The Royal Wolverhampton
NHS Trust

Midwifery Report including Birthrate Plus
30 July 2018

Agenda Item No: 9.4

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	July 2018
Title:	Midwifery Report
Executive Summary:	**1. Midwifery staffing and birth ratio.** The report provides an overview of Midwifery staffing to birth ratio at RWT. The report includes the recent Birth rate Plus work force review which was completed in April 2018 (attached) The report also provides an update on the annual birth rates for 2017/18. **2. Better births – Improving outcomes of Maternity Services in England.** The Black Country Local Maternity System (BCLMS) are Working collaboratively to make maternity services safer and more personal for women. **3. Safer maternity Care. The National Maternity safety Strategy – Progress and next steps.** A progress report has been published in November 2017 by the DoH and sets out additional measures to drive improvement further in terms of improving the rigour and quality of investigations into Term still births, neonatal and maternal deaths and serious brain injury. **4. Professional Midwifery Advocate role (PMA)** The report provides an update with progress on this new role
Action Requested:	To receive and note the report
Report of:	Tracy Palmer, Head of Midwifery and Gynaecology
For the attention of the Board. • **Alert** • **Assure** • **Advise**	To advise the Board with a progress update on the key programmes of work for Maternity services in line with the national ambition and safety strategy plans outlined within the National Maternity review: Better Births – Improving outcomes of Maternity services in England (2016). • Midwifery staffing and birth ratio. • Better births recommendations – Improving outcomes of Maternity Services in England

	• Safer Maternity care – The national Safety strategy – progress and next steps. • Professional Midwifery advocate role
Author: **Contact Details:**	Tracy Palmer Head of Midwifery Women's and neonatal services. Tel: 01902 695162 Email: tracypalmer@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality. 2. Proactively seek opportunities to develop our services
Resource Implications:	Workforce.
Public or Private: **(with reasons if private)**	Public
Appendices/ **References/** **Background Reading**	The Royal Wolverhampton NHS Trust Birth rate + Report (2018) National Maternity review (2016) Better Births - *Improving outcomes of Maternity services in England. NHS England* Safer Maternity Care (2017) The National Maternity Safety Strategy – Progress and next steps. Department of Health. Each Baby Counts (2015) RCOG A guide to support Maternity safety champions. NHSI (2018) NHS early resolution and Redress (2017) NHS Resolution .*http://ww.kingsfund.org.uk/projects/midwifery-regulation-unitedkingdom*
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: Equality of treatment and access to services High standards of excellence and professionalism Service user preferences Cross community working Best Value Accountability through local influence and scrutiny

Background Details:

1. Midwifery staffing and birth ratio

1.1 Birth to Midwife ratio improved and is 1:29. Minimal Midwifery vacancy 3.93 wte 2.78wte Support workers. (June 18) All vacancies have been appointed into and the directorate is waiting for commencement dates.

A Formal Birth Rate + assessment has been completed and the final report is attached (appendix 1). This assessment has provided The Royal Wolverhampton (RWT) a review based on acuity and 'models' of care, such as a Birth Centre/Midwife Led Service, together with a detailed breakdown of staff per area and model of care.

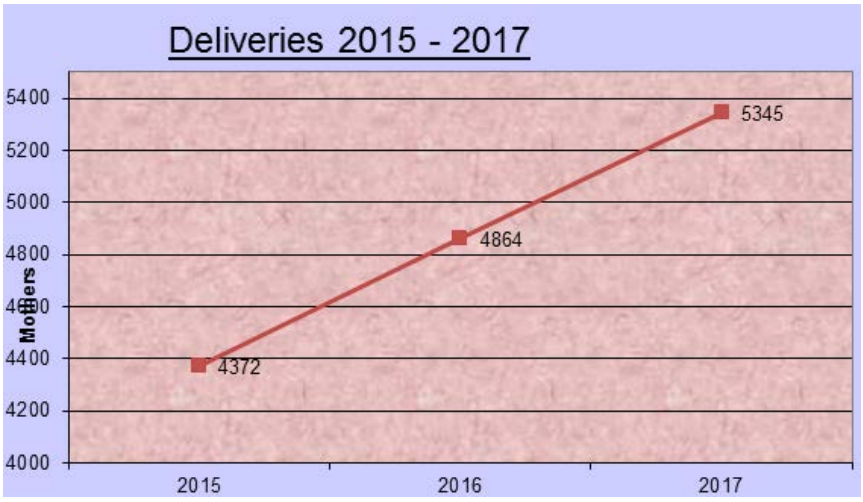
Data collection for 3 months has provided a reliable and valid case mix along with other intrapartum and ward activity.

