RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

www.rcm.org.uk

Setting the Context

The National Institute of Health and Clinical Excellence (NICE) published its guideline for safe midwifery staffing in maternity settings (NICE Safe Staffing Guideline NG4 2015) in February 2015.

The publication of the guideline follows a number of high profile reports into instances of poor and unsafe patient care (Francis R, 2013[1]) and more recently, the Kirkup Report into the failings in maternity care at Morecambe Bay (Kirkup B, 2015[2]).

Whilst the examples of substandard care detailed in these reports cannot exclusively be attributed to staffing shortages, they did highlight the need for robust procedures for establishing how many staff are needed to provide safe, effective and high quality care.

Having the right number of people, with the right skills, in the right place is fundamental to delivering a safe, high quality service alongside:

- effective leadership from board level to service delivery
- a governance framework that is accessible to all staff and women
- a culture of transparency when reviewing clinical incidents
- a culture of learning
- services that facilitate choice of place and type of birth
- continuity of carer
- effective and mutually respectful relationships between midwives and obstetricians
- sufficient capacity to meet demand
- the active involvement of women and families in investigations and reviews of care and of service delivery

The importance of getting staffing numbers right was recognised in the Francis Report, which recommended that evidence-based tools be developed and used for establishing what services are likely to require, in terms of staff numbers and skill mix.

It was as a result of this recommendation that NICE established the safe staffing guidance programme, out of which the safe midwifery staffing guideline was developed.

1. Francis R (2013) Final report of the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust. www.midstaffspublicinquiry.com/report
2. Kirkup B (2015) The Report of the Morecambe Bay Investigation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

The purpose of this RCM guidance is to assist Directors of Midwifery (DOMs)/Heads of Midwifery (HOMs) and other senior midwives, as well as general and divisional managers, implementing the safe staffing guideline for midwives in maternity settings.

This guidance document should be used in conjunction with:

- NICE safe staffing guideline for midwives in maternity settings
- Better Births: Improving outcomes of maternity services in England, the report of the National Maternity Review in England 2016
- RCM State of Maternity Services Report 2015
- How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability, National Quality Board 2013
- Birthplace cost-effectiveness study (Final Report part 5 2011, BMJ 2012)

Workforce and capacity challenges for maternity services

A number of key factors affecting both the demand for and supply of midwives, present challenges for the ability of maternity services to deliver safe, effective and high quality care.

Demand factors include:

- The birth rate in England, which remains at historically high levels despite tailing off slightly in recent years.
- The growing complexity of many births due to, among other things, rising rates of obesity and diabetes among pregnant women, more women presenting with long-term conditions and a substantial increase in the number of births to older mothers.
- Expectations that midwives will deliver an expanding range of public health messages and advice on subjects as diverse as nutrition and weight management, infant feeding, domestic violence, parenting skills, smoking cessation, screening and FGM.
- National policy drivers, such as the recommendations on continuity of carer in the National Maternity Review.

On the supply side:

- The number of midwives working in England has steadily increased over the last decade, but the increase has not been enough to match the rise in births.
- Changes in the age profile of the midwifery workforce in England, with 30% of midwives now aged 50 or older. This poses a particular challenge in the next decade as a significant proportion of the midwifery workforce will be eligible to retire.
- A sizeable proportion of the midwifery workforce is employed on a part-time basis. According to the NHS Staff Survey 2014 only 73% of midwives were contracted to work more than 30 hours per week. RCM research also shows midwives are choosing to work agency shifts as NHS employers have difficulty meeting their work flexibility requirements.
- Proposed changes to funding for healthcare education students, under which student midwives would pay tuition fees and access loans instead of a bursary, could drastically reduce the number of applicants for pre-registration programmes. This is a particular issue for midwifery education, given the number of mature students (many of whom will already be paying back loans for their first degree) that apply for midwifery training.

The overall picture then is one of increasing demands on maternity services set against limited capacity to meet these demands. This is apparent from the most recent RCM survey of Heads of Midwifery in 2015, which found:

- 90% of HOMs reporting that their service was dealing with more complex cases than was the case in 2014.
- 42% of HOMs reporting that their service had to be temporarily suspended due to demand exceeding capacity.
- 76% of HOMs reporting that they had to redeploy staff to cover essential services very or fairly frequently.
- 15% of HOMs reporting that their budget had been cut in the last year.

DOMs/HOMs therefore need to carefully deploy their resources and develop systematic, evidence-based and strategic responses to these challenges. For example, succession planning for midwifery leaders, matrons and HOMs/DOMs should be on the agenda particularly as many midwives in leadership roles are eligible for retirement in the next few years.

