Version 3 – February 2022

Division of Women & Childrens

Workforce Strategy for Maternity, Obstetrics & Gynaecology

INTRODUCTION
This Workforce Strategy will form part of the wider Women & Children's Workforce Strategy supporting the Trust's Strategic Objective of maximising the potential of our workforce by ensuring we have the right people with the right skills in the right numbers in order to deliver the most effective care.
This strategy has been developed using the Skills for Health Six Step Methodology to Integrated Workforce Planning, which is a practical approach to ensuring that we have a workforce of the right size with the right skills and competences.
The strategy is underpinned by the need to understand the strategic context of the challenges & drivers for change and then determining what the required workforce needs to be. We then need to review the potential supply for our workforce and how we will bridge the gap between demand and supply. In common with any plan this then needs to be monitored and evaluated. The plan will be iterative in nature as the maternity transformation agenda develops.

1.	**STEP ONE – DEFINING THE PLAN**
Methodology	
1.1	This strategy has been developed using the Skills or Health Six Step Methodology to Integrated Workforce Planning. This is a practical approach is underpinned by the need to understand the strategic context of a workforce plan and follow a process of thinking about what the required workforce needs to be to deliver the required outcomes and how we will bridge the gap between demand and supply.
2.1	**Step 1:** Defining the plan – by identifying the purpose and scope of the plan, establishing ownership and responsibilities **Step 2:** Mapping service change – by identifying the benefits of change, drivers & barriers and considering potential workforce models **Step 3:** Defining the required workforce – by mapping new services/ activities, identifying the skills needed and the types & numbers of staff required **Step 4:** Understanding workforce availability – by mapping the current workforce in terms of existing skills, demographics and supply options **Step 5:** Develop an action plan – by determining the most effective way to deliver the Planning to deliver the required workforce against time & resources **Step 6:** Implement, monitoring and revise fresh – implementation of plan, with progress measurement against targets.

Purpose of the plan	
	This Workforce Strategy has been developed to ensure that we are recruiting, retaining, developing, motivating and deploying our maternity workforce effectively in order to respond to the following key drivers: ▪ Ockenden Review of Maternity Service (2020) ▪ Kirkup Report (2015) ▪ National Maternity Review: Better Births (2016) ▪ NHS Resolution Maternity Incentive Scheme ▪ Medical Contract Reform 2021 ▪ HEE Maternity Support Worker transformation agenda ▪ SFHT Maternity Workforce Profile
Scope of the plan	
	This plan relates to the Maternity, Neonates, Obstetrics & Gynaecology service line which includes the following teams: ▪ Community Midwifery ▪ Acute Maternity ▪ Antenatal and Early Pregnancy ▪ Obstetrics & Gynaecology Medical Team The following staff groups are within the scope of this strategy: ▪ Midwives (Band 6 and above) ▪ Maternity Support Workers (MSW) ▪ Obstetrics & Gynaecology Consultants
Ownership of the plan	
	The key stakeholders to this strategy are: ▪ The Divisional Triumvirate ▪ Heads of Service ▪ Matrons & Senior Midwifes ▪ Ward Leaders ▪ Divisional Finance Manager ▪ Divisional HR Business Partner ▪ Head of Medical Workforce

Governance of the Plan	
	This plan will be presented at the Maternity Assurance Committee (MAC) which is Chaired by the Chief Nurse. A Highlight report will be presented to MAC on a quarterly basis and be included in Trust Board updates
Operational Delivery	
	The divisional oversight of workforce (which includes business case developments) is monitored by the W&C Monthly Board meeting. There is both a divisional transformation group, and a divisional workforce group in place that present highlight reports to W&C Board. These highlight reports are then shared at MAC to ensure exec oversight on progress and any identified challenges.

