Safe midwife staffing for maternity settings

NICE safe staffing guideline

Draft for consultation, 17 October to 13 November 2014

Contents

Introduction

The Department of Health and NHS England has asked NICE to develop evidence-based guidelines on safe staffing, with a particular focus on nursing and midwifery staff, for England. This request followed the publication of the Francis report (2013) and the Keogh review (2013).

Focus of the guideline

This guideline makes recommendations on safe midwife staffing requirements for maternity settings, based on the best available evidence. The guideline focuses on the pre-conception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including: at home, in the community, in day assessment units, in obstetric units, and in midwifery-led units (alongside hospitals and free-standing).

The guideline recommendations are split into different sections:

- Section 1.1 identifies organisational and managerial responsibilities to support safe midwife staffing requirements.
- Sections 1.2 and 1.3 identify factors that maternity services and midwives should take into account to determine safe midwife staffing requirements.
- Section 1.4 identifies processes for assessment and monitoring that should be used to provide information on whether safe midwifery care is being provided in all maternity settings.

(For further information, see the scope for the guideline.)

This guideline is for NHS provider organisations and others who provide or commission services for NHS patients. It is aimed at trust boards, chief nurses, hospital managers, unit managers, heads and directors of midwifery, midwives, and commissioners. It will also be of interest to regulators and the public.

Those responsible and accountable for staffing maternity services should take this guideline fully into account. However, this guideline does not override the need for,

and importance of, using professional judgement to make decisions appropriate to the circumstances.

This guideline does not cover workforce planning or recruitment at regional or national levels, although its content may inform these areas.

In this guideline, the term midwife refers to registered midwives only. Maternity support workers or other staff working alongside midwives are not included in this definition.

While we acknowledge that a multidisciplinary approach and the availability of other staff and health care professionals are an important part of safe midwife care, this guideline does not address staffing requirements in relation to other staff groups such as medical staff and maternity support workers.

Toolkits to support this guideline

The guideline will also be of interest to people involved in developing evidence-based toolkits for assessing and determining safe staffing requirements. NICE offers a separate process to assess whether submitted evidence-based toolkits for informing staffing requirements comply with the guideline recommendations. Details of any toolkits that can help with implementing this guideline are listed alongside other resources.

Woman and baby-centred care

Individually assessing the care needs of each woman and baby is paramount when making decisions about safe midwife staffing requirements. The assessments should take into account individual preferences and the need for holistic care and contact time between the midwife and the woman and baby.

Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Healthcare professionals and others responsible for assessing safe midwife staffing requirements for maternity settings should also refer to NICE's guidance on the components of good patient experience in adult NHS services.

Women and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. The Department of Health's Compassion in Practice strategy also sets a shared purpose for nurses, midwives and care staff to deliver high-quality, compassionate care, and to achieve excellent health and wellbeing outcomes.

Evidence to recommendations

When drafting these recommendations the Safe Staffing Advisory Committee discussed evidence from the systematic reviews described in section 2. In some areas there was limited or no published evidence. In these cases, the Committee explored whether it was possible to formulate a recommendation on the basis of their experience and expertise. The evidence to recommendations tables presented in appendix 1 detail the Committee's considerations when drafting the recommendations.

The Committee also identified a series of gaps in the evidence – please see section 3 for further details.

The Committee took into account the following factors when drafting the recommendations:

- whether there is a legal duty to apply the recommendation
- the strength and quality of the evidence base (for example, the risk of bias in the studies looked at, or the similarity of the populations covered)
- the relative benefits and harms of taking (or not taking) the action
- any equality considerations.

Strength of recommendations

Recommendations using directive language such as 'ensure', 'provide' and 'perform' are used to reflect that the committee was confident that a course of action would lead to improvements in safety.

If the quality of the evidence or the balance between benefits and harms means that more time should be taken to decide on the best course of action, the committee has used 'consider'.

The use of 'must' or 'must not' is only used when there is a legal duty to apply the recommendation or that the consequences of not following it could be extremely serious or potentially life threatening.

1 Recommendations

The recommendations in this guideline cover all aspects of maternity care provided by a midwife in:

- all maternity services (for example, clinics, home visits, maternity units)
- all settings where maternity care is provided (for example, home, community, free-standing midwifery led units, hospitals including obstetric units, day assessment units, and alongside midwifery units,)
- the whole maternity pathway (for example, pre-conception, antenatal, intrapartum, postnatal).

Recommendations in section 1.1 are aimed at hospital boards, senior management and commissioners. They focus on the responsibilities that organisations have and actions that organisations should take to support safe midwife staffing.

The other recommendations are aimed at maternity services and the midwives working in them. Sections 1.2 and 1.3 focus on the factors that should be systematically assessed to determine the number of midwives needed to ensure a safe midwife staffing establishment, such as the individual care needs of women and babies, staffing factors, environmental factors, and organisational factors.

Recommendations in section 1.4 are about monitoring whether safe midwife staffing requirements are being met and actions to respond to variation in the numbers of midwives needed and the numbers available. This includes recommendations to review the midwife staffing establishment and adjust it if required.

1.1 Organisational strategy

These recommendations are for hospital boards, senior management and commissioners.

Focus on care for women and babies

1.1.1 Ensure women and babies receive the midwife care they need, including care from specialist midwives, regardless of whether this is in:

- specific maternity services (for example clinics, home visits, maternity units)
- other settings where maternity care is provided (for example home, community, free-standing midwifery led units, hospitals including obstetric units, day assessment units, and alongside midwifery-led units)
- any part of the maternity pathway (for example pre-conception, antenatal, intrapartum, postnatal).

