

National Quality Board

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Safe, sustainable and productive staffing

**An improvement resource for
maternity services**

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

The NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health & Social Care

For further information about the NQB, please see:

www.england.nhs.uk/ourwork/part-rel/nqb/

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Summary

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of this resource has been the overarching policy publication *Better births* (2016) that highlighted the vision:

“for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.”

Critical to delivering this is the safe, sustainable and productive staffing of maternity services. This improvement resource has been designed to be used by those working in clinical settings and leading maternity services – from the midwife and obstetrician to the board of directors in NHS organisations. NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources (NQB 2016).¹

In developing this improvement resource we set out with a clear aim to reflect the diversity of healthcare professionals, women, partners and other support roles involved in safe, high quality maternity care. This multiprofessional approach saw collaboration from professional groups including the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Anaesthetists (RCoA) as well as Doulas UK, allied health professionals (AHPs),

¹ www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

sonographers and the National Childbirth Trust (NCT) to develop a comprehensive series of outputs and recommendations on staffing in maternity services.

The resource outlines a systematic approach for identifying the organisational, managerial and clinical setting factors that support safe staffing of maternity services. It makes recommendations for developing models of care, staffing, tools and monitoring, and acting on staffing issues and risk to meet women's needs. It builds on standards and recommendations from the RCM (2016), RCOG (2017), RCoA (2017) and the Care Quality Commission (CQC) (2016), and is informed by the National Institute for Health and Care Excellence (NICE) midwifery staffing guideline (NG4).² A comprehensive review of the research evidence relating to staffing maternity settings was undertaken as part of the development of this improvement resource.

The collaboration between professionals and women and their families in the production of this improvement resource builds on existing best practice and further enhances opportunities for safe and personalised maternity care.

The following recommendations outline the core responsibilities and expectations set out in this improvement resource.

² NICE (2015) *NICE guideline NG4 – Safe midwifery staffing for maternity settings*
www.nice.org.uk/guidance/ng4

Recommendations

In determining staffing requirements for maternity services:

1.	Boards are accountable for assuring themselves that appropriate tools (such as the NICE-recommended Birthrate Plus (BR+) tool for midwifery staffing) are used to assess multiprofessional staffing requirements.
2..	Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.
3.	Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE guideline NG4.
4.	Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources.
5.	Boards are accountable for assuring themselves that sufficient staff have attended required training and development, and are competent to deliver safe maternity care.
6.	Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.
7.	Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff.
8.	Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.
9.	Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.
10.	Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.
11.	Organisations must have mandatory training, development and education programmes for the multidisciplinary team, and establishments must allow for staff to be released for training and development.

12.	Organisations must take an evidence-based approach to supporting efficient and effective teamworking.
13.	Services should regularly review red flag events and feedback from women, regarding them as an early warning system.
14.	Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback.

1. Introduction

This is an improvement resource to support staffing in maternity settings. It describes the principles for safe maternity staffing across the multiprofessional team to ensure women and their families receive joined-up care appropriate to their needs and wishes. The resource is based on the [National Quality Board's \(NQB\) expectations](#) that to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, trusts will employ the right staff with the right skills in the right place and at the right time. It is also aligned to Commitment 9 of [Leading change, adding value: a framework for nursing, midwifery and care staff](#) (2016).

The purpose of this resource is to help providers of NHS-commissioned services, boards and executive directors to support their head/director of midwifery and other lead professionals in implementing safe staffing for maternity settings. NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing. They hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources.

This document is based on the NQB's model described in [Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time](#). We have amended it to show what is expected for safe and sustainable staffing in all maternity services based in community or acute care settings.

Figure 1: NQB’s expectations for safe, sustainable and productive staffing (2016) adapted for maternity settings

Safe, effective, caring, responsive and well-led care		
<p>Measure and improve</p> <ul style="list-style-type: none"> – patient outcomes, people productivity and financial sustainability – – report investigate and act on incidents (including red flags) – – patient, carer and staff feedback – 		
<p>Implementing <i>Better births</i> maternity vision</p> <ul style="list-style-type: none"> – implement Birthrate Plus (BR+), <i>Safer childbirth</i> – – develop local quality dashboard for safe sustainable staffing as part of the maternity dashboard – 		
Expectation 1	Expectation 2	Expectation 3
<p>Right staff</p> <p>1.1 Evidence-based workforce planning</p> <p>1.2 Appropriate skill mix</p> <p>1.3 Review staffing using the BR+ workforce planning tool annually and with a midpoint review</p>	<p>Right skills</p> <p>2.1 Multiprofessional mandatory training, development and education</p> <p>2.2 Working as a multi-professional team</p> <p>2.3 Recruitment and retention</p>	<p>Right place and time</p> <p>3.1 Productive working and eliminate waste</p> <p>3.2 Efficient deployment and flexibility including robust escalation</p> <p>3.3 Changes in working around <i>Better births</i>, including increased continuity and caseloading, and improvements in postnatal care and mental health initiatives</p>

This improvement resource outlines expectations for provider boards and operational responsibilities. It does not exist in isolation; board members should also refer to other resources in this series and in particular that for [neonatal care improvement](#) (Edition 1 soon to be released).

