Workforce Review

Executive Committee Meeting	**Date:** **Agenda Item:**	
REPORT TITLE:	Maternity Workforce Review	
EXECUTIVE SPONSOR:	Jane Dickson	
REPORT AUTHOR (s):	Michelle Cudjoe	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Executive Committee: 20.01.2021 Private Board November: 26th November 2020	
Action Required:		
Approval (√)		
Purpose of Report:		
This paper was presented to the Board in November 2020 in compliance with NICE Standard NG4 and the NHS Resolution requirement (CNST Standard 5) in relation to Safe Staffing for Maternity Settings. The requirement is that a systematic review of the midwifery establishment is submitted to the Board every six months. The Ockenden report has since recommended that Trust Boards confirm that they have a plan in place to meet Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for implementation.		
Summary of key issues		
• In line with the Trust's vision, the maternity service has a vision to maintain its outstanding rating and move from a rating of 'Good' to 'Outstanding' in the CQC safety domain. • In 2018/2019, a Trust commissioned Birthrate Plus review against the SaSH activity identified a deficit in midwifery staffing levels against the national standards in regard to the midwife to birth ratio. This		

workforce modelling was based on a traditional model of midwifery care.

- The Birthrate plus report demonstrated that for the above level of acuity the service should be funded to a ratio of 1:24. The staffing shortfall to achieve this was 33 wte. In 2019/2020 an uplift of 5 wte midwives and 3 wte Maternity support workers was allocated. This increase in midwifery staffing levels improved the overall staffing ratio to the current **1:29**
- In January 2020, the LMS undertook a midwifery workforce analysis based on the national requirement to implement the continuity of carer model of maternity care provision. This review identified a further increase of 2.10 wte for the traditional model from the previous year's analysis given an increase in the birth rate. The review demonstrated that implementing the smaller teams and caseloads required to achieve continuity of carer would result in a larger midwifery staffing deficit of 35 wte.

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- The attached workforce review was presented to the private board in November 2020 with a commitment to addressing the staffing shortfall and an action to source the required funding. The CEO, Chief Nurse, Medical Director and senior maternity team negotiated with external stakeholders in regard to funding the existing shortfall.

- A commitment to support further investment in the maternity service has been since been obtained from the ICS subject to ICS governing body approval.

- The report has been updated to include a recruitment phasing plan and the timescales for implementation is outlined in section 5 of the report

- It is also a requirement within the Ockenden report that CNST incentive money is reinvested and ring fenced for the maternity service

Recommendation:

- To increase the funded establishment by 27 wte thereby addressing the identified deficit within midwifery staffing levels and also enabling the implementation of continuity of carer for the most vulnerable women.

- Midwifery staffing levels will continue to be reviewed annually as

recommended. Quality metrics will be presented to the Board on a monthly basis.

- Any CNST incentive money received by the Trust is to be reinvested into the maternity service
- The board is asked to confirm the staffing plan and timescales for implementation in section 5 of the report.

Relationship to Trust Strategic Objectives & Assurance Framework:

SO1: Safe – Deliver safe, high quality care and *improving* services which pursue perfection and be in the top 25% of our peers

SO2: Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy

SO3: Caring – Work *with compassion* in partnership with patients, staff, families, carers *and community partners*

SO4: Responsive – To *continue to be* the secondary care provider of choice for the *people of our community*

SO5: Well led – To be a *high quality* employer of choice and deliver financial and clinical sustainability around a patient centred, clinically led leadership model

Corporate Impact Assessment:

Legal and regulatory impact	
Financial impact	
Patient Experience/Engagement	
Risk & Performance Management	
NHS Constitution/Equality & Diversity/Communication	

Attachment:

1. Summary

This midwifery workforce review is presented in compliance with Nice Standard NG4 and the NHS Resolution Maternity Incentive Scheme Standard 5.

This report highlights the findings of two externally commissioned Birthrate Plus workforce reviews against the SaSH activity, acuity and staffing profile. Whilst the two reviews are consistent, the first focussed on the ratio required for a traditional model of care and the second focussed on the staffing numbers required to implement smaller continuity of carer teams mandated following the launch of the Better Births National Maternity review.

The report also includes information regarding the supernumerary status of midwifery coordinators and the provision of 1:1 care in labour, both of which are outcome measures linked to safer maternity staffing. It demonstrates how the recent investment in maternity has been allocated to improve both of these safety measures.

