BI-ANNUAL MIDWIFERY STAFFING REPORT, SEPTEMBER 2023

Background:

This is the second of the bi-annual midwifery staffing reports for 2023, and follows the March 2023 paper presented to People Academy and Trust Board in May 2023.

In addition to the bi-annual midwifery staffing reports, Trust Board has been appraised of the midwifery workforce position on a monthly basis, as part of the Maternity and Neonatal Services reporting process.

The March 2023 paper concluded that the services immediate priority was taking the safety concerns highlighted in the Ockenden and Kirkup reports and the ongoing national midwifery staffing shortage into consideration by managing vacancy and recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care at 29%.

The second priority was to work towards the long term commitment made in 2021, to fund the establishment required to provide MCoC as a default position for all women.

The third priority was to recommission the full Birth Rate plus tool in autumn 2023 to give an up to date assessment of the acuity of women accessing the service, considering the annual birth rate.

The fourth priority was to review the current headcount uplift which incorporates the time required to complete Trust level mandatary training and the training requirements set in the maternity core competence framework, and write a paper to present to the Executive Team.

The Trust Board was supportive of the recommendations and agreed to continue to support the long term commitments previously made to fund the establishment required to provide MCoC as a default position and recommission the full Birth Rate plus tool in autumn 2023.

The previous bi-annual midwifery staffing reports included recommendations required to meet the Royal College of Midwives (RCM) Leadership Manifesto, which in turn is an Ockenden 2020 assurance standard.

Board was again, supportive of the recommendations regarding midwifery leadership.

The purpose of this report is also to evidence:

- A systematic, evidence-based process to calculate midwifery staffing establishment.
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated above.
- The midwifery co-ordinator 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.
- All women in active labour receive one-to-one midwifery care.

This report provides the minimum evidential requirement for the Trust Board to meet Maternity Incentive Scheme (MIS) safety action 5.

The review uses a methodology of professional judgement, Birth Rate Plus / birth to midwife ratios and a review of red flag and incident data.

Current Midwifery staffing position:

The Midwifery staffing position has remained challenging between the reporting periods 1 March to 31 August 2023 amid the continuing backdrop of well-publicised, national midwifery shortages.

The maternity service has been pro-active in having a 'rolling' recruitment process throughout the year as well as engaging in the Trust recruitment open days. This has resulted in small numbers of band 5 and band 6 midwives joining the team and has managed the expected annual attrition rates, but has not impacted on the required increase to the establishment. The service has also continued to pursue International Midwifery recruitment during 2023, which has not been without its own challenges and has resulted in a small number of internationally trained midwives joining the NMC register and joining the service.

Recruitment and challenges:

The current vacancy rate for safe staffing is -26.28 WTE and -45.26 WTE for MCoC.

There are 3 qualified midwives (2.34 WTE) currently in the recruitment process and are due to commence with us at the end of October following working their notice periods and also confirmation of HR checks.

The service participated in the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) centralised Newly Qualified Midwife (NQM) recruitment campaign for the third year running. This year the service has recruited 23 NQM, (21.29 WTE).

This cohort of NQM was affected by the Covid-19 pandemic, experiencing disruption to both academic and clinical placements. As a result of these challenges an increased number are not in a position to join the NMC register in October, with some being delayed until the New Year.

This will significantly impact on our autumn position, as only 11 midwives (10.41 WTE) are in a position to definitely start their midwifery career at the end of October 2023. There is a potential that a further 9 (8.24 WTE) NQM will commence as MSW's whilst they await their NMC PIN which has been delayed due to re-submission of academic work. However, 2 of these NQM's are expected to go on maternity leave by the end of the year. This is a very unusual position and means that the current staffing pressures will continue into the New Year.

In addition, 3 NQM's (2.64 WTE) will enter the NMC register late and are not expected to commence in post until January 2024.

If all midwives within the recruitment process commence in post the midwifery staffing rate will increase by 23.63 WTE.

