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University Hospitals Group

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Related Trust Policies (to be read in conjunction with)	04227 Roles and responsibilities of medical and midwifery staff working within the Maternity Services 09062 Mandatory training policy for Maternity Services 05098 Women's and Children's Division clinical governance structure policy 10084 Maternity Services escalation policy

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Appendix 1: Preliminary Equality Analysis

1.0 Purpose

1.1 The purpose of this strategy is to describe the current and future staffing models within Mid Essex Hospital Services NHS Trust (MEHT) Maternity Services to ensure safe staffing levels, and to detail what actions are taken to ensure that agreed staffing requirements are in place.

1.2 The guideline entitled 'Roles and responsibilities of medical and midwifery staff working within the Maternity Services' (register number 04227) details the actions to be taken for escalation of concerns regarding staffing levels, acuity/dependency and capacity issues within the service. This outlines the roles each member of the team has in supporting decision-making and ensuring the effective operational management of the Maternity Service.

1.3 The 'Maternity Services escalation policy' (register number 10084) details the actions to be taken by senior staff and Directorate Management to implement contingency at operational level to ensure the safety of women and babies requiring care at MEHT Maternity Service. This policy covers immediate and longer term contingency for high work load/activity, staff shortages and emergency situations. The areas of staffing covered are midwifery and support staff, obstetrics and anaesthetics.

1.4 This strategy will detail how staff are utilised within the maternity service and identify how shortfalls in staffing requirements are addressed at organisational and strategic level to meet the recommendations from workforce planning and the formal recommendations of the Birthrate Plus Workforce Assessment completed in November 2015.

2.0 Equality Impact Assessment

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.
(Refer to Appendix 1)

3.0 Background

3.1 The Department of Health (DH) and Royal College of Midwives (RCM) endorse the 'Birth Rate Plus' Midwifery Workforce Planning Methodology. This is based upon the principle of providing one-to-one care during labour and birth to all women, with additional midwife hours for women in the higher clinical need categories. The assessment specifies the number of whole time equivalents (wte) of Band 5-8 midwives and Band 2-3 support workers required for each Maternity Service.

3.2 Currently the RCM recommends a ratio of 1.0 wte midwife to 28 births in hospital, 1.0 wte midwife to 35 home births/midwife-led birthing units and caseload midwifery practice, plus an additional 8% specialist staff. NHS East, for ease of standardisation have recommended that all units work towards a ratio of 1:30.

3.3 This is not just about absolute numbers of staff but also about **effective deployment** of existing staff, to this end, there is potential for task shifting and role redesign and for some interventions to be performed by support workers which frees up midwifery time to provide critical antenatal and labour care. This is recognised in the 90/10 split agreed locally.

3.4 BR+ suggests that Antenatal Care and Intrapartum Care should only be provided by a midwife. For Postnatal Care in Hospital it is suggested that 20% of midwifery time might be replaced by Maternity Care Assistants (MCA) input. For Postnatal Care in the Community up to 25% of midwife time can be replaced by a MSW. Overall, the percentage of midwives to trained support staff is recommended to be 90/10, this split can be applied to the total clinical establishment as a means to estimate the contribution from non-midwives. The National Quality Board (NQB) guidance for Trusts; 'Safe sustainable and Productive staffing' (July 2016) was produced to reflect the changes within the NHS Five Year Forward View and the Lord Carter Review 'Operational productivity and performance in English NHS acute hospitals; Unwarranted variations' (February 2016).

3.5 Following receipt of the final BR+ Paper in November 2015 the Trust agreed to finance the uplift of midwifery posts to that recommended by Birthrate Plus, this was phased between month 2 and month 5 of the fiscal year 2015/16.

3.6 The current funded midwifery establishment of 148.94 wte, with an additional 16.21 wte specialist midwives which includes Head of Midwifery and Lead Midwives with the provision of 20% of the current Band 3 in post will provide a ratio of 1:29

3.7 The introduction of appropriately trained Maternity Care Assistants at Band 3 is recognised as the way forward to support midwifery practice and the required growth in midwifery numbers.

4.0 Introduction

4.1 In the past few years there have been a number of publications which make recommendations for safer staffing levels and skill mix within Maternity Services, these include:

- Maternity Matters: choice, access and continuity of care in a safe service: (2007 DH);
- Safer Childbirth: minimum standards for the organisation and delivery of care in labour: (2007) RCOG, RCM, RCOA, RCPCH;
- Staffing Standards in Maternity Services: (2009) RCM;
- Standards for Maternity Care: report of a working party (2008) RCOG, RCOA, RCM, RCPCH;
- Kings Fund: Staffing in Maternity Services getting the right people in the right place at the right time (2011);
- Kings Fund: Improving safety in maternity units; a toolkit for teams, (March 2012);
- Kings Fund: Safe births everybody's business (2008);
- National Maternity Review – Improving Outcomes of Maternity Services in England;
- Saving Babies Lives – A Care bundle for reducing stillbirth;
- NICE Guidance – Safer Staffing (2015);
- Safe sustainable and Productive staffing' (July 2016);
- Operational productivity and performance in English NHS acute hospitals; Unwarranted variations' (February 2016).

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4.2 Since 2007 when Safer Childbirth was released 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, reduction in available midwives, rising age of midwives and the associated percentage due to retire within the next 5 years couple with the difficulties to recruit and retain staff.

4.3 Birthrate Plus (BR+) has been used to assess the Midwifery and support staffing required within the service and the recommendations have been formalised in the MEHT BR+ Business Case and Workforce Action Plan, (Appendices A and C) these are monitored internally via the Executive Director Meetings and quarterly via the joint Clinical Quality Review Group (CQRG) held with the CCG and MEHT.

4.4 Workforce planning, recruitment, achievements against BR+ recommendations are monitored and discussed at Manager's Meetings, Temporary Staffing Working Party Group, Directorate Governance Meetings and with staff via newsletters and memos.

5.0 Context of Local Maternity Service

5.1 Maternity Services within Mid Essex NHS Trust span both the acute and primary health care settings. The majority of women are healthy, with low rates of social depravation however there is an increase in the age of the maternity population and increasing levels of obesity with associated complications. Women who have low risk pregnancies receive their antenatal and postnatal care provision from the community based midwifery and the lead professional is the midwife.

