NICE National Institute for Health and Care Excellence

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Stakeholder organisation	Section	Page Number	Sub-section, paragraph, line, consideration, or recommendation number	Comments	Response
Birth Trauma Association	Box 1			We would like to see some definition of which activities are appropriate for midwives & MSWs and which are not. See above.	Thank you for your comment. Evidence permitting the guideline will provide details on the range of activities provided by midwives to ensure safe care is being delivered. Following consultation comments and a stakeholder workshop we have altered the focus of the scope to midwives only. This is primarily due to the lack of a national standard for Maternity Support Workers (MSW). However, the scope will review whether access to MSW has an impact of staffing requirements for midwives.
Birth Trauma Association	Box 2			Not a single outcome related to Perinatal Mental Health despite this being the leading cause of morbidity in the Perinatal period – please add one.	Thank you for raising this point The outcomes listed in the scope are not intended to be an exhaustive list. We have amended the text to make this clearer. Perinatal mental health is covered by the NICE guideline referred to in the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Birth Trauma Association	Box 2			Please delete 'mode of delivery' as a measure of midwifery activity. It risks the unintended consequence of midwives delaying calling for help when help is needed. This is highlighted in repeated NHSLA documents and something we see in women's accounts all the time. There should be no pressure whatsoever to discourage a midwife from calling for help when it is needed. Making mode of delivery a quality measure for midwife activity is hugely risky and completely mistaken. Maternity PROMS are to be supported by NHS England and these would be much better to use these when they are ready.	Thank you for raising this issue. We agree that the phrasing of any mode of delivery indicator would need to be carefully considered in order to avoid an air of judgement and therefore potentially unintended consequences, However, we feel that the guidelines advisory committee would benefit for seeing the evidence available about this readily collected outcome before deciding whether or not it is a suitable indicator. We have added the PROMS to the potential sources of maternal feedback available.
Birth Trauma Association	General			We welcome this important and much needed Guideline and are pleased that NICE is now addressing the issue of safe staffing.	Thank you for your support
Birth Trauma Association	General			We would have preferred the safe staffing of maternity units to have included consultant and anaesthetic cover as well as midwives & MSWs in a single piece of guidance. Separating them is not helpful because to be safe they need to work as teams.	We understand your concern and will be feeding this back to our commissioners, NHS England and the Department of Health. However, covering these, and the many other staff groups involved in aspects of maternity care, will not be feasible during the time scale available for the current work. In both the stakeholder workshop and several stakeholder comments we have received support for restricting the scope to midwives only. However, we will be reviewing whether availability of other healthcare staff influences safe midwifery requirements.
Birth Trauma Association	General			In looking at organisational factors, there needs to be some metric that assesses the extent to which midwives and MSWs can communicate concerns about staffing levels and their working environment and feel listened to.	Thank you for raising this point, we anticipate that staff communication mechanisms would be covered under maternity team management and administration approaches.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Birth Trauma Association	General			Excellent to see reported feedback being used as an indicator.	Thank you, we agree that maternal feedback is a very important indicator
Birth Trauma Association	Para 15			We welcome the exploration of organisational and management considerations relevant to the safe and efficient delivery of services. What is missing in many organisations is a clear understanding of what midwives and maternity staff are required to do and whether they have the time to do it. There needs to be a measure of key pressures on staff. Staff report feeling that they are more likely to be in trouble for not doing the next week's staffing rota than if they leave a woman alone in labour for a while. Prioritisation is often wrong; what matters to managers often seems to take priority over the care of service users. We would be interested to see how NICE analyses the organisational issues to ensure that the quality of care of service users is prioritised over other pressures on the time of maternity staff.	The scope will specifically ~~to~~ look at the various activities and outcomes associated with midwifery staffing. We will also be reviewing maternity team management and administration approaches which we anticipate will cover the issues you have raised.
Birth Trauma Association	Para 5 Backgro und			There needs to be reference to the growing administrative and record keeping pressures on midwives. The UK does not have a particularly high midwife to woman ratio yet there is no doubt that some UK midwives are at breaking point. It would be good to see the debate reframed not around how many women per midwife but how many hours are needed to carry out which core midwifery tasks, how much of it is administration, how much unrelated to direct care and how much could simply not be done. The midwives' role has expanded enormously. Perhaps it should now contract back to core functions if additional funding cannot be found.	Thank you for raising this point, we have amended the scope to reflect both the administrative roles of midwives and the range of tasks they cover.
Bolton NHS Foundation Trust	general			Consideration needs to be made for the methodology of using BR+, for example with Greater Manchester some units calculate BR+ figures on actual numbers worked minusing sickness and maternity leave, whilst other use contacted hours. This means that comparison of figures on the dashboard are comparing like with like between trusts	Thank you for raising this issue, we anticipate that the comparability of indicators across the country will form part of the guideline advisory panels discussions.
Bolton NHS Foundation Trust	general			The commissioning spec in each area varies, a recent comparison between units show a wide variation in what's included in the spec and therefore what staffing has to cover. A recent comparison document showed that 6 other large trusts (6000+ births) national provided a very different levels of service, ie flu vaccination, BCG at bedside, transitional care and how that's supported, early pregnancy coverage, ENB, all vary across the country but have a major influence on staff provision.	Thank you for raising these points, we have amended the scope to reflect additional services that may be provided.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1			What is the impact on the clinical skill mix and the provision of care while supporting a newly qualified midwife?	Thank you for this suggestion, the impact of skill mix and supervision is included in the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1		Bullet point 2	Please could you include 'the impact of the need to use interpretation services' within the complexity of pregnancy section?	Thank you for your suggestion, the scope aims to cover all aspects of the care provided by midwives, including care provided to women with complex needs. We have deliberately not specified a complete list of these needs as we do not wish to restrict the scope.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1		Bullet point 5	Please could you include 'What is the impact of the cost of employing post RN student midwives on the service?'	Thank you for your suggestion, staffing costs are included as an outcome of interest.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1		Bullet point 4	Could you include 'How does providing support to midwives to complete mentorship programmes within the clinical environment affect staffing levels?'	Thank you for this suggestion, the impact of supervision and staff support is included in the scope.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1		Bullet point 4	Could you include 'How does providing support for the education of student midwives within the clinical environment affect staffing levels?'	Thank you for this suggestion, the impact of supervision and staff support is included in the scope.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1			What is the implication of safeguarding and complex social needs of women on the staffing requirements?	Thank you for raising this important point. Within the scope we will be reviewing social complexity, including safeguarding, under maternal risk factors; these terms are deliberately broad to ensure that no relevant issues are missed.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Central Manchester and Manchester Childrens University Hospitals NHS FT	Box 1		Bullet point 4	We think that the impact of the supernumerary status of newly qualified midwives during the preceptorship period on midwifery staffing levels needs to be considered (may fit better in box 1 bullet point 4)	Thank you for this suggestion, we have amended the scope to reflect this.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Section 16			We think this also needs to include the impact of Specialist Midwives when considering midwife 'availability' across a whole unit.	Thank you for this suggestion, we have amended the scope to reflect this.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Section 16			We think the impact on staffing of midwives with additional skills providing level 2 critical care to patients on 'high dependency' units located on delivery suites needs to be considered	The scope aims to look at the additional services provided by midwives in some settings and the roles you mentioned are encompassed within this. We have added critical care to the examples to illustrate the breadth of this care.
Central Manchester and Manchester Childrens University Hospitals NHS FT	Section 16			We think this section needs to include the impact of the skill mix in relation to level of experience, not only overall numbers of staff i.e. ratios of band 5, band 6 staff etc.	Thank you for this suggestion, skill mix is a staff level factor that will be considered as part of the scope
Central Manchester and Manchester Childrens University Hospitals NHS FT	Section 16			We think this section needs to look at the impact of the midwife undertaking a role in obstetric theatre (e.g. scrubbing for LSCS, acting as recovery nurse, acting as an ODP)	The scope aims to look at the additional services provided by midwives in some settings and the roles you mentioned are encompassed within this.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Countess of Chester Hospital NHS Foundation Trust	Box 1		What maternal and neonatal safety activities and outcomes are associated with midwife and MSW staffing levels and skill mix?	How would this be evidenced /collated?	Box 1 contains the questions we wish to answer through the evidence review, how they are evidenced will depend on the individual studies located.
Countess of Chester Hospital NHS Foundation Trust	Box 1		How does statutory midwifery supervision affect staffing requirements?	Will there be a national mandatory hours per month for each SOM as part of this guidance to ensure equity.	The evidence review will examine supervision arrangements and their impact on safe staffing requirements. It is not within the remit of this work to consider national mandatory hours per month for each SOM.
Countess of Chester Hospital NHS Foundation Trust	Box 1 & Section 15		What organisational factors influence safe staffing? These include: Management structures and approaches Organisational culture Organisational policies and procedures	How will these be measured i.e. Organisational culture?	Box 1 contains the questions we wish to answer through the evidence review, how they are categorised and measured will depend on the individual studies located.
Countess of Chester Hospital NHS Foundation Trust	Box 1 & Section 16		What other factors affect safe staffing requirements? These may include size and physical layout, and diversity of available clinical disciplines.	How would this be categorised / measured?	Box 1 contains the questions we wish to answer through the evidence review, how they are categorised and measured will depend on the individual studies located.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Countess of Chester Hospital NHS Foundation Trust	Section 15			Excellent to have nationally agreed MSW ratios	This NICE guideline, evidence permitting will make recommendations on safe midwifery staffing across all maternity settings. It will also identify the indicators that should be used within trusts to provide information on whether safe and effective care is being provided. It will not be nationally agreed MSW ratio.
Department of Health	Box 1		1st bullet	Suggest adding SUI's	The outcomes listed in the scope are not intended to be an exhaustive list. We have amended the text to make this clearer. Please note Serious Preventable Events are already included in the scope.
Department of Health	Box 1		3rd bullet	Suggest including a reference to social enterprises delivering all or some of the maternity pathway. We anticipate that social enterprises will increase.	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health	Box 2		section 2 Delivery of midwifery care 1st bullet.	Suggest adding Named midwife and continuity of care (QS22) and Equality and diversity – complex social issues (QS22)	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health	Box 2		section 2	Assume this includes CQC and NPEU Women's experience of maternity services surveys and the Friends and families test for maternity services.	Thank you for bringing these examples to our attentions. Yes, we would expect these, and other surveys, to be included as part of the maternal feedback.
Department of Health	General point			The scope needs to be clear that it covers the whole maternity pathway including antenatal, intrapartum and postnatal care	Thank you for your comment, we agree that the guideline should cover the whole maternity pathway and this is made clear under "What the guideline will cover" within the scope
Department of Health			Para 2 background	Suggest that the scope is consistent and explicit here. Is it midwifery and maternity support workers or 'staffing of maternity settings' as this implies inclusion of the wider maternity team which would for example include obstetricians, radiographers etc	Thank you for this suggestion, we have amended the scope to clarify this.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Department of Health			Para 2 background	The scope needs to be clear that it covers the whole maternity pathway including antenatal, intrapartum and postnatal care otherwise it will be limited in usefulness and will have the same limited use as other workforce tools that focus on births.	Thank you for your comment, we agree that the guideline should cover the whole maternity pathway and this is made clear under "What the guideline will cover" within the scope.
Department of Health			Para 5 1st bullet	Consider amending to 'Ensuring midwifery staffing matches the birth rate' rather than increasing annual number of births as during the first 6 months in 2013 it appears that the birth rate decreased.	Thank you for this suggestion, however it is the general increasing trend over time that we were intending to highlight here.
Department of Health			Para 5 2nd bullet	Suggest either adding to this bullet or adding a new bullet that covers social complexity rather than just clinical complexity.	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health			Para 5 3rd bullet	Such removing 'increasing'. To reduce interventions such as caesarean sections requires more input from midwives in a different way for example better CTG monitoring and interpretation.	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health			Para 5 4th bullet	Maternity Matters: Choice, access and continuity of care in a safe service is a DH policy document not an NCT document.	Thank you for raising this, we have corrected the scope
Department of Health			Para 5 4th bullet	Suggest referencing the mandates between the Govt and NHS England and Health Education England as both have specific references to personalised maternity care.	Thank you for your comment. We are keen to include any relevant mandates as you suggested and will be contacting you to ensure we have the correct reference details.
Department of Health			Para 5 5th bullet	This suggests a policy of more midwifery led units whereas the policy is for choice of place of birth. It would be better to phrase this about 'safe staffing in different delivery models' as this would include MLU's, home births and obstetric units.	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health			Para 5 6th bullet	Suggest adding scanning as an example as we know that there is a shortage of obstetric sonographers and radiography so midwives are taking on these roles.	Thank you for this suggestion, we have amended the scope to reflect this.
Department of Health			Para 5 7th bullet	This should include the safe ratio of part time to full time working to ensure that services are sustainable. The core training requirements for part time staff are the same for full time staff but the productivity reduces.	Thank you for your comment, the training needs of staff are covered elsewhere in the scope

