Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 14 July 2022

ADDENDA

12. Actions and Recommendations Tracker (Pages 1 - 20)

Attached are two documents on Maternity Services that were embedded in the Actions and Recommendations Tracker but were not possible to see.

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Oxford University Hospitals
NHS Foundation Trust

Briefing Paper on Maternity CQC action plan April 2022

Maternity Services received the Care Quality Commission (CQC) report on the 2nd of September 2021. Below you may see the "MUST" and the "SHOULD" do actions required of the Trust. An action plan was developed and has been shared with the board and governors.

MUSTS

Action the trust MUST take is necessary to comply with its legal obligations

1. The service must ensure there is a process to ensure the prevention and detection of the spread of infection in all areas (Regulation 12 (1)(2)(h).
2. The service must ensure women are allocated a lead professional at their first booking appointment (Regulation 12 (2) (a)).
3. The service must ensure women are risk assessed at every appointment during their pregnancy and document that their risk has been reviewed (Regulation 12 (2) (a)).
4. The service must ensure women are routinely asked about the risk of domestic abuse throughout their pregnancy (Regulation 12 (2) (a)).
5. The service must ensure they always use systems and processes to record and store medicines safely and in line with the provider's medicine policy (Regulation 12 (2)(g))
6. The service must ensure policies and guidance are reviewed in a timely manner. (Regulation 12 (2) (b)). Maternity 20 John Radcliffe Hospital Inspection report
7. The service must ensure they have a process to ensure they have oversight of transfer times from all community settings (Regulation 17 (2)(a) (b)).
8. The service must ensure they have a regular audit mechanism to demonstrate compliance with standards and procedures and to monitor improvement (Regulation 17 (2)(a) (b)).
9. The service must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. (Regulation 12 (1)(2i)).

SHOULDS

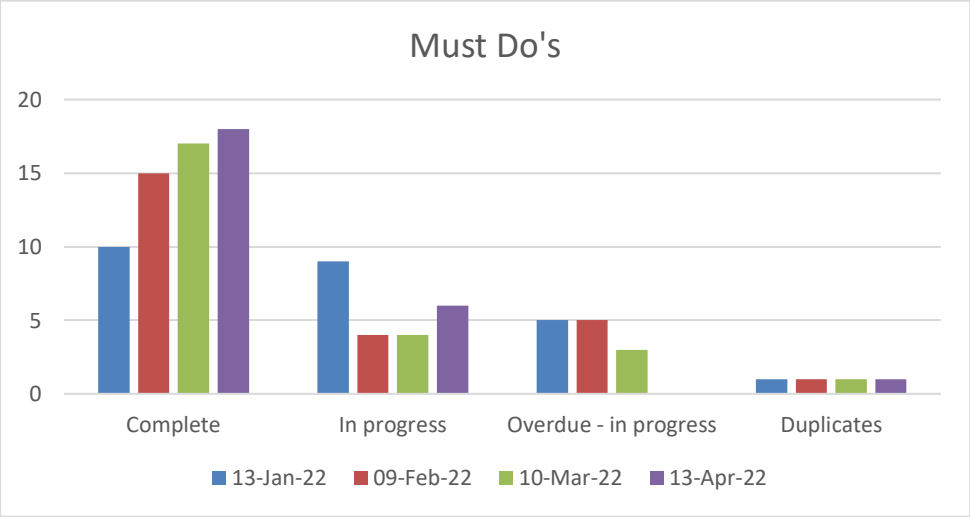
Action the trust SHOULD take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services;