This should be regardless of the time of the day or the day of the week.

Maintaining continuity of midwife services

1.1.2 Develop procedures to ensure that there are enough registered midwives in the organisation to provide safe care to each woman and baby at all times. The board should be responsible for the midwife staffing establishments and the budgets that are set across the organisation's maternity services.

1.1.3 Ensure that all maternity services have the capacity to:

- Deliver all midwifery care by registered midwives during pre-conception, antenatal, intrapartum and postnatal care.
- Allow for locally agreed skill mixes (for example, specialist midwives, consultant midwives).
- Provide 1 midwife to a maximum of 1 woman during established labour.
- Provide other locally agreed staffing ratios.
- Allow for the following:

  - uplift (annual leave, maternity leave, paternity leave, study leave, and sickness absence)
  - time for midwives to give and receive supervision; the supervision process must operate alongside organisational management processes (such as incident or complaint reviews)
  - ability to deal with fluctuations in demand (such as planned and unplanned admissions and transfers, and daily variations in midwife requirements for intrapartum care).
- Forward plan to predict and account for variations over time as indicated by records of midwife requirements (for example, demographic changes and patient choice).

1.1.4 Ensure that maternity services have plans in place to monitor and respond to daily fluctuation in demand for midwives. Plans could include:

- redistribute the midwife workload
- increasing the number of midwives needed beyond the midwife staffing establishment
- using on-call staff to respond to peaks in demand for midwives
- redeploying midwives to and from other areas of care

Service cancellations or closures should only be considered as a last resort.

1.1.5 Ensure that there are enough midwives with the experience and training to determine midwife staffing requirements for each shift.

1.1.6 Ensure that the midwife staffing establishment is developed by midwives trained in establishment-setting. The midwife staffing establishment should be approved by the head or director of midwifery and chief nurse (or delegated accountable staff).

1.1.7 Ensure a senior midwife or another responsible person is accountable for the midwife rosters that are developed from the midwife staffing establishment.

Monitor the midwife staffing establishment

1.1.8 Review indicator data (see recommendation 1.1.4, box 3 and section 8)

1.1.9 Review the midwife staffing establishment and indicator data at a board level at least every 6 months.

1.1.10 Ensure analyses of reported midwife red flags and safe midwife indicators are included in the board's review of the midwife staffing establishment.

1.1.11 Change the midwife staffing establishment in response to the outcome of the review, if appropriate.

Monitor and respond to changes

1.1.12 Ensure maternity services have procedures in place for:

- allowing any member of staff, woman, family member or carer to report midwife red flags (see box 1) to the person in charge of the shift or service.
- monitoring and responding to any unplanned differences in the number of midwives needed and the number of midwives available for all midwifery services
- monitoring and responding to midwife red flags (including escalation plans).

1.1.13 Ensure that responses to midwife red flags or unplanned differences in the number of midwives needed and the number of midwives available:

- take account of women and babies who need extra support from a midwife (for example, high-risk clinical situations)
- do not cause midwife red flags to occur in other areas.

1.1.14 Consider flexible approaches to respond to midwife red flags or unplanned differences in the number of midwives needed and the number of midwives available. This could include adapting shifts, changing the skill mix, and amending assigned location and employment contract arrangements.

Promote staff training and education

1.1.15 Ensure midwives are given the training, mentoring and preceptorship they need to deliver safe care.

1.1.16 Involve midwives in developing and maintaining staffing policies and governance about midwife staff requirements, including escalation policies and contingency plans.

1.2 Setting the midwife staffing establishment

These recommendations are for registered midwives (or other authorised people) who are responsible for determining the midwife staffing establishment

1.2.1 Determine the midwife staffing establishment for each maternity service (for example, pre-conception, antenatal, intrapartum and postnatal services) at least every 6 months.

1.2.2 Use the following systematic assessment to calculate the midwife staffing establishment. Evidence-based toolkits endorsed by NICE should be used to support this assessment:

- Use data that has been collected by maternity services over the past 6 months (see recommendation 1.3.4) to inform future midwife establishment setting.
- Select a defined period of time from the collected data (for example, a 2-week sample, or all 24 weeks of data) and determine the midwife activities that are needed.
- Calculate the total midwife hours that are needed over the period of time.
- Use the current number of bookings in the maternity service to predict likely midwife hours for the next 6 months.
- Identify the maternity care activities for which midwives are responsible, and the activities that can be delegated to or provided by other trained and competent staff. Base this on the local configuration of services

and range of staff available (such as maternity support workers, registered nurses, GPs). Use box 2 part B and C as prompts.

- Estimate the midwife time needed to perform the activities that will not be provided by other trained and competent staff, and apply the following midwife staffing ratios:
  - 1 midwife to a maximum of 1 woman during established labour

  Staffing ratios for other stages of care should be developed locally depending on the local service configuration and needs of individual women and babies.
- Divide the total midwife hours by the number of weeks in the defined period of time to give the weekly average number of midwife hours.
- Increase the weekly average number of midwife hours to account for uplift. Uplift should be locally determined and include annual leave, maternity leave, paternity leave, study leave and sickness absence.
- Divide the calculations by 37.5 to determine the number of whole time equivalents needed for the midwife establishment.