It is also useful to recognise how professional organisations and unions can support this work. A partnership approach with staff-side representatives is important in developing and monitoring workforce policies and practices, and in influencing the organisational culture.

1.1 Vision for maternity services

The vision for maternity services across England is “for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances” (*Better births* 2016). We call this ‘woman-centred care’.

Staff need to be supported to deliver woman-centred care, working in highly efficient teams in well-led organisations that are open, transparent, innovative and constantly learning to improve services.

Maternity staffing is central to delivering the triple aim of health and wellbeing, care and quality, and funding and efficiency, as described in *Five year forward view* and in Part 3 of the *Leading change, adding value nursing framework*. It is increasingly evident that personalised care leads to safer care and better outcomes. It is also well recognised that when staff work in well-led positive environments and are supported to take pride in their work, outcomes for women and babies improve.³

The current climate is challenging in many ways. Increasing acuity of births and the lack of availability of maternity staff reported by the Royal Colleges are significant issues for many units.⁴ Maternity leaders recognise that modernising maternity services will require new ways of working to support midwives and obstetricians, anaesthetists and neonatologists, as well as ensuring that staffing numbers are adequate and appropriate. Maternity services should aim for creative workforce design backed by excellent multidisciplinary training and education to enable teams to work together to provide safe services.

This resource is written in the context of the development of sustainability and transformation partnership (STP) plans and local maternity systems. Commissioners,

³ www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-review/

⁴ www.rcm.org.uk/download-state-of-maternity-services-report-2016

providers and higher education institutions need to work together in designing and redesigning the current and future workforce.

To develop these new ways of working and to support staff, *Better births* suggests certain preconditions are needed:

- empowered staff who are supported and able to establish their own ways of working that meet the needs of the women and babies they care for
- high quality maternity leadership that backs innovative ways of working and the design and maintenance of a workforce capable of providing continuity of carer
- a culture of learning and continuous improvement to maximise quality and outcomes, which includes multiprofessional training
- staffing levels adequately planned across each local maternity system
- a board-level champion for maternity to help clinical board members and the head of midwifery highlight and act on maternity issues raised at board level.

NICE guideline NG4, *Safe midwifery staffing for maternity settings* (2015) makes recommendations on safe staffing but is specific to midwifery. The King's Fund, RCM, RCOG, RCoA and Obstetric Anaesthetists Association (OAA) have considered the broader multiprofessional team when making recommendations for maternity service staffing.

1.2 Context: the maternity setting

Approaches to determining appropriate staffing levels in maternity services must be flexible and use the full multidisciplinary team to meet the needs of the mother and her baby (monitored through risk assessments as part of their care). This includes any reasonable adjustments that need to be made based on complex physical or mental health needs, or for people with learning disabilities (see [Appendix 5](#)).

In maternity, workforce planning poses a unique set of problems: each care 'episode' spans about 40 weeks, crosses hospital and community settings, and involves scheduled appointments. Many pregnancies need extra unscheduled care, often

involving more scans or other procedures as well as an unexpected inpatient admission in addition to the birth itself. The birth can be at home, or in a freestanding midwifery unit, midwifery-led unit or obstetric unit in an acute hospital. It is also necessary to consider risk escalation and transfer of women in labour between low and high risk settings when planning the workforce. The pregnancy, birth and postnatal pathways are mainly provided by midwives whose role and responsibilities are defined in statute. Midwives work alongside other clinicians, GPs, obstetricians, paediatricians, AHPs and other staff such as health visitors and support staff.

High quality maternity services will demonstrate:

- effective leadership from board to point of service delivery
- a governance framework 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
- a model of care that prioritises continuity of carer and includes a risk assessment to prioritise continuity of carer for women at high risk of adverse social circumstances or clinical complications
- effective and mutually respectful relationships between midwives and obstetricians and the clinical teams generally
- sufficient flexibility, capacity, workforce productivity and planning to meet demand
- the active involvement of women and families in co-designing services as well as investigations and reviews of care and of service delivery.

2. Right staff

Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, high quality and cost-effective care for women and their babies at all times. Staffing decisions must be aligned to operational and strategic planning, taking account of resources so that high quality care can be provided now and sustained in the future.

Decision-making to determine safe and sustainable staffing must be clear and logical, taking account of the wider multidisciplinary team. A transparent governance structure must include oversight of staffing requirements in a care setting with appropriate escalation to the board. This should be monitored for its effectiveness.

