NICE National Institute for Health and Care Excellence

Safe midwife staffing for maternity services

Report on field testing the draft guideline

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Background

The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health and NHS England to develop evidence-based guidelines on safe midwifery staffing in maternity settings. The Market and Audience Intelligence (M&AI) team was asked to support this programme of work by conducting field testing during the guideline consultation. The field testing required a broad range of midwives from different maternity settings to review the draft guideline, consider how it would be implemented within their organisation and setting, and provide feedback.

Summary

- Midwives are very engaged with NICE and have a high level of compliance with existing NICE guidelines. As a result, the guideline was highly anticipated.

- Midwives are passionate about safe staffing and welcome the attention the guideline will bring to the subject.

- Midwives found the guideline clear and easy to read, although some felt a summary would be useful.

- There was a concern that the guideline was open to local interpretation and relied heavily on professional judgement, as opposed to defining minimum staffing standards or ratios for each area.

- Midwives appreciate the importance of the recommendation for 1:1 care for intrapartum care. However, midwives would like the guideline to address all areas of care equally to ensure that appropriately staffing one area is not to the detriment of others i.e. under resourced. Therefore lack of ratios or minimum standards for antenatal, postnatal and community care was raised as an issue.

- Some midwives felt that due to the document length and the nature of the recommendations that the guideline was designed to instruct senior management how to set establishment and rotas rather than a document for ‘midwives on the ground’. It would be difficult for those on the ground to see how the recommendations applied to them, and how they would use them within their role.

- Make expectations of commissioners and boards clearer by explaining the consequences of not meeting the guideline and also the importance of ensuring that the staffing levels are based on quality of care as well as available budget.

- There was a general consensus that the guideline would have a positive impact on the way that staffing requirements were recorded and monitored.

- Many midwives suggested the inclusion of minimum ratios or a supporting tool to calculate staffing levels were essential to ensure the guideline had a positive impact on staffing levels.

Aims and Objectives

The main objective of the field testing was to obtain feedback on the draft 'safe midwifery staffing for maternity settings' guideline, with particular focus on the content and structure of the guideline and perceptions about implementation of the recommendations.

Method

A mixed method approach was developed for the field testing including in-depth interviews and a survey. The online survey was developed (using SNAP software) to allow participating trusts who could not take part in the interviews to have an opportunity to feedback on the draft guideline. The head of midwifery for each trust was asked to nominate midwives to take part in the interviews and send the survey link to all those eligible.

The draft guideline was released for consultation on the 17th October. All participating individuals had a minimum of a week to review the draft NICE guideline and consider how this would be implemented within their organisation. Data collection began on the 27th October. 24 interviews and 1 focus group of 6 participants were conducted. An additional 36 responses from these trusts were received via the online survey.

Trusts were identified that covered a good geographical spread across England, including large and small maternity units from both urban and rural areas. Consideration was given to identifying trusts that represented a variety of settings and models of care. Within each trust, the midwives involved ranged from band 5 to heads of midwifery (or equivalent); and worked across different areas and settings, to ensure the scope of the feedback was broad.

Analysis of the interview transcripts was conducted using a thematic approach. Excel was used to analyse the survey results.

Sample

66 midwives from across 10 trusts took part in the field testing. 30 individuals provided in-depth feedback via telephone and an additional 36 midwives feedback via an online survey. A breakdown of the sample is shown in table 1 and 2.

Table 1 – Trust sample

Region	**Sample - n 10**
London	4
Midlands	1
North West	3
South West	1
Yorkshire and Humber	1
Size of maternity unit[1]	**Sample - n 10**
Large	4
Medium	5
Small	1
Setting	**Sample - n 10**
Obstetric unit	10
Home / Community	10
Alongside MLU	8
Freestanding MLU	2

Table 2 – Participants sample (interviews)

Band	**Sample -n 30**
5/6	1
6	2
7	9
8	8
Head of midwifery / chief nurse	10
Experience setting staffing levels	**Sample - n 30**
No	3
Yes	22
Unknown	5
Area of care	**Sample - n 30**
All	7
AN and PN	3
Antenatal	1
Intrapartum	3
Non clinical - strategic role	11
Unknown	5
Community midwives	**Sample - n 30**
Community midwives	5
Non community midwives	20
Unknown	5

NOTE - An additional 36 participants contributed via the online survey, this equated to an additional 14 ‘band 6’ midwives, 16 ‘band 7’ midwives, 4 ‘band 8’ midwives and 2 hospital managers.

Findings

Midwives are supportive of the guideline

Midwives welcome the NICE guideline because it publicises a subject that is important to them. Midwives are engaged with NICE and regularly use its guidelines, so the development of this guideline was highly anticipated.

[1] Large maternity setting – more than 8000 births per year, medium – more than 3000, small – less than 3000

"I mean I think just the fact that we're having a guideline…it's a positive, just by itself…. think it's good that actually we're beginning to identify more things"
Head of Midwifery

"…I think it's great to have it all in one place that talks about reporting to the board and how, and being clear around escalation and clear around collecting your data, I think that's great."
Head of Nursing and Midwifery

The guideline is clear and a good starting point

Many felt the guideline was clear and easy to follow and it validated what they already did in practice.

