Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 10 July 2024

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Title:	**Maternity Safe Staffing for Quarter 3 and Quarter 4 2023/24**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee 27/06/2024**
	Regular Reporting

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

Executive Summary

1. This is the second bi-annual midwifery safe staffing report for 2023/24 and reviews safe staffing levels in Quarter 3 and Quarter 4 and provides an update on workforce planning for the maternity service.
2. The report provides 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. BirthRate Plus and recruitment plan: The service has increased its midwifery establishment from 283.77wte in 2019/20 to 310.50wte in 2023/24, based on the BirthRate Plus analysis and recommendations. The service has also developed a robust recruitment plan that aims to attract and retain the required number of midwives and maternity support workers by the end of 2024/25.
4. Safe staffing and escalation process: The report provides assurance that the service has an effective system for monitoring and maintaining safe staffing levels and responding to any staffing or capacity issues. The service uses a RAG rating system, a staffing and escalation SOP, and a safety huddle to assess and manage the staffing levels and acuity daily.
5. One to one care in labour and continuity of carer: The report confirms that the service has met the requirements of the NHSR Maternity Incentive Scheme for providing one to one care in labour and ensuring the supernumerary status of the delivery suite co-ordinator. The report also states that the service has one existing MCoC team for vulnerable women and birthing people, but the expansion of the MCoC provision is paused until the staffing establishment is increased.
6. Specific challenges and recommendations: The report acknowledges some challenges faced by the service around the retention of staff, the cost of living, and the flexible working requests.

Recommendations

7. The Trust Board is asked to note evidence that the midwifery staffing budget reflects establishment as calculated BirthRate Plus®.
8. 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 Q3/4 of 2023/24 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Perinatal Incentive Scheme (MPIS) for safety action 5.
9. 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 Plus® or equivalent calculations.
10. 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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1. Purpose

1.1. This report aims to assure the Trust Board that there is an effective system for monitoring safe midwifery staffing levels and workforce planning between October 2023 and March 2024, as required by Year 6 of the NHS Resolution (NHSR) Maternity Incentive Scheme.

2. Background

2.1. This is the second bi-annual midwifery safe staffing report for 2023/24 and reviews and provides assurance on Safe Staffing levels for Quarter 3 and Quarter 4.

2.2. The report provides assurance of the following:

a)	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b)	Evidence that midwifery staffing budget reflects the establishment as calculated in (a) above
c)	The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
d)	All women in active labour receive one-to-one midwifery care
e)	Submission of a midwifery staffing oversight report that covers staffing/safety issues to the board every 6 months during the Maternity Incentive Scheme (MIS) year five reporting period

3. BirthRate Plus® and Action Plan

3.1. BirthRate Plus® is a workforce planning and staffing acuity tool that uses a validated method to model midwifery numbers and skill mix and guide decision-making for safe and sustainable maternity services.

3.2. The Maternity Service updated its BirthRate Plus® analysis in 2021. The BirthRate Plus® analysis identified an increase in the acuity of mothers and babies, as well as the prevalence of chronic conditions, mental health issues, and social vulnerabilities. Based on the analysis, an increase of 22.38 full-time equivalent (FTE) staff members was recommended.

3.3. This recommendation included 3.89 FTE managers or specialists, 16 FTE clinical midwives, and 2.49 FTE maternity support workers.

3.4. The business case to support the BirthRate Plus uplift was agreed upon at the Trust Board in November 2023. The Trust Board shared this with commissioners (an NHSR MIS requirement), and the breakdown of the calculations is evident in this report.

3.5. The Maternity Services have increased the midwifery establishment from 283.77wte in 2019/20 to 310.50wte in 2023/24, demonstrated in Table 1 below.