2.1 Evidence-based workforce planning

Board responsibilities

NQB expects provider boards to ensure there is a strategic multiprofessional staffing review at least annually, aligned to the operational planning process or more frequently if changes to services are planned. In addition, a midpoint review should take place to provide assurance that staffing in maternity services is safe as well as sustainable. This is consistent with NICE guideline NG4 which requires boards to review their midwifery staffing every six months.

Organisations must ensure they use systematic evidence-based workforce planning tools to assess the total multiprofessional staffing requirements (number and skill mix) for their maternity services.⁵ NQB expects the use of a workforce-planning tool to be cross-checked with professional judgement and benchmarking with peers.

⁵ Birthrate Plus is one tool for calculating numbers of midwives required.

Boards should discuss multiprofessional skill mix and establishment reviews to assure themselves the right staffing is in place. As well as the strategic annual review and midpoint review, ongoing monthly local dashboards (in line with existing RCOG recommendations) must be monitored, reported and escalated to the board if necessary. Work is in progress to develop national indicators and a dashboard that services can adapt for their local maternity system.

Operational responsibilities

A maternity system needs to consider multiprofessional safe, sustainable staffing, including midwives, support workers, nursery nurses, obstetricians, anaesthetists, doulas, antenatal educators such as the NCT, and specialist staff.

RCM, RCOG, RCoA, OAA, NICE and Doula UK have issued guidance on safe and effective staffing. We have reviewed all this guidance in developing this improvement resource.

You should follow [NICE guideline NG4 \(2015\) for midwives](#). This guideline makes recommendations on safe midwifery staffing requirements for maternity settings, based on the best available evidence. It focuses on the preconception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including at home, and in the community, day assessment units, obstetric units and midwifery-led units (both alongside hospitals and freestanding). It aims to improve maternity care with advice on monitoring staffing levels and action to be taken if there are not enough midwives to meet the needs of women and babies in the service.

NICE's guideline includes recommendations for:

- trust boards, senior managers and commissioners
- senior registered midwives (or other authorised people) who are responsible for setting the midwifery staffing establishment
- senior registered midwives who are in charge of maternity services or shifts.

Those responsible and accountable for staffing maternity services should take NICE's guidance fully into account. However, it does not override the need for, and importance of, using professional judgement to make decisions appropriate to the circumstances.

NICE endorsed Birthrate Plus (BR+) as part of its review of evidence. This tool is useful as it looks not only at the midwife-to-birth ratio but considers the mother's and baby's acuity and complexity, making it maternity-unit specific.

Many influences on safe staffing in maternity services affect the number of specialists required to keep staffing safe and sustainable. Examples are population mix, social care needs, health inequalities, specific health needs, health complexities, safeguarding children and vulnerable adults services, and a fluctuating birth rate. Meeting the requirements of national screening programmes is another influence: several are associated with maternity services including the Fetal Anomaly Screening Programme (FASP) and newborn and infant physical examination (NIPE). Increasing complexities in health have led to an increase in obstetric, anaesthetic and neonatal interventions driven by concerns for patient safety.

Maternity settings face many workforce challenges. Midwifery numbers may need to increase because pregnant women with co-morbidities and complexities require more specialist input from obstetric, anaesthetic, neonatal and midwifery professionals.

Multiprofessional working and the medical workforce requirements

Providing high quality and safe care is critical and requires a sustainable, engaged workforce willing to work in multidisciplinary teams. Senior leaders are responsible for ensuring safe medical staffing for both elective and emergency work. RCOG and RCoA promote the principle that standards of care must be maintained by having the appropriate workforce with the necessary skills in the right place at the right time.

There should be regular reviews of training commissions for all professional groups, including midwifery, medical and AHPs.

RCOG's clinical standards⁶ suggest no single staffing model is suitable for all UK units and it is appropriate not to make recommendations about hours of consultant presence on the labour ward based on the number of deliveries or fixed levels for consultant presence for different sized units.

Guidance is due from RCOG that examines the relationship between consultant presence on labour wards and maternal and neonatal outcomes. Currently RCOG recommends that in the absence of clear evidence, labour wards should have a consultant presence for a minimum of eight hours a day, seven days a week with clear escalation plans for senior cover out of hours.⁶

Maternity services can be likened to emergency services: some aspects of the workload and casemix are unpredictable, so services should have robust escalation processes for times of unexpected or unpredictable workload. These should include midwives, obstetricians and anaesthetists from across the organisation. The escalation plan may be determined locally, but it should ensure safe services throughout 24 hours.

2.2 Working in the multiprofessional team

Several professional, clinical and support roles make up the maternity care team in addition to midwives. We describe some of these below. For further information about physiotherapy see [Appendix 3](#).

