



## Cover Sheet

Public Trust Board Meeting: 12<sup>th</sup> July 2023

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**Title:** Maternity Safe Staffing for Quarter 3 and Quarter 4 2022/23

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**Status:** For Information

**History:** Maternity Clinical Governance Committee  
26<sup>th</sup> June 2023 - Regular Reporting

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**Board Lead:** Chief Nursing Officer

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**Confidential:** No

**Key Purpose:** Assurance

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## Executive Summary

1. This is the second bi-annual report for 2022/23 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](#). It also informs the decision making process regarding the future planning for Midwifery Continuity of Carer.

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   |
| f) | Consideration of the current and future rollout of Midwifery Continuity of Carer (MCoC) against current staffing.   |

## Recommendations

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

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## Maternity Safe Staffing for Quarter 3 and Quarter 4 - 2022/23

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### 1. Purpose

1.1. It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements. 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 April 2022 to the end of September 2022. This is a requirement of Year 4 of the NHS Resolution (NHSR) [Maternity Incentive Scheme](#).

### 2. Background

2.1. The Maternity Incentive Scheme requires that OUHT 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   |
| f) | Consideration of the current and future rollout of Midwifery Continuity of Carer (MCoC) against current staffing.   |

### 3. Evidence Requirement update

#### 3.1. ***A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been completed.***

3.1.1. *BirthRate Plus®* workforce 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.

3.1.2. Maternity is currently in the process of refreshing the previous BirthRate Plus analysis. This completed in December 2022. 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 a significant increase in the acuity of mothers and babies. The report suggests there is a need to significantly increase the midwifery establishment to address acuity and a higher birth rate by 32.38 wte this to include management/specialist roles, clinical midwives and maternity support workers. A business case is currently in process to obtain the required uplift. The Trust plan to meet this uplift will require to be shared with commissioners (NHSR MIS requirement).

3.1.3. 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 establishment have occurred since 2018 along with the move from 20% to 23% uplift for inpatient areas, specialist services and community services.

3.1.4. The Trust continues to allow an over recruitment of Band 5/6 midwives up to 10% of the establishment as most midwives are early career midwives starting in the autumn following completion of their midwifery degree.

3.1.5. The Maternity Directorate has seen an increase in midwifery establishment from 283.77wte in 2019/20 to 310.50wte in 2022/23, demonstrated (fig. 1) below.

**Fig. 1: Midwifery Funded Establishment**

| Band                        | 19/20         | 20/21         | 21/22         | 22/23        |
|-----------------------------|---------------|---------------|---------------|--------------|
| 812072-B8B Midwives         | 2.34          | 2.10          | 3.10          | 4.8          |
| 812071-B8A Midwives         | 3.00          | 3.80          | 3.80          | 10.3         |
| 807070-B7 Nurse Specialists |               |               | 0.60          | 0.60         |
| 808700-B7 Qualified Nurse   |               |               | 1.00          | 1.00         |
| 812070-B7 Midwives          | 55.09         | 57.13         | 57.13         | 61.89        |
| 807060-B6 Nurse Specialists | -             | -             | -             | 1.00         |
| 812060-B6 Midwives          | 180.94        | 180.94        | 188.94        | 174.8        |
| 808500-B5 Qualified Nurse   | 1.00          | 1.00          | 1.00          | 18.4         |
| 812050-B5 Midwives          | 41.40         | 41.40         | 40.40         | 38.32        |
|                             | <b>283.77</b> | <b>286.37</b> | <b>295.97</b> | <b>310.5</b> |

**3.2. Details of planned versus actual midwifery staffing levels – to include evidence of mitigation/escalation for managing a shortfall in staffing.**