1.2 Summary of findings based on birth rates of 5345

RWT **Variance across staff groups**	**Registered Midwives**	**MSW'S**	**Total WTE**	**Variance**
Current clinical WTE	171.00	16.90	187.90	
BR+ WTE			196.71	
Birth rate + skill mix 90/10	177.04	19.67		
Variance by skill	-6.04	-2.77		
Current non-clinical	11.10			
BR+ non-clinical (9% of total clinical WTE)	17.70			-6.60
Overall variance (band 3 -8)				-15.41

1.3 Current Midwifery clinical staffing establishments are set correctly based on 5000 births, however MSW workforce is being reviewed to support clinical Midwifery teams for the post natal element of care which will impact positively on Birth ratio's for RWT. The non- clinical Midwifery structure deficit is being discussed with the CNO to determine appropriate structures / specialist services are In place to meet the requirements of the Maternity service.

1.4 Annual birth rate



1.5 In October 2017 the CEO formally wrote to CCG's providers and NHSE to inform that RWT would not be able to facilitate additional bookings / births over the commissioned 5000 in order to maintain safety, quality and Midwifery birth ratio standards. This took effect from November 2017.

1.6 Booking and birth rate data is being monitored closely within the Directorate with a formal review of projected birth rates which took place in early spring. Booking data is being monitored and the maternity service can demonstrate that the restrictions on bookings are now starting to impact on booking rates

1.7 The service model between Wolverhampton and Walsall Healthcare Trust was agreed in March 2016. RWT continues to support this service model

2. Better births – Improving outcomes of Maternity Services in England Key recommendations.

2.1 RWT is working collaboratively with Maternity Units and Commissioners within the Black County called Local Maternity Systems (LMS's) to develop and implement a local vision for improved services and outcomes based on the principals outlined in Better Births. .

2.2 The purpose of the BCLMS is to provide place-based planning and leadership to enable local maternal and neonatal services to become safer, more personalised, kinder, more professional and family friendly.

2.3 The BCLMS has been reviewed recently to ensure correct representation at The strategic oversight board and LMS implementation committee and to strengthen governance structure and function.

2.4 The BCLMS Transformation Plan has been written and endorsed by NHSE.

2.5 Key priorities within the transformation plan have been identified as :

To tackle perinatal and infant mortality – in line with the DoH ambition to halve stillbirth rates, neonatal and maternal deaths and brain injuries by 2030. This work aligns itself with the work with the Maternal and Neonatal Health safety collaborative of which RWT are involved in the first wave 2017/18.

- Implementing Better Births: Continuity of carer (DoH 2017) - agree within the LMS on the service model most appropriate for BC providers. Ensure consistent pathways, pathways and data sets to ensure continuity of maternity services across the Black Country.
- HoM has undertaken a review of Community Midwifery services to inform future service model for RWT re: Continuity of Carer. Vulnerable women's specialist Midwifery teams have been reviewed to increase support for Midwives in areas with increased depravation with complex safeguarding concerns. The Named Midwife for Safeguarding which is a statutory role has been advertised for RWT.
- Shared learning for serious untoward incidents (SUI) within the LMS.
- To continue to strengthen community inclusion by engaging with women and families as part of the Maternity Voices partnership (MVP) across the LMS.
- Determine workforce needs and workforce baselines to support understanding of future work force requirements.

3. Safer Maternity Care – The national Maternity safety Strategy – progress and Next steps.

3.1 In 2015 The Department of Health (DoH) set a challenging ambition to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030.

3.2 A progress report *Safer Maternity Care* (2017) has been published in November 2017 by the DoH and sets out additional measures to drive improvement further. The National ambition timescales has been re-set to halve rates (as above) by 2025 as opposed to 2030.

3.3 As part of this ambition The Department of Health announced the launch of the National Maternal and Neonatal Health Safety Collaborative in October 2016 lead by NHSE.