Table 1: Midwifery Staffing Establishment

Band	19/20	20/21	21/22	22/23	23/24
812072-B8B Midwives	2.34	2.1	3.1	4.8	4.8
812071-B8A Midwives	3	3.8	3.8	10.3	10.82
812070-B7 Midwives	55.09	57.13	57.13	61.89	66.13
807070-B7 Nurse Specialists	0	0	0.6	0.6	0
808700-B7 Qualified Nurse	0	0	1	1	1
807060-B6 Nurse Specialists	0	0	0	1	0
812060-B6 Midwives	180.94	180.94	188.94	174.8	164.5
808500-B5 Qualified Nurse	1	1	1	18.4	18.5
812050-B5 Midwives	41.4	41.4	40.4	37.22	44.75
TOTAL	**283.77**	**286.37**	**295.97**	**310.01**	**310.5**

3.6. The current BirthRate Plus® establishment uplift was incorporated into the midwifery recruitment planning from April 2024. Recruitment into the recommended management/specialist roles commenced in January 2024 and is complete with all roles successfully being appointed into.

3.7. An updated BirthRate Plus® Action Plan is included in Appendix 3. The active recruitment of new staff is ongoing. Table 2 below shows the number of new starters (in wte) balanced against the numbers of leavers within Q3 and Q4.

Table 2 Midwife/RN Starters and Leavers

Midwives/RN's wte	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
New Starters	13.6	5.93	8.24	1	0.8	1.92	31.49
Leavers	2.84	3	6.09	4.2	2	4.44	22.57

3.8. In Q3 and Q4, the Maternity Service recruited 31.49 wte Midwives/RNs. In the same period, there were 22.57 wte leavers. A large proportion of joiners are newly registered midwives. To ensure a smooth transition, the service has a supernumerary period and robust training and support, including a comprehensive preceptorship programme, mentoring scheme, and ongoing professional development opportunities.

4. Vacancy and Turnover

4.1. The table below presents the vacancy position for clinical midwives, midwifery support workers and includes specialist midwives across the service over the past six months.

Table 3: Vacancy, Turnover and Sickness Absence

HR

2023-2024	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)
Oct-23	-7.55%	12.92%	3.74%	5.05%	1.09%
Nov-23	-8.40%	12.90%	3.71%	4.49%	0.28%
Dec-23	-8.93%	13.45%	3.85%	4.07%	0.81%
Jan-24	-8.43%	14.08%	4.04%	4.31%	2.72%
Feb-24	-8.49%	13.73%	4.27%	4.31%	3.35%
Mar-24	-8.32%	13.67%	4.51%	4.17%	2.89%

4.2. Quarter 4 saw a slight increase in sickness absence and turnover has declined slightly. The service continuously monitoring this and are acting on any themes that emerge.

5. Unavailability

5.1. Table 4 below shows the number of midwives unavailable to work due to maternity Leave, sickness absence and non-medical absence. Collection of Covid related data stopped in December 2023. From January 2024 the dated was separated into short term sickness, long term sickness and non-medial absence.

Table 4: Unavailability

	Maternity Leave	Sickness Unrelated to Covid	Sickness related to covid	Short Term Sickness	Long term sickness	None-Medical Absence	Total number of staff unavailable to work
Oct-23	17.41 wte 5.73%	17.98 wte 5.72%	2.15 wte 0.68%	N/A	N/A	N/A	36.3 wte 11.56%
Nov-23	18.37 wte 5.56%	19.81 wte 6.0%	3.1 wte 0.93%	N/A	N/A	N/A	41.28 wte 12.48%
Dec-23	17.37 wte 5.25%	26.59 wte 8.04%	N/A	N/A	N/A	N/A	44.96 wte 13.6%
Jan-24	15.96 wte 4.84%	N/A	N/A	16.08 wte 4.88%	6.24 wte 1.89%	0.92 wte 0.27%	39.2 wte 11.9%
Feb-24	15.1 wte 4.58%	N/A	N/A	18.25 wte 5.54%	8.86 wte 2.69%	2.33 wte 0.7%	44.54 wte 13.53%
Mar-24	15.1 wte 4.58%	N/A	N/A	24.96 wte 7.58%	8.09 wte 2.45%	2.0 wte 0.6%	51.15 wte 15.53%

5.2. As can be seen above the unavailability rate has increased in the last quarter due to an increase in short term sickness absence. This data is shared with the maternity

leadership team, finance team, recruitment and retention midwives and Professional Midwifery Advocates (PMA) on a weekly basis. Work is ongoing within the service to support sickness absence management. As a service, Maternity also has a higher-than-average number of staff on maternity leave, year on year. These posts are usually advertised as temporary positions to enable backfill, however they have historically been difficult to recruit into due not being substantial positions.

