MATERNITY STAFFING REVIEW

Author: Elaine Broughton, Head of Nursing/Midwifery
Sponsor: Carolyn Fox, Chief Nurse

Executive Summary

Paper F

This report will advise the Quality and Outcomes Committee and the Trust Board that the results of the 2019 Birthrate Plus® acuity tool (that assesses the Midwifery and support staffing levels) identifies a shortfall in maternity staffing for both registered midwives and support workers for the University Hospitals of Leicester Maternity Services. Further investment in additional 20 registered midwives and 10 midwifery support workers is required.
This need for additional resources has been reached following the detailed and robust analysis and triangulation of the data and recommendations from the Birthrate Plus Acuity Tool, national maternity standards, NICE guidance and the CQC insight report all of which provide a professional view on the additional resources required in order for the service to maintain basic minimum staffing levels, the timely delivery of care with no delays in treatment and, with each woman having one to one care in labour.

The Birthrate Plus® recommended ratio of births to a whole time equivalent midwife in UHL is 23.4 births to one wte midwife. The current UHL ratio stands at 27.6 births to one wte midwife. The professional view of the Head of Midwifery is that we must increase the number of midwives using a staged approach, with the first stage seeing an increase in the number of midwives by 20wtes to change the ratio to 25.8wte to one birth.

The report also provides assurance that despite the shortfall in midwifery staffing, the current service has robust processes embedded across all units to mitigate the shortfalls on a 24/7 basis. There are with clear escalation processes in and out of hours to inform the senior midwifery and obstetric team of staffing challenges and to ensure a collaborative and professional approach to deliver safe midwifery staffing.

Questions

1. Does UHL meet the National Standards/NICE Guidance?
2. What is the current Acuity recording, monitoring and reporting process? Does this need to be reviewed and changed?
3. How is the Head of Midwifery Assured on a daily basis re: safe staffing across the Maternity units on both sites?
4. What does the Birthrate Plus Acuity tool / peer review tell us?
5. What is the CQC insight report telling us?

Conclusion

Some of the national recommendations may appear to be aspirational. It is recognised that a pragmatic approach is needed to prioritise immediate actions in terms of the resources required to increase the number of midwives and support workers in the most critical areas of the service.

1.0 INTRODUCTION

1.1 What are the national standards and available tools to provide data on safe staffing ratio's?

The Royal College of midwives endorse the Birth rate plus strategic workforce tool, (Birthrate Plus® Website 2007 www.birthrateplus.co.uk) which indicates the ratio of midwives to birth for the women who attend the service. Up until 2013, the national recommended ratio was one midwife for every 28/29 births. This was recognised as an overarching figure which was not applicable for all services and did not strictly adhere to the principles of the Birth rate plus tool, which is based on acuity and complexity recognising that tertiary maternity services were more likely to care for more complicated pregnancies; therefore more likely to have complications in labour and delivery and in the postnatal period (also, specialist input in the antenatal period and increased visiting was not accounted for). However, the tool recognises the staffing requirements in the community for antenatal, postnatal and home deliveries, as the community midwifery service is nearly always provided by the acute Trust.

It is recognised the tool is complicated and described as idealistic as it does not account for

- Advise on how best to deploy your workforce on a daily basis.
- Provide solutions to duty roster principles.
- Give solutions to maintaining adequate staffing on a 24/7 basis.
- Prescribe skill mix requirements outside the overall 90/10 application in clinical areas.

The tool does not allow for professional judgement in determining the need for specialist, management or consultant midwife posts which are essential particularly in Leicester to deal with the increasing complexity of our patient population.

In 2015 NICE produced guidance, Safe Midwifery Staffing for Maternity settings (NICE, 2015), which endorsed using a recognised tool for calculating staffing but also added some 'Red Flags' which may indicate that staffing was below the recommended numbers, which have been incorporated into the delivery suite reporting

1.2 Does UHL meet these standards?

In summary, UHL does not meet these standards. There has been Birth rate plus assessments in 2013, 2016 and 2018 to account for changes in acuity and complexity. The UHL maternity service is a busy, complex service and a significant shortfall of midwives is evident, given the ratio for the service was assessed as requiring 1:23.4 (23) ratio of midwives to births. Currently the ratio is 1:27.6 (28) which would be more than adequate for an average size DGH with minimal/moderate complexity and ethnic case mix.

The table on the next page provides the results of the Birthrate Plus® acuity assessment and confirms the current deficit in the number of wte midwives and maternity support workers.

