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PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Maternity Services Update		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst - Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	11th January 2023

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

The Trust Board is asked to receive this report, as an update on maternity & neonatal services: -

1. Maternity services commissioned a workforce review undertaken by Birth-rate Plus (BR+), having last been undertaken in 2018-19. The findings have shown a deficit of 36.38 whole time equivalents (WTE), this significant increase is multifactorial, and the reasons why explained in the paper.
2. Neonatal nursing workforce is based on the British Association of Perinatal Medicine (BAPM) standard, the service is funded to that expectation of 100% staffing requirements based on 80% occupancy. The service has been proactive in developing the required qualified in speciality nurse (training to provide specialist care to maximise the potential for life for the neonate) are currently in short supply nationally. The current vacancies sit at 5.86 WTE, with recruitment ongoing. High levels of short-term sickness are impacting on the service and is covered by bank or agency staff, to ensure safe staffing.
3. An overview of medical workforce provides the current position and forward plans to ensure safe staffing. A business case has been submitted and is pending approval for expansion of the Neonatal medical workforce across all tiers to comply with key recommendations from several national and regional requirements.

Please note the Ockendon framework and data has not been through process due to the holiday period impacting on Quality and Safety Committee and is therefore not included.

2. Alignment to our Vision *[indicate with an **'X'** which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Maternity and Neonatal data received at Quality and Safety Committee November 2022. Safety champion meeting December 2022.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**DISCUSS** the findings of the workforce review in maternity services and support the next steps
b.	**NOTE** and accept the neonatal workforce overview
c.	**NOTE** and accept the medical workforce overview

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*							
Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*						
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*						
Corporate Risk Register [Safeguard Risk Nos]		Workforce risks 4480,3831,3576,4575,4326,2625						
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

Report to Trust Board: 11th January 2023

Maternity & Neonatal Services Update

1. Introduction

1.1 Board level oversight for maternity and neonatal services is fundamental to quality improvement, to ensure transparency and safe delivery of services. Central to delivering high quality, responsive, safe, effective woman and family centred care is the correct workforce establishment.

2. Birth Rate Plus Maternity Workforce Review

2.1 Birth-rate Plus (BR+) is a framework for workforce planning and strategic decision-making, used across many maternity services in the country and is the only tool recognised by the Royal colleges.
It is based upon understanding 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 is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The system classifies women and babies based on their clinical need using clinical outcome data, leading to a weighted score system with five categories, the lower the score no interventions or deviations from routine care. Categories III to V require rising levels enhanced levels of care. Can we state that's its used across the country please in NHS trusts

2.1.1 The last full review was undertaken in 2018-19. The assessment is based on data from three consecutive months (June-August 2021).

2.1.2 The findings of the report were shared by BR+ with the Chief Nursing Officer, Director of Midwifery and Senior Maternity team and has been socialised with the Executive team. (*It should be noted in the report that BR+ imports are what maternity units classify as exports, the women who live in our geographical area, but choose to have the birth element of care in another provider).*

2.1.3 The full report can be found in the reading room.

2.2 The workforce review has shown a deficit in the establishment of 36.38 whole time equivalent (WTE) staff, based on a funded establishment of 296.39 against the current funded establishment of 260.01. The reasons for the marked increase are multifactorial including:

- An increase of 17% in categories III to V, with category III seeing a 6% increase and category V seeing a 7% increase.', indicating a higher acuity of women. (See appendix 1 for definition of categories)
- Increased safeguarding caseload
- Increased new-born examinations (NIPE) being undertaken by midwives (over 80%)

- Increased uplift to 22% from the previous 19.68%, it should be noted that a high proportion of maternity services set this at 24-25% due to the high levels of training required.

2.2 Next steps are the Group developing a business case, based on a phased approach, which will include the division of care between two Integrated Care Boards. This will go through due process within the Trust and via the ICBs for further discussion on funding routes.

2.3 Current maternity vacancies are at 16.87 WTE a reduction from 41.62 WTE, a further 13.32 WTE are in recruitment, however we also see leavers, due to retirement, promotions, moving out of area etc. All final year students have been offered posts (27 WTE). This is a much-improved picture.