With no prospect of any alleviation to current financial constraints, it is particularly important that managers who hold the maternity services budget keep a focus on cost-effectiveness by:

- periodically reviewing staffing and skill mix.
- ensuring that Maternity Support Workers (MSWs) are deployed effectively and trained appropriately.
- developing models of care that are evidence-based and effective, by for example reducing unnecessary interventions.

For services that are experiencing staff shortages or recruitment problems, DOMs/HOMs or other senior managers must:

- assist commissioners in understanding what the staffing requirements are for maternity services.
- support midwifery managers to develop effective local workforce planning and rostering arrangements.
- maintain quality standards through effective staff deployment.
- ensure that evidence of unsafe staffing is communicated to the Trust Board before staffing levels impact negatively on outcomes for women and their babies.

Implementing the Guideline

Implementation of the safe staffing guideline is likely to be more effective if it is accompanied by:

- joint collaboration between commissioners and providers of maternity services.
- support from the Trust Board, Executive and Non-Executive members, for implementation of the guideline and awareness of the staffing requirements necessary for successful implementation.
- services that are designed around the needs of women and families and which are cost effective.
- support from obstetricians and other members of the maternity team and positive engagement with their professional bodies and trade unions.

DOMs/HOMs and other senior managers will also need to address some key questions prior to implementation:

Strategy

- Does our service have a strategic plan?
- Is the strategy aligned with our vision and national and local priorities for maternity care?
- Does the strategy include a workforce plan aligned to the current and future needs of the service?
- Has our strategy informed our business plan?

Workforce

- What are our current and future workforce needs?
- How will our workforce needs be influenced by:
  - The National Maternity Review.
  - Changing demographics.
  - Numbers of midwives qualifying within our locality in the next three years.
  - Work/life balance issues i.e. the number of midwives who would like to work flexibly.
  - Including an emergent 'generation Y' workforce that has a different view to work than previous generations.
  - Number of midwives within the current workforce who are approaching retirement.

Finance

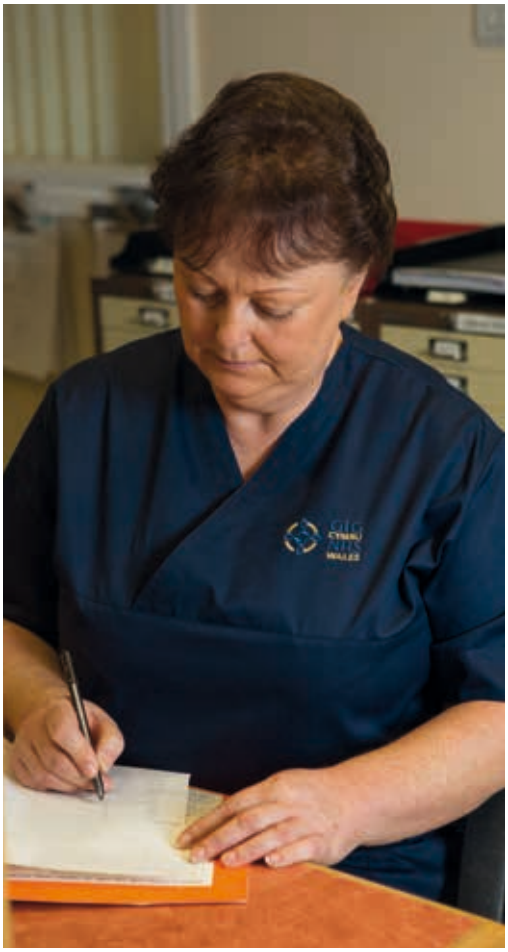
- What does our service cost?
- What is our income?
- Do costs exceed the allocated budget? If so, was this because:
  - the budget was set too low.
  - higher than planned rates of leave, sickness or other staff absence.
  - high staff turnover.
  - greater than anticipated demand for services.
  - more women with complex needs than expected.
  - recruitment difficulties leading to high usage of agency staff.
  - costs incurred in reconfiguring services.
- If there is a gap between cost and income, what additional resources are needed and what resources are available?
- What else needs to happen to plug the gap?

Change management

- Have we identified changes that we want to make?
- What does change look like?
- What needs to happen to realise the change?
- Over what period of time does the change need to happen?
- What are the cost implications of change?
- What are the risks and benefits of change?
- What actions are needed to mitigate the risks?

Workforce Planning

It is absolutely essential that implementation is underpinned by a systematic workforce strategy, and use of a recognised workforce planning tool for determining the total number of midwifery and MSW staff required per maternity service.



