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Q1: Is it clear throughout the guideline that the recommendations are intended to be applied to all maternity services where midwife care is provided (pre-conception, antenatal, Intrapartum, postnatal) and in all settings (home, community, hospital)?

Comment number	Organisation	responses	Developers response
1	Birthrate Plus	Yes very clear in general, the principles apply to all services. However there is need to highlight different components of the work for community midwifery separately in some areas of the guidelines Small midwife led units may also need separate discussion because of the need for 24 hours cover irrespective of workload flow Both community midwives and those working in small midwife led units also need to escort clients in emergency to the local hospital and this needs to be allowed for. It is possible to capture data which indicates the frequency of such events and a typical time spent in providing this care	Thank you for responding to this question. Your response will be shared with the committee for consideration.
2	Bolton Hospital NHS Foundation Trust (HoM)	It is clear that the recommendations in the guideline are intended to cover all aspects of maternity services and all maternity settings. However reference to preconception should be removed as this is not within current staffing models or service specification for maternity services	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
3	Bolton NHS Foundation Trust (DoN)	It is clear that the recommendations in the guideline are intended to cover all aspects of maternity services and all maternity settings. However reference to preconception should be removed as this is not within current staffing models or service specification for maternity services	Thank you for responding to this question. Your response will be shared with the committee for consideration.
4	Bradford Teaching Hospital NHS Foundation Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
5	Buckinghamshire Healthcare NHS trust	not really, by limiting the scope to NHS providers it creates the possibility that different standards may exist in Social enterprise, Charitable and Independent sector providers,	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
6	City Hospitals Sunderland, NHS Foundation Trust	Whilst pre-conceptual care is relevant to midwifery, this is not always undertaken by midwives, so consider removal. The calculations in the document are not explicit and are open to interpretation. They further suggest local adaptation and also suggest changes relating to professional judgement, we feel the scope for external influence is too wide and therefore not robust/ open to criticism.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
7	Countess of Chester NHS Foundation Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
8	Department of Health	Yes – however it needs to be clear why input ratios are thought to be appropriate for this workforce and not others.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
9	Doncaster and Bassetlaw Hospitals NHS FT	yes Include supervisors of midwives in lines 38-41	Thank you for responding to this question. Your response will be shared with the committee for consideration.
10	Epsom and St Helier NHS Trust	Yes it is clear that the guideline applies to all areas of maternity care. However, current work within our organisation does not involve pre-conception care and this would be difficult to measure within the current acute setting. There are a number of key issues missing from the document. This includes any regard for multiple sites where care is given e.g. if there are 2 sites with 2 labour areas, this would significantly change the level of staffing requirements. This should be included on page 17 or 50 under' local considerations' There is also no recognition for the role which Birth Rate plus which is currently used to support staff development needs for maternity services. There is no recognition of the role of the co-ordinator within the labour area and how this status should be monitored. This seems as odds with the current quality initiatives which maternity units are using to reflect safe staff levels.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
11	Epsom and St Helier NHS Trust	Yes it is clear that the guideline applies to all areas of maternity care. However, current work within our organisation does not involve pre-conception care and this would be difficult to measure within the current acute setting. There are a number of key issues missing from the document. This includes any regard for multiple sites where care is given e.g. if there are 2 sites with 2 labour areas, this would significantly change the level of staffing requirements. This should be included on page 17 or 50 under' local considerations' There is also no recognition for the role which Birth Rate plus which is currently used to support staff development needs for maternity services. There is no recognition of the role of the co-ordinator within the labour area and how this status should be monitored. This seems as odds with the current quality initiatives which maternity units are using to reflect safe staff levels.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
12	Guy's & St Thomas' NHS Foundation Trust	It is clear throughout the guideline that the recommendations are intended to be applied to all maternity services where midwife care is provided. However, it is worth noting that midwives generally have very little involvement with women pre-conceptually. If this aspect of care was to be included then additional staffing needs would have to be considered.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
13	Heads of midwifery in Wales Advisory Group	Yes this is clear throughout the guidance. However to capture this pre conceptually is unrealistic.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
14	Health Education England	Yes however it is not explicit whether these guidelines should apply to independent midwives if they are commissioned by the NHS to provide care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
15	National Childbirth Trust	Yes, this is made clear. However, the guideline should specific at the outset that there is evidence for extending midwifery care beyond six weeks. While in theory this can be achieved without additional midwives, since the high quality evidence was published (RCT, gold standard) there has been almost no implementation. (cf MacArthur, Winter, Bick, 2002. Effects of redesigned community postnatal care on women's health 4 months after birth: a cluster randomised controlled trial, Lancet). We believe this is because, in order to introduce and maintain service innovations, additional staffing is required to manage an innovative project through training, monitoring and motivating. There is still no evidence that outside of a trial setting, in the everyday world, this kind of woman-centred/ public health oriented innovation can be realised without additional staffing.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
16	National Federation of Women's Institutes	It is clear that the guideline refers to all settings – however further references to travel times are needed in relation to providing safe care in some of these settings (see below). 'Pre-conception care' is not wholly given by midwives and it is not clear in the guideline itself about how safe maternity staffing for pre-conception care would be achieved. Removing 'pre-conception' care from the guideline should be considered.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
17	NHS England	Yes it is clear that these recommendations apply to all settings where midwives work, however it is not clear if it also applies to independent maternity providers. Also, pre-conceptual care is frequently mentioned within the guidelines however this is not relevant as this is not commonly within the remit of midwifery care and should therefore be removed to avoid confusion.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
18	NHS England (Midlands & East)	Yes however it is not explicit whether these guidelines should apply to independent midwives if they are commissioned by the NHS to provide care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
19	NHS Forth Valley	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
20	North Middlesex University Hospital NHS Trust	Yes. Also the document states “agree at local level”, which is good in principle, however, it can also be very judgmental for each organisations, which can lead to unsafe staffing level. There are also concern regarding postnatal care and staffing level. Majority of the organisations focus on labour care due to high risk area and litigations. The midwives are allocated to cover labour ward at the expense of postnatal care. This may have an impact on poor women’s experience and also their breastfeeding support.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
21	Nottingham University Hospitals NHS Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
22	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
23	Obstetric Anaesthetists Association	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
24	Oxford University Hospitals NHS Trust	The guideline should state midwifery care. It is clear that the guideline relates to maternity services although additional resources would be required to provide pre-conception care to all women planning a pregnancy. This service is not currently provided in all services so would need to be resourced.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
25	Royal College of Midwives	It is clear throughout that the recommendations are intended to be applied to all maternity settings where midwife care is provided. However with regards pre-conception care, the RCM notes that in the current context midwives are rarely involved in this area of care, but if they were then additional staffing needs would have to be considered.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
26	Royal College of Nursing	The RCN fully supports the recommendations to develop national standards for the development; maintenance and reporting of safe staffing levels to accommodate best practice in maternity settings, and welcomes this NICE guideline to establish evidence based standard. Yes, generally, it is clear that the recommendations are intended to be applied to all maternity services, noting that it is NHS focused, and does not take account of individual or group independent midwifery practices. While the title says 'maternity settings' it is also not clear where some services (such as screening and parent education, which have been outsourced to independent services) will fit. Consideration has been given through the document regarding maintaining establishment and the need for it to meet the demands of the service. There is however, no mention of specialist midwifery services which are challenged to be maintained, in the current climate. Subsequent answers are also mindful of the need to have effective implementation strategies, and active monitoring and action, where standards are not being met.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
27	Royal Cornwall Hospital NHS Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
28	Royal Surrey County Hospital Foundation Trust	clearly stated	Thank you for responding to this question. Your response will be shared with the committee for consideration.
29	Stillbirth & Neonatal Death Charity (Sands)	Yes. However, we take this opportunity to highlight the need for additional time and staffing for all antenatal appointments, in addition to the booking appointment. In focus groups of midwives carried out in Q4 2013, participants talked about time pressures and the increasing amount of information they are required to give to women at these appointments.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
30	Taunton and Somerset NHS Foundation Trust	Yes it is clear, although I am not aware of any organisations where pre-conception care is provided by midwives	Thank you for responding to this question. Your response will be shared with the committee for consideration.
31	The Royal College of Obstetricians and Gynaecologists	Although important, it does not appear that this section adds any new information that is not contained within NICE antenatal and Intrapartum care guidance. In addition the recommendations do not provide any support on how they may be achieved. Although the establishment of midwives may be reviewed and readjusted every 6 months, this may not translate into achieving the new establishment figures. This guidance would be an appropriate place to address the support that medical staff provide to midwifery colleagues in service provision. Addressing this relationship would reinforce the role of true multi-disciplinary working which is known to keep service provision safe. As complexity increases the roles of high risk obstetricians and obstetric physicians is to 'normalise' birth. It is difficult to take this into account when considering the midwifery workforce on its own. In addition although the guideline stresses the different stages of pregnancy, the only toolkit suggested is for Intrapartum care. From the surveys of women's experiences we know that postpartum care is often understaffed and results in poor patient experience.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
32	The Shelford Group	It is clear throughout the guideline that the recommendations are intended to be applied to all maternity services where midwife care is provided. Each specific section reiterates the mandate of all maternity services and settings. However, it is worth noting that midwives generally have very little involvement with women pre-conceptually.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
33	The South West London Maternity Network	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
34	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	Yes this is clear however it needs to be noted that preconception care is not part of the Maternity Tariff and is not commissioned by CCGs for all Maternity Service's. There is no an acknowledgement that there is a material difference between providing care in a Tertiary Unit supporting level 3 neonatal care supporting IUT and the regions very high risk women compared to a District General Hospital supporting level 1 neonatal care these case mixes are vastly different and staffing calculations need to be reflective of the comparative risks and dependency. Conversely there needs to be a definition between low risk care in an Alongside Midwifery Unit and a Freestanding Maternity Unit. The FMU will have a delayed staffing solution response to a red flag by nature of its staffing model and geographic isolation.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
35	University Hospital South Manchester NHS Foundation Trust	Yes. The guidelines clearly identify that the recommendations apply to all maternity services where midwifery care is provided in all settings.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
36	West Hertfordshire Hospitals Trust	I don't understand how preconceptual care can contribute to midwifery safe staffing levels as this generally isn't provided by a midwife	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Q 2: Is it appropriate to set a staffing ratio of 1 midwife to a maximum of 1 woman during established labour?

Comment number	Organisation	responses	Developers response
37	Birthrate Plus	Our experience of assessing Intrapartum needs shows women whose labour and outcome puts them in the higher need groups e.g. C/S, diabetes, neonatal problems require an increased percentage of midwife time ; 1,2/1,3 and 1.4; on the same basis as that in intensive care units. This has been applied in almost all maternity services in England/Wales and found to be useful and reflective of need. It also allows for the oversight of specialist midwives within the delivery suite.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
38	Bolton Hospital NHS Foundation Trust (HoM)	Yes, this is welcomed as an addition along with the definition of established labour. However there is no mention of the cases where more than 1 midwife may be required. The birth rate plus tool uses an Intrapartum acuity tool which is very valuable for calculating those women with higher staffing requirement, emergency LSCS, pre-term delivery allowing identification of increased staffing requirement on the day and analysis of acuity over a longer time period	Thank you for responding to this question. Your response will be shared with the committee for consideration.
39	Bolton NHS Foundation Trust (DoN)	Yes, this is welcomed as an addition along with the definition of established labour. However there is no mention of the cases where more than 1 midwife may be required. The birth rate plus tool uses an Intrapartum acuity tool which is very valuable for calculating those women with higher staffing requirement, emergency LSCS, pre-term delivery allowing identification of increased staffing requirement on the day and analysis of acuity over a longer time period	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
40	Bradford Teaching Hospital NHS Foundation Trust	Appropriate as this is what is required for safety but unfortunately not always achievable in most units due to current staffing levels.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
41	Buckinghamshire Healthcare NHS trust	yes of course , though this should go further and make statutory recommendations for women: midwife ratios and these should be extended to include post natal and ante natal services also.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
42	City Hospitals Sunderland, NHS Foundation Trust	Yes we agree, however, it is not explicit how the ratios would be calculated or consideration for additional midwifery allocation for complex cases.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
43	Countess of Chester NHS Foundation Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
44	Department of Health	There are a number of sensitivities around setting staffing ratios. Is it not possible to nuance this given the sensitivities and be less categorical? Use of the word “ensure” when recommending 1-1 midwife to woman during established labour could in some circumstances see a reduction on the numbers of midwives being available in a birthing unit. There also needs to be some quantification of any financial impact arising from the guidance. No doubt there will be further engagement with DH around this aspect.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
45	Doncaster and Bassetlaw Hospitals NHS FT	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
46	Epsom and St Helier NHS Trust	How this will be measured may vary from unit to unit and it is unlikely that this would be accurately reflected in every unit. It is appropriate to set this ratio. However, it would be more realistic to suggest that this is met 90% of the time, rather than to expect this to be achieved 100%.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
47	Epsom and St Helier NHS Trust	How this will be measured may vary from unit to unit and it is unlikely that this would be accurately reflected in every unit. It is appropriate to set this ratio. However, it would be more realistic to suggest that this is met 90% of the time, rather than to expect this to be achieved 100%.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
48	Guy's & St Thomas' NHS Foundation Trust	Yes, it is appropriate to set a staffing ratio of 1 midwife to a maximum of 1 woman during established labour; this needs to remain an essential standard we endeavour to meet. However, ratios alone are not reflective of a) the context of care or b) the skill mix, which can both impact upon the ability to provide 1:1 care. Birthrate Plus has developed a classification system that accounts for a composite of key clinical outcomes and processes (e.g. length of labour, pre-term births, medical conditions, and emergency Caesarean section) that can be used to calculate the midwifery time required for the entire labour period.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
49	Heads of midwifery in Wales Advisory Group	Yes this is appropriate and will be supported by the Heads of midwifery in Wales	Thank you for responding to this question. Your response will be shared with the committee for consideration.
