Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**22nd July 2024**		

Title of Report:	**Bi-annual Midwifery and Neonatal Nursing Staffing Report**
Status:	**For approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
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Appendices	**Appendix 1: BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT**

1. Executive Summary of the Report

Maternity

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to review staffing establishment, to maintain continuity of maternity services, and to always provide safe care to women and babies across all settings.

This report gives a summary of the measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator (LWC) status, one to one care in labour and red flag incidents.

Birthrate Plus® (BR+) is the only recognised national tool for calculating midwifery staffing levels. The Trust report was published in April 2023; compliance with the report is a requirement of Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

In addition, Bath, Northeast Somerset, Swindon, and Wiltshire (BSW) Academy undertook a workforce planning review for the Local Maternity and Neonatal System (LMNS) in March 2023. A headroom of 28% was recommended taking into consideration the statutory and mandatory training requirement, sickness, annual leave, and maternity leave. Following a successful business case the headroom for maternity was agreed at 24% (plus agreed recruitment to maternity leave), this aligns to the headroom across maternity services in BSW. Since the review, further training has been mandated to include Oliver McGowan Learning Difficulty and Autism training and Adult Level 3 Safeguarding.

The vacancy in December 2023 (inclusive of maternity leave) is 12.12 whole time equivalent (wte), there have been 11.68wte new starters in this reporting period. Approval of the maternity business case saw investment of £425,958 for clinical and speciality midwife roles, equating to an increase of 15.91wte clinical midwives into the service. This has impacted the vacancy position in January 2024 and Q1 24/25 as budgets reflect the phased investment, with planned recruitment which is ongoing.

The reduction in annual turnover continues and shows stabilisation in the service from 19% in January 2023 to 5.96% in December 2023. Sickness rates for midwives remain below the Trust benchmark with a slight rise noted in December.

The new BR+ Midwife to birth ratio of 1:24 was introduced in July 2023 to align to the new BR+ report, this reflects the increasing acuity of mothers and babies and their subsequent care needs.

The midwife to birth ratio is calculated monthly using BR+ methodology and evidences an acceptable and safe level of staffing. The BR+ Acuity Tool is used to assess 'real time' workload arising from the number of women needing care during the processes of labour, birth, and postnatal period. The intrapartum tool shows compliance with 1:1 care in labour for the reporting period. There were three episodes when supernumerary status of the LWC was not maintained however reviews found this did not impact negatively on safe care. Monthly audits of supernumerary status of the labour ward co-ordinator and 1:1 care in labour shows a high level of compliance.

In addition, the ward-based acuity tool was relaunched in November 2023, this predicts the number of care hours required in 6-hour block periods which allows constant review of acuity and staffing in the acute unit. The reporting function of the ward-based tool is yet to go live, once launched this will be reviewed and monitored monthly as part of our speciality safety and quality committee.

Neonatal Services

NHS England – Specialist Commissioning Service Specification for Neonatal Critical Care Review (NCCR, 2024) covers the provision of Neonatal Critical Care, including neonatal intensive care, high dependency care, special care and transitional care.
There are four levels of Neonatal Units, the Dyson Centre of Neonatal Care is a level 2 Local Neonatal Unit (LNU).

Neonatal Critical Care is organised around Operational Delivery Networks (ODN) in close alignment with maternity services and the LMNS. The British Association of Perinatal Medicine (BAPM) and NHS Toolkit for High Quality Neonatal Services provide a framework and calculation tool to determine neonatal nurse staffing depending on cot capacity, acuity and is endorsed by Department of Health (DH) to ensure safe and productive working.

This report provides a summary of measures taken to achieve compliance with BAPM safe staffing for the LNU. The Southwest ODN conducted an annual review in Q3 using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS). In addition, the wider workforce is reviewed inclusive of allied health professionals (AHP) and medical establishment aligned to acuity.

The substantive nursing vacancy for December in the LNU for band 5 and 6 nurses is 1.97wte following recruitment of 2.08wte during the reporting period. LNU turnover rate is 1.7%. Sickness rates remain stable other than a slight rise in December comparable to midwifery staffing.

