

<b>MATERNITY STAFFING STRATEGY</b>	<b>Strategy Register No:</b> 09148 <b>Status:</b> Public
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## **1.0 Purpose of the Strategy**

- 1.1 The purpose of this strategy is to describe the current and future staffing levels to ensure safe staffing in Mid Essex Hospitals Trust (MEHT) maternity services, and to detail what actions are taken to ensure that staffing requirements are in place. The guideline Roles & Responsibilities of Medical and Midwifery Staff working within Maternity, details the actions to be taken to obtain back up for high work load/staff shortages/emergency situations. The areas of staffing covered are midwifery, obstetric and anaesthetics.

## **2.0 Equality and Diversity**

- 2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

## **3.0 Background**

- 3.1 Nationally there is a recognised workforce planning tool known as BirthRate Plus. Trusts utilise this tool to evaluate the level of midwifery staffing required across all areas of maternity services.
- 3.2 MEHT commissioned this to be undertaken in 2008 to provide the evidence for an increase in staffing requirements.
- 3.3 The findings from this report, in conjunction with the maternity matters joint assessment template, have been used in negotiations with the Primary Care Trust (PCT). Birth-rate plus has therefore formed the basis for commissioning midwifery staffing and agreeing funding. Following local discussions, the PCT agreed to a phased increase in midwifery staffing over the 3 years, between 2008 & 2011 to assist a supportive recruitment programme.
- 3.4 Within these negotiations there was also the agreement for 2 WTE Consultants posts to ensure 60 hours of consultant presence on the labour ward.
- 3.5 In January 2008 the HealthCare Commission review of Maternity Services 2007 was published. This review found MEHT to be in the best performing category however the midwifery ratios at the time were one of the elements that scored least well.

## **4.0 Introduction**

- 4.1 In the past 2 years there have been a number of publications, which make recommendations for safer staffing levels. One of the main reports is 'Safer Childbirth', produced by the RCOG in October 2007. It is fair to say that concerns have grown nationally, as well as locally, regarding staffing levels and the mix of skills involved in maternity care. This has been compounded by a rising birth rate and the difficulty to recruit and retain staff.
- 4.2 Midwifery staffing as part of the MEHT maternity matters action plan is on the Trust Risk assurance framework, which is presented at the Trust Board, for scrutiny by the Trust

executive team annually. This action plan is also discussed at both the Divisional Bi-Lateral meeting. The Trust submits regular updates to the PCT quality monitoring group.

## **5.0 Context of Local Maternity Service**

- 5.1 Maternity services span both the acute and primary health care settings. However, given the proximity of other acute services and the organisation of PCT boundaries, the majority of a woman's antenatal care is provided by the community based midwifery teams. The locations of these clinics vary between primary care and the acute Trust. However, a number of women also need to be referred to an obstetrician at some point during their pregnancy. Their care then becomes shared between the obstetrician and the midwife, with the former being the lead professional.
- 5.2 MEHT provides services across three sites, none of which are based on a District General Hospital (DGH) site. St Johns maternity unit provides high and low risk care, and is the consultant lead unit. There are two Midwife Lead Units, St Peters Hospital and William Julien Courtauld Hospital, these are eleven and thirteen miles from the main unit and provide antenatal, intrapartum and postnatal community based services. Satellite high risk clinics are provided in these facilities. A small proportion of women currently opt for a home birth within MEHT.
- 5.3 On returning home a woman will receive approximately 3 postnatal contacts with the community midwife. The first of these is in the woman's home with the remainder being provided at home or in a clinic setting, depending on the health and well being of the mother and baby.