50	Health Education England	Yes it is useful to have this staffing ratio but it would be helpful to state that this is a minimum, particularly when at the point of delivery it is common practice, in some units, for two midwives to be in attendance. This would help to prevent the staffing ratio being used to reduce staffing levels to a minimum level.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
51	National Childbirth Trust	It may not be sufficient as a ratio. 1) Birthrate Plus has highlighted the need for a higher ratio for women with complex needs. 2) It is considered good practice to have two midwives present for the birth itself (or a student) as a second pair of hands, one for the mother and one for the baby, and where there is a sick mother or baby or a multiple birth two qualified midwives are especially important. 3) It is vital that there are opportunities for mentoring and CPD post-qualification, this requires more experienced midwives being able to work alongside less experienced midwives. At the RCM conference (12-13 Nov 2014) a good example of need in this area has been demonstrated: the PEARLS study was an educational initiative to improve identification and repair of third and fourth degree perineal trauma, developed in response to poor quality care (cf Ismail, Kettle, McDonald et al 2013). Evidence shows that less experienced midwives need, in addition to training in a controlled setting, to be able to watch an experienced midwife demonstrate the continuous suturing method in the reality of the labour ward with oedema present following birth. Currently, with very tight staffing ratios, what is more likely to happen is that a senior midwife will take over a case to suture, provided that the junior midwife takes over care of the senior midwife's case. This prevents learning from being passed on and the expertise and wisdom of experienced midwives is not shared (discussion at parallel session, plus personal communication with Chris Kettle). Some of the very best midwives say that they learn a great deal from working in pairs form time to time, to compare notes on management in real time and being able to reflect on the same observed cases. So without more than a 1:1 ratio, we miss out on learning for both less experienced and more experienced midwives with a detrimental effect for the quality of care that women receive.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
52	National Federation of Women's Institutes	The NFWI welcomes this recommendation. Our research found that many maternity providers have not taken 1:1 care seriously; some trusts have aimed for only 75% of mothers to receive this care, for example. We would urge NICE to include the word 'every' in the recommendation to make it as strong as possible to avoid the current situation where 1:1 is merely an 'aspiration'. We would also encourage NICE to reword the recommendation to take into account the times when a woman (and/or her baby) will require more than one midwife, for example: 'A minimum of 1 midwife to a maximum of 1 woman during established labour' (in lines 152, 247, 298, 348)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
53	NHS England	Yes it is very helpful to state this as a minimum staffing level. The acknowledgement that 2 midwives will be present for the birth is missing however, as is the additional midwifery staffing requirement for high risk women and those with complex labours and how this should be determined and met.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
54	NHS England (Midlands & East)	It is appropriate to set this ratio as a minimum. In some cases there will be more than one midwife at the time of delivery.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
55	NHS Forth Valley	Yes That is the current guideline in use in Scotland when patient is in established labour	Thank you for responding to this question. Your response will be shared with the committee for consideration.
56	North Middlesex University Hospital NHS Trust	Yes. Also there should be a ratio for postnatal care. Nursing have set a ratio to 1:6. for the wards.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
57	Nottingham University Hospitals NHS Trust	yes, however there should be other guidelines as to wards and other settings.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
58	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	In NHS Scotland the Standard is that labouring women receive 1:1 care. This is scored as level 3 dependency and built into the metrics of the national maternity workload tool, and impacts on the recommended whole time equivalent (wte) outcome.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
59	Obstetric Anaesthetists Association	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
60	Oxford University Hospitals NHS Trust	The ratio of 1:1 midwife to woman in established labour is vital to provide a safe level of care. However the issue of acuity and dependency has not been adequately addressed in the guideline and there is a need to factor in additional midwifery support for women with medium or high risk needs. The changing demographics of the population is very relevant to pregnant women and there are more women becoming pregnant who require additional care and support. These include renal disease/transplant, obesity and the related medical and pregnancy problems, women from different ethnic groups with underlying medical conditions. The use of a robust tool to determine appropriate staffing levels is not clearly defined in the guideline and it is unfortunate that the use of a nationally recognised tool has not been proposed. One such tool is Birthrate Plus which has been used successfully in many maternity units for a long time and is refined on a regular basis. A task orientated approach is not appropriate in a midwifery setting as the needs of women and their babies are very diverse.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
61	Royal College of Midwives	Yes, the RCM welcomes this recommendation. However, what is also needed – and what is not explicitly stated within this guideline – is an additional recommendation to factor in additional midwifery time to meet the needs of women who are at moderate or high risk or who develop complications during labour. Birthrate Plus has developed a classification system that accounts for a composite of key clinical outcomes and processes, such as length of labour, pre-term births, emergency caesarean section etc., that can then be used to calculate additional midwifery time required during the period between onset of established labour and transfer to the postnatal ward. Essentially what this recognises is that some women will require care from more than one midwife during established labour. This is an example of where we believe the guideline fails to be clear as to its approach to the calculation of midwifery staffing needs. The RCM believes there are two possible approaches. The first is an approach which breaks service delivery into tasks e.g. care in established labour and builds up numbers of staff needed based on tasks. The task of looking after a woman in labour is deemed to take one midwife. The second is an approach which says 'what do women need?' and builds up staffing from that premise. This acknowledges that different women in labour have different needs with one midwife being the minimum. The RCM believes that the guideline currently lacks clarity as to which approach it is pursuing. The RCM believes that the best approach is to calculate the total number of midwives needed in a service area based on women's needs and then use a more task oriented approach to calculate ratios for specific areas. We make this point again in the general comments section.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
62	Royal College of Nursing	Yes. This is the minimum for labour care. However care needs to be taken when confining/defining 'established labour' as some women with long latent phases, need a lot of support too. To ensure safety and optimal outcome of labour, 1:1 care is important during labour, however it is also important to consider the needs of antenatal and postnatal women, and the impact quality care can have on outcomes, as well as labour care. There also needs to be consideration perhaps of the need for additional support for some high risk cases and the provision for relief of midwives providing one to one care for reasonable breaks.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
63	Royal Cornwall Hospital NHS Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
64	Royal Surrey County Hospital Foundation Trust	yes to 152,247,298 However clear definition of what one to one means must be included in the terminology of the guidance as it is apparent that maternity services already interpret this differently. e.g. One to one care in established labour – what is the definition of established. Is this based on current NICE Guidelines. Is it anticipated that the midwife will have no other planned activity during this time such as looking after a postnatal delivered woman or caring for an induction of labour who is not in established labour.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
65	Stillbirth & Neonatal Death Charity (Sands)	Yes, Sands welcomes this recommendation. The NPEU's Listening to Parents report (2014) revealed that 27% of women and partners whose baby died during labour were left alone and worried at some stage during labour and birth. We ask the guidance developers to consider also the allocation of additional midwifery support because of a woman's heightened risk at or after onset of labour.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
66	Taunton and Somerset NHS Foundation Trust	yes, that is a standard that we should aim for	Thank you for responding to this question. Your response will be shared with the committee for consideration.
67	The Royal College of Obstetricians and Gynaecologists	There is much evidence to support this gold standard but at present the financial pressure of providing 24/7 consultant delivered care will occupy resources that could be used for this midwifery staffing.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
68	The Shelford Group	Yes, it is appropriate to set a staffing ratio of 1 midwife to a maximum of 1 woman during established labour; this needs to remain an essential standard we endeavour to meet. However, this is only applicable in a hospital setting. In community/small birth centres/homebirth, it must be two midwives to one mother to provide emergency care. In addition, there are certain points that ought to be raised: • Ratios alone are not reflective of a) the context of care or b) the skill mix, which can both impact upon the ability to provide 1:1 care • There is an absence of any other tested outcome indicator for providing care during the Intrapartum period; as such, this is a minimum standard and offers a good place to start • There are two omissions in the text: the requirement for a more solid reference to staffing which enables 'peer practice' assessment; and the presence of a second midwife at the birth element of the Intrapartum care period, even in low risk normal labour and home birth • The guideline is not explicit in calculating the workforce establishment required to provide safe and effective care for those women not established in labour but who attend in the latent phase	Thank you for responding to this question. Your response will be shared with the committee for consideration.
69	The South West London Maternity Network	yes – it would be very hard not to recommend or to recommend something other than this. This should also include women receiving care for post theatre recovery and any High Dependency care on labour ward.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
70	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	Yes but there also needs to be acknowledgement of instances when this is unsafe and inadequate and the requirement is greater than 1 to 1 e.g. PPH Shoulder Dystocia NLS	Thank you for responding to this question. Your response will be shared with the committee for consideration.
71	University Hospital South Manchester NHS Foundation Trust	Yes. It is appropriate to set a staffing ratio of 1 to 1 during established labour.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
72	West Hertfordshire Hospitals Trust	This is an evidence based standard known to improve the safety of women and their babies, as well as being essential for psychological support	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Q3: Should the guideline set staffing ratios for specific settings (such as home births), or for other stages of care (such as antenatal care)? If so what ratio should be used and why?

Comment number	Organisation	responses	Developers response
73	Birthrate Plus	This can be very useful where it is based on observed and agreed hours etc. and data collected over a number of different services . For example Home birth ratios range from 1: 34 births per annum to 1:37 depending on geography and density of population. Also most important to differentiate between hospital births and community workload. Because of “cross border flow between services community midwives provide care for women in their area irrespective of where those women give birth. Therefore to use the local hospital births to assess community workload can be misleading. Similarly some hospitals and especially those providing care for women with specialist needs do not provide the ante-natal and postnatal care in the community for a significant proportion of their births. However it is possible to produce different ratios for hospital births and community cases and these have already been used widely is assessing workload patterns.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
74	Bolton Hospital NHS Foundation Trust (HoM)	Broad guidelines should be within the remit of this guideline. Especially for areas of home birth and community setting which already have recommended levels i.e. 1:96 for community midwifery caseloads in birth rate plus Ward areas would be difficult to make recommendations for as services have very different provision from one unit to another	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
75	Bolton NHS Foundation Trust (DoN)	Broad guidelines should be within the remit of this guideline. Especially for areas of home birth and community setting which already have recommended levels i.e. 1:96 for community midwifery caseloads in birth rate plus Ward areas would be difficult to make recommendations for as services have very different provision from one unit to another	Thank you for responding to this question. Your response will be shared with the committee for consideration.
76	Bradford Teaching Hospital NHS Foundation Trust	Very difficult to set general levels due to vast differences between units in terms of clientele needs of population. Units to be encouraged to set own local ratios.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
77	Buckinghamshire Healthcare NHS trust	Yes. International evidence such as in Australia may be helpful in prescribing ratios for Ante and post natal care, in particular high risk and / or high dependency women. The much used 1:8 ratio for nursing should be at least described as a minimum in these settings. Line 153 'other locally agreed ratios' is an unhelpful 'get out ' clause to those who prefer to disregard this guidance and should be removed. There is also no reference to transitional care, the care of the unwell neonate and reinforces the 'fudge' so often seen where the needs of the infant are ignored in setting Midwifery staffing ratios.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
78	City Hospitals Sunderland, NHS Foundation Trust	In principle we agree, however, again as in 1.1.3, the wording is not clear on calculations and how ratios are determined. Birthrate plus recommendations should be referenced in the document. This would also cover community care, in-patient post natal settings as well as Intrapartum complexities.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
79	Countess of Chester NHS Foundation Trust	Yes to ensure equity across the UK & ability to benchmark accurately Recommend ratio for antenatal & postnatal inpatient areas 1:8 mothers/babies daytime & 1:16 night time Home birth 1.45	Thank you for responding to this question. Your response will be shared with the committee for consideration.
80	Department of Health	See above. Finance reiterates concerns about simply using ratios as apparently hard and fast rules. Staffing ratios are seen as input measure and not as providing a reliable measure of quality or consistency. This is an issue that should be considered.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
81	Doncaster and Bassetlaw Hospitals NHS FT	Use Birthrate plus tool to determine staffing needs, triangulating with other data	Thank you for responding to this question. Your response will be shared with the committee for consideration.
