The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting: October 2024

Agenda item				
Report Title		Maternity 6-month staffing report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Kimberly Williams Interim Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		BAF4, BAF3
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	67, 87
Well Led	√	Our partners		
Consultation Communication		n/a		
Executive summary:		The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q1 and 2 of 2024/25 inclusive. The maternity service has faced complex staffing challenges over the last 6 months despite a comprehensive, forward-thinking workforce plan. This is due to an unprecedented amount of staff unavailability which has been further compounded recently by the restrictions introduced for recruitment, and the need for executive and system oversight of all vacancies. Maintaining safe staffing levels has required the service to frequently enact the maternity services escalation policy to ensure patient safety is always maintained as midwifery staffing is complex, with acuity changing rapidly based on individual care needs and patient complexities. Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.		
Appendices:		Appendix 1: Midwifery red flags		

1.0 Introduction

1.1 The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q1 and 2 of 2024/25 inclusive. This is a requirement of Year Six of the NHS Resolution Maternity (and perinatal) Incentive Scheme (MIS), and particularly for safety action 5 where the following standards are used:

Table 1

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care.
d	A six-monthly midwifery staffing report that covers the staffing/safety issues is submitted to the Trust Board.

1.2 The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented.

2.0 Background

2.1 SaTH last undertook a workforce assessment in 2022 using the nationally recognised Birthrate Plus (BR+) workforce tool which recommended a total clinical whole time equivalent workforce (WTE) requirement of 199.80 to be made up of registered midwives (RMs) and midwifery support workers (MSWs).

2.2 Additionally, there is a requirement for the service to have, 21.98wte for specialist roles and midwifery management giving a total requirement of 221.78wte.

2.3 The BR+ workforce assessment does not include any uplift for the rollout of Midwifery Continuity of Carer (MCoC) as the National Midwifery team no longer support the use of BR+ for this workforce model. Instead, they advise using the MCoC toolkit which has been designed by the National team however it is worth noting that this is only currently available in beta mode due to undergoing modifications on the advice of BR+.

2.4 As things currently stand, MCoC is paused at SaTH in line with the National letter of September 2022 which was issued following the publication of the final Ockendon report and recommendations on safer staffing.

2.5 To fully delivery MCoC, a workforce uplift will be required based on the findings nationally therefore this means there is a risk that the 199.80 WTE clinical workforce requirement mentioned above may increase in the future once the toolkit becomes available and the Board are asked to note this is a real possibility.

3.0 Current Position

3.1 The below table presents the current workforce position for clinical midwives and MSWs and includes those recruited to but not yet in post. It does not include any specialist midwives, midwifery management roles, or midwife sonographers. It is also exclusive of any staff on fixed term secondments to support the Maternity Transformation Programme.

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
MSWs and Midwives Bands 3 -7**	209.80	195.13	17	+2.32
Telephone Triage	5.6	5.6	0	0
Total	215.40	212.52	17	+2.32

**Does not include management roles or midwife sonographers*
*** Includes 10wte above BR+ for parental leave cover and additional 5.6wte for Triage above BR+*
**** An additional 17wte B5 midwives have been offered positions for autumn start*

3.2 Table 2 presents a stable workforce over-recruited by + 2.32wte, it is important to note that this includes a 10wte increase for unavailability through parental leave above the required recommendation of BR+, in addition to a telephone triage uplift of 5.6wte which again, is outside of BR+ but considered outstanding practice.

3.3 Table 3 presents the unavailability position for the last year, with particular attention being drawn to Q1/2 of 24 to which this report is focused on. Q1 saw our highest number of maternity leave since reporting began which is more than the 10wte agreed over establishment allows for. There is also a sustained long term sickness rate which whilst it has improved since Q1/2 of 22/23, remains consistently high.

Table 3

	Q3 2023	Q4 23/24	Q1 2024	Q2 2024
Parental leave*	14.4wte	17.59wte	18.69 wte	17.43wte
Long term sickness absence**	16.4wte	17.07wte	15.97wte	15.48wte
Supernumerary international midwives	*	10wte	10wte	1wte
Total	30.8wte	44.66wte	44.66wte	33.91wte

3.2 Additionally, the service welcomed 10wte international midwives who are counted within the workforce establishment but are not yet working independently due to being on the preceptorship programme. In Q4/Q1 this accounts for an additional unavailability which, when added to long term sickness and parental leave, becomes a substantial deficit. There has been a marked improvement in the area, with 1 International midwife remaining supernumerary.

3.3 The midwifery leadership team are working closely with HR business partners to proactively manage sickness/absence in accordance with Trust policy and guidance, forward planning sickness meetings in advance to ensure timeliness of support and action.