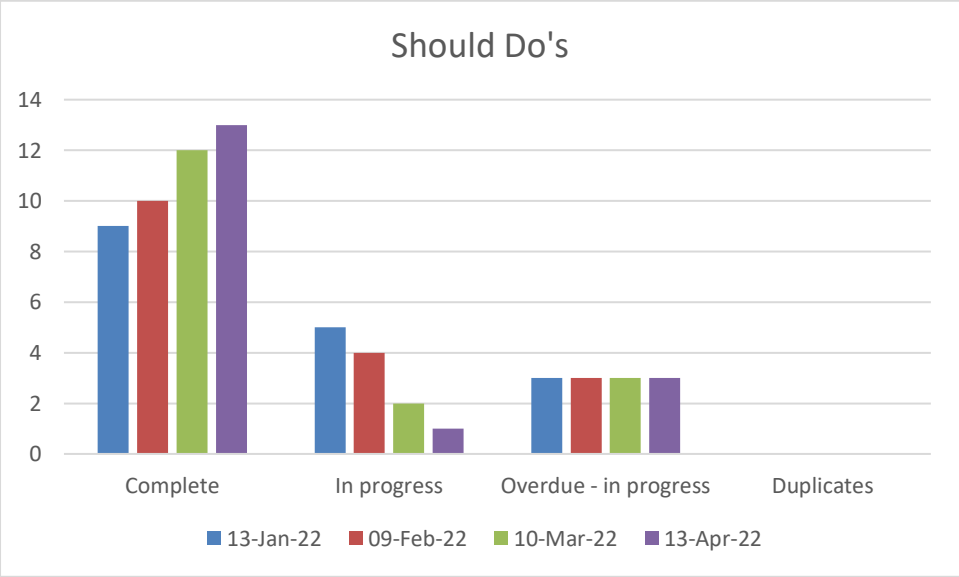
1. The service should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
2. The service should consider the environment to ensure women and their families are always treated with respect and dignity.
3. The service should ensure there is a dedicated room on labour ward for women and families who have experienced a bereavement. They should consider this environment to meet their needs.

4. The service should ensure their training in emergency procedures is effective, and all staff understand how to support an emergency evacuation from a birthing pool, when there are less than five staff available.
5. The service should consider including baby abduction as part of their regular skills and drills.
6. The service should ensure all staff are aware when services and maintenance work has been undertaken or is due.
7. The service should consider displaying safety information.
8. The service should scrutinize information around ethnicity and use it to inform decision around service development and in monitoring performance.

April 2022

The 17 overarching actions comprise 49 discrete actions (including one duplicate). The current position is as follows may be seen in the graph and tables below. Appendix 1 provides an update on the actions by exception that are either overdue or have changed.





Must Do	13-Jan-22	09-Feb-22	10-Mar-22	13-Apr-22
Complete	10	15	17	18
In progress	9	4	4	6
Overdue - in progress	5	5	3	0
Duplicates	1	1	1	1

Should Do	13-Jan-22	09-Feb-22	10-Mar-22	13-Apr-22
Complete	9	10	12	13
In progress	5	4	2	1
Overdue - in progress	3	3	3	3
Duplicates				

Must or Should do (Comms)	13-Jan-22	09-Feb-22	10-Mar-22	13-Apr-22
Complete	7	7	7	7
Incomplete	0	0	0	0
Duplicates	0	0	0	0

Appendix 1 Exception report

Must Do	CQC concern	Actions	Update
2.	The service must ensure women are allocated a lead professional at their first booking appointment	2.2 Refresh Antenatal Guideline to ensure that the requirement for the lead professional needs to be recorded at first booking appointment and each visit to the service in maternal handheld notes is explicitly stated.	Discussed at the Maternity Clinical Governance Committee (MCGC) on the 28/03/2022 and due to clinical workload, it was agreed that we would reprofile the end date for this to be approved by to the 31/05/2022. The author has updated the guideline and it is currently out for consultation. It is expected to go the Document Review Group (DRG) in May 2022 then will be ratified at MCGC.
3.	The service must ensure women are risk assessed at every appointment during their pregnancy and document that their risk has been reviewed	3.2 Refresh antenatal guideline to ensure that the requirement for professionals to record risk assessments at first booking appointment and each visit to the service in maternal handheld notes is explicitly stated in accordance with recently published NICE Antenatal Clinical Guidance NG201	
5.	The service must ensure they always use systems and processes to record and store medicines safely and in line with the provider's medicine policy / PGD	5.5 Records of completion of all staff who have completed Patient Group Directions (PGD's) competencies to be recorded and held centrally. This record will be accessible to all local managers, who may filter by existing staff on rotation at any given point in time	This was due to be completed by the 31/03/2022. Date reprofiled at MCGC on the 28/03/2022 to the 01/05/2022. The full completion of PGD training package is currently at 20%. There is more compliance in completion of staff of the quiz but the sign off of the package by managers is affecting the completion percentage. This is due to staffing and clinical priorities. The Practice Development team are assisting with this in some cases. Reminder emails to individuals have been sent out.
9.	The service must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged	9.1 Deliver and evaluate Maternity staff leadership away day	Seven members of the senior team attended a two-day course on Legitimate Leadership on the 30th and 31st March 2022 (3 band 8A's and 4 band 7's).