"I felt that it was simple and simply laid out and that I could read it and understand what the recommendations were."
Band 5 midwife

However, some felt the guideline was only a starting point and could not be used as a standalone document.

"I suppose…as a generic baseline, and it was useful in that sense"
Antenatal clinical manager

More specific detail is required

Almost half of those interviewed were disappointed as there was a desire for more specific detail particularly in regards to minimum staffing requirements (ratios) for each area. There was therefore an element of frustration that the guideline was quite broad and open to local and individual interpretation. Midwives did not feel the content was strong enough to drive any change in regards to staffing requirements within the trust. The fact that a named supporting tool was also not referenced was also a frustration to some.

"My initial thoughts were probably that it didn't give me enough information and tools to actually change what I currently do" Lead Midwife

Those who felt disappointed wanted the guideline to provide definitive staffing requirements for each area or setting, despite the fact there was a general awareness that there was a lack of evidence available outside of intrapartum care. There was a feeling by some that

explicitly stating a minimum level would influence budget holders, commissioners etc., whereas local interpretation and professional judgement would be too 'woolly' to drive any change.

> *"…it says use professional judgement when checking the calculations…my trust board will ignore that. " Head of Midwifery*

> *"… it talks about different people's responsibilities and at the beginning you've got, it sort of says about the commissioning responsibilities but I don't think it's strong enough. So basically it needs to say commissioners need to fund as a bare minimum xxx" Head of Midwifery*

As evidenced above there was a strong feeling by some that the responsibility of commissioners and board members needed to be more explicitly acknowledged within the guideline to ensure the care is 'going to be based on quality and good service' rather than 'how much something costs'.

Figure 2 provides further information on aspects of the guideline where midwives would like more information.

A guideline for senior management

There was a feeling from midwives across a variety of bands that the guideline was more tailored toward senior management and those involved in more strategic roles rather than those on the ground.

> *"I can't imagine staff on the wards reading it" Band 7 midwife*

A summary of the document was a suggested alternative that would be more relevant for them.

More focus on antenatal, postnatal and community care required

More focus on antenatal, postnatal and community care was requested by many of the midwives. Many appreciated the 1:1 ratio for established labour being included in the guideline. However, because that was the only minimum standard (ratio) provided in the draft guideline, midwives were concerned that could be to the detriment of other areas. For example, staff being deployed from other areas to ensure the intrapartum ratio is met, leaving the other areas potentially short staffed. Midwives conveyed the message that the emphasis of maternity care is centred on intrapartum care and the other areas can often be

overlooked, with one midwife referring to them as the ‘Cinderella’ of maternity services. Midwives accept this is a national issue that maternity settings face but hoped that the guideline would address the balance across areas and settings to ensure adequate staffing across all areas.

> *“I think labour takes a lot of attention and I think antenatal and postnatal wards needs a bit more work about the ratios that should be on those wards as well.”*
> *Band 7 midwife*

Favoured elements

- **Box 1 Midwife red flags** - The red flags were considered a ‘really useful system’ which will help with escalation. There was agreement that maybe the patient reported red flags should be included but questioned how this would be done in practice. Midwives generally disagreed that incidence of birth trauma should be considered a red flag.
- **Box 2 Factors to consider when determining number of staff and skill mix required** - The tasks listed in box 2 were good points of consideration. However, some participants felt it would be useful to have more detail, including examples showing the time taken to do each task or examples for different patient types (e.g. high and low risk, patient with complex needs).
- **Box 3 Safe midwife staffing indicators** – The indicators were considered by many to link with current practice within their organisation but midwives felt that the inclusion of these within the guideline would help to formalise the recording and monitoring of them.

Challenges

The following challenges envisaged when using the guideline were raised by midwives:

- As stated in the findings sections, many found that the recommendations in the guidelines were not strong enough and required more specific detail. Therefore many envisage using the guideline to influence change would be a challenge.

- Implementation of the guideline in terms of getting it embedded into the culture of the organisation and getting all staff on board.

- Time and resource to do the systematic assessment on a daily basis and conduct the data collections required.

- Difficulty implementing the guideline without having a named tool to support it.

- Recruiting midwives will be difficult if the guideline helps determine more staff are required.
- Long document - ‘midwives on the ground’ may not read.
- Does not match with other available / used information such as Payment by Results
- The guideline represents an ‘ideal’ - e.g. 1:1 ratio could be difficult to achieve

Points of consideration

The aim of the field testing was not to generate statistically significant findings that are generalizable to the wider population. The field testing was qualitative in nature and will not represent the views of all midwives. The field testing can only provide a steer and must be considered alongside other data and knowledge. However, the final sample did include midwives across different bands, settings and regions and the findings reflected comments received as part of the formal consultation.

Board members and commissioners were not included in the final sample despite efforts to engage these roles. Future field testing may need to consider different mechanisms for recruitment and communication we these roles.

Next Steps

The findings of the field testing will be reported to the safe staffing advisory committee for consideration when developing the final guideline.

Figure 2 – Elements midwives felt were missing or required more detail in the draft guideline