## **6.0 Process for Achieving an Increase in Maternity Staffing**

- 6.1 Mid Essex Maternity Services has not been required to submit a formal business plan to the PCT for an increase in maternity staffing. An increase has been agreed and documented in a joint maternity matters action plan. This action plan stipulates that both the Trust and the PCT will work together jointly to achieve an overall midwife to birth ratio of 1:30. This takes into consideration the RCOG Safer Childbirth recommendations of 1:28 for low risk cases and 1:25 where a higher degree of care is required.
- 6.2 The total number of additional midwifery posts recommended in 2008 on completion of birth-rate plus staffing assessment tool was 35 WTE.
- 6.3 In 2008/09 midwifery workforce increased by:
- 7 Midwives
  - 0.5 Screening Co-ordinator an uplift to the existing post to 1 WTE
  - 3 WTE Maternity Care Assistants
- 6.4 In 2009/10 maternity staffing has increased by:
- 2 WTE Consultant Obstetricians/Gynaecologists
  - 14 band 6 WTE midwives
  - 2 specialist midwifery posts

- Infant feeding co-ordinator
- Lead Midwife for Vulnerable Women

A total of 25.5 additional posts will have been funded by the end of the 2009/10 financial year.

- 6.5 In 2010/11 a further increase to the funded staffing establishments will be required to meet the recommendations of the birthrate plus recommendations.
- 6.6 The PCT have indicated that, in line with the maternity matters joint assessment, plan MEHT Maternity department would be supported in achieving a ratio of 1:30 for midwifery staffing.

## **7.0 Midwifery Current Workforce Roles**

- 7.1 Within MEHT, the current workforce incorporates;
- Midwives – working across all settings of the service.
  - Maternity Care Assistants – working mainly within the hospitals settings. Although a few have been established in community.
  - Administrative roles – working in ward areas as ward clerks and as secretarial support to managerial and midwifery specialist posts.
- 7.2 Overlaying this is a midwifery managerial structure and specialist midwives covering areas such as;
- Safeguarding
  - Infant feeding
  - Antenatal screening
  - Practice development
- 7.3 A vital role within the midwifery structure is that of the Supervisor of Midwives (SOM). The purpose of supervision of midwifery is to protect the public by actively promoting safe standards of care. The ratio recommended by the Nursing and Midwifery Council is usually no more than 15 midwives to 1 SOM. Within MEHT there has been an increase in the number of midwives being trained as SOMs and the current ratio is 1:20. Further plans are in place to train and appoint further SOMs and currently a further 2 are in training which will bring the ratio to 1:17 by the end of 2010.

## **8.0 Proposed Staffing Levels for Midwifery**

- 8.1 Whilst midwives are the most senior professional at the majority of all births and are the main providers of antenatal and postnatal care, it is difficult to prescribe appropriate staffing levels because patterns of care vary within the maternity service. Determining staffing levels in both the acute and community settings is dependent on service design, the types of buildings and facilities being used, the geographical and demographic circumstances locally as well as the models of care and individual midwives' capacity and capability.

- 8.2 The required staffing levels for maternity services are described in Safer Childbirth RCOG (2007). As described in section 5.0 in line with this document it has been agreed with the PCT that MEHT will aim for an overall ratio of 1:30 as described in the maternity matters action plan.
- 8.3 An allowance is also made for 21% of each WTE midwife's time to be spent on holiday, sickness and study leave. A further 1% should be allocated to statutory supervision.

## 9.0 Midwifery Requirements for Mid Essex Maternity Services

9.1 Based on the Birthrate Plus recommendations which is the staffing model recommended by the RCOG Safer Childbirth document (2007). As Mid Essex maternity services provide a rotational service across 3 sites the following staffing levels for each area were identified.

- St John's = 104.77 WTE
- William Julien Courtauld = 21.24 WTE
- St Peter's = 15.56 WTE

- 9.2 Based on the above the total number of midwives required by MEHT to be deployed across all care settings would be 141.57 WTE. However this excludes the 5% of management and specialist roles but includes statutory supervision.
- 9.3 As described on the completion of birth-rate plus in 2008, the department recognised that there was a need for significant levels of funding. It was therefore agreed that there would be a phasing of funding over a 3 year period.
- 9.4 Summary of current and proposed staffing levels for midwifery and support roles (excludes Administrative roles) is as follows:

Role description	Establishment 08/09 (WTE)	Current Establishment (WTE)	Proposed establishment WTE 09/10	Proposed Establishment 10/11
Midwives, incl Specialist roles	118.12	128.12	132.52 (+ 4 Jan-March 2010)	To be negotiated with the PCT
Consultants	6	8	8	8
MCA's	32.19	35.19	35.19	35.19

9.5 Currently the ratio of midwives to births is 1:36 with the Funding for 16. (2 specialist and 14 band 6 WTE midwives). By the end of 2009-2010 the ratio of 1:31 will be achieved based on a stable Birthrate. However if all posts are appointed to and all non-clinical posts removed from establishment, this will give a ratio of 1:34. The Strategic Health Authority (SHA) has been asked to identify what non-clinical posts should be removed from the ratio figures to give consistency across the region. This information is currently awaited.