Workforce initiatives:

Since the last bi-annual paper, 1 International Theatre Nurse and 2 further International Midwives have passed their Objective Structured Clinical Examination (OSCE) and have received their Nursing and Midwifery (NMC) PIN.

The service is currently supporting 4 International Midwives and 1 International Nurse. 1 International midwife has been supported by the service, Trust and NMC to relocate to the Neonatal Unit due to the challenges she was experiencing in view of her limited past midwifery experience. Further recruitment is underway but the service has made the decision to only recruit to 1 further candidate at this time, due to the level of support the current international registrants require by the labour ward workforce in addition to the significant number of midwifery students.

The service is also supporting the career development of 2 Maternity Support Workers (MSW). 1 MSW commenced the apprentice midwifery programme at the University of Huddersfield in March 2023 and the 2nd MSW commenced in September 2023. It is likely that there will then be a pause for 12 months to assess the feedback of the initial candidates and to manage the expected increase in undergraduate midwifery training numbers.

The Director of Midwifery is currently undertaking an improving population health fellowship with a project focused on raising the profile of midwifery amongst South Asian secondary school students. Engagement work has commenced with South Asian women with planned activities in Bradford schools from September.

Retention:

The service has continued to focus on the wellbeing and retention of the workforce and has a number of strategies in place to support NQM, International Midwives, MSW's apprentices and staff new to the organisation:

- Substantive band 7 Specialist Midwife for Pastoral Support.
- Seconded band 7 Specialist Midwife for International Recruitment.
- A Legacy Midwife (experienced midwives working alongside new staff in clinical practice).
- Robust preceptorship package.
- Access to Professional Midwifery Advocates (PMA).
- The recruitment of a Band 4 MSW lead and pastoral support is underway.

Sickness and Absence:

Midwifery and maternity staff sickness and absence rates have remained high during this reporting period despite a continued focus on staff wellbeing and the enhanced bank 'surge' rates in place during agreed set periods.

Staff remain stressed, tired and continue to demonstrate reduced resilience, which not only affects short term absence, but also the uptake of bank shifts. This was particularly noted over the peak summer months.

The Maternity Matrons continue to closely manage long term sickness and absence alongside HR colleagues in line with Trust policy.

The Outstanding Maternity Services Workforce work stream also continues with a number of wellbeing initiatives such a 'hug in a mug' and 'wellbeing tea trolleys' which have been positively evaluated by staff. The service also actively engages with the Trust Thrive initiatives.

Mitigation:

Safety has been maintained across all areas of the unit by daily redeployment of staff, flexing inpatient beds to preserve safe staffing ratios, use of non-clinical and specialist midwives to support clinical areas. The escalation policy is then implemented in situations where activity and acuity is higher than staffing levels can support, diverting, as a last resort, women where appropriate and possible.

The previous bi-annual paper described additional measures to improve safe staffing levels in Community Midwifery including the suspension of specialist midwife support roles, suspension of the intrapartum element of some continuity of carer (coc) teams. Acorn team (for vulnerable women) have recommenced a 24 hour intrapartum on call service 2 to 3 days per week since the week commencing 11th September 2023. A partial on call service will remain until this team is fully established.

It was hoped that the arrival of NQM in October/November will enable an enhancement of intrapartum care in some of the Midwifery Continuity of Carer (MCoC) teams, but this is likely to be delayed until the New Year.

<u>Obstetric Theatre</u>

There is a current vacancy of 1.77 whole time equivalent (WTE) nurses within the obstetric theatre agreed establishment. This is being actively recruited to. The last 2 recruitment efforts have not been successful in appointing suitable candidates. The service is liaising with the Trust International Nurse Recruitment Lead and Trust Theatre Nurse Leads to explore if further international recruitment or joint recruitment is feasible.

<u>MCoC:</u>

Communication from the National Maternity Transformation team in September 2022, informed that the 2024 target to achieve MCoC as a default position for all women, had been

removed. Trusts were formally asked to focus on achieving safe and sustainable staffing levels as a priority.