Midwife

The midwife's role is to ensure women receive the care they need throughout pregnancy, childbirth and the postnatal period. Much of this care will be provided directly by the midwife, whose expertise lies in the care of women and babies during normal birth and pregnancy. Where obstetric or other medical involvement is

⁶ RCOG (2016) *Providing quality care for women, Obstetrics and Gynaecology workforce*.

necessary, the midwife continues to be responsible for providing holistic support. This is to maximise continuity of carer and to promote a positive birth experience for women.

Maternity support worker role

Maternity support workers contribute most when midwives train, manage and supervise them, and they are integral to the maternity care team. RCM supported developing the role by publishing *Maternity support workers: learning and development standards*.

Employers have a responsibility to ensure the person undertaking these roles receives accredited training. The key principle in incorporating maternity support workers in the workforce skill mix is to use them to complement, rather than substitute for, midwives. In the interest of improving care quality, it is essential that this role is shaped by women's needs in any birth setting. In a 'high risk' labour ward, support workers may need further training – for example, for 'scrub' roles in obstetric theatre.

Obstetrician

In 2015, RCOG set up the safer women's healthcare working party to identify the workforce and service standards needed for safe, high quality maternity. It produced two multidisciplinary reports.^{7,8}

We recognise that service requirements vary hugely in terms of workload complexity, geography and current staffing models. For this reason no single staffing model is suitable for all UK units.

RCOG's key recommendations are:

⁷ www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/

⁸ www.rcog.org.uk/en/guidelines-research-services/guidelines/providing-quality-care-for-women-obstetrics-and-gynaecology-workforce/

- a high quality and safe service for women at all times is imperative
- all multidisciplinary team members must have the appropriate skills to deliver high quality care
- appropriate consultant presence should maximise training opportunities, with a balance between direct and indirect supervision
- the presence of consultants who are resident on call will vary according to need and should be part of a hybrid rota as suggested in *Providing quality care for women*; this will ensure experienced help is available at all times
- the success of different care models should be carefully monitored.

Prospective consultant cover on labour wards is currently provided in all services Monday to Friday, 9am to 5pm, and at weekends.

In larger obstetric units (4,000 plus births) and tertiary services, extended hours during the week until 8pm or later are desirable.

Anaesthetist

Anaesthetists are involved in the care of over 60% of pregnant women. All consultant-led obstetric units need dedicated obstetric anaesthetic services. RCoA's *Guidelines for the provision of anaesthesia services (GPAS) 2017* recommends staffing requirements for anaesthetists on the labour ward. In summary:

- The duty anaesthetist should be immediately available for the labour ward 24 hours a day, with consultant support also available 24 hours a day, and there should be clear lines of communication.
- In busier units (over 5,000 births) it may be necessary to have two duty anaesthetists available 24 hours a day in addition to the supervising consultant.
- In units offering a 24-hour neuraxial analgesia service the duty anaesthetist should be resident on the hospital site where neuraxial analgesia is provided (not at a nearby hospital).
- Where duty anaesthetists work on a shift pattern, adequate time for formal handover between shifts must be built into the timetable; ideally different

professional groups' timetables should be compatible to allow multidisciplinary handover and a structured tool should be considered to facilitate handover.

- Every obstetric unit should have a designated lead anaesthetist, who should be a consultant with specific programmed activities allocated to this role. The consultant should monitor staff training, workforce planning and service risk management, ensuring that national specifications are met and auditing the service against these agreed standards. The lead should ensure there are ongoing quality improvement projects in place to maintain and improve care in their units.
- The number of consultant sessions should reflect the obstetric anaesthetic workload and not just the delivery rate per year, taking into account regional and general anaesthetic procedures, clinics and non-clinical activities.
- As a basic minimum, 10 consultant anaesthetic daytime sessions per week should be spread evenly over the week. In busier units, increased staffing levels should be considered, reflecting the level of consultant obstetric staffing in the unit.
- In units where trainee anaesthetists work a full or partial shift system and/or rotate through the department every three months (or more frequently), provision of additional consultant programmed activities should be considered, to allow training and supervision into the evening.

Sonographers

Sonographers are healthcare professionals specialising in the use of medical ultrasound who undertake most ultrasound examinations in pregnancy. About 60% of sonographers are from an AHP background as they originally trained and are registered with the Health and Care Professions Council as radiographers. Midwives and doctors also undertake ultrasound examinations during pregnancy (CFWI 2016).⁹ Concerns about deficiencies in the number of sonographers are

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/597697/Sonography_workforce_review.pdf

longstanding, and a Health Education England (HEE) working group (as at June 2017) is investigating the problems and identifying solutions.