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Department of Health			Para 5	Suggest an addition bullet on the effects of changes to the medical workforce.	Thank you for your comment. We aim to keep the background to the scoping document as concise as possible and believe that the majority of the impact of changes to the medical workforce are covered in the bullet point discussing the additional roles adopted by midwives
Department of Health			Para 8	Suggest adding the requirement for Trust Boards to review and agree staffing levels annually	Thank you for raising this point. We agree that this agreement sits alongside any indicators of safe staffing identified in the guidelines. However, the paragraph refers to what NICE will provide and it may therefore be misleading to discuss these additional arrangements
Department of Health			Para 9	Suggest adding a reference to the Centre for Workforce Intelligence work on the development of a local maternity workforce planning tool.	Thank you raising this work. Birthrate plus is included as an example as it is the main tool in use across the UK and will be familiar to most guideline users. There are a number of similar tools in development, including the one your raise, and we hope that they will apply for endorsement.
Department of Health			Para 21	Suggest adding that the review will draw on 'national' and international published literature and the midwife and maternity support worker role in the UK is not replicated elsewhere internationally.	Thank you for this suggestion, the term international published literature encompasses any available literature from the UK.
Department of Health			Reported feedback 1st bullet	Suggest this specifically includes VBAC as this requires more midwifery input	Thank you for raising this, however we try to avoid creating lists of procedures to be considered as this runs the risk of other important procedures being missed.
Department of Health			Para 25 4th bullet	Suggest an additional bullet on Socially complex pregnancies as midwives report these requiring more time/input in a similar way to clinical risks and indicators	The consideration of socially complex pregnancies has been clarified in the scope

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Department of Health			Para 25	There needs to be a reference to Health Education England who are responsible for the education, training and development of the midwifery workforce.	Thank you for your comment, we would be happy to reference Health Education England and will be contacting you to ensure we have a suitable reference.
Ferring Pharmaceuticals Ltd.	general			Ferring has no comments and agree to the draft scope	Thank you for your support
Independent Midwives UK Ltd	General			We are concerned that although this document is reasonably comprehensive there is no mention of use of outside agencies.	The guidelines will cover all maternity service, including those provide by the NHS, private providers and charitable/social enterprises providing care to NHS patients and service users.
Independent Midwives UK Ltd	General			Also, while the aims may be good we are unclear how staffing levels may be increased – particularly without the use of outside agencies such as ourselves	NICE's role is to provide evidence based guidelines in relation to safe staffing. We are working with Health Education England to ensure workforce requirements are identified and built into future training.
Independent Midwives UK Ltd	General			My personal perspective is that I have seen all the above mentioned reports greeted with enthusiasm while real staffing levels fall due to pregnancy and sickness. In the 25 years I have been a midwife staffing levels and quality of care have dropped consistently.	Thank you for your comment.
Maternity Action	Background #16		Factors that may impact on safe midwife and MSW staffing at the maternity unit level	In line with the previous comment we would propose highlighting social as well as medical maternal risk factors as significant elements which might impact on staffing, and paying particular attention to maternal mental health.	Thank you for raising this important point. Within the scope we will be including social complexity as a maternal risk factor; these terms are deliberately broad to ensure that no relevant issues are missed.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Maternity Action	Box 1 Point 2			Maternal risk factors to include social complexity which may be reflected in late booking and/or poor or non-attendance at antenatal clinics. For migrant women this can be a result of fear of charging, misinformation about entitlements to NHS maternity care, fear of being reported to the Home Office, lack of understanding of maternity care system in the UK, or lack of childcare support for existing children. It may be especially common among: o women who do not speak or write English o recently arrived migrants o women who have experienced trauma and violence o women separated from family and social networks as a result of asylum dispersal policy or of fleeing conflict, persecution etc.	Thank you for raising this important point. Within the scope we will be reviewing social complexity and local socio-demographics which will cover the issues that you have raised; these terms are deliberately broad to ensure that no relevant issues are missed. In addition, the topics you have raised have been flagged in our equality and diversity form and NICE ensures that equality and diversity issues are considered at every stage of the guideline development process.
Maternity Action	Box 1 Point 3			We would recommend that in order to identify vulnerable migrant women, demographics consider not only ethnic origin but also other factors identified in the Maternity Services Data Set such as country of origin, number of years in the UK and women's ability to speak English (Interpreter required).	Thank you for raising this important point. Within the scope we will be reviewing social complexity and local demographics which will cover the issues that you have raised; these terms are deliberately broad to ensure that no relevant issues are missed. In addition, the topics you have raised have been flagged in our equality and diversity form and NICE ensures that equality and diversity issues are considered at every stage of the guideline development process.
Maternity Action	Box 2		Outcomes of interest- Delivery of midwifery care	We propose including a measure of quality based on • identification of women with complex social factors • provision of continuity of carer (antenatal, intrapartum, and postnatal care from a named caseload midwife) for such women	Thank you for raising these points, we have amended the scope in line with your suggestion.
Maternity Action	Section 2, Background #5		Reasons to review staffing	In line with the goal of the scope to promote equity, we recommend adding a point about the increasing recognition and understanding of complex social factors in pregnancy which require additional staffing input and more effort to provide continuity of carer as well as of care. This is recognised in NICE Guideline *Pregnancy and Complex Social Factors* CG110	Thank you for raising this point, we have amended the scope to reflect this.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Maternity Action	Section 2, Background #5		Rationale	Maternity Action draws particular attention to the maternity care needs of vulnerable migrant women and their higher risk of maternal mortality. The following issues are identified in CEMACH 2008 and CEMACE 2011: • Poverty (socio-economic deprivation) • Domestic violence/ abuse • Need for continuity of care for vulnerable women • Asylum seekers' higher risk factors • Asylum seekers higher rates of maternal mortality • FGM • High risk of undiagnosed cardiac disease in women from less developed countries • Poorer maternal health outcomes for minority ethnic groups • Higher risk of sub-optimal care among BME women • Role of psychiatric disease in causing maternal death	Thank you for raising this important point. Within the scope we will be reviewing social complexity and local demographics which will cover the issues that you have raised; these terms are deliberately broad to ensure that no relevant issues are missed. In addition, the topics you have raised have been flagged in our equality and diversity form and NICE ensures that equality and diversity issues are considered at every stage of the guideline development process.
Maternity Clinical Workforce Matters Ltd (MCWM)	Background		Paragraph 7	Based upon our own evidence, gleaned from conducting a number of external maternity workforce reviews for our NHS clients over the past year, we fully endorse the findings of the 2011 King's Fund report. Our evidence from the maternity frontline, and working closely with Heads of Midwifery, is that today's tools have significant shortcomings: they do not take a midwife team approach; they do not capture all the information (the service activities + non-clinical activities + patient risks + absences, etc.,) that the staff are required to deliver or cover; they do not guarantee 1 to 1 care for mums in established labour; and, they cannot flex staff availability and deployment with the natural peaks and troughs of maternity activity and patient risks, particularly in the labour ward and the post-natal ward. All this means that today's midwifery workforce planning, using today's planning tools, is inherently sub-optimal in terms: utilisation of staffing resources; managing patient risks; and Value for Money.	Thank you for raising this issue, these will be important factors to consider during the endorsement of the tools as well as during the review of the effectiveness of available evidence on the tools currently in use.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Maternity Clinical Workforce Matters Ltd (MCWM)	backgro und		Paragraph 9	In response to our concerns about the limits of current midwifery workforce planning systems, MCWM have developed a new midwifery workforce planning tool. It is designed for both providers and commissioners. The tool addresses all the shortcomings we have identified in the course of our maternity service reviews. It also has an explicit focus on guaranteeing 1 to 1 midwife care for mums in established labour. The tool is customised to each organisation. The tool's key attributes are: easy to understand and use; absolutely transparent; fully comprehensive (i.e. all inclusive of what midwives and their support workers are required to do and cover for); calculates several key parameters based upon activity volumes and complexity, including midwife and support midwife wte, skill mix, staffing budget, bed capacity numbers (and with ongoing work to model the predicted variable daily numbers of births in the labour suite with the objective of the consultant presence and 1 to 1 midwife staffing levels being flexed accordingly); can be questioned for scenario planning to investigate service improvement and cost savings options; and, provides standard reports and can provide customised reports. MWCM will be submitting the tool for assessment for its compliance with the anticipated guideline recommendations with a view to NICE endorsement.	Thank you for your interest in the endorsement process. We will ensure your details are passed to the Accreditation team who are managing the endorsement process.
Maternity Clinical Workforce Matters Ltd (MCWM)	Economi cs aspect		paragraph 23	It is essential that heads of midwifery and the senior team, when it comes to making operational decisions about the most effective options for workforce planning and deployment, must also be able to model different scenarios and determine their clinical and financial impact. In our view, any workforce planning tool is not eligible for endorsement unless it can also be used to answer the 'what if?' questions. Also, as a minimum, answers must be expressed clearly in terms of changes in staffing parameters (wte, skill mix, staffing costs) and in workload parameters (activity volumes, time allocation to tasks / procedures, patient risks).	thank you for your comment which we will share with our Accreditation team who are managing the endorsement process.
Maternity Clinical Workforce Matters Ltd (MCWM)	What the guideline will not cover		paragraph 19	While we agree with the generality of this statement, we believe an exception should be made with regard to the clinical staffing mix on the obstetric labour ward. Ensuring safe and effective obstetric labour ward staffing is a fundamental requirement for both medical (senior and junior) and midwife staffing. There is a strong quality and safety argument that the medical and midwife presence here should be seamlessly planned as one multi-disciplinary team and that any tool should have this capability.	Within the scope of the current piece of work we will be able to look at the impact of availability of other member of the team, in the various different settings, on safe maternity care.
Maternity Clinical Workforce Matters Ltd (MCWM)	What the guideline will not cover		paragraph 20	Please note that the MCWM midwifery planning tool is designed so that it can also be used for network, regional and national planning purposes. This capability is based on our view that the outputs of robust operational level workforce planning should also be used as the 'currency' to inform, drive and direct policy and planning at the higher network, regional and national levels. This bottom up approach enables a 'gap analysis' to be conducted between today's current workforce and the calculated midwife and support midwife requirements, providing the most accurate and comprehensive overview and so inform the recruitment and training agenda accordingly.	Thank you for your comment, we will share this comment with our Accreditation team who are leading on the tool endorsement process.
NHS England	general			I wish to confirm that NHS England has no substantive comments to make regarding this consultation	Thank you for your support

