Shaping the Future

Interim Maternity and Newborn Care Area Workforce Report
This interim strategy outlines the current Maternity and Newborn care area workforce context. The workforce strategy is subject to development as the Maternity and Newborn Care Area programme is finalised.

1. Introduction

The Maternity and Newborn Care Area covers preconception care, routine antenatal care, specialist antenatal care, birth and postnatal care including neonatal Special Care, High Dependency Care and Intensive Care.

The maternity workforce consists of midwives, obstetricians, maternity support workers, anaesthetists and other support staff (including hotel services and administrative staff). In 2008 the NHS South Central Maternity network developed a Maternity Matters workforce plan\(^1\) which modelled the growth required at a regional level of the maternity workforce in response to the dual pressures of increasing numbers of births and delivery of a safer, higher quality service. This strategy should be read in conjunction with the Maternity Matters workforce plan.

The neonatal workforce consists of registered nurses and midwives, paediatricians (including neonatologists), non-registered nursing staff, allied health professionals and other support staff.

The Neonatal network that covers the NHS South Central geography extends beyond the NHS SC administrative boundary and includes one unit from NHS South-East Coast and two units from NHS South West.

2. Workforce Demand Drivers

There are a number of drivers which have impacted on maternity and neonatal workforce demand.

Demand for maternity and neonatal services (and the associated workforce) is directly related to the number of births. After decades of decline, the birth rate has risen in NHS South Central from 41,077 in 2003-4 to 47,956 in 2008-9 (an average increase of 3.0% each year), with the biggest rise of 4.11% in 2006. Birth rate forecasts underpin the workforce demand forecasts. With the economic downturn, growth in the number of births each year has come to an end and forecasts have been revised to show a period of stability in the numbers of births.

The case-mix has increased in complexity over the last decade with an increase in the average age of first time mothers, an increase in the proportion of mothers who were born overseas or have long-term condition and with the increase in multiple births (associated with assisted conception).

Safer Childbirth outlined the Royal College’s recommended staffing levels for maternity units; NHS South Central adopted a 1:30 midwife-to-birth ratio as a standard.

The Neonatal Taskforce Toolkit\(^2\) also outlined a ratio of neonatal cots to nursing staff.

These ratios enable calculation of workforce demand for midwives and neonatal nurses based on levels of activity – see Figures 1 and 2 below.

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In 2008, the then Health Secretary, Alan Johnson, announced a package of measures to recruit an additional 4,000 midwives to the NHS by 2012.

The European Working Time Directive (EWTD) has increased demand for Junior Doctors to facilitate compliant EWTD rotas. In the NHS South Central region this has created a pressure point in obstetrics and gynaecology, and paediatrics in a number of trusts.

Prior to the launch of Modernising Medical Careers (MMC) in 2007, there was a significant pool of mid-grade doctors, often at Senior House Officer grade, who filled service posts if training posts were not available. Some of these posts would have been used to achieve 24-hour cover for specialities where this was a service requirement, such as obstetrics and gynaecology, and paediatrics. MMC aims to give every doctor the opportunity to achieve Certificate of Completion of Training status and as MMC has progressed there has been a reduction in the availability of mid-grade doctors leading to an increase in demand from services for non-training posts.

3. Workforce Supply

Figure 1 below shows the forecast demand and supply for midwives in the NHS South Central region.

At a sub-regional level, there is oversupply of midwives in the former Hampshire and Isle of Wight SHA area and undersupply in the former Thames Valley SHA area. A small number of trusts are experiencing midwife recruitment problems.

Figure 2 below shows the staffing levels (as at January 2009) compared to the BAPM standards and the Neonatal Taskforce Toolkit principles for neonatal staffing levels.

The main area of concern when comparing current to expected levels of staffing is the demand-supply gap in the nursing workforce. The standards set out differentiated nurse:cot ratios for Special Care, High Dependency Care and Intensive Care.

Expansion of neonatal nursing numbers will require a review of the training and clinical placement support for nurses undertaking post-registration training. Neonatal nurses have traditionally been recruited from midwifery and adult nursing. With the pressure to retain
midwives in midwifery services this ‘source’ is increasingly limited and vacancies have become harder to fill.

Figure 2: Neonatal Nursing Workforce (Bands 2-8) demand & supply forecast

The national shortage of sonographers is impacting on the ability to deliver antenatal screening programmes.