All Intensive Care Unit (ICU) and High Dependency Unit (HDU) babies should receive care from by a Neonatal Qualified in Speciality nurse (QIS), compliance is nationally agreed at 70% (National Quality Board, 2018). The Trust rate is currently 64.9%, this

will rise to 69.9% in April and again to 75% in July, with completion of existing staff on QIS course.

All LNUs should offer a transitional care service (BAPM, 2017), this is staffed from the LNU, with 95.6% shifts covered in Q3. The Trust currently provide a 4-bed service, however, Get it Right First Time (GIRFT) recommends we should offer an 8-bed service based on the current birth rate. However, all eligible babies in Q1-Q4 received transitional care.

It is also recommended neonatal services offer a 7-day outreach service for families (GIRFT 2022) who have been discharged from the LNU and have ongoing care needs. The Trust has a well-established 5-day service which provides direct patient and family time however there is limited resilience in our staffing model for sickness or annual leave, the service is reviewing the current model to support progression towards a seven-day service.

2.	Recommendations (Note, Approve, Discuss)
Approve.	

3.	Legal / Regulatory Implications
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Trust to support Birthrate Plus® report 2023 and meet BAPM Neonatal staffing standards. MIS year 5 standards.	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
2417	Maternity triage	12
2467	Maternity workforce	12
1763	Inability to fulfil BAPM AHP standards in NNU (Dietician, psychology, OT and Physio)	8

5.	Resources Implications (Financial / staffing)
Non-compliance with the Maternity Incentive Scheme for Trusts, which has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve compliancy.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports/Next steps
MIS combined Maternity and Neonatal Safety Quality report Q1, 2, 3 & 4. Birth rate + report data from 2022, presented 2023. Perinatal Quality Surveillance Tools (PQST) presented monthly. MIS Year 5 Board declaration paper January 2024.	

8.	Freedom of Information
Public	

9.	Sustainability
Non-Applicable	

10.	Digital
Non-Applicable	

BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT

1.0 Background

1.1 It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB, 2016) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

1.3 The Department of Health (DH 2009) recommended an adequate and appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery; organised into managed clinical networks, with hospitals providing neonatal care working together to ensure that babies and their families receive care in the most appropriate setting.

2.0 Executive Summary

This report provides a summary of the measures in place to ensure safe midwifery and neonatal nurse staffing; including clinical and specialist roles, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents. It also provides a summary of measures taken to demonstrate working towards compliance with safe staffing for the LNU to include an annual workforce review, including a mid-year review and collaborative working with the ODN to ensure recruitment and retention, skill mix and flexible working.

3.0 Birth rate Plus® Workforce Planning (Midwifery staffing)

3.1 BR+ is the only recognised national tool for calculating midwifery staffing levels, the Trust commissioned and received a new report in April 2023. The Trust is required to support the findings of the report to ensure compliance with Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). MIS established 10 Safety Actions to support safer care. Trusts that demonstrate achievement of all 10 Safety Actions recover the additional 10% of the maternity contribution charged under the scheme plus a share of the monies paid in to the scheme by the hospitals that did not achieve.

3.2 The April 2023 report evidenced a variance in current funded establishment and required clinical and non-clinical establishment (specialist midwives) to support safe staffing at the RUH. These findings are summarised in table 1.

Current Funded Establishment bands 3 – 7	Uplift	Birthrate Plus establishment bands 3 – 7	Variance Bands 3 – 7

175.20	20%	183.66	-8.46
175.20	24%	191.83	-16.63
175.20	28%	200.64	-25.44

Table 1 Clinical and Non-clinical variance from current establishment

3.3 The required increase in uplift is influenced by a number of National and local drivers.

i. NHS Three-year delivery plan (2023) for maternity and neonatal services
ii. MBRRACE-UK report (2022)
iii. National Bereavement Care Pathway (2023)
iv. NHS Staff Survey (2022)
v. Patient Safety Incident Response Framework (PSIRF, 2022)
vi. Increase of women and birthing people's complex needs
vii. The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes
viii. Transitional care provided on the ward rather than in the LNU
ix. Safeguarding needs requiring significant input
x. Shorter postnatal stays require sufficient community midwifery resource
xi. Triage to cover a 24-hour period, seven days per week, with two midwives throughout the 24-hour period and an additional midwife for 24 hours per day required to provide effective telephone triage
xii. Midwives undertake the Newborn and Physical Examination (NIPE) in the community setting
xiii. Cross border collaboration
xiv. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation; consequently, more women are meeting their midwife earlier. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss
xv. 7-day Neonatal outreach service

3.4 The Ockenden Final report (2022) advised maternity services as part of effective workforce planning review minimum staffing levels (to include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave).

