Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 17 January 2024

TB2024.05

Title:	**Maternity Safe Staffing for Quarter 1 and Quarter 2 2023/24**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee 27/11/2023**
	Divisional Review 08/01/2024
	Regular Reporting

Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This is the first bi-annual report for 2023/24 which reviews Safe Staffing levels Quarter 1 and Quarter 2.
2. The aim of this report is to provide assurance of an effective system of midwifery workforce planning in part fulfilment of requirements of the NHS Resolutions (NHSR) Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme – year 5. It also informs the decision-making process regarding the future planning for Midwifery Continuity of Carer.
3. 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 Maternity Incentive Scheme (MIS) year five reporting period

Recommendations

4. The Trust Board is asked to note evidence of midwifery staffing budget reflects establishment as calculated in (a) above.
5. Approve and take assurance from this report, that that there is an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q1/2 of 2023/24 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5.
6. In line with midwifery staffing recommendations from Ockenden, the Trust Board must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
7. The Trust Board is asked to consider whether staffing meets safe minimum requirements to continue with the existing MCoC team and note the continued recommendation to pause the expansion of the MCoC provision and rollout until an increase in establishment can be secured.

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Maternity Safe Staffing for Quarter 1 and Quarter 2 2023/24

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 2023 to the end of September 2023. This is a requirement of Year 5 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.
- 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. **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 have refreshed 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. The business case to support the Birth Rate Plus uplift recommendation was agreed at November 2023 Trust Board. The Trust plan to share this with commissioners (NHSR MIS requirement) and the breakdown of the calculations will be evident in the Q3/4 Maternity Safe Staffing Paper.

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.

3.1.4 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.

3.1.5 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.

3.1.6 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.

3.1.7 Fig. 1: Midwifery Funded Establishment

Band	19/20	20/21	21/22	22/23	23/24
812072-B8B Midwives	2.34	2.10	3.10	4.8	4.8
812071-B8A Midwives	3.00	3.80	3.80	10.3	10.82
807070-B7 Nurse Specialists			0.60	0.60	0
808700-B7 Qualified Nurse			1.00	1.00	1.0
812070-B7 Midwives	55.09	57.13	57.13	61.89	66.13
807060-B6 Nurse Specialists	-	-	-	1.00	0
812060-B6 Midwives	180.94	180.94	188.94	174.8	164.5.
808500-B5 Qualified Nurse	1.00	1.00	1.00	18.4	18.5
812050-B5 Midwives	41.40	41.40	40.40	38.32	44.75
	283.77	**286.37**	**295.97**	**310.5**	**310.5**

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 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 and the delivery suite coordinator

remains supernumerary. There is a robust staffing and escalation policy in place as per the OUH Rostering and Safe Staffing Policy v1.0Feb23.This incorporates the Maternity SOP's Staffing and Escalation for OUH Maternity Services and Manager on Call. Furthermore, to highlight and address any staffing shortfall, the Maternity Operational Bleep Holder leads a multidisciplinary Safety Huddle (Appendix 2) which reviews 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 or Teams call. 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 Director of Midwifery or her deputy and the Clinical Director via the Chief Nurse, Chief Operating Officer or Trust duty management team and executive on call out of hours.

3.2.4 The table below shows the RAG rating for actual midwifery staffing levels for April 2023 through to September 2023. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that day.

3.2.5 The RAG rating reported relate to the next shift, prior to mitigation having taken place. If a Red Level 3 rating is declared, mitigation using the SOP Staffing and Escalation for OUH Maternity Services will be applied. An updated email with the mitigation and updated RAG rating will be sent to the Central Trust Safe Staffing Team every 2 hours until the service is no longer declaring Red Level 3.

	RAG Rating		
	GREEN	AMBER	RED
April 2023	5	25	0
May 2023	10	21	0
June 2023	7	22	1
July 2023	6	20	5
August 2023	1	26	4
September 2023	0	26	4

3.2.6 Actions were taken as per Maternity SOP's Staffing and Escalation for OUH Maternity Services to mitigate against any RAG rating of Amber or Red 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.

3.3. 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 Q1 and Q2, the Maternity Directorate had recruited 31.72 wte midwives. In the same period, there were 20.93 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 24 wte midwives and Registered Nurses who will start in post October 2023-March 2024.

Midwives	April 23	May 23	June 23	July 23	Aug 23	Sept-23	Total
New starters	6	2	5	3.72	1	14	31.72
Leavers	6.01	4.32	1.64	3.64	1.92	3.4	20.93

3.3.3 Quarter 1 and 2 have continued to demonstrate a reduction in both sickness and turnover. The Directorate are continuously monitoring this and are acting on themes that emerge.

