Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 28 September 2022

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Title:	**Maternity Safe Staffing for Quarter 3 and Quarter 4 of 2021/22**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee 22/08/2022**
	Regular Reporting

Board Lead:	**Chief Nursing Officer**
Author:	**Rosalie Wright, Governance Midwife on behalf of Milica Redfearn, Acting Director of Midwifery**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This is the second bi-annual report for 2021/22 which reviews Safe Staffing levels Quarter 3 and Quarter 4.

   The aim of this report is to provide assurance of an effective system of midwifery workforce planning in part fulfilment of requirements of the Maternity Incentive Scheme Year Four, which was relaunched in May 2022.

2. The report provides assurance of the following:

a)	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b)	Evidence that midwifery staffing budget reflects the establishment as calculated in a) above
c)	The midwifery coordinator in charge of labour ward has 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
d)	All women in active labour receive one-to-one midwifery care
e)	Submission of a midwifery staffing oversight report that covers staffing/safety issues to the board every 6 months during the incentive scheme year four reporting period

Recommendations

3. The Trust Board is asked to note the results of this paper.

Contents

Maternity Safe Staffing for Quarter 3 and Quarter 4 of 2021/22

1. Purpose

1.1. The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from the start of October 2021 to the end of March 2022. This is a requirement of the NHSLA Maternity Incentive Scheme for Safety Action 5.

2. Background

2.1. The NHSLA Maternity Incentive Scheme requires that OUH FT demonstrates an effective system of midwifery workforce planning to the required standard.

2.2. The minimal evidential requirement for Trust Board comprises evidence to support a, b and c progress or achievement. It should include:

- A clear breakdown of BirthRate Plus or equivalent calculations to demonstrate how the required establishment has been calculated
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate Plus or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate Plus or equivalent calculations. Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.
- The plan to address the findings from the full audit or table-top exercise of BirthRate Plus or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.
- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. The midwife to birth ratio, the percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-

one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

2.3. This report will demonstrate:

a)	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b)	Evidence that midwifery staffing budget reflects the establishment as calculated in a) above
c)	The midwifery coordinator in charge of labour ward has 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
d)	All women in active labour receive one-to-one midwifery care
e)	Submission of a midwifery staffing oversight report that covers staffing/safety issues to the board every 6 months during the incentive scheme year four reporting period

3. Evidence Requirement update

3.1. *BirthRate Plus*® work force planning and real time staffing acuity tools use validated methodology to support the delivery of safer maternity care as required by the CNST Maternity Incentive Scheme. It is the only midwifery-specific national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services.

3.2. Maternity is currently in the process of refreshing the previous BirthRate Plus analysis. The 2018 case mix was reassessed using maternity dashboard and a 3-month sample of births from November 2021 to January 2022. The data reviewed shows an increase in the acuity of mothers and babies. Early indication suggests there is a need to consider increasing the midwifery establishment to address acuity and a higher birth rate.

3.3. The previous systematic evidence-based process of BirthRate Plus® tool in 2018 led to a business case being submitted which resulted in an agreement for an additional 2.8wte midwives at band 6. Further increases to establishments have occurred since 2018 as a result of; the move from 20 to 23% uplift for inpatient areas, specialist services and community services (Lotus Team).

3.4. *Details of planned versus actual midwifery staffing levels – to include evidence of mitigation/escalation for managing a shortfall in staffing.* Midwifery staffing is reviewed on a shift-by-shift basis and reported and escalated to the Trust central safe staffing meeting. The leadership team review the rostered staffing twice weekly in advance to check planned staffing against the agreed establishment for each clinical area. In the day, the 1570 Maternity Operational

Bleep Holder works with the multi- disciplinary team to ensure that when there is staff sickness, staff vacancies or an increase in demand within the maternity service, midwifery and support staff are moved to areas that require additional support, ensuring that women in labour have 1:1 midwifery care. At night, the 2nd Band 7 supporting the Delivery Suite Coordinator will carry the 1570 bleep and will work in partnership with the Midwifery Manager on-call to ensure that women in labour have1:1 midwifery care. There is a robust staffing and escalation policy in place as per the OUH Maternity Escalation Policy (February 2022). Furthermore, to highlight and address any staffing shortfall, the Maternity Operational Bleep Holder leads multidisciplinary Safety Huddles (see appendix 1) which review actual midwifery staffing versus acuity levels twice daily.