Three options have been identified to address the current shortfalls identified;

- Option A: To fund the identified shortfall of 35 wte thereby addressing both the staffing needs for the existing acuity within the case mix and achieving compliance with the continuity of carer target for the majority of women.
- Option B: To fund the shortfall against the Birthrate Plus traditional model of 27 wte, which would deliver safe staffing ratios – This alone may not be sufficient to deliver full continuity of carer, however many Trusts have found that with small amounts of additional investment the national target can be achieved. In this model the most vulnerable groups can be prioritised to receive care in a continuity of carer model.

The Safe Staffing ratios and costs listed in option B is what is a requirement within the Ockenden Review.

- Option C: Cap bookings to reduce activity and decrease the staffing deficit

2. Introduction

Key issues

The NHS Resolution Maternity Incentive Scheme stipulates that a bi-annual midwifery staffing oversight report is submitted to the Board and that the report includes evidence that:

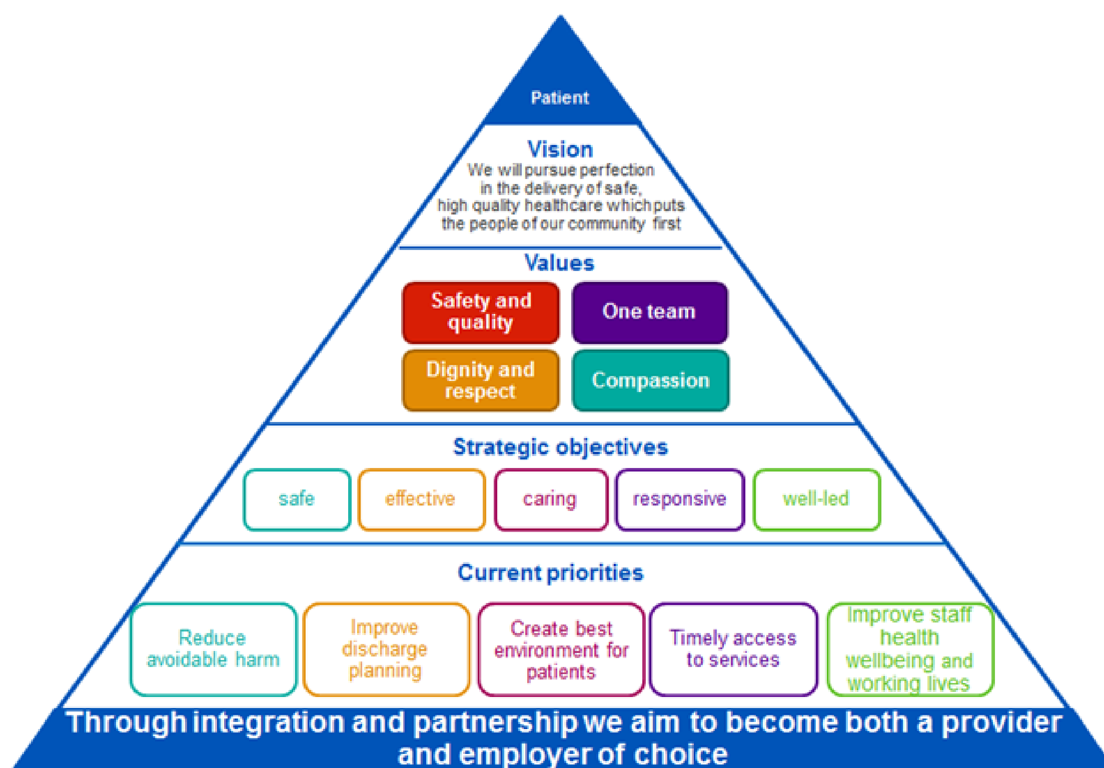
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service

c) All women receive 1:1 care in labour

This paper will address these three issues and will also provide assurance regarding existing contingencies to cover staffing shortfalls or address peaks in activity.

Trust Strategy



Care Quality Commission

In the 2018 CQC inspection the Trust was rated outstanding overall. As a core service Maternity was also rated outstanding and achieved an outstanding rating in four of the five domains with a 'good' rating for safety. The ongoing aspiration is to maintain Outstanding in all current domains and to further achieve Outstanding in the Safe domain. Achieving safe staffing is a key aspect of the safety domain.