3.4 RWT joined the collaborative in March 2017 as one of 45 Trusts involved in the first wave 2017/18. The focus centres on quality improvement and provides structured support for teams to develop plans for measurable improvements. RWT have completed their first wave and are supporting

The Dudley Group Hospital Maternity service in the second wave of the improvement project as part of the LMS plan.

3.5 Saving Babies lives Care Bundle (NHSE 2016) is designed to tackle perinatal mortality with focus on surveillance. RWT are working towards improvement activities across all 4 elements of the care bundle.

1. Reduce Smoking

2. Risk assessment and surveillance for fetal growth restriction

3. Raising awareness of fetal movements

4. effective fetal monitoring during labour

3.6 Perinatal and Mental Health bid for funding bid has been approved to provide specialist perinatal mental health service across the Black Country. RWT involved in pilot perinatal mental health advisory clinics in January 2018.

3.7 Rapid Resolution and Redress. NHS Resolution (2017). Each Baby Counts RCOG (2015). RWT reporting in line with both programmes.

3.8 Maternity units are awaiting direction from the DoH regarding their plans in terms of the proposed new way in which Term Stillbirths will be investigated. The DoH have announced in their report *Safer Maternity Care* (2017) that together with NHSE, NHSI and the new Healthcare safety Investigation Branch (NSIB) that they intend to publish by Q2 2018 information and guidance on the standards for maternity investigations to deliver Morecambe Bay and Better Birth recommendations.

3.9 Maternity safety champions are in place for RWT in line with national guidance, with representation from the Lead obstetrician, Senior Midwives (2) and Board level representation from the CNO.

4.0 Professional midwifery Advocate (PMA) role update.

4.1 The NMC as a health care professional regulator now has direct responsibility and accountability solely for the core functions of midwifery regulation.

4.2 The conclusions of the PHSO (2013) referred to the merits of midwifery supervision in the support it provided for midwives and therefore there was no requirement to remove the non-regulatory aspects of midwifery supervision.

4.3 Review of the non-regulatory aspects of midwifery supervision has been undertaken within evidence based context to develop a new model of supervision within the midwifery profession.

4.4 The A- EQUIP Model

- Three distinct functions; restorative, personal action for quality improvement and education and development.
- The model aims to support the Midwife through a process of clinical supervision.
- Enhances quality of care and supports preparedness for appraisal and revalidation.

4.5 The Professional Midwifery Advocate (PMA). This is a new role that replaces the supervisor of midwives. To undertake the role the midwife must successfully complete a PMA preparation programme provided by Health Education Institutes (HEI). RWT has 2 fully trained PMA's newly appointed into a seconded post.

4.6 The PMA will also be responsible for overseeing the non-regulatory duties of Midwifery supervision for example complex birth planning, advocacy for women and the birth reflections service.

4.7 The HoM has appointed 2 PMA's into post from April 2018 on a 10 month secondment. The role has proven to be beneficial thus far in terms of the above functions. This is an evolving role and will be reviewed in Autumn to evaluate the impact on service users, Midwives and the long term plan for the role in the future.

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

The Royal Wolverhampton NHS Trust

BIRTHRATE PLUS REPORT – April 2018

Birthrate Plus ®: THE SYSTEM

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.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Birth outcomes are not influenced by staff numbers alone. Nevertheless, a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition, BR+ caters for the various models of providing care, such as traditional, community based teams and caseload working. It is sensitive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Any maternity unit and service must be able to assess its staffing needs using a tried and tested system of workforce planning. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and utilises clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

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.

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 method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence-based guidelines, on-going monitoring and audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; and other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Wards provide care to 'normal' uncomplicated postnatal women needing basic midwifery care, which is often over-shadowed by other women who are more complex cases. This results in insufficient time being spent with such women who may require considerable assistance with breast feeding and general care of their baby.

The encouragement of early transfer home does mean that the level of midwifery input during their hospital stay is considerable, in order to ensure that the mothers are prepared for coping at home. It is a known fact that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives, midwifery support roles and GPs. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have significant impact on community resources in two ways. Some women receive ante and postnatal care from their "home" maternity service but give birth in another. Because these count as extra to the workload related to that recorded in relation to the annual births of a unit they have been termed as "imported" cross border" cases. Adjustments to midwifery establishments have been made to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. Wolverhampton is similar to most maternity services and books approximately 10% of women who then have no further contact with the midwife.