4. Workforce Priorities

4.1 Embed skill-mix
The identification of tasks along the care pathway and the competences required to deliver those tasks will allow re-design of job roles and skill-mix. This will need to be supported by a Professional Development framework for the non-registered workforce.

Scenario modelling of skill-mix to maximise productivity in maternity services is underway.

4.2 Support development of registered workforce and future leaders
Re-allocating tasks to the non-registered workforce will free time for the registered workforce to deliver the tasks that have to be carried out by the registered workforce and for their own Professional Development or Learning Beyond Registration. The suite of development opportunities should include skills and competences for future leaders.

Delivery of Professional Development and Learning Beyond Registration needs to be reviewed. While there will always be a need for formal taught courses, the opportunity exists to develop flexible learning approaches through work-based learning and e-learning which could make use of the unpredictable quiet periods of reduced service demand.

Moving to a modular framework Professional Development would enable multi-professional attendance and enhance team-working.

4.3 Collaboration
NHS South Central needs to work towards minimising the demand-supply gap in midwifery to ensure best use of available resources; in the short term there are insufficient numbers of
midwives to meet demand from Trusts; in the longer term posts will need to be established to enable Trusts to achieve 1:30 and for the new entrants to gain employment.

A regional approach to tackling recruitment issues for midwives and neonatal nurses would be beneficial, particularly with the regional variation between the over/under-supply of midwives.

4.4 Medical workforce modelling
A variety of approaches to achieve and maintain European Working Time Directive Compliant rota in obstetrics and gynaecology, and in paediatrics, will need to be modelled as part of the Medical Workforce planning system. These will need to support the required obstetric and anaesthetic cover levels in Safer Childbirth\(^3\) and the paediatric cover outlined in the Neonatal Taskforce Toolkit\(^4\) principles.

5. Alignment with Workforce Strategy
The table below identifies the links between the themes and vision set out in the NHS South Central Shaping the Future Workforce Strategy 2010 to 2015 and the Staying Healthy workforce priorities.

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Vision</th>
<th>Alignment</th>
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</table>
| 1. Share the journey: engage patients, carers and staff | Patients, carers, staff and the general public all need to be engaged and play their part in ensuring the NHS continues to provide excellent health care within a sustainable framework. | 4.1 Embed skill-mix  
4.2 Support development of registered workforce and future leaders  
4.3 Collaboration  
4.4 Medical workforce modelling |
| 2. Plan and Prepare: Manage the Change | To respond to the challenge and scale of both the forecast increase in demand for health care services, and the reduction in spending on public services we must actively plan the workforce and prepare intelligently to manage the change. | 4.1 Embed skill-mix  
4.2 Support development of registered workforce and future leaders  
4.3 Collaboration  
4.4 Medical workforce modelling |
| 3. Integrate and align: design a joint future | To maximise the effectiveness of our workforce planning we need to integrate and align our actions, taking a system wide perspective on the future workforce requirements to deliver the emerging service models. | 4.1 Embed skill-mix  
4.2 Support development of registered workforce and future leaders  
4.3 Collaboration  
4.4 Medical workforce modelling |
| 4. Tighten up business: drive up quality and value | To drive up quality and value, and reduce waste and variation in the way we deploy the workforce in NHS South Central, we need to | 4.1 Embed skill-mix  
4.2 Support development of registered workforce and future leaders |

implement excellent human resource management across all health sector employers.

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<tr>
<th>5. Step up flexibility: develop the workforce</th>
<th>To develop a more flexible workforce that can assimilate new skills rapidly and work in new and innovative ways, by targeting skills development and developing new employment models.</th>
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<th>6. Be accountable: focus leadership</th>
<th>To enable the service changes that need to be delivered we need a culture of accountability at all levels, and leadership that is focussed on delivering the best health care system in the world.</th>
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<th>6. Next steps</th>
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<td>• Review skill-mix in maternity and neonatal units to ensure that best use is made of available resources.</td>
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<td>• Establish Neonatal Network clinical educator role to co-ordinate education, training and professional development for all non-medical staff and establish a designated lead clinician to ensure appropriate education, training and professional development for all medical staff⁵. These roles should be supported by a network of designated professionals from each unit.</td>
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<td>• Consider development of a specialist role that is able to undertake simple sonography duties.</td>
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