

BIRTHRATE PLUS[®] ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

AUGUST 2024

**HARROGATE AND DISTRICT
NHS FOUNDATION TRUST
Harrogate District Hospital**

Table of Contents

Section 1	3
Birthrate Plus®: The methodology and factors affecting maternity services.	3
Section 2a	6
Discussion of Results for Hospital based care.	6
Table 1: Casemix	6
Table 2: Annual Activity	6
Table 3: Intrapartum services – births and other activity	7
Table 4: Pannal Ward Activity.....	7
Table 5: Birthrate Plus® Staffing 20.78%.....	8
Section 2b	9
Discussion of Results for Community based care	9
Table 6: Community activity and wte at 20.78% uplift	10
Section 3	10
Specialist Midwifery and Managerial Roles	10
Section 4 – Comparison of current funded and recommended staffing including overall summary 11	
Section 4a - Current Clinical Funded Bands 3 – 7	11
Table 7: Current Funded Establishment.....	11
Section 4b - Comparison of Clinical Staffing	11
Table 8: Comparison of Clinical Staffing.....	11
Table 9: Comparison of skill mix ratios and resulting wte	12
Table 10: Comparison of additional specialist and management wte	12
Table 11: Total Clinical, Specialist and Management wte	12
Appendix 1 – Birthrate Plus categories by scoring	13
Appendix 2 – summary table	14
Appendix 3 – results with 24% uplift	15

Section 1

Birthrate Plus®: The methodology and factors affecting maternity services.

Birthrate Plus® is a framework for workforce planning and strategic decision-making and has been in constant 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. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM).

The RCM recommends using Birthrate Plus® to undertake a systematic assessment of workforce requirements, since it is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3). Both the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) (NHSR 2023) and the Three-year delivery plan for maternity and neonatal services (NHSE 2023) include reference to using Birthrate Plus® as a midwifery staffing tool.

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

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and birth. Each of the indicators has a weighted score designed to reflect the different processes of labour and birth and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and birth with a higher score reflecting medical comorbidity or the need or request for intervention during the labour and birth.

Other categories classify women admitted to the birth suite for other reasons than for labour and birth.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. These are reviewed and updated in line with recommendation from national reviews such as Ockenden (2002) and Kirkup (2023). Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick and study leave allowance and for travel in community.

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

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

The emphasis of community based care is on 'normal/low risk/need care' being provided in the woman's home and other community setting by midwives and midwifery support workers. However, care of women and babies with safeguarding needs is an increasing demand upon community midwifery services.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there are women who birth in a particular hospital but from out of area so are 'exported' to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwives once pregnancy is confirmed. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal women.

Section 2a

Discussion of Results for Hospital based care.

1. This is a final report of the midwifery workforce requirement for maternity services in Harrogate and District NHSFT. The results show information for Harrogate District Hospital (HDH) and the local community.
2. The Birthrate Plus staffing is primarily based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.
3. Day to day management by ward and department managers, community team leaders and coordination of intrapartum services are included in the clinical establishments.
4. The decision was made to collect new casemix. The casemix has the major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V results in an increase from the one midwife to one woman ratio for Categories I and II. A 3 months' sample from December 2023, January and March 2024 was obtained by the midwifery team and additional scrutiny provided by the Birthrate Plus consultant. There has been a 10% increase in the number of cases in the higher categories of IV and V, a trend seen in many maternity services.
5. Table 1 shows the current casemix.

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
Delivery Suite casemix	2.2	9.5	16.9	36.8	34.6
	28.6%			71.4%	

Table 1: Casemix

6. Table 2 shows the total annual birth activity.

	Annual Total
Delivery Suite	1684
Home	30
Total Births	1714

Table 2: Annual Activity

7. All delivery suites have antenatal cases where women require monitoring and often treatment for obstetric or medical problems such as antepartum haemorrhage, preterm labour, reduced fetal movements, etc. Often the women are transferred to the maternity ward or to another unit if need a higher level of neonatal services. In addition, most maternity services provide care for women experiencing a pregnancy loss or termination for medical reasons. Postnatal readmissions may require a theatre procedure or enhanced midwifery care for conditions such as sepsis.

8. Table 3 shows all the recorded activity in delivery suite and recommended staffing wte for each care activity. The roster template per shift is also included.