5.2 The locations of antenatal and postnatal clinics vary between primary care settings, Children's Centres and the standalone Midwifery-led Maternity Units. Much of the postnatal care is provided in the woman's home by midwives working within a geographically defined team.

5.3 However, there are a number of women who also need to be referred to an obstetrician at some point during their pregnancy for ongoing monitoring. For these women with 'high risk' pregnancies the care then becomes shared between the obstetrician and the midwife, with the former being the lead professional.

5.4 MEHT provides services across three sites: Broomfield in Chelmsford, St Peters in Maldon and William Julien Courtauld (WJC) in Braintree.

5.4.1 **Consultant-led Maternity Unit at Broomfield Hospital**

- Provides high and low risk care and is situated within the main District General Hospital in Chelmsford;
- There is a 4 bedded co-located midwifery-led unit;
- Antenatal Clinic for high risk pregnancies and out of area women, with specialist fetal medicine and diabetes clinical leads;
- 24 hour Antenatal Inpatients, Day Assessment Unit and Triage;
- 20 bedded postnatal ward for high risk women and babies requiring transitional care;
- High Risk Labour ward with10 beds and a dedicated SANDs room;
- 2 Obstetric Theatres and a 4 bedded recovery bay;
- The co-located Birthing Unit delivers approximately 70 babies per month;
- The high risk Labour Ward including obstetric theatres delivers approximately 275 women a month.

5.4.2 Out of area women receive antenatal care at the Broomfield site, which provides some continuity in the antenatal period, once discharged postnatally they will return to the care of the community midwives in their local area.

5.4.3 With the recent publication of the National Maternity Review (Cumberlege Report 2015) the service provision will be reviewed over the next six months.

5.5 In addition to the consultant-led unit there are two Midwife-led Units.

5.5.1 St Peters in Maldon is 15 miles from the Maternity Unit at Broomfield and delivers approximately 17 women per month.

5.5.2 William Julien Courtauld (WJC) based at St Michael's Hospital in Braintree is 8 miles from the Maternity Unit at Broomfield and delivers approximately 17 women per month.

- Both units provide antenatal, intrapartum and postnatal services on site for low risk women, also offering a triage and Day Assessment Unit;
- Antenatal and postnatal Community Midwifery care is also provided from teams situated within the units at GP surgeries, health clinics, and in women's homes;
- Satellite high risk clinics are provided within these standalone units.

5.6 Approximately 1.3% of women residing in Mid Essex choose to have a home birth with care provided by midwives working within MEHT.

5.7 Community antenatal, postnatal and intrapartum midwifery care is provided throughout Mid Essex by community midwives based at St Peters in Maldon, William Julien Courtauld in Braintree and Broomfield in Chelmsford. The teams provide geographically –based case loading for women residing within the boundaries of these 3 areas. Midwives work closely with GP surgeries within geographical boundaries.

5.8 On returning home a low risk woman with a healthy baby 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 woman and baby.

5.9 Care is provided at all sites by midwives, support workers, administration assistants and obstetricians. Paediatricians are based solely at the Broomfield site. All staff groups will receive yearly mandatory training as outlined in the 'Mandatory training policy for Maternity Services (incorporating training needs analysis); register number 09062.

6.0 MEHT Birthrate Plus Evidence Based Ratios

6.1 In March 2019 The MSE commissioned a birth rate plus table top review and identified that the service needed an additional 3.59 wte band 6 midwives and 6.21 band 7 midwives. This was taken to the Trust Board as a business case and approved.

6.2 Staffing Allowances included in the ratios were calculated using 21% holidays/sick, study leave and maternity leave and 1% for Professional Midwifery Advocates and Community based staff 17.5% Travel Time Allowance added.

7.0 Description of Midwifery, Nursing and Support Staff Utilised within the Maternity Service

7.1 Current Workforce Roles.

7.2 Within MEHT, the current workforce incorporates:

- Midwives (Band 5-8) – working across all settings of the service and in specialist roles;
- Maternity Care Assistants (Band 3) – working within hospital and community settings;
- Healthcare Assistants (Band 2) – working in hospital settings;
- Administrative roles (Band 2-4) – working as ward clerks, administration support to specialist and managerial posts, administration support in antenatal clinic and postnatal areas.

7.3 There is a senior midwifery managerial structure at Band 8 level and Band 7 Specialist Midwives and Team Leaders covering the following areas:

7.3.1 **Specialist Roles:**

- Safeguarding,
- Vulnerable,
- Perinatal Mental Health,
- Antenatal and Newborn Screening including Failsafe Officer (Band 3);
- Practice Development Midwife;
- Risk Management;
- Audit/Guidelines/Quality;
- Bereavement Midwife;
- Diabetic Midwife;
- Perineal Trauma Midwife;
- Birth Reflections;
- BAC midwife.

7.3.2 **Team Leaders:**

- Antenatal Inpatients, DAU, Triage;
- Labour Ward;
- Postnatal Ward;
- Antenatal Clinic;
- Co-located Birthing Unit;
- St Peters, Maldon;
- WJC, Braintree;
- Antenatal Clinic.

7.3.3 **Midwifery Managers:**

- Head of Midwifery & Gynaecology
- Lead Midwife: Labour Ward and Birthing Unit, Inpatient Services
- Lead Midwife: Community, Standalones, and Birthing Unit,

7.4 Midwifery Roles

7.4.1 It is recognised that, regardless of place of birth, midwives will provide care for women and their babies. At Mid Essex Hospital Services NHS Trust midwives work throughout all areas of the maternity service and rotate to all sites as part of their contract of employment.

7.5 Broomfield Hospital Maternity Services

7.5.1 Within the hospital, midwives work 24 hours a day, seven days a week on:

- The Labour Ward and co-located Birthing Unit;
- The Postnatal Ward;
- Antenatal inpatients, DAU and Triage.

7.5.2 During the working week midwives work in the antenatal clinic between the hours of 08.30 and 17.30 hours.

7.5.3 In addition there is an Obstetric Theatre adjacent to the Labour Ward at the Broomfield site and a co-located recovery area which runs an elective list 5 days a week with a 24 hour emergency on call service. Midwives will support women and babies in this environment as required and work alongside a dedicated theatre team.