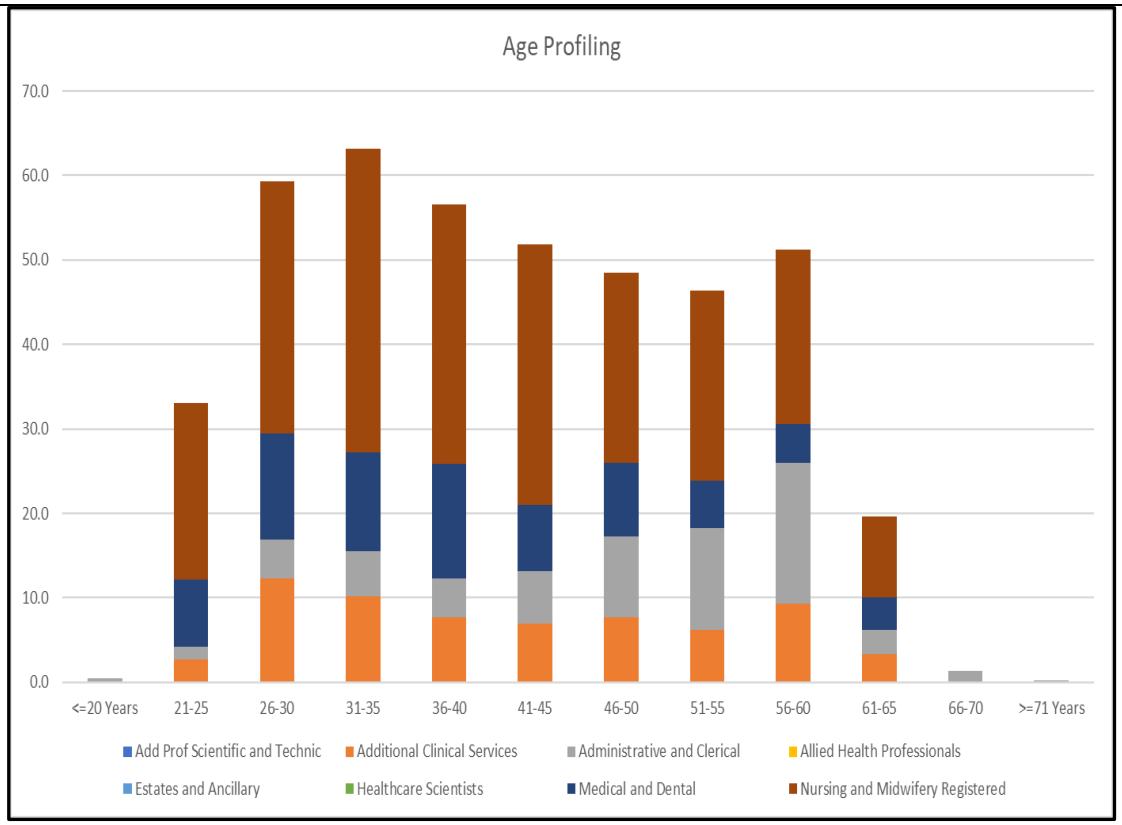
2.	**STEP TWO – IDENTIFYING THE SERVICE DIRECTION**
The following section provides an overview of the service and the key drivers and challenges, the majority of which are interdependent.	
2.1	**The current service**
	Community Midwifery The Community Midwifery team cares for women living in the areas of Mansfield, Ashfield, Sherwood and Newark. Named Midwives are linked to a GP practice and provide these women with all their antenatal and postnatal care in a variety of settings including GP surgery and patients homes. Women may have care with a midwife only or they may have shared care between the midwife and the obstetric team dependant on their risk factors. The community team also provides a home birth service for women wishing to deliver their baby in the home environment. The community team also provides a telephone advice line service during office hours. In addition, a small team of health care support workers called the Lime Green Team support women with infant feeding in the community setting with telephone consultations and home visits. **Acute (Hospital) Maternity** The Sherwood Birthing Unit includes the Triage assessment area, where women are asked to attend following a telephone Triage or following community midwife or GP referral. The Unit has 10 birthing rooms and a birthing pool which can be used for labour and birth where appropriate.

	There are also 2 rooms within the birthing unit to enable intensive monitoring of women with antenatal or postnatal complications, or to facilitate safe recovery following delivery by caesarean section. There are 2 operating theatres within the birthing unit in which both planned and emergency procedures are performed. The theatres are operated 24 hours a day. The Maternity Ward is a 32 bedded ward and cares for antenatal women and postnatal women and their babies and offer transitional care to high risk babies to prevent unnecessary separation of mothers and babies. It also includes a four bedded Induction Suite. **Medical Team** There are 13 Consultants in post in a blended role that offers both obstetric and gynaecology cover. All consultants have an annual job planning review and are supported with their sub speciality interests which are listed below: - 3.5 obstetrics 2.5 Gynae-Cancer 2.0 Uro-gynae 1.0 Endometriosis 2.0 Early pregnancy / miscarriage 2.0 General Gynaecology
2.1	**Future Workforce Model** **Midwifery Continuity of Carer (MCoC)**
	What is MCoC? MCoC is provided by midwives organised into teams of eight or fewer (headcount). Each midwife aims to provide antenatal, intrapartum and postnatal midwifery care to approximately 36 women per year (pro rata), with support from the wider team for out-of-hours care. Within this: • MCoC is not antenatal or postnatal care only or 1:1 care in labour. • The evidence for its benefits is clearly based on models employing continuity across antenatal, intrapartum and postnatal care • Each team has a linked obstetrician • All staff in the maternity service contribute to achieving MCoC and must feel involved in its provision. • MCoC is everybody's business.
	What are Maternity Units being asked to deliver?
	As set out in the NHS Operational Planning Guidance for 2021/22, LMNS should put in place the building blocks by March 2022, so that MCoC is the default model of care offered to all women. This involves by 31 March 2022