Intrapartum Services - Delivery Suite	Annual Total	WTE
Births	1684	20.44
Other activity	Annual Total	WTE
Antenatal Cases	88	0.68
Postnatal Readmissions	17	0.06
In-utero transfers out	11	0.05
Inductions of labour (10%)	81	0.14
Non-viable cases	23	0.27
Total WTE		21.64
Roster template per shift		4

Table 3: Intrapartum services – births and other activity

9. Table 4 shows the annual activity on Pannal Ward along with the recommend clinical staffing wte and roster template per shift.

Pannal Ward	Annual Total	WTE
Antenatal care		
Antenatal admissions	730	3.87
Antenatal ward attenders	0	0
Induction of labour (90%)	729	1.30
Postnatal care	Annual Total	WTE
Postnatal women	1684	15.03
Postnatal Re-admissions	46	0.24
NIPE sessions	210	0.10
Extra Care Babies	115	0.74
Total WTE		21.28
Roster template per shift		3.93

Table 4: Pannal Ward Activity

10. Often the inpatient antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital-based care.
11. Medical inductions of labour are mostly carried out on the ward with some taking place on delivery suite. The annual total are actual insertions but may be less women as some may have multiple insertions.
12. The ‘extra care babies’ are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.
13. There is some readmission activity to the ward which may be mothers and or babies.

14. Staffing is included for the NIPE service provided by the ward midwives. NIPE for home births is routinely included in the community staffing.
15. The staffing provision for Triage covers a 24-hour period, seven [7] days per week with 1 midwife on duty throughout the 24-hour period as well as the “Ask a Midwife” telephone line. This is in line with the RCOG guidance paper 17, 2023 and BSOTS model (Birmingham Symptom-specific Obstetric Triage System).
16. The Day Unit is staffed according to the current staffing model of which is adequate for the activity, namely Monday to Friday with 1 midwife for 7.5hours per day.
17. Outpatient Clinic services at the Trust are based on the average hours of each session time and numbers of staff to cover these, rather than on the number of women attending and a dependency classification. Professional judgement is used to assess the numbers of midwives and support staff required to ‘staff’ the clinics/sessions. The outpatients’ profile is unique to each maternity service.
18. The staffing figures (Table 5) include the current allowance of 20.78% uplift for annual, sick and study leave. This is at the lower end of the range of uplift seen across England of between 21 - 25%, and increasingly more Trusts are building in 23 to 24% to provide sufficient cover for study leave requirements.
19. Appendix 3 shows the required wte using an uplift of 24%.

Breakdown of Birthrate Plus[®] Clinical Staffing

		Staff group
Intrapartum Services	21.65	RMs
Triage	5.52	RMs
Pannal Ward	21.28	RMs
Outpatient Clinics	3.12	RMs
Day Unit	1.21	RMs
Frenulotomies	0.35	RMs
Total Clinical wte	53.13	RMs

Table 5: Birthrate Plus[®] Staffing 20.78%

Section 2b

Discussion of Results for Community based care

20. The community annual total includes women who birth in neighbouring units and receive either antenatal or postnatal care, or a combination of both, from the Trust midwives (community imports). The birth episodes are provided by neighbouring units.
21. Every Trust will have a proportion of women with safeguarding needs that may not reach the threshold for formal intervention but require a significant input from the community midwives such as increased surveillance, support, and signposting to other services. Additional staffing resource has been included for this additional care.
22. All Trusts have attrition cases, namely, women who may book and/or see a midwife in early pregnancy but either move out of area or have a pregnancy loss.
23. In addition, many Trusts will have export cases; women who birth in their Trust but live outside of the geographical area and therefore receive community care in their local trust. Table 7 includes this figure for reference.
24. The *total community cases* (hospital births) in table 6 includes all imports and excludes home births, exports, and attrition cases.
25. The *total community activity* in Table 6 refers to all women being cared for and includes all hospital births (excluding exports), home births, all imports as well as the attrition cases.
26. The annual community cases excluding home births and attrition is less than the annual births by 372 cases due to high export activity and minimal import activity. Community cases often differ to the total birth numbers, and this should be considered when understanding the staffing required for each area.
27. The staffing figures (Table 6) include the current allowance of 20.78% uplift for annual, sickness and study leave, and 12.5% for travelling time.