- 3.2.1. 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 and the delivery suite coordinator remains supernumerary. At night, the 2<sup>nd</sup> 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 have 1:1 midwifery care and the delivery suite coordinator remains supernumerary. 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 (Appendix 2) which review actual midwifery staffing versus acuity levels twice daily.
- 3.2.2. The RAG rating agreed at the Safety Huddle's is reported to the Central Trust Safe Staffing meeting twice a day via email. There is a robust escalation policy with agreed action pathways to be taken for each rating.
- 3.2.3. Requests to close/suspend maternity service are made via the Trust duty management team and executive on call.
- 3.2.4. The table below shows the RAG rating for actual midwifery staffing levels for October 2022 through to March 2023. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that day.
- 3.2.5. During this current report period, the RAG ratings are declared in current time and consider any mitigation needed to achieve the RAG rating. From December 2022 the RAG rating reported will be related to the next shift, prior to mitigation having taken place. This will lead to an increase in Red RAG ratings. If a Red rating is declared, mitigation using the [OUH Maternity Escalation Policy](#) (February 2022) will be applied. An updated email with the mitigation and updated RAG rating will be sent to the Central Trust Safe Staffing Team.

|               | RAG Rating |       |     |
|---------------|------------|-------|-----|
|               | GREEN      | AMBER | RED |
| October 2022  | 0          | 31    | 0   |
| November 2022 | 0          | 30    | 0   |
| December 2022 | 0          | 28    | 3   |
| January 2023  | 5          | 26    | 0   |
| February 2023 | 5          | 23    | 0   |
| March2023     | 18         | 13    | 0   |

3.2.6. 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.

3.2.7. From the 17<sup>th</sup> 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 temporary closure to intrapartum care of two of the freestanding Midwifery Led Units at Wantage and Chipping Norton. From January 2023 the units were re-opened and Level 2 is now no longer a default declaration.

3.3. ***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.***

3.3.1. An updated action plan can be found in Appendix 3. 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.

3.3.2. In Q3 and Q4, the Maternity Directorate had recruited 35.63 wte midwives. In the same period, there were 22.04 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 most newly recruited midwives are early career midwives starting after the completion of their university course. The maternity Directorate has recruited a further 36 wte midwives who will start in post September 2023-January 2024.



| Midwives     | Oct-22 | Nov22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Total |
|--------------|--------|-------|--------|--------|--------|--------|-------|
| New starters | 22.96  | 4     | 1      | 3.72   | 0.53   | 3.42   | 35.63 |
| Leavers      | 3.72   | 1     | 4.3    | 5      | 4.22   | 3.8    | 22.04 |

Quarter 1 and 2 demonstrated high turnover and sickness. Quarter 3 and 4 have demonstrated a reduction in both sickness and turnover. The Directorate are continuously monitoring this and are acting on themes that emerge.

| 2022 2023 | HR  |              |              |               |
|-----------|---|--------------|--------------|---------------|
|           | Revised Vacancy HR Vaccs plus LT Sick & Mat Leave (%) | Turnover (%) | Sickness (%) | Maternity (%) |
| April     | 33.81%  | 13.24%       | 7.93%        | 4.95%         |
| May       | 30.46%  | 15.59%       | 6.37%        | 3.45%         |
| June      | 30.08   | 16.23%       | 4.38%        | 2.96%         |
| July      | 37.99%  | 21.62%       | 7.58%        | 3.08%         |
| August    | 40.70%  | 20.15%       | 4.44%        | 4.21%         |
| September | 41.82%  | 21.80%       | 3.79%        | 4.28%         |
| October   | 5.82%   | 14.57%       | 4.56%        | 4.92%         |
| November  | 4.25%   | 14.04%       | 4.42%        | 5.25%         |
| December  | 6.59%   | 13.64%       | 4.49%        | 5.53%         |
| January   | -14.66%   | 10.98%       | 3.90%        | 5.50%         |
| February  | 5.65%   | 14.22%       | 4.09%        | 5.84%         |
| March     | -18.63%   | 10.33%       | 4.17%        | 5.52%         |

4. *The midwife: birth ratio and funded establishment.* The table below shows the midwife: birth ratio in the period covered by this paper.

|        | Oct-22                    | Nov-22  | Dec-22 | Jan-23                   | Feb-23 | Mar-23 |
|--------|---------------------------|---------|--------|--------------------------|--------|--------|
| Funded | 1:28.48                   | 1:28.14 | 1:27.8 | 1:27.6                   | 1:27.6 | 1:27.3 |
|        | Quarter 1 average 1:28.14 |         |        | Quarter 2 average 1:27.5 |        |        |

