

National Quality Board



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Safe, sustainable and productive staffing

**An improvement resource for
maternity: Appendices**

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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Appendix 1: NICE red flags¹ – 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.

- delayed or cancelled time-critical activity
- missed or delayed care (eg delay of 60 minutes or more in washing and suturing)
- missed medication during an admission to hospital or midwifery-led unit (eg 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 two hours or more between admission for induction and start of the process
- delayed recognition of and action on abnormal vital signs (eg sepsis or urine output)
- any occasion when one midwife is unable to provide continuous one-to-one care
- support to a woman during established labour.

Other midwifery red flags may be agreed locally.

¹ NICE (2016) [Organisational requirements for safe midwifery staffing for maternity settings](#)

Appendix 2: Ultrasound examinations in pregnancy

Developed by a member of the maternity improvement resource sub-group.

Measure and improve

- patient outcomes, people productivity and financial sustainability -
- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -

Need to be compliant with: NHS Fetal Abnormality Screening Programme (FASP) 2015 Society of Radiographers (SoR) and NICE guidance

Ultrasounds in pregnancy fall into the following categories:

1. early pregnancy before first scan
2. fetal abnormality scan for chromosomal abnormality 11w2d-14w1d
3. fetal anomaly screening programme scan 18w-20w6d
4. growth/surveillance scans from 21w onwards
5. cervical length assessment
6. Doppler evaluation of fetal and maternal blood vessels to evaluate flow
7. to guide invasive procedures such as amniocentesis and chorionic villus sampling
8. to provide specific information, eg placental location, fetal presentation and amniotic fluid volume
9. to provide evaluation of maternal conditions, eg ovarian cysts, DVT, renal pathology, obstetric cholestasis.

Right staff

Ultrasound practitioners (there is a recognised national shortage of 10-15% and a Health Education England working group is looking at solutions):

1. AHPs (70% of all examinations)
2. medical staff
3. sonographers
4. midwives
5. lead sonographers and deputy to oversee screening programme and ongoing education programme
6. engaging department assistants for the efficient working and provision of chaperone
7. advanced health practitioners to specialise in pregnancy-related problems
8. postnatal care requires neonatal/paediatric radiography/ultrasound/CT/MRI; this may also involve specialist AHPs

Right skills

FASP in service recommends any person undertaking a fetal anomaly scan on a pregnant woman for screening/diagnosis has a minimum of one of the following:

1. certificate/diploma in medical ultrasound of the College of Radiographers and evidence of continuous professional development (CPD)
2. postgraduate certificate in medical ultrasound approved and validated by a higher education institute and accredited by the Consortium for the Accreditation of Sonography Education. The qualification must be relevant to obstetric practice
3. Royal College of Obstetricians and Gynaecologists, Royal College of Radiologists diploma in obstetric ultrasound of advanced skills training modules (ASTM)

NB to undertake FASP screening all need complete assessment to have a DQASS number.

Right place and time

Imaging services need to allow time in their appointment schedules for the following in addition to applying the probe:

1. room preparation
2. assess the request/referral
3. explanation of examination/procedure
4. post-procedure explanation
5. cleansing of equipment
6. time for complex scans
7. time for procedure in line with FASP minimum 11w 1d 20min, 18w-20w 6d 30-45min
8. time to train
9. time to audit
10. time to document

Appendix 3: Physiotherapy in pregnancy and postnatally

Developed by a member of the maternity improvement resource sub-group.

Follow recommendations of:

NICE (2013): Urinary incontinence in women (CG171):

- offer pelvic floor muscle training to women in their first pregnancy as a preventive strategy for urinary incontinence (UI)
- offer a trial of supervised pelvic floor muscle training of at least three months' duration as first-line treatment to women with stress or mixed UI
- undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training for the treatment of UI.

Vleeming et al (2008): European guidelines for the diagnosis and treatment of pelvic girdle pain:

- individualized exercises in pregnancy
- stabilising exercises for control and stability, as part of a multifactorial treatment postpartum.

van Bente et al (2014): Recommendations for physical therapists on the treatment of lumbopelvic pain in pregnancy: a systematic review:

- evidence-based recommendations can be made for the use of exercise therapy in the treatment of lumbopelvic pain during pregnancy.