1.2.3 Base the number of whole-time equivalents on registered midwives, and do not include the following in the calculations:

- registered midwives undertaking a Local Supervising Authority Programme
- registered midwives with supernumerary status (for example, newly qualified midwives, midwives returning to practice)
- student midwives.

1.2.4 Use professional judgement when checking the calculations.

1.2.5 Review the midwife staffing establishment more frequently than every 6 months if the numbers of midwives needed may change rapidly (for example, for intrapartum care).

1.2.6 Design the midwife roster on the basis of the midwife staffing establishment calculation, taking into account any predictable peaks in

activity (for example, during the day when midwife activities are likely to be planned).

1.3 Assessing differences in the number and skill mix of midwives needed and the number of midwives available

These recommendations are for registered midwives in charge of assessing the number and skill mix of midwives needed on a day-to-day basis

1.3.1 Systematically assess differences between the number of midwives needed and the number of midwives available for each maternity service in all settings.

1.3.2 As a minimum, the systematic assessment should be performed:

- once before the start of the service (for example, in antenatal or postnatal clinics) or day (for example, for community visits), or
- once before the start of each shift (for example, in hospital wards).

1.3.3 Perform the systematic assessment more frequently if the numbers of midwives needed may change rapidly (for example, for intrapartum care).

1.3.4 Use the following systematic assessment:

- Assess the needs of each woman and baby in the service (use box 2 part A as a prompt)
- Identify the maternity care activities for which midwives are responsible, and the activities that can be delegated to or provided by other trained and competent staff. Base this on the local configuration of services and range of staff available (such as maternity support workers, registered nurses, GPs. Use box 2 part B and C as prompts).
- Estimate the midwife time needed to perform the activities that are not provided by other trained and competent staff, and apply the following midwife staffing ratios:
  - 1 midwife to a maximum of 1 woman during established labour

  - Staffing ratios for other stages of care should be developed locally depending on the local service configuration and needs of individual women and babies.
- Make additional allowances for other factors that may affect the time taken to provide midwife care (such as travel time, breaks, talking to other health professionals). Use box 2 part D as a prompt.
- Asses the range of maternity care activities that need to be undertaken and ensure that there are adequate numbers of midwives available to provide the care who have the relevant experience and skills
- Record the total number of midwife hours calculated from performing the assessment.

Evidence-based toolkits endorsed by NICE could be used to support this assessment.

1.3.5 Check if the number of midwife hours calculated is different to the number of midwives hours available.

1.3.6 Use professional judgement when checking the calculations.

1.3.7 Take action in line with locally developed procedures, including escalation plans, if the number of midwives available is different from the number of midwives needed. Action could include delegating activities to other staff or allocating additional on-call or temporary staff. Service cancellations or closures should be the last option. Take into account the potential of cancellations or closures to limit women's choice and to affect service provision and the reputation of the organisation

1.3.8 Continually monitor the midwife red flags detailed in box 1 and any additional locally agreed midwife red flags.

1.3.9 A midwife red flag should prompt an immediate escalation, for example by allocating additional midwives to the service or deploying other members of the multidisciplinary team, or reviewing the midwife staffing establishment before the planned review.

1.3.10 Keep records of the following to inform planning of future midwife establishments or other action:

- differences between the number of midwives needed and available for each shift and
- reported midwife red flags, and the action taken in response.

1.4 Monitoring and evaluating midwife staffing requirements

These recommendations are for senior midwives working in maternity services.

1.4.1 Monitor whether the midwife staffing establishment adequately meets the midwife care needs of women and babies in the service using the safe midwife staffing indicators in box 3. Consider continuous data collection of these safe midwife staffing indicators (using data already routinely collected locally where available) and regularly analyse the results. Section 8 gives further guidance on these indicators.

