Paper ref:	TB (06/21) 008

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	**Maternity Services Update**		
Sponsoring Executive	Melanie Roberts, Acting Chief Nurse		
Report Author	Helen Hurst, Director of Midwifery		
Meeting	Trust Board (Public)	**Date**	9th June 2021

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Midwifery Staffing remains a challenging environment, a robust recruitment and retention plan has been developed in conjunction with Human Resources and Education. Review of workforce and roster management is a key drive to maintaining quality, safe services, whilst maintaining the wellbeing of our staff. Assuring fluidity in staffing to meet the demands of acuity and capacity.

Care Quality Commission undertook an unannounced visit in May, the initial findings are within the report and cover the themes already identified and found within the maternity improvement plan. Good practice was also identified, particularly around governance, evidence based care, and audit and multi-professional team work to achieve good outcomes.

Equality Diversity and Inclusion Lead Role pilot launched to improve outcomes within our diverse local communities in line with National drivers for reducing health inequalities, supported by the Local Maternity and Neonatal System.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	√	Public Health Plan	√	People Plan & Education Plan	√
Quality Plan	√	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** the content of the report
b.	**DISCUSS** the report and highlight any areas for further information required
c.	**APPROVE** as required

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	X	Risk 4407,4356 workforce risks					
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Maternity Services Update
Report to the Public Trust Board:

1. Introduction

1.1 Safety in maternity and neonatal services has been of national focus since 2015 and this has been strengthened with the publication of the interim report of the Independent Maternity Review (Ockenden Report) which provides clear direction for the improvement of maternity services nationally.

1.2 This reports updates Board on three main areas:

- Midwifery staffing
- CQC Verbal update
- Equality Diversity and Inclusion Lead Role

2. Midwifery staffing

2.1 The current climate is challenging in many ways. Increasing acuity of births and the lack of availability of maternity staff reported by the Royal Colleges are significant issues for many units. It is imperative that we recognise that modernising maternity services will require new ways of working to support midwives and obstetricians, anaesthetists and neonatologists, as well as ensuring that staffing numbers are adequate and appropriate. We should aim for creative workforce design backed by excellent multidisciplinary training and education to enable teams to work together to provide safe services.

2.2 In maternity, workforce planning poses a unique set of problems: each care 'episode' spans about 40 weeks, crosses hospital and community settings, and involves scheduled appointments. Many pregnancies need extra unscheduled care, often involving more scans or other procedures as well as an unexpected inpatient admission in addition to the birth itself. The birth can be at home, in a midwifery-led unit or obstetric unit in an acute hospital. It is also necessary to consider risk escalation and transfer of women in labour between low and high risk settings when planning the workforce. The pregnancy, birth and postnatal pathways are mainly provided by midwives whose role and responsibilities are defined in statute.

2.3 Many influences on safe staffing in maternity services affect the number of specialists required to keep staffing safe and sustainable. Examples are population mix, social care needs, health inequalities, specific health needs, health complexities, safeguarding children and vulnerable adult's services, and a fluctuating birth rate. Meeting the requirements of national screening programmes is another influence: several are associated with maternity services including the Fetal Anomaly Screening Programme (FASP) and newborn and infant physical examination (NIPE). Increasing complexities in health have led to an increase in obstetric, anaesthetic and neonatal interventions

driven by concerns for patient safety. The document *"Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2018),* provides a set of expectations for nursing and midwifery staffing. The resource identifies three updated NQB expectations that form a 'triangulated' approach to staffing decisions as set out Annex 1.

2.4 Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

2.5 An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

2.6 Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered. In addition, BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones. The Trusts last BR+ full review was undertaken in 2018, since then we have seen a reduction in births, the deficit based on birth numbers is 11 WTE midwives, the monies to support this increase has been requested as part of the Ockenden bid (brought to Board last month).

2.7 Analysing the data from the Birthrate Plus Acuity Tool – Midwifery Red flags, the highest notification of red flags was for delayed continuation of induction of labour, this delay occurs in the majority for the transfer of women to labour for artificial rupture of membranes. It is encouraging to see that the reporting of incidents is gradually increasing with the compliance of using the acuity tool. It is also reassuring to see the use of management actions in response to these red flags, which provides insight into how the shift coordinators maintain safety within the unit, and escalate concerns. All cases are reviewed to assess impact of such delays.