Royal College of Midwives and Chartered Society of Physiotherapy (2013): Joint statement on pelvic floor muscle exercise:

- evidence-based information and advice for all pregnant women
- clear standards and referral pathway to specialist physiotherapist
- appropriate education and access to resources for midwives.

<u>Right staff</u>	<u>Right skills</u>	<u>Right place and time</u>
<p>Specialist physiotherapists. NB:</p> <ol style="list-style-type: none"> 1. there is a recognised national shortage of specialists in the UK 2. recruitment to specialist pelvic floor physiotherapy is a continuing problem 3. undergraduate training is minimal and geographically patchy with some universities not covering the subject at all 4. rotational posts for newly qualified physiotherapists to gain experience in the subject can also be poor 5. funding for specialist posts is poor in some areas with specialist physiotherapy not being seen as a priority for some CCGs despite NICE guidelines 	<p>For specialist physiotherapists:</p> <ol style="list-style-type: none"> 1. appropriate postgraduate training at Masters level is preferred 2. attendance at a recognised short course such as those offered by pelvic, obstetric and gynaecological physiotherapy (POGP) 3. peer training and support from experienced senior staff 4. continuing professional development (CPD). <p>For student midwives and midwives:</p> <ol style="list-style-type: none"> 1. appropriate undergraduate education and CPD (eg pelvic floor muscle exercises, pregnancy-related musculoskeletal dysfunctions) delivered by the appropriately skilled staff such as specialist physiotherapists. 	<p>Routine advice, eg pelvic floor muscle exercises:</p> <ol style="list-style-type: none"> 1. routine booking or antenatal appointment 2. antenatal class. <p>Specialist services for symptomatic women or those requiring extra advice/assessment/treatment:</p> <p><u>Right place</u></p> <ol style="list-style-type: none"> 1. private room 2. access to equipment as required 3. convenient location for service users. <p><u>Right time</u></p> <ol style="list-style-type: none"> 1. efficient referral pathway

<p>6. funding for training is not easily available.</p> <p>Suitably skilled midwives</p>	<p>2. access to appropriate resources 3. CPD.</p> <p>Interprofessional collaboration – midwives, obstetricians, specialist physiotherapists</p>	<p>2. no or minimal waiting list 3. convenient appointment times 4. sufficient length of appointment 5. timely follow-up appointments if required.</p>
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Appendix 4: Safe midwifery staffing indicators

Indicators are positive and negative events that should be reviewed when reviewing the midwifery staffing establishment, and should be agreed locally.

Outcome measures reported by women in maternity services

- Data for the following indicators can be collected using the [Maternity Services Survey](#):
 - adequacy of communication with the midwifery team
 - adequacy of meeting the mother's needs during labour and birth
 - adequacy of meeting the mother's needs for breastfeeding support
 - adequacy of meeting the mother's postnatal needs (postnatal depression and post-traumatic stress disorder) and being seen during the postnatal period by the midwifery team.

Outcome measures

- Booking appointment within 13 weeks of pregnancy (or sooner): record whether booking appointments take place within 13 weeks of pregnancy (or sooner). If the appointment is after 13 weeks of pregnancy the reason should also be recorded, in accordance with the [Maternity Services Data Set](#).
- Breastfeeding: local rates of breastfeeding initiation can be collected using NHS England's [maternity and breastfeeding data return](#).
- Antenatal and postnatal admissions and readmissions within 28 days: record antenatal and postnatal admission and readmission details including discharge date. Data can be collected from the [Maternity Services Data Set](#).
- Incidence of genital tract trauma during the labour and delivery episode, including tears and episiotomy. Data can be collected from the [Maternity Services Data Set](#).

- Birth place of choice: record of birth setting on site code of intended place of delivery, planned versus actual. Data can be collected from the [Maternity Services Data Set](#).

Staff-reported measures

- Missed breaks: record the proportion of expected breaks that were unable to be taken by midwifery staff.
- Midwife overtime work: record the proportion of midwifery staff working extra hours (both paid and unpaid).
- Midwifery sickness: record the proportion of midwifery staff's unplanned absence.
- Staff morale: record the proportion of midwifery staff's job satisfaction. Data can be collected using the [NHS staff survey](#).