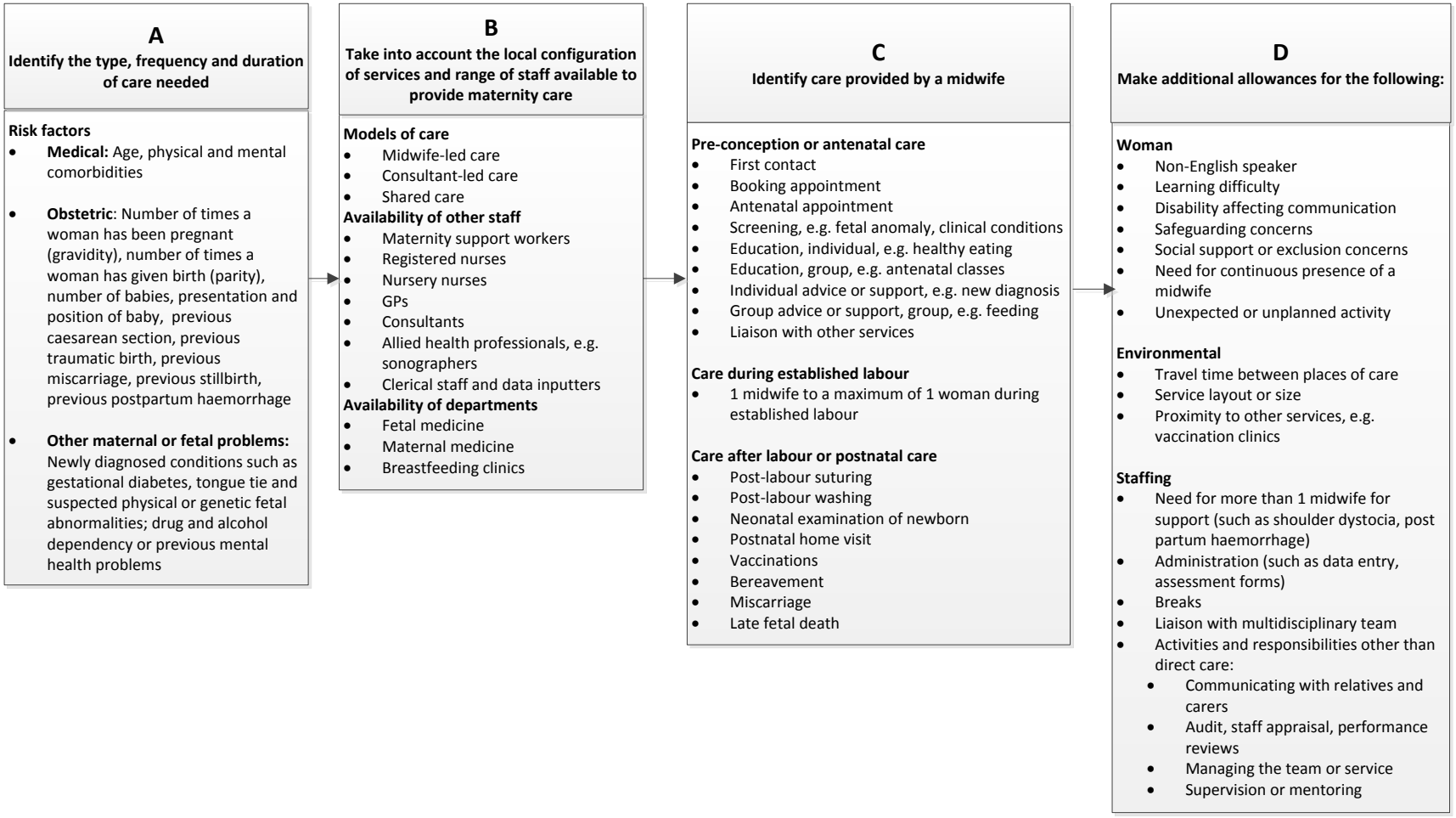
1.4.2 Compare the results of the safe midwife staffing indicators with previous results at least every 6 months. Review reported midwife red flags (box 1) at the same time.

Box 1: Midwife red flags. Occurrence of a midwife red flag should prompt an immediate response by the person in charge

- Delayed or cancelled time-critical activity because of midwife staffing issues (for example, identifying pre-eclampsia, or malposition, screening appointments)
- Midwife unavailable to make timely referral to other services (for example, services for ectopic pregnancy or miscarriage, referral to mental health services)
- Missed or delayed care because of midwife staffing issues (for example, delay in triage, delay in washing and suturing)
- Missed or delayed medication because of midwife staffing issues (for example, delay in prescription of gestational diabetes medication, pain relief not given when clinically appropriate,)
- Any occasion when one midwife is not able to provide continuous 1:1 support to women during established labour
- Incidence of birth trauma (for example, 3rd and 4th degree tears)
- Safeguarding cases inappropriately discharged home

Other red flags may be agreed locally

Box 2: Factors to consider when determining the number and skill mix of midwives needed (these are examples and not an exhaustive list)



Box 3: Safe midwife staffing indicators

Patient reported outcome measure
Data for these indicators can be collected via the Maternity Services Survey: - Adequacy of meeting mother's breastfeeding support. - Adequacy of meeting mother's postnatal needs (Postnatal Depression and Post Traumatic Stress Disorder (PN PTSD)) and being seen postnatally by the midwifery team. - Adequacy of communication with midwifery team.
Outcome measures
- Booking appointment within 13 weeks of pregnancy: Record booking appointments whether they take place within 13 weeks of pregnancy. If the appointment is over 13 weeks of pregnancy the reason should also be recorded, in accordance with the Maternity Services Data Set. - Breastfeeding: Local rates of breastfeeding initiation can be collected using NHS England's Maternity and Breastfeeding data return. - Antenatal and postnatal admissions: Record antenatal and postnatal admission details including discharge date. Data can be collected via the Maternity Services Data Set. - Incidence of genital tract trauma during the labour and delivery episode; including tears and episiotomy. Data can be collected via the Maternity Services Data Set. - Birth place of choice: Record of birth setting on site code of intended place of delivery, planned versus actual. Data can be collected via the Maternity Services Data Set.
Staff reported measures
- Missed breaks: Record the proportion of expected breaks that were unable to be taken by midwife staff. - Midwife overtime work: Record the proportion of midwife staff working extra hours (both paid and unpaid). - Midwife sickness: Record the proportion of midwife staff's unplanned absence. - Staff morale: Record the proportion of midwife staff's job satisfaction. Data can be collected via NHS staff survey.
Midwifery staff establishment measures
Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England. - Planned, required and available midwifery staff for each shift: Record the total midwife hours for each shift that were planned in advance, were deemed to be required on the day of the shift, and that were actually available. - The number of women in established labour and the number of midwifery staff available over a specified period, for example 24 hours. - High levels and/or ongoing reliance on temporary midwifery staff: Record the proportion of midwifery hours provided by bank and agency midwifery staff on maternity wards. (The agreed acceptable levels should be established locally.) - Compliance with any mandatory training in accordance with local policy (this is an indicator of the adequacy of the size of the midwife staff establishment).
Note: other safe midwifery staffing indicators may be agreed locally.