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Royal College of Nursing	General			The Royal College of Nursing welcomes this scoping exercise on safe midwifery staffing guideline for maternity settings. It is very timely and important that at a time when the birth rate continues to rise, and there is clear evidence of a continuing shortage of midwives to deliver high quality care, that work is completed on establishing a reasonable and fair staffing system.	Thank you for your support
Royal College of Nursing	What the guideline will cover			It is also essential that all women have access to one to one midwifery care during their birth experience, and that this does not compromise levels of care before or after birth.	We recognise this and 1:1 care during labour is included as an outcome of interest.
Royal College of Nursing	What the guideline will cover			It is important that this work takes account of previous work, in particular the use of well established tools such as Birth-rate plus, whilst using more recent evidence from the Centre for Workforce intelligence Unit on obstetric staffing, with the Royal College of Obstetricians and Gynaecologists' reports on High Quality Woman's Care (http://www.rcog.org.uk/high-quality-womens-health-care RCOG 2011 and Tomorrows Specialist RCOG 2012 http://www.rcog.org.uk/womens-health/clinical-guidance/tomorrows-specialist. It is also important to use recent findings from the Birthplace study, which provided evidence to support a range of models of care, including midwifery led.	Thank you for bringing this research to our attention, we will make sure it is considered as part of the development of the evidence review.
Royal College of Nursing	What the guideline will cover			Any scoping exercise needs to take account of appropriate support for midwifery care, including the role of maternity support workers.	An important part of these guideline will be to examine the impact of the availability of other healthcare staff, including maternity support workers, on maternity staffing requirements.
Royal College of Nursing	What the guideline will cover			It is equally valuable to ensure that all levels of midwifery staff are represented across the care spectrum, from student midwife through to strategic midwife posts. As has been shown in the past it is important to have women and women's needs well represented at discussions to develop the scoping exercise.	Thank you for your comment, we will have a range of experience represented on our advisory committee.
Royal College of Nursing	What the guideline will cover			As part of the environmental factors that will support safe staffing at the maternity level, it would be helpful if consideration is given to the establishment of effective channels of communications, initiatives leading to reduction of paper work and effective administrative support.	Thank you for your comment, management and administrative approaches will be considered as part of the evidence review.
Royal College of Paediatrics and Child Health	general			We should consider the social complexities of many of the families in our geographical areas (very low income and socially deprived). We should take into account non-English speaking women and families and the high volumes of families where social care are involved. We can only see where it talks about women with complex pregnancies..	Within the scope we have added "social complexity" and local level demographic factors to cover the issues that you have raised; these terms are deliberately broad to ensure that no issues are missed.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Scottish Government Health Department	General			• Principle of identifying safer staffing levels on a national basis good • Review of evidence behind existing tools welcomed • Reassured that NHS Scotland Nursing and Midwifery Workload and Workforce Planning Programme (NMWWP) model does consider factors identified in No 16 of the document in its methodology • NMWWPP tool will be able to extract observation of tasks which may be assigned to clinical support staff but does not recommend skill mix • Main review questions outline outcome indicators, risk levels and demographic information which may be associated with staffing, but would also have to be triangulated against organisational performance, culture etc to ensure staffing being utilised appropriately in an effective environment • Outcomes of interest well defined, however: o Serious preventable events do not include social risk and public health role of the midwife in ensuring safe environment for children and potential child harm as a never event o Delivery of midwifery care does not include continuity of carer in ante natal and post natal period which is going to be one of our national quality indicators and does not address post natal care in the community setting which would relate to the modelling currently being undertaken as part of the PRAM work in Scotland o Feedback would be beneficial to have national patient experience programme as has just been undertaken in Scotland o Age profile of staff and predicted retirements should be considered in other section on p6 • Social complexity should be included in maternal and neonatal factors on appendix A • It is not clear from the status report in safe staffing for maternity settings who specialist committee members will be, but would have thought it should include a range of midwifery leaders responsible for service provision, policy development and strategic posts, and also a range of workforce planning personnel.	Thank your for your comments and support. In particular, we have strengthened references to safeguarding, continuity of care, patient feedback, and social complexity within the scope as you recommended. The advisory panel will indeed contain representation from a variety of midwives with the levels of experience you suggest.
Swansea University	backgro und		Section 19	This point states that the guideline will not cover the involvement of other healthcare professionals (other than midwives and MSWs) yet the work of paramedics in particular is vital in relation to the safety and the potential staffing levels of free-standing midwifery-led units. Paramedic and ambulance transfers (including neonatal transfers) will need to be included in this guideline.	Thank you for raising this issue, we have amended the scope to reflect that the health care staff listed are examples rather than an exhaustive list

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Swansea University	backgro und		Section 20	This point states that the guideline will not cover the assessment of the reliability and validity of tools or resources used to assess and establish safe staffing levels yet in Box 1 it includes the following review question - What approaches for identifying required maternity staffing levels and skill mix are effective, and how frequently should they be used? - This seems contradictory	Through the review we intend to identify current tools/approaches in use and whether there is evidence that they have an impact on safe midwifery care. To assess the reliability and validity of tools requires detailed studies of each tool individually and a comparison to a gold standard measure - this level of assessment is beyond the scope of this work.
Swansea University	Box 1			The following point requires greater emphasis on some very important factors…… What other factors affect safe staffing requirements? These may include local community geography and demographics, unit type, size and physical layout, and diversity of available clinical disciplines. - How do birth settings and models of midwifery care (such as caseloading) affect safe staffing requirements? It should be presented as follows to ensure enough emphasis on some of the vital points buried within the first sentence…..: What other factors affect safe staffing requirements? - How does local community geography affect the maternity care workload? - How do local population demographics including levels of poverty and disadvantage affect the maternity care workload? - How does unit type, size and physical layout affect the maternity care workload? - How does the diversity of available clinical disciplines affect the maternity care workload? - How do birth settings and models of midwifery care (such as caseloading) affect safe staffing requirements?	Thank you for your suggestions, we have restructured this section of the scope to provide greater clarity.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Swansea University	Box 1			The following point requires greater emphasis on some very important factors…… What organisational factors influence safe staffing? These include: Management structures and approaches -Organisational culture -Organisational policies and procedures, including staff training It should be presented as follows What organisational factors influence safe staffing? These include: -Management training -Management structures and approaches -Organisational culture -Organisational policies and procedures -Staff pre-registration education -On-going staff training -Career development	Thank you for your suggestions, we have restructured this section of the scope to provide greater clarity.
Swansea University	Box 2		Outcomes of interest serious preventable deaths	It must be made clear that the whole contents of the Maternity Dashboard will be used – not just the stated items	Thank you for your comment, the scope has been amended to clarify this
Swansea University	Box 2		Outcomes of Interest Delivery of Midwifery Care	1) This section should include rates of initiation of breastfeeding and continuation of breastfeeding in the first 28 days 2) Mode of delivery should read Mode of birth or delivery 3) The point related to Drug omissions and other midwife associated drug errors should take account having enough staff to check for any adverse effects of medicines that are prescribed by doctors and/or administered by midwives.	Thank you for your comment. The provision of feeding advice to new mothers is listed in box 2 as one of the outcomes of interest. Monitoring the provision of this advice is a more direct measure of midwifery care than breastfeeding rates themselves, which are influenced by a number of different factors outside the control of the midwife.
Swansea University	Box 2		Outcomes of interest Other	The final point should read: Costs, including care, staff and litigation costs	Thank you for raising this, we have amended the scope in line with your suggestion.
Swansea University	Reference list			It is J. Sandall, not J. Sandell	Thank you for raising this issue, we have amended the scope to correct this.
The Multiple Births Foundation	General			The Multiple Births Foundation (MBF) considers that the scope is comprehensive and includes all the key areas that should be taken into account in developing the guideline.	Thank you for your support.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 1		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer	We looked at particular aspects of women's maternity care in order to gauge overall patient satisfaction, but the same indicators have a safety basis. We would welcome continuity of carer and 1:1 care in established labour (both NICE recommendations already) to be present in the literature review for setting safe staffing. Continuity and 1:1 care in labour are practices that are 'likely on past evidence to increase opportunities for normal birth without compromising safety' (Newburn & Dodwell, 2010). Clinical Commissioning Groups have been advised that 'continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well-coordinated and integrated care'.(Tyler, 2012) This means they will need to focus on 1:1 care in labour, as well as providing 'adequate staffing and a skill mix and deployment that ensures midwives are able to deliver continuity of antenatal and postnatal care' (Tyler, 2012).	Thank you for informing us about this report, it is very important that the views of mothers are represented and we have added a reference to the report to the list of key documents. We also have continuity of care, 1:1 care during labour and maternal satisfaction included in our outcome measures.
The National Federation of Womens Institutes	Box 1		Main review Questions for the Guideline: activities and outcomes associated with safe maternity staffing: Public Health role of midwives	We hope the safe staffing guideline can also think about safety from a public health perspective; one of the recommendations of our Report was to look at workforce planning and projections with midwives' essential public health role built in, rather than something tacked onto the end. Unfortunately, most current midwifery workforce projections based on 'supply and demand' concentrate on birth rate only. 'They do not measure…increasing complexity of care, inequalities, policy drivers; and the subsequent impact of these on the increasing role expectations required of the midwife.'(Chief Nursing Officers of England Northern Ireland Scotland and Wales, 2010). The safe staffing guideline is an opportunity to rectify this. The UK government and Welsh government views every midwifery contact with a woman as an opportunity to improve her wider health and that of her family, in recognition of the fact that development in early childhood is key for subsequent life chances and well-being over the life course (Department of Health, 2007; Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010; Welsh Government, 2011). LSA reports have examples of the specialist public health roles midwives are taking up. o In the South West, for example, maternity units have employed specialist midwives for public health issues such as smoking, obesity, teen pregnancy and mental health.(Pearce & Davies, 2012) In Yorkshire, free training has been offered to midwives to learn about caring for refugees and asylum seekers. (Paeglis et al., 2012)	The primary aim of the scope is to examine safe staffing for current services. However, we fully acknowledge the important role that midwives may play in providing public health messages to mothers and we have included this when we consider the impact of additional roles on midwifery staffing. We will also be exploring the impact of access to specialist midwives.