Identifying how many midwives and MSWs are needed will vary from service to service and will depend on a number of variables, such as models of care, configuration of services, case mix, length of stay in the acute setting and the competency levels of MSWs. Each of these will have implications for how staff are deployed. For example, if there is a high proportion of women going home within six hours following birth, there will need to be sufficient community staff to meet this demand.

All services will be subject to peaks and troughs in demand throughout the year. Workforce planning will need to be augmented by acuity tools and escalation plans in order to ensure that services respond promptly to sudden fluctuations in activity, or changes to staffing levels (caused for example, by unexpected absences). Detailed descriptions of relevant workforce planning tools are set out in Appendix One.

Implementing the Guideline

Focus on care for women and babies

What does the guideline recommend?

Ensure that women, babies and their families receive the midwifery care they need, including care from specialist and consultant midwives, in all:

- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units).
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery – led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services). (Recommendation 1.1.1)

What needs to happen?

This requires DOMs/HOMs, commissioners and those involved in commissioning and providing public health services to have a clear understanding of the needs of their local population based on current and future demographic trends associated with, for example: ethnicity, deprivation, age, fertility and birth rates, prevalence of conditions such as diabetes and obesity etc.

DOMs/HOMs, senior midwives and general managers will also need, on at least an annual basis, to match the population needs assessment with a profile of the current midwifery and MSW workforce including details such as age, turnover, years of qualification and ratio of newly qualified to experienced midwives.

Setting staffing establishments

What does the guideline recommend?

Develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment (see recommendation 1.2.2) to ensure continuity of maternity services, and to provide safe care at all time to women and babies in all settings. The board should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings. (Recommendation 1.1.2)

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

Undertake a systematic process to calculate the midwifery staffing establishment. The process (or parts of the process) could be supported by a NICE endorsed toolkit (if available). (Recommendation 1.2.2)

Note: NICE have developed a process for calculating the midwifery staffing establishment which is set out across the remainder of recommendations 1.2.2, 1.2.3 and 1.2.4. This is supported by Figure 1 in the guideline, which summarises the process[3].

The RCM view is that Birthrate Plus® provides a more robust and proven methodology for determining midwifery staffing establishments.

What needs to happen?

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Of course birth outcomes are not influenced by staff numbers alone. Nevertheless a recognised and well-used tool like BR+ is crucial for determining the number of midwives needed to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Strategic workforce planning should be augmented by the use of daily acuity tools. The value of these tools is that they can be used to alert the midwife in charge to fluctuations in activity, particularly when staffing levels are inadequate to meet demand. They also provide an objective basis on which to implement escalation procedures. A retrospective analysis of these acuity tools, on a weekly or monthly basis, can assist in determining:

- whether or not staff are appropriately deployed.
- the proportion of time during which there were insufficient staff.
- the proportion of time during which the escalation plan had to be implemented.
- the number of occasions on which the service had to be suspended and the duration of each suspension.
- the degree to which staffing levels contributed to unexpected clinical incidents.

3. Safe midwifery staffing for maternity settings, NICE guideline [NG4], Published date: February 2015' https://www.nice.org.uk

Accounting for capacity

What does the guideline recommend?

Ensure that maternity services have the capacity to do the following:

- Deliver all pre-conception, antenatal, intrapartum and postnatal care needed by women and babies.
- Provide midwifery staff to cover all the midwifery roles needed for each maternity service, including co-ordination and oversight of each service.
- Allow for locally agreed midwifery skill mixes (for example, specialist and consultant midwives and practice development midwives).
- Provide a woman in established labour with supportive one-to-one care.
- Provide other locally agreed staffing ratios.
- Allow for:
  - uplift (which may include consideration of annual leave, maternity leave, paternity leave, study leave including mandatory training and continuing professional development, special leave and sickness absence).
  - time for midwives to give and receive supervision in line with professional guidance.
  - ability to deal with fluctuations in demand (such as planned and unplanned admissions and transfers, and daily variations in midwifery requirements for intrapartum care). (Recommendation 1.1.3)

What needs to happen?

In terms of capacity issues, there are few examples of maternity services providing direct **pre-conception care** with the exception of care in the postnatal period that can positively influence future pregnancies and longer-term health through, for example:

- family planning.
- supporting women to initiate and continue breastfeeding for at least six months.
- providing women with vaccinations who are non-immune to rubella.
- supporting women with dietary advice and weight management for those who have a raised BMI.
- advising women on pelvic floor exercises.
- supporting women in accessing smoking cessation services.
- ensuring that women who have had pre-eclampsia, pregnancy induced hypertension, gestational diabetes, perineal trauma or other complications receive the appropriate follow-up care and advice.
- advising women regarding cervical screening.