Since the time of the CQC assessment, the recommendation to achieve continuity of carer has been mandated in maternity contracts and incentivised by CNST. The main objective of continuity of carer builds on the benefits of a relational model of care and aims to ensure that women have their care provided by the same midwife over the continuum of the antenatal, intrapartum and postnatal care.

As a result of the impact of Covid19, NHSE has amended this target stipulating that 35% of women will receive continuity of carer by March 2021, with priority given to those of greatest need such as BAME women. With the revised guidance on caseload sizes the Trust is currently achieving 6% compliance. In order to improve compliance, new models of care including

midwives working in smaller teams (no greater than 8) with significantly smaller caseloads (of 36 women) need to be implemented.

Maternity Safety

Safety remains a top priority within the Maternity Service, the Chief Nurse and Medical Director are the identified Board Level Safety Champions for the Maternity Service and meet with Maternity leads on a monthly basis to discuss safety issues within Maternity.

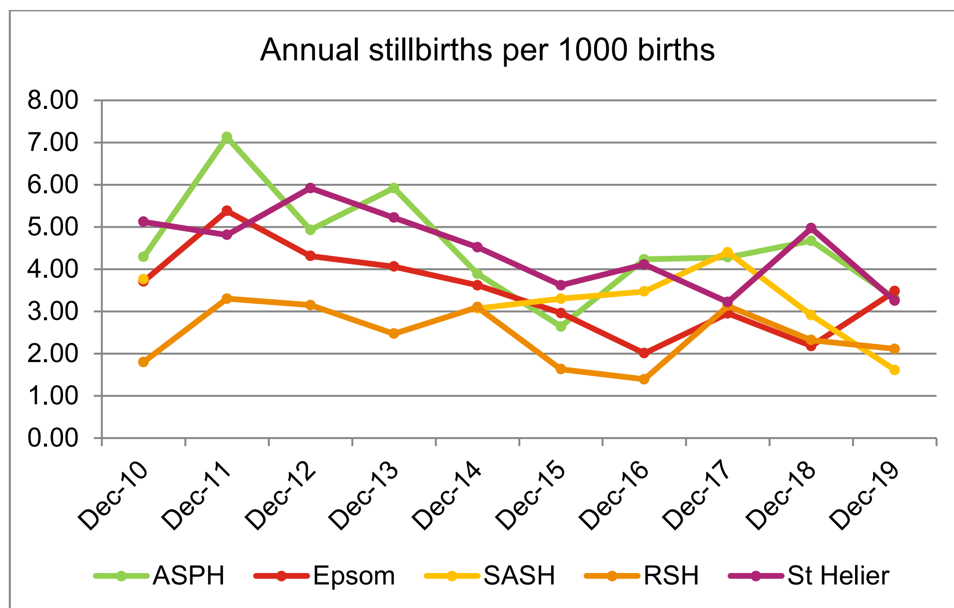
The NHS CNST scheme supports the delivery of safer maternity care through an incentive scheme which rewards Trusts that meet 10 specific safety actions linked to the delivery of best practice in maternity and neonatal services. In 2019/2020 the Trust declared compliance with all ten safety actions outlined below. It is worthy of note however that the standards have been changed for 2020/2021 to now include a specific target of 35% compliance with Continuity of carer within Standard 9. Given the existing staffing shortfall the service is unlikely to be compliant with this standard in 2020/2021. Unlike previous years there is also a risk that compliance with Safety Action 8 – 'in –house' training may not be achieved given the impact of the pandemic on the workforce this year.

