Business Contingency Planning – Midwifery Staffing

Business contingency planning for significant reduction in Midwifery Staffing

Classification:	Business Contingency Plan		
Authors Name:	**Melissa Davis**		
Authors Job Title:	**Head of Midwifery, Gynaecology & Paediatrics**		
Authors Division:	**Women's & Children's**		
Departments/Group this Document applies to:	**Midwives, Registered Nurses in Maternity, Maternity Care Assistants, Nursery Nurses**		
Approval Group:		**Date of Approval:**	16/02/2022
		Last Review:	13/01/2022
		Review Date:	16/10/2024
Unique Identifier: MIDW/GL/217	**Status:** Approved	**Version No:** 1.1	
Scope: Maternity		**Document for Public Display:** Yes	
To be read in conjunction with the following documents: Maternity Escalation Guideline OPS/GL/9			

Index

Statement 2
1.0 Roles and Responsibilities: 3
2.0 Implementation and dissemination of document 3
4.0 Statement of evidence/references 9
5.0 Governance 9
5.1 Document review history 9
5.2 Consultation History 10

Statement

The maternity escalation guideline defines the planned actions to support the continued management of services in response to staffing, activity, and capacity challenges.

In the event of significant midwifery staffing shortages, resulting in an inability to provide business as usual operation of maternity services, which is not able to be mitigated by the actions within the maternity escalation procedure, business contingency will be triggered.

This sets out the incremental actions required to enable continued provision of critical maternity services in response to increasing midwifery staffing shortages.

1.0 Roles and Responsibilities:

It is the role and responsibility of the maternity divisional triumverate, maternity on call managers, maternity bleep holder, labour ward co-ordinators, divisional and operational teams to be familiar with the Business Contingency Plan for midwifery staffing in line with Trust Business Continuity Management System (BCMS) Policy and national guidance.

2.0 Implementation and dissemination of document

The document will be published on the trust intranet and cascaded via internal communication platforms to relevant stakeholders.
The document will be referred to and linked within the Maternity Escalation Guideline.

3.0 Business Contingency Plan – Steps

The following steps are to be taken dependent on the level of shortage of midwifery staff, until such time that the provision of critical services is maintained.
Steps referred to below may have already been invoked as part of the Maternity Escalation Guideline, in which case, in the event of the need to activate the Business Contingency Plan, proceed to the following step.

3.1 Deployment of Specialist Midwives

The specialist midwives contribute to a daily on call rota to support the provision of acute clinical maternity services during escalation.
In the event that this is unable to mitigate continued escalation, or the reduction of midwifery staff has impacted the ability to maintain minimum safe staffing levels, specialist midwives will temporarily be released from their usual role to be included within the clinical rosters.

The order in which specialist midwives will join the clinical rosters at any specified point will be based on a time specific impact assessment in relation to the current provision of service and priorities.
The impact assessment will be completed by the midwifery senior leadership team and must be agreed with the Head of Midwifery, Deputy Head of Midwifery or Maternity Clinical Governance Lead and a briefing will be escalated to the Chief Nurse.

The impact of this is detailed within the impact assessment in appendix 1.

If there is an indication to change the order of release from usual roles, this must be discussed and agreed with the Head of Midwifery, Deputy Head of Midwifery or Maternity Clinical Governance Lead.
When organizing the deployment of specialist midwives onto the clinical rosters, consideration will be given to any specific requirements including skills and experience.
In the event of a specialist midwife being deployed onto the clinical rosters, it will be the responsibility of their direct line manager to organise the delivery of critical elements of their role.

3.2 Deployment of Ward Managers

The ward managers operate on a part clinical, part supervisory basis in order to complete critical functions of staff and clinical environment management.
In the event that the deployment of specialist midwives has not enabled the maintenance of minimum safe staffing levels, the ward managers will temporarily be released from their supervisory responsibilities to undertake full clinical duties.

The impact of this is detailed within the impact assessment in appendix 1.