7.5.4 Additional services are provided by the midwifery team which include:

- Dedicated NIPE clinic (7 days per week);
- Perineal Trauma Clinic;
- Birth Reflections;
- BAC's;
- Antenatal Education/Hypnobirthing/Breastfeeding support and education.

7.6 St Peters and WJC Midwifery-led Units

7.6.1 In both units midwives work 24 hours a day, seven days a week providing care in the following areas:

- Triage, labour and birth;
- Postnatal Ward;
- Day Assessment Unit.

7.6.2 During the working week midwives work in antenatal clinic between the hours of 08:30 – 17:30 and provide postnatal clinics over the 7 day week 08:30-17:30 and also provide antenatal care in GP surgeries, health centres and children's centres. Midwives working in these units also provide community visiting at home 7 days a week 08:30-16:30 for women in the postnatal period who live in the districts of Maldon and Braintree.

7.6.3 In addition midwives working in these standalone units provide an on call service 24 hours a day to support home births within each locality of Braintree and Maldon and to support the midwifery staff on site at each unit, requiring a second midwife for support for labouring women at the unit.

7.7 Chelmsford Community Services

7.7.1 Chelmsford community midwives have their base at the Broomfield site and the Midwives provide antenatal care in the community during the working week between the hours of 08:30 – 17:00 and postnatal care within the community and clinic setting 7 days a week.

7.7.2 For women who request a home birth within the Chelmsford locality of Mid Essex, care is provided by the community midwives from the Broomfield site. Midwives work in the community between 08.30 and 17.00; outside of these hours an on call service is provided to cover home births and labour care on the co-located midwifery-led Birthing Unit at the Broomfield site.

7.8 Nurses and Staffing of Obstetric Theatres

7.8.1 Nurses working at the Broomfield Maternity Unit are employed by Main Theatres to work in Obstetric Theatres and support midwives in providing care to women and their babies in the operative setting. The service provides a dedicated midwife for all elective lists (Monday-Friday).

7.8.2 Nurses provide a full theatre and recovery service for women who have had operative interventions either under regional or general anaesthetic in the Obstetric Theatres. Additionally midwives provide direct midwifery support and care in the obstetric theatre and recovery areas.

7.8.3 There is rostered cover during the working week Monday-Friday 08:00- 16:00 from Registered Nurses for the booked elective work within the Maternity Obstetric Theatres and 24 hour/7 day week on call support for emergency work.

7.8.4 All Theatre staff (apart from midwives) who work in Obstetric Theatres are employed and managed by main theatres from the District General Hospital.

7.8.5 There are no nurses employed within the postnatal area of the service.

7.9 Support Workers

7.9.1 The maternity service utilises maternity care assistants (Band 3, NVQ qualification) within the hospital setting, at the standalone midwifery-led units and within the community. Maternity care assistants are available 24 hours a day within the hospital and work within the community between 08.30 and 17.00 hours.

7.9.2 Maternity Care assistants also provide cover at the stand alone units in line with the lone worker policy.

7.9.3 Healthcare assistants (Band 2) are also employed within the hospital setting at the Broomfield site working 24 hours a day, 7 days a week supporting trained healthcare professionals.

7.10 Administrative Staff

7.10.1 The maternity service is supported throughout by administrative assistants, personal assistants and ward clerks.

7.10.2 The Broomfield site and the 2 standalone midwifery-led units have ward clerks for each department and administrative assistants in antenatal clinic and also supporting the Postnatal Ward.

7.10.3 Ward clerks work at Band 3 level and Administrative Assistants at Band 2 level, they work Monday-Friday 09:00-17:00 hours.

7.11 **Student Midwives and Return to Practice Midwives**

7.11.1 The maternity service also offers clinical placements for student midwives and return to practice midwives.

7.12 **Others**

7.12.1 The care needs of women whilst pregnant can be diverse and demanding. The provision of the appropriate care to these women can only be provided when the staff caring for them has the appropriate skills.

7.12.2 MEHT Maternity Services utilises volunteers within the maternity service at the Broomfield site, they undertake 8 week placements and work under the direct supervision of the Band 7 Specialist Midwives. They provide administration support in the form of filing, photocopying, typing and 'front facing' duties, such as directing patients to the appropriate area.

7.12.3 The maternity service does not employ any other specific clinical staff from other specialities, however utilises the skills of the appropriate professionals when necessary or as described within clinical guidelines used within the service. For example, ultrasonography services, radiology, Diabetologist and medical and surgical specialities as required.

7.13 **Professional Midwifery Advocates**

7.13.1 Provides an essential role within the Maternity Service. The professional Midwifery Advocates provides a mechanism for support and guidance to every midwife.

8.0 Required Staffing Levels for Midwifery and Support Staff within the Maternity Service

8.1 Midwives are the most senior professionals at the majority of all births and are the main providers of antenatal and postnatal care, minimum safe staffing levels of midwives and support workers are often difficult to calculate due the fluctuation of activity and patterns of care within the maternity service.

8.2 Thus, appropriate staffing levels are calculated using the BR+ recommendations for overall levels within each part of the service, combined with the recommendations from Safer Childbirth which are inputted into a financial model for baseline funded staffing ratios (FSR) for each ward area. This is then balanced against calculated patterns of activity based on the birth rate and case mix of women using the service.

8.3 These baseline funded staffing levels are reviewed as part of the annual audit of staffing within the service and adjusted accordingly in relation to the birth rate and changes in models of care.

8.4 On the whole, 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, the birth rate, case mix and associated activity generated, as well as the models of care and individual midwives' capacity and capability.

8.5 The required staffing levels for maternity services are described in Safer Childbirth RCOG (2007); they are also outlined in later documents from the Kings Fund, which support role redesign and the use of Maternity Care Assistants in supporting midwives roles.

8.6 Band 2 posts are over recruited against funded levels and staff in post could be supported to achieve Band 3 competencies following the 'apprenticeship' scheme. Band 2 posts within the existing funded establishment could be converted into Band 3 posts

8.7 The BR+ Business Case was revisited in 2015 and presented to the Executive Directors for review of funding of these posts was agreed.