3.5 A midwifery headroom of 28% was recommended by BSW Academy in March 2023 taking into consideration the statutory and mandatory training requirements, sickness, annual leave, and maternity leave.

3.6 The maternity business case funding was agreed in December 2023 with a headroom of 24% over a 3-year implementation plan to align to the headroom in the other maternity providers in BSW. Year 1 and 2 will see an increase in headroom to 24%, year 3 proposal to recruit a Consultant Midwife was not signed off and now forms part of the system wide Acute Hospital Alliance review of Midwifery workforce across BSW.

3.7 A number of clinical midwives are seconded into specialist roles, the majority of which are externally funded. The clinical posts are backfilled with fixed term contracts to ensure safe staffing numbers are maintained. The rate of secondments over the reporting period has been between 9wte and 6wte consistently.

3.8 In addition to clinical midwifery posts, consideration needs to be given to recommendations from national reports such as Ockenden, MIS and the 3-year Maternity Plan concerning new roles required to support safer high quality maternity services such as Pelvic Health, Trauma, and Inclusion Midwives. These are currently funded non-recurrently by the Integrated Care Board (ICB) until March 2024 and included in the secondment figures above. There needs to be consideration in future workforce planning relating to how these posts will continue if funding is not allocated from the ICB, which is a national issue within maternity services.

4.0 Recruitment and retention

4.1 Due to the complexities of maternity rosters, there have been challenges in ensuring accurate oversight of the midwifery workforce. In Q2, a thorough review of acute and community establishments was undertaken to ensure accuracy of the pipeline figures which are detailed in table 2. Maternity leave and secondment figures remain stable. There will be an increase in substantive vacancy in Q4 and Q1 24/5, due to the planned investment into the maternity service.

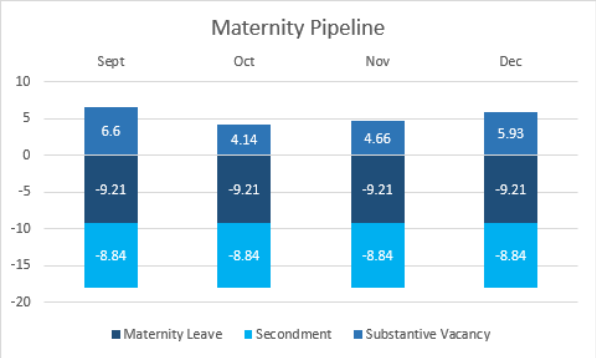

Table 2 midwifery pipeline

4.2 Over the past 24 months, maternity services have run active recruitment campaigns, including national and local advertising, successfully recruiting six Internationally Qualified Midwives and two registered Nurses who are undertaking the nurse to midwife MSC conversion course.

4.3 The success of our retention team has continued to support 100% retention of our Newly Qualified Midwives for 2 years.

4.4 Table 3 demonstrates the reduction in turnover rate from 19% in January 2023 to 5.96% in December 2023 with only five midwives leaving the Trust in this reporting period. In addition, a total of nineteen band 5 midwives have achieved their band 6 within this period.

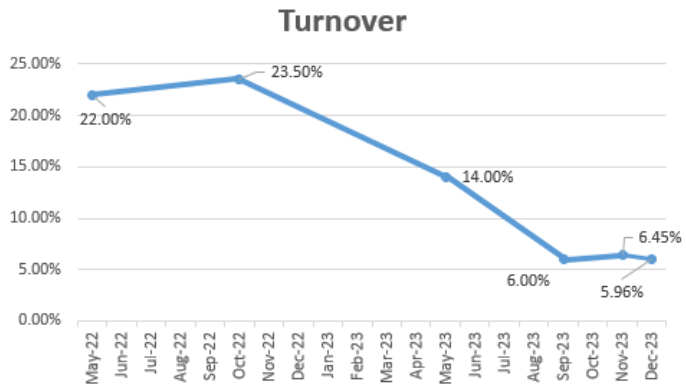

Table 3 Turnover %

5.0 sickness rates

Sickness has remained stable however it is noted an increase in December, this is mirrored in neonatal nurse staffing with the top reason for both areas being cold, cough, flu – influenza.