3.4 Furthermore, the specialist midwifery workforce has been reviewed in their entirety to support an increase in staffing for the short term. Table 4 below presents the current specialist workforce, which makes up 21.8wte.

Table 4

Specialist Role	WTE	Specialist Role	WTE
Fetal Monitoring Midwives	1.0	Public Health Lead Midwife	1.0
Continuity of Carer Lead	1.0	Perinatal Pelvic Health Midwife	0.6
Infant Feeding Lead	0.6	Improving Women's Health Midwife	1.0
Saving Babies Lives Lead	1.0	Lead Education Midwife	1.0
Digital Midwife	1.0	Clinical Practice Educators	2.0
Maternal Mental Health Midwife	0.6	Clinical Practice Facilitators	2.0
Transformation Matron	1.0	Guideline Midwife	1.0
Antenatal Screening Midwife	1.0	EDI Midwife	1.0
Professional Midwifery Advocate- Vacancy *	1.0	Multiple Pregnancy Midwife	0.6
Frenulotomy Lead Midwife	0.4	Bereavement Midwives	2.0
BFI Lead Midwife	1.0		
Total	**9.6**	Total	**12.2**
Full total			**21.8**

3.5 Moreover, managers work clinically when required, including providing an on-call regular need to enact the midwifery escalation policy to support safe staffing.

3.6 Daily staffing meetings remain in place to focus on a two-week forward look ahead which provides a further opportunity to identify hot spot areas and action appropriate solutions to maintain safe staffing levels.

3.7 Each month the planned versus actual staffing levels are submitted to the national database and NHS Improvement using the information provided from the Healthroster Allocate rostering system and reported monthly to the workforce meeting.

3.8The service also benefits from a recruitment and retention midwife thanks to initial funding from Health Education England (HEE); this post has been further extended as a commitment to continuing to supporting midwives/MSWs to remain in practice.

4.0 Workforce Plan

4.1 Midwifery has an attrition rate of around 20wte each year in addition to continued long-term unavailability made up from a combination of parental leave and long-term sickness absence. While there is an element of funding available to cover parental leave in the short term, historically, it has always been difficult for providers to recruit to temporary posts especially in the presence of a national midwifery workforce gap.

4.2 This required SaTH to be proactive from a workforce perspective, agreeing with finance to convert some of the funding from recurring temporary positions to 10wte substantive positions that would attract midwives looking for stability and job security.

4.3 The below table presents the planned recruitment currently in train as part of the workforce plan, the majority of which is either already advertised and in the process of being recruited to or about to be advertised and pending executive/system approval as part of the interim financial restrictions.

Table 5

Planned Recruitment	WTE	Additional Info.
Midwifery Apprentice programme	9.0 over 3 years	3 commenced the programme in Sept 23, this has been paused currently in line with the current recruitment freeze.
International Midwifery Recruitment	2 per year	Initial programme recruitment trajectory (10 per year) followed by 2 per year subject to nominal role.
Midwifery Support Worker Apprentice programme	3.0	This has been approved at local/ executive level.
Apprentice Midwife sonographer	2.0	This has been approved at local/executive level, awaiting system approval level.

Breastfeeding support midwife	0.6	This has been paused in line with current recruitment freeze.

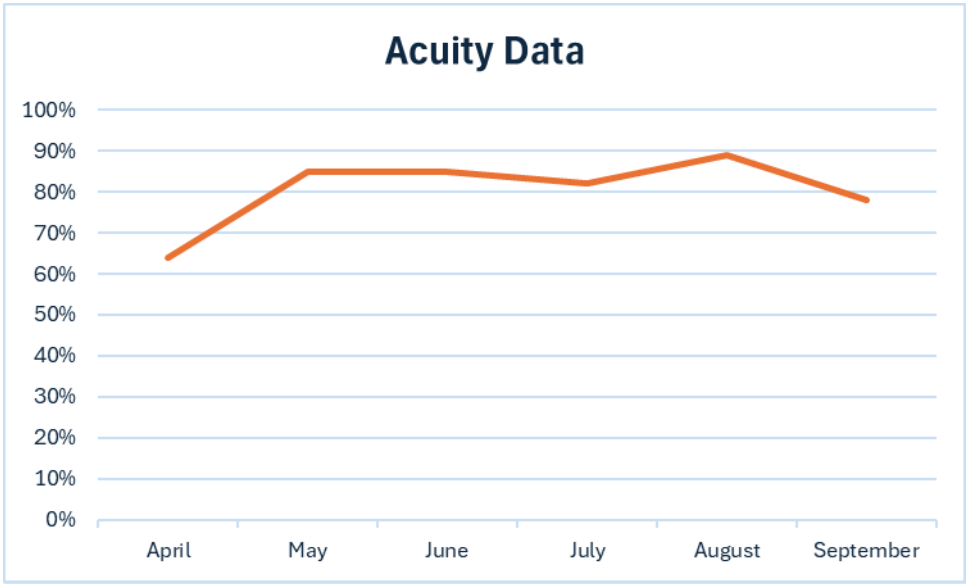
4. Acuity Data

4.1 For this report, acuity is referencing intrapartum activity (the number of women being cared for on the delivery suite) and is measured using the BR+ acuity tool. BR+ defines acuity as "the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency."