9.0 Midwifery Staffing for Maternity Services

9.1 The establishment figures outlined are to cover all areas of the maternity service and relate to funded midwifery establishments.

Table One:

Broomfield	Opening times	Midwifery Funded Establishment
Labour Ward	24 hours	47.39 WTE funded - Feb 2016
Birthing Unit	24 hours	13.74 WTE funded – Feb 2016
Postnatal Ward	24 hours	24.38 WTE funded – Feb 2016
Antenatal Inpatients, DAU, Triage	24 hours	17.66 WTE funded – Feb 2016
Antenatal Clinic	Mon-Fri 08:00-17:00	4.0 WTE funded – Feb 2016
Obstetric Theatres	Planned Mon-Fri 08:00-17:00 Emergency 24 hours	MW included in LW funded establishment
Chelmsford Community	7 days 08:00-17:00 on call service 24 hours	15.16 WTE funded – Feb 2016
Specialist Midwives, Managers, HoM		13.56 WTE funded – Feb 2016
WJC		15.38 WTE funded – Feb 2016
St Peters		15.80 WTE funded – Feb 2016
A further 3.59 wte band 6 and 6.21wte band 7 following Birthrate Plus		
Funded establishment in 2019: 167.07 WTE		
Birthrate Plus 2019 (incorporates 21% for sickness, study leave, annual leave) – 178.93 WTE		
Current vacancy rate subject to regular review		

9.2 In addition to the funded establishment in line with Birthrate Plus, there are midwifery roles needed to provide maternity services, namely:

- Head of Midwifery & Gynaecology;
- Lead Midwife – Acute Inpatient Services (Band 8a);
- Lead Midwife – Community Services (Band 8a);
- Lead Midwife for Clinical Governance (Band 8a);
- Practice Development (Band 7);
- Infant Feeding Advisor (Band 7);
- Antenatal Screening Co-ordinator (Band 7);
- Specialist Midwife for Safeguarding (Band 7);
- Perinatal Mental Health (Band 7);
- Audit, Guidelines (Band 7).

10.0 Process for Achieving an Increase in Midwifery and Maternity Care Assistant Staffing

10.1 The Head of Midwifery/Nursing and Executive Lead for Maternity Services submitted a formal business plan to the Executive Directors in July 2019 funding was agreed and an increase in budget provided funding to recruit to Birthrate Plus recommendations.

10.2 Funding for support staff is in line with acuity and dependency. Business plan was submitted in 2014/15 and again in 2016/17 for an increase in staffing to provide transitional care. This remains unfunded.

11.0 Funded Clinical Establishment Band 2-3

Broomfield	Opening times	Midwifery Funded Establishment
Labour Ward	24 hours	10.08 WTE funded - Feb 2016
Birthing Unit	24 hours	0WTE funded – Feb 2016
Postnatal Ward	24 hours	11.70WTE funded – Feb 2016
Antenatal Inpatients, DAU, Triage	24 hours	5.05 WTE funded – Feb 2016
Antenatal Clinic	Mon-Fri 08:00-17:00	1.84WTE funded – Feb 2016
Chelmsford Community	7 days 08:00-17:00	3.13WTE funded – Feb 2016
WJC		9.26WTE funded – Feb 2016
St Peters		10.50WTE funded – Feb 2016
		Total: 51.56

12.0 Funded Ward Establishment Rosters within the Maternity Service

12.1 Midwives, Nurses and Support Staff.

Table: **Broomfield Consultant Led Unit**

	Labour Ward (LW)	**Postnatal Ward**	**Antenatal Inpatients/Day Assessment Unit/Triage**	**Birthing Unit**
Early	LW Co-ordinator x 1 Midwives X 6 (Mon- Fri) + 1 OT MCA x2	Midwife x 3 MCA x 2 Midwife (mid) x 1 NIPE x 1	Midwife x 3 MCA x 1	Midwife x 3
Late	LW Co-ordinator x1 Midwives x 6 MCA x2	Midwife x 3 MCA x 2	Midwife x 3 MCA x 1	Midwife x 3
Night	LW Co-ordinator x1 Midwives x 6 MCA x2	Midwife x 3 MCA x 2	Midwife x 3 MCA x 1	Midwife x 2

Table: **Chelmsford Community and Broomfield ANC**

	Chelmsford Community	**Chelmsford On call Home birth**	**Chelmsford Weekends**	**Antenatal Clinic**
Early	0900-1700 Midwives x 5 MCA x 2	Midwife x 2 7 days a week	0900-1700 Midwives x 3	08:00-17:00 Midwife x 2 ANNB Screening Co-ordinator /Failsafe MCA x 2

Table: **St Peters and WJC**

	Labour Cover	**Postnatal Cover**	**Antenatal Clinic/DAU**	**Community**	**On calls** **Homebirth and IP activity**
Early	Midwife x1 MCA x1	Labour Midwife	Midwife x 1	08:30 -16:30 x 4 MCA x2	
Late	Midwife x1 MCA x1	Labour Midwife	Midwife x 1		
Night	Midwife x1 MCA x1 Covers all inpatient activity				Midwife x1

13.0 Band 2- 4 Administration/Ward Clerk Requirements with the Maternity Service

13.1 As well as having a clinical establishment as detailed above, the hospital services require support staff for administration & clerical duties, supporting the clinical care and providing general duties in the wards and department.

13.2 Assessment of these roles is on the number required in the relevant areas on a shift by shift basis, as the dependency of mothers and babies is not used as the basis of calculation. These are supportive roles and do not replace clinical midwifery posts.

13.3 Band 4 Personal Assistants: funded 1.6 wte, fully recruited, these posts support the Head of Midwifery and Midwifery Managers, Gynaecology Lead.

13.4 Band 3 Ward Clerks: funded 8.0 wte recruited 6.43 wte (current recruitment for vacancies); these posts provide cover 5 days a week on Labour Ward, Antenatal Inpatients, postnatal ward and the standalone units.

13.5 Band 2 Administrative Assistants: funded 7.4 wte, recruited 5.47 (current recruitment for vacancies), these posts cover ANC and provide support for the postnatal area.

