Brighton and Sussex University Hospitals NHS Trust

Maternity Services Staffing: Midwifery, nursing and support staff for all care settings

Maternity Document: MD086
Date agreed: January 2016

As discussed at previous audit and safety meetings as part of the review of guidelines following the review of women's services governance Julie Wade was attached to the governance team to undertake some guideline reviews. At the back of the guidelines Julie has attached a clear summary of her review. These guidelines will be circulated on a daily basis for your comments. Whilst is acknowledged that in an ideal world only a few guidelines would be sent out for comments however unfortunately as we need to get all our guidelines in date and be safe and fit for purpose we do not have that luxury. Further it also recognised that Julie is a midwife and some of these guidelines are obstetric focused. We are very grateful for everyone's support in taking our guidelines forward.

Guideline Reviewer:	Julie Wade
Version:	2.3
Approval Committee:	Women's Services Safety and Quality Committee
Date agreed:	January 2016
Review date:	January 2019
Cross reference:	**HR032** Annual Leave Policy **HR013** Managing Sickness Absence Policy **HR030** Parent Leave Policy **MP058** Escalation Protocol Management Structure Consultation Paper

Contents

Introduction

This document provides a description of:

1. Midwifery and support staffing arrangements within the BSUH (Brighton and Sussex University Hospitals) Maternity Department;
2. The policies and procedures in the Department for addressing short, medium and long-term issues with medical cover; and
3. The process for reviewing longer-term medical staffing needs and future staffing plans for the obstetric anaesthetic Department.

This will help inform future business cases for further investment, provide annual evidence to the Trust Board

Maternity services are currently provided on two sites; Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH). The service also supports homebirths and community services.

The document will act as an information document for the purpose of evidence for CNST (Clinical Negligence Scheme for Trusts)

Section One - Existing Staff Capacity

1.0 Midwifery and Support Staffing

1.1 The Associate Chief Nurse Women & Children / Head of Midwifery has overall responsibility for ensuring a safe service with appropriate staffing levels are maintained at all times.

1.2 Currently there is a 8 week rota within the maternity units. All staff groups work predominately long days however a few continue to work early shifts and late shifts.

1.3 Shift patterns for maternity services

Long day	07:30 to 20:00
Night	19.30 to 08.00
Early shift	07:30 to 13.50
Late shift	12:30 to 20:00

1.4 Community Staff shift patterns

Community staff work day shifts only, with a variety of start times dependant on their allocated work for the day which is indicated on the rota in advance. There are also two homebirth midwives who will be on duty for a long day or night shift and will be

Midwifery, nursing and support staff for all care settings (RSCH PRH only)

available for homebirths. If they are not needed for any homebirths they will continue with community work or help out on the unit as needed during their shift.

1.5 Midwives are supported by the practice development team to meet their competencies from a band 5 to 6 with many completing within a year of qualifying. All staff are supported to achieve their mandatory training requirements through a rolling programme lead by the practice development team.

1.6 The units are staffed as a whole and midwives and support staff work flexibly across the care settings according to where the activity is. This means templates are worked out to cover the main care settings (see below). The labour ward co-ordinators will consider the clinical requirements and allocate staff to clinical areas as required on a shift by shift basis. This is also reviewed as required during the shift. A minimum of 2 midwives with support staff would be left on the antenatal/ postnatal ward.

1.7 Midwifery Nursing, support staff groups utilised by the maternity services in each care setting

Royal Sussex County Hospital – Brighton

1.7.1 Care settings at RSCH:

- Labour ward, level 13: 6 en-suite and 1 non en-suite birthing rooms, 1 obstetric theatre, 1 emergency theatre, 2 bed recovery area, 1 high risk en-suite birthing room, 2 bed assessment room, 1 pool room on the ward and 2 pool rooms off the ward.
- Triage: a 2 room area for predominantly early labour assessment
- Level 12 (postnatal and antenatal): 22 postnatal beds, 7 antenatal beds
- Antenatal clinic: a 7 room area with Ultrasound facilities and waiting room
- Day assessment unit: a 2 bed area with seating for phlebotomy, and waiting area