SUMMARY: RESULTS/FINDINGS

New Cross Hospital & Local Community Wolverhampton

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 20% for annual, sick & study leave allowance and 15% for travel in community. Non-clinical midwifery roles are included. *A detailed summary is included on page 7*

The overall clinical establishment for total of births at The Royal Wolverhampton NHS Trust is summarised as follows:

(a) Consultant Led Unit (DS & Maternity Ward)	109. 35wte
(b) Midwifery Led Birth Centre	18.63wte
(c) Outpatients /Community	68.73wte
(d) Total Clinical WTE Hospital & Community	196.71 wte
(e) Plus Additional Non-clinical roles @ 9%	17.70 wte

Discussion of Findings

1. The main factor in the results is the casemix using the BR+ scoring system based on 3 months' data from October to December 2017 collected from the Maternity Information System; data was then validated by the BR+ Team to ensure the data quality was 100%.

2. Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % m/w increase is applied to Categories III (20%); IV (30% & V (40%). Community antenatal care is based on NICE guidance, as is postnatal care with allocation of average midwife hours for the women to cover their standards a/n & p/n assessments, Parent Education, socio-economic issues and all clinical needs.

3. The annual births are based on 5345 as below:
    - 4339 in New Cross Hospital
    - 989 in Midwifery Led Birth Centre
    - 17 at Home or BBAs in community

4. The casemix is unique to each individual unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making (*see appendix 1 for Birthrate scoresheet)*.

NEW CROSS HOSPITAL	**CAT I**	**CAT II**	**CAT III**	**CAT IV**	**CAT V**
Delivery Suite Casemix	2.9%	10.7%	25.5%	32.4%	28.5%
Generic Casemix D/S & MLU	6.8%	22.3%	21.0%	26.5%	23.4%

The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Unit and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

5. The Delivery Unit casemix will predominantly be those women in categories III to V thus impacting on the workload for this service and also for postnatal care in the ward. The Birth Centre models of care are based on a casemix of category I and II and any higher category activity is included as transfers and included in DS casemix. 86% of DS births are in Categories III, IV & V which does impact on the staffing requirements.

6. The Generic Casemix indicates that 29.1% of births are in the lower categories I & II with 70.9% in the moderate to high categories, of which almost 50% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of Membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 48 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 55% ranging from 41 to 69%. The Royal Wolverhampton Trust is in line with the national average at 50% in categories 1V & V.

7. Category III women have moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries as well as normal births with continuous fetal monitoring fall into this group.

8. The women in Category IV are those having an elective CS or epidural for pain relief with a normal birth. Women with low birth weight/preterm babies; high-risk inductions of labour and PPH fall into this group.

9. Category V includes emergency CS, and women with obstetric/medical problems, such as increased diabetes, obesity related problems, mental health and high incidence of complex safeguarding issues

10. The assessment of midwives for the Birth Centre activity is based on a 'package of care' that includes intra-partum care with 2 midwives at for the birth, postnatal care until transfer home and examination of the new-born. There are a number of women (310), who commence labour in the Birth Centre but are transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the Birth Centre staffing whilst the actual birth and post-delivery care is within the D/S establishment. In addition, there are 1180 women who attend the Birth centre with a labour query but not admitted.180 women required transfer to the postnatal ward and were not discharged home from the BC. The reasons will be both maternal and baby related.

11. The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital so used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters.

12. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. Category A2 women (n=220) are high risk-antenatal cases that would usually be 'admitted' to a ward for on-going care following a stay on delivery suite having one to one midwifery care.

13. Inductions of labour take place on the labour ward and are then transferred to the postnatal ward – an annual total of 2500, which will be fewer women as some may receive more than one dose of prostin/propess.

14. All maternity units have significant antenatal activity that is both planned and unplanned cases and often the latter equates to the actual number of women delivering in the service. The maternity unit

deal with this activity in a variety of ways, such as via DAU, the antenatal ward and through a dedicated Triage/Assessment area. Some additional non-birth activity is caring for women who have a fetal loss prior to 24 weeks gestation. The staffing for this activity is based on having a 24/7 Triage that sees women with labour queries and many more presenting reasons as well as planned antenatal cases, so acts like a day unit. 5111 women were seen in the Triage unit.