## 10.0 Maternity Support Workers or Equivalent

10.1 Within MEHT there are currently 2 types of Maternity Care Assistants (MCAs). The banding for this group is at present band 2. However there are a number who have

completed the NVQ qualification who are now band 3 as they have achieved certain competencies.

## **11.0 Administrative Staff**

11.1 The maternity department reviewed and increased the administrative workforce in 2008 and implemented additional ward clerk posts to support DAU/Triage and labour ward. At the same time the Midwifery led units had additional hours to provide clerical support for 5 days per week which covers both ward and clinic duties. There is no plan presently to increase this group of staff.

## **12.0 Staffing of Obstetric Theatres**

12.1 Within MEHT there is already a funded arrangement in place for main theatres to provide theatre cover for planned and emergency care 24 hours per day, 7 days per week. This includes emergency cover, and the planned elective caesarean sections which take place Monday to Friday between 8.30 a.m. – 13.00 p.m. Theatres also provide the team for all operative deliveries, and other surgical procedures which are undertaken in obstetric theatres. This allows the midwife to remain with their women and provide care for the neonate.

## **13.0 Process for Conducting an Annual Audit for Midwifery and Support Staffing**

13.1 From April 2010 an annual audit of midwifery and support staffing levels in MEHT Maternity Services will be undertaken by the Head of Midwifery in conjunction with the divisional finance manager. This will confirm the existing levels against activity and form the basis for negotiations for future investment in line with the recommendations inherent within Safer Childbirth. The audit will be based on the data available from the computerised roster system and the financial data detailing the funded establishment.

## **14.0 Actions to be taken when there is Staff Sickness/High Workload**

14.1 The policy 09097 details the actions to be taken by staff in the event of there being staff shortages due to high workload or sickness.

## **15.0 Process for the Development of a Contingency Plan to Address Ongoing Staffing Shortfalls**

15.1 Where the staff in post does not reach the funded establishment, bank staff are utilised to fill vacant posts. MEHT has a rolling recruitment plan with regular national advertisements to allow continual recruitment to vacant posts.

15.2 In the event that safe midwifery staffing levels cannot be maintained through the actions detailed in 7.1 and 8.1 the manager on call will consider closure of the midwifery led units to allow centralisation of staff and services at the main maternity unit.

## **16.0 Obstetrics Current Consultant Workforce**

16.1 Within MEHT there is a funded team of 8 WTE consultants all of whom cover Obstetrics and Gynaecology.

- 16.2 MEHT provides 60 hours of labour ward cover in line with the RCOG Safer Childbirth minimum standards for labour ward.
- 16.3 In addition they also cover antenatal clinics and a specialist clinic in partnership with the diabetic team.
- 16.4 In SPA time for the following lead roles in Obstetrics are:-
- Clinical Director for Obstetrics and Gynaecology
  - Lead for Obstetrics
  - Clinical lead for Risk Assurance Framework
  - Fetal Medicine
  - Research/Audit
- 16.5 Consultants have combined posts in Obstetrics and Gynaecology. The medical commitment to obstetrics has been agreed and funded at 60 hours with the PCT. The RCOG report 'Safer Childbirth' recommends that there should be strong, programmed consultant presence on labour ward. There will be no further investment requested until or unless the birth rate reaches more than 5000 which is in line with these recommendations.
- 17.0 Actions to be taken when there is Staff Sickness/High Workload**
- 17.1 The policy 04227 Roles & Responsibilities of Medical and Midwifery Staff working within Maternity details the actions to be taken by staff in the event of there being staff shortages due to high workload or sickness.
- 18.0 Annual Review of Obstetric Workforce**
- 18.1 An annual review of obstetric staffing levels is undertaken as part of the Trust business planning and capacity planning process.
- 18.2 Where necessary an action plan will be developed to address shortfalls and a business Case will be developed to support the appointment of further consultant obstetricians to Achieve the recommendations within Safer Childbirth.
- 19.0 Anaesthetic Cover for Obstetrics**
- 19.1 A consultant anaesthetist has the necessary skills and experience to act independently on the labour ward providing a complete consultant anaesthetic service.
- 19.2 The duty anaesthetist is an anaesthetist who has been assessed as competent to undertake duties on the Delivery Suite under a specified degree of supervision.
- 19.3 Where a duty anaesthetist is covering the labour ward there is consultant support available for 24 hours per day.
- 19.4 The duty anaesthetist is resident on Labour Ward.