Month	sickness %
July 2023	2.52%
August 2023	2.65%
Sept 2023	3.56%
Oct 2023	3.32%
Nov 2023	4.70%
Dec 2023	5.62%

Table 4 sickness % for midwives

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	14	27
Anxiety/stress/depression/other psychiatric	3	55
Genitourinary & gynaecological disorder	1	31

Table 5 top three reasons for sickness (overall % sickness hours) in December for midwives

6.0 Fill rates

6.1 Table 6 highlights the stabilised position for midwifery shift fill rates over the past 6 months. These will improve further as new starters end their supernumerary status in Q4/Q1.

Month	Day qualified %	Night qualified %
July 2023	85.4%	88.3%
August 2023	80.9%	88.9%
Sept 2023	77.6%	85.4%
Oct 2023	81.0%	86.6%
Nov 2023	87.2%	86.4%

Dec 2023	85.0%	89.8%

Table 6 Shift fill rates

7.0 Escalation

7.1 Improved staffing in the acute maternity unit has further reduced the requirement to redeploy community midwives, this is now only used in times of escalation or due to short term absence. Staffing and OPEL status is reviewed daily by the senior operational leadership team where redeployment is considered based on acuity to ensure safe staffing is maintained.

7.2 When staffing is less than optimum, the following measures are taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically!
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and the labour ward coordinator remains supernumerary
- Activate the on-call midwives from the community to support Bath Birth Centre
- Request additional support from the on-call midwifery manager
- Consult closely with maternity services at opposite sites to manage and move capacity as required (mutual aid)

7.3 Although the staffing position has stabilised over the past 6 months there has been an ongoing need for on call attendance which appears to correlate to the birth activity (Table 7). As we recruit to the new establishments, the need for on call support in the acute setting is anticipated to decrease.

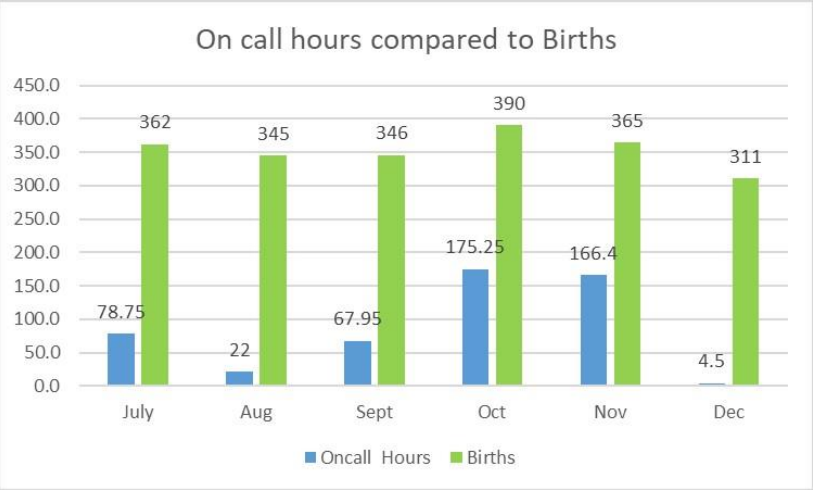

Table 7 On-call hours and birth number comparison per month

8.0 Midwife to birth ratio

The midwife to birth ratio is calculated monthly using BR+ methodology. The new BR+ Midwife to birth ratio 1:24 target was introduced in July 2023 to align with the outcome

RUH BR+ Report 2023, this reflects the increasing acuity of mothers and babies and their subsequent care needs.

Midwife to birth ratio	Target	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Substantive only	1.24	1.31	1.29	1.29	1.32	1.30	1.26
Including bank	1.24	1.28	1.28	1.26	1.27	1.29	1.27

Table 8 midwife to birth ratio

9.0 BR+ Live Acuity Tool

9.1 The BR+ Acuity Tool is used to assess 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, birth and postnatally. It is a measure of 'acuity', and the system is based upon the clinical indicators used in the well-established BR+ workforce planning system.