The National Federation of Womens Institutes	Box 1		Managerial approaches: Statutory supervision of midwives	We would like to draw NICE's attention to the local LSA reports of recent years outlaying the problems of managing supervising demand along with general workload and how this damages the recruitment and retention of SoMs. Our report called for maternity providers to provide dedicated time across the NHS for supervisors of midwives to carry out their statutory duties – which are safety-based - and to avoid using Supervisors of Midwives as a stop-gap measure to cover for chronic staff shortages. o In Wales, Supervisors of Midwives stepping down and taking extended leave of absence is 'of particular concern', and is being attributed to 'increasing pressures on midwives and midwifery services generally' (Higson, Ness, & Richards, 2012). o Similarly, 'stress', leading to resignations and leave of absences is caused by the 'prevalent' practice of calling South East Coast SoMs into units at times of peak activity (Curruthers & Hughes, 2012). o The South West notes its difficulty in attracting midwives to step up to become SoMs, partly because some midwives feel the extra responsibilities are simply added to their existing workload (Pearce & Davies, 2012). o Most LSA regions noted clinical demands eat into the time when SoMs are supposed to be undertaking supervisory activity (Bacon, 2012; Kirby, 2012; McKay & Smith, 2012; Read, 2012). o in London, an audit found 84% of SoM teams 'are overwhelmed by their substantive posts and find the competing demands a challenge' (Read, 2012). o SoMs have reported carrying out their role 'in their own time because they are so passionate about the difference their support has on midwives practising'.(Curruthers & Cro, 2012; Pearce & Davies, 2012)	Thank you for drawing this report to our attention; supervision and its impacts on safe staffing requirements are elements we hope to review evidence permitting.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 1		Main Questions for the guideline: Maternal choice and its relationship to safety	We would ask for the addition of a specific reference to safe staffing enabling women's right to get her choice of birthing location (unless it is necessarily overridden because of clinical concerns for her safety or that of her baby), and the right to change her mind. It may be helpful for NICE to look at how safety is interpreted differently by women in different birthing locations, as the draft scope includes work to assess safe staffing for community, obstetric units, and midwifery-led units (though we would welcome specific references to alongside midwifery units, freestanding midwifery units and home). As there is little research into the reasons why women want to give birth in certain places, we wanted to find out if there were aspects of care that were particular to certain locations or if more practical considerations were at play. We hoped the findings could further inform decisions about investment in increasing choice. • 'Facilities' and 'I would feel safe' were the most common reasons given for choosing a birth location, appealing to 67% and 58% of women respectively. More medical intervention and conversely, less medical intervention were the next two most popular attributes (around 45% of women). • 71% of women choosing a home birth listed safety as one of their reasons for choosing this. This is a higher proportion of mothers than those who were choosing to give birth in obstetric units (68%). Safety does not always mean technology. • Choosing a location on the basis of it being the 'least bad' option was rare, but more often it was factored into the decision to birth at home than anywhere else. • Of the attributes, having friendly or known staff was the least common reason to choice to give birth in a location. This may be a natural consequence of women not expecting to know who their midwife/midwives would be 'on the day', and therefore shows continuity of carer is not a policy that women necessarily believe is possible and is not determining their location choices. • More women wanting to give birth in obstetric units listed 'practical' as a reason than women choosing elsewhere; but had fewer women listing facilities or friendly staff as a reason. Obstetric units were mainly appealing because of available medical technology, safety, and also because of their reputations for 'giving great care'. • FMUs appealed on the basis of being friendly or known much more than other locations, and for having less medical intervention. They appealed much less on the basis of safety than other locations. • AMUs were the locations that had the broadest basis of appeal, with women's considerations quite evenly distributed across all the attributes. Facilities of AMUs were most appealing, followed by 'less medical intervention'.	Thank you for this suggestion. Within the scope we will be reviewing both the impact of both birth rate and birth setting on safe midwifery staffing.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 1		Main Questions for the guideline: Maternal choice and its relationship to safety	Quotes to illustrate the subtlety of 'safety' to patients: • 'Privacy, security, one-to-one care and respect for myself and my child as individuals.' Mum wanting a home birth • 'I liked the idea of the brand new, midwife-led centre as it had birth pool etc., and the fact that I was in hospital so help was on hand if I needed it or if there were complications.' Mum wanting to birth in an AMU • 'I wanted to give birth in a midwife-led unit outside of hospital because there was a double bed for my husband and it was more relaxed.' Mum wanting to birth in an FMU • 'I wanted to be located in a hospital as, because this was my first child, I didn't know what level of pain relief I wanted and I wanted to keep it possible to have everything if needed.' Mum wanting to birth in an obstetric unit We wanted to investigate the data trusts/boards held about the risk levels of the women they took care of, women's location choices, (and if they didn't get their choice, why not) and where women ended up. Few trusts were able to tell us about low risk women in their care and fewer still could provide the location preferences of low risk women. This is disappointing in light of the Department of Health's choice to set the maternity tariff payment on the basis of its estimate that 65% of women could be placed on the standard resource pathway (Department of Health, 2012b).	Thank you for this suggestion, we have included patient feedback as an outcome of interest.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 1		Main Questions for the guideline: Maternal choice and its relationship to safety	Of the trusts and boards we asked about location choices of the women in their care, 46 did not hold any data about low risk women or did not address the question, and 22 trusts refused to answer on the basis of cost or privacy. A few trusts mentioned that due to the changes coming to PbR they would be holding this kind of information soon. We are especially concerned at the frequent mention of handheld notes and paper records as the form in which data on women's choices or their risk status is held by trusts/boards, which makes retrieval and analysis of this information very difficult. It simple makes it harder for commissioners to identify what women are wanting from their maternity care. o Very roughly, from the data supplied from 35 trusts and boards, from 2007 to 2012 (which totals over 80,000 'low risk' births), the proportion of women recorded as planning a birth in a obstetric unit is 66%, and home only 4%. Only 25% of births were recorded as 'planned' to happen in AMUs or FMUs. o These proportions are very similar to where, from our survey data, we know women of all risk levels ended up. They are not a reflection of our survey data on choice exercised at the start of a care pathway. If we know that safety plays a big part in why women want to give birth in particular areas, then it is important to note what happens to women after they make a decision. Do they get what they want and if they don't, why not? We asked women who had expressed a location choice about whether they gave birth in the place they intended, or if something happened that meant they gave birth elsewhere: 58% of women birthed where they intended to, though this was much more likely to happen if women were choosing an obstetric unit birth. o Most who were 'moved' did so because the kind of medical care they or their baby required changed. But over 400 women (9.5%) did not get their choice for other reasons. Worryingly, over 100 women were denied their location choice because of a lack of staff or beds. o In all, 97% of women who intended an obstetric-led birth got what they chose. For women choosing a home birth, this figure is 47%, and for AMUs, 42%. Only a third of women choosing an FMU actually birthed there. We would urge NICE to see if there is any connection to women not giving birth in their chosen locations, and safe midwifery and MSW staffing. We know safety is a big consideration for women choosing a home birth. Our survey also found that around half of women who wanted a home birth didn't get one. Several trusts and LSAs reports mention their attempts at increasing home birth and the barriers – including staff numbers and working structure – to achieving this. Safe staffing in other locations, as well as in the home birth service itself, will help women get their choice Quotes to illustrate: o 'When recruited to fill establishment we will be able to promote home births with more emphasis.' East of England trust o 'Due to the lack of resources, any ideas and plans have to be developed within budget and the new Head of Midwifery is hoping to start a dedicated home birth team by using midwife hours that will be released from staff working in different ways.' Yorkshire trust o 'Some units remain challenged to maintain the home birth service at times of increased clinical activity in the delivery suite.' East of England LSA report	Thank you for this suggestion, we have included patient feedback as an outcome of interest.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 1		Main review Questions: Managerial approaches: Trust buy-in to existing guidance	Using FOI requests we asked every NHS trust in England and board in Wales about their birth to midwife ratios. Like the NAO, we too received replies suggesting the recommended ratios were not taken seriously by many providers; we found 80% of trusts and boards did not meet the standard set out by the four royal medical and midwifery colleges of one midwife for every twenty eight births per year. Similarly, the Care Quality Commission found one in seven hospital trusts providing maternity care in England didn't have the recommended standard of one midwife for every 28 births and almost one in 20 midwifery posts was vacant (Care Quality Commission, 2012). Some trusts/boards told us they had not run Birthrate Plus for years; others believed in SHA targets. We found this curious as it is the standard the CQC used to hold them to account. We would also like to draw NICE's attention to several trusts responding to us who said they achieved the ratios only when agency staff were employed or no staff were sick. We remain unconvinced that this is a sustainable situation going forward for the NHS and hope your guidance will be clear on appropriate leeway needed to allow for reasonable staff absences.	Thank you for bringing this to our attention
The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	1:1 care: We welcome the use of 1:1 care in established labour as a safe staffing indicator, as there is a strong clinical basis for this and it also has a positive effect on women's feelings of safety. We also think a clear indication from NICE that 1:1 can be achieved through safe staffing is necessary to clarify to Trusts/Boards the importance of taking this indicator seriously. The NAO's recent work has put an estimate on how many more midwives the average ward would need for 1:1 care to be achieved (Comptroller and Auditor General, 2013). We asked women about whether the care they were given during established labour and birth was 1:1. In total, 80% of women said they had experienced 1:1 care, 4.5% either did not experience established labour or were not cared for in the usual way (for instance, those undergoing caesarean sections or who birthed alone by accident) and 13% said their care was not 1:1. The remainder could not remember or didn't know.	Thank your for your comment