1.7.2 Management and staff groups:

The Maternity unit is managed by Midwifery Manager 8A and supported by a Labour Ward Lead (Level 13) and Midwifery ward manager (Level 12)

1.7.3 Labour ward, triage and Level 12

In addition there is a team of Band 7 Labour ward coordinators who work permanently on labour ward with a minimum of 1 per shift one to lead the shift and usually another Band 7 midwife to support more junior staff. The remaining midwives are band 5 or 6 with the majority being band 6.Triage is staffed from within this template with a Band 6 midwife and 1 maternity care assistant. Triage unit is open 24/7.

1.7.4 Antenatal Clinic and Day Assessment Unit (DAU)

The Antenatal clinic and Day Assessment Unit are managed by 1.4 WTE Band 7 midwives. The clinic and DAU midwives are supported by Maternity Care Assistants. Outpatient induction of labour is also undertaken in this area.

Princess Royal Hospital – Haywards Heath

1.7.5 Care settings at PRH:

- Labour ward (also called Central Delivery Suite): 8 birthing rooms (2 of which are pool rooms), 1 Obstetric Theatre, and 1 bereavement room (Willow room).
- Bolney Ward (postnatal, antenatal and triage): 18 beds in 3 bays (6 beds in each bay) and 7 side rooms (2 have bathrooms)
- Triage: 3 beds and 2 chair recliners for monitoring
- ANC: 6 clinical rooms and 3 offices of which 2 have ultrasound facilities. There is a waiting area and quiet area/screening room to discuss anomaly scans
- DAU: 1 bed and 2 chairs for monitoring. Also a waiting area

1.7.6 Management and staff groups:

The Maternity unit is managed by Midwifery Manager 8A (1WTE) and supported by a Labour Ward Lead (CDS) and Midwifery ward manager (Bolney)

1.7.7 Labour ward, triage and Bolney

In addition there is a team of Band 7 Labour ward coordinators who work permanently on labour ward one per shift. The remaining midwives are band 5 or 6 with the majority being band 6. Triage is staffed from within this template with a Band 6 midwife and 1 maternity care assistant. Triage unit is open 12 hours 7 days a week.

1.7.8 Antenatal Clinic and Day Assessment Unit (DAU)

The Antenatal clinic and Day Assessment Unit are managed by 0.6 WTE Band 7 midwife. The clinic and DAU midwives are supported by Maternity Care Assistants and Maternity support worker who assist with the Antenatal screening programme.

Community Teams (covers both PRH and RSCH)

1.7.9 The Community is managed by Community Matron Band 8a (0.8wte) for the whole maternity service and consists of 9 Teams: 6 in the Brighton area and 3 in the Princess Royal area;

Brighton & Hove area	Princess Royal Hospital area
East Team	North Team
West Team	

1.7.10 The Brighton teams are based in Children's Centres broadly linking with GP geographical areas. The Brighton teams have 3.2 WTE Band 7 as a team leader

1.7.11 The Hayward's Heath teams are geographically based linking with the GP's surgeries. The case loads are supported by the teams but average around 140 women per midwife. The Hayward's Heath teams are led by one Band 7 team leader.

1.7.12 The teams consist of Band 6 midwives. There are also Maternity Support Workers (Band3) who work with the community teams.

1.7.13 The community midwives cover a number of clinics and children's centres in the local area. One Midwife on each site is allocated to Home births during the day. The Team leaders are responsible for off duty, organising cover for clinics, parent education, team meetings. Many of the community midwives also work in the units to maintain their intrapartum skills, and there is a flexible programme available for Midwives who wish to do this.

1.7.14 There is 24 hour cover for Homebirths provided by two midwives on duty (one at each site) for each long day or night shift. If they are not needed for any homebirths they will continue with community work or help out on the unit as needed during their shift.