3.5. The RAG rating agreed at the Safety Huddle's is reported to the Central Trust Safe Staffing meeting once a day via dial-in and is updated via email if it changes during the period this report covers. Since May 2022 this is reported twice a day to the Central Safe Staffing meeting. There is a robust escalation policy with agreed action pathways to be taken for each rating.

3.6. The table below shows the RAG rating for actual midwifery staffing levels for October 2021 through to September March 2022. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that day.

	RAG Rating		
	GREEN	AMBER	RED
October 2021	0	31	0
November 2021	0	30	0
December 2021	0	31	0
January 2022	0	31	0
February 2022	0	28	0
March 2022	0	31	0

3.7. Actions were taken as per OUH Maternity Escalation Policy to mitigate against any RAG rating of Amber. This included "staff movement between areas" and "supernumerary workers within numbers" as reflected in the Red Flags reported, (see appendix 4) as well addressing staff shortfall by using on-call staff and sourcing additional staff.

3.8. From the 17th August 2021, Level 2 (amber) has been the default declaration as Maternity required a contingency and mitigation plan to address the ongoing staffing pressures which included the closure of inpatient and bereavement beds on Level 7 and the temporary closure to intrapartum care of two of the freestanding Midwifery Led Units at Wantage and Chipping Norton.

3.9. *An action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.* An updated action plan can be found in Appendix 2. The Maternity Directorate continues to actively recruit new staff. The table below shows the number of new starters (in wte) balanced against the numbers of leavers.

3.10. In Q3 and Q4, the Maternity Directorate had recruited 33.78 wte. In the same period, there were 26.72 wte leavers. This is not reflective of the number of new starters the maternity service recruit as recruitment occurs predominantly in September to November each year. This is because the majority of newly recruited midwives are early career midwives starting after the completion of their university course.

Midwives	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
New starters	6.63	10.17	7.82	3.24	4	1.92	33.78
Leavers	14.28	4.84	0	3	2	2.6	26.72

3.11 The midwife: birth ratio and funding establishment

The table below shows the midwife: birth ratio in the period covered by this paper.

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Midwife to birth ratio	1:28.7	1:27.3	1:27.0	1:25.0	1:27.6	1:26.9
	Quarter 1 average 1:28.1			Quarter 2 average 1:26.5		

The midwife to birth staffing ratio is set at 1:28. The midwifery staffing budget reflects the current maternity establishment. The budgeted establishment is for 304 wte Midwives and 89 wte Maternity Support Workers. The average for Quarter 3 was 1:28.7 and Quarter 4 WAS 1:26.5. The midwife to birth ratio was calculated to be within the targeted establishment for the maternity services, however it does not account for the high number of midwives unable to work clinically or staff off sick due to COVID. The high number of staff unable to work required mitigation action to address the shortfall. The midwife to birth ratio is monitored monthly on the maternity dashboard and reported at the monthly MCGC meeting.

3.12. *The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® accounts for 8-10% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.* The 2018 BirthRate Plus® report recommended that management or specialist midwife roles should not be included in the clinical numbers. The report suggested that within OUH management and specialist roles should account for 9% of the establishment. The current funded establishment is 26.74wte.

3.13. We continue to review maternity services to ensure the appropriate level of manager and specialist midwives are not included in the midwifery numbers, however during the COVID-19 period, several manager and specialist midwives were required to and continue to work clinically to support safe care provision.

3.14. In Q3 and Q4 the number of management and specialist midwife roles in post accounted for 6.5% of the workforce. This is due to vacancies within the Consultant Midwifery and Diabetic team. The Maternity services are actively recruiting and reviewing specialist and leadership roles

3.15. The BirthRate Plus re-fresh will provide up to date calculations for us to review against our establishment.

3.16. *Evidence from an acuity tool (which may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation/escalation to cover any shortfalls.* The twice daily Safety Huddle (see appendix 1) monitors, among other things, the provision of 1:1 care in labour and the supernumerary status of the Delivery Suite Co-ordinator. If there is an occasion when 1:1 care in labour is in jeopardy and/or the Delivery Suite Co-ordinator does not have supernumerary status this is promptly escalated to the Maternity Operational 1570 Bleep Holder. Mitigating actions are then taken to address the issue and the corresponding Red Flag is uploaded to the electronic Health Roster System as appropriate. This data is also reviewed at the Maternity Clinical Governance monthly meeting.