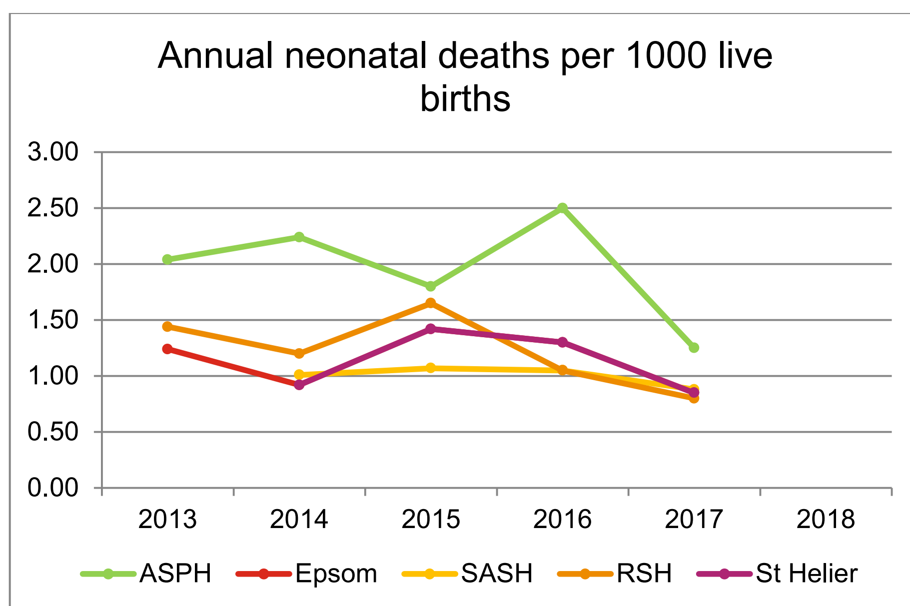
As with the CNST incentive scheme, within the Ockenden report there is also a requirement that external funding allocated for maternity staff is ring fenced for use within Maternity

Safety action 1	Using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard.
Safety action 2	Submission of data to the Maternity Services Data Set (MSDS) to the required standard.
Safety action 3	Demonstrates that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme.
Safety action 4	Demonstrate an effective system of clinical* workforce planning to the required standard.
Safety action 5	Demonstrate an effective system of midwifery workforce planning to the required standard.
Safety action 6	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2.
Safety action 7	Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services.
Safety action 8	Evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year
Safety action 9	Demonstrates that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues
Safety action 10	Reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?

In November 2015 the national maternity ambition was launched, setting out the aim to reduce the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth in England
by 50%. Since that time, the Trust has invested in the implementation of the Saving Babies Lives bundle with an increase in both the number of sonographers required to implement new standards linked to the identification of intra uterine growth restriction (a risk factor in stillbirth) and in procuring an online tool to enable CTG competency assessment for all staff.

The table below demonstrates a sustained reduction in the still birth rate since this quality improvement work was introduced in 2017 and provides a positive comparison with local maternity services. It is worthy of note, however, that whilst the data reflects outcomes for all women who gave birth at SASH there is a disproportionate involvement of BAME women within this as demonstrated in later tables.





The total number of still births is small which is demonstrated in the overall Trust rate of stillbirths per 1000 births. However, the table below clearly shows a variation between involvement of BAME women compared to non BAME women in adverse outcomes including stillbirths. Whilst only 26% of the overall number of women who book at SASH are of a BAME background 66% of all stillbirths were born to BAME mothers.

Stillbirths

2019-20	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTAL**
Stillbirths Pre-labour	0	0	1	1	0	1	0	0	1	0	0	1	**5**
Intrapartum	0	0	1	0	0	0	0	0	0	0	0	0	**1**
TOP > 24wks	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Demographics													
WHITE	0	0	2	0	0	0	0	0	0	0	0	0	**2**
BAME	0	0	0	1	0	1	0	0	1	0	0	1	**4**

Adverse Incidents

On reviewing the data in relation to adverse incidents it is evident that whilst the number of incidents is low that this data also shows a disproportionate involvement of BAME families.

Maternity Serious Incidents 2019-2020	BAME split
7	4 (58%)
Maternity Moderate Incidents	BAME split
17	8 (47%)

Whilst the maternity safety data demonstrates improvements linked to quality improvement work in relation to an overall reduction in stillbirth, there are a number of women who continue to be disproportionately affected. This cohort of women will benefit the most from the trusting care relationship achieved through continuity of carer.

3. Workforce Factors

- A systematic midwifery workforce review was undertaken in 2018-2019 utilising the Birthrate Plus tool endorsed by NICE. This analysis was undertaken prospectively to assess midwifery staffing requirements to enable a safe traditional model of care.
- A further Birthrate Plus analysis was undertaken to specifically understand the midwifery workforce requirements needed to achieve the Continuity of Carer recommendation. At this time the traditional analysis was also refreshed.
- The two workforce reviews used a consistent methodology in terms of reviewing activity and acuity but the second focussed specifically on continuity of carer.