1.8 Specialist Midwives

The following staff provide specialist clinical care, skills, teaching and management for the whole of the maternity services and work both at RSCH and PRH:

1.8.1 Maternity Risk Midwife
1.8.2 Practice Development / Audit Lead
1.8.3 Clinical Skills Facilitators x2 WTE
1.8.4 Antenatal Screening Coordinator
1.8.5 Bereavement Lead
1.8.6 Teenage Pregnancy Midwife
1.8.7 Infant Feeding Specialist
1.8.8 Substance Misuse / Travellers / homeless

1.9 Supervisors of Midwives (SoM)

1.9.1 The supervisors of midwives provide a rota for 24/7 on-call which covers all of maternity services. The rotas and contact details are available via both labour wards.

1.9.2 The expected ratio of supervisors to midwives is 1:15. It is expected that 3 trainee supervisors who are supported annually to maintain ratio levels. (See *Appendix A* for list of current SoM's)

1.10 Manager's on-call

1.10.1 There is a manager on-call rota 24/7 which the 3 managers and Deputy Head of Midwifery support. The Associate Chief Nurse Women & Children / Head of Midwifery covers calls especially when the manager has been called out over night or in the event of sickness.

1.10.2 The Head of Midwifery is available to be contacted out of hours and will return calls / messages as soon as is able

1.11 Required staffing levels for each care setting

1.11.1 In maternity services it is recognised that intrapartum care is provided in diverse birth settings, at home, in midwifery units and acute hospitals. The planning for staffing and skill mix levels needs to reflect the local model of care, case mix, the needs of women, their families and service design.

1.11.2 The totality of midwifery care has an impact on and implications for antenatal, intrapartum and postnatal provision within the acute sector, as well as in primary care and community settings. The need for continuous care means that labour ward staffing requirements cannot be considered in isolation or separated from the total establishment of the maternity service. Equally, staffing of the labour ward must not be at the expense of other areas of the maternity services, such as community midwifery.

1.11.3 Using the methodology from *Safer Childbirth (RCOG 2007)* and Birthrate Plus the following workforce calculations have been made. This is based on the total births of 6009 for the period 1st April 2011 to 31st March 2012.

1.11.4 The latest formal commissioned Birthrate Plus review was completed in July 2009 and the Head of Midwifery has repeated this exercise for data collected for 2013. With colleagues an assessment of the case mix arising from the intrapartum episode using current birth statistics;

	Categories I-III	Categories IV - V
RSCH	56%	44%
PRH	58%	42%

Categories	Definition
I	Low risk women, home birth, birth centre, hospital, normal no intervention
II	Low risk women, home birth, birth centre, hospital, normal no intervention
III	Moderate degree of intervention; induction, fetal monitoring, instrumental birth, 3rd degree tear, pre term
IV	Higher risk / higher choice; normal birth with epidural for pain relief, El C/S, post birth complications
V	Highest risk; emergencies, Em C/S, multiple births, still births, sever pregnancy induced hypertension

1.12 Parameters of Care and Staffing Allowances included in the ratios

1.12.1 Community based staff; Home, Caseload and Community care for hospital births

17.5% Travel Time Allowance

1.12.2 Community care for hospital births

12 –15 hours for all antenatal and postnatal care including parent education depending upon the birth outcome and neonatal needs.

1.12.3 Home Births

All antenatal and postnatal care as above, plus an allowance of 17 hours for intrapartum care including second midwife present for the birth, and first follow up visit.

1.12.4 Hospital Ratios include the following:

Measured workload for antenatal outpatient activity including clinics and day units,

- All antenatal inpatient activity, plus ward attendees
- Postnatal care in hospital
- Neonatal examination of the newborn

1.13 Skill Mix Rationale

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

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

1.13.3 Overall the % of midwives to trained support staff is 90/10, so this split can be applied to the total clinical establishment as a means to estimate the contribution from non-midwives. However, this remains a local decision and is not a recommendation of Birthrate Plus®.