If there is an indication to change the planned full implementation of the ward managers into the clinical rosters this must be discussed and agreed by the Inpatient or Outpatient Maternity Matron with the Head of Midwifery or Deputy Head of Midwifery and a briefing will be escalated to the Chief Nurse.
Ward managers will typically be clinically deployed to their clinical areas of responsibility unless otherwise indicated and in this event consideration will be given to any specific requirements including skills and experience.
In the event of a ward manager being deployed onto the clinical rosters, it will be the responsibility of their direct line manager to organise the delivery of critical elements of their role.

3.3 Deployment of Consultant Midwives

The Consultant Midwives undertake a 50% clinical 50% non-clinical role in order to enable the development and quality monitoring of clinical care provision to continue, while engaging in a research and education function.
In the event that previous measures have not enabled the maintenance of minimum safe staffing levels, the Consultant Midwives would temporarily undertake 100% clinical roles and support the clinical rosters.

The impact of this is detailed within the impact assessment in appendix 1.

If there is an indication to change the implementation of full clinical roles this must be discussed and agreed with the Head of Midwifery or Deputy Head of Midwifery and a briefing will be escalated to the Chief Nurse.
In the event of a Consultant Midwife being deployed onto the clinical rosters, it will be the responsibility of their direct line manager to organise the delivery of critical elements of their role, **this includes their participation in the maternity on call roster, which would stop for the period of time of 100% clinical care delivery.**

3.4 Reduction in face-to-face bookings

Once a referral for maternity care is received, a face-to-face booking appointment is organised to provide information, identify the recommended pathway of care and complete the pregnancy information.
In the event that previous measures have not enabled the maintenance of minimum safe staffing levels, the booking appointments would transition to virtual contacts initially, with a follow up for collection of blood tests, urine sample and measurement of height, weight and CO level.

The impact of this is detailed within the impact assessment in appendix 1.

3.5 Reduction in face-to-face postnatal community contacts

Once discharged home following birth, the community midwifery service provides postnatal care on an individualised basis, dependent on the care and monitoring needs.

In the event that previous measures have not enabled the maintenance of minimum safe staffing levels, the face-to-face postnatal visits would initially be reduced to essential day 3 and day 5. All other contacts would take place either virtually, or face to face interventions as required facilitated by the maternity support workers.
Drop-in sessions would be facilitated to offer an option for those who are unable to access platforms for virtual contacts or require face to face midwifery care.

This would support the release of midwives from the community midwifery setting in order to support the acute inpatient clinical rosters to maintain minimum safe staffing levels.

The impact of this is detailed within the impact assessment in appendix 1.

If required, day 3 and 5 face to face contacts would be changed to virtual video contacts, supported by midwives who are isolating with maternity support workers facilitating the face-to-face elements including the newborn weight, blood spot and any maternal observations required.
In the event that the day 3 and 5 contacts were delivered via a virtual video platform, a discharge face to face drop in would be facilitated to ensure a minimum of one face to face midwife review prior to discharge from maternity services.
Drop-in sessions would be facilitated to offer an option for those who are unable to access platforms for virtual contacts or require face to face midwifery care.

3.6 Reduction in face-to-face antenatal community contacts

During pregnancy, a schedule of routine antenatal appointments is undertaken, alongside any urgent or additional antenatal monitoring, in order to continually assess wellbeing and the requirement for further care interventions or monitoring.

In the event that previous measures have not enabled the maintenance of minimum safe staffing levels, specific routine antenatal appointments would take place virtually including 16 weeks, 25 weeks and in some cases 31 weeks.
This would take place on an individual risk assessment and drop-in sessions would be facilitated to offer an option for those who are unable to access platforms for virtual contacts or require face to face midwifery care.

The impact of this is detailed within the impact assessment in appendix 1.

In the first instance, movements to virtual methods of care delivery in replacement for face to face would enable midwifery staff who are unable to attend work but able to work off site, to support the delivery of care aspects.
This would enable midwifery staff on site to be released to prioritise the provision of acute care.
Alternatively, the delivery of virtual aspects of services provision would be organised to

reduce midwifery time associated with the contacts, increasing availability to support the provision of acute care.
Standard Operating Procedures will be in place and available for reference for changes to pathways for delivery of care.