Because BR+ is a workforce planning tool that applies across the whole maternity care pathway, it can be used to assess the staffing required to provide these elements of postnatal care.

Where maternity services are engaged with the provision of pre-conception care, this should be part of a collaborative approach that also involves public health, health visiting, primary care and children's services.

With regards ***co-ordination and oversight roles*** within the maternity service, the workforce plan must make it clear that these senior midwifery roles are in addition to the staffing costs required to deliver one-to-one care in labour.

In terms of allowing for ***locally agreed skill mixes***, using accurate knowledge about the health needs of the local population and historical data will enable senior midwives and workforce planners to determine which specialist posts are required e.g.:

- a consultant midwife for public health;
- specialist midwives for diabetes, for haemoglobinopathies/antenatal screening and for women who have previously had a stillbirth or a low birth weight baby;
- specialist/consultant midwives for recently arrived asylum seekers/women with refugee status and for perinatal mental health services.

Ensuring that there is sufficient capacity to ***provide every woman in established labour with one-to-one care*** from a midwife is a core recommendation within the guideline. This must always be calculated on the total number of clinical whole time equivalent (WTE) midwives required exclusive of specialist and managerial posts. However, where managers and/or specialists are expected to contribute to providing clinical care then the proportion of their time allocated for clinical care should be factored in to the calculation for providing one-to-one care.

In addition to determining the overall staffing requirements for the maternity service, DOMs/HOMs and managers also need to ensure that there are sufficient staff to meet unexpected fluctuations in demand and particularly increases in dependency levels.

This requires services to be proactive and workforce plans to be set in the context of locally determined models of care, staff numbers and skill mix. Services that react to events rather than be proactive are more likely to have to regularly use their escalation plans and to redeploy staff from other areas to delivery suite at times of high demand. This can create additional pressures for the postnatal ward where significant safeguarding and other social risk factors can have a knock-on impact on midwifery staffing, and community and home birth services.

Consideration should therefore be given to:

- staffing delivery suites at a minimum of 80% of demand to ensure that the peaks in demand can be met. This is not an exact science and it will be for local management to determine the optimum level of demand on which to set staffing levels: lower the percentage the higher the probability of a greater dependency on escalation plans and regular redeployment of staff; whereas staffing acute areas at 100% of demand will result in over resourcing and inefficient use of staff.
- developing a robust on-call system or an overtime rota that ensures there are sufficient staff to meet the highest peaks in demand.
- deploying staff who do not work full-time and who are willing to be on-call a number of times per year on an on-call rota. This will ensure that the rota includes only those staff not on duty on the day of the on-call, and who are not expected to work the following day. On-call costs should be included when setting the staffing establishment budget. Bear in mind too that paying overtime to staff who work on-call is significantly cheaper and more cost effective than paying for agency staff. This is particularly pertinent following the introduction, in September 2015, of a ceiling on the amount that individual NHS Trusts can spend on agency staff.
- ensuring that there is sufficient emphasis in role and service redesign on the training and deployment of MSWs in order to support midwives caring for women and babies in the postnatal period, whether in acute, midwife-led, community or home settings. Whilst every effort should be made to avoid situations where a midwife providing postnatal care is called away to cover delivery suite, if this situation does occur then it would not be appropriate to use an MSW to substitute for the midwife.

When allowing for ***uplift***, DOMs/HOMs may find it helpful to analyse the previous two years time/costs relating to:

- sickness absence, maternity leave and study leave.
- continuous professional development (CPD), both mandatory and non-mandatory.
- training required to maintain competency in providing safe maternity care.
- overtime, bank and agency costs during use of escalation plans, during peaks in activity or when there are otherwise significant staffing shortages.
- the supervisory and managerial duties of senior midwives (bands 7 and above) relating to, for example:
  - maintaining the staffing rota.
  - responding to complaints.
  - financial management.
  - undertaking appraisals.

This analysis can be used to consider:

- how likely it will be that within the next financial year, uplift costs will show a similar pattern.
- a more cost-effective way of providing mandatory and competency training i.e. a collaborative approach through a sector network.
- whether all midwives require the same amount and level of training? For example, midwives in specialist posts who require training that relates specifically to their job description may not need the same amount of updating for areas such as the acute labour ward.
- how to reduce rates of sickness absence.
- how the hours spent each year on these additional costs convert into WTE midwives.

An accurate and up-to-date assessment of uplift costs helps to ensure that:

- realistic budgets are set.
- the demands of the service are met.
- additional costs relating to agency staffing and other additional in-year requirements are avoided or minimised.
- there is less likelihood of an overspend at year end.