4.2 A positive acuity score means that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the delivery suite at the time. In addition, the tool collects data such as red flags which are defined as a "*warning sign that something may be wrong with midwifery staffing.*"

4.3 The below graph presents the acuity data for Delivery Suite over the last 6 months (April 2024 – September 2024) inclusive:

Graph 1



5.4 The agreed standard for positive acuity nationally is 85%, with providers fully established and with minimal unavailability achieving more than that figure. As can be evidenced on the above graph, the unavailability described within this report is impacting on the service daily, affecting our overall performance and safer staffing position.

5.5 There has been an increase in positive acuity over the last 6-months, with the service reaching the national target consecutively for three months. September was a particularly challenging month for the service as in addition to the unavailability described within table 3, there was a significant amount of short-term sickness/carer's leave.

5.6 A number of immediate actions were taken in response to this to ensure patient safety which included a review and redeployment of the specialist midwifery workforce to support safer staffing as described earlier within this report.

6.0 Red Flags

6.1 A midwifery red flag is known as a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service (usually the Delivery Suite Coordinator) should be notified. The midwife in charge should determine whether midwifery staffing is the cause and what action is needed.

6.2 The table below shows the number of red flags in month, followed by the percentage of shifts identified by the tool as red, amber, or green acuity. Any event of the coordinator not being supernumerary, or 1:1 care in labour not being met require immediate escalation as per the escalation of maternity services policy to the manager of the day, or on-call manager out of hours.

Table 6

Month	Red Flags	One to one Care not met	Co-ordinator not supernumerary	Positive (green) Acuity %	Acuity Amber %	Acuity Red%	Acuity Compliance Rate
April 2024	49	0	0	64%	28%	8%	85%
May 2024	30	0	0	85%	13%	2%	88%
June 2024	18	0	0	85%	14%	1%	86%
July 2024	34	0	0	82%	14%	4%	87%
August 2024	24	0	0	89%	8%	3%	85%
September 2024	56	0	0	78%	20%	2%	82%

6.3 To meet standards b and c of the NHS Resolutions MIS safety action 5, the number of times when 1:1 care in labour has not been met is reported, along with the status of 'coordinator not supernumerary' via the hospitals incident reporting system Datix, in addition to being recorded on the BR+ acuity tool.

6.4 As can be evidenced from table 6 above, the service was able to maintain 1:1 care in labour for all women 100% of the time and there were no occasions whereby the coordinator was not supernumerary as defined within the technical guidance of the NHS Resolutions MIS.

6.5 The maternity service holds twice daily safety huddles during which all red flags are discussed from across the service areas. Where there is a shortfall, midwives will be rotated from one area to another to support any increase in acuity and facilitate safe care.

6.6 The escalation policy is implemented should any area require additional midwifery staffing based on patient numbers and acuity/complexity and all staffing incidents are triangulated at the maternity incident review meeting to identify any impact on patient care.

7.0 Retention

7.1 The midwifery service has a retention lead midwife who oversees recruitment and retention, and this is having a positive impact on our turnover rate which is significantly below the Trust target for all staff groups (except midwifery management due to a whole new structure). Rates are typically between 3-5% against the Trust target of 13.1%.

7.2 This is in-keeping with the service having retained our entire cohort of newly qualified midwives who commenced in post in 2021 and 2022, successfully supporting them all to achieve band 6 midwife competencies. Similarly, in 2024, we have 17 wte newly qualified midwives commencing employment, this autumn

8.0 Midwife to Birth Ratio

8.1 There is no national standard midwife to birth ratio however for years, the midwifery world has worked to the well cited ratio of 28 or 29.5 births to every 1wte.