3.7 Reduction in provision of supernumerary for midwives

Provision of supernumerary periods forms part of the organization of induction for newly qualified midwives as part of their preceptorship; midwives who are joining the trust as new members of staff; midwives who are rotating to areas of practice where they have less familiarity and to support re-introduction of staff following periods of absence.

In the event that previous measures have not enabled maintenance of minimum safe staffing levels, a reduction or removal of supernumerary time in order to enable increased substantive fill rates within the Eroster would take place.
A review of each individual midwife impacted, would be undertaken by members of the senior midwifery leadership team.

The impact of this is detailed within the impact assessment in appendix 1.

If there is an indication not to alter the supernumerary status of individual staff members, this must be discussed and agreed with the Head of Midwifery or Deputy Head of Midwifery and Chief Nurse.

3.8 Reduction in delivery of mandatory midwifery training

Mandatory training is an essential requirement of the core competency document, which outlines the training to be received by all clinical midwives in order to support the provision of a safe service.

In the event that previous measures have not enabled maintenance of minimum safe staffing levels, all aspects of mandatory midwifery training will be risk assessed and a temporary reduction in elements delivered will take place, in order to increase substantive fill rates within the Eroster.

Any proposed changes to the provision of midwifery training will require a risk assessment which is escalated to the Board Level Maternity Safety Champions for approval prior to Gold command.

The impact of this is detailed within the impact assessment in appendix 1.

3.9 Reduction of expected midwifery ratios within the inpatient setting

Staffing templates exist within the inpatient midwifery setting in order to advise on the expected number of midwives available within a clinical setting for the provision of care within that setting. However, on a day-to-day basis, midwifery staffing is allocated depending on the activity within the maternity service and the requirement for staff to match the activity experienced.

The implementation of continuity of carer has changed the delivery of the maternity service resulting in incremental changes to the expected shift plans and ultimately movement away from agreed staffing levels, towards staffing levels which support the activity as required.

In the event that previous measures have not enabled maintenance of minimum safe staffing levels, in order to maintain the provision of 1:1 care in labour, midwifery staffing ratios in other areas of inpatient service provision would be reduced and supported by alternative staff.

In the postnatal inpatient setting, midwifery staffing would be reduced to 1 midwife overseeing the postnatal inpatients, supported by registered nurses, maternity support workers and nursery nurses.
In the antenatal inpatient setting, depending on the number of admissions, the midwifery staffing would be aligned with the need for care delivery following a risk assessment and taking into consideration the available staffing provision.
Maternity triage and labour ward are priority areas to maintain minimum safe staffing levels in order to enable the delivery of acute care.

The impact of this is detailed within the impact assessment in appendix 1.

If minimum safe staffing levels are unable to be maintained on labour ward, resulting in 1:1 care not being provided to women in established labour, in addition to informing the manager on call, the Head of Midwifery must be informed.

In hours – following review by the Head of Midwifery, an inability to provide 1:1 care in established labour will be escalated to the Chief Nurse and Gold command.

Out of hours - following review by the Head of Midwifery, an inability to provide 1:1 care in established labour will be escalated through silver command for escalation to the exec on call.

4.0 Increase in responsibilities of 3rd Year Student Midwives

3rd year student midwives experience increasing independence during clinical placements in preparation for being autonomous practitioners at the point of qualification and can support the continuous provision of 1:1 care in labour.

In the event that previous measures have not enabled maintenance of minimum safe staffing levels, on a case-by-case basis, 3rd year students will supported to provide increased provision of care within inpatient settings.

A review of each individual 3rd year student would take place in collaboration with the learning environment lead, university education lead and members of the senior midwifery leadership team to identify the appropriate course of action. Following which a briefing will be escalated to the Chief nurse for review and approval through Gold command.

The impact of this is detailed within the impact assessment in appendix 1.

4.1 Responsibilities of the Inpatient & Outpatient Matron

The mitigations for many of the aspects detailed above, in addition to the continuation of the 24-hour maternity manager on call are within the responsibility of the maternity matrons.