Ultrasound examinations during pregnancy provide information of critical diagnostic importance (see [Appendix 2](#)). It is essential for patient safety that properly trained and competent practitioners conduct all ultrasound examinations. These examinations depend on the operator and require specialist skills and knowledge. Professionals working in this imaging modality are also responsible for the report of the examination and ensuring results affecting patient management are appropriately communicated.¹⁰

The number of ultrasound examinations during pregnancy varies according to clinical need. Some women may have only the two FASP scans offered to every pregnant woman in England; others may have eight or more. Scans may also be requested to evaluate maternal conditions such as suspected deep vein thrombosis, renal or biliary pathology. It is essential that the time allocated for any ultrasound examination is sufficient to enable it to be carried out competently. There are commissioned examination times for the two screening scans^{11,12} and guidelines with information on examination times published by NICE¹³ and the Society and College of Radiographers.¹⁴

Calculating whole-time equivalents for sonographer numbers will therefore depend on multiple factors such as the number of scans a woman may have during pregnancy, scan times, annual leave, mandatory training, continuing professional development, management, audit duties, teaching commitments, etc. It should also be considered whether an extended working day or week is in place or planned, as this will affect the number of whole-time equivalent staff required to run the ultrasound service safely. National screening programme requirements (eg

¹⁰ www.sor.org/sites/default/files/document-versions/bfcr1417_standards_ultrasound.pdf

¹¹ www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/04/serv-spec-16-apr16.pdf

¹² www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/04/serv-spec-17-apr16.pdf

¹³ www.nice.org.uk/guidance/cg129 (CG129 Multiple pregnancy – Section 1.3.3.4)

¹⁴ www.sor.org/learning/document-library/ultrasound-examination-times-and-appointments-0

screening support sonographer time) must also be satisfied. It is also necessary to take account of future expected growth in obstetric ultrasound examination numbers in local safe staffing calculations. Note too that sonographers are recognised as being at risk of work-related musculoskeletal disorders.¹⁵

2.3 Tools

Use BR+ with NICE guideline NG4 (2015) and the Royal Colleges' staffing guidance when planning workforce requirements in maternity to ensure the right staff with the right skills are in the right place at the right time. BR+ already recognises the value in expanding skill mix to ensure efficient use of staff. It recommends that about 10% of 'midwifery' time can be reallocated to appropriately trained and graded support staff. As experience grows of integrating support staff to meet the challenges of providing new care models associated with *Better births*, both BR+ and RCM are reviewing the scope for increasing the time support workers can free up.

The Centre for Workforce Intelligence (CFWI) and HEE have developed a maternity care pathways tool to support workforce deployment. The tool is useful for comparing care models but cannot be used for national benchmarking as it only allows local service changes to be compared, not comparisons with local or national standards. CFWI says the tool is not a replacement for BR+.

2.4 Professional judgement for specific local needs and population demographics

Use professional judgement in assessing and planning safe staffing levels to cover the clinical workload. As this is subjective, do not use it in isolation but as one component of assessment alongside workforce tools.

¹⁵ www.sor.org/learning/document-library/work-related-musculo-skeletal-disorders-sonographers

Registered nursing and midwifery staff have statutory professional obligations to raise concerns about inadequate or unsafe staffing levels as part of their code (NMC 2015).

It may be necessary to consider local factors when assessing safe staffing, such as the ward layout and geography, distance/proximity and access to facilities such as labour wards, theatre delivery suites, ante/postnatal wards and the neonatal unit. It is also necessary to consider factors affecting community-based maternity care, such as rural and urban settings, and the findings of external national review.

2.5 Allowing for uplift

Establishments in maternity settings should include an 'uplift' to allow management of planned and unplanned leave for all staff, and to ensure effective management of absences. It is important to set a realistic, accurate uplift since underestimation may mean day-to-day staffing requirements are not met. A consequence could be unexpected and unfunded over-reliance on temporary staff.

It is necessary to take account of local factors when calculating the percentage allowances for uplift. Examples include:

- annual leave entitlement
- sickness absence (planning should be based on the organisation's target level of sickness absence)
- parenting leave
- study leave (mandatory training and role-specific training) – this will vary depending on numbers of new and newly qualified staff in the team
- specific additional roles that require allocated time, eg link nurses
- supervision in line with national and local policy.

3. Right skills

To use the workforce efficiently and effectively it is important to identify the skills needed to deliver the care required and to deploy the right staff flexibly and responsibly within available resources. It is also necessary to consider how desirable it is to offer mothers continuity of carer.¹⁶

In maternity care, multiprofessional team members' skills complement each other, and when deciding who should deliver care, the mother's needs and wishes should be considered. To deliver the most effective and productive care, deployment across the multiprofessional team should also be considered.

Board responsibilities

Organisations must have robust mandatory training, development and education programmes for multidisciplinary teams. Boards must assure themselves that sufficient staff have attended such training and are competent to deliver safe maternity care. Staffing establishments must allow for staff to be released to undertake the required training and development.

It is also necessary to analyse training needs across the organisation annually. The board needs to assure itself that this analysis is used to identify and build staff skills to meet changing demands on maternity services. This should take into account the new care models being developed to implement the *Better births'* recommendations.