The national message is clear that MCoC is still the ambition, and that whilst the target date has been removed, Trusts should continue to assemble the 'building blocks' required to achieve this at such a time it is safe to do so, working with local, regional and national continuity leads to ensure that this is achieved.

This is very much the approach already taken at BTHFT and whilst no new teams are planned, the service continues to prioritise existing teams developed to support women from ethnic minority groups/vulnerable backgrounds. The removal of a target alleviates a significant recruitment pressure and also enables us to evaluate the existing teams and make improvements/amendments as necessary. This approach continues until safe staffing levels are sustained.

Royal College of Midwives (RCM) Leadership Manifesto:

BTHFT maternity service mainly reflects the outlined recommendations of the Royal College of Midwives (RCM) Leadership Manifesto, with the exception of:

An Associate Director of Midwifery (ADM), Band 8c, which will be advertised in late 2023/24, to fulfil the Royal College of Midwives (RCM) Leadership manifesto and achieve compliance with the corresponding Ockenden recommendation.

The addition of Consultant Midwives, as recommended by the manifesto, will also be considered once an Associate Director of Midwifery has been appointed.

Annual Training Needs Analysis:

The 'Three Year Delivery Plan for Maternity and Neonatal Services' published in March 2023 requires trusts to undertake an annual training needs analysis and ensure training is available to all staff in line with the National maternity core competency framework version 2 (v2). Compliance with the core competency framework v2 is one of the safety standards within the Maternity Incentive Scheme (MIS).

A training needs analysis has been undertaken and a 3 year training plan developed (currently in draft) which meets the requirements of the National Maternity core competency framework v2. This work has demonstrated that the number of training days required to fulfil the framework is 5 days (39 hours), which is an increase from the 3 days currently provided to the midwifery workforce. This is required for each midwife employed, not whole time equivalent. This does not include any dedicated protected time for Trust mandatory training or any additional individual training needs, for example leadership development, newborn examination training, professional midwifery advocate training.

The current agreed 'headroom' uplift to accommodate training requirements is 22%. This no longer meets the national and local training requirements for maternity staff, plus the required Trust mandatary training. To enable the service to incorporate the time required for all training requirements the 'headroom' within the rosters would need to be increased to 24.3% based on the current headcount. Trust Board is asked to agree the 2.3% increase in 'headroom' uplift.

Calculation of midwifery staffing establishment:

The tools utilised to calculate the required establishment for the birth rate include:

- Birth Rate + tool methodology.
- Midwife to Birth ratio.
- Planned versus actual midwifery staffing levels.
- Supernumerary co-ordinator status and 1:1 care in labour data taken from Cerner and SafeCare.
- Red flag incidents associated with midwifery staffing including mitigation to cover shortfalls.

Birth Rate + tool methodology:

Birth Rate + exists as the only recognised tool to calculate midwifery staffing levels, and a full review was last commissioned in November 2020, with a report being received in April 2021. A summary of the report and recommendations was presented at the Executive Team Meeting in May 2021.

A Birth Rate Plus table top review has been completed every six months since the last full review report and included in the bi-annual midwifery staffing papers. This exercise has been repeated for the purpose of this paper and assumed that the case mix of Bradford Teaching Hospitals NHS Foundation Trust had remained unchanged, but was recalculated to reflect the change in the annual birth rate from 5001 to 5159. The recommendation of 10% non-clinical and management roles has been incorporated into the desk top tool.

Year 5 of the Maternity incentive Scheme requires the bi-annual staffing review to include the percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate+ accounts for 10% of the clinical person establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The service now has 25.4 WTE ‘Additional Senior Management and Specialist Midwives’ which is 10% of safe staffing numbers (CoC 29%) this includes specialist midwives and unit managers’ non-clinical time and now meets the recommendation following the move to having more non-clinical time for ward managers a change of model aimed at an improved contribution to the Quality and Safety agenda.