	and encouraged to collaborate in improving the quality of care.	9.3 Undertaken specific tailored programme of work facilitated by external provider commissioned by the Trust to support and develop improvement in culture.	Update given at MCGC on the 28/03/2022 The commission of Ibex Gale to audit the culture was clarified as complete. The report is outstanding and will be reviewed by DOM, CD and Safety Champion prior to a decision regarding the circulation of its findings and recommendations.
Should Do	**CQC concern**	**Action s**	**Update**
11	The service should consider the environment to ensure women and their families are always treated with respect and dignity.	11.2 Privacy curtains will be in place in all relevant clinical areas. Compliance will be audited via scheduled matrons walk round and documented via the MyAssurance app	Nine rooms on Delivery Suite (DS) required additional privacy curtains to be put up in rooms so that both doors have a privacy curtain. In the previous report five had been updated and there were four outstanding. Update given at MCGC on the 28/03/2022 – these have all been completed.
		11.3 Sliding signs for all doors to rooms in which patients receive care will have sliding room in use/room vacant signs on them. Maternity team to liaise with procurement and estates to facilitate this action	These were delivered however they all said "Meeting Room" on them which is not what the department ordered. There was a delay with the company collecting them and they have been returned on the 7th March 2022 – awaiting the new signs. Outstanding action.
12	The service should ensure there is a dedicated room on labour ward for women and families who have experienced a bereavement. They should consider this environment to meet their needs.	12.4 Business plan to be developed and approved to enable two existing birthing rooms on the periphery of the delivery suite footprint to be converted into a bespoke bereavement suite, optimising the rebirth environment for women and their families.	OSM met with DS manager, Bereavement midwife and capital programme manager in January. The bereavement room on DS (room 16) has potential to improve soundproofing by adding an additional internal door, for which the OSM has put a new works request in. He has also recommended a redecoration in line with bereavement requirements.

			The only way to improve the women's experience on OA would be to build new capacity. Maternity has proposed a scoping exercise/feasibility study via capital prioritisation programme for 2022/23 for complete refurb/rebuild of Women's centre and to include the bereavement facilities.
16	The service should consider displaying safety information.	16.3 Consider examples of good practice Trustwide to standardise the metrics displayed for consistent messaging to staff and service users rotating through different practice areas.	This was due by the 31/03/2022. Work has commenced on it, but further update required to look at this.

Appendix 2 CQC Action Plan

CQC action plan -Maternity update A

Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 09 March 2022

TB2022.024

Title:	**Maternity Safe Staffing for Quarter 1 and Quarter 2 of 2021/22**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee 28/02/2022**
	Regular Reporting

Board Lead:	**Chief Nursing Officer**
Author:	**Beatrice Culligan, Deputy Head of Midwifery – Acute & Tertiary**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This is the first bi-annual report for 2021/22 which reviews Safe Staffing levels Quarter 1 and Quarter 2.

The aim of this report is to provide assurance of an effective system of midwifery workforce planning.

2. The report provides assurance of the following:

a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b	The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c	All women in active labour receive one-to-one midwifery care
d	Submission of a midwifery staffing oversight report that covers staffing/safety issues to the board every 6 months during the incentive scheme year four reporting period

Recommendations

3. The Trust Board is asked to note the results of this paper.

Contents

Maternity Safe Staffing for Quarter 1 and Quarter 2 of 2021/22

1. Purpose

1.1. The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from April 2021 to September 2021. This is a requirement of the NHSLA Maternity Incentive Scheme for Safety Action 5.