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	The answers to our question show that the definition of one-to-one is not easily understood by women. Many women say they had 1:1 care and then write of situations in the comments field showing this clearly wasn't the case. Further, there is an expectation among some women that one-to-one care would not be possible. Comments from women in our survey also show how one-to-one care is patchy – women say they had one-to-one care and then write of situations when this clearly wasn't the case; one-to-one changes with every shift change, every handover, and it is at these moments that women feel especially vulnerable. Some women took the extra step of hiring other supporters, such as doulas, to compensate for what they thought would be a lack of care. Others thought that being left alone wasn't so bad when they knew it was very likely going to happen to them. We urge NICE to keep this in mind when writing the guideline. Some quotes from our survey responders to illustrate: • 'Partly – one midwife provided 'one-to-one' care then there was a shift change and the same level of care was not provided.' • 'During delivery yes, during established labour no.' • 'Yes, for first 24 hours was amazing, but the last four were not. Hardly saw my midwife and she did not communicate.' • 'Yes, however, over the course of my induction we saw five shift changes, this meant that some of the care was inconsistent. They would not break my waters due to the fact they were understaffed…' • 'I had one midwife for duration of labour and birth but she had to keep leaving me for other patients.' • 'Although I had the same midwife during labour I felt there were long periods where I was left alone.'	Thank you for your comment. The definition of any indicators is likely to be discussed by the advisory panel during guideline development but it is useful for us to be aware of potential issues in advance.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	We also made FOI requests to Trusts and Boards about their provision of 1:1 care. We would like to draw NICE's attention to the result that many trusts were unable to provide any answers about 1:1 care provision, and the ways they came to their answers was variable. This should be borne in mind when using 1:1 care as an indicator. • We asked trusts/boards about their provision of one-to-one care and 55 provided figures from their own measurement: 23 of these report 100% or 'all women', though 15 have not specified how this 100% was measured. • Some trusts/boards measured the delivery of one-to-one care in labour daily, others do monthly audits, or seven-day snapshots three times a year. • Others use patient surveys; discrepancies can exist between what women report and what trusts and boards measure. For instance, a trust in the South West found, 'a survey of women in June 2012 showed that 92% of women felt they had one-to-one care in labour when they wanted it', but its own audit two months later in August 2012 put the delivery of one-to-one care at only 67% of women.	Thank you for your comment. The definition of any indicators is likely to be discussed by the advisory panel during guideline development but it is useful for us to be aware of potential issues in advance

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	We also asked trusts about how they were going to improve their provision of 1:1 care. Whether trusts/boards are measuring 1:1 care, or what their one-to-one care is currently assumed to be, does not necessarily determine their plans, if any, to improve their provision. • Nineteen specified in their FOI responses that the recruitment of more midwives was crucial to improving their 1:1 care provision, but six of these trusts/boards were not measuring how one-to-one was being delivered at the time. • Seven trusts/boards spoke of changing their skill mix, or the way they were organised, to improve one-to-one care. Again, some of these trusts/boards currently measure 1:1, others don't. • Others have changed their systems to help give midwives in the labour ward the time and space to care for those women in the second stage of labour and beyond. Quotes to illustrate: o 'We are in the process of increasing the number of maternity support workers who will take on non-midwifery duties releasing midwifery time to work on the labour ward.' South East trust, not currently measuring one-to-one o 'Plans in progress to reduce the number of women not in established labour on the labour ward to enable intrapartum midwives to be with labouring women; increase the number of midwives on birth centre by restructuring community model; embed maternity triage; implementing of an induction of labour bay.' London trust, currently measuring one-to-one • Five trusts/boards said calling in community midwives was a way to improve 1:1 care. This short-term solution is worrying as these trusts/boards are all making the effort to measure it, and all said their current provision was less than 95% (one trust was only 80.1%). It also poses practical problems for mums: one respondent said she received 1:1 care but 'it was contract staff so unfamiliar with hospital, e.g. couldn't find me a pillow'. While 1:1 care is important, simply moving staff around only compromises care elsewhere and health regulators in both England and Wales have stressed this point. The Care Quality Commission noted in 2012 that staff working in antenatal and postnatal care were often pulled into the labour wards, leaving those areas understaffed and unable to deliver the care that women need (Care Quality Commission, 2012). Supervisors of Midwives reports of recent years make clear that 1:1 care in labour is a challenge that staff numbers directly contribute to. The impression from 2011-12 LSA reports is that while 1:1 is the ideal, and 'a goal for supervisors of midwives (Mannion, 2012), the capacity to guarantee this level of care for every women is highly dependent on staff numbers. Quotes to illustrate: • 'The percentage of women who receive one-to-one care in labour can be seen to decrease as capacity and midwifery resources are stretched' (Curruthers & Hughes, 2012); and conversely, • 'One of the impacts of this rise in workforce has been that in March 2012 98% of women stated they received one-to-one care in labour' (compared to 85% in August 2009).'(McKay & Smith, 2012)	Thank you for your comment. The definition of any indicators is likely to be discussed by the advisory panel during guideline development but it is useful for us to be aware of potential issues in advance

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	Continuity of carer, and known midwife at birth: Despite continuity of carer being a consistent policy call and recommendation, it has been slow to translate to the actual care women receive: • We found many women in our survey were provided with a phone number for a 'team' or midwives, rather than having one specifically assigned to them. 35% of women were not given the name and telephone number of a specific named midwife. • Our survey found only 12% of women gave birth with a midwife present who was known to them beforehand. Sadly, even for the women who ended up in the birth location they planned, this figure is only 14%. Our report urged CCGs and boards to look at how providers can facilitate relationships between midwives and women during the antenatal period, and continue this into the intrapartum period, especially as many women give birth in locations which were chosen by them and known to providers months beforehand. • Women were asked about the impact of knowing, or not knowing, their midwife in labour. Overwhelmingly, those who knew their midwife reported positive impacts. 80% of women said it made them feel more confident or more relaxed, and only 20% of women said it made no difference to them or had a negative impact. • Women frequently used words like 'lucky' and 'grateful' and 'coincidence' when describing the relationship they were able to build with their midwife. We also asked the 4,810 women who didn't know their midwives, what impact this had on them. Options were provided for women to choose but many chose to write their own impacts. These were classified and combined with the original options to see more clearly the pattern of impacts women reported. In total, 3,285 women said there was no impact from not knowing their midwife, and over 1,000 specified a particular negative impact. Hundreds of others wrote things that are between these two poles and show the nuances of women's expectations and fears of the birth experience. It also shows how perceptions of safety are dependent on many factors – expectations of women, professionalism of staff, as well as familiarity. We would urge this to be borne in mind when interpreting any data from the maternity Friends and Family test. For example: 'Not knowing my midwife had no impact on me' - 68% of respondents • 'The two midwifes that looked after me were lovely and listened to our wishes – they also introduced themselves and did a proper handover.' • 'Hadn't met the midwife but she was excellent and I felt safe – this is more important than whether I'd met her before.' 'Not knowing my midwife had no impact because I didn't expect to know them' - 1% of respondents • 'I was used to having no continuity. I saw a different midwife throughout my pregnancy.' • 'I didn't mind – it was what I'd been told to expect and they were lovely.' • 'I knew in advance that I would not know the midwife, but they were so professional and attentive I felt confident that I was getting good care.' 'Not knowing my midwife had no impact but it would have been nice' - 4% of respondents • 'I'd had such unremarkable antenatal care, I didn't expect to know my birth midwife though I would have preferred to.' • 'It would have been nice to know them, but I hadn't seen the same midwife twice throughout my pregnancy so was used to it.'	Thank you for your comment. Continuity of care and access to a named midwife are outcomes we plan to review.