14.0 Staff Duties

14.1 The responsibilities of some groups of staff working on the labour ward are clearly defined within national guidance. The maternity service has described the responsibilities of these staff groups in ‘Roles and Responsibilities of medical and midwifery staff working within the Maternity Services’; register number 04227.

15.0 Process for the Annual Review of Midwifery and Support Staffing Levels

15.1 A monthly review of staffing levels has occurred, triggering a formal workforce assessment using the Birth Rate Plus methodology commenced In March 2019 and completed in August 2019.

15.2 Workforce planning reviews now occur quarterly via the Workforce Planning Action Plan which is presented at CQRG and Directorate Governance Meetings if a shortfall or concern is identified.

15.3 A yearly review and audit of staffing levels will be undertaken in March each year and includes the review of midwifery and support staffing levels against the birth rate and subsequent generated activity in the antenatal and postnatal periods.

15.4 The Birth Rate plus methodology will be used with the established formula to determine staffing requirements against acuity, dependency, community cases, high risk cases and imports and exports.

15.5 An assessment of case mix will also form part of this audit and will be monitored through the new Payment by Results scheme whereby clinical data is collected at point of booking and discharge. Increases in complexity will trigger a review of staffing and specialist services required to support women with more complex needs.

15.6 The annual audit 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, handheld records and capture techniques and the financial data detailing the funded establishment for each area.

15.7 The annual audit will take into consideration the birth rate throughout that period and the projected increase in births based on best available evidence from local public health data and trends evident throughout each month captured via maternity statistics. Trends will be analysed for local and out of area births, including imports and exports within the service.

15.8 Shortfalls in staffing required against the 1:30 ratio will be logged on the Directorate Risk Assurance Framework (RAF) which will be presented bi-monthly at Directorate Governance Meetings and at least annually at Board level via the PS&Q.

16.0 Development of Business Plans

16.1 The process for approval of a Business Case, is submission and presentation to the Executive Directors, if ‘chairs action’ is not taken at this point then the Business Case will be submitted to the Investment Group, chaired by the Director of Finance for consideration.

16.2 The Investment Group has the remit of ensuring that all major investment, disinvestment and development decisions (both revenue and capital) receive appropriate overview and scrutiny. This will be a group reporting to the Finance and Performance Committee.

17.0 Process for the Development of Short Term Contingency Plans

(Refer to Maternity Services Escalation Policy; register number 10084)

17.1 The Maternity Services has an Escalation Policy that describes the processes and procedures that are brought into action when there is an increase in activity or a reduction in staff. These are described in detail in the Escalation Policy.

18.0 Obstetrics Current Consultant Workforce

18.1 **Introduction**

To provide safe, consistent and high quality patient care, Safer Childbirth (RCOG) has set standards for consultant cover for the Labour Ward based on the clinical activity and number of births per year within the service. Ideally, in the future, there will be 24 hour consultant presence in the majority of obstetric units as work patterns evolve. Until then, it is recommended that the Consultant for Labour Ward must be available on the labour ward when they have a fixed session and their presence is needed, they must also be available for telephone advice at all times while on call.

18.2 **Staff Utilisation**

In Mid Essex Hospitals NHS Trust Maternity Service a consultant obstetrician (the Clinical Lead) is responsible for planning the obstetric rota and authorising any alterations that have to be made to ensure safe cover by a consultant.

18.3 In order to prospectively plan cover, all consultants must give at least 6 weeks notice prior to booking/taking study/annual leave. If a situation arises where a consultant is absent at short notice for whatever reason, the rota organiser (Clinical Lead) will arrange for another consultant to provide consultant cover, this is usually the consultant from the Antenatal Clinic.

18.4 If short term emergency locum consultant cover is required due to consultant's having other commitments or a consultant needing longer term unforeseen absence then the secretary to the medical resource department will be informed immediately and they will organise this through a locum agency after the applicants CV is approved by the Clinical Lead.

18.5 Short notice arrangements or difficulty with cover is escalated to and further discussed with the Clinical Director and Head of Midwifery & Nursing; this will ensure communication of agreed contingency throughout the Directorate.

18.6 **Description of the Staff Utilised within the Maternity Service Miss Rao to update)**

Doctors in Training	
8 Registrars	**9 SHOs**
4 Trainee Doctors	1 Career SHO Trainee
4 Trust Specialist Doctors	1 Career SHO Trust Doctor
TOTAL: 8 Registrars	5VTS/GP Trainee /2 FY2's

Registrar and SHO cover 24/7 on Labour Ward
12 hour shift rota:- Electronic handover of data between Junior Doctors
AM handover 08.00-08.30/PM handover 20.00 to 20.30

18.7 **Consultant Obstetricians**

18.8 The role of the consultant obstetrician on the Labour Ward is to ensure a high standard of care for women and their babies with complex medical or obstetric needs, and to be available for the acute, severe and often unpredictable life threatening emergencies.

18.9 At Mid Essex Hospital Services NHS Trust, there is currently a team of 10 Consultant Obstetricians, 9 Obstetric Consultants who are rostered to provide on call cover and prospective presence on the Labour Ward in line with Safer Childbirth (RCOG 2007) recommendations. The 10th Obstetric Consultant covers Antenatal Clinic and C sections.

18.10 All 9 are full time Consultant Obstetricians and Gynaecologists working within the Maternity Services.

18.11 Consultants with special interests in Obstetric care are as follows:

- Fetal Medicine Consultant;
- Lead Consultant for Diabetes in Pregnancy;
- Lead Consultant for Day Assessment Unit/Labour Ward;
- Lead Consultant for Medical Disorders Complicating Pregnancy.

18.12 In high risk cases requiring operative intervention 2 consultant obstetricians will be present for the procedure; this will include women with complex medical or obstetric conditions. In addition, where medical intervention may be required a multidisciplinary approach to the woman's care will occur with a management plan in place.