2. Background

2.1. The NHSLA Maternity Incentive Scheme requires that OUH FT demonstrates an effective system of midwifery workforce planning to the required standard. This report will demonstrate that:

a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b	The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c	All women in active labour receive one-to-one midwifery care
d	There is a bi-annual oversight report that covers staffing/safety issues to the Board.

3. Evidence update

3.1. A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been calculated.

Following the systematic evidence-based process of BirthRate Plus® tool in 2018, a business case was submitted which resulted in an agreement for an additional 2.8wte midwives at band 6. Further increases to establishments have occurred since 2018 as a result of; the move from 20 to 23% uplift for inpatient areas, the Lotus Team, the Bereavement midwife, the Perinatal Mortality review Midwife, the trainee Consultant midwife post (this was linked to the maternal request caesarean sections), the Fetal Monitoring Specialist Midwife, the Continuity Midwife, the Diabetes Specialist Midwife and Obstetric nurses.

Maternity is currently in the process of refreshing the BirthRate Plus analysis and will report the findings in the next paper.

3.2 Details of planned versus actual midwifery staffing levels – to include evidence of mitigation/escalation for managing a shortfall in staffing.

The midwifery staffing levels are reviewed a minimum of twice a week, to check planned staffing against the agreed establishment for each clinical area. In the day the 1570 Maternity Operational Bleep Holder works with the multi-disciplinary team to ensure that when there is staff sickness, staff vacancies or an increase in demand within the maternity service, midwifery and support staff are moved to areas that require additional support, ensuring that whenever possible women in labour have 1:1 midwifery care. At night the 2nd Band 7

supporting the Delivery Suite Coordinator will carry the 1570 bleep and will work in partnership with the Midwifery Manager on-call to ensure that women in labour have, where possible, 1:1 midwifery care. There is a robust staffing and escalation policy in place. Furthermore, to highlight and address any staffing shortfall, the Maternity Operational Bleep Holder leads multidisciplinary Safety Huddles (see appendix 1) which review actual midwifery staffing versus acuity levels.

The RAG rating agreed at the morning Safety Huddle is reported to the Trust SafeCare meeting once a day via dial-in and is updated via email if it changes. There is a robust escalation policy with agreed action pathways to be taken for each rating.

The table below shows the RAG rating for actual midwifery staffing levels for April through to September 2021. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that particular day.

	RAG Rating		
	GREEN	AMBER	RED
April 2021	17	13	0
May 2021	27	4	0
June 2021	20	10	0
July 2021	23	8	0
August 2021	9	22	0
September 2021	0	30	0

Actions were taken as per Staffing and Escalation Policy to militate against any RAG rating of Amber. This included “staff movement between areas” and “supernumerary workers within numbers” as reflected in the Red Flags reported, (see appendix 4) as well addressing staff shortfall by using on-call staff and sourcing additional staff. Please note that maternity was in local contingency planning from 8pm on Thursday the 26th of August which meant that two of the freestanding Midwifery Led Units were closed to intrapartum care as well as the Co-located Midwifery Unit being closed to inpatient and bereavement care. This accounts for 5 of the August amber RAG declarations as well as amber RAG rating for the entirety of September.

3.3 An action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken. Where deficits in staffing levels have

been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls

An updated action plan can be found in Appendix 2. The Maternity Directorate continues to actively recruit new staff. The table below shows the number of new starters (in wte) balanced against the numbers of leavers. Following the recent establishment review of staffing levels, staffing establishments have been adjusted to reflect the outcome of this process.

In Q1 and Q2 this period we have recruited 24.65wte. In the same period there were 24.83wte leavers. This is not reflective of the number of new starters the maternity service recruit as recruitment is occurs predominately September to November each year.