	• undertaking a Birth-rate Plus assessment or equivalent to understand the current standard-model midwifery workforce required and following this through with recruitment • co-designing a plan with local midwives, obstetricians and service users for implementation of MCoC teams in compliance with national principles and standards and phased alongside the fulfilment of required staffing levels. • Delivering Midwifery Continuity of Carer at full scale plan should also take into account the need to support maternity staff to recover from the challenges of the pandemic • prioritising those women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway by March 2022 • developing the ability to measure progress electronically and report it to the Maternity Services Data Set (MSDS) • developing an enhanced model of MCoC that provides extra support for women from the most deprived areas, for implementation from April 2023.
	What are the building blocks for midwifery staffing?
	In planning for a MCoC service, the revised national guidance released in October 2021 described the following building blocks: a. Safe staffing (underpinned by Birthrate plus review) b. Communication and engagement c. Skill mix review d. Training e. Team Building f. Linked obstetrician g. Pay h. Evaluation of plan i. Review of plan
	What is Birthrate Plus ®?
	Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. 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.
	A Birthrate Plus review of SHFT maternity staffing took place in September 2020, based on the following principles: ▪ Based on birth data from Feb – Apr 2020 ▪ 58% of women categorised as ‘higher risk’

	▪ Assumptions made for 35% MCOC ▪ Repeated consultations and reviews conducted leading to final version ▪ Data & conclusions triangulated against LMNS workforce modelling
	The BR+ report therefore recommended that the total clinical establishment for Maternity needed to increase by **12.37fte** qualified midwives to achieve the required number needed to ensure each woman receives one-to-one care in labour and a 90:10 skills mix (90% Registered Midwife to 10% Maternity Support Worker). This uplift has been included as part of the annual staffing paper.
	How are we recruiting and retaining? Given the national context around maternity services and the shortage of trained midwives, retaining staff is as important as the recruitment. Allowing staff to recover and understand the impact the pandemic has had on them is crucial alongside the recognition that staffing levels are maintained safely whilst plans are drawn up to describe the future changes in midwifery care pathways. **Recruitment** • Rolling advert for trained midwives in place that offer a variety of flexible working options. Interviews are set up regularly on receipt of appropriate applications • Working with our students and universities to encourage applications. We have recently offered 15 students Band 5 preceptorship roles • Exit interviews – to hear feedback **Retention** • Professional midwifery advocate service rolled out on 1 February 2022 to offer restorative supervision • Band 7 midwife focussed on recruitment and retention with particular focus on supporting student midwives • Monthly midwifery forum chaired by the Chief Nurse to encourage speaking up • Monthly safety walk rounds by Safety Champions to talk to teams on shift • Monthly Midwifery Matters brochure to update colleagues on progress around recruitment and actions taken as a result of the midwifery forum and safety walk arounds
2.4	**MEDICAL WORKFORCE SECTION**
	Splitting Elective and Emergency Work and Additional Lead Roles • Currently the Senior Medical Workforce has more programmed activities within Gynaecology and this should be an even split between Obs & Gynae. With the recruitment of the 14th Consultant, this will have gone someway to redress the balance and offer 5.75 WTE dedicated to Obstetrics out of 13 consultants.