8.2 The last BR+ assessment which was undertaken in 2022 advised an overall ratio for SaTH of 22.2 births to 1wte which is based on extensive data from BR+ studies and is calculated from a detailed assessment of our workforce planning. The below table shows the WTE broken down by area:

Table 7

Type of care	WTE
Delivery suite births, all hospital care	29.9 births to 1wte
All hospital births, all hospital care	29.4 births to 1wte
Homebirths	33.1 births to 1wte
Community AN & PN Care, all hospital care	96.8 cases to 1wte
All community care including attrition and safeguarding	91.9 cases to 1wte
Overall ratio for all births	**22.2 births to 1wte**

8.3 There is disparity within the community teams with some areas providing a much smaller caseload than others which is not equitable and is impacting on overall morale in the community. For example, Shrewsbury team are supporting caseloads as low as 1:51, with Market Drayton as high as 1:91. This has been highlighted from the community benchmarking assessment which identified variation in shift patterns as a theme and contributory factor. A Quality Improvement project has been registered to review the recommendations from the report. This will also require a full management of change to resolve.

8.4 The below table represents the midwife to birth ratio for all births which is determined by the number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability as detailed earlier within this report.

Table 8

	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024
Midwife to Birth Ratio	1:23	1:23	1:22	1:22	1:22	1:23

8.5 The figures in table 8 are occasionally above the desired overall ratio of 1.22 and this is due to the unprecedented amount of staff unavailability detailed within table 3.

9.0 Medical Staffing

9.1 The Trust operates a tier 3 rota system for obstetric medical staffing which means there is 24/7 on-site consultant presence as opposed to a consultant being on-call from home.

9.2 One of the many benefits of a tier 3 rota is that there is no delay out of hours when consultant attendance is required as they are already on site and therefore do not have to mobilise into the maternity unit.

9.3 From a rota perspective, the below table shows the number of medical staff supporting each tier of the rota currently and only includes those:

Table 9

Rota Tier	No of Medical Staff- wte
Tier 1 (ST1-ST3)	11
Tier 2 (ST4-ST8)	11
Tier 3 (Consultant*)	25

*Exclusive of Gynaecology

9.4 In respect of the tier 1 and 2 rota, there have been rota gaps in the last 6 months however, they have been back filled.

9.5 Within the Obstetric tier 3 rota, there are twenty that contribute to the on-call rota. Of these, two are Trust locums and one is agency locum. Locums were appointed as the service recognised that the various gaps were being filled by existing staff as internal locums which was not sustainable in the long term.

9.6 Additionally, it is worth noting that the provision of obstetric care is always prioritised given that this is the acute service, however this does mean that there are often gaps within the Gynaecology service as elective care is cancelled to release capacity to support obstetrics. The knock-on effect of this is that the numbers of patients waiting for elective gynaecological procedures continues to increase leading to a sustained reduction in referral to treatment (RTT) performance for this specialty area.

9.7 The specialty has a comprehensive locum induction package that sets out the requirements for all locums to undertake both PROMPT and fetal monitoring training prior to working clinically to reduce the risks to patient safety that are known to be linked to staff unfamiliar to the working environment/multidisciplinary team. This induction package links into the requirements of NHS Resolutions MIS and specifically, the obstetric workforce element of safety action 4.

10.0 Midwifery Continuity of Carer

10.1 MCoC at SaTH remains paused in line with both the recommendations on safe staffing from the Ockenden Report, and the National letter published in September 2022.

10.2 The letter advised that any Trust that was unable to 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.

10.3 As the Trust continues to improve its staffing provision, there will be an

expectation from the LMNS, regional and national teams to review our position in terms of restarting MCoC as a model of care. However, although our vacancy position has improved significantly, we continue to have an extremely high unavailability which must be taken into consideration before any alterations are made to current service provision.

10.4 In the meantime, we are committed to implementing the building blocks of MCoC and are looking at the feasibility of a dedicated homebirth team and elective caesarean section team which would have no impact on current service position as this service is provided from within our current establishment.

11.0 Conclusion

11.1 The maternity service has faced some complex staffing challenges over the last 6 months despite a comprehensive, forward-thinking workforce plan. This is due to an unprecedented amount of staff unavailability which has been further compounded recently by the restrictions introduced for recruitment, and the need for executive and system oversight of all vacancies.

11.2 Maintaining safe staffing levels has required the service to frequently enact the maternity services escalation policy to ensure patient safety is always maintained as midwifery staffing is complex, with acuity changing rapidly based on individual care needs and patient complexities.

11.3 Despite the challenges described within this report, the service has seen an improvement in our overall retention rates for all staff groups which are significantly better than the Trust target.

11.4 Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.

12.0 Actions Requested of the Committee/Board**

12.1 Review and discuss this paper, advising the Director of Midwifery of any additional details required.

12.2 Note the content for upwards reporting to the Board via QSAC

Appendix 1

Maternity red flag events, NICE (2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time-critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Other midwifery red flags may be agreed locally.