2.8 Upon review of the management actions, it is evident to see that there were 38 occasions where redeployment from another clinical area was necessary to maintain safety. There were 2 occasions where the matron/ward manager was redeployed from duties to assist with clinical workload, and 6 occasions where there was escalation to the senior management team of midwifery red flags occurring on site. This escalation gave opportunity of oversight and advice to be given, in relation to care planning and operational issues to support the coordinators in their role and maintain safety of the maternity unit. Where redeployment occurs it is of paramount importance that a full review of that areas acuity and capacity has been undertaken to maintain safety.

3. Inpatients

3.1 The Unit undertakes daily staffing meetings led by the Inpatient matron, on delivery suite to ensure flexibility and fluidity to meet acuity and capacity demands. These are supported by all areas, including community midwifery and neonates, including a staffing proforma to clear identify required vs actual. Table 1 below shows the fill rates for the last 12 week period. Bank shifts are predominantly covered by substantive staff solely, no agency is utilised in maternity services. It is important to ensure staffs health and wellbeing whilst ensure safe staffing levels.

			Early	Late	Night
Safe Staffing	**Delivery Suite**	**Qualified**	**10**	**10**	10
		MSW band 3	**2**	**2**	2
	Induction Bay	**Qualified**	**2**	**2**	2
		MSW band 3	**1**	**1**	1
	M1	**Qualified**	**2**	**2**	2
		MSW band 3	2	2	1
	M2	**Qualified**	3	3	2
		MSW band 3	2	2	2
	Serenity	**Qualified**	4	4	3
		MSW band 3	2	2	1

			March	April	May
% fill rate	**Delivery Suite**	**Qualified**	**90%**	**95%**	**95%**
		MSW	**95%**	**95%**	**95%**
	Induction Bay	**Qualified**	**95%**	**100%**	**100%**
		MSW	**100%**	**95%**	**95%**
	M1	**Qualified**	**95%**	**95%**	**95%**
		MSW	**95%**	**95%**	**100%**
	M2	**Qualified**	**95%**	**95%**	**95%**
		MSW	**100.0%**	**100.0%**	**90%**
	Serenity	**Qualified**	**80%**	**90%**	**95%**
		MSW	**75%**	**80%**	**90%**

3.2 Concerns around the reliability of the rosters within inpatients, has been raised in several platforms as a concern. The concerns centre mainly on the use of paper and electronic rosters, and skill mix within the Delivery Suite. In response to these concerns, the inpatient matron was able to complete a review of rosters, and respond to safety concerns raised by staff in the safety boxes within the clinical areas. The matron has assumed full oversight of the rosters and skill mix within shifts and a notable difference is evident within the more recent rosters in comparison to Dec- March. It was noted that during March, many inpatient areas had high levels of annual leave (up to 25% in some areas) which had an impact on safe staffing levels.

3.3 Measures put in place have included;

- Ensuring all ward managers have access to barnacles, to assist them in roster management and planning (previously not using).
- Monthly 1:1's with ward managers and matron to include roster review as standing item on 1:1 template.
- All managers to have oversight of annual leave percentages for the entire year, including review of hours left for all staff and regular communication to staff regarding the process and expectations around booking AL via standardised effective handover throughout all inpatient areas.
- Delivery Suite roster to cease using paper w/c 5th July.
- Full roster access requested and given, for all Delivery Suite shift coordinators. This will enable the shift coordinator to manage the roster in real time – add sickness, book/cancel bank which will mitigate any risk of discrepancies with this roster. Due to its large size, it is essential that this roster is kept up to date live to ensure accuracy.
- Roster training planned for shift coordinators, live roster management from w/c 5th July.
- Agreed skill mix levels, to mitigate the risk of being band 7 heavy on weekend shifts (as reported as a concern by staff within Delivery Suite). Agreed level of 3 band 7s per shift (1 x in charge, 1 x IOL bay, 1 x HDU/triage). This is reviewed by the inpatient matron prior to roster sign off.
- General oversight of bank usage- the majority of staff picking up bank shifts within the unit are band 7's, but it has not been raised as a concern that this is at the detriment of more junior staff not being able to pick up an enhanced shift – however this remains an area of interest to monitor.