2 Evidence

The Committee considered the following reports which are available on the NICE website.

Evidence review 1: Warttig S, Little K (2014) Decision support approaches and toolkits for identifying midwife staffing requirements. NICE.

This report considered the following review questions:

- What approaches for identifying midwife staffing requirements and skill mix at a local level, including toolkits, are effective? How frequently should they be used?
- What evidence is available on the reliability or validity of any identified toolkits?

Evidence review 2: Bazian (2014) Safe midwife staffing for maternity settings: The relationship between midwife staffing at a local level and maternal and neonatal outcomes, and factors affecting these requirements. Bazian Ltd.

This report considered the following review questions:

- What maternal and neonatal activities and outcomes are associated with midwife staffing requirements at a local level?
- What maternal and neonatal factors affect midwife staffing requirements, at any point in time, at a local level?
- What environmental factors affect safe midwife staffing requirements?
- What staffing factors affect safe midwife staffing requirements at a local level?
- What unit-level management factors affect midwife staffing requirements?
- What organisational factors influence safe midwife staffing at a unit level?

Evidence review 3: Hayre J (2014) Safe midwife staffing for maternity settings: Economic evidence review. NICE.

This report systematically reviewed and assessed the economic evidence for all of the review questions covered in evidence reviews 1 and 2.

3 Gaps in the evidence

The Safe Staffing Advisory Committee identified a number of gaps in the available evidence and expert comment related to the topics being considered. These are summarised below.

- There is limited evidence directly identifying the relationship between midwife staffing and maternal or neonatal safety outcomes. Where data are available there is a lack of evidence establishing links between midwife staffing levels and skill mix and outcomes.
- There is no evidence about organisational factors that might modify the relationship between midwife staffing and safety outcomes
- There is limited evidence about staffing, environmental, and management factors that might modify the relationship between midwife staffing requirements and safety outcomes
- There is a lack of evidence on focusing on midwife staffing levels outcomes for preconception, antenatal or postnatal care.
- There is a lack of evidence for decision support approaches, frameworks, methods or toolkits.
- There is very limited economic evidence around safe midwife staffing in maternity settings.
- There is a lack of evidence about staffing ratios for midwives working in maternity settings

4 Research recommendations

Research recommendations are in development and will be included in the final guideline.

5 Related NICE guidelines

Details are correct at the time of consultation on the guideline (October 2014). Further information is available on the NICE website.

Published

- Fertility. NICE clinical guideline 156 (2013)
- Ectopic pregnancy and miscarriage. NICE clinical guideline 154 (2012)
- Caesarean section. NICE clinical guideline 132 (2011)
- Multiple pregnancy. NICE clinical guideline 129 (2011)
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010)
- Hypertension in pregnancy. NICE clinical guideline 107 (2010)
- Induction of labour. NICE clinical guideline 70 (2008)
- Diabetes in pregnancy. NICE clinical guideline 63 (2009)
- Antenatal care. NICE clinical guideline 62 (2008)
- Intrapartum care. NICE clinical guideline 55 (2007)
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007)
- Postnatal care. NICE clinical guideline 37 (2006)

Under development

NICE is developing the following guidance (details available from the NICE website):

- Antenatal and postnatal mental health (update). NICE clinical guideline. Publication expected December 2014
- Intrapartum care (update). NICE clinical guideline. Publication expected December 2014
- Postnatal care (update). NICE clinical guideline. Publication expected December 2014

- Diabetes in pregnancy (update). NICE clinical guideline. Publication expected February 2015
- Intrapartum care for high risk women. NICE clinical guideline. Publication date to be confirmed

6 Glossary

Antenatal

The period of time after conception and before birth.

Established labour

Established labour is when there are regular and painful contractions, and there is progressive cervical dilatation from 4 cm.

Establishment

In the context of this guideline establishment refers to the number of registered midwives funded to work in an organisation providing maternity care. This includes all midwives in post, as well as unfilled vacancies or vacancies being covered by temporary staff. Midwife establishments are usually expressed in number of whole-time equivalents.

Indicator

A measurable element of performance that can be used to assess the quality of care provided.

Intrapartum

The period of time from the start of labour to birth of the baby and delivery of the placenta and membranes.

Postnatal

The first 6 weeks after birth.

Pre-conception

In the context of this guideline, pre-conception refers to care provided by midwives to women before they are pregnant.

Preceptorship

A period of time when newly qualified midwives are supported by a clinical instructor or preceptor.

Red flags

Events that prompt an immediate response by the person in charge of the service, ward or unit. The response may include allocating additional staff to the ward or other appropriate responses.

Requirement

The number and skill mix of staff needed in a service.

Registered midwife

A qualified midwife registered with the nursing and midwifery council.

Roster

The daily staffing schedule for each maternity service.

Skill mix

The composition of the midwifery team in terms of qualification and experience.

Short fall

A deficit in the number or skill mix of midwives needed to deliver safe care

Supervision

An activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. Supervision of midwives is a statutory responsibility which provides a mechanism for support and guidance to every midwife practising in the United Kingdom..

Uplift

Uplift is likely to be set at an organisational level and takes account of annual leave, maternity leave, paternity leave, study leave (including time to give and receive supervision), and sickness absence.

7 Contributors and declarations of interest

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A NICE team was responsible for this guideline throughout its development. The team prepared information for the Safe Staffing Advisory Committee and drafted the guideline.