82	Epsom and St Helier NHS Trust	I am uncertain how one would set the standard for antenatal care as this work is flexible and weaves into the community setting. It would be useful to set a standard for home birth. However what this should be would be determined through individual assessment of each woman.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
83	Epsom and St Helier NHS Trust	I am uncertain how one would set the standard for antenatal care as this work is flexible and weaves into the community setting. It would be useful to set a standard for home birth. However what this should be would be determined through individual assessment of each woman.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
84	Guy's & St Thomas' NHS Foundation Trust	It would be of benefit to have explicit guidance as to the appropriate staffing of other areas and/or settings of care e.g. antenatal care in the community; postnatal care on the ward. This guidance has been partly provided by Birthrate Plus where a ratio of one midwife for every 96 cases for community services activity is recommended. This is based primarily on the time needed to provide all of the elements of antenatal and postnatal care to women and has been refined to adjust for cross border workload. For inpatient postnatal settings, staffing ratios must take into account that there are two 'patients' – a mother and a baby – and that the ratio will be influenced by dependencies such as number of post-surgical women. The model used for calculating nurse ratios for inpatient areas, which takes account of number and acuity of the patients could be adapted for a postnatal ward. Any calculation of staffing requirements should reflect the context of care e.g. staffing needs of a tertiary unit which delivers very complex care would be very different to a DGH.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
85	Heads of midwifery in Wales Advisory Group	If no ratios are set then this could lead to a variation in numbers of midwifery staffing levels throughout the NHS	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
86	Health Education England	The staffing ratio for the required establishment of clinical midwifery staff should reflect workforce need for the whole service to ensure safe and adequate staffing levels for all care points and not just 1:1 midwifery care in labour. It should also include a requirement for non-clinical midwifery staffing time that is essential to effective service delivery. The absence of a recommended ratio developed from existing models in the presence of available tools (which calculate the overall staffing requirement for not only midwifery staff but also for skill mix/ non-registered support staff) presents a significant risk to maternity services. The Birthrate plus tool has been widely used as a consistent approach to determining midwifery staffing across maternity services in England There is concern that the frequent use of the terminology 'locally agreed' could allow Trust Boards and CCGs to determine what is 'locally agreed' based upon available financial resources as opposed to the actual staffing needs required for the delivery of safe, high quality services. There is no benchmark or expected standard to measure against which could lead to reductions in current staffing levels. Furthermore this guidance may serve to further reduce the drivers and levers Heads of Midwifery Service currently have.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
87	National Childbirth Trust	NCT is extremely concerned that there are too few midwives in the system to provide quality postnatal care for mothers and babies (2 'patients' or service users). Our survey of women found that the NICE Postnatal Care guideline was not being implemented (Newburn and Bhavnani, Left to their own Devices). Women who had a CS or forceps birth were most likely to report that their needs were not being met. We would like to see a recommendation on the ratio of midwives to women on postnatal wards in OUs and a minimum number of postnatal home visits a woman could expect as her right. As our study found, patterns of postnatal care were highly variable. There needs to be flexibility to respond according to need. Currently, many women and babies in need are being neglected leading to unnecessary physical and psycho-social problems that are costly in human terms and also create NHS costs longer-term in readmission, reduced breastfeeding (and associated infection-related admissions to hospital for babies before 13 weeks) (Renfrew et al), and high rates of perinatal depression. Perinatal trauma which is not addressed and resolved through discussion of case notes, management of labour and counselling, also creates more human suffering and requests for repeat or subsequent CS in a next pregnancy. As routine interventions, including screening and monitoring, increase, the opportunities for forming a relationship, really listening to women, acknowledging their feelings, anxieties and concerns gets squeezed out. Expectations change and some midwives may hardly notice that they are almost entirely task-oriented rather than person-oriented. The Cochrane review on midwifery-led continuity models of care by Sandall et al and the Birthplace in England cohort study both show that the care provided in most of our OUs (where more than 8/10 women have their baby) is failing to provide women with adequate staffing. (Birthplace recognised that women having a home birth BOTH had more midwifery time and cost less, partly as there were so many fewer caesareans.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
88	National Federation of Women's Institutes	We know that currently, staff from postnatal and antenatal settings are 'sacrificed' in order to fulfil the needs of Intrapartum women. The Care Quality Commission noted that when staff are moved the quality of care in the other settings drops (CQC Market Report, June 2012), and so too did the Auditor General in Wales (Briefing paper on the progress made in improving maternity services in Wales, 2012). The risk is that while the guideline provides a very explicit ratio for Intrapartum care (and rightly so), it leaves the ratio for other stages of maternity care to local decision-makers. This keeps the current situation - whereby there is little incentive for postnatal and antenatal staffing to be considered inviolable. We would urge NICE to consider the risks of not setting ratios for other stages of women's and babies' care, in light of what we know already happens with maternity staffing angled towards Intrapartum care. Further, contributors to the Safe Births Inquiry in 2008 claimed that maternity services were of low priority for trusts, due to the absence of centrally imposed targets which are set for other areas of health care and command board attention (Safe Births: Everybody's Business, 2008). While noting the guideline is not designed for regulators, but may be 'of interest' to them, we are concerned that the ratio recommended by NICE in this guideline will be contradictory to the safe staffing ratios applied by the Care Quality Commission, who in 2012 used a ratio of 1 midwife for every 28 births. Their latest report does not specify their inspection standard, but states, 'In maternity we found shortages of midwives and consultant obstetricians was a frequent issue, including cases where the ratio of midwives to mothers was below recommended safe levels' (CQC, State of Care 2013-14). We have asked the CQC for detail on this 'ratio' and hope that NICE have done so too. The risk is that the that the CQC inspection reports, which are used to help empower patient choice and drive up standards, will not be analogous to the safe staffing guidance issued by NICE. We would urge NICE to consider this point carefully, especially as providers will have a duty to deliver safe staffing to both NICE's and the CQC's standards simultaneously.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
89	NHS England	The Birthrate Plus workforce tool provides differentiated ratios for different settings and scenarios; and is the recommended tool according to the NQB Safe Staffing Guidance, therefore this should be reference as the tool to use to assist in determining appropriate safe and high quality staffing ratios within a service.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
90	NHS England (Midlands & East)	It would be helpful if the NICE endorsement programme could consider established midwifery staffing toolkits such as Birthrate plus in advance of the publication of the final guideline. There is repeated reference to “locally agreed” within the guideline and there is a concern that this may allow boards and commissioners to influence the staffing levels based upon levels of available resource rather than service need.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
91	NHS Forth Valley	Would be perhaps helpful in some settings such as home birth however actual number of patients does not reflect the amount or intensity of midwifery care required and any ratio would need to take into account the diverse range of social and economic inequalities of differing geographic areas	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
92	North Middlesex University Hospital NHS Trust	Yes, Antenatal booking time – which varies in different organisation from 30 minutes to 90 minutes. Time allocated also need to take on board, use of language line or the interpreting services as when using the interpreting service, it takes longer. This is an issue for city areas. Antenatal appointment time also varies in different units from 10 minutes to 30 minutes. Women with complex social factors can take long due to various referrals during antenatal period. Referrals to different services take up time.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
93	Nottingham University Hospitals NHS Trust	yes the ratio should take into account babies. NUH feels it should be 1:4 i.e. 1 midwife to 4 mums and 4 babies. Different ratios need to be set for multiple births and premature babies.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
94	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	The NHS Scotland Maternity Tool metrics are based on observation studies of midwives and support workers in a variety of settings e.g. ante natal, post natal, labour, mixed wards, community, clinics and community maternity units. Each area has its own calculator based on activity and patient acuity.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
95	Oxford University Hospitals NHS Trust	A nationally agreed staffing ratio would be preferable for all maternity settings as locally agreed establishments will be dependent upon a number of issues including the need to reduce costs; staffing numbers will be reduced which will have a detrimental effect on women and babies. The RCM, RCOG and Birthrate Plus have already set standards for the ratios of midwives to women and these should be used. If the staffing ratios are incorrect establishments will not meet the needs of the women and services will be reduced i.e. home birth service, breast feeding support etc. It is important to differentiate between different types of service and the care provision within each area. There are specific staffing requirements for tertiary and midwifery led units and this must not lost in the guideline. An agreed methodology needs to be developed or agreed as a matter of urgency once the guideline has been published to ensure a consistent approach.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
96	Royal College of Midwives	The wording in section 1.1.3 is not clear and it may be better if it said “provide agreed staffing ratios for other maternity areas e.g. antenatal clinic, postnatal ward and community.” There is scope for setting staffing ratios for other settings. For example, Birthrate Plus recommends a ratio of one midwife for every 96 cases for community services activity. This is based primarily on the time needed to provide all of the elements of antenatal and postnatal care to women and has been refined to adjust for cross border workload. Birthrate Plus has also differentiated between staffing needs of, for example, tertiary referral centres and home birth teams. For inpatient postnatal settings, staffing ratios must take into account that there are two ‘patients’ – a mother and a baby – and that the ratio will be influenced by dependencies such as number of post-surgical women. For the employment of Consultant Midwives, Safer Childbirth (RCOG, RCM, RCPCH, RCOA, 2007) recommended a minimum of one Consultant Midwife for every 900 low risk births and one Consultant Midwife for every Midwife-Led Unit/Birth Centre (the latter has been adopted as one of the quality standards for maternity services, as part of the London health programme). The recommendation that “staffing ratios for other stages of care should be developed locally depending on the local service configuration and needs of individual women and babies” is not specific enough. Birthrate Plus determines the demand for midwife care on a classification system that accounts for the key outcomes and processes during the Intrapartum period. This then provides a basis for assessing midwife hours and length of stay for postnatal care in hospital and for the subsequent community midwife care. The guideline should recommend use of a similar methodology for determining staffing ratios for other stages of care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
97	Royal College of Nursing	Yes. It could be argued that a staffing ratio for postnatal care should be set. There is emerging evidence of reduced / minimal midwifery involvement in elements of postnatal care in some care settings and care being delivered by unregistered staff or others from a different discipline such as nursing. This is also an area which generates complaints, and lack of continuity of care by midwives may be contributing to this. A pregnant woman should see a midwife at each antenatal appointment, even if seen by a GP as well as the care focus for the professions is different. The safe ratio for midwife care at a home birth is arguably 2 midwives to 1 woman during late first stage and second stage at a home birth. Home births are more challenging. Historically 2 midwives should be in attendance for the delivery at home (not necessarily the whole labour) In reality resources don't permit this to happen and increasingly midwifery assistants are taking the place of the second midwife. This does raise issues although some are being addressed through the provision of training for MA's. It could be argued that this is also deskilling Midwives. We believe guidance would be helpful but specific totals may need to be set at ground level as this will often depend on the clientele experienced between different types of units. Use of previous nursing tools for ward work may help, but should not be the exclusive tool as much of antenatal and postnatal care takes place in community or home settings. Again consideration is needed for specialist services as these are ever expanding. There should be some acknowledgement of avoiding depleting other areas to unsafe levels to cover other areas. This should also acknowledge the need to avoid including students as staff when they should be supernumerary. There is need for further research on the impact of nurses and healthcare assistants working with midwives, and how this impacts of care and on midwifery skills/job	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
98	Royal Cornwall Hospital NHS Trust	Yes but birthrate plus sets these already so why has no reference been made to this long established model which is endorsed by the RCM and the Department of Health	Thank you for responding to this question. Your response will be shared with the committee for consideration.
99	Royal Surrey County Hospital Foundation Trust	Yes.153,248,299 Locally developed guidelines meet the majority of situations However for home births the minimum standard of two midwives for delivery should be implemented to ensure adequate emergency cover to enable resuscitation of both mother and baby if required and for personal safety of midwifery staff involved in care. (Local agreement of Lone worker policies under Health and Safety legislation must be considered)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
100	Stillbirth & Neonatal Death Charity (Sands)	We consider that this would be helpful but cannot comment on a ratio. We note the increasing popularity of homebirths and the implications of the Birthplace study (2014), and we couple this with the knowledge that the majority of stillbirths occur in low-risk women with no antecedent or associated obstetric factors (CMACE 2011).	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
101	Taunton and Somerset NHS Foundation Trust	I think it would be useful to begin the debate and attempt to set some standards for antenatal care as currently staffing ratios in this area are often depleted to “flex” up on LW to provide 1:1 care. Re home births the standard of 1:1 care would apply in labour and the standard of 2:1 at birth is considered gold standard at home birth although not always the case in other birth settings and/or captured in formal guidance. This issue could do with mention/clarity.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
102	The Royal College of Obstetricians and Gynaecologists	It is inappropriate to set ratios for different settings as the complexity of women may vary. It would also not be possible to take into account changing risk assessments and therefore complexity of the women at the time that the establishment is set. In the case of postnatal care, it is appropriate to factor in neonatal staffing to care for the baby.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
103	The Shelford Group	This would be more difficult to achieve as ratios do not tell the whole picture; it is difficult to divorce them from the context of care, i.e. the complexity of the women's needs, the skill and experience of the midwife, and the available infrastructure. The guideline should make reference to how acuity and dependency can be set within the inpatient areas, and refer to caseload management. The challenge is that there is no tested evidence of ward-based acuity and dependency, with a number of units having looked to develop this individually. Tertiary units will deliver very complex care to women that would not be equalled in a DGH. Furthermore, it would be helpful to ensure two midwives were present at home births in the event of both maternal and neonatal concerns. RCOG have made specific recommendation in 'Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour', which are worth referencing.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
104	The South West London Maternity Network	Views agree that it would be difficult as there are so many variables – which the Birthrate Plus tool seeks to address Members consider that there should be similar ratios for midwifery which are comparable to nursing. These will need adjustment against acuity and also caring for babies. For example on the postnatal ward the midwife should not be allocated any more than 6 women as she will also have approximately 6 babies too with the probability that > 50 % of those will require help with feeding or antibiotics observations. Postnatal care and neonatal observations need to be explicitly mentioned as time limits and staffing issues often mean these are late or missed, this has been the observations from recent SoM reviews in the sector. Antenatal care will also include women who are high risk and will need care that equates to labour care. Especially with regard to monitoring induction etc. This ratio should be no higher than 1:6.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
105	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	Yes An overall ratio fails to ensure staffing is safe in all areas it focussed on the Intrapartum areas and leaves a level of doubt in other areas such as clinics, day case , assessment areas and triage areas which are risky and would benefit with guidance. There should be guidance on a maximum for community caseloads!:98(RCM) Consideration of Intrapartum calculations for various intensity of units is important as regional and tertiary units carry a higher dependency of woman and neonate hence require a more enhanced ratio to units with a low risk case mix. Ward ratios for Antenatal /postnatal or ante/post mixed wards need guidance Specialist roles need consideration e.g. Antenatal Screening Midwives-how many per 1000 booked women? Breastfeeding facilitators again how many per woman?	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
106	University Hospital South Manchester NHS Foundation Trust	It would be useful to set staffing ratios for postnatal inpatient areas for those women requiring a higher level of care or support, such as those identified on the intermediate /intensive tariff, or women who are unwell. It would also be useful to set ratios for Transitional Care babies receiving support on the postnatal ward.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
107	West Hertfordshire Hospitals Trust	Yes staffing ratios that take account of community and homebirth ratios are essential. Otherwise hospitals only focus on inpatient activity and births. The standard for community to midwife ratios (without births) has been 1:100 but this isn't adequate if there is skill mix and a lot of public health duties.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Q4: Is the definition of uplift appropriate for midwife staff?
Are any routinely included factors missing from the definition of uplift?
Should any of the included factors be deleted from the definition of uplift?

Comment number	Organisation	responses	Developers response
108	Birthrate Plus	Very appropriate and valid pattern Very pleased to see the allowance for supervision of Midwifery Yes,1. community services need an allowance for time spent in travel. May vary from 10% - 20% in relation to type of area e.g. widespread rural services and/or density of population in inner cities Experience has found the need to add allowances to delivery suites and wards to allow for overall management of the workload, staff rotas etc. this can be an agreed % added to the client driven staffing needs. No *(Should any of the included factors be deleted from the definition of uplift?)*	Thank you for responding to this question. Your response will be shared with the committee for consideration.
109	Bolton Hospital NHS Foundation Trust (HoM)	These differ from the usual uplift given as it includes maternity and paternity leave however mandatory training needs to be included as this has a major effect on staffing when midwives have over 112 hours of mandatory training annually. Although all the aspects of the uplift are included there is no reference to minimum levels	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
110	Bolton NHS Foundation Trust (DoN)	These differ from the usual uplift given as it includes maternity and paternity leave however mandatory training needs to be included as this has a major effect on staffing when midwives have over 112 hours of mandatory training annually. Although all the aspects of the uplift are included there is no reference to minimum levels	Thank you for responding to this question. Your response will be shared with the committee for consideration.
111	Bradford Teaching Hospital NHS Foundation Trust	Yes. Important to include maternity leave as this is commonly excluded. No	Thank you for responding to this question. Your response will be shared with the committee for consideration.
112	Buckinghamshire Healthcare NHS trust	Yes, though good practice in some trusts (including Buckinghamshire) where Maternity leave is back filled from a central budget could be given more prominence here. Without this level of support Maternity leave would otherwise very adversely affect Midwifery numbers irrespective of ratios and allowances	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
113	City Hospitals Sunderland, NHS Foundation Trust	We agree that uplift is appropriate and should be standardised. Whilst annual leave and sickness absence is included we feel maternity leave needs further consideration as this is a key risk to maternity establishments. The uplift should also recognise the extensive midwifery mandatory training in addition to Trust mandatory training, required for midwives.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
114	Countess of Chester NHS Foundation Trust	No Should include mandatory supervision hours for SOM's based on 15hrs a month per SOM No	Thank you for responding to this question. Your response will be shared with the committee for consideration.
115	Department of Health	Would like to see the addition of CPD included within the uplift Additionally – time included for administrative work	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
116	Doncaster and Bassetlaw Hospitals NHS FT	yes Mentorship Ensure that delivery of education is taken into account Clinical supervision No	Thank you for responding to this question. Your response will be shared with the committee for consideration.