6. Planned Versus Actual Midwifery Staffing Levels and Mitigation

6.1. Planned versus actual midwifery staffing refers to the comparison between the number of midwifery staff that were scheduled to work (planned) and the number of staff that worked (actual) during a specific period.

6.2. All maternity inpatient areas report the actual versus planned midwifery and care staffing for alongside other wards in the Trust this data is reported on the monthly safe staffing dashboard (Appendix 1). This data is reviewed by the Director of Midwifery and presented monthly in the safe staffing report to the Trust Board.

6.3. As indicated in Appendix 1 the service apart from the Spires and Level 5 maintained fill rates above planned. It is important to note that midwifery staffing across in and outpatient areas dynamically adapts to meet the service needs and is informed by the maternity staffing and escalation standard operating procedure. It is therefore necessary to review midwifery staffing fill rate across the service as opposed to area specific.

6.4. Where actual staffing levels fell below planned the maternity service adjust to maintain safe staffing levels. The Trust has in place a robust maternity staffing and escalation standard operating procedure detailing planned actions to take in the event of staffing, activity or capacity concerns and challenges.

6.5. Midwifery staffing is reviewed on a shift-by-shift basis and reported and escalated to the Trust central safe to identify the required staffing within all areas to manage the planned and acute activity.

6.6. The Maternity Operational Bleep Holder works with the multi- disciplinary team to ensure that when there is staff sickness 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. The Maternity Operational Bleep Holder leads a multidisciplinary Safety Huddle (Appendix 2) which reviews actual midwifery staffing versus acuity levels twice daily.

6.7. In addition, the maternity leadership team review weekly the rostered staffing in advance to check planned staffing against the agreed establishment for each clinical area.

6.8. The RAG rating agreed at the Maternity Safety Huddle's are reported to the Central Trust Safe Staffing meeting twice a day. There is a robust escalation policy with agreed action pathways to be taken for each rating.

7. Actual Maternity Staffing RAG Rating

7.1. Table 5 below shows the RAG rating for actual midwifery staffing levels for October 2023 to March 2024. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that day.

Table 5: Maternity Staffing RAG Rating

	RAG Rating		
	Red	Amber	Green
Oct-23	2	26	3
Nov-23	0	30	0
Dec-23	2	16	13
Jan-24	0	17	14
Feb-24	1	26	2
Mar-24	2	28	1

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

7.3. Actions are taken as per Staffing and Escalation for OUH Maternity Services SOP to mitigate against any RAG rating of Amber or Red. This includes 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.

8. Midwife to Birth Ratio

8.1. The BirthRate Plus® assessment undertaken in 2021 advised an overall ratio of 22.9 births to 1wte, this is based on extensive data analysis and is calculated from a detailed assessment for workforce planning purposes.

8.2. The table below represents the midwife to birth ratio for all births which is determined by the 22.9 births to 1wte number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability through sickness or maternity leave.

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

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded	1:25	1:23	1:23	1:21	1:22	1:23
	Quarter 3 average 1:23.66			Quarter 4 average 1:22		

9. Supernumerary Delivery Suite Co-Ordinator Status and One to One Care in Labour

9.1. 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 compromised and/or the Delivery Suite Co-ordinator is at risk of not having supernumerary status, this is promptly escalated to the Maternity Operational 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.