Table 1: Birthrate Plus® acuity results for UHL

	Birthrate Plus Clinical WTE		Current Funded wte RMs & MSWs (adjustment for ANCs & p/n services)		Variance		TOTAL WTE
	RMs	MSWs	RMs	MSWs	RMs	MSWs	
Leicester Royal Infirmary (I/P & Wards)	153.69	12.24	125.44	8.24	-28.25	-4.00	-32.25
Leicester General Hospital (I/P & Wards)	105.05	9.08	82.23	6.29	-22.82	-2.79	-25.61
UHL Antenatal Services	21.85		12.20	7.00	-2.65		-2.65
UHL Community & St Mary's Melton	124.71	15.60	109.60	8.80	-15.11	-6.80	-21.91
Specialist Midwives Contribution to clinical wte	12.95 (includes 1.35wte Band 3s)						
	RMs		MSWs				
Overall Clinical Variance	-55.88		-13.59				

In addition to the clinical establishment, is a requirement for non-clinical staffing in the maternity services. The usual method is to apply 9% to the clinical wte and this will cover the additional roles as listed on page 5 and avoid duplication. This is a local decision and not a direct recommendation of Birthrate Plus.

Alongside the birth rate plus assessment, local knowledge of estate, pathways and proximity to other services should be assessed.

Red flag reports are completed and acuity data is kept and robust it is a requirement to be compliant with the completion of the tool 90% of the time for results to be accurate. The data shows there is a shortfall of staff 40% of the time. On any one shift the midwives can rotate between areas, moving to areas of higher activity.

UHL does not meet the individualised assessment ratio's for UHL, but it does comply with standards in NICE, as establishments are reviewed every six months and Birth rate plus assessments are completed as required.

In the latest Birth rate plus workforce assessment from 2018, the service was assessed as being 55wte midwives and 13wte Band 3 maternity support workers short. There has been rolling recruitment throughout the year and promotion of the service at national events and UHL is traditionally very successful at the recruitment and retention of midwives. However the output from universities is limited and during the summer months, there are not many midwives applying for posts.

Midwifery staffing remains on the risk register and discussed at Maternity Governance, CMG Board and delivery suite forum.

2.0 Acuity Process

Leicester Maternity services have been using the birth rate plus intrapartum toolkit since 2009. Since April 2019 the new acuity app has been introduced, measuring acuity every four hours and indicates how many women as well as the complexity of women present on the delivery suite and calculates any shortfall of staff, the new app also automatically indicates any red flags and produces a report. Professional judgement by the Band 7 co-ordinator is always used in combination with the tool.

There are five categories used,

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:

The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 to 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 to 13**

Moderate risk/need such as Induction of Labour with Syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or Syntocinon may become a Category IV.

CATEGORY IV **Score = 14 to 18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

In Leicester Maternity services 67% of women on delivery suite are in category IV and V at Leicester Royal Infirmary and 63% at Leicester General Hospital requiring 1.2 to 1.4 WTE

midwives for each woman according to the staffing tool. Data collected in the intrapartum toolkit can be viewed over any time period, and on a monthly basis can indicate the percentage of time the staffing met the acuity needs and provide guidance as to whether there is a genuine long term shortfall in staffing on the delivery suites or whether it is a peak in activity or some very sick women.

2.1 How Birthrate Plus has influenced staffing in UHL

The intrapartum acuity tool feeds into the workforce assessment and supports staffing requirements. Leicester Maternity service underwent a full birth rate plus workforce assessment in 2016, which demonstrated a shortfall in staffing of 90 midwives of which 10% could be support staffing at Band 3 or above. In 2018 the Trust supported an increase of 15wte midwives through a business case.

A further refresh of the Birth rate plus assessment was funded through the LMS, as it is recognised the birth rate has fallen in the past two years, however with implementation of recommendations from better births the LMS required assurance the workforce were able to progress these, the assessment also included the investment of 15 midwives by the Trust. The final report was received in March 2019, which suggests a shortfall of 55 midwives across the service and 13 Band 3 maternity support workers.

Five years ago there was investment from the CCG's for public health Band 3 support workers in the community setting, they worked alongside the midwives providing support for breastfeeding, stop smoking, parent education and weight reduction. In the acute units the Band 3 role was not developed as robustly and skills utilised, therefore the managers tended to fill Band 3 vacancy with a nursery nurse. However, there is now a national Job Description, and the support workers can provide continuity for women and support midwives in a more proactive way.

2.2 Does the Acuity Process need to change?

The updated App does now measure ward acuity as well as delivery suite activity, it produces reports more easily and incorporates the red flags from the NICE Guidance, these are currently reported separately.

There is a staffing review with the Head of Midwifery, electronic rostering and Corporate Nursing every six months, the results of which are reported to Board by the Chief Nurse.

3.0 Daily assurance on staffing in maternity services

All staffing is rostered on the health roster system, the required rules regarding midwife in charge, skill mix etc. are built into the demand template and the rostering system. These rules are:

- A Supernumerary Band 7 co-ordinator on delivery suite
- An experienced midwife trained in providing enhanced care on every shift, with an equal mix of Band 5 and 6 across all the shifts.