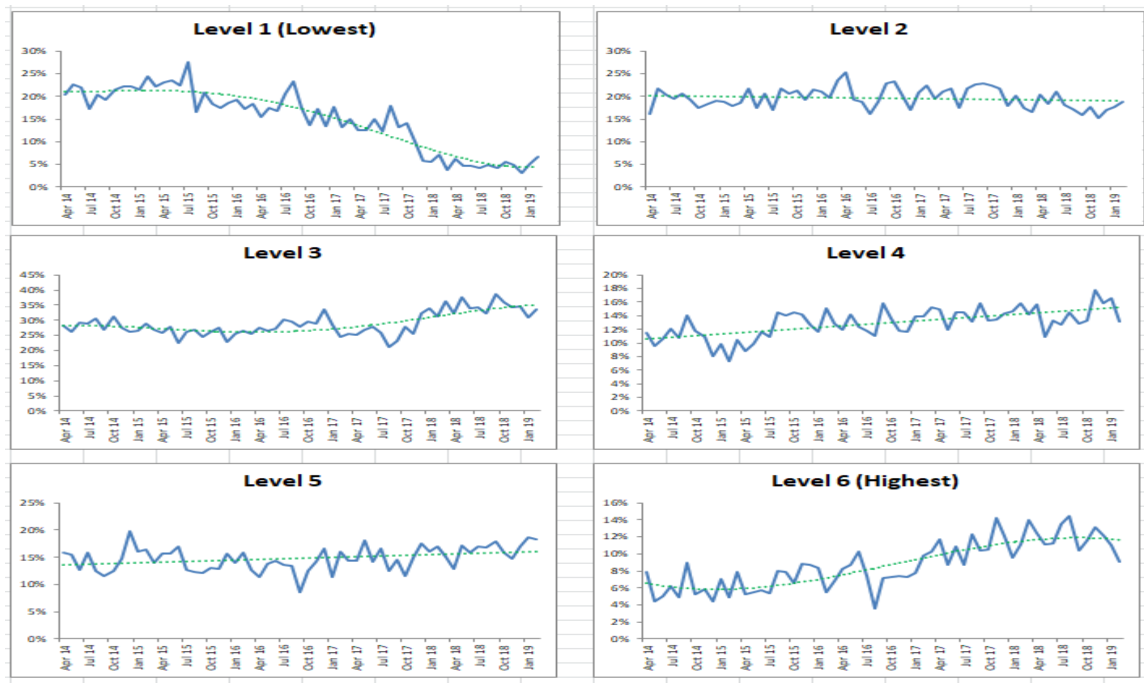
Patient Profile/Case mix

The birthrate plus workforce analysis identified that the Generic Case mix for SASH indicated that 20% of births were in the lower categories I & II, with 80% in the moderate to high risk categories, of which 66.8% fell into IV & V the highest risk categories.

Of the 55 maternity units in England that undertook a BR+ assessment from 2015 to 2017, the average % of women in the highest risk Categories IV & V is 56% range from 41 to 69%.
The Surrey and Sussex Healthcare Trust at 66.8% is in the upper range, indicating that a significant % of the population require more clinical input.

The above findings of the birth rate plus workforce analysis regarding acuity was consistent with both an internal analysis of SASH data in relation to acuity and a comparison between SASH deliveries vs the National case mix.

An analysis undertaken in 2019/2020 used the 6 levels of the HRG grouper and demonstrated a compelling increase in acuity (levels 1 & 2 demonstrating a decline and a corresponding increase in level 6) from 2016 onwards.



In order to provide all aspects of midwifery care in a safe and sustainable way for the case mix described above the Birthrate plus review identified a requirement to staff the maternity service to a ratio of 1:24 for a traditional model of care. The identified shortfall was **33.09** wte staff . When this was refreshed in 2019/2020 the shortfall increased to **35.1 wte** based on a slight increase in the birth rate.