9.2. In this data period there were no Red Flags regarding the provision of 1:1 care in labour and 2 Red Flags regarding the supernumerary Delivery Suite Co-ordinator. The delivery suite coordinator was not supernumerary on 2 occasions when they needed to provide post-natal care on delivery suite whist waiting for additional midwives to attend using the escalation process. There were no incidents or additional red flags reported during this time.

9.3. The agreed staffing Red Flags are listed in Appendix 4 and incidents for Q3 and Q4 are outlined in Appendix 5.

9.4. 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.

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

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Birth location changed due to maternity staffing	1	0	0	0	0	2

9.6. The Maternity Operational Bleep Holder and area co-ordinators continue to focus each day on ensuring staff can take breaks and leave their shifts on time. Unfortunately, staff shortages led to an increase in the number of staff not taking their full breaks or working over their shift allocation.

9.7. 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 however it should be noted that it does not indicate that the Delivery Suite Coordinator had stopped being supernumerary, as described above.

9.8. 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.

9.9. 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. Q3 and Q4 showed a reduction in on call hours used to support the consultant unit at the John Radcliffe compared to Q1 and Q2

Midwives	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total Hours
Hospital Midwife on-call hours used	267.25	122.75	139.5	86.5	187.25	283.75	1087.15
Community Midwife on-call hours used	212.25	85.25	102.25	109.25	60.25	282.5	851.75

10. Midwifery Continuity of Carer (MCoC)

10.1. 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 area and also the area of greatest ethnic diversity.

10.2. The analysis of the current Maternity staffing figures supports the recommendation 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.

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

11. Workforce Plan

11.1. Data collated over the past five years has highlighted an average Midwifery attrition rate of 45wte each year. In addition, the service experiences high unavailability which includes a combination of maternity leave and short/long-term sickness absence. While there is an element of funding available to cover maternity leave in the short term, historically, it has always been difficult for service to recruit to temporary fixed posts in combination of a national midwifery workforce gap.

11.2. The Trust continues to support 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.

12. International Recruitment

12.1. The service was awarded £54,000 to support the International Recruitment (IR) initiative and this was used 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.

12.2. Twelve Internationally Educated Midwives (IEM) have been appointed, five commenced in post in Q4(2022-2023) and the sixth midwife started in September 2023. A further six IEMs commenced employment in December 23.

12.3. 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.

13. Midwifery Short Course

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

13.2. A further five candidates started in September 2023, they will become registered midwives in July 2025. Funding for both courses is provided by Health Education England (HEE).

13.3. Funding for a further six candidates to start in September 2024 has been approved and interviews for this course will take place in April 2024.

14. Midwifery Apprenticeship Programme

14.1. The service approved funding for the Midwifery Apprenticeship Programme, subsequently two OUHT Maternity Support Workers have been successfully recruited and commenced their midwifery training in conjunction with Winchester University in January 2024. A further two apprenticeship places have been agreed and are planned to start in January 2025.

15. Specific Challenges related to Safe Staffing

15.1. The Maternity Service wish to bring to the Board's attention some challenges faced around the retention of staff to support the maintenance of safe staffing. Examples include:

- Staff relocating due to high cost of living.
- Retirement.
- Staff requesting flexible working to support work/life balance.
- Staff wishing to take a career break for travel.

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

16. Conclusion

16.1. Midwifery staffing is complex, and acuity can often change rapidly based on individual care needs and complexities of cases and therefore maintaining safe staffing levels continues to be challenging.

16.2. Despite these challenges, the service has developed a robust recruitment and retention plan and are on track to have no midwifery vacancies by Autumn 2024. The forward-thinking workforce plan has enabled the service to become proactive rather than reactive and actively plan for a known attrition rate. Robust workforce planning and our commitment to the delivery of national drivers known to impact on patient safety such as the Saving Babies Lives Care Bundle and the CNST MPIS, safety continues to improve as we evidence that these elements are embedded into everyday practice.

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

17. Recommendations

17.1. The Trust Board is asked to note evidence of midwifery staffing budget reflects establishment as calculated by BirthRate Plus®.