15. The Inpatient antenatal annual episodes of 570 excludes elective cases, namely Inductions and Elective Caesarean Sections. It is not feasible to produce comparative data for antenatal admissions in similar sized units as practices depend on bed capacity, geography, clinical decision-making, clinical risk factors and availability of outpatient services. There are some ward attenders (250) and possibly due to overflow from Triage.

16. The postnatal ward provides care to women who birth in the Delivery Suite. Midwives carry out the majority of NIPE checks on the postnatal ward (3217).

17. As with all maternity units, there are babies requiring additional observation and monitoring in postnatal wards. Of the total babies, 236 babies had a longer than average stay so became the 'inpatient'. There were 320 PN re-admissions which creates additional workload, and this is factored into the staffing requirements.

18. Outpatient Clinic services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service and will heavily depend on the obstetric specialities provided, complexity of women, etc.

19. The community cases are based on those women birthing in New Cross Hospital and having all ante & postnatal community care locally plus any women, who may birth in neighbouring units, but belong to the local CCG area. The total number of community cases is 5135 including home births, less than birth at New Cross Hospital, as 1000 women are transferred to neighbouring Trusts for their community care, there are 790 additional women who receive postnatal care having birthed in neighbouring hospitals.

20. As with most maternity services, a % of women (300 p.a.) will see a midwife in early pregnancy as per NICE Antenatal Guidelines and the 'Early Contact' recommendation, but do not progress further with their pregnancy. A total of 2 hours of midwifery time is allocated to these women as an average.

21. A skill mix adjustment of 90/10% can be applied to the clinical total of 196.71wte and local community where an average of 10% of the total clinical wte can be competent and qualified support staff usually being Bands 3 & 4 [See Appendix 2]. This equates to 19.67wte support staff split between postnatal care in hospital and community. Thus, of the total clinical 196.71wte, 177.04 wte are RMs.

22. The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs.

23. The total clinical establishment does not include the following roles:
    - Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
    - Practice Development role
    - Clinical Governance role
    - Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
    - Additional hours for antenatal screening over & above the time provided in actual clinics

- Coordination for such work as Safeguarding Children
- PMAs (A-Equip)

24. The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 17.70 wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

25. The Royal Wolverhampton Trust currently uses Midwife Support Workers to deliver their Newborn Hearing Screening Programme and have adopted the guidelines issued by the Public Health Department. The hearing screening clinics run seven days a week. It must be noted that this service requires 2.26wte in addition to the Band 3 MSWs currently working in the community.

Comparison chart to show variance against staff groups

	Registered Midwives	MSWs	Total wte	Variance
Current Clinical wte	171.00 wte	16.90 wte	187.90 wte	
Birthrate Plus wte			196.71 wte	- 8.81 wte
Birthrate Plus skill mix 90/10	177.04 wte	19.67 wte		
Variance by skill mix	-6.04 wte	- 2.77 wte		
Current Non-clinical	11.10 wte			
Birthrate Plus Non-clinical (9% of total clinical wte)	17.70 wte			- 6.60 wte
Overall Variance (Bands 3 – 8)	**-15.41wte**			

The Royal Wolverhampton NHS Trust

First draft 28/03/18

Data collected October - December 17

20% uplift

Total births in service **5345**

CASEMIX

	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	2.9	10.7	25.5	32.4	28.5
%Generic Casemix	6.8	22.3	21.0	26.5	23.4

				Required WTE	
Consultant Led Unit			**No.**		
Delivery Suite Births			4339	49.94	**49.94**
Other DS Activity			**No. Episodes of care**		
	Category X		*via Triage*		**7.77**
	Category A1		*via Triage*		
	Category A2		*220*	2.34	
	Prostins		*2500*	4.42	
	Escorted Transfers OUT		*12*	0.06	
	Non-viables		*79*	0.95	
Triage			*5111*	5.38	**5.38**
Birth Centre			**No.**		
Births only			*989*	11.98	**18.63**
Transfers to DS			*310*	3.13	
Ward Attenders/Cat X			*1180*	1.06	
PN Care of women			*809*	2.46	
			No.		
Antenatal Care	Antenatal admissions		*570*	3.63	**3.79**
	Antenatal Ward Attenders		*250*	0.16	
			No.		
Postnatal Care	Postnatal women		*4519*	38.07	**42.47**
	Postnatal Re-admissions		*320*	1.64	
	NIPE		*3217*	1.55	
	Extra Care Babies		236	1.21	
OUTPATIENT SERVICES					
Antenatal Clinics	FAU/USS			6.11	**14.07**
	Specialists Clinics			2.52	
	Midwife Led Clinics			0.81	
	Obstetric Clinics			4.64	
			No.		
COMMUNITY SERVICES	Home Births		*17*	0.48	**54.66**
	Community Cases		*5118*	51.31	
	Community Bookings ONLY		*300*	0.38	
	Additional Safeguarding			1.57	
	NIPE		*1893*	0.91	
CLINICAL MIDWIFERY WTE REQUIRED					**196.71**
	Additional non-clinical midwifery wte @ 9%			17.70	