117	Epsom and St Helier NHS Trust	Current uplift does not include maternity leave. It would be helpful to include maternity leave into this as this impacts currently on the current level of staffing ability to provide safe care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
118	Epsom and St Helier NHS Trust	Current uplift does not include maternity leave. It would be helpful to include maternity leave into this as this impacts currently on the current level of staffing ability to provide safe care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
119	Guy's & St Thomas' NHS Foundation Trust	The definition of uplift is appropriate for midwifery staff, but a recognition that midwives need to have higher levels of post-registered education and training should be clarified, and uplifts altered to address this. This is particularly important if compliance is used as an indicator. Other factors to consider are maternity leave (which is typically high in the midwifery workforce) and mandatory training which usually equates to between 5 and 7 days per midwife. It is also common practice to factor in a 1% uplift for supervision of midwifery. No included factors should be deleted from the definition up uplift, as these activities require 24 hour care. Other roles that should be taken into account include management, development, education and governance roles, which are essential to the safe running of the service but not directly involved in the clinical care of women. These should either be calculated separately or included in the overall uplift.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
120	Heads of midwifery in Wales Advisory Group	The definition of uplift is appropriate in addition Up lift for travelling time for midwives who provide care within the community and acute settings should be included. This is important in rural areas and can add to time required for care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
121	Health Education England	Uplift is an appropriate term which is recognised and understood. Other areas that should be included are time for effective mentorship of students given that all midwives are required to be Sign Off mentors. The NMC standards to support learning and assessment in practice (NMC 2008) require workload adjustment where midwives are supporting student midwives in practice. In a final placement there should be protected time of one additional hour per week for each student/mentor partnership. Supervision should be defined - in this context does this refer to statutory supervision activities or clinical supervision? Supervisors of Midwives time should be included for undertaking the statutory role and investigations.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
122	National Childbirth Trust	Generally we support this. NCT would like to see a specific uplift for the provision of continuity of carer provision. We know that investment of a higher staffing ratio makes it possible for more midwives to be willing to carry an individual caseload and to provide continuity of carer/relationship across the care pathway (pregnancy, Intrapartum care, postnatal care). We believe that all NHS trusts should provide a continuity of carer model for at least the most vulnerable women and those who particularly request continuity of carer. The Sandall et al Cochrane review shows that continuity of carer reduces costs in the long term, so up-front investment in midwifery (higher levels of pay for those midwives carrying a caseload who have all-round responsibility and considerable on-call commitments) would save money in the longer term. Otherwise, NCT welcomes the recommendations relating to fluctuations in demand and to the statutory supervision of midwives. As discussed above, we are concerned that there are many aspects of care delivery and service innovation that have never been quantified. Please check your calculations to ensure that all of the following are covered: • Training • Midwives involved in mentoring students • Need for consultant midwives and other specialists. • Greater travelling in rural and remote areas, especially when more home visits are needed in pregnancy or postnatally • More time is needed for women who do not have English as a first language or are new to NHS services (e.g. asylum seekers/refugees) • Attendance at labour ward forum and maternity services liaison committee meetings/ PPI activities and outreach • Sickness and maternity leave cover (the workforce often have personal caring roles and pregnancies are frequent).	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
123	National Federation of Women's Institutes	We welcome NICE's list of the things that must be taken into account when ensuring maternity services have the right capacity. Our research showed some providers could only provide certain standards of care 'when no staff were sick/on leave'. We are glad the Guideline will make clear that these normal demands on, and needs of, staff must be taken into account. We suggest some further definitions of uplift: time for more senior midwives to mentor newly qualified midwives; any mandatory training requirements; travel time for midwives in the community to get to different sites; time for permanent staff to induct new staff or bank staff (as recommended by the National Quality Board, A guide to nursing, midwifery and care staffing capacity and capability, 2013); and time for management/analysis of staffing to implement this Guideline effectively.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
124	NHS England	The definition of uplift needs to be explicit in defining what is included; i.e. It needs to specify that Statutory supervision, mandatory training and mentor sign off (both parties) etc., are also within the uplift and what the parameters for this should be. Whilst we recognise that there will be locally determining factors to consider, and as such the ratios should be agreed locally. However there should still be some parameters given through the recommendations which specify minimum percentages of time that must be incorporated for each of these critical off-line workforce activities to be protected.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
125	NHS England (Midlands & East)	Yes. Other factors to be included/considered within the definition of uplift include time for mentorship The NMC standards to support learning and assessment in practice (NMC 2008) require workload adjustment where midwives are supporting student midwives in practice. In a final placement there should be protected time of one additional hour per week for each student/mentor partnership. Supervision should be defined - in this context does this refer to statutory supervision activities or clinical supervision? Supervisors of Midwives time should be included for undertaking the statutory role and investigations.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
126	NHS Forth Valley	The definitions given are the current definitions used for midwifery staff in this Board. Parental leave and changes to annual leave entitlement since Agenda for Change have not been reflected in the current uplift figures	Thank you for responding to this question. Your response will be shared with the committee for consideration.
127	North Middlesex University Hospital NHS Trust	Uplift or Time Out is both fine. However, currently, this also varies from 18% to 24% in different organisations. No – excellent that you have included risk and supervision time. No	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
128	Nottingham University Hospitals NHS Trust	yes. Good to see maternity leave be included. No, but may want to include link roles specific to maternity e.g. HIV and diabetes no	Thank you for responding to this question. Your response will be shared with the committee for consideration.
129	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	The Maternity Workload Tool (NHS Scotland) includes a 22.5% uplift, as per national guidance, to cover predicted absence allowance. This uplift is included in all Scottish Nursing and Midwifery Workload Tools.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
130	Oxford University Hospitals NHS Trust	Uplift needs to include the additional roles within the maternity services and examples include: governance, public health, practice development midwives and infant feeding specialists. There are others. These roles are key to providing a safe, evidence based service to women and their babies. Travel time especially in inner city and rural areas should be included. Study leave to ensure midwives complete mandatory training is essential and the level of uplift needs to be made explicit; this will ensure a consistent approach. It is helpful that the need to manage fluctuations is demand has been identified in the guideline given the difficulty this poses for managing the service. It is positive that the provision of statutory Supervision of Midwives has been included in the guideline. The need to forward plan is challenging and it is unclear how this will be achieved as there are many more factors than those mentioned in 1.1.3. There are no factors to be deleted from the definition of uplift.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
131	Royal College of Midwives	The definition of uplift is appropriate for midwifery staff and the RCM particularly welcomes the recommendations relating to dealing with fluctuations in demand and to the statutory supervision of midwives. Having said that, whilst it is correct to state that supervision has to work alongside organisational management processes etc., it is not appropriate for this document. However, the definition of uplift is incomplete in that it needs to take account of mandatory training – in addition to study leave – and also needs to account for management, development and governance roles, which are essential to the safe running of the service but not directly involved in the clinical care of women. As well as midwifery managers this will encompass clinical governance and audit midwives in non-clinical roles, practice development midwives, midwives involved in mentoring students of newly qualified midwives undertaking a preceptorship programme in addition to the percentage of a specialist and/or consultant midwife's time that is not spent in direct care. For community midwives, allowance needs to be made for the time they will spend travelling to or from clients. For midwives who are accredited workplace representatives, allowance should be made for the time spent undertaking trade union duties. We would also recommend that maternity services should establish a minimum level of uplift. This should not be too difficult since annual leave is a given, there is an average sickness rate in the NHS, there could be an expert view taken on maternity leave (which is typically high in the midwifery workforce) and mandatory training usually equates to between 5 and 7 days per midwife. It is also common practice to factor in a 1% uplift for supervision of midwifery.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
132	Royal College of Nursing	No, Uplift is not a familiar term to many. There is no consideration within this for the time to cover mentorship of students. Up to a point. Does 'study leave' include annual mandatory updating? If not it should and this needs to be made clear. Updating is mentioned in Box 3 but probably needs to be spelled out more clearly	Thank you for responding to this question. Your response will be shared with the committee for consideration.
133	Royal Cornwall Hospital NHS Trust	Yes No but study leave can be variable so a minimum % should be stated	Thank you for responding to this question. Your response will be shared with the committee for consideration.
134	Royal Surrey County Hospital Foundation Trust	Yes 155, 254 see comment The definition of uplift is appropriate but consideration of the statutory supervision of midwives as in 157 should exist alongside the employee rights as all midwives must have an annual review as per the NMC legislation.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
135	Stillbirth & Neonatal Death Charity (Sands)	We trust that study leave includes CPD events.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
136	Taunton and Somerset NHS Foundation Trust	think it should specifically include revalidation activity as well as supervisory activity. It would be good to attempt to define % uplift for this. Also feel that safeguarding supervision should be specifically included	Thank you for responding to this question. Your response will be shared with the committee for consideration.
137	The Royal College of Obstetricians and Gynaecologists	This definition appears to be appropriate. However, the issue has been with flexibility of services to deal with the daily/weekly fluctuations. It would be useful to provide further details and/or evidence on how to do this most effectively. Within the definition of 'uplift', it is appropriate to consider gaps caused by retirement (and the time taken to recruit replacements) and those for staff working part-time.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
138	The Shelford Group	The definition of uplift is appropriate for midwife staff, but a recognition that midwives need to have higher levels of post-registered education and training should be clarified, and uplifts altered to address this. This is particularly important if compliance is used as an indicator. The guideline, while detailing the use of uplift, does not make reference to how this should be calculated, nor does it make reference to minimum percentage values, unlike the neonatal toolkit, which defines uplift at 25%. The guideline should define specifically those roles vital to the quality and safety of the care, but not directly involved in hands-on care provision; for example, education, risk, quality and coordinator roles should be protected and not included in actual workforce calculations. Additional uplift for the supervision of midwives should be included, as this is an NMC requirement, to maintain registration. Intrauterine Transfers from other units are a routinely included factor that is missing from the definition of uplift. No included factors should be deleted from the definition up uplift, as these activities require 24 hour care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
139	The South West London Maternity Network	Uplift for maternity often includes extended training programmes which may or may not equate to more than 4 days. This needs to be taken into account. So therefore the range of up lift for midwifery should not be in the lower ranges. Statutory supervision will always add an extra time and so should not be forgotten. The supervisory process should operate alongside management processes such as personal development reviews. Midwifery staff still need to have annual leave, study leave, allowance for sickness absence. Most trusts do not allow for maternity/parental leave – but this needs to be accounted for somehow so should be included (as it should for nursing) Need to include time spent in supernumerary status (for whatever reason) somewhere – if not having a budgeted allowance for this, then it needs to be a % in the uplift. Otherwise the service guarantees it will be overspent (unless doing unacceptable and cutting services to fit budget) Time for mentorship is not included and this should be included in the uplift as midwives need to properly mentor and assess students and this should be an aspect of the uplift and potentially a red flag if breached; there is a standard already from the NMC about time provision when working with students in the practice setting. Discussion about supervision of midwives is limited, Uplift needs to include time for SoMs to undertake their role and a red flag if time limits on investigations are breached.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
140	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	No the uplift is locally agreed and not Nationally defined which leads to discrepancy. There are increased training requirements for Midwives compared to other disciplines locally 4 annual Mandatory Training days for midwives compared to 1 for Nursing .Statutory Midwifery Supervision (the delivery of and receipt of) requires recognition. The amount of mandatory requirements accounts for most of the uplift therefore this reduces the amount of other professional leave permissible which may become an issue for revalidation? University cohorts of one large group per annum are not conducive to recruitment following workforce reviews every 6 months this requires a level of review as there is not a pool of midwives in the job market waiting to fulfil the identified deficits The suggested review of bookings is a poor indicator of activity and dependency as much of the latter is unpredictable especially risk.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
141	University Hospital South Manchester NHS Foundation Trust	The definition of uplift is appropriate. The uplift should be set at an appropriate %, and should include the time to give and receive supervision. No	Thank you for responding to this question. Your response will be shared with the committee for consideration.
142	West Hertfordshire Hospitals Trust	Yes -Uplift is the name given to all workforce establishment planning in both nursing and midwifery. Directors of Nursing and HR Directors set the uplift to include sickness absence tolerance (varies from 2.5-4 % by service), annual leave and training (including mandatory training) Uplift for maternity is usually higher than nursing because of the past directives from CNST maternity standards to reduce high cost litigation. Mandatory training is set by the Trust, study leave is postgraduate or profession specific.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Q5: Are the actions for setting the midwife establishment correct? Are there any steps missing, or any steps that should be deleted from the draft recommendation?

Comment number	Organisation	responses	Developers response
143	Birthrate Plus	Agree on 6 months data for establishment but would not recommend a sample of 2 weeks for further assessment as caseload varies considerably not only in numbers but in case-mix . Important to distinguish between establishment figures based on long term data and that gained from more “real-time” assessment of activity In general agree with formula for staffing numbers. Once staff for all section s of the service have been identified, then decisions can be made on skill mix and redeployment. This is not possible where data analysis produce a total figure for whole service There is need to add to the total establishment the numbers of specialist midwives, e.g. diabetic, breast feeding, teenage pregnancies etc. . who work between areas of care This will depend upon local management decisions and case-mix of clients In ward areas the work of shift co-ordinators should be extra to that derived purely from client needs/hours	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
144	Bolton Hospital NHS Foundation Trust (HoM)	The way of calculating the hours in complex and does not allow for individualised care, something which is stressed at the start of the paper. The audit of 2 weeks would not allow enough time to give an adequate impression of staffing As previously stated there is no reference in the paper to issues such as numbers of staff for emergency LSCS or when more than 1 midwife is required in the Intrapartum period The method of calculating staffing will mean there is no universal method being used as units will put their own timings on all aspects of care making it very difficult to quantify but also very difficult to explain to exec boards and CCG's	Thank you for responding to this question. Your response will be shared with the committee for consideration.
145	Bolton NHS Foundation Trust (DoN)	The way of calculating the hours in complex and does not allow for individualised care, something which is stressed at the start of the paper. The audit of 2 weeks would not allow enough time to give an adequate impression of staffing As previously stated there is no reference in the paper to issues such as numbers of staff for emergency LSCS or when more than 1 midwife is required in the Intrapartum period The method of calculating staffing will mean there is no universal method being used as units will put their own timings on all aspects of care making it very difficult to quantify but also very difficult to explain to exec boards and CCG's	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
146	Buckinghamshire Healthcare NHS trust	The overriding concern is the guidance does not endorse Birth rate plus or any manpower tool for maternity .So the guidance would come out promoting local level agreement for maternity staffing and this is not helpful. Our second major concern is the use of red flags . The red flags suggested here - we find difficult to link to " safe practice / staffing " . By using red flags as a sensitive predictor of safe staffing is – it is too late by the time you have triggered. Overall this is a disappointing and a concerning document . The "Safer Childbirth " document RCOG RCM 2007 provides far clearer guidance.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
147	City Hospitals Sunderland, NHS Foundation Trust	We are uncertain whether we should be reliant on current number of bookings to predict likely midwife hours. The case mix must be a determinant in predicting midwifery hours required and staffing ratios during the Intrapartum period need to factor in additional midwives for high risk care. We also feel strongly that additional time needs to be factored in for complex birth planning i.e. Child protection – documentation/ report writing, meetings, conferences	Thank you for responding to this question. Your response will be shared with the committee for consideration.
148	Countess of Chester NHS Foundation Trust	Uplift to include SOM hrs	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
149	Department of Health	This appears reasonable	Thank you for responding to this question. Your response will be shared with the committee for consideration.