Planning ahead

What does the guideline recommend?

Ensure that maternity services use local records of predicted midwifery requirements and variations in demand for midwifery staff to help plan ahead and respond to anticipated changes (for example, local demographic change and women's preferences for place of care). (Recommendation 1.1.4)

What needs to happen?

Acuity tools provide real-time data on activity, which allows the midwife in charge, the on-call midwifery manager and the consultant obstetrician to quickly assess the dependency needs of women and babies, and the number of staff available to meet these needs. This will assist in staffing delivery suites to meet peaks in demand. This approach also supports the delivery of quality care in the postnatal period and in community settings because it reduces the need to redeploy staff from these areas to the delivery suite (and prevents the occurrence of red flags too – see page 26 for further information about red flags).

Acuity tools also generate data that can be used to inform future workforce plans. For example, a simple 'workforce and booking dashboard' (covering a two to five year period and updated on a monthly basis) can be used to assess at a glance fluctuations in women accessing the service set against the funded establishment.

See Appendix One for more information about maternity acuity tools.

Successful implementation of this recommendation will also depend on having appropriate IT systems and dedicated staff in place in order to enter, maintain, retrieve and analyse the data.

Procedures for developing, approving and monitoring the staffing establishment

What does the guideline recommend?

Develop procedures to ensure that the midwifery staffing establishment is developed by midwives with training and experience in setting staffing establishments. Procedures should ensure that the midwifery staffing establishment is approved by the head of midwifery and the director of nursing and midwifery or chief nurse. (Recommendation 1.1.5)

Monitor whether the midwifery staffing establishment adequately meets the midwifery care needs of women and babies in the service using the Safe Midwifery Staffing indicators in box 4. Consider data collection of these safe midwifery staffing indicators (using data already routinely collected locally where available), and analyse the results. (Recommendation 1.4.1)

Compare the results of the safe midwifery staffing indicators with previous results at least every six months. (Recommendation 1.4.2)

What needs to happen?

Whatever tools or methodologies are used for workforce planning, DOMs/HOMs must be equipped with the leadership skills to apply the principles of workforce planning and to use the available evidence based tools as well as their clinical judgement in agreeing staffing levels. They also need to have the ability to work effectively and collaboratively on workforce planning matters with their finance director, chief nurse or other executive directors. In particular they will need to be able to demonstrate and justify the rationale underpinning service and role redesign, the recommended funded establishment

and decisions about staff deployment. In particular DOMs/HOMs will need to consider how they can ensure that women receive one-to-one care in established labour without redeploying staff in a way that reduces the quality of care within other areas of the pathway.

The development of senior midwives and those with a clinical leadership responsibility should ensure that they have an understanding of workforce planning tools, and how they can be used to inform decisions as to what constitutes safe staffing.

Midwives involved in setting the staffing establishment should also be trained in scenario modelling based on potential changes in key indicators such as rates of normal births, home births and caesarean sections.

When monitoring the staffing establishment refer to the Safe Staffing Indicators in the NICE guideline 'Safe midwifery staffing for maternity settings[4]. These can be supplemented by additional local indicators, if required e.g. results from the 'Friends and Families Test', staff surveys, feedback from the local MSLC or user group, 'Releasing time to care' schemes, CQC survey results. The key consideration here is the relationship between outcomes and staffing levels; e.g. if there are staffing shortages, have these contributed to a rise in complaints or serious incidents or an increase in staff sickness absence?

Where there has been a discernible decline in the quality of care, a review of the workforce and activity should be undertaken. A desk-top review using a tool such as BR+ will enable managers to ascertain whether or not factors such as a rise in birth numbers, an increase in other activity or a change in practice has implications for the midwifery staffing establishment.

Midwife shifts and rosters

What does the guideline recommend?

Ensure that there are enough midwives with the experience and training to assess the differences in the number and skill mix of midwives needed, and number of midwives available for each shift. (Recommendation 1.1.6)

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

4. Safe midwifery staffing for maternity settings, NICE guideline [NG4], Published date: February 2015' https://www.nice.org.uk

Base the midwife roster on the midwifery staffing establishment calculations, taking into account any predictable peaks in activity, and risk categorisation of women and babies (for example, during the day when midwife activities are likely to be planned, or for a service dealing with higher risk category women and babies). (Recommendation 1.2.5)

What needs to happen?

Appointing a midwife responsible for managing recruitment and retention supports a more structured and seamless process for midwifery recruitment and retention.