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	The selection of comments below show how women's confidence can be shaken when multiple professionals are involved in care, and further, how it makes it much more difficult for women to contribute to decisions about her and her baby's care, a direct denial of NHS England's policy objective of 'no decision about me without me.' Not knowing my midwife previously had a negative impact on me/my baby' 21% of respondents o 'It added to the apprehensions prior to labour and I saw a number of different people in the six hour space before I was induced, none of whom attended the delivery. I felt a bit like a specimen rather than a birthing mother during this time.' o 'I felt at the mercy of fate/shift patterns for getting one I felt comfortable with.' o 'Because resources were stretched, the midwives at the birth centre had been pulled onto the labour ward, so I got a replacement midwife called in from the community team who wasn't familiar with the facility e.g. told me I couldn't use gas and air in the birth pool (?!) and said water births were unhygienic – when I was already in the pool... That was frustrating' o 'I kept having to start again with new midwives – trying to build rapport and get the natural birth we wanted.' o 'It was very daunting being so vulnerable and being cared for by strangers.' o 'I didn't really see the point of the 'point of contact' midwife as when it came to the labour they were nowhere to be seen or even after, which would have been so useful. I saw little point in building the relationship over nine months then not to see them when it really counted.' Our survey shows the vast majority of women report positive effects from knowing their birthing midwife before birth and having developed a relationship with her. Many women do not get the opportunity to build this kind of relationship and while they on the whole seem unperturbed, many have resigned themselves to the fact they are not likely to get to know one midwife in particular. Further, other women were deeply upset and hurt by being cared for by 'strangers' with the end result that they were left disempowered. The comments also show how shift change/handover is a key point at which the perception of being vulnerable increases.	Thank you for your comment. Continuity of care and access to a named midwife are outcomes we plan to review.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		main review questions for guideline: activities and outcomes associated with safe maternity staffing: 1:1 and continuity of carer (continued)	In conjunction with the positive comments from women who knew their midwife, and the clinical literature that demonstrates the positive impact of continuity of care, we can clearly see relationships between midwives and mothers are worth fostering and it can be argued the relationships have a positive effect on feelings of safety of women. In a later question, we asked women about overall aspects of their maternity care that would have liked to have seen improved. The aspects of care - across the entire antenatal, intrapartum and postnatal period - were based on NICE guidance. The results of this question are revealing because while many women reported receiving one-to-one care, and feel little or no negative impact from not knowing their midwife previously or being able to get attention when asking for it, it is precisely these aspects of their care expressed in different ways – 'give me more attention' and 'stay responsible for me' – that the greatest number of respondents identified as needing improvement.	Thank you for your comment. Continuity of care and access to a named midwife are outcomes we plan to review.
The National Federation of Womens Institutes	Box 2		Outcomes of Interest: closures and suspensions	Suspensions and closures of units/services are categorised as serious incidents and have to be reported. However, the difficulties of 'measuring' closures/suspensions and what they mean is acute: 'there is still no national clarification of the definition of "diverts" "suspensions" and "closures", so consistency of reporting cannot be assumed' (Paeglis et al., 2012). But while data is scarce, suspensions or closures are stressful for birthing women and break the 'choice guarantee', negatively affecting their experience and satisfaction.(Curruthers & Hughes, 2012; Pearce & Davies, 2012; Read, 2012). They do nothing to increase the perception of safety of certain units and discourage other women from planning to give birth there. They often happen in response to an anticipated unsafe situation, and so we would recommend NICE consider them in relation to safe midwifery staffing. • The reports from the LSAs make clear that lack of staff to cope with workload and a lack of beds leads to suspensions and closures.(Curruthers & Hughes, 2012; Higson et al., 2012; Kirby, 2012; Paeglis et al., 2012; Pearce & Davies, 2012; Read, 2012) • We asked Trusts and Boards about if they closed/suspended their services, when, and the number of women affected. The data shows almost all trusts/boards that were effected by closures from 2009-10 have shown improvement in 2011 and 2012, experiencing fewer incidents, or none at all. However, of the 46 trusts that did close or suspend maternity services during 2009-10, 20 of them had at least two incidents of further closures/suspensions in 2011 or 2012. LSA reports and this FOI information from trusts/boards seems to suggest ongoing problems of closure affect a small number of trusts consistently. • Looking at the reasons why trusts closed to admissions (or provided a 'reduced service', or stopped providing a home birth service) during 2011 and 2012, of the 455 closure episodes that 24 trusts were able to give details on, 186 of those were primarily due to staff shortages, and 182 to capacity ('no beds'). These reasons mirror BBC Panorama's findings a year earlier.	Thank you for this suggestion, we have amended the scope to reflect this.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		Outcomes of Interest: Postnatal care	We would urge NICE to place its existing postnatal care guidance (NICE, 2006) alongside the other NICE guidance (such as CG45 and CG55) as a quality outcome. We believe that postnatal care is a significant weak point of the maternity care pathway, heavily affected by staff shortages and managerial decisions to leave it at the mercy of intrapartum care demand. The Care Quality Commission noted in 2012 that staff working in antenatal and postnatal care were often pulled into the labour wards (Care Quality Commission, 2012). We believe the investment in this aspect of care will have massive benefits for mothers and babies, especially in relation to improving breast feeding rates and preventing post-partum depression. We believe the way trusts are currently implementing your guidance is inconsistent. One of the recommendations coming from our research was for NHS England to issue guidance to CCGs on the development of a framework to assess postnatal care in line with clinical guidance issued by NICE and the feedback from service-users, and for the All Wales Maternity Services Implementation Group to do the same. We believe the safe staffing work by NICE is another way this situation can be improved. In short, there needs to be clarification of appropriate postnatal care, and therefore appropriate staffing can be made to achieve it. o There were 51 trusts/boards who said they had no 'target' for the number of postnatal visits they provided to women. Some said this was in accordance with NICE guidance o Thirty trusts/boards said they did have a target (though this would be superseded in line with individual need); Three said that their targets were in accordance with NICE guidance. o Variation is rife: o 'We run our services in line with the recommendations set by the National Institute for Health and Clinical Excellence – Postnatal Guidelines (2008). The target is four visits.' Welsh Board o The target minimum is one, but this would depend upon the circumstances and condition of the mother and baby.' London trust o 'The NICE antenatal guidelines are adopted within the unit; women are offered a minimum of three visits postnatally but will often have additional visits if support is needed.' West Midlands trust	Thank you for raising this, we agree that postnatal care is as important as the other areas of maternity care and is equally represented in the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		Outcomes of Interest: Postnatal care	Data collection on basic aspects of postnatal care is poor. Only 12 trusts/boards were able to provide data on the number of postnatal visits each woman under their care actually received after their baby was born. The detail in this data is variable: o For the period January to September 2012, there were, on average, four postnatal attendances per patient.' London trust; o 'We aim to give all postnatal women three visits. We maintain handwritten statistics only and these demonstrate over 95% compliance with this goal.' London trust While it will be a challenge to implement a recommendation for safe staffing in relation to midwifery postnatal care in light of the current situation being data-poor, we hope NICE can explore this area further, as it warrants attention. We asked women about their contact with midwives after they gave birth. Results included: o A quarter of women in our survey were unable to make postnatal appointments at times convenient for them. o 18% of women expressed dissatisfaction with their overall contact with postnatal carers following birth. These women's concerns frequently centred on the amount of time they were able to spend with the midwife, or the information, help and advice that they received, from a succession of different people. Some women didn't feel safe when a new stranger had to be invited into their home. o Others felt that the appointments were rushed; concern about staffing shortages and the pressure the midwives appeared to be working under was a strong theme. o Comments also suggest that better scheduling, planning and communication about postnatal care visits would have a significant impact in improving many women's experiences of postnatal care. o Despite most women seeming to be satisfied by the overall contact level with their midwives after they had given birth, when asked at what point they felt that they needed more support from midwives, postnatal care stood out as a weak point in the system: 57% of women said they would have welcomed more support in the postnatal period, dwarfing other points along the care pathway.	Thank you for raising this, we agree that postnatal care is as important as the other areas of maternity care and is equally represented in the scope. Data collection aspects of any indicators recommended will be considered by the advisory panel.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	Box 2		Quality midwifery activity: antenatal care	We would like to draw your attention to the recent finding of the impact of unscheduled antenatal care on hospitals because of lack of primary care in the community. Advice to maternity commissioners[1] suggests better access to community antenatal care could save millions of pounds, through enabling women to contact their midwives first, rather than going into hospital: 'Almost half of all spending on maternity care is unscheduled antenatal care – that is additional care beyond the routine and planned care women receive from their midwives and doctors. … A large number of women also make contact with maternity services out of hours with queries about travel advice, swollen ankles, 'large for dates'. … In most cases these women have not sought any other advice before attending. If women with these low level medical conditions can be supported and cared for in primary care, this will ease the pressure on busy maternity units and save commissioners money'.	Thank you for raising this, community based antenatal care is as important as the other areas of maternity care and your point illustrates the need to consider maternity staffing across the spectrum. We have added stage of the maternity care pathways to the review questions within the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	General			The National Federation of Women's Institutes represents 213,000 women across England, Wales and the Islands, based in over 6,500 individual Institutes. A strongly democratic, grass-roots ethos remains at the core of all NFWI activity. Our campaign for More Midwives was developed after a resolution submitted by a local WI member was passed at the 2012 NFWI Annual meeting. The resolution calls for increased investment in the training, employment and retention of midwives. The resolution was the subject of a year-long debate amongst our 213,000 members, before being passed with a 97% majority. In the months since the campaign was launched we have been trying to better understand the experiences of women who have recently given birth and the relationship between staffing and patient experience. We surveyed 5,500 women in England and Wales who have used maternity services in the last five years, and made FOI requests to access data from all English Trusts and Welsh Boards who provide maternity care. Three-quarters of our respondents gave birth in 2012 and 90% were first time mothers. Our May 2013 publication, Support Overdue reports on this research, examining the experiences of women through the whole maternity journey. It echoes the findings of the National Audit Office's recent report, Maternity Services in England, in demonstrating how the continuing shortage of midwives is impacting all parts of the maternity system and preventing the government's policy objectives, and NICE's clinical guidance, from being achieved. The research was undertaken in conjunction with NCT. Our approach - taking the patient experience and holding providers to account - was based on our assessment of the importance of experience and accountability in improving NHS services. Patient experience of care is Domain Four of the NHS Outcomes Framework 2013/14 (Department of Health, 2012a). The five domains are based on the definition of quality by Lord Darzi: high quality care comprises effectiveness, patient experience and safety. Our research explored some of the themes that other recent surveys had covered, such as those by the Care Quality Commission, NCT, the National Perinatal Research Unit, and the NHS's Delivered With Care. We built on those surveys by asking more detailed questions to find out, beyond clinical outcomes, how women feel about their care from midwives and others in the NHS. We looked at otherwise neglected areas of care, such as choice and access to advice. FOI requests enabled us to compare the stated policy goals for maternity care with what trusts and boards were actually delivering to hold providers and commissioners to account. We are grateful to NICE for letting us have the opportunity to feed into the safe staffing work. We are especially heartened by the choice to develop safe staffing guidance for maternity as a priority of the overall safe staffing workplan, following the Francis Inquiry. We hope our own research, outlined in Support Overdue and quoted here will be helpful to you in developing appropriate indicators, setting appropriate boundaries for the work and enabling a patient-centred approach to be at the forefront of your thinking. Our research provides draws on women's experiences to provide evidence of how staffing is key to providing the best possible care. The NHS staff survey shows midwives are under enormous pressure, and the NAO has found maternity services are not cost-effective. We believe the NICE safe staffing guidance could have massive, unintended but most welcome consequences. 'Safe staffing' will improve patient experience. It will prove to be cost effective in the long term, easing the burden of negligence pay-outs on maternity spending and promoting the wider public health agenda. It will allow midwives to practice in the ways that are more personally satisfying, leading to fewer early retirements and less burnout. It will standardise care, ending the postcode lottery that is deeply unfair to women. It will provide a clear statement of intent to commissioners and providers that maternity can no longer be treated as the 'Cinderella' of the National Health Service.	Thank you for informing us of this report, it is very important that the views of mothers are represented and we have added a reference to the report to the list of key documents

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The National Federation of Womens Institutes	General		comments on what safe staffing looks like	Several questions in our research directly addressed perceptions of safety; other times, women made spontaneous references to their feelings of safety in particular circumstances. The list below is quotes from women who were asked to write the most memorable aspect of the care they received from their midwife. We think this could be illuminating in developing a more holistic approach to determining what safe midwifery staffing 'looks like' from a patient's perspective: • Sally, my midwife was the first person I saw when I walked into the hospital in labour….All day she helped me, with breathing, rubbing my back, advising me on what medicine I might want or not. I felt totally secure in her care. She advised my partner of ways to help me. When it came to stage two, she kept my spirits high, and encouraged me even when I wanted to give up. She was, I truly believe, the reason I had such a smooth labour. • In the very last moments the calmness of the midwives when my baby had his chord round his neck and the swiftness with which they acted to make sure nothing went wrong. • My midwife taking control when I couldn't, she made me push when I thought I couldn't. The baby was in danger so we had to be quick and she made me make it happen • When my son was in the special care baby unit the midwife took time to explain why he was there and what they were doing to him and for him. It was very reassuring to have someone with experience of his problems to care for him. • During the labour and birth the team were outstanding, I had a traumatic birth that was over 21 hours and we had someone with us all the time. We felt like they understood my fears, the situation and were in control. • The lady who was there first my early stages of labour came to see me when she came back on shift after my baby was born to see us both. • I had an emergency C-section, she helped my husband weigh our little girl and helped him settle her whilst I was still in surgery. Just writing this makes me cry with joy for meeting such a fantastic person. • Being brought tea and toast after giving birth! Such a kind, homely touch, and my goodness I needed that cup of tea! • When I was kept on an antenatal ward all night on my own in labour with foetal heart monitor on … waiting for a space on a delivery suite for induction. The midwife came and sat with me and chatted with me and kept ringing the labour suite to try and get me onto it, she was kind and caring.	Thank you for informing us about this report, it is very important that the views of mothers are represented and we have added a reference to the report to the list of key documents. We also have maternal satisfaction included as one of our outcome measures.