2023 2024	HR			
	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)
April	3.82%	13.98%	3.86%	5.41%
May	3.86%	13.3%	4.19%	5.33%
June	3.86%	13.3%	4.19%	5.33%
July	7.0%	11.88%	3.22%	6.54%
August	7.0%	12.24%	3.74%	4.21%

September	-25.04%	15.31%	3.95%	4.19%

4. **The midwife: birth ratio and funded establishment**.

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

Funded	April 23	May 23	June 23	Jul-23	Aug-23	Sept-23
	1:25.6	1:25.4	1:27.2	1:26.51	1:26.9	1:28.39
	Quarter 1 average 1:26.06			Quarter 2 average 1:27.2		

4.2. 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 310 wte Midwives and 89 wte Maternity Support Workers. The average birth to ratio for Quarter 1 was 1:26.06 and Quarter 2 was 1:27.2 The midwife to birth ratio was calculated to be outside the targeted establishment for the maternity services; strategies to improve this ratio are in place. 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.

5.2. The table below shows the number of midwives unavailable to work due to Maternity Leave, Career breaks and Sickness. There has been a significant increase in the number of midwives that are taking a career break, Q1&2 will not include this group of staff, they will be treated as leavers.

Midwives	Apri-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23

All absence (includes, M/L, Sickness, Careers leave/Career Breaks.	44.06 14.3%	45.15 14.52%	36.19 11.82%	37.54 12.26%	45.55 13.89%	41.13 13.22%

6. Non-Clinical Midwifery Roles

6.1. 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 /student lead.
- Practice Educators
- Practice Development
- Governance
- Professional Midwifery Advocate (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
- Mental Health
- Healthy Lifestyle
- Digital

- Equality, Diversity, and Inclusion (EDI) Midwife

6.2. Applying 11% to the Birthrate Plus clinical wte (2018 assessment) 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. Now the Trust has approved the 2022 Birthrate plus assessment to support the increase in budgeted establishment of 322.38 wte, in Q3 the current % for additional staff will be 12.09%. A slightly higher percentage is evident and in line with Maternity units of comparable size and available services.

Current Funded Additional specialist and management roles	Birthrate Plus recommended wte	wte Variance
39wte	37.45wte	1.55

6.3. The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® recommends that 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 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 0 Red Flag uploaded regarding the provision of 1:1 care in labour and 1 Red Flag uploaded regarding the supernumerary Delivery Suite Co-ordinator. The delivery suite coordinator was not supernumerary during an acute clinical incident, this role was undertaken by

the maternity beep holder. 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 Q1 and Q2 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, suspension of community births and providing community births on a case by case basis.

7.7. The table below shows the proportion of births where the intended place of birth was changed due to staffing.

	Apr-23	May-23	June-23	July-23	Aug-23	Sept-23	Total
Birth location changed.	0	2	4	3	3	3	15

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 the 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.

7.11 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 reduce as new starters come into the service and the predicted number of births reduce.

Midwives	Apr-23	May- 23	Jun 23	Jul-23	Aug-23	Sept-23	Total

Hospital midwives on call hours	121.75	117.8	154	175	256.5	299.5	1124.5
Community midwives on call hours	76	58	147.25	122.75	305	430.25	1139.25

8. Midwifery Continuity of Carer (MCoC)

8.1. The service has one current MCoC Lotus Team providing care to vulnerable women and birthing people with the highest need, however the service is currently transitioning to a model of geographical based, mixed-risk caseloads in order to make the CoC team more sustainable. This team will be based and work from OX4 Blackbird Leys which is our most deprived and of greatest ethnic diversity area.

8.2. Following analysis of the current Maternity staffing figures, it is recommended that the implementation of any additional MCoC teams should remain paused and not be progressed until an increase in the staffing establishment required to support MCoC can be secured.

8.3. The current MCoC team is a fully embedded resource that forms part of the current Midwifery establishment.

9. International Recruitment

9.1. 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 Recruitment Midwife lead started in post in April 2023.

9.2. Six Internationally Educated Midwives (IEM) have been appointed, five commenced in post in Q4 and the sixth midwife started in September 2023. A further six IEMs are currently going through the recruitment process and commenced employment in December 23 onwards.

9.3. 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

10.1. The four candidates that started the course in September 2022 will become registered midwives in July 2024.

10.2. A further five candidates started in September 2023, they will become registered midwives in July 2025 funding for both courses is from Health Education England (HEE).

11. Midwifery Apprenticeship Programme

11.1. The service are introducing the Midwifery Apprenticeship Programme, two OUHT Maternity Support Workers have been successfully recruited and will commence in January 24.

12. Specific Challenges related to Safe Staffing

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

- Staff relocating due to high cost of living.
- Retirement.
- Staff requesting flexible working to support work/life balance.