We have a current midwife establishment of 223.04.

Table 1

	BIRTHRATE PLUS 2022 **WTE** Bands 3 to 8	**VARIANCE** September 23 position of midwifery vacancy
Current funded position	279.77	- 51.7
Core Services and with **Continuity Teams at 29%**	254.35	- 26.28
Core Services and with **Continuity Teams at 35%**	256.53	-28.46
Core Services and with **Continuity Teams at 51%**	264.52	-36.45
Core Services and with **Continuity Teams at 100%**	273.33	-45.26

As discussed previously, although the target date for achieving MCoC has been removed, the message from National Maternity leaders is clear that MCoC should not be considered until safe staffing levels are achieved. However, achieving MCoC as a default position remains the overarching ambition. The Maternity Service at BTHFT has adopted this position over the last 12 months and at the current time has no intention to progress any new continuity teams or pathways, but will continue to focus on women and birthing people from our most vulnerable populations.

Instead, the priority is to achieve the 254.35 WTE Birth Rate + have assessed as required to provide safe staffing levels based on existing MCoC pathways and models of care. The

current vacancy against this figure is -26.28 WTE which will increase with usual attrition rates between now and newly qualified midwife appointments in October.

The second priority for 2023/24 will then be to recruit a further 2.18 WTE required to achieve 35% MCoC in addition to safe staffing, gradually working towards the number required to achieve 51% MCoC.

It is felt that this incremental approach is realistic and more achievable in the current climate of midwifery staffing shortages.

Trust Board is asked to continue to support the long term commitment made in September 2021, to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE. The table top calculation for this paper, based on an increased birth rate from the previous report to 273.33 WTE, but it must be noted that if the birth rate increases or decreases further in 2023 this figure may change again.

However, Trust Board is also asked to support the required uplift in 'headroom' from 22% to 24.3% so this can be accurately built in to the calculations used in the Birth Rate Plus full review in November 2023. This will reinforce the delivery of the national maternity core competency framework v2, Maternity Incentive Scheme year 5 and Three Year Delivery Plan for Maternity and Neonatal Services'. It is recommended that achieving the training requirements will be prioritised above the ambition to achieve MCoC, therefore there is no additional ask to increase the existing agreed establishment at this time.

Midwife to Birth ratio:

Based on the current agreed establishments of 248.2 WTE midwives, we aim for a midwife to birth ratio of 1:20.2. Please note, the figures below include all staff (including maternity leave and long term sickness and absence) and an agreed over establishment to balance this.

A review of the previous six month period is as follows (Table 2):

Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
1:23.3	1:23.7	1:23.5	1:23.5	1:23.4	1:24.4

The ratio is calculated on the number of midwives employed and does not account for any monthly variations in staffing due to sickness and absence. Please note that this ratio is a Birth: Midwife (as previously described regionally and what was previously reported into the regional dashboard to exclude Band 8 midwives and the specialist midwife for Quality and Safety). This differs from the skill mixed numbers in the Birth Rate Plus tool (as per Table 1).

Planned versus Actual midwifery staffing levels:

Details of planned and actual midwifery staffing levels are available to view on the monthly 'Heat map' data produced by the Chief Nurse team. Where staffing levels fall below planned, mitigation includes the redeployment of staff, including specialist midwives, to cover shortfalls. Beds are also reduced if necessary to maintain safe staffing levels. If these actions are insufficient, the maternity escalation policy is triggered and unit 'divert' declared.

Supernumerary labour ward co-ordinator status and the provision of one to one care in labour:

Supernumerary labour ward co-ordinator status:

The labour ward staffing model is as follows:

- 1 x Supernumerary Band 7 co-ordinator.
- 7 x Midwives including an additional Band 7 per shift.
- 1 x Obstetric Theatre practitioner. (This may be a theatre nurse or midwife).