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Declarations of interests

The following members of the Safe Staffing Advisory Committee made declarations of interest. All other members of the Committee stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Georgina Dwight	Remuneration from consultancy undertaken in 2011 for Acertus LTD – search and Selection	Personal pecuniary interest	Declare and participate
Hugh McIntyre	Chair of Quality Standards Advisory Committee	Personal pecuniary interest	Declare and participate
Elaine Inglesby	Member of the Safe Staffing Alliance	Personal non-pecuniary interest	Declare and participate
Julia Scott	NICE Social Care Fellow (until May 2014), honorary Fellow of Brunel University	Non-personal pecuniary interest	Declare and participate
Julia Scott	Chief Executive of the College of Occupational Therapists	Personal non-pecuniary interest	Declare and participate
Becky Bolton	Editorial board member for Emma's Diary, in association with RCGP	Personal non-pecuniary interest	Declare and participate

Julie Orford	Attended a maternity services user group forum meeting in May 2014 at Norwich UEA and received a small attendance fee of £21.42	Personal pecuniary interest	Declare and participate
Julie Orford	In last 12 months has worked with NICE as a lay topic specialist on the Quality Standard for Miscarriage and Ectopic pregnancy	Personal pecuniary interest	Declare and participate
Jane Herve	Trustee and Chair of midwives@ethiopia, a small charity working with partners in Ethiopia for 2 years; Resigned in March 2014. The aim of the charity was to teach midwives and health extension workers to improve outcomes for women and their babies. Payment was not received	Personal non-pecuniary interest	Declare and participate
Tracey Cooper	Lancashire Teaching Hospitals Trust – substantive post full time Care Quality Commission, NHS England – performed one hospital inspection in March paid £470 while on annual leave from post above. NICE, Intrapartum guideline update group- travel expenses only	Personal pecuniary interest	Declare and participate
Tracey Cooper	Department of Health- won a bid for improving birth environments National Institute for Health Research – applied for research funding for midwifery research between LTHTR (Trust above) and UCLAN	Non-personal pecuniary interest	Declare and participate
Tracey Cooper	MIDIRS Advisory Group- travel expenses only Member of Royal College of Midwives Registered with the NMC	Personal non-pecuniary interest	Declare and participate

Chris Bojke	Senior Research Fellow in the Health Policy team at the Centre for Health Economics, University of York. Freelance economist work for Roboleo Ltd and Bresmed	Personal pecuniary interest	Declare and participate
Chris Bojke	Wife is a senior research fellow in the Technology Assessment team at the Centre for Health Economics, University of York	Personal family interest	Declare and participate

575

8 Indicators for safe midwife staffing

Outcome measures from women's reported experiences of maternity services

Safe midwife staffing for maternity settings indicators: woman reported outcome measures

Data collection

Local collection could use the following Maternity Services Survey questions developed by the Care Quality Commission which contains a number of questions where the mother's experience of care could be affected by the number of available midwifery staff:

Adequacy of meeting mother's breastfeeding support

E1. During your pregnancy did midwives provide relevant information about feeding your baby?

E4. Were your decisions about how you wanted to feed your baby respected by midwives?

E5. Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?

E6. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

F14. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Adequacy of meeting mother's postnatal needs (Postnatal Depression and Post Traumatic Stress Disorder (PN PTSD)) and being seen postnatally by the midwifery team

F6. Would you have liked to have seen a midwife (More often? Less often? I saw a midwife as much as I wanted)

F9. Did the midwife or midwives that you saw take your personal circumstances into account when giving you advice?

F10. Did you have confidence and trust in the midwives you saw after going home?

F11. Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 4- 8 weeks after the birth)

F12. Did a midwife or health visitor ask you how you were feeling emotionally?

F13. Were you given enough information about your own recovery after the birth?

F16. Were you given enough information about any emotional changes you might experience after the birth?

Adequacy of communication with midwifery team

B12. During your pregnancy, did you have a telephone number for a midwife or midwifery team that you could contact?

B14. Thinking about your antenatal care, were you spoken to in a way you could understand?

B15. Thinking about your antenatal care, were you involved enough in decisions about your care?

C12. Did the staff treating and examining you introduce themselves?

C14. If you raised a concern during labour and birth, did you feel that it was taken seriously?

C16. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

C17. Thinking about your care during labour and birth, were you involved enough in decisions about your care?

D3. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

F1. When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact?

Local collection of patient experience could use these questions to provide a more frequent view of performance than possible through annual surveys alone, but please note NHS Surveys asks that local patient surveys avoid overlap with national patient surveys: www.nhssurveys.org/localsurveys

Outcome measures

Responsiveness to mother's personal needs.

Data analysis and interpretation

The annual national survey results for your hospital can be compared with previous results from the same hospital and with data from other hospitals (but be aware that comparison between hospitals is subject to variation in expectations of care between different populations). Data from more frequent local data collection, where available, can be compared with previous results from the same ward and with data from other wards in your hospital.

Safe midwife staffing for maternity settings indicator: booking appointment with 13 weeks of pregnancy

Definition

A booking appointment is when a woman sees a midwife or a maternity healthcare professional. NICE guidance on antenatal care (CG62) recommends that early in pregnancy all women should receive appropriate written information about the likely number; timing and content of antenatal appointments associated with different options of care and be given an opportunity to discuss this schedule with their midwife or doctor. .

Data collection

Proportion of pregnant women who have seen a midwife or a maternity healthcare professional for health and social care assessments of needs, risk and choices by 12 weeks and six days of pregnancy.