9.2 The BR+ classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the LWC, this assessment identifies the number of midwives needed in each area to meet the needs of the women (based on the minimum standard of one to one care in labour for all women and increased ratios of midwifery time for women in the higher needs categories).

9.3 Availability of a supernumerary LWC is mandated in Saving Babies Lives V3 (2023) to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload without having a caseload to manage or a labouring woman. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 9 outlines the compliance for the past 6 months.

Month	Days per month	Shifts per month	Compliance
July 2023	31	62	100%
August 2023	31	62	99%
September 2023	30	60	99%
October 2023	31	62	98%
November 2023	30	60	100%
December 2023	31	62	100%

Table 9 Supernumerary status of LWC

9.4 A review of incidents/events and outcome data provided assurance that reduced compliance did not impact negatively on safe care, nor did evidence the LWC provided 1:1 in labour care.

9.5 Women in established labour are required to have 1:1 care and support from an assigned midwife to ensure the safe, high-quality provision of care. If there is an occasion when 1:1 care cannot be achieved, the LWC follows a series of clinical or management actions depending on need, as part of the escalation policy – Maternity Escalation Guideline M69.

	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 10 1:1 care in labour

10.0 Neonatal Nurse Staffing

The Neonatal Nursing Workforce Tool (2020) has been adapted from the Clinical Reference Group (CRG) Workforce Calculator (Dinning) Tool (2013) and provides a consistent method for calculation of nursing establishment requirements. NHSE (2016) recommends an uplift of 25%, this tool should be used for direct patient care in the LNU only.

Based on occupancy and activity calculations in 2022/23 for the LNU, Transitional Care (TC) and Outreach safe staffing levels were maintained. As recommended by NHSE, TC and Outreach should be delineated from the inpatient neonatal budget, there is on-going work to review the model of care to support alignment with these recommendations.

10.1 Overall vacancy in December is 1.97wte, recruitment was unsuccessful in October/November with bank staff being used to cover vacancy, further recruitment in January 2024 failed to fulfil vacancies thus post remain out to advert.

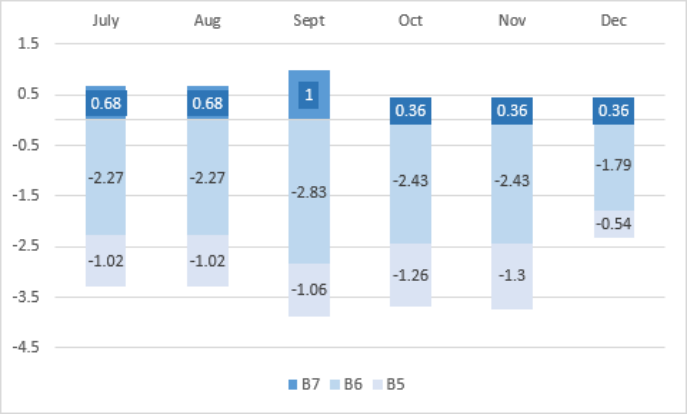

Table 11 nurse vacancy pipeline

10.2 Nurse turnover rate remains stable and well below the Trust rolling KPI of 11%.

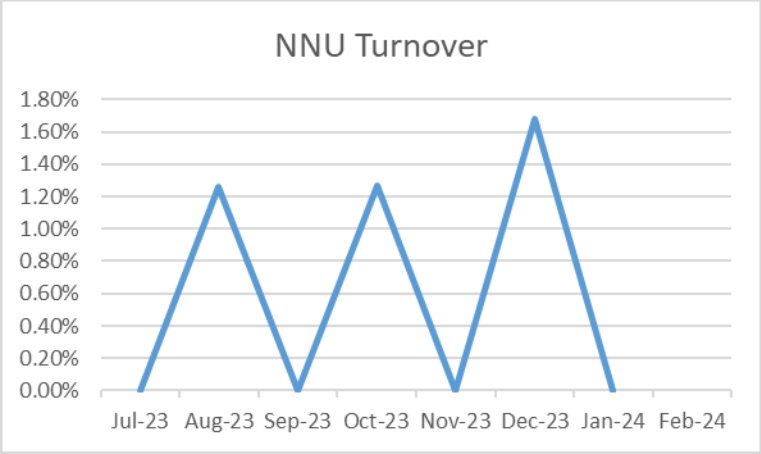

Table 12 nurse turnover %

11.0 Sickness

Sickness has remained stable however it is noted an increase in December, this is mirrored in midwifery staffing with the top reason for both areas being cold, cough, flu – influenza.