1.13.4 Units Leave allowance = 24%. This includes annual leave, an element of sick and study leave.

RSCH	**Ratio applied**		**No. of births/ episodes**	**WTE staffing**
Hospital births	1:	42	3421	81.45
Home births	1:	35	164	4.68
Traditional community	1:	96	3421	35.63
Total				**121.76 WTE**

PRH	**Ratio applied**		**No. of births/ episodes**	**WTE staffing**
Hospital births	1:	45	2361	52.46
Home births	1:	35	60	1.71
Traditional community	1:	96	2361	24.59
Total				**78.76 WTE**

1.14 Additional Roles

1.14.1 All maternity services require additional roles to manage and provide maternity services over and above clinical care. This includes senior midwifery management, governance, risk, practice development, antenatal screening coordinator, and specialist midwives. An element of these roles is included in clinical care.

1.14.2 Birthrate Plus and Royal College of Midwives recommends this should be 8% = 15 WTE. At BSUH non clinical roles = 6.88 WTE = 3.6%.

1.14.3 Birthrate Plus recommends an allowance of 1% for Supervision of Midwifery =2WTE

1.14.4 Summary

	ROYAL SUSSEX	PRINCESS ROYAL
BR+ Ratios WTE	121.76	78.76
TOTAL BR+ WTE	200.52	
TOTAL funded Midwife comparative WTE	165.4 (1.4.12)	
BR+ Additional WTE, Support staff 10% = 20 WTE	15.72 WTE = 9% (shared across Trust)	
TOTAL current Midwives & Support staff	**181.12**	
Difference between BR+ & current WTE	- 19.4 WTE Total (-15.12 Midwives) (- 4.28 Support staff)	
Overall ratio for ALL births as including hospital & home. (not as per BR+)	**29 births to 1 WTE**	**30 births to 1 WTE**

1.15 Required Staffing Levels

The required staffing levels for all midwifery, nursing and support staff for each of the care settings in BSUH NHS Trust maternity services: Calculated using Table 6 of Safer Childbirth and Birthrate Plus ratio (RCOG, 2007): 1st April 2012 to 31st March 2013.

Royal Sussex County Hospital

Maternity Unit Labour ward, Triage and Level 12 RSCH

1.15.1 Midwives (included in midwife to birth ratio)

75.13 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	12(+1)	12(+1)	12(+1)	12(+1)	12(+1)	12	12
Night	12	12	12	12	12	12	12

(+1 = theatre RGN on an early shift Monday to Friday)

1.15.2 Nursing and Support staff

Nursery Nurse (included in midwife to birth ratio)

5.37 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	1	1	1	1	1	1	1
Night	1	1	1	1	1	1	1

Maternity care assistants (not included in midwife to birth ratio)

16.1 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	4(+1)	4(+1)	4(+1)	4(+1)	4(+1)	4	4
Night	3	3	3	3	3	3	3

(+1 = theatre mca on an early shift Monday to Friday)

Maternity Unit Antenatal clinic and day unit RSCH

1.15.3 Midwives (included in midwife to birth ratio)

2.91 WTE	Mon	Tue	Wed	Thurs	Fri
Long day	1	1	1	1	1
8am-4pm	1	1	0	1	1

1.15.4 Nursing and Support staff (Maternity care assistants)

(not included in midwife to birth ratio)

3.75 WTE	Mon	Tue	Wed	Thurs	Fri
8am-4pm	3	3	3	3	3

Maternity Unit Labour ward, Bolney ward & triage PRH

1.15.5 Midwives (included in midwife to birth ratio)

44.85 c	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	9	9	9	9	9	9	9
Night	9	9	9	9	9	9	9

1.15.6 Nursing and Support staff

Nursery Nurse (included in midwife to birth ratio)

5.37 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	1	1	1	1	1	1	1
Night	1	1	1	1	1	1	1

Maternity care assistants (not included in midwife to birth ratio)

16.1 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Long day	3	3	3	3	3	3	3
Night	3	3	3	3	3	3	3

Maternity Unit Antenatal clinic and day unit PRH

1.15.7 Midwives (included in midwife to birth ratio)

3.0 WTE	Mon	Tue	Wed	Thurs	Fri
8am-4pm	3	2	2	2	3

1.15.8 Nursing and Support staff (Maternity care assistants)

(not included in midwife to birth ratio)