Numerator: the number in the denominator who have seen a midwife or a maternity healthcare professional for health and social care assessments of needs, risk and choices by 12 weeks and six days of pregnancy.

Denominator: the number of pregnant women.

Data source: Local data collection. This data are currently collated and presented at CCG level through the CCG Outcomes Indicator Set 2014/15 (C1.13). It is also collected through the Maternity Services Data Set.

Outcome measures

Pregnant women that have had a booking appointment by 13 weeks of pregnancy

Data analysis and interpretation

The number of pregnant women not receiving a booking appointment by 13 weeks of pregnancy may be sensitive to the number of available midwifery staff. Timely bookings require a multidisciplinary approach, and missed booking appointment rates may also be affected by:

- patient choice, availability and accessibility
- availability and accessibility of appropriate facilities

- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe midwife staffing for maternity settings indicator: breastfeeding

Definition

Breastfeeding is defined as the proportion of mothers' who have initiated or not initiated breastfeeding and the number and proportion of infants who have been fully, partially or not at all breastfed at 6–8 weeks.

Data collection

a) Proportion of mothers who have initiated breastfeeding.

Numerator: the number in the denominator who initiated breastfeeding.

Denominator: the number of mothers.

Data source: Local data collection. Data can also be collected using NHS England's Maternity and Breastfeeding data return.

b) Proportion of infants who have been fully or partially breastfed at 6–8 weeks.

Numerator: the number in the denominator who have been fully or partially breastfed.

Denominator: the number of infants at 6–8 weeks.

Data source: Local data collection. Data can also be collected using NHS England's Maternity and Breastfeeding data return.

Outcome measures

a) Reported number of mothers who initiate breastfeeding.

b) Reported number of infants who have been fully or partially breastfed at 6–8 weeks.

Data analysis and interpretation

Breastfeeding rates should be compared with previous results from the same maternity service with caution because frequency at maternity service level rates may be too small for significant increases or decreases in these to be apparent.

Although breastfeeding rates may be sensitive to the number of available midwifery staff and support they offer, breastfeeding support requires a multidisciplinary approach, and breastfeeding rates may also be affected by:

- patient choice
- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe midwife staffing for maternity settings indicator: antenatal and postnatal admissions

Definition

An antenatal admission is defined as a mother who has been admitted to a hospital as an inpatient, prior to onset of labour, which includes admissions for non-obstetric conditions, planned caesareans, inductions and false labours.

A postnatal admission is any admission to a hospital as an inpatient after childbirth and to the point of the baby's discharge from maternity services.

The reason for admission and date of discharge should be recorded in accordance with the Maternity Services Data Set. .

Data collection

a) Proportion of mothers admitted to a hospital as an inpatient in the antenatal period.

Numerator: the number in the denominator admitted in the antenatal period.

Denominator: the number of mothers admitted to hospital as an inpatient.

Data source: Local data collection. Data can also be collected using the Maternity Services Data Set.

b) Proportion of mothers admitted to a hospital as an inpatient in the postnatal period.

Numerator: the number in the denominator admitted in the postnatal period.

Denominator: the number of mothers admitted to a hospital as an inpatient.

Data source: Local data collection. Data can also be collected using the Maternity Services Data Set.

Outcome measures

a) Reported number of antenatal admissions.

b) Reported number of postnatal admissions.

Data analysis and interpretation

Rates of antenatal and postnatal admissions should be compared with previous results from the same maternity service with caution because frequency at maternity service level rates may be too small for significant increases or decreases in these to be apparent.

Although antenatal and postnatal admission rates may be sensitive to the number of available midwifery staff, rates of antenatal and postnatal admissions require a multidisciplinary approach, and antenatal and postnatal admission rates may also be affected by:

- patient choice
- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe midwife staffing for maternity settings indicator: incidence of genital tract trauma

Definition

Trauma of the genital tract is defined as when a mother suffers a tear during labour.

Any incidence of genital tract trauma should be recorded and can be further defined in accordance with Maternity Services Data Set to record the type of tear and indicating whether a mother underwent an episiotomy to extend the tear:

- none
- labial tear
- vaginal wall tear
- perineal tear –first degree (injury to perineal skin only)
- perineal tear – second degree (injury to perineum involving perineal muscles but not involved the anal sphincter)
- perineal tear – third degree (partial or complete disruption of the anal sphincter muscles, which may involve either or both the external (EAS) and internal anal sphincter (IAS) muscles)
- perineal tear – fourth degree (a disruption of the anal sphincter muscles with a breach of the rectal mucosa)
- episiotomy
- cervical tear
- urethral tear
- clitoral tear
- anterior incision

Data collection

Proportion of mothers who experience genital tract trauma during labour.

Numerator: the number in the denominator who have experienced genital tract trauma.

Denominator: the number of mothers who have been in labour.

Data source: Local data collection. Data can also be collected using the Maternity Services Data Set.

Outcome measures

Reported number of genital tract trauma.

Data analysis and interpretation

Rates of genital tract trauma should be compared with previous results from the same maternity service with caution because frequency at maternity service level rates may be too small for significant increases or decreases in these to be apparent. Incident reporting systems may be affected by under-reporting. Periodic local collection of data on whether genital tract traumas are going unreported will identify if changes in reported genital tract trauma rates are true changes in actual genital tract trauma rates or are affected by changes in completeness of reporting.