Comparison of Birthrate Plus® staffing totals with Current Funded Establishment based on above dataset

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles and skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can be applied.

The table below outlines the comparison of Birthrate Plus® results with current funded establishments based on above data and results;

Comparison of Maternity Staffing

BR+ Total	214.41 wte	The total wte for hospital & community calculated using Birthrate Plus methodology. Includes PMA and Specialist Midwives and Senior Management
Current Funded establishment	199.00 wte	Includes Bands 3 - 8
BR+ Total Skill Mix Adjustment at 90% & Non-Clinical wte	194.74 wte	The Midwifery wte for hospital & community calculated using Birthrate Plus methodology. Includes PMA and Specialist Midwives and Senior Management
Current funded clinical wte (bands 5 – 8)	182.10 wte	The current funded midwifery wte includes Sp. MW & Managerial clinical contribution, but excludes non-clinical midwifery roles
Difference between BR+ wte & current funded midwifery wte	-12.64 wte	The variance between BR+ wte & funded wte based on midwifery staffing
BR+ % Skill Mix Adjustment @ 10%	19.67wte	Total as support staff who contribute to the clinical total in postnatal care and who can replace midwife hours
Current Funded Support roles	16.90wte	The Current funded support wte for the postnatal aspect of care
Difference between BR+ Support roles to include in comparative total	-2.77wte	Variance between BR+ Clinical wte & Current Funded wte based on support roles for the PN aspect of care
Overall Difference between BR+ wte and establishment	**-15.41wte**	**The actual difference between BR+ wte & current funded wte combining midwives & appropriately trained support staff**

Using ratios of births/cases to midwife wte for projecting staffing establishments

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will take into account an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (usually 9%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 106 cases to 1 wte is the correct ratio to apply. To use the 1:24 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Example; A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 35 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results
The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Ratios:

- Home births — 35 births to 1 wte midwife
- Delivery Suite births (all hospital care) — 35 births to 1 wte midwife
- Birth Centre births — 53 births to 1 wte midwife
- Ante & Postnatal Community care only — 100 cases to 1 wte midwife
- Overall ratio for **all** births — 27 births to 1 wte midwife

Note: The overall ratio for Royal Wolverhampton NHS Trust of 27 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte, but they are not directly comparable for the above local factors. The latter ratios are based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

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.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.

Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

MATERNITY SUPPORT WORKERS/CARE ASSISTANTS Appendix 2

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centred.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must be that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of wte staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total wte can be competent and qualified support staff usually being Bands 3 & 4.

The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. Some services are moving towards an 85/15% split with more MSWs working in community and increasing support staff on the p/n ward to work with transitional care babies.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies but are in addition to the calculated clinical establishments.

To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

References:

Safe Midwifery Staffing for Maternity Settings NICE 2015 NG4 *www.nice.org.uk/guidance/ng4*

Ante Natal Care for Uncomplicated Pregnancies NICE 2017 CG62 https://www.nice.org.uk/Guidance/CG62

Better Births a five year forward view for Maternity care https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Royal College of Midwives 2016 *Guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings*

Royal College of Midwives 2016 '*Getting the Midwifery Workforce Right'* https://www.rcm.org.uk/sites/default/files/Getting%20the%20Midwifery%20Workforce%20Right%20A5%2024pp_2_1.pdf

Royal College of Midwives 2015 State of Maternity Services https://www.rcm.org.uk/briefings-and-reports

How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013)

Kings Fund 2011 Staffing in Maternity Units: getting the right people in the right place at the right time (King's Fund 2011)

RCOG 2007 Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour (RCOG 2007)