Ensuring that there is a dedicated and experienced senior midwife who is accountable for staff rostering is essential for ensuring the development of expertise in rostering, responding appropriately to gaps in the rota, recognising and ensuring an appropriate skill mix and forward planning.

E-rostering is used in many maternity units and should be regarded as a vital tool in ensuring safe staffing. However, in order to ensuring that e-rostering supports flexible working arrangements, rather than contributing to a lack of flexibility, the e-roster should:

- be introduced following consultation and engagement with staff, rather than be imposed as a top-down measure.
- be underpinned by clear rules and agreements around flexible working patterns.
- use software that can take account of work-life balance issues and that records actual staff numbers versus planned numbers for each shift.
- include appropriate training in use of e-rostering systems for all staff responsible for rotas.
- be reviewed at least every three months and updated regularly with details of staff changes.

Responding to variation in demand for maternity services

What does the guideline recommend?

Develop escalation plans to address demand for maternity services and variation in the risks and needs of women and babies in the service. (Recommendation 1.1.8)

Develop escalation plans in collaboration with midwives who are responsible for determining midwifery staffing requirements at unit or departmental level. (Recommendation 1.1.9)

Ensure that escalation plans contain actions to address unexpected variation in demand for maternity services and midwifery needs. (Recommendation 1.1.10)

Actions within the escalation plans related to midwifery staffing should be approved by the head of midwifery, director of nursing and midwifery or chief nurse. (Recommendation 1.1.11)

Follow escalation plans if the number of midwives available is different from the number of midwives needed. Service cancellations or closures should be the last option. Take into account the potential of cancellations or closures to limit women's choice and to affect maternity service provision and the reputation of the organisation. (Recommendation 1.3.4)

What needs to happen?

Escalation plans should include a set of procedures to be implemented when demand outstrips current workforce and/or bed capacity. Most maternity services are familiar with developing and using escalation plans. Escalation plans should not be used as a substitute for safe staffing and should only be implemented in exceptional circumstances.

The six-monthly Board-level review of the midwifery staffing establishment should include analysis of the frequency with which escalation plans have been implemented. If there is evidence that the use of escalation plans is increasing, then this should be brought to the board's attention more often than every six months. This should then trigger a review of the staffing establishment. However, even if escalation plans are rarely used it does not follow that staffing levels can be assumed to be safe. Where there are sudden increases in either dependency or activity levels, staff may feel the need to respond promptly to the demand. This can occur before or in anticipation of the additional demand lasting for a short period, especially when approaching shift changes. It is during these periods that clinical incidents can occur.

DOMs/HOMs and other senior midwives should be involved in developing escalation plans and policies. Developing and using escalation policies and plans should therefore be an integral element of leadership training.

Escalation policies should:

- outline step by step actions to be taken.
- identify the key personnel to be involved in decision making in response to short, medium and long term staffing shortages.
- set out the contingency actions to be taken in the event that capacity problems cannot otherwise be resolved.
- include a clear process for informing relevant external organisations, such as neighbouring maternity units and local ambulance services.

The plans and policies should be user friendly. Displaying a step by step communication summary flow chart within clinical areas will aid a seamless execution of the escalation plan.

Maternity services should regularly monitor the frequency with which escalation plans are used and assess their effectiveness in resolving staffing issues. In particular, the Trust Board must be informed about the number of occasions (over an agreed period of time) when an escalation plan was implemented.

Monitoring the adequacy of midwifery staffing establishment

What does the guideline recommend?

Review the midwifery staffing establishment at board level at least every six months, ensuring the review includes analysis of:

- data on variations in maternity service demand.
- midwifery red flag events.
- safe midwifery indicators. (Recommendation 1.1.12)

Review the midwifery staffing establishment at board level more often than every six months if the head of midwifery or director of nursing and midwifery identifies that this is needed. (Recommendation 1.1.13)

Change the midwifery staffing establishment if the review indicates this is needed and consider flexible approaches such as adapting shifts and amending assigned location. (Recommendation 1.1.14)

As a minimum, assess the differences between the number of midwives needed and number of midwives available for each maternity service in all settings:

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

This assessment could be facilitated by using a toolkit endorsed by NICE. (Recommendation 1.3.1)

During the service period or shift reassess differences between the midwifery staff need and the number available when:

- there is unexpected variation in demand for maternity services or midwifery care (for example, if there is an unexpected increase in the number of women in established labour).
- there is unplanned staff absence during the shift or service.
- women and babies need extra support or specialist input.
- a midwifery red flag event has occurred. (Recommendation 1.3.2.)