Effective multidisciplinary teamwork is required to deliver high quality, safe and sustainable maternity care given the knowledge and skills – and therefore disciplines

¹⁶ Maybin J, Charles A, Honeyman M (2016) *Understanding quality in district nursing services – learning from patients, carers and staff*. London: The King's Fund.
www.kingsfund.org.uk/publications/quality-district-nursing

– needed to provide holistic care to women during and after pregnancy.¹⁷

Organisations should therefore enable multiprofessional teams to come together from across the organisation and work flexibly. These teams must have clinical leaders, so the board should assure itself of the quality of its organisation's programmes to develop clinical leaders and how well existing clinical leaders are appraised.

The board must be sure its organisation recruits and retains adequate numbers of competent staff, so should look at workforce data as a way of cross-checking that care is safe and effective.

Operational responsibilities

Maternity services staff should be able to provide care in whichever setting a woman chooses to have her baby. Pathways should be developed across boundaries to enable a woman and her family to receive care close to home. High risk mothers and babies should be able to access care in centres of excellence.

Multiprofessional working and training should be established to build relationships among teams and encourage mutual respect for each other's roles.

Maternity services users may have shared needs across health and social care, so providers and commissioners should work together to provide cross-organisational and cross-boundary care.

NHS providers should work with higher education institutions to ensure adequate access to training to develop expanding roles for midwives, such as Newborn and

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www.nhs.uk/safety/documents/improving-safety-in-maternity-services-e2809320a20toolkit%20for%20teams.pdf

Infant Physical Examination (NIPE), consultant midwives masters programmes and ultrasonography.

Maternity services support staff should be developed to enhance and expand community postnatal care, as well as to support vulnerable women and families. Strong leadership is pivotal in providing safe, sustainable staffing in maternity services.

3.1 Recruitment and retention

Recruitment and retention strategies at organisation and ward level are vital parts of the workforce plan.

Clinical managers can identify or anticipate problems with recruitment and retention by monitoring, managing and planning for:

- vacancy rates
- sickness absence
- turnover
- the team's age profile
- outcome from retention/exit interviews.

Staff should be recruited using a competencies and values-based selection process aligned to the NHS Constitution and local policy, to support a culture of quality care and experience.

Important factors in attracting new staff and retaining existing staff are:

- personal circumstances, aspirations, preferences and career stage
- clinical specialty/workload/models of care provided
- ward and/or organisational culture
- leadership/team dynamics
- the particular needs of Black, Asian and minority ethnic staff, which require organisations to be proactive in supporting all staff in their development, to

identify talent early, and to help secure leadership positions and equality of opportunity¹⁸

- flexible working arrangements/shift patterns
- quality of clinical learning environment
- preceptorship programmes/ongoing education and training opportunities
- geographical location, eg ease of travel and cost of living.

Ward and organisational leaders need to boost retention across generations by understanding what motivates people to stay in their jobs. For more details, see *Mind the gap: exploring the needs of early career nurses and midwives in the workplace* (HEE 2015).

Strategies to improve retention can prove cost-effective by retaining experienced staff while avoiding agency and recruitment costs. Leadership and adequate resources strongly influence turnover intention.¹⁹

Close links between higher education institutions and NHS organisations are vital for training and developing the correct number of midwives, doctors and AHPs for future maternity services.

Organisations should be aware of the age profile of their staff and consider flexible working and retaining staff of retirement age to ensure valuable skills are not lost early. RCM's *State of maternity services report 2016* shows that since 2010 the number of midwives in England aged under 50 has fallen, while the number in their 50s or 60s has increased. Consider succession planning for midwifery leadership roles such as head/director of midwifery, consultant midwife and the professional midwifery advocate.

¹⁸ www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2017.pdf

¹⁹ Hayes LJ, O'Brien-Pallas L, Duffield C et al (2012) Nurse turnover: A literature review – An update. *Int J Nurs Stud* 49(7):887–905.

3.2 Mandatory training, development and education

The head of midwifery and senior medical leader are responsible for ensuring all unit staff undertake mandatory training at time intervals determined by the trust. Training and development must be linked to annual individual appraisals and development plans, and must be provided within the team's available resources. Training needs analysis should be undertaken at least annually to ensure all staff have equal access to training opportunities and that the unit has adequate numbers of appropriately trained staff.

All maternity support workers should be effectively trained and have appropriate skills.

The clinical manager should be aware of development opportunities outside formal education. Learning is effective both on and off the job, such as through network study days, shadowing opportunities, e-learning and simulation. Choose the most effective and efficient method.

All clinical team members must be appropriately trained to be effective in their roles. The senior midwife is responsible for assessing individual midwifery team members' training requirements, then prioritising and developing a plan to meet them using available resources. For members of the wider multiprofessional team, this responsibility lies with the appropriate senior clinical manager.