Month	sickness %
July 2023	5.03%
August 2023	2.60%
Sept 2023	1.47%
Oct 2023	2.19%
Nov 2023	2.90%
Dec 2023	5.62%

Table 13 Sickness % for registered nurses

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	6	13
COVID-19	4	17
Heart, cardiac & circulatory problems	2	62

Table 14 top three reasons for sickness (overall % sickness hours) in December for registered nurses

12.0 Qualified in Speciality (QIS)

All ITU and HDU patients should be cared for by a nurse who is QIS trained, for special care babies it is best practice if they are QIS trained although standards can still be met if they are supervised by a QIS nurse. The Unit also requires one QIS trained nurse in charge of the unit and another for Transitional Care. The compliance level is 70% with our aspiration being for 100% nursing staff to be trained.

Our current QIS is 64.9% of the qualified workforce with 3.4wte undertaking their QIS in September and December 23/24. On completion of the first cohort compliance will increase in Q1 2024 to 69.9% and the second cohort in Q2 will see compliance rise to 75%. Table 15 represents QIS trained neonatal nursing staffing provision per shift over the review period.

MONTH	DAY SHIFT	NIGHT SHIFT
July 2023	100%	90%
August 2023	100%	100%
September 2023	73%	67%
October 2023	94%	90%
November 2023	97%	100%
December 2023	97%	100%

Table 15 QIS shift fill rates

During periods of high acuity staff are redeployed and rosters changed to ensure adequate QIS trained nurses are available for baby's needing intensive or high dependency care. This is further mitigated by all nurses completing the Southwest Neonatal Foundation programme and local induction programme, and all are supported with gaining experience in intensive and high dependency care.

13.0 AHP staffing

In addition to nursing staff, LNUs require key contributions from an essential group of AHPs to enhance service provision and optimise short and long-term neurodevelopment and mental health of infants and their families; this is advocated in the NCCR report.

The provision of Ockenden funds has supported recruitment of AHPs within our LNU however this does not fully meet the BAPM recommendations, the current provision and deficit are identified in table 16:

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	0.6
OT	0.5	0.5
SALT	0.2	0.6
Dietician	0.2	0.7
Psychologist	0.3	0.6

Table 16 AHP wte comparison

14.0 Specialist roles

BAPM Service specification also states additional provision should be implemented for staff delivering quality, management and other non-direct patient-facing roles which are additional to the direct patient care ratios. Every provider of neonatal care should ensure that non-direct patient-facing roles including provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator, discharge planning / outreach co-ordinator, patient safety and governance nursing lead and infant feeding lead are in addition to other roles outlined in the Toolkit for High Quality Neonatal Services (2009).

We currently have three such roles in place; 0.8wte as Neonatal Education and Safety Governance lead, procurement/stock rotation and 0.5wte Family Integrated Care Lead. Remaining specialist roles, in line with BAPM recommendations, are allocated to individuals within our clinical nurse budget and subject to being redeployed during times of staffing escalation.

It is also recommended neonatal services offer a 7-day outreach service for families (GIRFT 2022) who have been discharged from the LNU but have ongoing care needs. We have a well-established 5-day service which provides direct patient and family time however there is limited resilience in our staffing model for sickness or annual leave, the service is reviewing the current model to support progression towards a seven-day service.

15.0 Further actions to be undertaken over the next six months

1. Review the need to increased headroom required to support the BR+ 2023 report and findings from BSW academy review for maternity staff

2. Support effective retention and recruitment strategy to ensure continued stabilised midwifery workforce

3. Undertake review of externally funded posts and agree workforce planning strategy to mitigate risk of removal of national funding

4. To perform a fiscal review of nursing workforce to align with NHSE recommendations

5. To review the current model of care on LNU to support progression towards a seven-day outreach service.

6. To continue to seek funding to ensure compliance with BAPM standards for neonatal nursing and AHP staff

15.0 Conclusion

Maternity services are a high-risk specialism, the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high-quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

Neonatal services offer the best start in life to babies who have care needs which will have a lifelong effect if not provided in line with National standards.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.