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

13. Conclusion

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

14. Recommendations

14.1. The Trust Board is asked to note evidence of midwifery staffing budget reflects establishment as calculated in (a) above.

14.2. Approve and take assurance from this report, that that there is an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q1/2 of 2023/24 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5.

14.3. In line with midwifery staffing recommendations from Ockenden, the Trust Board must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.

14.4. The Trust Board is asked to consider whether staffing meets safe minimum requirements to continue with the existing MCoC team and note the

continued recommendation to pause the expansion of the MCoC provision and rollout until an increase in establishment can be secured.

15. 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.

Apr 23	Care Hours Per Patient Day							
Ward Name	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
MW The Spires	132	18.85	9.9	8.64	8.4	27.49		18.2
MW Delivery Suite	510	12.86	17.1	2.27	2.1	15.13		19.2
MW Level 5	990	3.51	3.17	2.11	2	5.62		4.9
MW Level 6	353	3.09	5.7	1.39	2	4.48		8

May 2023	Care Hours Per Patient Day							
Ward Name	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
MW The Spires	116	18.85	11.3	8.63	9.0	27.48		20.3
MW Delivery Suite	527	12.86	17.3	2.30	2.1	15.16		19.4
MW Level 5	1023	3.51	3.38	2.11	2	5.62		5.2
MW Level 6	379	3.09	5.39	1.40	2	4.49		7.4

June 2023		Care Hours Per Patient Day								
Ward Name		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
MW The Spires		147	18.87	8.3	8.64	7.0	27.51			15.4
MW Delivery Suite		510	12.86	16.7	2.29	2.3	15.15			19.00
MW Level 5		990	3.51	3.33	2.10	2	5.61			4.9
MW Level 6		354	3.10	5.46	1.40	2	4.5			7.3

July 2023		Care Hours Per Patient Day							
Ward Name		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
MW The Spires		114	18.86	12.3	8.64	8.4	27.50		20.7
MW Delivery Suite		527	12.92	16.7	2.30	2.1	15.22		18.7
MW Level 5		1023	3.51	3.33	2.10	2	5.61		5.1
MW Level 6		406	3.10	5.00	1.40	2	4.50		6.5

August 2023		Care Hours Per Patient Day							
Ward Name		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
MW The Spires		74	18.87	18.8	8.64	12.5	27.51		31.3
MW Delivery Suite		527	12.90	16	2.29	2.2	15.19		18.2
MW Level 5		1023	4.56	3.41	2.10	2	6.66		5.2
MW Level 6		499	3.10	3.73	1.40	1	4.50		4.8

		Care Hours Per Patient Day

September 2023 Ward Name		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
MW The Spires		103	18.86	12.6	8.64	7.7	27.50		20.3
MW Delivery Suite		510	12.93	15.5	2.28	2.6	15.21		18.1
MW Level 5		990	4.56	3.62	2.10	2	6.66		5.3
MW Level 6		466	3.09	4.033	1.39	1	4.48		5.2

16. 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.

17. 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	*Evidence collated and submitted for analysis by BirthRate Plus Team in October 2022.*	Completed December 2022
	To submit staffing paper with recommendations from BirthRate Plus.	Director of Midwifery	December 2022	*Analysis report due in Summer 2023.*	Awaiting outcome (Oct 2023)
	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus.	Matrons	**October** 2023	*Completed tools for all clinical areas with evidence of adjusted staffing.*	Rolling
	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 midwives in post from Q1 2022.*	Rolling

18. Appendix 4 – Monitoring Staffing Red Flags as recommended by NICE guidance NG4 'Safe Staffing for Maternity Settings' (2015)

18.1. 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.

19. Appendix 5 Maternity Staffing Red Flags uploaded onto Trust System April 2023 to September 2023

Red Flags for all areas	Apr. 22	May 22	Jun 22	Jul 23	Aug 23	Sep 23
Staff moved between specialty areas	32	32	51	49	93	123
Supernumerary workers within the numbers	10	11	35	38	31	33
Administrative or Support staff unavailable	8	5	2	4	0	6
Staff unable to take recommended meal breaks	49	64	53	70	106	146
Staff working over their scheduled finish time	28	34	17	30	43	70
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	2	0	0	0	0	1
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	0
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 (No of days)	24	21	23	25	30	30
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	1	0	0	**0**

20. Appendix 6 Letter from NHS England – Continuity of Carer

20.1. The Trust received a letter from NHS England on Continuity of Carer on the 21 September 2022 advising them that there is no longer a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans to work for them in line with safe staffing. A copy of the letter is available on the following three pages.

Classification: Official

Publication reference: PR2011

NHS England

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

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

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

21 September 2022

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 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.

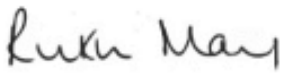
Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

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