4. Community Midwifery Staffing

4.1 Across the years Community Midwifery has seen many changes, coupled with the complex and diverse population we serve, this has impacted on both retention and recruitment to this area of the workforce. Reviewing the data for this area highlighted historic vacancies that are 'hard to fill'. Work was undertaken in 2019 led by the

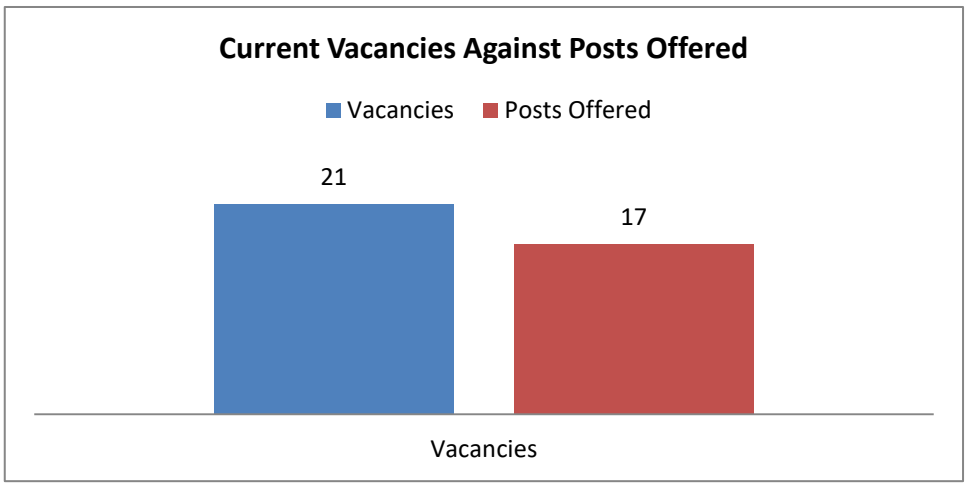
community midwifery team to redesign the model in line with Better Birth's with the creation of 'families'. In conjunction some of the historic vacancies were used to create an 80:20 split between midwives and maternity support workers (band 3), as seen in other areas with hard to fill vacancies (Portsmouth, Oxford, Stoke on Trent) thereby releasing midwifery time. Over the past 12-24 months there has been significant leadership changes in the Community Midwifery team, this impacted the ability to deliver a service to National and local standards. Caseloads are being reviewed as one of the 16 key actions from the community transformation plan, which forms part of the overall improvement plan.

4.2 The Community Midwifery team each day undertakes daily staffing huddle led by the Team managers and the oversight from the two Outpatient Community Matrons, to ensure flexibility to meet the service requirements on across Sandwell and West Birmingham. Each day the teams report a Sit rep (Situation report) covering actual acuity Vs demand alongside the workforce details.

4.3 Bookings are reviewed via a tracker, to ensure timely booking appointments are in place to meet the requirements for screening. Assurance is provided to the Directorate leadership team twice weekly and to the Director of Midwifery, Group leadership team and Chief Nurse in the form of the tracker each week. Vast improvements have been made in timeliness of appointments with the introduction of the early bird pathway; this can be seen in the reducing amount of urgent bookings that are on the tracker.

4.4 For Community Midwifery and all the departures this has impacted the team which then invoked the BCP which is amber at present and under continual review. There is no agency that is utilised for Maternity, however continual use of bank across inpatients/outpatients to support the service. Annex 2 shows the current staffing incidents in the last 3 months.

5. Workforce



5.1 A robust recruitment and retention plan has been developed in conjunction with Human Resources and Education, including an incentives paper that has been given approval by Executive Team and is to be heard for noting at the Integrated Care Systems People's Board. This includes a number of incentives for both new starters and existing staff in hard to fill areas.

6. Care Quality Commission (CQC)

6.1 During May an unannounced CQC visit happened within maternity services over a two day period which covered all aspects of the service both in acute and community midwifery care. No immediate concerns were raised and the Trust has received a letter providing initial feedback. The initial feedback was as follows:-

- Effective risk management, governance and evidence-based practice. Women's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence.
- Medical staff and midwives had respect for each other and worked as a team for the common goal of patient safety and satisfaction.
- There was a systematic programme of clinical audits to monitor quality and operational processes. Leaders identified were action should be taken.
- It was evident that the divisional triumvirate worked well together.
- Staffing – lack of midwives to meet the needs of women and babies in the service. This negatively affected well-being and presented a potential risk to patient safety. This was particularly evident amongst community midwives where morale was very low.
- The senior leadership team understood the challenges to quality and sustainability and had action plans to address areas of risk. However, midwifery staff did not all feel supported, respected or valued by the senior management team. There was a clear discrepancy between the views of leaders and the far less positive perceptions of midwives, who were anxious about their working culture and were not confident that concerns were taken seriously.