2.0 WTE	Mon	Tue	Wed	Thurs	Fri
8am-4pm	2	2	1	2	1

Community both PRH and RSCH

1.15.9 Midwives (included in midwife to birth ratio)

Midwifery, nursing and support staff for all care settings (RSCH PRH only)

59.0 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
9am -5pm	39	39	39	39	39	20	20

1.15.10 Nursing and Support staff (included in midwife to birth ratio)

5.2 WTE	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
9am -5pm	3	3	3	3	3	3	3

Section Two - Managing Short-Medium Term Midwifery, Nursing and Support Staffing Staff Issues

2.0 Short and Long Term Staffing Shortfalls / Unexpected Increased Workload and Contingency Planning

2.1 Process for identifying and addressing short-medium term midwifery, nursing and support staff staffing issues

2.1.1 Every Department will have staffing issues and unexpected increased workload from time to time and thus the Department should have a clear process for identifying and addressing short- medium staffing issues.

2.1.2 Overall responsibility for ensuring that there is appropriate Midwifery, nursing and support staff staffing rests with the Head of Midwifery

2.2 Planning rotas

2.2.1 Midwifery, nursing and support staff rotas are completed 6 weeks in advance on Rostapro and are approved by the Managers on each site. In community the rota is not done on Rostapro and the rota's are done by the community Team Leaders and approved by the community manager

2.2.2 At this point, any gaps in the rota are identified and a plan put in place for addressing them. Staffing arrangements are monitored monthly via the maternity dashboard and using the NPSA score card for 1 to 1 care in labour. These are reviewed at the midwifery management meeting monthly and bimonthly MSLC forums. Exceptions are reported to the Safety & Quality Committee and Chief Nurses Division quarterly reporting. The Associate Chief Nurse Women & Children meets monthly with the Chief Nurse and discusses staffing ratios.

2.2.3 On a day to day basis, the Labour ward leads, working in conjunction with the matrons on each site, manages the midwifery, nursing and support staff rota and are responsible for reviewing staffing provision, identifying any gaps in the rota and escalating these as appropriate (see below).

2.2.4 Where the gaps are due to problems in recruiting, these are escalated to the Head of Midwifery / Deputy Head of Midwifery who develop and agree a plan. This may involve taking an alternative approach to working patterns.

2.2.5 For the period until staff can be secured, the Department will look to cover this using existing staff and Bank staff (and very rarely agency nurses/Midwives to support).

2.3 Planned Leave

2.3.1 For all leave arrangements refer to *HR032 Annual Leave Policy*

2.3.2 Head of Midwifery and Deputy Head of Midwifery:
The Head of Midwifery's leave is approved by the Chief of Division; the Head of Midwifery approves the Deputy Head of Midwifery they endeavour to never be on leave at the same time. When either of them is on leave, they cover or cancel meetings as appropriate.

2.3.3 Specialist Midwives: all annual leave must be approved by the individual's line manager. Specialist midwives are expected to make their own contingency plans about covering work/ commitments in their absence (such as colleague cover) to ensure any specific work will still be covered and communicating this to the department and other relevant people.

2.3.4 Midwives (band 5, 6, and 7), RGN and MCA, MSW, Nursery Nurses: All annual leave requests should also be added by the individual to Rostapro. These will be reviewed by the designated Band 7 midwife on each site for approval. Any requests for leave over 2 weeks in length should be submitted to the Manager.

2.3.5 The number of staff allowed leave at any one time is decided by a formula that determines the minimal amount of staff available for clinical work, thus the number of staff allowed leave. No annual leave will be taken over to the next financial year. Staff are expected to take a quarter of their annual leave every quarter year.