150	Doncaster and Bassetlaw Hospitals NHS FT	No	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
151	Epsom and St Helier NHS Trust	The actions for setting the establishment are not clear from this document. The document indicates that recommendation 1.3.4 i.e. use the following systematic assessment: however, this is not very systematic or prescriptive and potentially difficult to calculate/assess. This may lead to a system where one service is measuring differently from another. On page 17 – Box 2 number and skill mix of midwives needed – this does not indicate the differences which may be included where there are multiple sites where care is given, particularly where there are 2 labour areas and multiple birth areas. Birth Rate plus is not mentioned as a measurement tool to assist with the calculation of requirements. The 'red flag' box indicates that incidence of birth trauma directly links to staff numbers and yet birth trauma may still occur where staff numbers are good. (3rd 4th degree tears). These should be exclude from this box). Suggested items which may be added to 'red flag' would be: Delay in admission to labour/birth area due to staffing issues. Cancelled or delayed community appointments. Impact of running multiple sites. Number of patient complaints.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
152	Epsom and St Helier NHS Trust	The actions for setting the establishment are not clear from this document. The document indicates that recommendation 1.3.4 i.e. use the following systematic assessment: however, this is not very systematic or prescriptive and potentially difficult to calculate/assess. This may lead to a system where one service is measuring differently from another. On page 17 – Box 2 number and skill mix of midwives needed – this does not indicate the differences which may be included where there are multiple sites where care is given, particularly where there are 2 labour areas and multiple birth areas. Birth Rate plus is not mentioned as a measurement tool to assist with the calculation of requirements. The 'red flag' box indicates that incidence of birth trauma directly links to staff numbers and yet birth trauma may still occur where staff numbers are good. (3rd 4th degree tears). These should be exclude from this box). Suggested items which may be added to 'red flag' would be: Delay in admission to labour/birth area due to staffing issues. Cancelled or delayed community appointments. Impact of running multiple sites. Number of patient complaints.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
153	Guy's & St Thomas' NHS Foundation Trust	It is not recommended that the current number of bookings should be used to predict likely midwife hours. We would instead recommend that maternity services use any indicators of the changing needs of women, such as the number of older women, the number of women who don't speak English as a first language and the overall expected birthrate to predict likely midwife numbers or hours needed. The use of the 1:1 midwife staffing ratio in labour needs to be supplemented by a system for factoring in additional midwifery staffing time based on women's needs as reflected in the outcomes and processes that occur during the Intrapartum period. The Birthrate Plus model uses this approach for labour and could be adapted for other settings whereby acuity and case mix are used to inform staffing requirements.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
154	Heads of midwifery in Wales Advisory Group	Demand and capacity modelling on a six monthly basis using the last six months activity- is this really practical, this will be challenging to achieve in practice. This may not be accurate for places with small numbers if reviewing every 6 months. There will be a challenge to perform this modelling six monthly and an unrealistic expectation to change staffing levels every 6 months and what happens if six months later the staff are no longer required. There is no mention of birth rate plus, however talks more about local agreements which will become challenging as this will lead to different interpretation of the guidance and no actual national guidance on safe staffing levels. Maternity services require strict guidance for safe midwifery staffing levels antenatally, postnatal and the pre-conceptual element that is mentioned a lot would be very difficult to calculate. All women in the population of child bearing age would need to be counted and be actively providing pre-conceptual services to them all as most pregnancies are in fact not planned is an unrealistic target.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
155	Health Education England	As outlined above, there is no guidance about how 'locally agreed' should be determined, with each organisation setting their own there is a risk that women will receive vastly different levels of service across the country with no parameters to audit or measure against. Establishment setting also needs to take account of acuity and multi-site working. Midwifery led units / stand-alone units should factor in transfer time to escort mothers to obstetric services.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
156	National Federation of Women's Institutes	We would suggest removing 'pre-conception' care from line 224, and remove all the other references to pre-conception care. Line 233: If those setting the midwifery establishment are collecting 6 months' worth of data, they may as well use all of it as a sample as this will pick up normal fluctuations in birth rates across months and also get a lot of data from weekends; using only two weeks risks bias. Line 233: We would like to see women and babies listed first in setting the establishment, for example it could read: "and determine women's and babies' needs over that period that require midwifery activity." Line 237: as well as using the number of bookings, planners could use demographic data, as booking data is not always reliable (women double book, pregnancies are of variable length etc.) Our research found many trusts were unable to give very much detail from booking data. Hopefully the new maternity dataset will rectify the situation where much data was held on paper notes. Line 242: we welcome the acknowledgement that MSWs have a part to play in delivering midwifery care. We note the Prime Minister's Commission on the Future of Nursing and Midwifery (Front Line Care, 2010) noted the proportion of administration work undertaken by highly qualified midwives was wasteful.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
157	NHS England	There is no guidance about how 'locally agreed' should be determined, with each organisation setting their own there is a risk that women will receive vastly different levels of service across the country with no parameters to audit or measure against. Existing tools from Birthrate Plus and CfWI should be recommended to assist services to set local establishments. The use of the 1:1 midwife staffing ratio needs to be supplemented by a system for factoring in additional midwifery staffing time based on women's needs as reflected in the outcomes and processes that occur during the Intrapartum period. A further consideration will be to factor in the impact on staffing levels of the relationships that midwives form with other agencies involved in caring for women while they are pregnant. For example, the requirement for midwives to attend safeguarding meetings or case conferences has become a significant and growing issue for many maternity services.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
158	NHS England (Midlands & East)	Establishment setting also needs to take account of acuity and multi-site working. Midwifery led units / stand-alone units should factor in transfer time to escort mothers to obstetric services.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
159	NHS Forth Valley	The process identified is that which is currently under taken to identify midwifery workforce requirement It would be more helpful to use annual data than 6 monthly data to inform the establishment so that the inevitable surges in activity could be included	Thank you for responding to this question. Your response will be shared with the committee for consideration.
160	North Middlesex University Hospital NHS Trust	Specialist midwifery roles e.g. Safeguarding, Bereavement etc. needs to be acknowledge to ensure high quality compassionate care	Thank you for responding to this question. Your response will be shared with the committee for consideration.
161	Nottingham University Hospitals NHS Trust	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
162	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	See part 2 (main comments table)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
163	Oxford University Hospitals NHS Trust	It would be interesting to have sight of the evidence based toolkits endorsed by NICE in order to make an informed response to this question. Predicting midwifery establishments is difficult due to the nature and fluctuations in the service. The unpredictability of the pregnancy pathway and not being able to plan when the majority of women will be admitted makes this challenging and at times difficult to manage. The demographic changes also need to be considered i.e. the increase in the number of women whose first language is not English. This has an effect on the time required for appointments etc. as an interpreter is required. The increasing numbers of women who require additional social support affects midwifery time as does the impact of dealing with other agencies such as social services, police etc. Selecting a specific time period will not provide reliable data on which to set establishments especially if this is only for a 2 week period. The choice agenda and the needs of women should be the key driver for every service and the midwifery establishment should be appropriate to support the care of women and their babies.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
164	Royal College of Midwives	The actions for setting the midwife establishment contain a number of flaws: • As previously stated, midwives are at present rarely involved in providing pre-conception care. • The driver for all of these calculations should be the needs of the woman, not the activities of the midwife. A focus on the needs of the woman should lead to user centred maternity services, which can be more responsive to changes in populations. The task oriented approach assumes an institutional driver for care and is not an appropriate way to plan a service which is personalised and individualised and based on choice. Accordingly, the second bullet point under 1.2.2 should be rephrased as follows: “Select a defined period of time from the collected data and determine the needs of women resulting in midwife activities” and the third bullet point should read: “Calculate the total midwife hours that are needed over the period of time, based on the needs of women.” • The RCM is extremely sceptical about the practicability of the recommendation that the current number of bookings is used to predict likely midwife hours. We are advised by HOMs that issues such as early attrition, premature births, and the fact that the EDD is only a very loose indicator of delivery date and, in large urban areas, double bookings make this a very imprecise indicator other than in terms of taking a general view of likely activity over a wide period of time. We would instead recommend that maternity services use any indicators of the changing needs of women, such as the number of older women, the number of women who don’t speak English as a first language and the overall expected birthrate to predict likely midwife numbers or hours needed. • As previously stated, the use of the 1:1 midwife staffing ratio needs to be supplemented by a system for factoring in additional midwifery staffing time based on women’s needs as reflected in the outcomes and processes that occur during the Intrapartum period. • A further consideration will be to factor in the impact on staffing levels of the relationships that midwives form with other agencies involved in caring for women while they are pregnant. For example, the requirement for midwives to attend safeguarding meetings or case conferences has become a significant and growing issue for many maternity services.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
165	Royal College of Nursing	No deletions, there is a need to be more explicit regarding link to exclusions identified in 1.2.3. The need to address skill mix and level of risk associated with the specific community being cared for needs to be made more explicit. Tertiary centres will have greater demands than a standalone low risk birth centre.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
166	Royal Cornwall Hospital NHS Trust	There are no evidence based toolkits available through the links in the document. Point 61 when clicked says ‘oops something went wrong, sorry’ and the other tool is a nursing tool and is merely a flow diagram with no specific criteria for aiding the setting of safe staffing – not helpful.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
167	Royal Surrey County Hospital Foundation Trust	For 229-257 see below The steps appear to be workable. Please provide clarity with a defined date within the two week period if this is the methodology chosen. E.G It should be written in the guidance that individual trusts may chose the data capture period. Does the guidance consider specialist roles as being outside of the daily staffing ratios? If so can the guidance include who this core group should include? For example: safeguarding midwife governance midwife audit midwife mental health liaison midwife practice development midwife Supervisor of Midwives Trust boards need to be clear about these important roles and they need to be protected and not included in the clinical workload which impacts the ratio. Consider Time to lead and supernumery status of band 7 co-ordinators has not been included in the examples within the tables Should there be recognition with another column within the tables for women who require additional care throughout their pathway. You define one to one care in labour but women with complex needs require one to one care – such as High dependency care in the antenatal, Intrapartum and postnatal period. How will this acuity be captured?	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
168	Stillbirth & Neonatal Death Charity (Sands)	We urge that the time needed to provide good-quality care and ongoing support to bereaved parents is considered, as is the time needed to support women with concerns who may contact the unit antenatally	Thank you for responding to this question. Your response will be shared with the committee for consideration.
169	Taunton and Somerset NHS Foundation Trust	I believe the actions/steps broadly follow those undertaken in accredited workforce planning tools (birthrate plus). My concern wold be that this is in reality a hugely complicated calculation, which is outside the capabilities of most “midwives”/managers….hence why maternity services currently use accredited tools. To have to do this manually “supported” by these tools would seem ludicrous and would create an industry in itself. The document talks about “midwives trained in establishment assessment”….what would this training look like/consist of??....would it not be more sensible to re-indorse those tools we know to be accredited and NICE recommended rather than re-invent the wheel continually on a local level?? Would be concerned re margin of error also which would require running accredited tool alongside. I believe this would create a huge amount of additional work up with little/no benefit.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
170	The Royal College of Obstetricians and Gynaecologists	The establishment is set as an average. As mentioned above, in order to keep maternity services safe, obstetricians need to be able to respond flexibly to daily and weekly fluctuations. At present, within current contractual obligations, flexibility is difficult to achieve. Alongside the Red Flags, it may be appropriate to consider trends identified by the maternity clinical performance and governance dashboard tool in units where this is used - https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-7/	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
171	The Shelford Group	The actions for setting the midwife establishment are correct, and none should be deleted. However, it has been raised that 1.2 onwards is a complex formula, and 1.2.2 appears to allude to Birthrate Plus. Calculating the total midwife hours needed over the period of time is a considerable task, and may be considered a poor predictor of need. Basing midwifery activities on local configuration of services with the use of a prompt will result in subjective calculations. Page 20 (3) states that there is a lack of evidence about staffing ratios; how was this staffing formula tested and evaluated? With regards to lines 233-234, the 24-week period should be replaced to 26 weeks, to be truly reflective of a six-month period. The timing of midwifery activities will need to include some variance for routine and non-routine, and may need to be reflective of tertiary services. The reference to 'locally agreed' is not correct – there needs to be a defined consistent approach if we are to avoid immensely different staffing levels. Steps that are missing from the draft recommendation include: • Mental capacity and the deprivation of liberty • Indirect care givers who contribute to the safe functioning of the maternity service, e.g. Healthcare Governance staff • Clarity on how the infrastructure and context needs to be considered in conjunction with the actual number of midwives on duty. Establishment numbers alone are not an effective measure or guarantee of safe staffing • There is not sufficient reference to the impact of preceptorship and the guidance is not robust enough, with reference to the skill mix • The guidance is not robust enough in respect of the diverse needs of the client group; for example, the complexity and diversity of need for the use of interpreters	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
172	The South West London Maternity Network	I would propose that public health data should be used to forecast future births in area. In midwifery it is future forecasting which is important. A simple calculation would be to exclude all managerial/educational aspects and all specialist midwives within the calculation and only include direct women facing midwives at an approximate ration of 1:28, similar to a caseload model. We are amazed that Birthrate Plus is not mentioned here, as this is what that tool does, taking into account the multitude of variables between services. The processes are broadly correct – but having read through, tit is likely that maternity services will come out as showing more staff are required (not that this would be unwelcome, but very likely unaffordable with current tariff arrangements) Need to reference other documents such as Kings Fund staffing in Maternity Units How to ensure the right people with the right skills …….. NAO Hard Truths Commitments CQC All members felt that the Birthrate plus system needs to feature more strongly	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
173	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	There needs to be recognition for units caring for very complex women antenatally (foetal medicine and the increase bereavement care this may consequently generate) Intrapartum women with complex medical conditions referred to tertiary units require more than 1 to 1 in labour up to 1.4 in some clinical instances such as retained placenta. Postnatal care requires attention as there needs to be recognition for Maternity Services delivering Transitional Care to sick neonates on the postnatal wards. How can Trusts afford to have midwives beyond the establishment –this suggests the establishment calculation is insufficient and missing elements? The suggestion of using on –call midwives could be potentially at the detriment of women's choice as the on call model relates to Community Staff on call for Home Birth. The exclusions from the calculations such as midwives on a Local Supervisory Programme again is often an issue at short notice and can be very unpredictable perhaps best included to some degree in the calculation as this can occur in any maternity unit. Registered midwives with supernumery status needs consistent definition-management allocation ,governance support , infant feeding, screening co-ordinator counselling/bereavement , education roles-if every Trust has different inclusions and exclusions comparative data will be impossible	Thank you for responding to this question. Your response will be shared with the committee for consideration.
174	University Hospital South Manchester NHS Foundation Trust	The actions for setting the establishment are correct provided the evidence-based toolkits referred to are fit for purpose and reflective of practice.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
175	West Hertfordshire Hospitals Trust	The actions seem to be related to quality indicators rather than established workforce assessments that balance workload and acuity, with workforce.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Q6: Are the actions for checking the number of midwives needed and the number of midwives available on a day to day basis correct? Are there any steps missing, or any steps that should be deleted from the draft recommendation?

Comment number	Organisation	responses	Developers response
176	Birthrate Plus	Yes but need to be based upon; clear definitions of maternal/infant need. , preferably clinical indicators together with professional judgement and assessment for time needed. Toolkits for assessing Intrapartum workload need to allow for regular updates and to easily record fluctuations in staffing needs over time and days to enable objective review. The delivery suite workload also includes significant numbers of women who do not give birth during this time. They may be women who need reassurance and discharge, but others have higher needs of antenatal care. On wards there is need to allow for the fluctuating demand for care during the day and for frequent admissions and discharges which are more difficult to define and manage. Also need to assess infant needs where these are higher than normal e.g. transitional care. Toolkits which enable these factors to be includes need further development	Thank you for responding to this question. Your response will be shared with the committee for consideration.