SURREY & SUSSEX NHS TRUST	**13.11.18**		
	RMs	**MSWs**	**Bands 3 - 7**
Current Total Clinical	143.95	6.80	157.06
Contribution from Specialist MWs	6.31		
Total Current Funded	**150.26**	**6.80**	**157.06**
BR+ Clinical wte			**182.72**
Skill Mix Adjustment (90/10)	164.45	18.27	-25.66
Variance +/-	-14.19	-11.47	
TOTAL CLINICAL VARIANCE		**-25.66**	
	BR+	Current	**Variance**
Non-clinical midwifery wte @ 9%	16.44	9.01	**-7.43**
			-33.09
TOTAL BIRTHRATE PLUS WTE			**199.16**
CURRENT FUNDED WTE (Bands 3 to 8)			**166.07**
			-33.09

Following the workforce review in 2019-2020, the Trust invested in the maternity service. There was an increase in the midwifery establishment of 5 wte midwives and 3 wte support workers leaving a shortfall of **27.1 wte**. However, the investment improved the midwifery ratio from **1:31** to **1:29.**

A proportion of the investment was utilized to implement two modified continuity of carer teams for BAME pregnant women. The metrics below were devised to support the agreed investment from the Quality Fund into midwifery staffing, and monitor the effectiveness of the investment to achieve agreed outcome measures.

Dashboard metrics

- % women booked on to Continuity of Care - all - Measured monthly
- % women booked Continuity of Care - BAME - measured monthly
- Number still births in month - all - measured monthly with annual calculation of per 1000 births
- Number of still births in month - BAME- measured monthly with annual calculation of per 1000 births
- Number of preterm births – measured monthly with annual calculation
- BAME Women booked by 10 weeks – monthly measurement
- Total Number of Serious and moderate harm incidents – All
- Total number of serious and moderate harm incidents – BAME

Workforce requirement to achieve the Continuity of Carer requirement

Further to the workforce review commissioned by the Trust, the SES LMS commissioned Birthrate plus to undertake an LMS wide midwifery workforce review in 2019-2020. This was undertaken to specifically understand the midwifery workforce requirements needed to achieve the Continuity of Carer requirements as well as address activity and acuity. As shown in the table below, the analysis for continuity of carer revealed a larger staffing shortfall (8 additional wte) given the requirement for smaller caseloads and the mandated provision of continuity of care across the whole of the maternity pathway.

Continuity of Carer Teams	**Annual Activity**	**Clinical WTE**
Integrated Team (includes home births)	1165	38.49
High Risk team	182	7.00
Hybrid Model	602	20.06
Hospital Births – all inpatient and outpatient care (core services)	2514	96.41
Total Community	3002	30.02
Additional Roles required including management,specialists etc		17.28
TOTAL CLINICAL WTE and shortfall		**209.26 (-35.09)**

Since the time of this review the National team have produced another model to re-analyse the specific requirements for continuity of carer and determine how this differs from traditional birthrate plus baseline. The service is currently working with the national team to determine whether or not this equates to the birthrate plus analysis for Continuity of Carer. It is acknowledged however that if the service is funded to the traditional model specified by Birthrate plus that it will be possible to achieve at least 35% compliance of continuity of carer.

Additionally, if funding from the CNST incentive scheme is reinvested into maternity this can also be used to further support the Continuity of Carer target.

Supernumerary status of the labour ward coordinator

NHS Resolution stipulates that the midwifery coordinator in charge of the labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure that there is an oversight of all birth activity within the maternity unit.

Within the service there are 8.7wte midwifery coordinators. This resource allows for the allocation of a coordinator in a supernumerary capacity, as required by the NHS Resolution scheme. During working hours a maternity Matron is allocated as ‘matron of the day’ to support operational oversight of the service. The Matron of the day and the Labour Ward Manager support the labour ward coordinators during working hours to ensure that supernumerary status is maintained. Given that outside of hours there is less of a staffing resource to utilise during peaks in activity, it was necessary to preserve the supernumerary status of the coordinators at night. Consequently, a proportion of the investment received in 2019-2020 which included Band 7 midwives was utilised to increase the delivery suite template at night, thereby ensuring that the midwifery coordinator maintains supernumerary status and ensures oversight of the activity.

All women should receive 1:1 care in labour

1:1 care in labour is an outcome measure linked to safer staffing which is monitored on a monthly basis within the Division. A review of the maternity dashboard for 2019-2020 identified that 99% of women received 1:1 care in labour. (The figures below exclude women who had an elective caesarean section)

Metric Name	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
1:1 care	283	347	305	316	341	347	326	298	296	304	322	320
women	284	353	306	321	347	353	328	302	302	310	326	327
1:1 Care in Labour	**99.6%**	**98.3%**	**99.7%**	**98.4%**	**98.3%**	**98.3%**	**99.4%**	**98.7%**	**98.0%**	**98.1%**	**98.8%**	**97.9%**

Of the 53 women reported as not having 1:1 care in labour 52 had a precipitate labour and had their baby either at home before the arrival of a midwife, en route to the hospital or in a setting such as the ED before arriving to the labour ward.