Although genital tract trauma rates may be sensitive to the number of available midwifery staff, rates of genital tract traumas require a multidisciplinary approach, and genital tract trauma rates may also be affected by:

- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe midwife staffing for maternity settings indicator: birth place of choice

Definition

Birth place of choice is defined as the intended place of delivery (type and geographical). The type could be a NHS Hospital or domestic address and the geographical would be the NHS Trust site code. The intended place of delivery and actual place of delivery should be recorded as well as the reason for the change of place (if applicable) whether that be type or geographical.

Data collection

a) Proportion of births where the intended type of birthplace did not change.

Numerator: the number in the denominator where the intended type of birthplace did not change.

Denominator: the number of births.

Data source: Local data collection. Data can also be collected using the Maternity Services Data Set.

b) Proportion of births where the intended geographical birth place did not change.

Numerator: the number in the denominator where the intended geographical birth place did not change.

Denominator: the number of births.

Data source: Local data collection. Data can also be collected using the Maternity Services Data Set.

Outcome measures

Rates of change in intended place of births.

Data analysis and interpretation

Rates of change in intended place of birth should be compared with previous results from the same maternity service with caution because frequency at maternity service level rates may be too small for significant increases or decreases in these to be apparent.

Although rates of change in intended place of birth may be sensitive to the number of available midwifery staff, rates of change in intended place of birth require a multidisciplinary approach, and genital tract trauma rates may also be affected by:

- clinical need
- patient choice
- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Staff reported measures

Safe midwife staffing for maternity settings indicator: missed breaks

Definition

A missed break occurs when a midwife is unable to take any scheduled break due to lack of time.

Data collection

Proportion of expected breaks for midwives working in maternity that were unable to be taken.

Numerator: the number in the denominator that were unable to be taken.

Denominator: the number of expected breaks for midwives in maternity services.

Data source: Local data collection.

Outcome measures

Proportion of missed breaks due to lack of time amongst midwives.

Safe midwife staffing for maternity settings indicator: midwife overtime

Definition

Midwife overtime includes any extra hours (both paid and unpaid) that a midwife is required to work beyond their contracted hours at either end of their shift.

Data collection

a) Proportion of midwives in maternity services working overtime.

Numerator: the number in the denominator working overtime.

Denominator: the number of midwives in maternity services.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

b) Proportion of midwife hours worked in maternity services that are overtime.

Numerator: the number in the denominator that are overtime.

Denominator: the number of midwife hours worked in maternity services.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

Outcome measures

Staff experience.

Safe midwife staffing for maternity settings indicator: staff morale

Definition

Midwife staff morale includes the proportion of midwives who claim to have job satisfaction.

Data collection

Proportion of midwives in maternity services who report job satisfaction.

Numerator: the number in the denominator who report job satisfaction.

Denominator: the number of midwives in maternity services.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

Outcome measures

a) Midwife job satisfaction.

b) Rates of midwifery staff turnover.

c) Rates of sickness.

Midwife establishment measures

Safe midwife staffing for maternity settings indicator: planned, required and available midwifery staff for each shift

Definition

The number of midwife hours which were planned in advance, deemed to be required during that shift and that were actually available.

Data collection

Proportion of total midwife hours for each shift that were planned in advance and that were actually available.

Numerator: the number in the denominator that were actually available.

Denominator: the number of midwife hours for each shift that were planned in advance.

Data source: Local data collection, which could include data collected for the NHS England and the Care Quality Commission joint guidance to Trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

Outcome measures

Deviation between planned and available midwifery staff.

Safe midwife staffing for maternity settings indicator: high levels and/or ongoing reliance on temporary midwifery staff

Definition

Registered midwives who are working in maternity services who are not contracted with the maternity service.

Data collection

a) Proportion of registered midwives who are working in maternity services who are not contracted with the maternity service.

Numerator: the number in the denominator who are employed on bank contracts.

Denominator: the number of registered midwife shifts per calendar month to work in maternity services.

Data source: Local data collection.

b) Proportion of midwives who are working in maternity services who are on agency contracts.

Numerator: the number in the denominator who are employed on agency contracts.

Denominator: the number of registered midwife shifts per calendar month to work in maternity services.

Data source: Local data collection.

Outcome measures

Expenditure (£) on bank and agency staff per ward.

Safe midwife staffing for maternity settings indicator: compliance with any mandatory training

Definition

Midwives who are working in maternity services who are compliant with the mandatory training that has been agreed in line with local policy.

Data collection

Proportion of registered midwives working in maternity services who are compliant with all mandatory training.

Numerator: the number in the denominator who are compliant with all mandatory training.

Denominator: the number of registered midwives in maternity service establishment.

Data source: Local data collection.

Outcome measures

% compliance with all mandatory training.

About this guideline

How this guideline was developed

The Department of Health asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on safe midwife staffing in maternity settings (see the scope).

The recommendations are based on the best available evidence. They were developed by the Safe Staffing Advisory Committee – for membership see section 7.

The guideline was developed in line with the methods and processes contained in Developing NICE guidelines: the manual.

Other versions of this guideline

The recommendations from this guideline will incorporated into a NICE Pathway.

We will produce information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice will be available at final publication of the guideline.

The NICE website will have details of the NICE endorsement programme for decision support toolkits.

Your responsibility

This guideline represents the views of NICE and was arrived at after careful consideration of the evidence available and the Committee's considerations. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guideline is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of

opportunity and foster good relations. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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