2.4 Maternity / paternity leave

2.4.1 For all leave arrangements refer to *HR030 Parent Leave Policy*

2.4.2 When staff are on maternity leave the staffing shortfall is addressed by:

- Deputy Head of Midwifery will lead on prospectively identifying when leave will be taken on a rolling basis
- Contacting HR and agree external adverts for short term contracts to cover 60% of the hours of the staff member on leave
- Following recruitment staff on short term contacts will cover the length of the expected maternity leave

2.5 Short term leave / absence / sickness / unplanned increased workload

2.5.1 For all leave arrangements refer to *HR013 Managing Sickness Absence Policy and Procedure*

2.5.2 Head of Midwifery and Deputy Head of Midwifery:
The HOM would contact the Chief and DHOM and the Deputy would contact the HOM to advise of the short term sickness leave or unplanned increased workload. Contingency and cover arrangements would be made.

2.5.3 Specialist Midwives: Specialist midwives are expected to contact the LW coordinator to inform them about short term sickness / absence as per policy. The LW coordinators must escalate this to line managers / matrons who will make own contingency plans about covering work/ commitments (such as

colleague cover) to ensure any specific work will still be covered and communicating this to the department and other relevant people.

2.5.4 Midwives (band 5, 6, 7) MCA, MSW, Nursery Nurses: When staff are on short term leave the staffing shortfall is addressed by:

1. Labour ward coordinator (will support from the operational management team) will review the staffing and consider amending the rota to address the shortfall (e.g. asking staff to change shifts)
2. If unsuccessful the LW coordinator will contact the Bank office and ask for Bank staff to cover the work required.
3. If unsuccessful the LW coordinator will instigate the *MP058 Escalation Protocol*

2.6 For cases of unplanned increased workload the LW coordinator should attempt to find staffing cover within the existing pool of staff (e.g. ask staff from another ward / area to cover) and refer to the processes set out in the escalation protocol.

Section Three - Future Staffing Requirements / Ongoing Staffing Shortfalls

3.0 Process for Annual Review of Midwifery, Nursing and Support Staffing in all Care Settings within the Maternity Service

3.1 Annual review:

An annual review of the midwifery, nursing and support staffing levels in maternity service will be undertaken to establish whether they are in line with the recommendations in *Safer Childbirth* (RCOG, 2007)
This will be led by the Head of Midwifery. The timing of this review will coincide with budget setting, the commissioning timetable and taking into account any new national requirements (NICE guidance, Royal College recommendations etc.). Staffing levels are compared with current and anticipated activity levels and expected changes in service which may impact on staffing. The process of how and when this audit occurs is set out in *Section 4.1*

3.2 For Midwifery, nursing and support staff, this process will be led by the Head of Midwifery who should consult with and involve other members of the Midwifery Management team and Supervisors of Midwives. The results of this staffing review will be presented by the Head of Midwifery at the Women's Safety Quality Committee (WSQC) meeting. The department should consider whether it has the ability to address the issues through departmental efficiencies / working differently / review of resource allocation

3.3 Should the Department conclude that it has insufficient resources (or does not have the ability to make the changes required) to deliver the quality and level of care that is required as informed by the annual review, the management team should first consider whether funding for additional resources can be found within the specialty's budget through efficiencies/working differently.

3.4 If this is not possible, the Head of Midwifery will present the annual review results to the Divisional Management Team at the Women's and Children's Divisional meeting. The Women's and Children's Division should consider whether it has the ability to address the issues through divisional efficiencies / working differently / review of resource allocation

3.5 **Business case (plan):** If this is not possible, an allocated appropriate member of staff will prepare a business case, which reflects the results of the annual review. There is a standard Trust Business Case template. The template requires Departments to consider all of the possible options, the impact of these on other teams within the hospital, the revenue and capital implications of each option and the risks associated with options and how these might be managed.

3.6 Once completed, the business case is submitted to the Divisional Management Team (Chief, General Manager and Divisional Finance Manager) who will review the case and determine whether the Division is willing to support it. If they are, the Divisional Management Team may decide to provide funding from Divisional funds. If the funds are not available within the Division, the Business Case will be submitted to the Trust Executive Team for consideration (via Internal Prioritisation Group). Before being submitted to the Trust Executive Team, the business case must be signed off by the Divisional Finance Manager, Divisional Director and the Director of Estates.