Consider the following when undertaking the assessment:

- risk factors and risk categorisation, acuity and dependency of each woman and baby in the service.
- environmental factors.
- time taken to perform the necessary midwifery care activities. (Recommendation 1.3.3)

Analyse records of differences between the number of midwives needed and those available for each shift to inform planning of future midwifery establishments. (Recommendation 1.4.4)

What needs to happen?

The midwifery staffing report that goes to the Board should be evidenced based with an explicit link drawn between staffing numbers and outcomes.

The report should:

- identify any perceived shortfalls in the quality of care which have been linked to:
  - sickness leave and other staff absence.
  - difficulties in recruiting or retaining staff.
  - skill mix concerns, particularly relating to the development of MSWs.
  - concerns about the quality or effectiveness of clinical leadership.
  - management of rosters.
  - concerns about the culture of practice e.g. unnecessary interventions.
  - evidence of incomplete/inadequate incident reporting and team debriefing.
  - incidence of staff unable to attend mandatory training due to staffing shortages.
  - findings of staff surveys.
- summarise data relating to key performance indicators, including:
  - the proportion of clinical incidents and 'near misses' in which staffing issues were a contributory factor.

  - » the proportion of complaints from women where staffing issues are likely to have been a contributory factor.
  - » the number and type of red flag incidents raised in response to staffing issues.
  - » the number of occasions when staff have been redeployed to acute areas from the postnatal ward or community settings.
  - » the number of occasions when services have been suspended, the duration of each suspension and the principal reason for each suspension.
  - » the number of occasions when services such as home births or elective procedures have been cancelled.
  - » the number of times that staff have missed breaks.
- strategies, proposed actions or actions already taken to address the identified shortfalls.

The clinical governance lead midwife should be responsible for ensuring that systems and processes are in place for the weekly collation of relevant data.

See Appendix One for details of acuity tools that can be used on a daily/hourly basis. A similar scoring system could be developed and applied to the antenatal and postnatal ward.

Monitoring and responding to changes

What does the guideline recommend?

Ensure that maternity services have procedures in place for monitoring and responding to unexpected changes in midwifery staffing requirements. (Recommendation 1.1.15)

Ensure maternity services have procedures in place for:

- informing members of staff, women, family members and carers about what midwifery red flag events are and how to report them.
- the registered midwife in charge of the shift or service to take appropriate action in relation to midwifery red flag events.
- recording and monitoring midwifery red flag events as part of exception reporting. (Recommendation 1.1.16)

Involve midwives in developing and maintaining midwifery staffing policies and governance, including escalation planning. (Recommendation 1.1.17)

Ensure that actions in relation to midwifery red flag events or unexpected changes in midwifery staffing requirements:

- take account of women and babies who need extra support from a midwife.
- do not cause midwifery red flag events to occur in other areas of the maternity services. (Recommendation 1.1.18)

If a midwifery red flag event occurs the midwife in charge of the service of shift should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Action may include allocating additional midwifery staff to the service. (Recommendation 1.3.5)

Record midwifery red flag events (including any locally agreed midwifery red flag events) for reviewing, even if no action is taken. (Recommendation 1.3.6)

Analyse reported midwifery red flag events and any locally agreed midwifery red flag events and the action taken in response. (Recommendation 1.4.3)

What needs to happen?

According to the NICE guideline, a red flag event is a warning sign that something may be wrong with midwifery staffing. Accordingly, red flag events should be the exception and not the norm.

The NICE guideline includes a list of suggested red flag events for maternity services and these are set out in Appendix Two. Other red flag events may need to be agreed locally, particularly those that impact on the quality of antenatal and postnatal care, for example delays to:

- discharging mother and baby home.
- admitting a baby to the neonatal unit.
- catheterising a woman with retention of urine.
- transferring a woman in labour/premature labour from the antenatal ward to the delivery suite.
- performing an assessment and/or vaginal examination on a woman whose labour has been induced.
- recognising a jaundiced baby.
- recognising a new-born with hypoglycaemia and/or hypothermia.

Or if births take place on an antenatal ward.

All members of the maternity team, including MSWs, should be able to identify a red flag event and report it to the midwife in charge. The process for reporting red flag events should be seamless; a simple flow-chart to describe the process should be visible within staff areas.

When a red flag event occurs there should be an agreed template, including questions relating to:

- the number of staff on duty.
- whether or not staffing numbers have contributed to the red flag event.
- whether the red flag event was wholly or partly attributable to staff competency issues. If this is the case it will need to be dealt with are per clinical governance policy and the staff level of competence reviewed.

The number of red flag events should be recorded and reviewed on a weekly basis. Red flags should also be entered on the maternity dashboard and reviewed every month by the senior management team. Reviews of serious incidents and complaints should be cross-referenced for evidence that a red flag was raised at the time of the incident.