177	Bolton Hospital NHS Foundation Trust (HoM)	Informally this is what midwives do at the start of each shift or day, however it is unclear how they would record this assessment as again it is based on the activities required to be carried out by the midwife rather than the acuity of the woman and her baby. The guidance references use of evidence based tools for this but does not go into details of what those are or how they wold be used as frequently as would be necessary for assessment on a daily basis and more frequently if the situation arises	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
178	Bolton NHS Foundation Trust (DoN)	Informally this is what midwives do at the start of each shift or day, however it is unclear how they would record this assessment as again it is based on the activities required to be carried out by the midwife rather than the acuity of the woman and her baby. The guidance references use of evidence based tools for this but does not go into details of what those are or how they wold be used as frequently as would be necessary for assessment on a daily basis and more frequently if the situation arises	Thank you for responding to this question. Your response will be shared with the committee for consideration.
179	Buckinghamshire Healthcare NHS trust	(*no response*)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
180	City Hospitals Sunderland, NHS Foundation Trust	Agree	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
181	Countess of Chester NHS Foundation Trust	No changes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
182	Department of Health	This appears reasonable	Thank you for responding to this question. Your response will be shared with the committee for consideration.
183	Doncaster and Bassetlaw Hospitals NHS FT	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
184	Epsom and St Helier NHS Trust	I think that what maternity services do each day is exactly this: i.e. we ensure that we have sufficient staff to provide the care which is required for that day. We do need to ensure that we do not create an industry and that the reporting of these issues does not become yet another requirement which takes midwives away from the front line care – this seems to be creating an industry out of something midwives have done well for many many years. I do think that monitoring the labour areas would be beneficial but the fluid nature of other areas would be more difficult to monitor and this may become a task in itself rather than a tool to improve.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
185	Epsom and St Helier NHS Trust	I think that what maternity services do each day is exactly this: i.e. we ensure that we have sufficient staff to provide the care which is required for that day. We do need to ensure that we do not create an industry and that the reporting of these issues does not become yet another requirement which takes midwives away from the front line care – this seems to be creating an industry out of something midwives have done well for many many years. I do think that monitoring the labour areas would be beneficial but the fluid nature of other areas would be more difficult to monitor and this may become a task in itself rather than a tool to improve.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
186	Guy's & St Thomas' NHS Foundation Trust	The actions for checking the number of midwives needed and the number of midwives available on a day-to-day basis is correct provided it is tested, robust and user-friendly when applied. Steps missing from the draft recommendation include: • An assessment of the written and electronic contemporaneous records that need to be completed for each woman and her baby/babies • Consideration for the importance of professional judgement, e.g. sometimes clinical areas do not have planned staffing available but can work safely and effectively with the numbers available, on certain occasions No steps need to be deleted from the draft recommendation	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
187	Heads of midwifery in Wales Advisory Group	The BR+ acuity tool is used to record midwife to work load ratios during Intrapartum care 24 hours. This captures the process described. However there is no tool for postnatal and antenatal.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
188	Health Education England	No - this is not a systematic assessment. This approach is open to varied interpretation. Local midwifery staff do not have the necessary skills, expertise or time to undertake this process in real time as outlined. The suggestion of locally developed staffing ratios will lead to the introduction of wide variations in staffing establishments which is a retrograde step for the midwifery profession and midwifery services The idea of assessing the staffing numbers at the beginning and during a shift and recording red flags are useful in theory but in practice this would be difficult to achieve as these assessment would be very time consuming. The suggestions of how to address the problems are those already employed e.g. re-deployment, getting extra staff, using skill mix etc. are well established methods within services and it is difficult to see what the guidance adds. It is not clear which midwives are to be included in the calculation e.g. midwifery managers, practice educators etc. so it would be helpful to make it explicit that this is the establishment for midwives providing clinical care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
189	National Federation of Women's Institutes	Line 299: We would like to see some clearer direction for locally agreed staffing ratios for other stages of maternity care. For example, there could be a specific reference to Box 2. We would like to see the word 'should' replaced by 'must' to avoid the current situation where Intrapartum care is emphasised over other kinds of maternity care simply because it has a ratio while the others don't. Line 318-319: the NFWI is delighted with the acknowledgement that service closure/suspension is a last resort and damages women's choices and the reputation of a provider.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
190	NHS England	It is unclear whether this is intended to be a real time or forward planning process – or is it for both? There needs to be more pro-active forward looking action using available tools, such as Birthrate plus, to assist services in achieving more accurate day to day planning and forecasting. This will support services to manage peaks in demand more effectively and utilise quieter periods to carry out more of the off-line activities necessary. There needs to be clear understanding that time spent on off line activities during quieter periods is an opportunity to invest in the workforce and the future quality of care rather than viewing this as a waste of resource and place for potential cost savings.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
191	NHS England (Midlands & East)	The suggestion of locally developed staffing ratios will lead to the introduction of wide variations in staffing establishments which is a retrograde step for the midwifery profession and midwifery services The idea of assessing the staffing numbers at the beginning and during a shift and recording red flags are useful in theory but in practice this would be difficult to achieve as these assessment would be very time consuming. The suggestions of how to address the problems are those already employed e.g. re-deployment, getting extra staff, using skill mix etc. are well established methods within services and it is difficult to see what the guidance adds. It is not clear which midwives are to be included in the calculation e.g. midwifery managers, practice educators etc. so it would be helpful to make it explicit that this is the establishment for midwives providing clinical care.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
192	NHS Forth Valley	The suggested actions are those which are taken on a daily basis	Thank you for responding to this question. Your response will be shared with the committee for consideration.
193	North Middlesex University Hospital NHS Trust	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
194	Nottingham University Hospitals NHS Trust	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
195	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	See part 2 (main comments table)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
196	Oxford University Hospitals NHS Trust	It is unclear how the calculations will affect excess or insufficient midwifery staffing levels. The use of a systematic assessment should include acuity, dependency, HDU type care which is now managed on Labour wards rather than transferring women out of maternity services. The use of GP's is problematic as many now decline to offer services to pregnant women. Would this be an additional cost as GP's would be paid an additional fee for this work? The Birthrate Plus tool advocates a review of workload and staffing every 4 hours due to the nature of maternity services and the fluctuating workload.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
197	Royal College of Midwives	The guideline should provide clearer examples of the circumstances in which a more frequent systematic assessment is needed. This could be for exceptional situations, such as unusually high dependency levels, particularly onerous travel times, or the need for staff to attend activities i.e. case conferences, meetings etc. The RCM strongly disagrees with the recommendation that breaks are included as one of the factors for which additional allowance needs to be made. Breaks should be taken as a matter of course by midwives and should therefore be included in baseline calculations.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
198	Royal College of Nursing	Yes, no deletions. There is a need to know how long this process will take. If time consuming may actually impact on care provision. The use of a flow chart might help here.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
199	Royal Cornwall Hospital NHS Trust	factors are correct and would give an indication of the staffing levels needed	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
200	Royal Surrey County Hospital Foundation Trust	288 – 309 As above for the inclusion criteria I would emphasise that local arrangements around any acuity which is not included in the guideline may be interpreted in such a way that it is not taken forward and therefore it may be useful for the guidance to provide some text about what is reasonable to include as additional resources.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
201	Stillbirth & Neonatal Death Charity (Sands)	No comment	Thank you for responding to this question. Your response will be shared with the committee for consideration.
202	Taunton and Somerset NHS Foundation Trust	I think this is constructive guidance that would force the issue of increased flexibility. However, I do not think the difficulties of actually changing employment contracts/place of work, hours, redeployment across the service should be underestimated. On the whole, although midwives do want to be more responsive, they do not support ways of working that add uncertainty to their working lives.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
203	The Royal College of Obstetricians and Gynaecologists	There needs to be a stipulation to feed this information to those responsible for the rota and off-duty. Otherwise there will continue to be disconnect.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
204	The Shelford Group	The actions for checking the number of midwives needed and the number of midwives available on a day-to-day basis is correct provided it is tested, robust and user-friendly when applied. Steps missing from the draft recommendation include: • An assessment of the written and electronic contemporaneous records that need to be completed for each woman and her baby/babies • Consideration for the importance of professional judgement, e.g. sometimes clinical areas do not have planned staffing available but can work safely and effectively with the numbers available, on certain occasions • Safeguarding is not explicit There is no real acknowledgement of the seasonal or circadian nature of maternity services, meaning planned levels of staffing may not be enough at peak times. No steps need to be deleted from the draft recommendation.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
205	The South West London Maternity Network	It seems mostly what we all do anyway. Plan shift numbers; assess staffing in relation to activity and still mix on the day, and make adjustments accordingly The day to day checking should be against the required ratios in all areas. However there needs to be flexibility and this should be centred on bed occupancy.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
206	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	The staffing of ward areas does need a level of guidance with recognition there are at least 2 patients per bed space whether in utero or in a cot? If the public want to know how many staff are on duty we need guidance about what safe staffing looks like numerically to them.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
207	University Hospital South Manchester NHS Foundation Trust	The actions for checking the number of midwives needed and available are correct provided the evidence-based toolkits referred to are fit for purpose and reflective of practice. No steps are missing and none should be deleted.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
208	West Hertfordshire Hospitals Trust	No , they are unsophisticated and inadequate. The detail is about operational management not workforce predicted need.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Q7: Are there any other factors (other than those already listed as examples) that should be considered as midwife red-flags?

Comment number	Organisation	responses	Developers response
209	Birthrate Plus	no response	Thank you for responding to this question. Your response will be shared with the committee for consideration.
210	Bolton Hospital NHS Foundation Trust (HoM)	Partial suspension of service or unit divert/ closure due to midwifery staffing levels and non-acceptance of an intrauterine transfer for midwifery staffing reasons should also be included as a red flags. Incidence of birth trauma should be removed as a red flag as this is a common occurrence and cannot be seen as indicative of reduced staffing levels. This red flag is not worded correctly and is not qualified to midwife deliveries	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
211	Bolton NHS Foundation Trust (DoN)	Partial suspension of service or unit divert/ closure due to midwifery staffing levels and non-acceptance of an intrauterine transfer for midwifery staffing reasons should also be included as a red flags. Incidence of birth trauma should be removed as a red flag as this is a common occurrence and cannot be seen as indicative of reduced staffing levels. This red flag is not worded correctly and is not qualified to midwife deliveries	Thank you for responding to this question. Your response will be shared with the committee for consideration.
212	Bradford Teaching Hospital NHS Foundation Trust	Lack of access to interpreting services for women who do not have English as a working language.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
213	Buckinghamshire Healthcare NHS trust	(*no response*)	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
214	City Hospitals Sunderland, NHS Foundation Trust	We agree that red flags should be considered under the following headings Clinical ,Organisational, user And whilst we agree other red flags would be agreed locally, it may be appropriate to include as a standard risk included in the Maternity Safety Thermometer.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
215	Countess of Chester NHS Foundation Trust	Delayed IOL due to labour ward activity Not sure why third/fourth degree tear is included as a red flag for staffing	Thank you for responding to this question. Your response will be shared with the committee for consideration.
216	Department of Health	Not aware of any	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
217	Doncaster and Bassetlaw Hospitals NHS FT	cancelled clinics e.g. community clinics Suspension of home birth service	Thank you for responding to this question. Your response will be shared with the committee for consideration.
218	Epsom and St Helier NHS Trust	As indicated I do not feel that incidence of 3rd and 4th degree tears should be included. I would add: Delay in transfer to labour ward Cancelled community visits/care. Delay to planned IOL or C/S may be another factor which indicates activity/staffing pressures.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
219	Epsom and St Helier NHS Trust	As indicated I do not feel that incidence of 3rd and 4th degree tears should be included. I would add: Delay in transfer to labour ward Cancelled community visits/care. Delay to planned IOL or C/S may be another factor which indicates activity/staffing pressures.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
220	Guy's & St Thomas' NHS Foundation Trust	The opportunity to have locally agreed red flags would be recommended and to make the reporting more systematic the 'red flag' incidents could be organised under three headings: 1. Clinical red flags i.e. outcomes known to be based on poor staffing. These would include: • A serious untoward incident or never event where lack of a midwife or poor midwifery staffing levels were identified in the root cause analysis. • Missed or delayed care because of midwife staffing issues (for example, delay in triage, delay in 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 2. Organisational red flags. These would include any time when staffing numbers fall below those agreed, any time when staff have to be reassigned, any time when midwives who are on call for community based services are called in to cover hospital labour wards (unless this is specifically allowed for in their rotas and establishment), any time when there is a closure of all or part of a maternity service 3. User red flags. These would include any complaint from a user where staffing levels are identified as part of the complaint or evidence from user surveys that women are not able to contact a midwife they know and trust and when they are left alone, and worried, in labour or immediately after birth. Whilst red flags may be a useful indicator of safe staffing levels, the process for collecting and acting on them should not be overly bureaucratic.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
221	Heads of midwifery in Wales Advisory Group	The red flags in Box 1 can be incorporated into locally agreed trigger risk factors and recorded by performance indicators / dashboards to local maternity boards.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
222	Health Education England	Delayed or cancelled time-critical activity may include induction of labour. Missed or significantly delayed post-natal visit. Missed or delayed postnatal or neonatal observations of vital signs. Lack of time to teach, assess or supervise students that impacts on their progression or results in a substandard learning experience on placement. Delay in Induction of Labour should be included in the box rather than agreed locally as this has a big impact on safety for women and their babies and also on complaints. Should the delays include dealing with a compromised baby? It is unclear where a delay in washing might occur as this tends to be a MSW role Complaint or Serious Clinical Incident relating to midwife staffing levels. A midwife unexpectedly leaving his/her shift before completion e.g. due to sickness	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
223	National Federation of Women's Institutes	We recommend some further incidents that could be included on this list of red flags: • incidents of midwives being redeployed into Intrapartum care (from postnatal wards, or from the community, for example) • 'Never events', • Maternal or infant (at term) death • Any temporary suspensions or closures of services • We would also like to see specific reference to postnatal visits as an example in 'missed or delayed care' (many of the examples in the red flag box relate to Intrapartum care; we think it's important to show that flags can happen anywhere along the maternity pathway). We also think that there are other aspects of care experienced by women and their families that are deservedly 'red flags' because they have implications for women's feelings of safety. For example, being left alone/calling for attention and being ignored in the period immediately after birth; women who are kept waiting by staff upon their arrival at a unit (for example, those who are left outside as no one is there to open the door for them to enter), mothers who give birth outside of a unit when they had presented to a unit previously whilst in labour and been turned away, etc.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
224	NHS England	It is not clear whether the red flag system is being recommended for use to flag up potential harm/issues as a result of a staffing shortage – thus initiating preventative action; or if this is to be incidence led – thus highlighting that an issue has occurred as a result of a staffing shortage in order to prompt remedial action. These issues are not exclusively linked to staffing shortages. Also, we must be very clear that the occurrences in Box 1 are not interpreted to be acceptable to 'not do' if there is a staffing shortage – i.e. Timely referral, missed/delayed care or medication. This section may need further work to address these points.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
225	NHS England (Midlands & East)	Delayed or cancelled time-critical activity may include induction of labour. Missed or significantly delayed post-natal visit. Missed or delayed postnatal or neonatal observations of vital signs. Lack of time to teach, assess or supervise students that impacts on their progression or results in a substandard learning experience on placement. Delay in Induction of Labour should be included in the box rather than agreed locally as this has a big impact on safety for women and their babies and also on complaints. Dealing with a compromised baby. Complaint or Serious Clinical Incident relating to midwife staffing levels. A midwife unexpectedly leaving his/her shift before completion e.g. due to sickness	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
226	NHS Forth Valley	The examples given would be routinely “flagged up” by the use of the Incident reporting system(Safeguard) which are all seen by the ward managers and department managers. Clinical issues are monitored by use of a dashboard which is discussed at both managerial and clinical meetings monthly	Thank you for responding to this question. Your response will be shared with the committee for consideration.