Midwives	April-21	May-21	June-21	July-21	Aug-21	Sept-21	Total
New starters	1.46	3.84	1.59	1.6	1.8	14.36	24.65
Leavers	0	6.31	2.52	1	7.16	5.64	24.83

3.4 The midwife: birth ratio

The table below shows the midwife: birth ratio in the period covered by this paper.

	April-21	May-21	June-21	July-21	Aug-21	Sept-21
Midwife to birth ratio	1:26.99	1:24.07	1:26.34	1:30.18	1:29.29	1:29.29
	Quarter 1 average 1:25.80			Quarter 2 average 1:29.59		

The midwife to birth staffing ratio for Q1 averaged 1:25.80 and Quarter 2 averaged 1:29.59. This is reflective of the higher number of mothers birthed over the summer months. The midwife to birth ratio is monitored monthly on the maternity dashboard and reported at the monthly MCGC meeting.

3.5 The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® accounts for 8-10% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The 2018 BirthRate Plus® report recommended that management or specialist midwife roles should not be included in the clinical numbers. The report suggested that within OUH management and specialist roles should account for 9% of the establishment.

We continue to review maternity services to ensure the appropriate level of manager and specialist midwives are not included in the midwifery numbers, however during the COVID-19 period a number of manager and specialist midwives were required and continue to work clinically to support safe care provision.

In Q1 and Q2 the number of management and specialist midwife roles in post accounted for 7.94% of the workforce.

A consultation was planned in Q2 to increase our Fetal and Maternal Medicine midwifery team band 7 specialist midwives by 2 wte while maintaining the overall establishment within the department. This would result in 1 additional wte band 7 specialist midwife for maternal medicine and 1 wte additional band 7 specialist midwife for fetal medicine. This would support both the learning and development of staff within our tertiary level service and support succession planning to stabilise the future workforce.

The BirthRate Plus re-fresh will provide up to date calculations for us to review against our establishment.

3.6 Evidence from an acuity tool (which may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation/escalation to cover any shortfalls

The twice daily Safety Huddle (see appendix 1) monitors, among other things, the provision of 1:1 care in labour and the supernumerary status of the Delivery Suite Co-ordinator. If there is an occasion when 1:1 care in labour is in jeopardy and/or the Delivery Suite Co-ordinator does not have supernumerary status this is promptly escalated to the Maternity Operational 1570 Bleep Holder. Mitigating action is then taken to address the issue and the corresponding Red Flag is uploaded to the electronic Health Roster System as appropriate. This data is also reviewed at the Maternity Clinical Governance monthly meeting.

In this data period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status.

3.7 Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

The agreed staffing Red Flags are listed in appendix 3.

The Red Flag incidents for the Q1 and Q2 have been outlined in appendix 4.

Q2 saw a peak in birth activity. This is reflected in an increase in Red Flags; evidencing implementation of mitigations (such as the movement of maternity staff between the clinical areas) to allow all areas to remain open and to ensure women's choice in place of birth is facilitated.

The Maternity Operational Bleep Holder and area co-ordinators continue to focus each day on ensuring staff are able to take breaks and leave on time.

It should be noted that the Red Flags for staffing includes 'Supernumerary workers within the numbers'; this includes staff who are supernumerary in one clinical area being moved to cover a staffing shortfall in another clinical area where they are able to be counted within the numbers. It also includes staff working in offices or on study leave who are relocated to work within the numbers. The data therefore shows a number of occasions where this has flagged but please note that it does not indicate that the Delivery Suite Coordinator had stopped being supernumerary, as described above.

To militate against any shortfall in staffing over summer period, the 'Flexible Midwifery Pool Scheme' continued to focus on night and weekend shifts. The pool provides staff incentives by paying an enhanced rate to work with the NHSP Bank. The table below shows the total number of on call hours used across Q1 and Q2. The significant spike in on call hours used throughout July, August and September is indicative of the consistent pressure on maternity services throughout those months and the escalation and mitigations put in place to ensure 1:1 care in labour and the maintenance of the supernumerary status of the delivery suite co-ordinator was protected.