Midwifery staff establishment measures

Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint [guidance to NHS trusts on the delivery of the 'Hard Truths' commitments](#) on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

- Planned, required and available midwifery staff for each shift: record the total midwife hours for each shift that were planned in advance, were deemed to be required on the day of the shift, and that were actually available.
- The number of women in established labour and the number of midwifery staff available over a specified period, eg 24 hours.
- High levels and/or ongoing reliance on temporary midwifery staff: record the proportion of midwifery hours provided by bank and agency midwifery staff on maternity wards. (The agreed acceptable levels should be established locally.)
- Compliance with any mandatory training in accordance with local policy (this is an indicator of the adequacy of the size of the midwifery staff establishment).

Note: other safe midwifery staffing indicators may be agreed locally.

Appendix 5: Generic statement on care of people with learning disabilities

All healthcare providers must strategically plan for an interdisciplinary workforce that is able to meet the often complex needs of people with learning disabilities. It is a legal requirement that reasonable adjustments are made to ensure that people with learning disabilities have equal opportunities for their health needs to be met ([Equality Act 2010](#)). People with learning disabilities are more likely to have undiagnosed or wrongly diagnosed health needs and die prematurely from preventable causes ([Healthcare for all 2008](#), CIPOLD 2013).

Meeting these requirements in terms of safe and sustainable staffing includes: ensuring that within the staffing establishment sufficient numbers of specialist staff are available:

- providing regular training to the wider workforce to ensure that they are able to identify people who may present with learning disabilities, autism or other complex communication needs
- embracing flexibility in the way care is delivered allowing enough time and support to enable quality outcomes
- ensuring all staff are aware of their duties under the [Mental Capacity Act \(2005\)](#) and the need to work in partnership with the individual, their families, carers and other multi-agency professionals
- having workforce plans with the capacity to ensure that everyone's right to receive appropriate healthcare is realised
- appropriate liaison with community multidisciplinary teams if reasonable adjustments are not sufficient to ensure equality of healthcare.

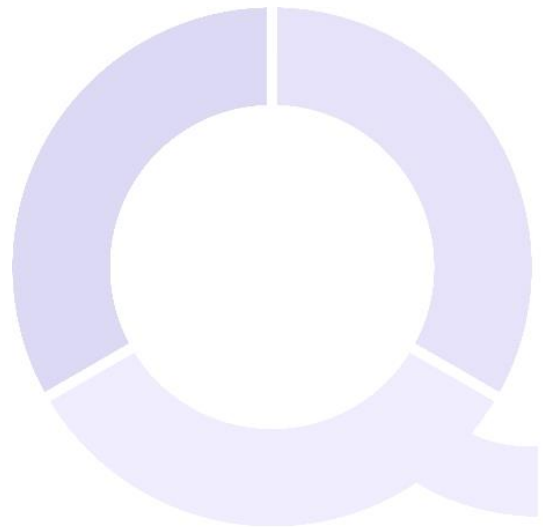
Appendix 6: Professional judgement principles

Staffing decisions based solely on professional judgement – the expert opinion of clinical staff – are considered subjective and may not be transparent. Professional judgement and scrutiny should however be used to interpret the results from evidence-based tools, taking into account the local context and patient care needs. This element of a triangulated approach is key to bringing the outcomes from evidence-based tools and comparisons with peers together in a meaningful way.

Professional judgment and knowledge should also inform the skill mix of staff and will be used at all levels to inform real-time decisions about staffing that are taken to reflect changes in case mix, acuity/dependency and activity. The skill mix between registered and non-registered care staff reflects the likely workload and skills and competencies required to care for patients locally.

Consideration should be given to the following principles of professional judgement:

- the contextual factors in reaching a decision (eg competence, experience, staff known to the patient, familiarity with the team, activities and environment, etc)
- it is suitable for use in all specialties
- it is based on the subjective and objective judgement of the lead midwife for their particular area
- registered professionals are accountable and responsible for their decisions and actions including legal and ethical considerations
- it takes account of actual workload during specific period of time
- it is inclusive of all activity, eg planned and unplanned workload, ward attenders and ad hoc activity
- it informs decisions on required numbers
- numbers and skill mix judgements are validated when agreement is reached between lead nurse and manager.



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