18.13 A Consultant Obstetrician is present on the Labour Ward between 08.00 to 20.00 hours from Monday to Friday. On Saturday and Sunday, there is a Consultant Obstetrician present on Labour Ward for 4 hours each day. Outside these hours a Consultant Obstetrician is available on an on-call basis and can be present on the Labour Ward within 30 minutes. The Maternity Unit has a list of clinical situations when a consultant will be available to support doctors in training. This presence on the Labour Ward forms part of the 'Hot Week' Consultant Obstetrician Rota.

18.14 In addition, the Consultant Obstetricians cover antenatal clinics, 6 at Broomfield and one each at St Peters Maternity Unit and WJC at Braintree.

19.0 Required Staffing Levels

19.1 We are currently working towards 98 hours consultant cover. Funding is required for an 11th consultant:

19.1.1 Labour Ward in Broomfield Hospital with approximately 4430 births per year requires 98 hours of consultant presence according to Safer Childbirth workforce recommendations.

19.1.2 Midwife Led Units in St Peters, Maldon and WJC, Braintree with approximately 471 births per year have continual staffing review through the head of Midwifery/Nursing, ensuring adequate consultant support for Labour Ward matters. This includes the monthly audit of transfer rates from both units and the input required from Consultants for women on the co-located Birthing Unit at Broomfield.

19.1.3 At Broomfield there are 3 tiers of obstetric cover – lower, middle and consultant. On site there are 8 middle grade doctors (Specialist trainees years 3-7 or speciality doctors or Trust doctors) providing the middle tier obstetric cover in a 1:8 shift system. This is compliant with the European Working Time Directive (EWTD). There are also 9 lower grade doctors at Broomfield Hospital providing the lower tier of obstetric cover in a 1:9 shift system. This is compliant with EWTD.

19.2 **Doctors staffing levels**

- 10 Consultant Obstetricians/Gynaecologists (9 Consultants for Labour Ward and on call;
- 8 Obstetric/Gynaecology Registrars;
- 9 Obstetric/Gynaecology Senior House Officer's.

19.3 **Consultant Obstetricians funded rosters**

19.4 At present the Labour Ward at Mid Essex Hospital Services NHS Trust provides 68 hours onsite consultant cover on the labour ward in line with the recommendations of Safer Childbirth (RCOG 2007). As mentioned above, there is a Business Case in progress, working towards 98 hours of consultant presence on the Labour Ward.

19.5 The 'Hot Week' Obstetric Consultant covers the Labour Ward on site, Monday to Thursday 08.00 -17.00 hours on a 1 in 9 cycle.

19.6 The evening Obstetric Consultant on call covers Labour Ward on site from 17.00 to 20.00 hours and thereafter will be on call from home.

The weekend Obstetric Consultant will cover the Labour Ward on Friday from 08.00 to 20.00 hours on a 1 in 9 cycle.

WEEKDAY OBSTETRIC CONSULTANT COVER 1 in 9 CYCLE			
DAYS	08.00 - 17.00 Resident on Call	17.00 – 20.00 Resident on Call	20.00 – 08.00 From Home
Monday	Covered by Hot Week Consultant	Obstetric Consultant Cover by on-call	On-call from home Obstetric Consultant
Tuesday	Covered by Hot Week Consultant	Obstetric Consultant Cover by on-call	On-call from home Obstetric Consultant
Wednesday	Covered by Hot Week Consultant	Cover by on-call Obstetric Consultant	On-call from home consultant

Thursday	Covered by Hot Week Consultant	Cover by on-call Obstetric Consultant	On-call from home Obstetric Consultant
Friday	Covered by Hot Weekend Consultant	Covered by Hot Weekend Consultant	On call from home consultant cover
	WEEKEND COVER **09:00 – 13:00**	**WEEKEND COVER** **13:00 – 09:00**	
Saturday	Hot Consultant 4 hours	On call from home consultant cover	
Sunday	Hot Consultant 4 hours	On call from home consultant cover	

WEEKDAY OBSTETRIC REGISTRAR COVER			
Days	08:00- 20:00	20:00- 08:00	
Monday - Friday	Resident on call	Resident on call (2 in total)	**Friday 20:00- 08:00** **Extra Locum Registrar on call**
WEEKEND OBSTETRIC REGISTRAR COVER			
Weekend	08:00- 20:00	20:00- 08:00	
Saturday	2 Registrars Resident on call	2 Registrars Resident on call	Locum Registrar cover to make up to 2 Registrars on call at weekend
Sunday	Resident on call	Resident on call	

20.0 Roles and Responsibilities of Medical Staff within the Service

20.1 The responsibilities of groups of staff on Labour Ward are clearly defined within –Safer Childbirth 2007.

20.2 The guideline entitled 'Roles and responsibilities of medical and midwifery staff working within the Maternity Services' (register number 04227) details the actions to be taken for escalation of concerns regarding staffing levels, acuity/dependency and capacity issues within the service. This outlines the roles each member of the team has in supporting decision-making and ensuring the effective operational management of the Maternity Service.

20.3 **Consultants Role in Labour Ward**

- The consultant on call for obstetrics must be available on the Labour Ward when they have a fixed session there and their presence is required. They are available on the telephone for advice at all times while on-call.

- Their role encompasses providing a service for those patients who require senior medical assistance while at the same time undertaking routine procedures when there is a need to do so, due to the workload on the unit.

- Teaching and Training: The consultants' role encompasses visible, clinical leadership and teaching and supporting trainees, midwives and nurses at all times. Obstetrics is an apprenticeship-based speciality and the consultant must be present to ensure that the trainee is taught and supervised effectively. The consultant must be available at all times until the trainee has been assessed as fit for independent practice.

- Supporting Staff: In particular, the presence of the consultant is required when there is the potential for adverse events or poor outcomes to occur or in the unforeseen event of a serious incident requiring consultant input. Consultant attendance on the maternity unit in these situations will provide the highest level of expertise into the management of the situation, ensure support for the woman and her family, as well staff on duty.

- Respond to call for help: Doctors at every level have a duty to call for help and escalate clinical concerns about the ongoing management of a woman/fetus, to the consultant on call. When the need arises, trainees must discuss the management of a patient with the Consultant and when required the Consultant will attend to support and advise. A trainee's request for a Consultant to attend should be stated in clear, precise terms, so that there can be no misinterpretation. The request should be documented in the notes.