3.17. In this data period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status.

3.18 *Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising. The agreed staffing Red Flags are listed in appendix 3. The Red Flag incidents for the Q3 and Q4 have been outlined in appendix 4.*

3.19 *Both Q3 and Q4 saw a significant increase in Red Flags due to staff vacancies, sickness* due to covid and accommodating staff who were unable to work in the clinical areas. Mitigation action was taken which included the movement of maternity staff between the clinical areas, consolidating inpatient bed and the

temporary closure to intrapartum care of two of the freestanding Midwifery Led Units. The impact of the closure of freestanding Midwifery Led Units reduced the birthplace choices for women in their locality.

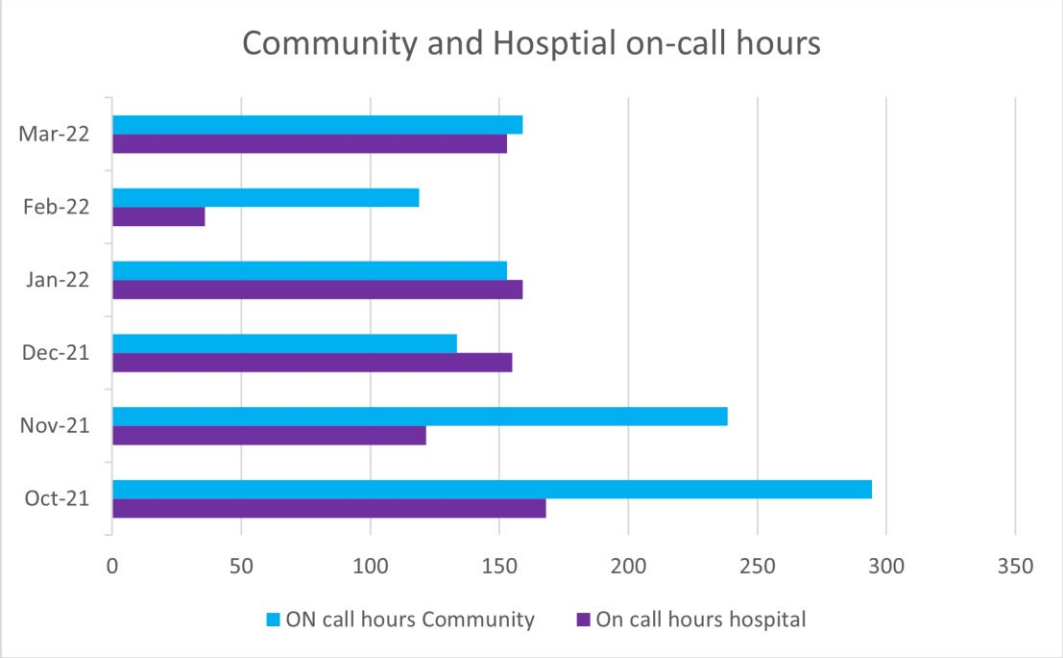
3.20 The Maternity Operational Bleep Holder and area co-ordinators continue to focus each day on ensuring staff can take breaks and leave on time. Unfortunately, staff shortages led to increase in the number of staff not taking their full breaks or working over their shift allocation.

3.21 To ensure one to one care in labour was prioritised and safety of care provision on-call midwives were called into the hospital.

3.22 The table below shows the midwife: birth ratio in the period covered by this paper.

On call hours	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	360	462.5	288.5	312	155	312

3.23 The graph below shows the number of on-call hours worked by community and hospital midwives. The number of on-call hours gradually decrease as recruited midwives commence their roles and complete their induction programme.



3.24 It should be noted that the Red Flag for staffing includes 'Supernumerary workers within the numbers'; this includes staff who are supernumerary in one clinical area being moved to cover a staffing shortfall in another clinical area where they are able to be counted within the numbers. It also includes staff working in offices or on study leave who are relocated to work within the numbers. The data therefore shows a number of occasions where this has

flagged but please note that it does not indicate that the Delivery Suite Coordinator had stopped being supernumerary, as described above.