6.2 In summary the CQC confirmed our current challenges and acknowledged that we had plans in place and were aware of the work that was needed to be undertaken within maternity services. A full report is to be expected within 20 working days.

6.3 The maternity services improvement plan (see appendix 1) is already in place to address the issues noted by the CQC, with particular emphasis on culture and bridging the perceptions and feelings of staff to improve working culture, communications and ensure a service that is inclusive not exclusive. The plan is monitored via bi-weekly meeting by the Group leadership team, thereafter reporting progress and seeking support where required to the Chief Nurse.

6.4 Part of the improvement plan was to commission an external review on culture to ensure that the voices of staff and our hard to reach communities could be heard. Part 1(staff voices) of this piece of work has been completed by Debbie Graham, the draft document has been shared with the Executive team and scrutinised by the CEO, Chief Nurse and Medical Director, prior to sharing with the Group leadership teams. The report highlight no new theme previously identified, but provides greater detail and context. Debbie will commence Part 2 (communities) of her review shortly. This will link and support the work of the maternity voices partnership (MVP). The service has been undertaking listening events in multiple formats, supported by Executive colleagues and the outputs of these have been utilised to create a shared vision for the service and also a communication strategy for staff.

6.5 As part of our commitment to improve and ensure we are a great place to work and receive care we have worked with Tim Keogh from Kinder Life to design a development programme. 'Co-creating our Maternity Culture' is a two-part workshop for us to design the culture we want for ourselves and our patients. We expect and will support everyone who works in the service, in all roles and at all levels, to take part. (See appendix 2).

7. Equality Diversity and Inclusion Lead Midwife Role

7.1 A number of barriers can be identified that undermine timely access to high quality care for many Black, Asian and minority ethnic groups, with still birth rates twice those of their white counterparts and a 45% higher neonatal death rate. Given the health inequalities and therefore poorer outcomes, the maternity service proposed the requirement for an Equality Diversity and Inclusion Lead to the Local Maternity and Neonatal System (LMNS) for funding of this pilot role within the organisation. The outputs of this pilot role will report progress to the LMNS quarterly, with the aspiration that the pilot proves the requirement for the lead role and as such can be replicated across the LMNS.

7.2 In order to ensure improved provision the diversity, Equality and Inclusion lead will also assess the training needs of staff so that conversations around race and culture are sensitive and meet the needs of the communities we serve.

7.3 The lead will work alongside culturally diverse and vulnerable groups to dispel perceptions and provide assurance that safe, quality care will be provided in maternity services and ensure any barriers that prohibit women and their families accessing such care are removed.

8. Summary

8.1 In summary the paper outlines the current positon in maternity services and the work that is being undertaken to ensure the service is improving and providing high quality care to our women, babies and families, whilst ensuring all voices are heard.

9. The Trust Board is asked to:

a) Note the content of the report

b) Discuss the report and highlight any areas for further information required

Helen Hurst
Director or midwifery

Annex 1

Safe, effective, caring, responsive and well–led care
Measure and improve – patient outcomes, people productivity and financial sustainability – – report investigate and act on incidents (including red flags) – – patient, carer and staff feedback –
Implementing *Better births* maternity vision – implement Birthrate Plus (BR+), *Safer childbirth* – – develop local quality dashboard for safe sustainable staffing as part of the maternity dashboard –

Expectation 1 **Right Staff**	**Expectation 2** **Right Skills**	**Expectation 3** **Right Place and Time**
1.0 Evidence-based workforce planning 1.1 Appropriate skill mix 1.2 Review staffing using the Birthrate plus workforce planning tool annually and with a midpoint review	2.1 Multiprofessional mandatory training, development & education 2.2 Working as a multi-professional team 2.3 Recruitment & retention	3.1 Productive working & eliminating waste 3.2 Efficient deployment & flexibility including robust escalation 3.3 Changes in working around Better births, including increased continuity and caseloading and improvements in postnatal and mental health issues

Annex 2

Staffing Related Incidents Submitted 1/3-31/5/2021	
Incident	**Number**
St - Drs Hrs Breach - Excess Hours Worked	1
St - Failure To Assess Staffing Requirements	3
St - Failure To Book Additional Staff	1
St - Failure To Provide Staff	8
St - Lapse In Professional Registration	1
St - Medical Staff Off Area	3
St - Staffing - Lack Of Suitably Trained / Skilled	6
St - Staffing - No Breaks	5
Grand Total	28