20.4 It is also expected that there are clinical conditions where the consultant obstetrician will attend the Labour Ward in person if they are not already present. For example:

- Eclampsia;
- Maternal collapse (such as massive abruption, septic shock);
- Caesarean section for major placenta praevia;
- Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated;
- Return to theatre – laparotomy;
- Uterine rupture;
- When requested.

20.5 Available to attend if required: for the procedures listed below, the consultant should either attend in person or be immediately available to support the Middle Grade Junior Doctors.

- Vaginal breech delivery;
- Twin Delivery;
- Trial of instrumental delivery in theatre;
- Caesarean section at full dilatation;
- Caesarean section in women with body mass index greater than 40;
- Confirming intrauterine fetal demise;
- When antenatal/intrapartum or postnatal woman presents with or develop acute medical/surgical illness requiring senior multidisciplinary input;
- 2nd stage caesarean section.

20.6 Consultants decision to attend: When a senior trainee is on call it is the consultants decision whether to attend when the situations above occur.

20.7 Doctors in non training grades: Doctors in the non training grades should have their capabilities and experience assessed by a consultant and a clear decision should be made as to the level at which they should be working. The doctor should then have the same cover as a trainee with equivalent experience.

20.8 Handover: If there are any high risk obstetrics, high dependency care or ITU cases there should be a formal handover (by telephone call or in person) between consultants following a period of on call.

21.0 Annual Audit Process

21.1 The number of obstetricians required to provide care in the clinical area is dependant upon workload activity. As set out in the Safer Childbirth: minimum standards for the organisation and delivery of care in labour (2007). Consultant presence will be reviewed monthly as a standing agenda item at consultant meetings and evidence provided by the monthly maternity dashboard.

22.0 Business Plan Process

22.1 Where obstetric staffing shortfalls are identified within the audit or risk management systems a Business Case will be developed by the clinical director and directorate manager in line with the Trust Business case process.

23.0 Process for the Annual Review of Staffing Levels

23.1 Where necessary an action plan will be developed to address shortfalls and a Business Case will be developed to support the appointment of further medical staff to achieve the recommendations within Safer Childbirth. This would be in response to a consultant leaving the service or an increase in the birth rate that would necessitate an increase in consultant presence hours on the Labour Ward.

23.2 The annual review considered the management referral system that is in place and had an agreed upper birth rate of 4500 births a year. Based on these figures 9 Consultant Obstetricians will continue to provide 68 hours of presence on the Labour Ward.

24.0 Process for the Development of Business Plans for funding for medical staff

24.1 **Steps:**

1. Business case proforma to be completed;
2. Authority to recruit proforma to be completed;
3. Authority to invest proforma to be completed;
4. Business case proforma from idea to reality to be completed;
5. When the above 4 steps are completed HR is informed for job advertisement to be published;
6. Short listing, interview and appointment.

25.0 Process for the Development of Longer Term Contingency Plans

25.1 Provision of safe staffing levels is essential to providing women with a safe and positive birth experience. This may be affected short term by an increase in workload activity within the birth setting, staff sickness or long term by inadequate obstetric and midwifery staffing levels. Contingency plans will be developed as required to address staffing shortfalls by the Clinical Director and the Head of Midwifery & Nursing. Business plans will be escalated to the Hospital Associate Medical Director and Trust Medical Director.

25.2 Appointment of 9th SHO and 10th Consultant was between 2016-2018.

25.3 To increase consultant presence on Labour Ward to 98 hours per week.

25.4 14 hour cover every day 7 days a week.

25.5 Hot Week Obstetric Consultant 8am to 5pm.

25.6 On-call Obstetric Consultant from 5pm to 10pm Monday to Thursday. Weekend Obstetric Consultant to cover from 8am to 10pm on Friday, Saturday and Sunday 1 in 9 cycle.

26.0 Process for the Development of Short Term Contingency Plans

26.1 For periods of short term staffing shortfalls (e.g. sudden increase in workload, short notice staff sickness) a local resolution should be sought by informing the on call consultant who may also contact the Clinical Director. This may trigger the requirement to book locum cover to ensure contingency plans are met, if redeployment of existing staff is not possible or does not cover the shortfalls.

26.2 Should the staffing issue pose a medium to long term risk the escalation process will be followed, which will include immediate communication to the Clinical Director, booking locum staff and rearrangement of the rotas based on necessary skill mix to ensure safe patient care.

26.3 In circumstances where the Clinical Director is unavailable to make decisions on short term staffing contingency, the on call consultant must act in the best interests of safe clinical care and put in place measures to manage the immediate issue.

26.4 Medium to long term staffing shortfalls: Where ongoing staffing shortfalls are identified through the risk management systems or staffing audit a contingency plans will be developed by the Clinical Lead. The plans will be presented at the Directorate Governance meeting and monitored by this group. The short fall will also be added onto the Risk Assurance Framework (RAF). Where required the Clinical Director and Head of Midwifery & Nursing will escalate the issues to the Trust Board through the Patient Safety and Quality Committee.

26.5 Monitoring: Staffing issues are a monthly standing agenda item on the Obstetric Clinical Governance Meeting and Directorate Meeting.

26.6 Action points identified from the annual audit are also reviewed and progress monitored on a sis monthly basis, through the Obstetrics Clinical Governance Group, identified issues are escalated through the Hospital Medical Directors to the appropriate operation committee.

26.7 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.

26.8 For sickness and compassionate leave, Labour Ward cover is overseen by the Obstetric SHO and Registrar or locum SHO or registrar requested from the locum agency set up by the Trust. The rota is available from the Gynaecology Secretary and this is archived electronically .

26.9 The Policy entitled ‘Maternity Services Escalation Policy’ (10084) details the actions to be taken by staff in the event of there being staff shortages due to high workload or sickness..

27.0 Anaesthetists and their Assistants Utilised on the Labour Ward

27.1 **Anaesthetists** - In Broomfield Hospital the anaesthetic cover includes tenconsultant sessions. These cover Labour Ward for the time period 8 am until 6:15pm, Monday to Friday. There is also a duty anaesthetist available for Labour Ward for 24 hours a day seven days a week. This is an anaesthetist who has completed at least one year of training and has been assessed as suitable to cover Labour Ward. There is also a trained anaesthetic assistant available 24 hours a day to support the anaesthetist.