The maternity matrons will take further specific responsibilities for the provision of essential tasks following deployment of staff who they directly line manage.
They will act as a supportive mechanism for staff within the clinical areas of their responsibility, enabling an increased level of support for midwifery staff, during times of significant pressures

within the service.

The maternity matrons are **only** to be included in any clinical rosters following discussion and approval with the Head of Midwifery and in the event of maternity matrons being deployed to any extent onto the clinical rosters, it will be the responsibility of their direct line manager to organise the delivery of critical elements of their role. **This includes their participation in the maternity manager on call rota, for which their participation would be reduced dependent on the organization of clinical care delivery.**

The impact of this is detailed within the impact assessment in appendix 1.

4.2 Responsibilities of the Maternity Clinical Governance & Quality Improvement Lead (MCGQIL)

The MCGQIL is responsible for the assurance of clinical governance within maternity and therefore holds an essential responsibility for the reduction of risk and maintenance of governance processes and procedures within the department.

The MCGQIL will take further specific responsibilities for the provision of essential tasks following deployment of staff who they directly line manage, including the provision of essential training.

The MCGQIL is **only** to be included in the clinical rosters following discussion and approval with the Head of Midwifery and in the event of the MCGQIL being deployed to any extent onto the clinical rosters, it will be the responsibility of their direct line manager to organise the delivery of critical elements of their role. **This includes their participation in the maternity on call rota, for which their participation would be reduced dependent on the organisation of clinical care delivery.**

For any planned deployment of the MCGQIL, a briefing will be sent to the Board Level Maternity Safety Champions for approval prior to escalation to Gold Command.

The impact of this is detailed within the impact assessment in appendix 1.

4.0 Responsibilities of the Head of Midwifery & Deputy Head of Midwifery

The continuation of essential functions within the national, regional and local management of maternity services will ultimately be the responsibility of the Head of Midwifery, supported by the Deputy Head of Midwifery.

During significant service pressures which require deployment of staff outside their usual roles, resulting in the re-allocation of essential service implementations, the overall risk assessment and service impact, with associated mitigations is the responsibility of the Head of Midwifery, supported by the Deputy Head of Midwifery.

This includes continued provision of the maternity manager on call rota, which may be subject to adaptations as required following review and approval by the Head of Midwifery.

Further mitigations taken from a regional perspective to support midwifery staffing are outside the scope of this contingency plan but would be implemented as required.

National and Regional responses to significant midwifery staffing shortages, with associated guidance and procedures are outside the scope of this contingency plan but action would be taken in response to these as required.

Implementation of this contingency plan must be escalated to the Head of Midwifery and a briefing must be provided to the Chief Nurse.

Daily updates of the aspects implemented within the contingency plan must be documented on the site SIT REP forms returned to the site team.

If this Business contingency planning Midwifery Staffing is utilised please refer to associated documents: Community maternity COVID-19 SOP

4.0 Statement of evidence/references

Statement of evidence: MKUH Business Continuity Management System (BCMS) Policy

References: NHS Commissioning Board (2013) Business Continuity Framework

External weblinks: NHS England Emergency Preparedness, Resilience and Response (EPRR) website [available from] https://www.england.nhs.uk/ourwork/eprr/bc/ (accessed: 6.01.22)

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1			**New document**
1.1	**March 2024**	Approval from Maternity Assurance Group and Women's Health Guideline Review Group	Deadline extended as Chief divisional midwife is new to post.

5.2 Consultation History

Include staff in consultation who will be required to ensure the SOP is embedded. This table should be completed in full even if no comments are received

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Nicky Burns-Muir		10.01.2022	10.01.2022	Escalation and reporting processes clarified	Yes – majority endorced
Maternity Doctors and Midwives email	Maternity	13/01/2022	26/01/2022	None	Yes
Maternity Guideline group	Maternity	26/01/2022	26/01/2022	None	
Maternity CIG	Maternity	03/02/2022	03/02/2022	None	
Trust Documentation Committee	Corporate	16/02/2022	17/02/2022	None	
Women's Health Guideline Review Group	Women's Health	06/03/2024	-	Version 1.1 approved as chairman's actions	Yes