There was 1 reported Red Flag recorded on Safe Care for failure to achieve supernumerary labour ward co-ordinator status, during the 6 months, 1 March to 31 August 2023.

The co-ordinator provided direct care to an antenatal woman for a total of 3 hours at the end of a shift as there were no other midwives available during that time. Minimal care was required as the induction process had not yet commenced.

This is an isolated incident and is not a cause for concern and does not affect compliance with the standard described in the Maternity Incentive Scheme.

Provision of one to one care in active labour and mitigation to cover any shortfalls:

Table 3 below demonstrates the monthly one to one care in labour rates taken from Cerner Maternity.

Table 3

	March	April	May	June	July	Aug
Received 1:1 Care Overall	95%	89%	90%	86%	86%	87.5%
No	21	39	44	58	51	49
No Labour	67	81	58	65	51	63
Yes	343	308	355	335	300	308

1:1 care in labour above the 90% standard was achieved in 2 of the 6 months within the reporting period. This metric is monitored by 2 Labour Ward Co-ordinators who review all cases where a no responses or absent response is recorded in EPR. They undertake data quality to ensure the accuracy of the data. This safety standard has declined from all previous staffing reports but coincides with the number of unit diverts/attempted diverts and the workforce challenges previously highlighted during the same period.

In all cases where 1 to 1 care was not achieved there was no significant harms to mothers or babies. Detailed senior leadership scrutiny is being undertaken to further understand the extent of time that women are not receiving 1 to 1 care in established labour and the reasons why this is not being achieved. This will aid the development of an improvement plan which is a requirement of the Maternity Incentive Scheme and will require Board level sign off prior to self-declaration in February 2024.

Maternity Unit 'Closures'

The CQC were concerned by the number of maternity unit closures reported in the 12 months prior to the November 2019 inspection. The NHSE/I Maternity Support Programme team also identified the number of units diverts as an area requiring further attention.

The decision to divert maternity services is often complex, multifactorial and never taken lightly. Whilst midwifery staffing levels do trigger a need to divert on some occasions, this is never the single root cause and is usually combined with increased admissions to the intrapartum areas and high levels of acuity and complexity.

In the reporting period, 1 March to 31 August 2023, there were 0 full diverts, 11 partial diverts and 4 occasions where the need to divert was declared but the unit remained open due to neighbouring organisations being unable to accept admissions.

Partial diverts are declared when women, usually those requiring intrapartum care, are diverted to another unit, whilst BTHFT maternity continue to triage and see women with other clinical issues such as reduced fetal movements. Partial diverts also include incidences where neighbouring units can initially accept women and then become unable to accept further, meaning that BTHFT then receive all admissions.

A total of 31 women were diverted to other units for care, some of whom returned to continue care at BTHFT after the event.

There were 4 occasions where the need to divert services was declared but neighbouring units were unable to accept. On these occasions the services continued to triage and admit women who have chosen BTHFT as their care provider.

It must be stressed that there are no reported incidences of harms caused to women and babies during times of diverts or attempted diverts, but this affected the ability to provide one to one care in labour and the quality of care provided to mothers and babies.

Unfortunately, there is no consistent regional or national data available to act as a comparator and indicate whether or not BTHFT is an outlier in this area. It must also be

noted that whilst unit escalation policies across the LMNS and the region are becoming standardised, units have very different ways of addressing capacity and staffing issues which makes it even more challenging to benchmark the BTHFT position.

For example, neighbouring units with more than 1 site rarely divert to other organisations, but frequently divert between their own units. Other organisations do not divert services as an acute response, but divert women to other units for elective procedures such as induction of labour. This is not captured as a unit divert.

The updated maternity escalation policy has been brought in line with LMNS and Regional policies and reflects OPEL principles. The variation in how individual organisations consider what constitutes a divert of service, remains a hot topic at both LMNS and Regional level, and it is anticipated that steps to address and standardise this will be taken in 2024.

Table 4 is a monthly break down of diverts, partial diverts and attempted diverts during the reporting period.