227	North Middlesex University Hospital NHS Trust	When there is a serious incident, this can have an impact on the staffing level for the day and several days after due to additional patient care and staff support that may be needed	Thank you for responding to this question. Your response will be shared with the committee for consideration.
228	Nottingham University Hospitals NHS Trust	No, however lead midwives are concerned that will be multiple red flags raised on daily basis. Suggest also red flag when staffing levels fall to below safe numbers. Red flag to be included for baby falls.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
229	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	*(no response)*	Thank you for responding to this question. Your response will be shared with the committee for consideration.
230	Obstetric Anaesthetists Association	Adequate midwifery staffing is required to allow women to have their choice of pain relief in labour. This is not mentioned in the document. Safe epidural analgesia can only be provided by obstetric anaesthetists when 1:1 care is available in labour, due to the risk of both maternal and foetal complications if inadequate monitoring occurs. Women who are denied their choice of analgesia in labour should be a red flag. Midwives play an essential role in the management of the high risk parturient. Adequate staffing and skill mixes are essential to ensure that high risk parturient receive the level of care that is required to optimise management of their condition and to detect where escalation occurs to a higher level of dependency.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
231	Oxford University Hospitals NHS Trust	The red flag relating to Safeguarding should also include women who are not referred during pregnancy. Missed or delayed medication should not include examples as the sentence is self-explanatory. An adverse outcome for either mother or baby due to midwifery staffing levels. In line with the Safe Staffing initiative if the service red flags because of poor staffing ratios in relation to activity this should be included. Unable to provide routine services such as Antenatal clinics or postnatal care as community midwives have been called into the hospital. Closure of the maternity service due to staffing constraints. Withdrawal of the home birth service of MLU provision due to staffing levels.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
232	Royal College of Midwives	Whilst the RCM broadly agrees with the red flags listed in Box 1, we believe they should be organised under three headings: 1. Clinical red flags i.e. outcomes known to be based on poor staffing. These would include: • A serious untoward incident or never event where lack of a midwife or poor midwifery staffing levels were identified in the root cause analysis. • 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 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) 2. Organisational red flags. These would include any time when staffing numbers fall below those agreed, any time when staff have to be reassigned, any time when midwives who are on call for community based services are called in to cover hospital labour wards (unless this is specifically allowed for in their rotas and establishment), any time when there is a closure of all or part of a maternity service, any time when there is a failure to provide a labour ward coordinator and any time when a service is withdrawn and women's choice not provided for. 3. User red flags. These would include any complaint from a user where staffing levels are identified as part of the complaint or evidence from user surveys that women are not able to contact a midwife they know and trust and when they are left alone, and worried, in labour or immediately after birth.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
233	Royal College of Nursing	Midwife red flags should include analysis of Incident Reports generated as a result of understaffing on a shift. These will add information as to which shifts are more vulnerable to sudden shortages Inability to complete contemporaneous notes at an appropriate time e.g. not after shift should have finished. No time for adequate handover Issues around staff receiving breaks especially on long days	Thank you for responding to this question. Your response will be shared with the committee for consideration.
234	Royal Cornwall Hospital NHS Trust	We do not agree that 3 and 4 degree tears or safeguarding cases discharged home are midwifery red flags rather an indication of poor practice (safeguarding) or nothing at all (trauma). Unless a woman had delivered unattended and sustained a 3 or 4 degree tear as a result this is a meaningless indicator. What would be more useful indicators are: - Unattended births in hospital/birth centres (NOT BBA) - Delivery suite co-coordinator NOT supernumerary - Labouring women on the antenatal ward and not receiving 1:1 care in labour - Closure of birth centres/suspension of home births	Thank you for responding to this question. Your response will be shared with the committee for consideration.
235	Royal Surrey County Hospital Foundation Trust	Delay in transfer to another maternity service for on-going care	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
236	Stillbirth & Neonatal Death Charity (Sands)	We ask the guidance developers to consider as red flag events: • all SUIs with a staffing element identified • all complaints from women/partners/family members where staffing is an issue at any time during the maternity pathway • any postnatal report of emotional trauma subsequent to a stillbirth or serious event in labour. We ask that the guidance recommends that services have in place systems to ensure that service users are aware of the red flags, the procedures for reporting them and the expected outcomes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
237	Taunton and Somerset NHS Foundation Trust	Specifically delayed induction	Thank you for responding to this question. Your response will be shared with the committee for consideration.
238	The Royal College of Obstetricians and Gynaecologists	Use of Red Flags is potentially misleading. Red Flags is a clinical term to highlight symptoms that require prompt investigation. The use of the term in this context is not helpful. Many of the examples in Box 1 are process issues and very subjective and not clearly evidence based. By encouraging reporting of these, there is the danger of added bureaucracy and administration in the system, which risks overburdening the service and reducing the time that is spent caring for patients. The principle is fine but it would be helpful to see a more specific list of factual events, for example, missed PET or 3rd degree tear and renaming it to something other than red flag.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
239	The Shelford Group	The following should be considered when setting midwife red-flags: • The support of the MDT team when the whole unit is busy, e.g. when a pathological CTG is not assessed in a timely way by the medical team • Delay in the undertaking of caesarean sections • Delay in the initiating the induction of labour • There are concerns that perceived time critical events could cause unnecessary alarm, but a delay would not always lead to increased risk or harm, e.g. a delay in washing might not be considered a red flag event if a woman is given explanations for the delay and provided with apologies • Delay in the repair of a third or fourth degree tear of more than one hour; third- and fourth-degree tears are recognised birth traumas, but unless a woman is unattended at birth, this is not linked to staffing, nor is it a quality indicator • Unexpected or avoidable transfer to the Neonatal unit for elements such as hypoglycaemia/hypothermia, where care has been omitted due to staffing levels • Delayed epidural due to staffing pressure/balance in skill mix on the shift of midwives are able to administer IV medication • Transfer of an antenatal woman out of the service due to lack of staffing The opportunity to have locally agreed red flags (similar to clinical incident reporting) would be recommended. In the first red flag delay in the induction of labour, the process should be more explicit. Furthermore, whilst they are well intentioned, the gathering of red-flag information can be a bureaucratic burden, which can detract professional staff from the delivery of direct care in order to meet data requirements for these. These should therefore be approached with caution.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
240	The South West London Maternity Network	We don't think that that all of the red flags are indicative of poor staffing levels e.g.: • Delay in recognition of pre-eclampsia may not be caused by staffing levels but also by failure of the individual clinician • Timely referral could be an issue but ultimately that would probably interfere with others who need care, as the complicated cases will often take over. • Delayed care definitely but again for consideration, staffing levels may be adequate but there may be an uncontrolled in flux of work, so therefore the issue is the ability to flex staff when needed and at short notice. • Missed or delayed medication • Definitely when 1:1 care cannot be provided including recovery care • Incidence of birth trauma should not be included as it is not indicative of poor staffing levels • Missed safeguarding could be We would like to see added flags for supernumerary coordinator on labour ward, in line with NICE Intrapartum guidelines. Someone having an overview and being able to guide and support staff is essential – which they cannot do effectively if looking after someone 1:1 for more than a coffee break. Having recorded this locally in some units for past 2-3 years, it is an important measure of whether staffing and activity are aligned. Closure of unit or part of service (e.g. MLU or homebirth) when due to shortage of midwifery staff (rather than capacity – this follows another process) Poor training numbers – this is because when staffing is poor, midwives are 'pulled back' from study days to work clinically. This can be a legitimate step in escalation process on a particular day as long as overall training remains high e.g. 85-90% in 12 months (note – CNST required 75% compliance) • And if a woman delivers her baby unattended whilst she is in hospital on (e.g. on antenatal or labour ward)	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
241	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	Bullet point 3 includes a delay in washing-I feel this is far less important than initiating skin to skin contact and promoting early neonatal feeding (which washing delays!) Bullet point 5 If a midwife cannot provide care to the critically ill woman or HDU care 1:1.2-1.4 depending on the condition? Bullet point 6 I don't see the correlation of birth trauma to staffing it's a competency issue rather than number of staff on shift issue?	Thank you for responding to this question. Your response will be shared with the committee for consideration.
242	University Hospital South Manchester NHS Foundation Trust	No.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
243	West Hertfordshire Hospitals Trust	The red flags should only describe midwives booked for rota versus midwives actually present, otherwise they will be ignored by managers. The escalation policy when workload is high should be captured by RCM labour ward acuity tool and bed occupancy	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Q8: Is it reasonable that a booking appointment made by week 13 is used as an indicator of safe midwife staffing?

Comment number	Organisation	responses	Developers response
244	Birthrate Plus	Would be useful to also record where the booking takes place i.e. hospital or community setting	Thank you for responding to this question. Your response will be shared with the committee for consideration.
245	Bolton Hospital NHS Foundation Trust (HoM)	Yes, the standard is 12+6 so the indicator needs slightly rewording but this is recognised as one of a range of indicators that provides a good indication of staffing levels within maternity.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
246	Bolton NHS Foundation Trust (DoN)	Yes, the standard is 12+6 so the indicator needs slightly rewording but this is recognised as one of a range of indicators that provides a good indication of staffing levels within maternity.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
247	Bradford Teaching Hospital NHS Foundation Trust	Yes ……. early booking means early access to care and advice. (However, the pressure to achieve the early booking target sometimes means that the booking cannot be undertaken by the named midwife which is an issue in terms of building a rapport and continuity.)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
248	Buckinghamshire Healthcare NHS trust	(*no response*)	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
249	City Hospitals Sunderland, NHS Foundation Trust	Agree, however, this should read 12+6 days, but more recently consideration should be to complete the bookings by the 10th week.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
250	Countess of Chester NHS Foundation Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
251	Department of Health	This appears reasonable.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
252	Doncaster and Bassetlaw Hospitals NHS FT	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
253	Epsom and St Helier NHS Trust	This neither may nor may not be an indicator of safe staff. Equally this may not be a reason for delay in booking. I think this does assist with examining activity and pressures within the antenatal area.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
254	Epsom and St Helier NHS Trust	This neither may nor may not be an indicator of safe staff. Equally this may not be a reason for delay in booking. I think this does assist with examining activity and pressures within the antenatal area.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
255	Guy's & St Thomas' NHS Foundation Trust	No, it is not thought to be reasonable that a booking appointment made by week 13 is used as an indicator of safe midwife staffing. This is instead an indicator that safe clinical care is given, and not a reliable measure of staffing. Furthermore, there are often other women-led factors influencing the timing of bookings, e.g. chaotic lifestyles, drug and alcohol dependencies, change of address, safeguarding issues.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
256	Heads of midwifery in Wales Advisory Group	ANSW and the strategic vision for maternity services in Wales advocate require booking by 10 weeks. This recommendation may lead to confusion with reporting data in Wales. An agreement needs to be made which one is an appropriate target to measure.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
257	Health Education England	No because: • it does not take into account 'out of area women' who receive antenatal care at another organisation or those who will have community care provided to them but not a delivery episode, neither does it allow for complexity of care the mother may require. • there may be a late diagnosis of pregnancy or other delay in referral outside the control of the midwife. • NICE guidance is currently: 'ideally by10 weeks' in the Antenatal Care Pathway. There is a view that the threshold should be reduced to 11 weeks to ensure access to appropriate time-critical screening occurs.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
258	National Federation of Women's Institutes	The NFWI believes that safe staffing is more crucial for what happens after women are booked in by 13 weeks; that is, is she given a named midwife, given a number to call/email, and that any phone calls/emails are answered in a timely matter. We are pleased these kinds of aspects of care are listed in Section 8.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
259	NHS England	No, it is not a suitable indicator of safe midwife staffing. There is definite no link between the 2 things. The only way these could be linked would be if data was available on bookings, which were delayed beyond 13 weeks as a direct result of a staffing shortage. The recommended guidance from NICE is that women should be booked by 10 weeks therefore we feel this should be clearly referenced in the guidelines and recommendations.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
260	NHS England (Midlands & East)	No because: • it does not take into account 'out of area women' who receive antenatal care at another organisation or those who will have community care provided to them but not a delivery episode, neither does it allow for complexity of care the mother may require. • there may be a late diagnosis of pregnancy or other delay in referral outside the control of the midwife. • NICE guidance is currently: 'ideally by10 weeks' in the Antenatal Care Pathway. There is a view that the threshold should be reduced to 11 weeks to ensure access to appropriate time-critical screening occurs.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
261	NHS Forth Valley	In Scotland the outcome measure is that 85% of women are booked by 12 weeks which this Board meets . For this measure not to be met would not necessarily be an indication of staff shortages . There could be many reasons for this e.g. patients having difficulty in accessing the system	Thank you for responding to this question. Your response will be shared with the committee for consideration.
262	North Middlesex University Hospital NHS Trust	There are many variables for getting the booking done by 13 weeks. E.g., booking appointments, women's choice, clerical staff processing the booking referral and also availability of midwives to carry out the booking.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
263	Nottingham University Hospitals NHS Trust	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
264	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	*(no response)*	Thank you for responding to this question. Your response will be shared with the committee for consideration.
265	Oxford University Hospitals NHS Trust	This should be 10 weeks as many Commissioners have set this standard.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
266	Royal College of Midwives	Yes, although to be strictly accurate it should be within 12 weeks and 6 days rather than 13 weeks. However, current practice (particularly due to advances in screening) means that many services are working towards booking by the 10th completed week of pregnancy.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
267	Royal College of Nursing	Time of booking may well be affected by other factors not necessarily low staffing therefore difficult to say how accurate this would be as a measure. Perhaps use alternative criteria such as referral for booking scan or first contact.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
268	Royal Cornwall Hospital NHS Trust	Yes but allowing for 10% over as women will book late or move into the area after 13 weeks. We have problems with some of the safe staffing indicators as they may not reflect safe staffing numbers e.g. breastfeeding rates are influenced by multiple factors and midwifery staffing indicators are a small part of this, birth place of choice can change throughout pregnancy so a better indicator would be temporary closure of birth centre/suspension of home birth service. Working overtime actually facilitates safe staffing and is an indicator of perhaps high sickness – needs a rethink. Staff morale is not an absolute indicator of safe staffing and reflects a multitude of other factors e.g. NHS pensions/lack of pay rise for 3 years etc.so should be removed	Thank you for responding to this question. Your response will be shared with the committee for consideration.
