a substantial number of newly qualified midwives (NQM) joining the organisation following graduation. Although the service recruited 22 NQM during 2022, roughly half of this cohort commenced in post in October/November 2022. This is due to a number of factors:

- Maternity leave
- Bereavement leave
- Delay in completing clinical hours required to graduate
- Delay in completing the academic requirements

The maternity service has remained pro-active in having a 'rolling' recruitment process throughout the year, which has resulted in small numbers of band 5 and 6 midwives joining the team.

Since the last bi-annual paper, 2 International Midwives have passed the OSCE and have a Nursing and Midwifery (NMC) PIN, and have now commenced in post. A further International Midwife is currently at 'boot camp' and a further 3 expected to arrive in the country in the next few months. In addition to this, the service has secured additional funding for 4 more International Midwives, taking the total to 10.

A Band 7 midwife is seconded to support both the International Recruitment process and the individual midwives on arrival in the country, to enhance the experience and aid retention.

The service is also supporting the career development of Maternity Support Workers (MSW) and has facilitated 1 MSW to commence the apprentice midwifery programme at the University of Huddersfield in March. Recruitment is currently underway to support a second MSW to commence the programme in September 2023. It is likely that there will then be a pause for 12 months to assess the feedback of the initial candidates and to manage the expected increase in undergraduate midwifery training numbers.

The service will participate in the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) centralised Newly Qualified Midwife (NQM) recruitment campaign, expected to commence in May 2023.

Retention:

The service has continued to focus on the wellbeing and retention of the midwifery workforce and has a number of strategies in place to support NQM and new to the organisation staff:

- Substantive band 7 Specialist Midwife for Pastoral Support
- Seconded band 7 Specialist Midwife for International Recruitment
- 2 x Legacy Midwives (experienced midwives working alongside new staff in clinical practice)
- Robust preceptorship package
- Access to Professional Midwifery Advocates (PMA)

Sickness and Absence:

Midwifery and maternity staff sickness and absence rates have remained high during this reporting period despite a continued focus on staff wellbeing and the enhanced 'super surge' rates in place since September.

Following the Trust wide review of nurse/midwifery bank rates in March, the maternity service will drop to the 'surge' rate from 1 April. It is unknown how this will affect the uptake of bank shifts, but any compromise to safety will be escalated as required.

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.

The previous bi-annual paper described additional measures to improve safe staffing levels in Community Midwifery including the suspension of specialist midwife support roles, suspension of the intrapartum element of some continuity of carer teams. This continued during the current reporting period, but following a recent review, Acorn Team (for vulnerable women) will resume intrapartum on calls from the 1 April.

Obstetric Theatre

There is a current vacancy of 1.48 whole time equivalent (WTE) within the obstetric theatre agreed establishment. This is being actively recruited to.

MCoC:

As reported in the last paper, communication from the National Maternity Transformation team in September 2022, informed that the 2024 target to achieve MCoC as a default position for all women, had been removed. Trusts were 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. This approach continues until safe staffing levels are sustained.

Royal College of Midwives (RCM) Leadership Manifesto:

Following Board approval of the September 2021 Bi-annual Midwifery Staffing paper, the service has appointed a Deputy Associate Director of Midwifery (DADM), Band 8b, meeting the first element of the manifesto.

An Associate Director of Midwifery (ADM), Band 8c, will be advertised in late 2023/24, 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.

Following approval of the September 2022 Bi-annual Midwifery Staffing paper recommendation that a Specialist Midwife for Diabetes should be added to the structure to improve outcomes for women and babies in this cohort, the service have successfully appointed a Band 7 midwife to this role.

The addition of Consultant Midwives as recommended by the manifesto, will be considered once an Associate Director of Midwifery has been appointed.

Annual Training Needs Analysis:

The recently published 'Three Year Delivery Plan for Maternity and Neonatal Services' requires trusts to undertake an annual training needs analysis and make training available to all staff in line with the core competency framework. Compliance with the core competency framework is also contained within the Maternity Incentive Scheme standards.

A training needs analysis was undertaken in May 2022 and demonstrated that the number of training days required to fulfil the core competency framework, plus meeting the Trust mandatory training, has increased from 3 days to 4 days. This does not include any additional individual training needs, for example leadership development, newborn examination training, professional midwifery advocate training.

The current agreed 'headroom' uplift to accommodate training requirements is 22%. This no longer meets the national and local training requirements for maternity staff and needs urgent review and executive approval prior to the next full Birth rate Plus review.

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

A Birth Rate Plus table top review has been completed every six months since the last full review report and included in the bi-annual midwifery staffing papers. This exercise has been repeated for the purpose of this paper and 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 5135 to 5001. The recommendation of 10% non-clinical and management roles has 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 clinical person establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The service now has 25.8 WTE 'Additional Senior Management and Specialist Midwives' which is 10.4% of safe staffing numbers (CoC 29%) this includes specialist midwives and unit managers' non-clinical time and 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. We have a current RM establishment of 222.92.

Table 1

	BIRTHRATE PLUS April 2023 WTE Bands 3 to 8	VARIANCE February 23 position of midwifery vacancy
Current funded position	279.77	-41.48
Core Services and with Continuity Teams at 29%	248.13	-9.84
Core Services and with Continuity Teams at 35%	250.24	-11.95
Core Services and with Continuity Teams at 51%	258.00	-19.71
Core Services and with Continuity Teams at 100%	266.57	-28.28

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

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 248.13 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 -9.8 WTE which will increase with usual attrition rates between now and newly qualified midwife appointments in October.

The second priority for 2023/24 will then be to recruit a further 2.1 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 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 birth rate is 266.57 WTE, but it must be noted that if the birth rate increases or decreases further in 2023 this figure may change again.