COMMUNITY SERVICES		
	Annual Total	WTE
Home Births	30	0.84
Community Cases (own births)	1330	12.98
Imports AN & PN care	12	0.12
Attrition Cases	114	0.15
Additional Safeguarding	42	0.19
<i>Exports *</i>	354	
Total Community Cases (hospital births)		1342
Community cases compared to births		-372
Total Community Activity (including home births)		1372
Total WTE		14.28
<i>*figure included for reference only.</i>		

Table 6: Community activity and wte at 20.78% uplift

Section 3

Specialist Midwifery and Managerial Roles

28. The total clinical establishment shown in Table 7 below excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.
29. All maternity units have Specialist Midwives who provide expert midwifery care to groups of women or provide support and training to colleagues. In addition, they may have a strategic role in service delivery (RCM)
30. Some Specialist Midwives may have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The remaining % is included in the non-clinical roles.
31. In addition, every maternity unit requires specific non-clinical managerial and leadership roles to support the overall functioning of the unit. Some of these are summarised below.
- Director of Midwifery
 - Matron
 - Named Midwife Safeguarding
 - Digital Midwife
 - Infant Feeding Coordinator
 - Fetal Wellbeing Lead
 - Clinical Educator
 - Diabetes Midwife
 - Recruitment & Retention Midwife
 - Perinatal Mental Health Midwife
 - Bereavement Specialist Midwife
 - Lead Midwife for Quality and Safety

32. In addition to these posts, consideration should also be given to recommendations from national reports such as Ockendon 2022 and the Royal College of Midwives 2019 (Strengthening midwifery leadership: a manifesto for better maternity care) with regards to new roles.
33. The service may also benefit from additional senior leadership roles. This may be a Head of Midwifery and/or a Consultant Midwife to provide operational oversight of the service, quality improvement and service innovation.
34. To provide the specialist and managerial roles required, the service currently has a 15.5% uplift added to the clinical wte. This is more than what is seen in larger units but is reflective of the needs of a smaller service ensuring these roles are provided. Applying 15.5% to the Birthrate Plus[®] clinical wte provides 10.45wte additional staff for the above roles. It is a local decision as to which posts are required and appropriate hours allocated.

Section 4 – Comparison of current funded and recommended staffing including overall summary

Section 4a - Current Clinical Funded Bands 3 – 7

35. Comparisons are made with the current funded establishment as per table 8 below.

RMs Bands 5 – 7	Specialist Midwives contribution	MSWs bands 3/4	Current Total Clinical wte
61.63	3.10	1.90	66.63

Table 7: Current Funded Establishment

Section 4b - Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	Birthrate Plus [®] establishment bands 3 – 7	Variance Bands 3 – 7
66.63	67.41	-0.78

Table 8: Comparison of Clinical Staffing

36. There is a deficit in the current funded clinical establishment of **0.78 wte**.
37. Most maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), possibly Band 4 Nursery Nurses and sometimes Band 5 RNs working in postnatal

services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix, using professional judgement along with their local knowledge of the service. The total clinical wte includes a small contribution from appropriately trained Band 3 MSWs in the community postnatal services.

38. The current skill mix is 97/3% and using this skill mix, the clinical deficit is largely in the Registered Midwife workforce. Maintaining the skill mix at this level and having MSWs providing baby care in community services only will support escalation of midwives during periods of high activity and acuity. The higher level of RMs will ensure an adequate number are available for mentoring and supervision of students and support workers.

Skill mix %	RMs	MSWs	Variance
97/3%	65.49	1.92	-0.78
	-0.76	-0.02	

Table 9: Comparison of skill mix ratios and resulting wte

Section 4c - Comparison of non-clinical midwifery roles

Current Funded Establishment	Birthrate Plus® recommended	Variance
10.36	10.45	-0.09

Table 10: Comparison of additional specialist and management wte

39. There is a deficit in the current funded establishment for non-clinical roles of **0.09wte**.

Section 4d - Summary of results

Current Funded Clinical, Specialist and Management wte	Birthrate Plus® Total recommended wte	Variance wte
76.99	77.86	-0.87

Table 11: Total Clinical, Specialist and Management wte

40. Overall, the results show there is a deficit in the total funded establishment of **0.87wte**.

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Birth

There are five [5] categories for mothers who have given birth during their time in the birth suite [Categories I – V)

CATEGORY I Score = 6

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:

The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal birth with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II Score = 7 – 9

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III Score = 10 – 13

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental birth with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV Score = 14 –18

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal birth will also be Category IV, as will those having a straightforward instrumental birth.