4.1. The recommended safe midwife to birth staffing ratio was set at 1:26 in 2018. The midwifery staffing budget reflects the current recommended safe establishment (based on the 2018 assessment of 7500 births). The budgeted establishment is for 296.97 wte Midwives and 89 wte Maternity Support Workers. The average birth to ratio for Quarter 3 was 1:28.14 and Quarter 4 was 1:27.5. 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 due to sickness (Covid and none Covid), maternity leave and redeployed staff due to Covid restrictions. The high number of staff unable to work has required action to mitigate the shortfall. The funded midwife to actual birth ratio is monitored monthly on the maternity dashboard and reported monthly to the Maternity Clinical Governance Committee.

## 5. Planned Versus Actual Midwifery Staffing Levels

5.1. All maternity In-Patient (Including Intrapartum) areas report the actual v's planned midwifery and care staffing for day and night shifts alongside the other wards in the Trust this data is reported on the monthly safe staffing dashboard. (Appendix 1) Planned versus actual staffing is retrospectively reported from Healthroster, calculated from birth numbers and includes the number of care hours per patient (registered Midwife and care staff) that were filled against the planned (baseline) for the calendar month. This data is reviewed by the Director of Midwifery and presented monthly in the safe staffing report to the Board of Directors.

6. The table below shows the number of midwives unavailable to work due to Maternity Leave, Career breaks Sickness and Covid related absence.

| Midwives                             | Oct-22          | Nov-22         | Dec-22          | Jan-23          | Feb-23         | Mar-23          |
|--------------------------------------|-----------------|----------------|-----------------|-----------------|----------------|-----------------|
| All absence (includes Covid)wte / %) | 37.16<br>12.06% | 47.35<br>14.7% | 44.71<br>14.01% | 47.91<br>15.16% | 42.9<br>13.89% | 42.95<br>13.54% |
| Covid Absence wte / %                | 3.35<br>1.07%   | 6.32<br>1.96%  | 2.72<br>0.85%   | 9.21<br>2.91%   | 3.82<br>1.2%   | 3.82<br>1.2%    |

### 6.1 Non-Clinical Midwifery Roles

The total clinical establishment as produced from Birthrate Plus® (December 2022) is 340.45wte and this excludes the senior management and the non-clinical element of the specialist midwifery roles needed to provide maternity services, as summarised below.

- Director of Midwifery, Heads of Midwifery, Matrons/Managers with additional hours for team leaders to participate in strategic planning & wider Trust business.

- Consultant Midwife
- Recruitment and Retention Lead / International Recruitment
- Practice Educators
- Practice Development
- Governance
- PMA role
- Additional time for clinical specialist midwives as below to undertake audits, training of staff, preparation of information, etc. Perinatal Mental Health
- Screening and Public Health
- Fetal Monitoring
- Infant Feeding
- Bereavement
- Diabetes
- Trauma
- Healthy Lifestyle

Applying 11% to the Birthrate Plus clinical wte provides additional staff of 37.45wte for the above roles with it being a local decision as to which posts are required and appropriate hours allocated.

| Current                                    | Funded | Birthrate Plus recommended | wte Variance |
|--|--------|----------------------------|--------------|
| Additional specialist and management roles |        | wte                        |              |
| 33.56wte                                   |        | 37.45wte                   | -3.89wte     |

6.2 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.

6.3 The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® recommends that 8-10% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.

6.4 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 periods of high activity, several manager and specialist midwives were required to, and continue to work clinically to support safe care provision.