The National Federation of Womens Institutes	What the guideline will not cover			We agree that the focus on midwives and MSWs is appropriate at this stage. We understand this is the basis of NICE's task as determined by the Department of Health and NHS England and this is the best place to start considering while 'all women need a midwife, some will need to see a doctor too' (Tyler, 2012). We note the lack of clear evidence thus far for the effectiveness of MSWs (Sandall et al., 2011), and believe that the variability in their employment band, their roles, remits and their lack of professional status means that assessing their role in patient safety may be difficult. We do know however that many Trusts are using them, and the Royal College of Midwives' position statement on their relationship with midwives may be helpful in providing a basis for assessment (Royal College of Midwives, 2013). Midwives do not work in isolation, and the role of all the professionals in women's care will have an impact on the care midwives and others can give; each staffing decision along the pathway of care will impact the staffing needed (and the outcomes) along the remaining path. We know many women are still referred to midwives from their GPs; we know the impact on pressed emergency departments by unscheduled antenatal care. The King's Fund review of England's maternity services (Magee & Askham, 2007) identified the impact of a shortage of midwives was compounded by their administrative overload. The 2008 inquiry into maternity services found midwives were sometimes diverted to tasks that could more appropriately be done by maternity support workers, theatre support staff, nurses or cleaners (Independent Inquiry into the safety of maternity services in England, 2008). We hope that the successful implementation of NICE's midwifery safe staffing guideline will actually make the role of other professionals clearer. When this happens, it may become appropriate for NICE to specify those roles in safe staffing, such as they have done for midwives. We would welcome this, in the realisation that while our specific interest is midwifery staffing, we know that for women there is no distinction between the safety they require from one set of professionals, and that of another.	We understand your concern about the variation in MSW support. In both the stakeholder workshop and several stakeholder comments we have received support for restricting the scope to midwives only, as you suggest. However, we will also be reviewing whether availability of other healthcare staff, such as MSW, influencing safe midwifery requirements.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	Appendix A		staff factors	Continuing education and training should be included in staff factors. It is well known that staff performance and wellbeing are positively influenced by access to good quality on-going education and training. (see Prof Michael West – 'Developing cultures of high quality care' lectures)	Thank you for this suggestion. Appendix A contains only a summary of the elements included in the scope, however we have amended the scope to reflect the importance of training.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	Background	page 2		The use of 'enhanced recovery' for mothers undergoing Caesarean Section should be included, as this has an impact on safety and quality of care.	Thank you for this suggestion, we have added completion of recommended care after a caesarean section to the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	Backgro und	page 2		The specific roles a midwife may undertake in the operating theatre and in the safe recovery of patient after operative procedures should be included, and comment made about the requirement for appropriate training to deliver these roles and remain up to date. Good operating theatre practice, with team briefings and review of cases makes a positive difference to patient outcomes.	Thank you for this suggestion, we have amended the scope to reflect this.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	Box 1		Main review questions for guideline	Comment about main review questions: The review questions have a fairly broad remit at this stage, aiming to address various aspects of maternal and neonatal safety activities and outcomes in the context of acceptable levels of midwives and midwifery support workers. However it is not clear that this scope recognises the role of midwives in the safe provision of labour analgesia. When the scope is finalized it is essential that the role of the midwife in the provision of epidural and other modes of labour analgesia is a specific part of the guideline to be developed. E.g. National recommendations [1] regarding the provision of labour epidural analgesia mandate the presence of 1:1 midwifery care. 1) http://www.oaa-anaes.ac.uk/assets/_managed/editor/File/Guidelines/obstetric_anaesthetic_services_2013.pdf	Thank you for this suggestion, 1:1 midwifery care during labour, including those where analgesics have been administered, will be included in the scope of this work.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	Box 2		Outcomes of interest	There is no mention of breast feeding rates. These are correlated with the amount of midwifery support available on post natal wards.	Thank you for your comment. The provision of feeding advice to new mothers is listed in box 2 as one of the outcomes of interest. Monitoring the provision of this advice is a more direct measure of midwifery care than breastfeeding rates themselves, which are influenced by a number of different factors outside the control of the midwife and would therefore be a less sensitive indicator of safe maternity staffing.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		There should be a section on provision of all forms of analgesia, including safe monitoring of mothers who use epidurals or patient controlled intravenous opioids for labour.	The role of the midwife in the safe provision of analgesics is now specifically mentioned in background section and their role in the safe monitoring of mothers during labour is included as an outcome of interest in the scope.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		The specific role of the midwife in providing assistance to the anaesthetist should be included. This includes siting and management of epidurals, and resuscitation of women in the labour ward and in the operating theatre.	The role of the midwife in the safe provision of analgesics is now specifically mentioned in background section and their role in the safe monitoring of mothers during labour is included as an outcome of interest in the scope.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		Several important aspects of post-anaesthetic recovery including the midwife's role in enhanced recovery should be specifically addressed. A comment should be made on safe staffing levels to provide appropriate quality care and 'on the job' training of midwives new to these roles.	Thank you for this suggestion, we have amended the scope to reflect both care during recovery and staff training.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		The guideline should also cover specific/special requirement for maternities that require some form of 'critical care' during or after labour. Staff training and facilities. This high risk area need to be included.	The scope aims to cover all aspects of the care provided by midwives, the roles you mentioned are encompassed within this. We have added critical care to the examples to illustrate the breadth of this care.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		There should be specific mention of the role of midwives in high dependency care of mothers and in resuscitation of mothers.	The scope aims to look at the additional services provided by midwives in some settings and the roles you mentioned are encompassed within this. We have added critical care to the examples to illustrate the breadth of this care.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		The midwife's role in neonatal resuscitation and their major contribution to neonatal intensive care should be a factor in the report.	The scope aims to look at the additional services provided by midwives in some settings and the roles you mentioned are encompassed within this. We have added critical care to the examples to illustrate the breadth of this care.
The Royal College of Anaesthetists with contributions from the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthesia Association	What the guideline will cover	page 3-4		Comment on point 17: It is clear from work on the safety culture in general theatre, that joint 'off the job' training including simulator based training plays a vital role in the delivery of effective care. Such training has to be team based and not delivered separately to doctors, midwives and nurses. This guideline should comment on the need for simulator based multidisciplinary training (incl. drills/skills) as part of team education and development.	Thank you for raising this issue. Unfortunately, the scope of these guidelines cover maternity staffing levels only. The training of midwives and the rest of the MDT is outside the remit of this piece of work.
The Royal College of Midwives	Backgro und		paragraph 6	Whilst the RCM agrees with the quotation from Safer Childbirth and the related point about emphasising the need for maternity services to be considered as a whole, this is not consistent with the statement in paragraph 19 that the guideline will not cover healthcare professionals other than midwives and Maternity Support Workers (MSWs). If this quote is to be retained in the guideline then there needs to be some further accompanying text to explain the context in which it is being used.	Thank you for raising this, this statement has now been removed to prevent confusion

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Midwives	Box 1 review question		paragraph 21	With regards the main review questions in Box 1, the RCM recommends adding: • Safeguarding to the maternal and neonatal factors affecting staffing requirements in different environments. • The requirement for non-practising midwifery roles e.g. clinical governance, audit/risk, and practice development to the management approaches affecting staffing requirements. • The requirement to support student midwives and preceptorship roles of newly qualified midwives to management approaches affecting staffing requirements.	Thank you for this suggestion, we have amended the scope in line with your suggestions, however, the examples provided in this section are not intended to be an exhaustive list.
The Royal College of Midwives	Box 2 outcomes to be considered		paragraph 22	The RCM is concerned that the stated intention in paragraph 22, to determine the relationship between the outcomes in box 2 and midwife and MSW-dependent activities, implies the existence of correlations between these outcomes and staffing levels. Given that there is very little evidence to link these outcomes to staffing levels, the wording is not helpful. Our understanding is that the outcomes listed in Box 2 are intended to inform the literature review being undertaken as part of the guideline development process. If this is correct then we would recommend rewording paragraph 22 accordingly and would also suggest adding: • Stillbirths, retained swabs and postnatal depression to serious preventable events. • Safeguarding, administration of flu jabs, CO monitoring and data entry to delivery of midwifery care	Thank you for raising this issue, we have amended the scope in line with your suggestions. The outcomes listed in box 2 were not intended to be an exhaustive list and we have amended the scope to make this clearer.
The Royal College of Midwives	What the guideline will cover,		Paragraph 14	The RCM has some reservations about whether the guideline should cover all care provided by MSWs as well as midwives. This is because there is considerable variation in the roles, responsibilities, qualifications and pay banding of the wider maternity support workforce. The RCM therefore recommends that the guideline should focus on midwifery staffing and then take account of what can be appropriately delegated to MSWs, depending on local circumstances. The RCM guide The Role and Responsibilities of Maternity Support Workers (RCM, 2011) sets out advice on the tasks that MSWs can and cannot legitimately undertake - http://www.rcm.org.uk/college/your-career/maternity-support-workers/roles/. With regards the list of settings that the guidelines may cover, the RCM recommends listing both alongside midwife-led units (AMUs) and freestanding midwife-led units (FMUs) since these settings require different staffing models. We also recommend making clear that community refers to community settings across the antenatal, intrapartum and postnatal pathways.	We understand your concern about the variation in MSW support. In both the stakeholder workshop and several stakeholder comments we have received support for restricting the scope to midwives only, as you suggest. However, we will also be reviewing whether availability of other healthcare staff, such as MSW, influencing safe midwifery requirements. We have also clarified the settings as suggested.
The Royal College of Midwives	What the guideline will cover,		Paragraph 15	The RCM understands that it is not intended that this guideline will set a minimum staffing ratio. However, we feel that the first element set out in paragraph 15 ("establishing safe and efficient staffing levels for midwives and MSWs at the local level to meet maternal and neonatal needs") could be interpreted as meaning that the guideline will set minimum staffing levels. We therefore recommend amending this wording to make clear that this is not what the guideline will do.	Thank you for your comment. We have amended the text in this section and the review section outlines that the guideline will consider the various factors that need to be considered when establishing safe and efficient staffing requirements.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