CATEGORY V Score = 19 or more

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-birth. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

SUMMARY of DATA & REQUIRED WTE for

Harrogate and District NHS Trust		Final version	26/07/2024			
		Annual Data	2023/24			
20.78%	Total Births in service	1714				
5.41	Total Community Cases (inc. imports & home births)	1372				
Dec 2023, Jan & March 2024	Cat I	Cat II	Cat III	Cat IV	Cat V	
%Casemix	2.2	9.5	16.9	36.8	34.6	
	28.6		71.4			
	Annual Nos.			Required WTE		
Delivery Suite						
	Births	1684		20.44	20.44	
Other DS Activity	Antenatal Cases	88		0.68	1.21	
	Inductions of labour	81		0.14		
	Postnatal Readmissions	17		0.06		
	Escorted Transfers OUT	11		0.05		
	Non-viables	23		0.27		
Triage including "Ask a midwife" advice line		5548		5.52	5.52	
Pannal Ward						
Antenatal Services	Antenatal admissions	730		3.87	21.28	
	Induction Doses	729		1.30		
Postnatal Services	Postnatal women	1684		15.03		
	Postnatal Re-admissions	46		0.24		
	NIPE	210		0.10		
	Extra Care Babies	115		0.74		
Outpatients Services						
Antenatal Clinics	Midwife booking			0.75	3.12	
	Midwife follow up			0.75		
	Obstetric clinics			1.46		
	Antenatal classes			0.17		
Day Unit				1.21	1.21	
Frenulotomies		180		0.35	0.35	
COMMUNITY SERVICES						
	Home Births	30		0.84	14.28	
	Community Cases (<i>Own births</i>)	1330		12.98		
	Imports (<i>AN & PN care</i>)	12		0.12		
	Attrition Cases	114		0.15		
	Additional Safeguarding	42		0.19		
CLINICAL MIDWIFERY WTE REQUIRED				67.42		
Additional Management and Specialist roles				8.09		

Please note that due to rounding in excel, the sum of the figures in the summary above may differ very slightly when manually added together (67.41).

At the request of the DOM the results are shown when 24% uplift for annual leave, sickness and study leave.

	Current budgeted establishment	Birthrate Plus recommended wte	Variance
Clinical wte	66.63	69.75	-3.12
Specialist and management wte	10.36	10.81	-0.45
Total clinical, specialist and management wte	76.99	80.56	-3.57

Overall, there would be a deficit of 3.57wte when compared to the current budgeted establishment.

SUMMARY of DATA & REQUIRED WTE for
Harrogate and District NHS Trust

 Final version ▲ 26/07/2024

Annual Data 2023/24

24.00%

Total Births in service

1714

5.56

 Total Community Cases
(inc. imports & home births)

1372

Dec 2023, Jan & March 2024

	Cat I	Cat II	Cat III	Cat IV	Cat V
%Casemix	2.2	9.5	16.9	36.8	34.6
	28.6			71.4	

Annual Nos.
Required WTE
Delivery Suite

Births

1684

20.99

20.99
Other DS Activity

Antenatal Cases

88

0.70

1.25

Inductions of labour

81

0.15

Postnatal Readmissions

17

0.06

Escorted Transfers OUT

11

0.06

Non-viables

▲ 23

0.28

Triage including "Ask a midwife" advice line

5548

5.67

5.67
Pannal Ward
Antenatal Services

Antenatal admissions

730

4.03

22.16

Induction Doses

729

1.33

Postnatal Services

Postnatal women

1684

15.66

Postnatal Re-admissions

46

0.25

NIPE

210

0.11

Extra Care Babies

115

0.78

Outpatients Services
Antenatal Clinics

Midwife booking

0.77

3.20

Midwife follow up

0.77

Obstetric clinics

1.50

Antenatal classes

0.18

Day Unit

1.24

1.24
Frenulotomies

180

0.36

0.36
COMMUNITY SERVICES

Home Births

30

0.88

14.88

 Community Cases (*Own births*)

1330

13.53

 Imports (*AN & PN care*)

12

0.12

Attrition Cases

114

0.15

Additional Safeguarding

42

0.20

CLINICAL MIDWIFERY WTE REQUIRED
69.75

|Additional Management and Specialist roles

8.37