7. *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.*
- 7.1. The twice daily Safety Huddle (see Appendix 2) 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 any occasion when 1:1 care in labour is in jeopardy and/or the Delivery Suite Co-ordinator is at risk of not having 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. This data is reviewed monthly at the Maternity Clinical Governance Committee meeting.
- 7.2. In this data period there was 1 Red Flag uploaded regarding the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator. The delivery suite coordinator was not supernumerary for a period of 1 hour during an acute clinical incident, this role was undertaken by the midwifery manager on call. There were no incidents or additional red flags reported during this time.
- 7.3. *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.*
- 7.4. The agreed staffing Red Flags are listed in Appendix 4.
- 7.5. The Red Flag incidents for the Q3 and Q4 have been outlined in Appendix 4.
- 7.6. Mitigation action was taken which included the movement of maternity staff between the clinical areas, consolidating inpatient beds and the continued temporary closure to intrapartum care of two of the freestanding Midwifery Led Units until January 2023. The impact of maternity staffing and the closure of freestanding Midwifery Led Units resulted in 23 women not able to have their choice of birthplace.
- 7.7. **The table below shows the proportion of births where the intended place of birth was changed due to staffing.**

|                         | Oct-22 | Nov-22 | Dec-22 | Jan-22 | Feb-22 | Mar-22 | Total |
|-------------------------|--------|--------|--------|--------|--------|--------|-------|
| Birth location changed. | 4      | 4      | 0      | 5      | 5      | 5      | 23    |

- 7.8. 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.
- 7.9. 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 several 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.
- 7.10. To ensure one to one care in labour and safety of care provision was prioritised, on-call midwives were called in to the hospital to support services.

The table below shows the number of midwives on call hours required within the John Radcliffe maternity unit during this reporting period. Hospital On Call midwives are rostered to be on call at night. Community midwives are on call for the 24 hour period, although the hours shown below are predominantly at night. It is anticipated that during the next quarter the number of on-call hours will increase as the summer pressures impact on the service.

| Midwives                         | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Total |
|----------------------------------|--------|--------|--------|--------|--------|--------|-------|
| Hospital midwives on call hours  | 207    | 136    | 135.25 | 135.25 | 144.5  | 79     | 837   |
| Community midwives on call hours | 154    | 34     | 171.5  | 36.5   | 108.75 | 67.25  | 572   |

## 8. Midwifery Continuity of Carer (MCoC)

- 8.1. The current MCoC Lotus Team is a fully embedded resource that forms part of the current Midwifery establishment.
- 8.2. An additional MCoC team is planned, prioritising those that are more likely to experience poorer outcomes, focusing on birthing families from minority ethnic backgrounds, and those from the most deprived areas (mapped out in OUHT’s Perinatal Equity and Equality Analysis and Maternity Booking Assessment data 2020/21).
- 8.3. Following the analysis of the current staffing figures, it is recommended that the implementation of the additional MCoC team should not be progressed until an

increase to the current midwifery establishment can be secured. This is subject of a separate funding bid.

- 8.4. The current MCoC Lotus Team is a fully embedded resource that forms part of the current Midwifery establishment.

## **9. International Recruitment**

The service was awarded £54,000 to support the International Recruitment (IR) initiative in which the service planned to use the award to support an IR lead to ensure smooth integration and development of those new posts. The International Midwife lead is due to start in post April 2023.

6 International midwives have been appointed, 5 commenced in post in Q4 and the 6<sup>th</sup> midwife will start in September 2023.

The recruitment of internationally trained registered nurses (RN's) continues, with their expertise being utilised on the post-natal ward, recovery and High Dependency areas.

## **10. Midwifery Short Course**

The 4 candidates that started the course in Q2 will become registered midwives in July 2024.

A further 6 candidates will start in September 2023, funding for both of these courses is from Health Education England (HEE).

## **11. Specific Challenges related to safe staffing**

11.1 The Maternity Directorate wish to bring to the Board's attention some challenges faced around maintaining safe staffing. Examples include-

- The service was awarded £37,926 of external funding to employ a Maternity Support worker to recruit, support, develop and reduce the turnover of this important part of the workforce. Despite funding being allocated, financial processes have meant a significant delay to advancing this externally funded appointment.

11.2 These challenges align with the Maternity Safety Support Programme (MSSP) Diagnostic report as presented to the Trust Board on the 30th of November 2022.