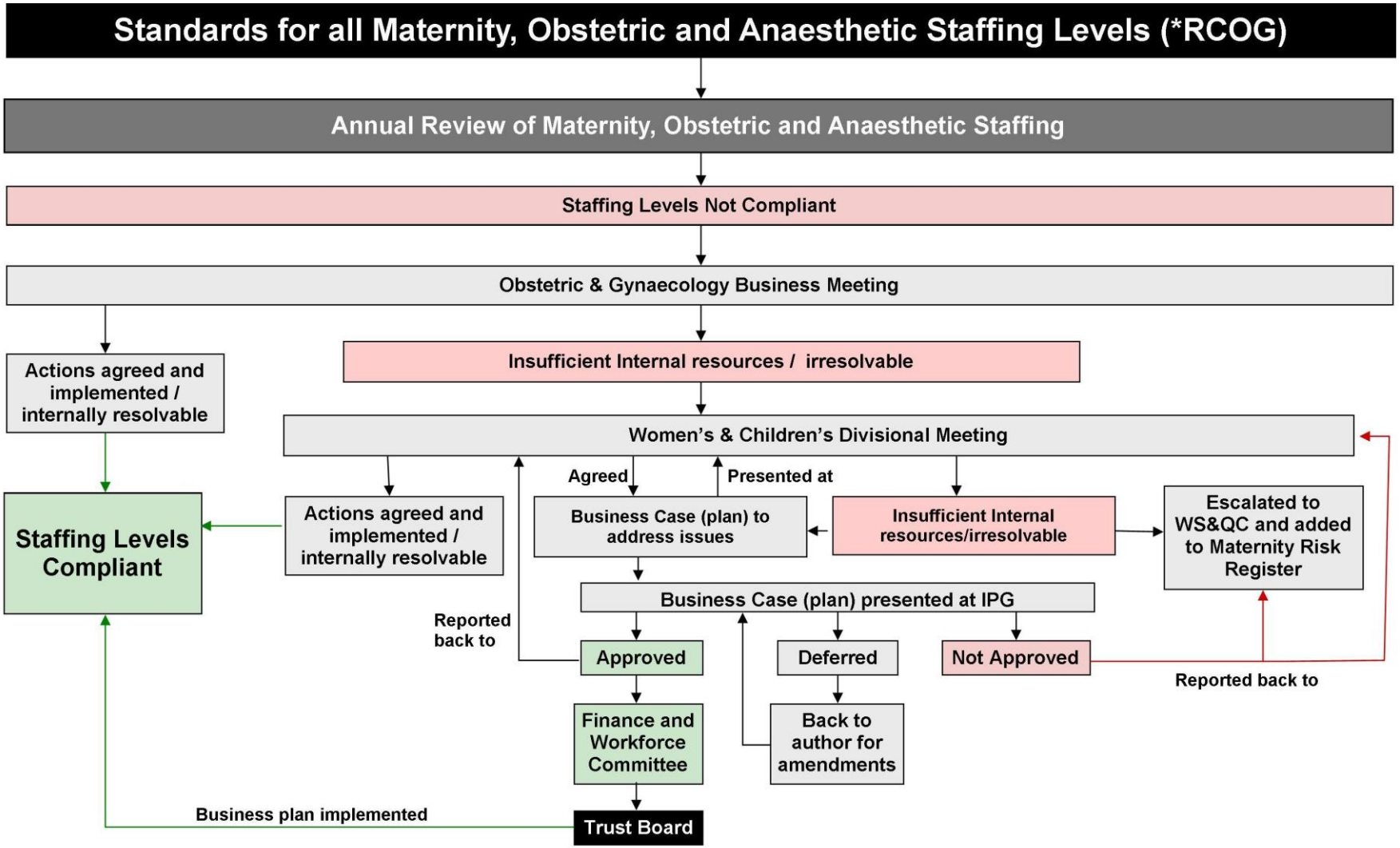
3.7 The staffing issue/s identified which cannot be resolved at divisional level will also be reported to the Maternity Risk Manager and entered onto the Trust Risk Register (Women's and Children's Division section). The issue will remain on the Risk Register, monitored by the Trust Safety and Quality Committee and the Women's Safety and Quality Committee meeting, until resolved