In addition, consider:

Benchmarking peer review

Dashboards enable commissioners and maternity clinical networks to review individual trusts' care quality, and a direct benchmark for care quality against staffing levels ([Advocating for Education and Quality Improvement - A-EQUIP](#)).

Peer comparisons can act as a platform for further enquiry.

Shift pattern

The type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These should be monitored to understand the effect on staff and women.

Multiprofessional working

Thinking about how services can be designed for the future, and talking and listening to staff, can enable organisations to develop flexible, effective models that are more likely to be sustainable.

Changes to roles and responsibilities of specific professional and support staff are likely to affect workforce requirements for the wider multiprofessional team – for example, maternity support workers undertaking additional postnatal responsibilities such as newborn blood spot screening.

Skill mix

Decision-makers should consider the skill mix necessary to make maternity services as safe, efficient and effective as possible. It should form an integral part of providers' operational planning processes. Clinical leaders and managers should be trained to make effective decisions on staffing and establishments to sustain high quality. This should include recognising the intended and unintended consequences of changing the skill mix.

Registered professionals require periodic revalidation. Although individual midwives and nurses are responsible for ensuring they revalidate, many organisations have adopted a partnership approach.

4. Right place, right time

Staff should be deployed in ways that sustainably ensure mothers and babies receive the right care first time and in the right setting. This will include effective planning, management and rostering, with clear escalation policies if concerns arise.

Board responsibilities

The [Carter report](#) and the Five Year Forward View's triple aim require boards to ensure productive working, eliminate waste and reduce variation. This applies to staffing maternity services too. Boards should ensure they are able to deploy and alter the maternity workforce to safely meet the demands of the service. Boards must be accountable for ensuring their staff are deployed so that women receive the right care first time and in the right place.

This includes having clear escalation and contingency plans and policies, a sufficiently flexible workforce to meet demand, and clear guidance on and monitoring of the use of bank and agency staff. We recommend e-rostering to help deploy staff to match acuity and demand.

Strategic staffing assessments, aligned to operational planning processes, give boards a clear short-term view of the likely temporary requirements as well as a view of the support roles their organisation should develop.

Organisations' workforce plans must align with STP requirements and the local maternity system. They should be multi-year plans built around the local population's needs, and developed with HEE and commissioners of maternity services.

Boards must be accountable for ensuring that their organisations' measurement and governance systems focus on accurately capturing care outcomes, and a culture in which staff investigate and learn from both excellent and poor care delivery.

For the board, these systems must be able to analyse patient outcomes, people productivity and financial sustainability. The governance systems must be able to

report, investigate and act on incidents (including red flags), and include feedback from women and staff.

Operational responsibilities

Better births advocates continuity of carer, choice of place and type of birth, and increased perinatal mental health provision and postnatal care, to name but a few of the recommendations. To develop in line with *Better births*, maternity services should plan to provide what women want while ensuring that teams do not suffer 'burnout'. All professionals and women should have a say in how to implement plans efficiently, effectively and successfully.

Reviewing non-value adding activity should be part of the strategic staffing review. Technology can be used to improve information and advice for families, such as using Skype clinics for postnatal and feeding advice.

Community professionals' time could be streamlined; for example, postnatal care in multiple local hubs could decrease travel time for staff and minimise disruption for mothers (but postnatal home visits do need to be maintained as women with greatest need may not feel able to get out of the house).

4.1 Efficient rostering, flexibility and responsiveness

Where the day-to-day workload is unpredictable, a maternity service should consider electronic rostering of staff and flexible self-rostering.

Most organisations have minimum core staffing establishments. However, they should have flexible arrangements for redeploying staff and escalation processes to address unexpected workload without resorting to using an agency.

Staff of all disciplines should be encouraged to escalate staffing concerns, and organisations should seek their views on how to do this.

Flexible working

Flexible working within and between maternity settings is essential to meet women's and babies' care needs. Flexible working may help retain staff. This needs to be balanced with service requirements and the job satisfaction of staff who do have flexible working and are rostered opposite those who do. Organisations can offer this in different ways:

- part-time working
- compressed hours
- job share
- self-rostering/range of shift patterns
- flexitime/twilight shifts
- annualised hours
- term-time contracts
- flexible retirement schemes.

Follow [NHS Employers' guidance](#) when developing opportunities for flexible working.

4.2 Minimising agency staffing

Temporary staff can be a valuable and valued part of the workforce and a useful contingency for covering anticipated and unanticipated staff shortages. However, relying on high levels of agency staff is unlikely to represent an effective or sustainable solution to having the right staff with the right skills in the right place at the right time. Continuity of care during and following pregnancy is more difficult if an organisation relies on temporary midwives.