The Royal College of Midwives	What the guideline will cover,		Paragraph 19	The RCM agrees that the guideline should not cover healthcare professionals other than midwives and MSWs (subject to our above comments on paragraph 14). Although a number of healthcare professionals, including obstetricians, paediatricians, anaesthetists and GPs, make important contributions to maternity care, we think there is an important distinction to be drawn between how staffing levels are determined for medical staff (for whom the key determinants are where the medical staff are and whether they can be accessed for expert advice) and for midwives (for whom actual numbers at work is of critical importance). We also feel that given the variety of other staff groups that are involved in the provision of maternity care, that there are pragmatic reasons for limiting the scope of the guideline to midwives. We do however think that consideration should be given to commissioning NICE to develop separate guidance that will cover the contribution of the wider maternity workforce.	We understand your concern about excluding other staff groups and will be feeding this back to our commissioners, NHS England and the Department of Health. However, as you suggest, covering the many other staff groups involved in aspects of maternity care will not be feasible during the time scale available for the current work. In both the stakeholder workshop and several stakeholder comments we have received support for restricting the scope to midwives only. However, we will be reviewing whether access to other healthcare staff influencing safe midwifery requirements.
UHNS Trust	5			There is a requirement to document communities with high levels of asylum seekers and refugees . These populations have an increased input involving interpretation services ,safeguarding support ,specialist input for conditions such as FGM Female Genital Mutilation or mental health needs as a result of post traumatic stress from war torn areas or cultural separation.	Thank you for raising this important point. Within the scope we will be reviewing social complexity and demographic factors which will cover the issues that you have raised; these terms are deliberately broad to ensure that no relevant issues are missed. In addition, the topics you have raised have been flagged in our equality and diversity form and NICE ensures that equality and diversity issues are considered at every stage of the guideline development process.
UHNS Trust	6			Guidance for staffing in the whole will enable analysis of services which book more or significantly less women than they actually deliver.	Thank you for your comment

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

UHNS Trust	8			Recognition of the impact of Maternity Support Workers and the areas of care the midwife can safely devolve responsibility in line with NMC guidance is welcome.	Following consultation comments and a stakeholder workshop we have altered the focus of the scope to midwives only. This is primarily due to the lack of a national standard for Maternity Support Workers (MSW). However, the scope will review whether access to MSW has an impact of staffing requirements for midwives.
UHNS Trust	14			Care in different environments is a welcome analysis as there is staffing support recommended for stand alone and consultant units however medical staff support needs recognition.	We agree and have strengthened this aspect of the scope
UHNS Trust	15			Managerial and specialist midwifery support to support the general midwifery workforce is required. Recognition of the impact and statutory requirements relating to midwifery Supervision require consideration.	We agree with your comment, the impact of supervisory arrangements is specifically referred to in box 1. The scope will also cover whether access to other staff such as specialist midwives will have an impact on staffing requirements for midwives.
UHNS Trust	box 2			Report feedback should consider MSLC minutes detailing localised patient feedback which is valuable feedback of local population views supporting personalised care.	Thank you for this suggestion, we have amended the scope in line with your suggestion.
Women's Health Academic Centre, Division of Women's Health, King's College, London	14			How will MSW be defined? There was substantial variation in grade and scope of role in a study we conducted for the DH (Sandall, Manthorpe et al. 2007). A key issue regarding outcome impact and cost, are both numbers of staff but also skill mix and the level of task shifting and substitution. Some MSW have a foundation degree and are band 4 and some have a few weeks training and band 2. We feel it is crucial to know understand how the support workforce can be used more effectively.	Following consultation comments and a stakeholder workshop we have altered the focus of the scope to midwives only. This is primarily due to the lack of a national standard for Maternity Support Workers (MSW). However, the scope will cover whether access to MSW has an impact of staffing requirements for midwives. Skill mix of midwives is another important factor that will be considered.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Women's Health Academic Centre, Division of Women's Health, King's College, London	16			In recently completed HSDR funded research (Sandall, J. et al 10/1011/94 The efficient use of the maternity workforce and the implications for safety & quality in maternity care), parity and clinical risk (defined by NICE CCG 55 criteria at the end of pregnancy) were the largest independent predictors of maternal and perinatal outcome. Any staffing modeller must include these two parameters.	Thank you for informing us of this research, we anticipate that both of these factors will be considered under maternal risk factors
Women's Health Academic Centre, Division of Women's Health, King's College, London	16			The configuration of a trust (whether it has two OU, or an FMU or AMU) has impact on outcome and cost. Not merely considering fixed costs, but because of the impact on clinical outcomes (eg lower rate of CS and thus shorter length of stay in low risk women planning birth in midwifery led settings). Both need to be taken into account in any staffing modeller.	These factors will be considered under environmental factors as part of the evidence review and data permitting the economic analysis and modelling report.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Women's Health Academic Centre, Division of Women's Health, King's College, London	17			We agree, in order to meet the NHS mandate for continuity of care, which now has a greater evidence base (Sandall J 2013) continuity of care models require a different staffing model, and that benefit-cost modelling is important. Previous NICE guidance has broken up guidelines pragmatically into the antenatal, intrapartum and postnatal periods (as if they are separate). However this approach has failed to emphasise the impact of continuity of midwifery care across the pregnancy and childbearing trajectory, on a range quality and safety of care outcomes through fewer handovers / building of trust. For example, Women who were randomised to midwife-led continuity models of care were less likely to experience regional analgesia, episiotomy, and instrumental birth, and were more likely to experience no intrapartum analgesia/anaesthesia spontaneous vaginal birth. But experienced 30 minutes longer mean length of labour, and with no differences between groups for caesarean births. Women who were randomised to receive midwife-led continuity models of care were also less likely to experience preterm birth and fetal loss before 24 weeks' gestation, although there were no differences in fetal loss/neonatal death of at least 24 weeks or in overall fetal/neonatal death. Women who were randomised to midwife-led continuity models of care were eight times more likely to be attended at birth by a known midwife, and women reported higher ratings of maternal satisfaction with information, advice, explanation, venue of delivery, preparation for labour and birth, choice for pain relief and behaviour of the carer and control. The effects were the same across team and caseload midwifery models and whether caseloads were low or mixed risk. An estimated mean cost saving for each eligible maternity episode is UK£12.38. This translates to an aggregate saving of £1.16 million per year, if half of all eligible women avail of midwife-led care. This equates to an aggregate gain of 37.5 quality adjusted life years (QALYs) when expressed in terms of health gain using a NICE cost-effectiveness threshold of £30,000 per QALY. The uptake of midwife-led maternity services affects results on two levels, first by its role in determining caseload per midwife and thus mean cost per maternity episode, second at the aggregate level by determining the total number of women who switch to maternity-led services nationally (Ryan 2013). In addition, we feel it is important to know the effect of the size of the trusts and number of births in an OU and AMU. What is the relationship between size, outcome and cost, and the additional effect on staffing requirements and cost of an additional 1,000 women giving birth in an OU. Would two obstetric teams be required over 7,500 to 8,000 birth for example, and thus is there a point at which economies of scale are no longer economies but incur substantial additional cost?	Thank you for bringing this additional research to our attention. In this guideline we aim to cover the entirety of the maternity pathway. We have also included continuity of care as an outcome of interest in the scope.
Women's Health Academic Centre, Division of Women's Health, King's College, London	20			Greater clarity is required between the statement in this section which states that it will NOT look at the reliability and validity of tools used, and the statement on para 9 regarding the aim to offer an endorsement service of such tools. On what basis will these tools be endorsed then?	The endorsement process will look at whether the tools are suitably compliant with the new guidelines. To assess the reliability and validity of tools requires detailed studies of each tool individually and a comparison to a gold standard measure - this level of assessment is beyond the scope of this work.

Midwifery Staffing in Maternity Settings Scope: Consultation Comments and NICE responses Consultation period: 28 February – 27 March 2014

Women's Health Academic Centre, Division of Women's Health, King's College, London	22			We suggest also looking at outcomes in the RCOG indicators (which will be including normal birth) and the HAELO maternity safety thermometer (PPH > 1000, Apgar < 7, 3rd and 4th degree perineal tear, sepsis, and women's experience of feeling unsafe (using two questions from the CQC survey). We suggest including straightforward healthy outcomes such as vaginal birth and breastfeeding. We suggest looking at CQC survey responses to assess women's views. We suggest looking at omitted care (Ball, Murrells et al. 2014)	Thank you for these suggestions - the scope outlines a number of possible outcomes that will be considered evidence permitting. This is not intended to be an exhaustive list and we will ensure your suggestions are shared with the relevant team undertaking the evidence reviews for consideration.
Women's Health Academic Centre, Division of Women's Health, King's College, London	general			The scope document itself in para 6 notes that " The 2007 report by the Royal College of Obstetricians and Gynaecologists (RCOG) and others emphasises the need for maternity services to be considered as a whole, stating: 'The need for continuous care means that labour ward staffing requirements cannot be considered in isolation or separated for the total establishment of the maternity care from pre-conception to postnatal. Equally, staffing of the labour ward must not be at the expense of other areas of the maternity services, such as community midwifery.'" We agree with this view and suggest that a safe service provided by a trust requires adequate levels of midwifery staffing and obstetric staffing.	We understand your concern about excluding obstetric staff and will be feeding this back to our commissioners, NHS England and the Department of Health. However, covering these, and the many other staff groups involved in aspects of maternity care, will not be feasible during the time scale available for the current work. In both the stakeholder workshop and several stakeholder comments we have received support for restricting the scope to midwives only. However, we will be reviewing whether availability of other healthcare staff influencing safe midwifery requirements.
Women's Health Academic Centre, Division of Women's Health, King's College, London	General			Staffing of maternity services differs from staffing a ward. Pregnant women receive care from trust employed staff in the home, community, midwife units and obstetric units. In addition pregnant women require care during pregnancy, birth and the postnatal period. Although most care is planned, a substantial proportion is unplanned.	Thank you for your comment, we have reflected this by including birth settings and stage of the maternity care pathway as factors that may influence safe midwifery staffing requirements

**Midwifery Staffing in Maternity Settings Scope:
Consultation Comments and NICE responses
Consultation period: 28 February – 27 March 2014**

Women's Health Academic Centre, Division of Women's Health, King's College, London	general			Settings should state home, community settings, freestanding midwife units, alongside midwife units and obstetric units.	Thank you for raising this, we have amended the scope to reflect this.