Deploying a dedicated senior midwife (bleep holder) responsible for solely operational issues to each shift, (a role developed by Kingston Hospital NHS Foundation Trust) has proved to be an effective way of responding to unexpected changes in staffing, and thereby reducing the incidence of red flag events.

Promoting staff training, education and time for indirect care activities

What does the guideline recommend?

Ensure midwives have time for:

- participating in continuous professional development, statutory and mandatory training, and supervision.
- receiving training, mentoring and preceptorship.
- providing training and mentoring for student midwives or other maternity service staff.
- supervising and assessing the competencies of other midwives and non-midwifery staff (including maternity support workers).
- taking part in indirect care activities such as clinical governance, safeguarding, administration and liaison with other professionals.
- setting the midwifery staffing establishment.
- assessing the midwifery requirements for each day or shift, including collecting and analysing data. (Recommendation 1.1.19)

What needs to happen?

As previously stated, the requirements for participating in or receiving training and for indirect care activities must be included when calculating the required staffing establishment.

To decide prospectively on the percentage of uplift required, retrospective data should be collated and reviewed to include time spent on, among other things:

- continuous professional development.
- supervision.
- attending relevant meetings.
- assessment and mentoring of students.
- administrative and management duties.

As per recommendation 1.1.3 (above) the time calculated should be converted into whole time equivalents, costed and then included in the funded establishment.

Conclusion

Implementation of the above recommendations has to be underpinned by systems and validated workforce tools that:

- support workforce planning.
- capture adequate data on staffing and outcome measures.
- ensures there is appropriate and prospective uplift.
- alerts clinical managers to the need to implement escalation plans.
- allows for easy retrieval, interpretation and analysis of data.

However, workforce planning and setting establishment levels are just the beginning of a process for ensuring that services are safe, effective and responsive to service users. What is also needed is:

- effective leadership from the Trust Board down to the frontline.
- systems and appropriately skilled individuals who are able to triangulate workforce data with information collated from, among other things:
  - clinical dashboards
  - clinical incidents
  - complaints
  - rota analysis
  - skill mix
  - measures of service user and staff satisfaction
- services that are proactive in ensuring that there are the appropriate number of midwives deployed to provide 1:1 care in labour at all times. For example by developing the MSW role to support the role of the midwife and maximise workforce capacity.

Appendix One

Current workforce planning and acuity tools

Birthrate Plus (BR+)

The Birthrate Plus workforce planning tool has been used extensively over the last 20 years by more than 100 NHS Trusts in the UK as well as maternity providers in Ireland and Australia.

It is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

BR+ measures the workload for midwives arising from the needs of women, from initial contact in pregnancy until final discharge from midwifery care. It measures the demand for midwifery care through the retrospective allocation of women and babies to five outcome categories, which are based on a composite of clinical factors of process and outcome. It then calculates the number of hospital and community midwives required to meet this demand.

BR+ is based on the total activity, not just the number of births per unit, needed to meet the needs of women including:

- all antenatal and postnatal care.
- antenatal outpatient activity.
- antenatal inpatient activity and ward attenders.
- delivery in all settings.
- all postnatal care in hospital.

BR+ supports:

- service redesign, for example by developing services that women can receive outside of acute settings.
- role redesign, for example assessing the time needed when suitably trained midwives undertake the neonatal examination of the newborn previously undertaken by junior paediatricians.
- local, regional and national strategic planning.

The RCM publication *Working with Birthrate Plus®* provides practical guidance for using the BR+ methodology and the *Birthrate Plus®* Intrapartum Acuity Tool.

Centre for Workforce Intelligence (CfWI)/Health Education England Maternity Care Pathway Tool

The Maternity Care Pathway Tool is designed to support maternity services providers in planning their future workforce and service design. It works by capturing a high level summary of current workforce numbers and service activity for the entire maternity service workforce. It can be used for modelling service change scenarios, such as changes in the birth rate, profile of the local population or the skill mix of the local workforce.

Whilst the tool supports local decision making it is entirely reliant on birth and workforce data generated by the service. The tool and its outputs are designed to be used alongside, rather than as an alternative, to established workforce planning tools such as BR+.

Appendix Two

Midwifery red flag events

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed for.

- delayed or cancelled time critical activity.
- missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- delay of more than 30 minutes in providing pain relief.
- delay of 30 minutes or more between presentation and triage.
- full clinical examination not carried out when presenting in labour.
- delay of 2 hours or more between admission for induction and beginning of process.
- delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally.

Promoting · Supporting · Influencing

www.rcm.org.uk