	• There is also a requirement to split the elective from the emergency work in Obstetrics, currently there are no separate elective lists and the specialty believe there is a need for 3 lists on a weekly basis. This is currently subject to difficulty in recruiting into theatre posts and is monitored by the Maternity Programme Board. **Workforce Considerations** • 5 members of the Senior Medical Workforce are over 55 years of age, with 3 over 60 years of age, 2 of which are participating on the on call rota which is not in accordance with the RCOG guidance that consultants over 60 should not participate in the on call rota. • With future appointments there is an opportunity to consider the new role of Specialist within the workforce profile.
2.5	**Maternity Support Worker Transformation Fund**
	In March 2018 the government announced that work would be undertaken to develop and professionalise the Maternity Support Worker (MSW) role. Following a successful pilot HEE is mow supporting full implementation of the framework in all maternity providers in recognition of the vital contribution maternity support workers make to the delivery of safe and personalised care for women and their babies.
2.6	**Workforce Profile**
	The Workforce Profile includes demographic information such as age, gender and diversity information in relation to the existing workforce. The age demographic is particularly relevant as we know we have an aging workforce within the midwifery and medical workforce which needs understanding and mitigating. The February 2022 position is shown on the graph overleaf.



In developing the MCoC plans and aligning to national guidance, the Divisional workforce group and transformation group must consider the following when developing future models of care: -

- 100% of the Midwifery workforce are female and are of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups.
- 74% of the Band 6 Community Midwife workforce are part-time, with 12 Band 6 Midwifes working full time and 29 working part-time.
- 73% of the Acute Band 6 workforce and 69% of the Acute Band 5 workforce are part-time

Local Developments

There have been small increases in numbers of women coming to SFHT following the CQC outcome at NUH in 2021/22. With the long-term plan to move maternity services on to one site at NUH, that being the QMC site, it is likely that the numbers will increase further leading up to and following that change.

3.	**Step 3:** **Defining the Required Midwifery Workforce**
	The following table sets out the workforce requirements to enable delivery of the requirements of MCoC guidance "Delivering Midwifery Continuity of Carer at Full Scale" and includes the recommended uplift determined by the BR+ assessment. This also includes a 10% uplift to account for the increased number of bookings and births seen over 2021/22.

IP/IOL +AN/PN+Triage+Outpatients =	Total	**117.16**
	IFT	**4.16**
	Core Community	**35.14**
	Senior Management & Specialist Midwives	**11.94**
	TOTAL ESTABLISHMENT	**168.40**

Key:
IP – Inpatient
IOL – Induction of Labour
AN – Antenatal
PN – Post Natal
IFT – Infant Feeding Team

	Defining the Required Medical Workforce The medical workforce will be reviewed in line with RCOG guidance along with annual job planning. Succession planning will continue to be monitored by the division to ensure balance between the obstetric and gynaecology services.

4.	**Step 4: Midwifery Workforce Capacity and Capability** To develop a workforce plan that aligns to all current national guidance, the following will be considered: - **Model of working** It is important to factor in protected time off for each team member in line with their WTE contract. **Team size**

	MCoC teams are made up of no more than eight midwives (headcount). With full capacity, this could mean, depending on team size, organisation and number of home births, midwives work just one out-of-hours session per week, which should be no more onerous than a night shift and can be planned well in advance. Out-of-hours sessions are part of the contracted hours, not in addition to them. It is worth noting that trusts report MCoC teams smaller than 6.8 WTE struggle to fill the out-of-hours element, as each midwife would have a greater burden of out of hours to cover. In some trusts a high proportion of midwives work part time. Ideally team sizes should be no more than eight headcounts. **Caseload** Each midwife cares for 36 completed cases per year and books slightly more women to account for attrition. Part-time midwives have a pro-rata caseload: a 0.8 WTE midwife will care for 30 women and a 0.6 WTE midwife 24. Team size is therefore expressed in terms of WTE. **On-call working** No midwife is expected to work over their contracted hours. When working flexibly they can keep a tally of hours worked to ensure that they do not work additional hours. This should be monitored on a four-weekly basis to ensure no-one works more than their contracted hours. This is not 'on-call' working in the traditional sense, ie where midwives work hours additional to their set hours.

5.	**Step 5: Action Plan**
	It is the responsibility of the division to create and update the workforce action plan. This workforce plan will be subject to quarterly review at MAC.
	The purpose of the Workforce Plan will be to highlight the workforce risks and how these are being controlled, mitigated and managed. To include: ▪ Recruitment or retention difficulties including supply ▪ Development needs including specialist development ▪ Vulnerability of or lack of relevant development available ▪ Lack of available finance or short term funding ▪ Turnover of a particular workforce group or lack of turnover to allow opportunities for redesign ▪ Impact of change on staff morale and motivation ▪ Competition from other industries ▪ Issues relating to succession planning ▪ Ageing workforce and retirement plans
	The Workforce Planning Action Plan which describes the key actions required to implement the workforce plan. Any service should have up to six high level actions to implement their Workforce Plan and will include the specific work required to implement any change or redesign work they have agreed for their service.