If a lack of regular staff forces consideration of the use of agency staff, this recruitment should be made from in-house staffing banks. Only if this is impossible should a framework agency be approached.²⁰

All temporary staff should receive local training and induction so they are familiar with how the organisation works.

²⁰ www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

5. Measure and improve

5.1 Measure patient outcomes, people productivity and financial sustainability

Trusts should collect data clinical area and organisation-level data to monitor how staffing levels affect quality of patient care and outcomes, the use of resources and staff themselves. The aim is to continuously improve patient outcomes and the efficient and effective use of resources in a culture of engagement and learning. In maternity care this data is presented through a local maternity dashboard.

The dashboard should include safe and sustainable staffing data to support decision-making and to inform assurance. Maintaining and reviewing the maternity dashboard indicates where workload is high – for example, induction of labour rates, caesarean section rates, monthly bookings.

It is necessary to review the dashboard monthly and to take account of the budgeted establishment and expenditure to date, including temporary staffing. Interpreting all metrics against activity and outcome data is essential and should be monitored at a unit level. Learning lessons to improve the quality and safety of women's and babies' care is a prime function of the dashboard review – see [RCOG guidance](#) and an [example dashboard](#).

Care hours per patient day (CHPPD) data is collected from midwifery-led units and obstetrics (areas with inpatient beds). This is another source of information available to organisations and service managers that can be used to help cross-check staffing information and to inform decisions.

5.2 Report, investigate and act on incidents

NHS providers should follow best practice guidance in investigating all patient safety incidents and perinatal and maternity deaths. This includes root cause analysis,

examining human factors in serious incidents and learning from incidents. Women, families and carers should be involved in every stage of an investigation. Providers should consider any identified staff capacity and capability issues and act accordingly.

Staff should be actively encouraged to report any occasions where a less than optimal level of staffing seems likely to, or has resulted in, harm to a patient (CQC 2015).

All staff should be made aware they have a professional duty to put the interests of women first and must act to protect them if they consider they may be at risk (NMC 2015). For a ward-to-board approach, this includes incident reporting when staffing levels are less than optimal.

Incident and quality report findings with all feedback and learning from incidents and mortality reviews should be acted on.²¹

Staffing gaps may be identified and notified to organisations from any of the following:

- CQC reviews
- feedback from other regulators
- HEE quality visits
- NHS Improvement diagnostic reviews
- specialised commissioning visit reports
- peer review process.

If these methods identify any shortfalls, action plans must be produced to identify how they will be addressed to maintain safety.

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

In addition, NICE guideline NG4 (2015) outlines midwifery red flag events that warn 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. They should determine whether midwifery staffing is the cause and what action is needed (see [Appendix 1](#)).

Organisations should have a protocol for frontline staff to escalate to a senior level concerns about the safety and effectiveness of care.

5.3 Patient, carer and staff feedback

The views of women, their families and staff provide vital insight into staffing capacity, capability and morale. Findings from incidents should be considered alongside feedback so the nature and causes of any issues can be rapidly identified and acted on.

This feedback can be gained in various ways, such as:

- complaints and compliments
- user stories
- local surveys
- Friends and Family Test
- maternity services liaison committee and maternity voice partnerships
- focus groups
- doulas.

Staff themselves can provide vital feedback on the working environment. This can be collected in various ways:

- staff satisfaction surveys
- General Medical Council trainee feedback/undergraduate student feedback
- exit interviews
- recruitment and retention statistics
- vacancy rates
- sickness and absence levels.

Any areas of concern highlighted by women, their families or staff using any of these methods must be carefully scrutinised.

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7. Supporting material

There is a wealth of information, guidance and recommendations for maternity staffing encompassing all the professions which contribute to the care of women throughout the continuum of pregnancy, childbirth and beyond, including those referenced in this improvement resource. This list of guidance and supporting material is not exhaustive but is wide ranging.

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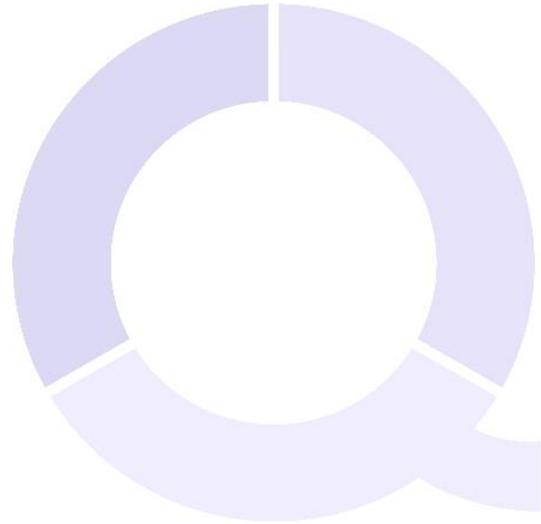
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