27.2 **Anaesthetic Practitioners** - Staff provision for the Obstetric Theatre includes the following funded posts: 1.0 wte Anaesthetic Practitioner , in addition to this , main theatres provides 1.0 wte Band 6 , 1.0 wte Band 5 and 1.0 wte Healthcare Assistant.

28.0 Required Anaesthetists and their Assistants Staffing Levels Anaesthetists

28.1 Anaesthetists and their Assistants in Broomfield Hospital: the anaesthetic cover for Labour Ward includes tenconsultant sessions. The Safer Childbirth Report 2007 and the Association of Anaesthetist Guidelines for Obstetric Anaesthetic Services (2005) recommends 10 consultant sessions per week. The Associate Specialist works in the

same capacity as a consultant and is considered by the Anaesthetic Department to be of the same calibre and experience as a consultant. The consultants for these sessions cover Labour Ward for the time period 8 am until 6:15pm, Monday to Friday.

28.2 Included in their duties during this time are two anaesthetic antenatal clinics on two afternoons (13.30-17.00) during the working week. The consultant covering Labour Ward is also responsible for the elective caesarean section list, i.e. there is not a separate anaesthetist available for this list as is recommended in Safer Childbirth Report 2007. This is under review and is something we will consider if our birth rate goes above 5000 per year.

28.3 There is also a duty anaesthetist available for labour ward for 24 hours a day seven days a week. This anaesthetist is not responsible for any other areas (in line with Safer Childbirth Report 2007). This is an anaesthetist who has completed at least one year of training and has been assessed as suitable to cover Labour Ward (as recommended by Safer Childbirth Report 2007). They are either an anaesthetist in training or a trust grade doctor. There is also a trained anaesthetic assistant available 24hour a day to support the anaesthetist. If the duty anaesthetist needs help or advice out of day time hours there is consultant cover from home, this consultant is available for maternity and paediatric emergencies.

Anaesthetic Practitioners

28.4 Cover is provided by the allocated practitioners over a 24 hour period. In the event of an obstetric emergency, a second team, including the anaesthetic practitioner would be requested from main theatres to provide immediate cover. This request will sometimes result in an appropriate operating list being stopped until the team can return.

29.0 Staff Duties - Consultant Anaesthetists

29.1 There is a lead anaesthetic consultant for obsteric anaesthesia in Broomfield Hospital. This consultant is responsible for ensuring an anaesthetic presence at the Labour Ward Forum and risk meetings, for liasing with obstetric and midwifery collegues and for auditing the obstetric anaesthetic service.

29.2 Day to day management of the rota for obstetric anaesthesia is managed by an associate specialist in the anaesthetic department. The anaesthetic department ensures there is a duty anaesthetist available at all times for labour ward. This is an anaesthetist who has completed at least one year of training and has been assessed as suitable to cover labour ward.

30.0 Process for the Annual Review of Anaesthetic Staffing Levels

30.1 National guidance for anaesthetic staffing from both Safer Childbirth Report 2007 and The Association of Anaesthetists of Great Britain and Ireland are for 10 consultant sessions per week. We provide 10 consultant sessions . Both these bodies recommend consideration of extra anaesthetic cover if the birth rate is >5000 deliveries per year, the epidural rate is >35% or the caesarean section rate is >25%. The one area in which we do trigger these numbers is our caesarean section rate which is above 25%. The requirement for extra staffing would be initially discussed at a meeting of the obstetric anaesthetists and then brought to the monthly departmental meeting. This would occur if it was felt by the obstetric anaesthetists covering labour ward that there was not enough

anaesthetic staff to meet the demand or if there were unnecessary delays for patients due to shortage of anaesthetic staff.

30.2 The anaesthetic staffing levels on labour ward are reviewed on a daily basis by the anaesthetic administration personnel and never fall below the required safe minimum level.

31.0 Process for monitoring compliance and action plans

31.1 A minimum safe staffing agreement is in place in the anaesthetic department. This outlines the basic anaesthetic staffing of the obstetric unit below which we will not go. Weekly monitoring of this compliance is undertaken by the departmental administration personnel and counter checked by the clinical director. If there is a shortfall in the staffing it is always rectified either by re-deployment in the acute situation, or by locum staff if time permits. We never go below minimum staffing levels.

32.0 Process for the Development of Business Plans

32.1 Business plans are developed by the Clinical Director with assistance of the Executive Director with responsibility for the area and the business administrator for the directorate. Support from the Medical Director and Chief Nurse is sought if appropriate. A business plan requesting Authority to Recruit is scrutinised by the Investment Group and once funding is agreed advertisement occurs through the offices of the medical resource team.

33.0 Process for the Development of Longer Term Contingency Plans

33.1 If it is decided more anaesthetic staff are required a business plan will be put together and submitted to the investment committee. The trigger for this process would be a possible reduction below safe staffing levels or an increase in the workload in the labour ward, stimulating a review of the safe staffing level. This level is regularly discussed at our monthly departmental meetings. At corporate level this is recognised through the Directorate Risk register which is provided to the Patient Safety and Quality Committee at least once per year and the accumulated Trust wide risk register produced to the board bi-monthly.

34.0 Process for the Development of Short Term Contingency Plans

34.1 During working hours all concerns are co-ordinated by the administration personnel of the Anaesthetic directorate. Escalation to Clinical Director level occurs and re-deployment of staffing resource is prioritised to fulfil the minimum safe staffing level. This may involve simple redeployment of staff or a need to cancel elective service elsewhere.

34.2 Out of hours the same function is co-ordinated by the on call consultant.

34.3 In extreme circumstances the on call manager and executive may need to be involved.

Anaesthetic Practitioners

34.4 In the event of short notice sickness, a suitable team member will be redeployed from main theatres to obstetric theatres.

34.5 Theatres run on a substantive workforce and agency is not used.

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Appendix 1: Preliminary Equality Analysis

This assessment relates to: 09148 Maternity Staffing Strategy

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Angela Woolfenden	**Job Title**	Lead Midwife Community Services	**Date**	September 2019

…….End of policy……