Table 4:

MONTH	**DIVERTS**	**ATTEMPTED DIVERTS**	**PARTIAL DIVERTS**	**NUMBER OF WOMEN DIVERTED**
MARCH	0	0	1	4
APRIL	0	0	2	2
MAY	0	0	3	10
JUNE	0	0	3	13
JULY	0	1	2	2
AUGUST	0	3	0	0
TOTALS	**0**	**4**	**11**	**31**

Number of red flag incidents:

The Maternity Incentive Scheme, Year 5, safety action 5 has been revised and the recommendation is now that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.

Incidents associated with midwifery staffing are reported via Datix and are investigated by the maternity quality and safety team. In the six month time period 1 March to 31 August

2023 there were 21 reported incidents where 'staff' or 'staffing' were mentioned in the narrative or service provision issues (eg staffing) chosen as the incident reporting category.

All incidents were reviewed and graded as no harm, and describe an inability to provide a level of care to the expected standard rather than physical harm or poor outcomes for mothers and babies. The 21 reported incidents include 17 relating to the 14 unit 'diverts/attempted/partial diverts' already described, and the majority of other incidents describe the occasions where staff were redeployed to enhance safety in a variety of clinical areas.

There has not been any incidents requiring a level one investigation or serious incident (SI) report during the same time period, where midwifery staffing is directly cited as a causative or contributory factor to any harm caused to a mother and baby. However, in recent weeks there have been near miss incidents where midwifery staffing has been a contributing factor.

Red Flag incidents are reviewed daily (Monday to Friday) by the midwifery matrons and are included in the daily Maternity SitRep submission to the Regional Chief Midwifery Officer Team.

Agreed Red Flags:

- Failure to provide 1:1 care in labour.
- Number of women waiting >30 minutes for epidural.
- Failure to achieve supernumerary labour ward co-ordinator status.
- Delayed or cancelled critical activity.
- Missed or delayed care.
- Staffing shortfalls.
- Delay in triage after presentation.
- Delay in induction process.
- Number of women waiting augmentation/induction of labour for >12 hours.
- Delay in medical review.
- Delay in transfer to labour ward from the birth centre.
- Delay in transfer from MAC to Labour Ward.
- Delay in transfer from inpatient ward to Labour Ward.
- IT connectivity issues.
- Unplanned omission in providing medications/delay in providing pain relief.
- Delay in morning postnatal medical review.
- Vital signs not assessed or recorded.
- Additional Capacity Beds.

Antenatal clinic do not currently use Safe Care due to their outpatient/session based working with high variance in cover and activity requirements.

There were 702 Red Flag incidents recorded on Safe Care from 1 March 2022 to 31 August 2023. This is the highest number of Red Flag incidents ever recorded in a 6 month period and shows an ongoing improvement in the culture and recording of red flag incidents. This

increase also reflects the staffing and acuity challenges and number of diverts and attempted diverts as already covered in this report. Appendix 1 provides a breakdown of the red flags raised by area and category.

Key points:

- 127 of the 702 red flags relate to registered midwife (RM) short fall of less than 2 RM* per shift plus a further 171 red flags reporting an RM short fall. This continues to reflect the ongoing staffing challenges. It is possible that there is a small amount of 'double counting' and recording of staffing short falls in the 2 different columns, which will be reviewed by the Matron team.
- 64 red flags were due to delay in medical review and 16 red flags reported due to delay in morning postnatal medical review which is outside the scope of midwifery staffing and this paper. These are escalated to the Clinical Director.
- 31 red flags were reported for an inability to provide 1:1 care in labour for any period of time. However, this is inconsistent with the actual number of women reported on Cerner who didn't receive 1:1 care overall, and suggests an under reporting of red flags pertaining to this area.
- 75 red flags were reported by the birth centre regarding delayed cancelled critical activity. These red flags are in relation to the birth centre being closed due to staffing redeployment, resulting in women being cared for on the labour ward rather than their intended birth centre location or when care cannot be facilitated on the birth centre due to all the rooms being occupied.
- 74 red flags were reported regarding delayed transfers to labour ward and 70 red flags for delays in the induction process. These flags coincide with the unit acuity and staffing pressures already described in this report and are reflective of the pressures other units are also experiencing both regionally and nationally. Delayed inductions of labour have been recognised as a safety concern within the LMNS and improvement work is ongoing to standardise the timeframes that Trusts use to constitute a delay in the various stages of the induction process and also to share practices which will support a reduction in delays. There will also be a requirement in the next few months for Trusts to report IOL delays within the weekly Maternity SitRep. Locally, as part of the Outstanding Maternity Service Women's Journey work steam, the induction of labour sub group has already implemented a number of improvements within this pathway, for example the use of balloon induction and there are plans to further enhance this pathway by offering outpatient induction.