## **12. Conclusion**

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

**13. Recommendations**

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

## Appendix 1 – Monthly Safe Staffing Dashboard

The data used within this report is pulled retrospectively from Healthroster and includes the care hours per patient day (registered nurse and care staff) that were filled against the planned (baseline) number of hours for the calendar month

| January<br>2023   | Care Hours Per Patient Day                                    |   |                                       |                     |                   |                  |                  |                |
|-------------------|---|---|---------------------------------------|---------------------|-------------------|------------------|------------------|----------------|
|                   | Cumulative count over the month of patients at 23:59 each day | Budgeted Registered nurses and midwives | Actual Registered nurses and midwives | Budgeted Care Staff | Actual Care staff | Budgeted Overall | Required Overall | Actual Overall |
| Ward Name         |   |   |                                       |                     |                   |                  |                  |                |
| MW The Spires     | 163   | 18.85                                   | 8.0                                   | 8.62                | 5.8               | 27.47            |                  | 13.8           |
| MW Delivery Suite | 527   | 20.74                                   | 19.0                                  | 4.71                | 2.1               | 25.45            |                  | 21.1           |
| MW Level 5        | 1023  | 4.21                                    | 3.31                                  | 3.17                | 2                 | 7.38             |                  | 4.9            |
| MW Level 6        | 374   | 3.11                                    | 5.47                                  | 1.85                | 2                 | 4.96             |                  | 7.4            |

| February<br>2023  | Care Hours Per Patient Day                                    |   |                                       |                     |                   |                  |                  |                |
|-------------------|---|---|---------------------------------------|---------------------|-------------------|------------------|------------------|----------------|
|                   | Cumulative count over the month of patients at 23:59 each day | Budgeted Registered nurses and midwives | Actual Registered nurses and midwives | Budgeted Care Staff | Actual Care staff | Budgeted Overall | Required Overall | Actual Overall |
| Ward Name         |   |   |                                       |                     |                   |                  |                  |                |
| MW The Spires     | 90  | 18.85                                   | 15.5                                  | 8.62                | 10.9              | 27.47            |                  | 26.4           |
| MW Delivery Suite | 555   | 20.74                                   | 2.9                                   | 4.72                | 1.8               | 25.46            |                  | 17.1           |
| MW Level 5        | 924   | 4.21                                    | 5.26                                  | 3.17                | 2                 | 7.38             |                  | 4.6            |
| MW Level 6        | 331   | 3.11                                    | 23.30                                 | 1.85                | 2                 | 4.96             |                  | 7.7            |

| March 2023        | Care Hours Per Patient Day                                    |   |                                       |                     |                   |                  |                  |                |
|-------------------|---|---|---------------------------------------|---------------------|-------------------|------------------|------------------|----------------|
|                   | Cumulative count over the month of patients at 23:59 each day | Budgeted Registered nurses and midwives | Actual Registered nurses and midwives | Budgeted Care Staff | Actual Care staff | Budgeted Overall | Required Overall | Actual Overall |
| Ward Name         |   |   |                                       |                     |                   |                  |                  |                |
| MW The Spires     | 156   | 18.86                                   | 8.6                                   | 8.64                | 6.0               | 27.50            |                  | 14.6           |
| MW Delivery Suite | 527   | 20.75                                   | 18.2                                  | 4.73                | 1.9               | 25.48            |                  | 20.1           |
| MW Level 5        | 1023  | 4.21                                    | 3.27                                  | 3.17                | 2                 | 7.38             |                  | 4.8            |
| MW Level 6        | 397   | 3.11                                    | 4.95                                  | 1.85                | 2                 | 4.96             |                  | 7.3            |



## Appendix 2 – 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)
- Induction of Labour Midwife

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.