	April-21	May-21	June-21	July-21	Aug-21	Sept-21
On call hours	38	64	65.5	252	158	283

4. Assurance

The evidence described in this paper provides assurance that there is an effective system of workforce planning to ensure safe staffing levels.

5. Recommendation

The Trust Board are asked to note the results of this report.

6. Appendix 1 – Safety Huddle

The Safety Huddle is a multidisciplinary meeting held twice a day, one at 09:00 and one at 16:00 hours. Members of the Maternity Safety Huddle include:

- Maternity Operational Bleep Holder
- Delivery Suite co-ordinator
- Duty Consultant Obstetrician
- Duty Consultant Anaesthetist
- Neonatal Unit Duty Sister (this was introduced in April 2021 to improve communication)
- Midwifery Manager on-call (may represent via telephone)
- Director of Midwifery
- Clinical Midwifery Managers for each area (or deputy)

Using the RAG rating system of Red, Amber or Green the safety huddle members will assess the unit's workload, staffing and acuity and declare Maternity's RAG status as follows:

- **Green** signifies that the maternity service has available beds and appropriate staffing levels for the workload
- **Amber** signifies the maternity service is at the upper limits of bed capacity, staffing or activity
- **Red** signifies that there are no available beds or all available staff are committed to labour care. The service cannot guarantee 1:1 midwifery care in labour or safe staffing in other areas of the service.

7. Appendix 2 – Action Plan for BirthRate Plus 2021/2022.

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Monitor the midwifery establishment in line with BirthRate Plus	2022 Re-fresh of BirthRate Plus	Director of Midwifery	April 2022	Evidence collated for 12 month period due for submission for analysis by BirthRate Plus Team March 2022	Ongoing
	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus.	Leadership Team	December 2020	Completed tools for all clinical areas with evidence of adjusted staffing.	Complete Rolling
	To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting.	Leadership Team	Rolling programme	Minutes of monthly MCGC meeting with up-to-date dashboards.	Rolling
	To annually review the recruitment and retention plan.	Leadership Team	Rolling programme	Recruitment and retention plan for 2020/2021	

8. Appendix 3 - Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015)

The agreed staffing red flags were approved and ratified in 2017

- (All Areas) Staff moved between specialty areas
- (All Areas) Supernumerary workers within the numbers
- (All Areas) Administrative or Support staff unavailable
- (All Areas) Staff unable to take recommended meal breaks
- (All Areas) Staff working over their scheduled finish time
- (All Areas) Delays in answering call bells
- (All Areas) Delay of more than 30 minutes in providing pain relief
- (All Areas) Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan
- (All areas) Beds not open to fully funded number - state number not staffed and reason
- (All areas) Elective activity or tertiary emergency referrals declined

- (Maternity Only) Delay of 30 minutes or more between presentation and triage
- (Maternity Only) Full clinical examination not carried out when presenting in labour
- (Maternity Only) Delay of 2 hours or more between admission for induction and beginning of process
- (Maternity Only) Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.
- (Maternity Only) The Midwifery Labour Ward Coordinator has supernumerary status.

9. Appendix 4 Maternity Staffing Red Flags uploaded onto Trust system October to December 2020

Red Flags for all areas	April-21	May-21	June-21	July-21	Aug-21	Sept-21
Staff moved between specialty areas	69	35	26	90	77	81
Supernumerary workers within the numbers	2	8	2	22	23	13
Administrative or Support staff unavailable	0	0	0	0	0	0
Staff unable to take recommended meal breaks	0	0	1	4	3	1
Staff working over their scheduled finish time	11	4	1	7	1	2
Delays in answering call bells	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0	0	0	0
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan	0	0	0	0	0	0
Beds not open to fully funded number - state number not staffed and reason	0	0	0	0	11	60
Elective activity or tertiary emergency referrals declined	0	0	0	0	0	0
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	1
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	21	7	14	41	38	35
Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour	0	0	0	0	0	0

10. Conclusion

10.1. The evidence described in this paper provides assurance that there is an effective system of workforce planning to ensure safe staffing levels.

11. Recommendations

11.1. The Trust Board is asked to note the results of this paper.