3. Neonatal Nursing Workforce Overview

3.1 The neonatal unit (NNU) has 29 cots. 5 are designated as Intensive Care cots (IC1), 5 are designated as High Dependency (IC2) and 19 as Special Care. We are also commissioned for 4 Transitional Care cots which are based on the post-natal wards but are not currently staffed by NNU. The British Association of Perinatal Medicine (BAPM) sets standards for nursing to cot ratios based upon acuity. These ratios (nurse to baby) are:

- IC1 – 1:1
- IC2 1:2
- Special care and transitional care 1:4

3.1.1 The service is funded in line with the standard at 100% BAPM staffing requirements based on 80% occupancy, with an establishment of 77.15 WTE band 3-8B, this includes 7.5 WTE Advanced Neonatal Nurse Practitioners that are included in the Junior Doctor establishment (tier1+2)

3.2 The current vacancies stand at 5.86 WTE, which will reduce to 4.74WTE in February 2023. The service has had success with their developmental programme which has reduced the deficit in qualified in speciality (QIS) posts, which is a national issue. Table 1 provides the detail of the vacancies by band.

Table 1

Band	Establishment	Actual
3	3.57	3.53
4	7.88	6.94
5	17.26	21.46 (includes QIS development)
6	25.61	20.84
7	14.42	12.97
8A (ANNP & Matron)	4.85	2.55
8B	3.56	3.0

3.3 Short term sickness is currently running at high levels at 15.88 WTE and long-term sickness at 1.31 WTE. Maternity leave only accounts for 1 WTE. Bank and agency are utilised to cover sickness to ensure safe staffing.

3.4 There are currently 2.2 predicted leavers, vacancies are in the recruitment process.

4. Medical Workforce

4.1 Obstetrics

4.1.1 No gaps at consultant level – currently 3 locum Cons in place – one substantive appointment made (starting Jan 23) and two further substantive posts awaiting RCOG approval to replace current locum posts.

4.1.2 Junior rotas remain compliant with European working time directive with an average of 1:8 for on call night or weekend shifts.

4.1.3 In August a new school of trainees at ST level commenced – this has resulted gaps in the registrar rotas which were not present in previous 12 months -
Tier 2 ST3-5 – 2 vacancies due to maternity leave and reduced Deanery provision

4.1.4 Out of hour (OOH) shifts have been prioritised, but this has still resulted in some rota gaps these are filled by internal locum shifts an external locums. There are minimal episodes of consultant obstetricians having to act down. Acting down policy enacted.

4.1.5 SWBH is the top-ranking Trust for obstetrics and gynaecology within West Midlands, based on trainee feedback and scoring, leading to us being the top choice for trainees wishing to rotate to.

4.2 Neonates

4.2.1 Junior tiers (Tier 1 & Tier 2) are made up of combination of doctors (Deanery trainees and Trust) and Advanced Neonatal Nurse Practitioners (AANP's)working at 1 in 9 on tier 1 and 1:8 on tier 2.
In September we saw an improved picture for the junior tier with commencement of new school of trainees from Deanery, filling posts. Gaps that occur are due to sickness.

4.2.2 Senior Tier 3 (Consultants) work at 1 in 7.5 for service/on calls (split 1 in 3.75 weekends)- includes 1 post covered by locum consultant. A senior trainee has been acting up to support the 2 gaps within the 1:8 consultant rota, this has been supported by the neonatal lead. This has supported Consultant staffing and the ability to perform extra duties outside of direct clinical care and manage the rota around summer leave.
In September and October, we saw two 6–12-month Locum Consultant posts commence.

4.2.3 A Business case for expansion of Tier1/2 and 3 rotas to meet national recommendations has been submitted to the Trust and is pending approval. This will see:

- Tier 1 becomes 1 in 12 rota (currently 1 in 9)
- Tier 2 becomes 1 in 10 rota (currently 1 in 8)
- Tier 3 becomes 1 in 10 rota (currently 1 in 7.5)

4.2.4 Regular meetings involving Neonatal Lead, Clinical Director and WCH Group Director and Group Director of Operations are in place and have been occurring since March and continue to help implement agreed actions quickly.

4.2.5 Neonatal medical staffing at consultant level and junior doctor/Advanced Neonatal Nurse Practitioner level sits as separate red risks on Directorate register – managed by specialty and directorate leads and group director of operations

5. Summary

Review of workforce provides an insight into the increasing complexities of maternity care required for local populations and provides the Board with data to support a workforce that supports the requirements.

6. Recommendations

The Trust Board is asked to:

a. **DISCUSS** the findings of the workforce review in maternity services and support the next steps
b. **NOTE** and accept the neonatal nursing workforce overview
c. **NOTE** and accept the medical workforce overview

Helen Hurst
Director of Midwifery
20th December 2023

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I Score = 6
This is the most normal and healthy outcome possible. A woman is defined as Category I [lowest level of dependency] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II Score = 7 – 9
This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III Score = 10 – 13
Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV Score = 14 –18
More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V Score = 19 or more
This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.