Trust Board is also advised that in line with the recommendations of the March 2023 'Three Year Delivery Plan for Maternity and Neonatal Services', an annual training needs analysis will be undertaken prior to the next Birth Rate Plus full review, to ensure that the midwifery 'headroom' is accurately built in to the calculation to ensure that the core competency framework is met. Meeting the core competency framework is a condition of the Maternity Incentive Scheme.

Midwife to Birth ratio:

Based on the current agreed establishments of 247.2 WTE midwives, we aim for a midwife to birth ratio of 1:20.2. 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):

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
01:24.5	01:24.5	01:23.3	01:23.5	01:23.1	01:23.3

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 (as previously described regionally and what was previously reported into the

regional dashboard to exclude Band 8 midwives and the specialist midwife for Quality and Safety). This differs from the skill mixed numbers in the Birth Rate 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 was 1 reported Red Flag case of failure to achieve supernumerary labour ward co-ordinator status, recorded on Safe Care during the 6 months September to February 2023.

This was for a total of 2 hours when the co-ordinator provided direct care to a woman requiring bereavement care and there were no other midwives available during that time.

This is an isolated incident and is not a cause for concern.

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

	Sept	Oct	Nov	Dec	Jan	Feb
Received 1:1 Care Overall	87%	90%	88%	91%	96%	95%
No	58	45	49	32	23	23
No Labour	59	59	49	54	69	58
Yes	343	347	310	305	321	323

1:1 care in labour fell below the 90% standard on 2 occasions during the 6 monthly reporting period, but has improved in the last 3 months as a result of Labour Ward Co-ordinator oversight and monitoring of this metric.

Maternity Unit 'Closures'

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, September to February 2023 there were 0 full diverts, 5 partial diverts and 0 attempted diverts. This is an improved position on that reported in the previous 6 months, when there were 10 partial diverts and a further 5 occasions where the service needed to divert but no other organisations were able to accept.

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 7 women were diverted to other units for care, some of whom returned to continue care at BTHFT after the event. This is compared to 18 women affected in the previous reporting period.

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
SEPTEMBER	0	0	1
OCTOBER	0	0	2
NOVEMBER	0	0	1
DECEMBER	0	0	0
JANUARY	0	0	0
FEBRUARY	0	0	1
TOTALS	0	0	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.

Incidents associated with midwifery staffing are reported via Datix and are investigated by the maternity Quality and Safety team. In the six month time period September 2022 to February 2023 there were 7 reported incidents where 'staff' or 'staffing' were mentioned in the narrative. This is a significant reduction on the 25 reported in the previous 6 months and is thought to be due to staff utilising the red flag reporting system for shortfalls where 'no harm' has occurred.

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 7 reported Datix include 5 relating to the 5 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.

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

Community Midwifery now uses safe care to identify missed/delayed care, registered midwife shortfalls and 'other' ad hoc safety concerns.

There were 649 Red Flag incidents recorded on Safe Care, 1 September 2022 to 28 February 2023. Similar numbers to that reported in the previous 6 months. Appendix 4 provides a breakdown of the red flags raised by area and category.

Key points:

- 45 of the 649 red flags relate to registered midwife (RM) short fall of less than 2 RM* per shift plus a further 198 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.
- 79 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. However, this is inconsistent with the actual number of women reported on Cerner who didn't receive 1:1 care overall, and suggests an under reporting of red flags pertaining to this area.
- *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.

For the purpose of this paper, a table top Birth Rate + exercise has been conducted and has identified a further drop in the annual birth rate resulting in a reduction in the midwifery establishment requirements of 13.20 WTE.

The national recommendation is that the full acuity tool is completed every 3 years. The request is that People Academy and Trust Board agree to the recommission of Birth Rate Plus in autumn 2023.

The ongoing priority remains unchanged from the 2022 bi-annual recommendations, and 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 has identified that the increased Trust mandatory training requirements, plus the maternity specific core competency framework requirements have increased significantly and that this exceeds what is currently built into the current 22% built in headroom. The recommendation is that the service awaits the publication of year 5 of the Maternity Incentive Scheme and any potential further changes to training compliance, before presenting a paper for Executive approval that outlines a revised headroom which includes what is required to deliver training compliance.

There has been a noted decrease in both the number of unit diverts and staffing related Datix reports compared to the previous 6 months. The reason for this reduction is currently unknown as red flag reporting numbers remain similar, including the number of 'shortfall in midwifery' flags. One suggestion could be that although staffing challenges have remained similar, there has been an improvement in how we manage unit escalation preventing the need to divert services. This potential improvement would coincide with the launch of the revised Escalation guideline and staffing strategy in October 2022.

However, on the other hand, the number of red flags remains consistent and it could be suggested that staff are now recording shortfalls here rather than on Datix where 'no harm' has occurred.

The service remains committed to proactive recruitment including International Midwives, Midwifery Apprentice programmes 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% with only 1 reported red flag in a 12 month period.

Recommendations:

- Taking the safety concerns highlighted in the Ockenden and Kirkup 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 29%.
- Trust Board is asked to continue to support the long term commitment made in 2021 and again in March and September 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. However, the recent table top review calculates this as 266.57 WTE.
- Trust Board is asked to support the request to recommission the full Birth Rate plus tool in autumn 2023 to give an up to date assessment of the acuity of women accessing the service, considering the decrease in annual birth rate.
- The service recommends that a review of the current headcount uplift which incorporates the time required to complete mandatory training, is undertaken and a paper presented to the Executive Team. This is based on the significant increase in training both at Trust level and as part of the maternity core competence framework.

Appendices:

4. Red Flag report September 2022 to February 2023