- 19.5 The consultant anaesthetists with sessions on labour ward have appropriate training in obstetric anaesthesia and provide an epidural service for labour and regional, or general anaesthesia for women undergoing surgical interventions.
- 19.6 There is a nominated consultant anaesthetist in charge of obstetric anaesthesia services. This consultant is responsible for the organisation and audit of the service, for maintaining and raising standards through provision of evidence-based guidelines, for providing anaesthetic input to the Delivery Suite. The consultant anaesthetist (or deputy) will attend the Labour Ward Forum and be responsible for Risk Management.
- 19.7 All anaesthetic support for anaesthetists is provided by Operating Department Practitioners (ODPs).
- 19.8 All ODPs have undergone appropriate training and are adequately skilled. Competencies are constantly updated.
- 19.9 There are 10 funded consultant anaesthetic PAs/sessions per week to cover labour ward.
- 19.10 However, not all of these are provided by consultant anaesthetists. Some are covered by associate specialists.  
At MEHT there is always a consultant anaesthetic presence on the labour ward during 8.30am-13.00pm. Between 13.00 and 17.00 there is always a consultant available on the consultant unit site for the labour ward.
- 19.11 At MEHT as the consultant unit is not on the DGH site specific guidance is in place to manage women who are of high anaesthetic risk and therefore would be cared for at the DGH.
- 19.12 An annual review of anaesthetic staffing and assistants levels is undertaken as part of the Trust business planning and capacity planning process.
- 19.13 Where necessary an action plan will be developed to address shortfalls and a business Case will be developed to support the appointment of further consultant anaesthetists to achieve OAA/AAGBI Guidelines for consultant anaesthetic sessions on labour ward. A similar process will be undertaken to ensure adequate ODP staffing levels.

## **20.0 Actions to be taken when there is Staff Sickness/High Workload**

- 20.1 The policy 09097 details the actions to be taken by staff in the event of there being staff shortages due to high workload or sickness.

## **21.0 Conclusion**

- 21.1 There has been significant investment in the staffing levels in maternity within the last 2 years. The provision of 60 hours consultant obstetric labour ward cover and the 24 hour staffing of maternity theatres by main theatre has improved maternity staffing.
- 21.2 MEHT has also benefited from the funding which has allowed continuous recruitment of both permanent and bank staff to increase posts by 25.5 by the end of the 2009/10

financial year. There is a deficit of 9.5 WTE to achieve the 35 WTE that were recommended by birth-rate plus. There is the commitment from the PCT to achieve this and also to reach the ratio of 1:30. However with an increasing birth rate MEHT birth-rate will need to be recalculated and renegotiated in the 2010/11 commissioning process.

## 22.0 References

1. Department of Health, *Maternity Matters*, 2007.
2. Royal College of Obstetricians and Gynaecologists, *Safer Childbirth*, October 2007.
3. Royal College of Obstetricians and Gynaecologists, *Maternity Dashboard, Clinical Performance and Governance Scorecard*, Good Practice Guide No 7, January 2008.
4. Jean A Ball and Marie Washbrook, *Birthrate Plus, A framework for workforce planning and Decision making for midwifery services*. Books for Midwives Press, 1996.