- The ward managers are on rotation to hold the bleep and receive all sickness calls; they review the staffing and activity throughout the day, moving staff as necessary depending on activity.
- The matrons provide support and work flexibly throughout the week depending on commitments, to support the service.
- Should a shortfall occur that is not manageable, this is escalated to the Matron and HOM, workforce, off duty and staffing across the service are reviewed and midwives are moved accordingly.
- SOS text is sent to staff and the roster across the other site is reviewed.

If more staff cannot be sourced, activity is monitored and the out of hour's co-ordinator liaises with staff across all sites, as well as the home birth team to assist/support. The on call manager is informed as per the escalation policy and during the day the matron and ward managers would deal with escalation.

At times of high activity, when both acute units are under pressure and staffing is not felt adequate to deal with the surge in patients, the on call manager will contact the HoM and the on call consultant if not already on site.

The assurance on a daily basis is supported by two local guidelines Escalation, Transfer of Activity and Closure Policy and Midwifery and Support Staffing policy

5.0 Peer review

At the regional Heads of Midwifery meetings, within the East Midlands, staffing levels, vacancy and ratios are discussed to compare however the detail in relation to how the staffing is distributed is not discussed. Many units do not meet the Midwife to birth ratios recommended in their birth rate plus reviews, locally Nottingham, Lincoln and Derby.

In October 2018 NHS England arranged a table top exercise for Heads of Midwifery, workforce and finance leads to attend, this was held for the Midlands and East of England. It was well attended by the West Midland Trusts from Birmingham, all the East Midlands Trusts and Cambridge, Norfolk and Norwich, and Ipswich. The purpose was to ascertain whether Trust's had sufficient staffing to support the continuity of care pathways and bench mark within the region. Staffing numbers by grade and deliveries were submitted beforehand. Each Trust worked out their ratio and shortfall in staff. Leicester maternity service had the greatest shortfall of staff, some units being over their required numbers.

There was reluctance in the group to distribute the findings from the exercise unfortunately. This was escalated within the CMG by the transformation lead an Trust workforce lead and incorporated into the January staffing report.

6.0 CQC Insight report

Early in 2018 it was brought to the attention of the Head of Midwifery that UHL maternity service were highlighted on the CQC insight report as having a lower number of Band 7 midwives to Band 5/6 midwives.

Mitigation and assurance was provided to the CMG performance review panel at that time. The Head of Midwifery is confident the number of Band 7 and 8A midwives in the service provides 24 hour cover on the delivery suite and there is a Band 7 in each unit taking responsibility out of hours. The ratio varies in each area there are more Band 7's in the acute units than in community but the average in UHL is one Band 7 Midwife to every 7.2 midwives, the service has remained on the insight report for this reason and continues to flag.

Reference on the insight report relates to: **CQC KLOE S2, Indicator-Ratio of band 7 midwives to band 5/6 midwives (Electronic Staff Record - ESR Data Warehouse 13 Sep 2017) ratio for UHL is 0.12 the national average according to the report is 0.24**.

However, there is no evidence of this standard in the NICE Guidance, the Birth rate plus maternity staffing tool nor the Key lines of enquiry, prompts and ratings characteristics for healthcare services (CQC, June 2017). There is never a shift on delivery suite that does not have a Band 7 co-ordinating workload and overseeing quality and safety. In the event of sickness, the Band 7's are flexible and change shifts, do extra shifts, or the ward managers will cover.

7.0 Summary

The evidence in this report identifies a shortfall in maternity staffing both midwifery and support workers. Despite this shortfall, there is a robust process of escalation to mitigate, the senior midwifery team and obstetric team work together to ensure the service is safe.

The national standards and acuity data for UHL maternity service may appear aspirational, but in the professional opinion of the Head of Midwifery, further investment is needed in the form of 20 registered midwives and 10 midwifery support workers to maintain safety, particularly across two acute sites.

With these numbers we could improve the national average for the ratio of Band 7's to Band 5/6 (CQC insight report), develop the midwifery team supporting vulnerable women i.e mental health and domestic violence and meet national requirements in relation to fetal monitoring midwifery champion's (0.4wte each site), digital midwife 1wte, and continuity of care lead 1wte. The acute clinical areas would have safe staffing to support women and community midwives would have time to ensure all necessary data is captured to capture activity and tariff payments.

8.0 Recommendations / Next Steps

The Trust Board is asked to note the contents and the recommendations within this report.

References

Ball J A and Washbrook M; Birthrate Plus®: Using Ratios for Workforce Planning. British J Midwifery November 2010 Vol. 18 No 11 pp724-730

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