269	Royal Surrey County Hospital Foundation Trust	Yes it is. However late bookers do exist as women choose not to engage with services and this needs to be reflected in the guidance	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
270	Stillbirth & Neonatal Death Charity (Sands)	Yes (although we support all efforts to encourage earlier booking)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
271	Taunton and Somerset NHS Foundation Trust	yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
272	The Royal College of Obstetricians and Gynaecologists	The evidence of this quality indicator has led to some perverse initiatives and pulling of resources. The data from the confidential enquiries has, in general, used 20 weeks as the cut off as an indicator for increased risk. This evidence should be examined and potentially incorporated into this guidance. Booking prior to 13 weeks, to our knowledge has come about because of the timing of screening tests in this country.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
273	The Shelford Group	It is not entirely reasonable that a booking appointment made by week 13 is used as an indicator of safe midwife staffing. This is instead an indicator that safe clinical care is given, and not a reliable measure of staffing. The booking of appointments is difficult to attribute to midwifery staffing, as it is reliant upon the administration/GP team, who are key drivers of this. It would be better to look at Referral to Treatment Time, as this is a better indicator of midwifery capacity and availability. Furthermore, there are often other factors influencing the timing of bookings, e.g. chaotic lifestyles, drug and alcohol dependencies, change of address, safeguarding issues. If the definition on page 22 (6) is to be used, the Shelford Group feel this is not a measurable element of performance than can assess the quality of care provided. As the NICE antenatal guideline recommends, booking should have happened ideally within ten weeks; this standard should be reflected within the staffing guidelines. UK National Screening Committee guidelines also recommend that antenatal screening be offered as early as possible.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
274	The South West London Maternity Network	There are too many other variables, such as referral time from GP and this can be influenced by admin and clerical numbers and space capacity rather than midwives.. Need to consider the drive to reduce the timing for bookings from before 12+6 weeks to by 9+6 to enable earlier screening for hepatitis and other maternal conditions to enable earlier support by specialist teams.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
275	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	There may be adequate midwifery staffing but despite this the service may have late bookers culturally or due to the demographics in the area as long as midwives are readily available and accessible increasing numbers is unlikely to increase early booking however if caseloads are too high and women cannot access a midwife this may be an issue therefore caseloads size is a more robust measure?	Thank you for responding to this question. Your response will be shared with the committee for consideration.
276	University Hospital South Manchester NHS Foundation Trust	Yes	Thank you for responding to this question. Your response will be shared with the committee for consideration.
277	West Hertfordshire Hospitals Trust	This is out of date and was recommended in safer childbirth. NHS England now prefer booking by 10 weeks to enable compliance with screening targets. This reflects efficiency of operational management and communication, not safety of staffing levels	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Q9: Is the definition of supervision accurate? Should definitions for the following be included (and if so what should the definition be?):
• Mandatory supervision
• Statutory supervision
• clinical supervision
• Local Supervising Authority Programme

Comment number	Organisation	responses	Developers response
278	Birthrate Plus	no response	Thank you for responding to this question. Your response will be shared with the committee for consideration.
279	Bolton Hospital NHS Foundation Trust (HoM)	The definition should be taken from NMC documentation Mandatory supervision is not a term that is used in maternity services	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
280	Bolton NHS Foundation Trust (DoN)	The definition should be taken from NMC documentation Mandatory supervision is not a term that is used in maternity services	Thank you for responding to this question. Your response will be shared with the committee for consideration.
281	Bradford Teaching Hospital NHS Foundation Trust	To add….'and enables the delivery of safe, quality care.'	Thank you for responding to this question. Your response will be shared with the committee for consideration.
0282	Buckinghamshire Healthcare NHS trust	(*no response*)	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
283	City Hospitals Sunderland, NHS Foundation Trust	The glossary should include midwifery supervision. Mandatory supervision is not a term used.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
284	Countess of Chester NHS Foundation Trust	Not fully Statutory Supervision Statutory supervision provides a mechanism for support and guidance to every practising midwife in the U.K. A Supervisor of Midwives must meet the requisite standards of experience and education for the role of SOM as set by the NMC and are accountable to the Local Supervising Authority Midwifery Officer. The purpose of statutory supervision of midwives is to protect women and babies and actively promote safe standards of midwifery practice. LSA Practice Programme This should be used when development and assessment of a midwife's practice is required following a supervisory investigation using the LSA Framework. The midwife needs to be supernumerary to facilitate this programme. Clinical Supervision Clinical supervision in the workplace is a way of using reflective practice and sharing experiences as part of continuing professional development with the aim of improving patient care. It helps build trust and rapport, and provides an articulate process that is empowering, supportive and, when necessary, directive. It addresses the intricacies of nursing whilst fostering sensitivity to oneself alongside care and respect for others.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
285	Department of Health	Further definitions of levels of supervision could be helpful, especially mandatory supervision (in what circumstances and why)	Thank you for responding to this question. Your response will be shared with the committee for consideration.
286	Doncaster and Bassetlaw Hospitals NHS FT	yes Should include that it is a statutory function which protects the public by ensuring high standards of midwifery practice	Thank you for responding to this question. Your response will be shared with the committee for consideration.
287	Epsom and St Helier NHS Trust	I think that Statutory Supervision should be defined correctly to identify the link Stat Supervision plays in maintaining the safety of mother any baby. Equally – Local Sup programme should be fully explained and numbers on local programmes are already centrally monitored – I do not think this should be reported on along with staff levels as it is specifically involved in improving the ability of a midwife. Safeguarding Supervision is currently required for staff who regularly undertake a safeguarding responsibility _- this relates to most community midwives and some inpatient midwives. This should be defined. Other areas of need include: Time for midwife counsellor staff and Safeguarding midwives to have access to counselling support sessions – this may impact on staff levels and needs.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
288	Epsom and St Helier NHS Trust	I think that Statutory Supervision should be defined correctly to identify the link Stat Supervision plays in maintaining the safety of mother any baby. Equally – Local Sup programme should be fully explained and numbers on local programmes are already centrally monitored – I do not think this should be reported on along with staff levels as it is specifically involved in improving the ability of a midwife. Safeguarding Supervision is currently required for staff who regularly undertake a safeguarding responsibility _- this relates to most community midwives and some inpatient midwives. This should be defined. Other areas of need include: Time for midwife counsellor staff and Safeguarding midwives to have access to counselling support sessions – this may impact on staff levels and needs.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
289	Guy's & St Thomas' NHS Foundation Trust	Whilst the definition is correct, the difference between clinical and statutory supervision should be made more explicit. Mandatory supervision is not a term used in midwifery. A Local Supervising Authority (LSA) Programme is part of statutory supervision.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
290	Heads of midwifery in Wales Advisory Group	Wales has a different model of Supervision of midwives which requires to be included in the guidance.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
291	Health Education England	There should be clearer definitions to avoid misunderstanding. All definitions should be included, and be clear and concise. There may be confusion as supervision and mentoring are listed together as an activity on p.17 Box D (supervision or mentoring). These are very different activities and should be separated. It is not clear what the difference is between mandatory and statutory supervision. In statutory supervision the workload of the Supervisor of Midwives is usually more than the supervisee and this difference should be reflected. It is not clear what the term 'mandatory' supervision refers to. A definition of mentoring should be included in the glossary, with the role of the sign-off-mentor and registrant clearly defined	Thank you for responding to this question. Your response will be shared with the committee for consideration.
292	National Federation of Women's Institutes	We would suggest using the NMC's definition of statutory supervision.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
293	NHS England	The definition of supervision is fine. Statutory Supervision should be included with its definition – which should specify that it is required by law, with details of what is required i.e. 1 annual review Clinical Supervision should be included with its definition – as if the purpose of the guideline is to recommend what is good practice, it should be explicit that clinical supervision is one of the key components and provides real time assurance and support to staff in ensuring they are providing safe and high quality care. A Local Supervising Authority (LSA) Programme is something that is put in place when a midwife's practice is being called into question and she requires some remediation. Mandatory supervision is not a term used in midwifery.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
294	NHS England (Midlands & East)	There should be clearer definitions to avoid misunderstanding. All definitions should be included, and be clear and concise. There may be confusion as supervision and mentoring are listed together as an activity on p.17 Box D (supervision or mentoring). These are very different activities and should be separated. It is not clear what the difference is between mandatory and statutory supervision. In statutory supervision the workload of the Supervisor of Midwives is usually more than the supervisee and this difference should be reflected. It is not clear what the term 'mandatory' supervision refers to. A definition of mentoring should be included in the glossary, with the role of the sign-off-mentor and registrant clearly defined.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

Table of responses to consultation questions – Registered Stakeholders

Comment number	Organisation	responses	Developers response
295	NHS Forth Valley	Supervision of midwives is a statutory requirement contained within the Nursing & Midwifery Order 2001 and outlined within the Midwives rules and standards (NMC 2004). Effective supervision enables the development of midwifery leadership, which creates a practice environment where midwives assume their professional accountability for high quality, evidence based midwifery care (LSA,NMC 2008). Supervision is acknowledged as a supportive, proactive function that empowers midwives by supporting their practice and professional development. The philosophy of midwifery supervision ensures that the midwife is confident and clinically competent to carry out her role, supported by her supervisor of midwives, thereby ensuring the safety of mothers and babies It is important that the same definition as defined by the NMC so that patient s and staff are very clear on the role and remit of supervision.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
296	North Middlesex University Hospital NHS Trust	In midwifery there is a statutory supervision and each midwife needs to have a named supervisor of midwives. Also the staffing calculation needs to consider the time for statutory supervision which currently recommends two days per month for each supervisor of midwives and for the contact supervisor of midwives, four days a month. The caseload for each supervisor is 1:15. Therefore, when calculating midwives numbers, above needs to be taken on board as the Trust also have to employ supervisor of midwives to carry out the statutory function. Currently this is not met in many organisations and the ratios and time allocated various in different organisations. Local Supervising Authority Programme are in place with a maximum time to complete is 450 hours for the midwives with support of the named supervisor of midwives. There is no mandatory supervision. However, there is mandatory training and this also differ in all organisations.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
297	Nottingham University Hospitals NHS Trust	yes *(for all points)*	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
298	Nursing and Midwifery Workload and Workforce Planning Programme (Scotland Gov)	*(no response)*	Thank you for responding to this question. Your response will be shared with the committee for consideration.
299	Oxford University Hospitals NHS Trust	The definitions should be the same used by the NMC. Statutory supervision of midwives is correct. Mandatory supervision and clinical supervision are not relevant to midwifery practice.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
300	Royal College of Midwives	The wording in the glossary is a description of clinical supervision. The RCM recommends that there should also be included a definition of statutory supervision, which is a regulatory system designed to protect the public. Under the system of statutory supervision, all practising midwives must notify their intention to practise on a yearly basis. Statutory supervision is however also meant to support midwives maintain and develop their practice. A Local Supervising Authority (LSA) Programme is something that is put in place when a midwife's practice is being called into question and she requires some remediation. Mandatory supervision is not a term used in midwifery.	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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301	Royal College of Nursing	It is not very clear and not entirely accurate. What is referred to here is Statutory Supervision of Midwives which all registered midwives must use formally at least once a year in order to stay on the Register. It is therefore also a mandatory activity under the Midwives Rules and Standards (2012 Rule 9). It would be useful to include definitions of other types of supervision as listed. Clinical as a mechanism through which staff can reflect on their clinical practice to enable improvements and identify learning needs (CQC 2013 http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf). It is neither statutory nor mandatory and may apply to all health care staff A Local Supervising Authority Programme is now known as the Local Supervising Authority Practice Programme. This is a formal programme designed to assess and develop a midwife's clinical competence and knowledge in order to enable her / him to practice safely The definition appears correct. Mandatory, statutory and clinical are less used in Midwifery more nursing. The LSA may be worth adding.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
302	Royal Cornwall Hospital NHS Trust	No – supervisors of midwives are experienced practising midwives who have undergone education and training in the knowledge and skills needed to supervise midwives – doesn't necessarily mean they are a skilled supervisor What is meant by mandatory supervision? Clinical supervision is a different entity and is used primarily in nursing What about safeguarding supervision – this should be included	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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Comment number	Organisation	responses	Developers response
303	Royal Surrey County Hospital Foundation Trust	Needs further expansion which I am sure the LSAMO's will provide. However there is a great deal of work undertaken by supervisors of midwives which supports care planning for individual women and this is not represented well in the draft guidance. Currently the guidance appears to be focused on the clinical midwife and not reflect the expanse of the supervisor role.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
304	Stillbirth & Neonatal Death Charity (Sands)	No comment	Thank you for responding to this question. Your response will be shared with the committee for consideration.
305	Taunton and Somerset NHS Foundation Trust	I think this should be strengthened. Line 479-480 captures clinical supervision only. Mandatory supervision should include annual supervisory review (currently not mandatory). Safeguarding supervision should be specifically mentioned and defined as ? the supported reflection /guidance/counselling with a named individual with safeguarding expertise and training….should be dedicated time also	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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306	The Royal College of Obstetricians and Gynaecologists	Appraisal is not explicitly mentioned. It may be useful to use it as it has become an essential part of most organisations staff development procedures.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
307	The Shelford Group	The definition of supervision should include its purpose: to protect women and babies by actively promoting safe standards of midwifery practice. The title should be supervision of midwives or statutory supervision. The definitions for mandatory and clinical supervision are not required. Statutory is included within the definition of supervision. The Local Supervising Authority Programme is part of the Statutory Supervision, and should be included within the glossary. When concerns regarding a midwife's ability to practice safely have been identified, a midwife may be placed upon a LSA practice programme. The aim of this programme is to provide a formal process that develops and assesses a midwife's competence, in order for her to return to working competently without direct supervision.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
308	The South West London Maternity Network	There are clear definitions of Statutory Supervision and Local Supervising Authority program elsewhere. All of these are defined by statute in the Nursing and Midwifery Order 2001 SI2002/253 and the Midwives Rules 2012 SI Including other definitions will only cause more confusion	Thank you for responding to this question. Your response will be shared with the committee for consideration.

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309	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	• Supervision is poorly defined there is the statutory function as defined by the NMC this is mandatory and statutory. • The “business of providing and supporting supervision within the organisation” is a statutory duty but how it is conducted is not mandated(the LSA assure the various local interpretations deliver the LSA requirement. • Clinical supervision is different and does not require a midwife to be a registered SOM any midwife can conduct the role to support members of staff. There needs to be an acceptance of mentorship of students and preceptorship of newly qualified staff within the service as this detracts midwives from direct care in order to support and teach. • Local Supervisory Programmes are defined as per the NMC and agreed with the LSAMO as appropriate	Thank you for responding to this question. Your response will be shared with the committee for consideration.
310	University Hospital South Manchester NHS Foundation Trust	The definition relates specifically to Statutory Supervision. This should be made clear within the document.	Thank you for responding to this question. Your response will be shared with the committee for consideration.
311	West Hertfordshire Hospitals Trust	No Supervision should be based on midwife to supervisor ratios and the need will increase with high proportions of part time staff.	Thank you for responding to this question. Your response will be shared with the committee for consideration.