4. Assurance

The evidence described in this paper provides assurance that there is an effective system of workforce planning to ensure safe staffing levels.

5. Recommendation

The Trust Board are asked to note the results of this report.

6. Conclusion

The evidence described in this paper provides assurance that there is an effective system of workforce planning to ensure safe staffing levels.

7. Appendix 1 – Safety Huddle

The Safety Huddle is a multidisciplinary meeting held twice a day, one at 09:00 and one at 16:00 hours. Members of the Maternity Safety Huddle include:

- Maternity Operational Bleep Holder
- Delivery Suite co-ordinator
- Duty Consultant Obstetrician
- Duty Consultant Anaesthetist
- Neonatal Unit Duty Sister (this was introduced in April 2021 to improve communication)
- Midwifery Manager on-call (may represent via telephone)
- Director of Midwifery
- Matrons for each area (or deputy)

Using the RAG rating system of Red, Amber or Green the safety huddle members will assess the unit's workload, staffing and acuity and declare Maternity's RAG status as follows:

- **Green** signifies that the maternity service has available beds and appropriate staffing levels for the workload
- **Amber** signifies the maternity service is at the upper limits of bed capacity, staffing, or activity
- **Red** signifies that there are no available beds or all available staff are committed to labour care. The service cannot guarantee 1:1 midwifery care in labour or safe staffing in other areas of the service.

8. Appendix 2 – Action Plan for BirthRate Plus 2021/2022.

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Monitor the midwifery establishment in line with BirthRate Plus	2022 Re-fresh of BirthRate Plus To submit staffing paper with recommendations from BirthRate Plus.	Director of Midwifery Director of Midwifery	April 2022 October 2022	*Evidence collated and submitted for analysis by BirthRate Plus Team in March 2022. Analysis report due in June 2022.*	Ongoing
	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus.	Leadership Team	December 2020	*Completed tools for all clinical areas with evidence of adjusted staffing.*	Complete
	To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting.	Leadership Team	Rolling programme	*Minutes of monthly MCGC meeting with up-to-date dashboards.*	Rolling
	To annually review the recruitment and retention plan.	Leadership Team	Rolling programme	*Recruitment and retention plan for 2020/202. This is currently being updated*	Rolling

9. Appendix 3 - Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015)

The agreed staffing red flags were approved and ratified in 2017

- (All Areas) Staff moved between specialty areas
- (All Areas) Supernumerary workers within the numbers
- (All Areas) Administrative or Support staff unavailable
- (All Areas) Staff unable to take recommended meal breaks
- (All Areas) Staff working over their scheduled finish time
- (All Areas) Delays in answering call bells
- (All Areas) Delay of more than 30 minutes in providing pain relief
- (All Areas) Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan
- (All areas) Beds not open to fully funded number - state number not staffed and reason
- (All areas) Elective activity or tertiary emergency referrals declined

- (Maternity Only) Delay of 30 minutes or more between presentation and triage
- (Maternity Only) Full clinical examination not carried out when presenting in labour
- (Maternity Only) Delay of 2 hours or more between admission for induction and beginning of process
- (Maternity Only) Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.
- (Maternity Only) The Midwifery Labour Ward Coordinator has supernumerary status.

10. Appendix 4 Maternity Staffing Red Flags uploaded onto Trust system October 2021 to March 2022

Red Flags for all areas	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Staff moved between specialty areas	136	120	101	94	60	136
Supernumerary workers within the numbers	20	6	7	9	3	6
Administrative or Support staff unavailable	0	0	2	0	1	2
Staff unable to take recommended meal breaks	4	3	2	53	59	97
Staff working over their scheduled finish time	26	8	17	21	24	53
Delays in answering call bells	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0	0	0	0
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan	0	0	0	0	0	0
Beds not open to fully funded number - state number not staffed and reason	62	60	62	4	1	2
Elective activity or tertiary emergency referrals declined	0	0	0	0	0	0
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	1
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	33	28	37	48	29	48
Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour	0	0	0	0	0	0