*It must be noted that clinical areas are never left with less than 2 team members and that staff are redeployed from other areas to maintain minimum safe staffing levels.

Conclusion:

The service believes that this report meets the Maternity Incentive Scheme required standard to demonstrate an effective system of midwifery workforce planning.

For the purpose of this paper, a table top Birth Rate + exercise has been conducted since the last 6 monthly review and has identified an increase in the annual birth rate resulting in a increase in the midwifery establishment of 6.76 WTE.

The national recommendation is that the full Birth Rate Plus acuity tool is completed every 3 years. This has been commissioned to commence in autumn 2023.

The ongoing priorities remain largely unchanged from the previous bi-annual recommendations, and are to continue to manage vacancy and recruit to the calculated establishment required to achieve safe staffing based on existing MCoC models and pathways of care. The service has identified that the increased Trust mandatary training requirements, plus the maternity specific core competency framework requirements have increased significantly and that this exceeds what is currently built into the current 22% built in headroom. The recommendation is that the Trust Board approve an increase in 'headroom' to 24.3% required to deliver training compliance.

The next priority is then to incrementally increase the midwifery workforce to introduce more MCoC teams with the ultimate ambition of achieving MCoC as a default position for all women. This approach is in line with National Maternity Transformation ambitions, a recommendation which remains unchanged except for the removal of a target date for achieving.

The service remains committed to proactive recruitment, including International Midwives and Midwifery Apprentice programmes, and reinforcing the systems and processes in place to retain staff through preceptorship and pastoral care.

The supernumerary status of labour ward co-ordinators is fiercely protected and is consistently 100% with only 1 reported red flag in a 6 month period.

There has been a noted increase in the number of unit diverts/attempted diverts compared to previous reports and this understandably coincides with only achieving above the 90% target of 1 to 1 care in labour in 2 of the 6 months in the reporting period. Detailed senior leadership scrutiny is being undertaken to further understand the extent of time that women are not receiving 1 to 1 care in established labour and the reasons why this is not being achieved. This will aid the development of an improvement plan.

The workforce and acuity pressures are also impacting on the number of delays experienced by women on the induction of labour pathway. The service is looking at the data capture around delays in induction of labour, actively engaging with the LMNS improvement work to standardise measures and undertaking local quality improvement work.

There are no additional financial requests for Trust Board consideration in this paper and analysis.

Recommendations:

- Taking the safety concerns highlighted in the Ockenden and Kirkup reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to continue to support the services proposal that the first priority is managing vacancy and recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care at 29%.
- Trust Board is also asked to support the required uplift in 'headroom' from 22% to 24.3% so this can be accurately built in to the calculations used in the Birth Rate Plus full review in November 2023. This will reinforce the delivery of the national maternity core competency framework v2, Maternity Incentive Scheme year 5 and Three Year Delivery Plan for Maternity and Neonatal Services.
- Trust Board is asked to continue to support the long term commitment made in 2021, to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE. However, the recent table top review calculates this as 273.33 WTE.

Appendices:

4- Red Flag report 1 March 2023 to 31 August 2023