3.8 **Process for monitoring progression of business plan and contingency plan (and review of action plan)**. The progress of the business plan will be reported back to the department by the Chief of Women and Children at the Women's and Children's Divisional meetings as a standing item until closed. The results of the business plan will be reviewed by the Chief of Women and Children and presented at the Women's and Children's Divisional meetings. Any actions plans arising from the business plan will be monitored at the Women's and Children's Divisional meeting.

3.9 Once the business case has been submitted and all processes followed, should funding be denied, the business case will remain with the Board (and on the Trust Risk Register) and be their responsibility.

3.10 **Review and escalation process for addressing long term/ongoing staffing shortfalls in Maternity services**

Brighton and Sussex University Hospitals NHS Trust



4.0 Monitoring Compliance

For details on how audit is undertaken, results reviewed and how action plans are monitored see the *Monitoring Compliance* document

4.1 Minimum Auditable Standards:

4.1.1 the Midwifery, nursing and support staff utilised by the maternity services in all care settings

4.1.2 required staffing levels for Midwifery, nursing and support staff utilised by the maternity services in all care settings as set out in section 1.11 (against standards for *Safer Childbirth* RCOG)

4.1.3 the implementation of contingency plans to address ongoing shortfalls and short term staffing shortfalls (e.g. sickness or increased workload)

4.1.4 if in place, the monitoring of the business plan and action plans from this that reflects the annual review

Type	Annual Audit / or more frequently as indicated
Who	Head of Midwifery / Deputy Head of Midwifery
Lead	Head of Midwifery
How	1. a list of current Midwifery, nursing and support staff utilised by the maternity services in all care settings obtained from the rota (from rostapro) and from Human Resources department 2. a review of the rota from the previous 12 months (this will be 6 separate weeks taken from a 12 months period) comparing actual staffing levels with the standards set out in section 1.11 (or similar pattern with different time period) 3. identify cases from the rota from the previous 12 months of long term and short term absence and show evidence, from the rota and correspondence, where the contingencies as set out in section 2 were followed 4. a review of the Maternity risk register from the previous 12 months and the minutes of the Women's and Children's Divisional meeting and WSQC meeting , with any action plans relating to the business case
Frequency	Overall results presented annually
Presented to	W&C divisional meeting
Monitoring of action plan by	Head of Midwifery
Completion/ exception reported to	W&C divisional meeting

5.0 References

Birthrate Plus 2009 Evidence based ratios fro Midwifery Workforce Planning. Birthrate Plus.

Royal College of Obstetrics and Gynaecology. 2007. Safer Childbirth: minimum Standards for the Organisation and Delivery of Care in Labour. RCOG press, London.

Appendix A - Current supervisors of midwives;

Julia Banks	Community Team Leader
John Bell	Lead Research Midwife/LW Coordinator
Helen Smith	LW Coordinator
Claire Bradley	Clinical Skills Facilitator
Jane Cleary	Clinical Skills Facilitator
Dawn Elson	Matron RSCH
Debi Fillery	Nurse Consultant for Safeguarding children and young people
Lisa Jury	Community Midwife
Mags Rathbone	Community Midwife
Julie Sinden-Edwards	LW Coordinator
Nicky Van Eerde	Matron PRH
Katie Tibble	LW Coordinator
Anne Woodroffe	LW Coordinator
Mel Sanders	Community Midwife
Pip Andrews	Postnatal Ward Manager RSCH
Vanessa Hayward	Midwife
Sue Defreitas	LW Coordinator
Carey Burt	LW Coordinator
Debbie Laing	LW Coordinator
Leslie Leale	Midwife
Fiona Rose	Safeguarding Midwife
Louise Jennett	Practice Education Facilitator