## Appendix 3 – Action Plan for BirthRate Plus 2021-2023

| 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  | Director of Midwifery | November 2022     | <i>Evidence collated and submitted for analysis by BirthRate Plus Team in October 2022.</i>   | Complete |
|   | To submit staffing paper with recommendations from BirthRate Plus.   | Director of Midwifery | December 2022     | <i>Analysis report Received. Business case underway to support increase in staffing.</i>  | Complete |
|   | Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus. | Matrons               | January 2023      | <i>Completed tools for all clinical areas with evidence of adjusted staffing.</i>   | Ongoing  |
|   | To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting.                | Leadership Team       | Rolling programme | <i>Minutes of monthly MCGC meeting with up- to-date dashboards.</i>   | Ongoing  |
|   | To annually review the recruitment and retention plan.   | Leadership Team       | Rolling programme | <i>Recruitment and retention plan for 2022/2023 is currently being updated. Recruitment and Retention Midwife to be appointed in late 2022.</i> | Ongoing  |

## Appendix 4 - 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.



**Oxford University Hospitals**  
NHS Foundation Trust

## Appendix 5 Maternity Staffing Red Flags uploaded onto Trust system October 2022 to March 2023

| Red Flags for all areas  | Oct. 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 |
|--|---------|--------|--------|--------|--------|--------|
| Staff moved between specialty areas  | 72      | 31     | 57     | 28     | 40     | 27     |
| Supernumerary workers within the numbers   | 2       | 0      | 0      | 0      | 21     | 27     |
| Administrative or Support staff unavailable  | 0       | 1      | 7      | 9      | 4      | 9      |
| Staff unable to take recommended meal breaks   | 4       | 47     | 67     | 40     | 64     | 50     |
| Staff working over their scheduled finish time   | 2       | 24     | 13     | 17     | 35     | 28     |
| 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   | 31      | 30     | 31     | 8      | 6      | 0      |
| 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  | 29      | 19     | 21     | 21     | 23     | 13     |
| 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      |
| The Midwifery Labour Ward Coordinator does NOT have supernumerary status (defined as having no caseload of their own during their shift) | 0       | 0      | 0      | 0      | 0      | 1      |

## Appendix 6: Letter from NHS England – Continuity of Carer

Classification: Official

Publication reference: PR2011



- To:
- Trust chief nurses
  - Trust directors of midwifery
  - Trust COO
  - Trust CEO
  - Trust medical directors
  - Trust clinical directors for obstetrics

NHS England  
Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

**21 September 2022**

- cc.
- Regional directors
  - Regional chief nurses
  - Regional medical directors
  - Regional chief midwives
  - ICB chief nurses
  - LMNS Chairs

Dear colleagues

### **Midwifery Continuity of Carer**

We are writing to you to set out essential and immediate changes to the national maternity programme in the light of the continued workforce challenges that maternity services face. There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.

Over the past two years staff have had to work in ways that they never imagined, in difficult circumstances and we know that maternity services are experiencing stress and strain. The top priority for maternity and neonatal services must continue to be ensuring that the right workforce is in place to serve women and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. We hope this will enable your services to improve in line with the evidence, at a pace that is right.

We know trusts have submitted their MCoC plans and will have considered safe staffing levels in submitting their plans. Thank you for your work on these and your efforts to implement MCoC to date

We expect you to continue to review your staffing in the context of Donna Ockenden's final report. Your local LMNS, regional and national colleagues are here to support you with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

As we have said previously:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

**Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.**

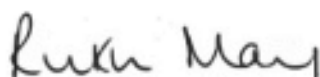
Approved educational institutions (AEI's) educating pre-registration midwifery students will continue the implementation of the future midwifery standards of the NMC. It is



expected that midwifery students will be taught the MCoC model, alongside other approaches to safe, high-quality care for women. The NMC has written to education providers to confirm that this remains a requirement of registration and to suggest how this can be achieved when students are placed in those organisations that are not able to fully implement MCoC at this time. Where this is the case, students will still benefit from practice supervisors and assessors being able to explain and discuss the concept and we would ask for your support to encourage this to happen.

With the advice of the independent working group established after the final Ockenden report, we will publish a national delivery plan for maternity services this winter which will bring together actions for maternity services, including next steps for improving continuity across all professional groups.

Yours sincerely,



**Dame Ruth May**  
Chief Nursing Officer,  
England



**Prof Jacqueline Dunkley-Bent OBE**  
Chief Midwifery Officer  
National Maternity Safety  
Champion  
NHS England



**Dr Matthew Jolly**  
National Clinical Director for  
Maternity and Women's  
Health  
National Maternity Safety  
Champion  
NHS England