Excluding those women who had a precipitate labour and a baby born before the arrival of a midwife in another setting, **99.9%** of women had 1:1 care in labour. Only one woman did not have 1:1 care due to clinical activity

Staffing Contingencies

The 'Hands on Help' on call system is a robust staffing contingency that is in place to address short term shortfalls in midwifery staffing or unexpected peaks in activity. This is a system in which a midwife is on call and is called in to support the unit during either peaks in activity or short term staffing shortfalls. Additionally, the service operates a two tier 24/7 manager on call system with a Band 7 or Matron being the first on call and the Director of Midwifery or Head of Midwifery second on call. This enables senior oversight and clinical support particularly outside of hours.

The following steps are also taken to address staffing shortfalls or peaks in activity:

- Utilisation of bank staff (and occasionally agency),
- Redeployment of specialist staff and staff from other areas within the maternity service.
- Senior management team working clinically
- Suspension of the maternity service is only undertaken as a last resort and to safeguard the quality and safety of care.

The contingencies described above were utilised during the pandemic when a large proportion of the maternity workforce was absent either due to shielding, pregnancy or covid related symptoms. Owing to the significant shortfall in staffing other action such as the introduction of remote consultations and a modified schedule of antenatal and postnatal visits was also introduced. Given

that elective work paused in other areas of the organisation, nursing staff from other areas were redeployed to the maternity service to support postnatal care.

4. Options

Option A

To source the funding required to address the total staffing deficit identified by the systematic Birthrate plus Continuity of Carer specific workforce review. Funding the additional 35 wte staff will not only provide a safe level of staffing for the activity and acuity identified by the review but will also enable the service to achieve continuity of carer for at least 40% of women. The service will have a specific focus on prioritising the needs of BAME and vulnerable groups to reduce the inequalities identified in the report.

Of the 35 wte, 26.53 can be Band 6 midwives and 8.47 Band 3 support workers

Post	Grade	WTE	Cost £'000
Midwife	Band 6	27	£1,465
Maternity Support Worker	Band 3	8	£278
Total		**35**	**£1,743**

Option B

To agree funding for the shortfall against the birthrate plus traditional model. This will adres safe staffing for a traditional model as well as enable approximately 35% compliance with the CoC target.

Of the 27.1 wte a skill mix can also be included of 19 wte Band 6 midwives and 8 wte Band 3 support workers

Grade	Inc Pt	WTE	Annual Cost £BASIC	PATTERN	FROM PATTERN
B6	MID	19	44,486.75	1.3	1,098,822.73
B3	MID	8	26,703.00	1.4	299,073.60
Total					1,397,896.33

Option C

Reduce activity by capping bookings to improve existing ratios.

- This can be achieved by limiting access to women who are not within the geographical area but have opted to have their maternity care at SASH thereby limiting the number of bookings undertaken each month.

Should option C be considered as a viable option, the service will need to identify the optimum number of births per month based on the available midwifery resource and the available beds in Maternity.

Preferred Option

- Option B: This is the preferred option as it enables safe midwifery staffing in line with the Ockenden review, progression towards the national recommendation of continuity of care and avoids the de-stabilising of other services.
- Midwifery staffing levels will continue to be reviewed six monthly as recommended.
- Any external funding received from the CNST scheme will be reinvested into Maternity.

5. Recruitment and implementation plan

To manage safe induction and supervision the recruitment of additional staff can be phased over the financial year as outlined in the table below

Phasing Option 2

Post	Grade	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total 2021/22
Midwife	Band 6	10		9										19
		£46	£46	£88	£88	£88	£88	£88	£88	£88	£88	£88	£88	£974
Maternity Support Worke	Band 3	4		4										8
		£12	£12	£24	£24	£24	£24	£24	£24	£24	£24	£24	£24	£261
Total		£58	£58	£112	£112	£112	£112	£112	£112	£112	£112	£112	£112	£1,235

Appendices

Appendix 1 NG4

safe-midwifery-staffi
ng-for-maternity-sett

Appendix 2 Maternity Workforce Review

BR+ Final
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