17.2. 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 Q3/4 of 2023/24 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Perinatal Incentive Scheme (MPIS) for safety action 5.

17.3. 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 Plus® or equivalent calculations.

17.4. 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.

18. 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.

Oct-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	74	18.85	18.6	8.64	11.2	27.49		29.8
MW Delivery Suite	527	12.89	15.9	2.28	2.5	15.17		18.4
MW Level 5	1023	4.56	3.45	2.1	2	6.66		5.1
MW Level 6	443	3.09	4.77	1.39	2	4.48		6.4

Nov-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	72	18.86	15.9	8.63	12.6	17.49		28.4
MW Delivery Suite	592	12.91	13.4	2.29	2.5	15.2		15.8
MW Level 5	990	4.57	3.42	2.11	2	6.68		5.1
MW Level 6	362	3.09	5.83	1.39	2	4.48		7.8

Dec-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	111	18.86	12.8	8.63	7.8	27.49		20.6
MW Delivery Suite	527	12.91	17.2	2.28	2.6	15.19		19.8
MW Level 5	1023	4.57	3.04	2.11	2	6.68		4.7
MW Level 6	389	3.09	5.5	1.39	2	4.48		7.5

Jan-24	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	112	18.85	12.1	8.64	9.3	27.49		21.4
MW Delivery Suite	526	12.91	16.1	2.3	2.5	15.21		18.6
MW Level 5	1023	4.57	2.99	2.11	2	6.68		4.8
MW Level 6	369	3.09	6.05	1.39	2	4.48		8.4

Feb-24	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	109	18.85	11	8.64	10	27.49		20.9
MW Delivery Suite	493	12.89	16.7	2.29	2.6	15.18		19.3
MW Level 5	957	4.56	3.17	2.11	1	6.67		4.6
MW Level 6	506	3.09	3.9	1.39	2	4.48		5.7

Mar-24	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	73	18.87	16.8	8.63	15.7	27.5		32.5
MW Delivery Suite	527	12.91	17	2.27	2.6	15.18		19.6
MW Level 5	1023	4.56	3.17	2.1	1	6.66		4.6
MW Level 6	534	3.09	3.64	1.36	2	4.48		

19. 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.

20. Appendix 3 – Action Plan for BirthRate Plus 2021-2024

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	Nov-22	Evidence collated and submitted for analysis by BirthRate Plus Team in October 2022.	Completed 2022
	To submit staffing paper with recommendations from BirthRate Plus.	Director of Midwifery	Dec-22	Agreed Uplift to a midwifery establishment of 332.06 wte from April 2024	Completed March 2024
	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus.	Deputy HOM and Matrons	Mar-24	Completed for in-patient areas, AN Services, Governance, Education and Public Health. Community teams still under review	To be completed by June 2024
	To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting.	Leadership Team	Ongoing	MCGC Minutes	Completed March 2024
	To annually review the recruitment and retention plan.	Leadership Team with Recruitment and Retention Midwives.	May-24		

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

21.1. 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 do 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.

22. Appendix 5 Maternity Staffing Red Flags Oct 2023 to March 2024

Red Flags for In-Patient Areas	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Staff moved between specialty areas	84	34	46	34	42	79
Supernumerary workers within the numbers	28	31	23	62	24	74
Administrative or Support staff unavailable	5	3	7	12	4	8
Staff unable to take recommended meal breaks	110	79	62	37	103	160
Staff working over their scheduled finish time	66	31	23	30	44	64
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	0	0	0	0	0	0
fundamental care needs are met as outlined in the care plan	0	0	0	0	0	0
Beds do not open to fully funded number - state number not staffed and reason	0	0	0	0	0	0
Elective activity or tertiary emergency referrals declined	0	0	0	0	0	0
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	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)	28	30	18	12	6	29
Number of women delayed during IOL process	152	123	56	32	25	115
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)	1	0	0	0	0	1

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

23.1. 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

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

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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

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