

Maternity Workforce Strategy – Transforming the Maternity Workforce

Phase 1: Delivering the Five Year Forward View
for Maternity

Report



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The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement**
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC).

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

**NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.



Foreword by Professor Ian Cumming OBE and Sarah-Jane Marsh

[Better Births, the Five Year Forward View for Maternity Care](#) was built on two fundamental principles: the importance of women being able to make choices about their care and the safety of the mother and baby being paramount. It set out a vision for a modern maternity service that delivers safer, more personalised care for women and babies, improved outcomes, and reduced inequalities.

The NHS England-led Maternity Transformation Programme brought together a wide range of organisations to lead delivery of this vision across nine work streams. HEE has been leading work to transform the workforce (Workstream 5) and is supporting many other areas of the programme.

This strategy is built on a wholesale analysis of workforce information and aims to ensure that there are sufficient numbers of staff in maternity services – both now and in the future. As well as setting out the vision set out in **Better Births**, this strategy also supports the delivery of the Government's ambition for reducing the rate of stillbirths and neonatal and maternal deaths in England.

Midwives, neonatal nurses, doctors (particularly obstetricians and gynaecologists), support workers and sonographers represent the core clinical workforce, but we recognise that there are many other workforces that provide support in and to maternity services.

Some of the measures described in this strategy are aimed at optimising capacity and many are already underway. These include increasing midwifery training placements, expanding capacity to deliver third trimester ultrasound, reducing attrition within the obstetrician and gynaecology consultant training pathway, producing a competency, education and career framework for maternity support workers and developing tools to support workforce planning locally.

Equally important is the drive to improve maternity safety. We recognise that this needs to be underpinned by a cultural shift, but we believe that this can be achieved by creating strong leadership at every level of maternity systems, focussing on learning and sharing good practice, and improved multi-professional team working.

Within this strategy, our primary focus has been to identify the key actions to increase capacity by 2021. HEE will continue to work with its partners to develop a longer-term strategy to ensure we have enough people, with the right skills in the right place, to allow our maternity services to continue to evolve to meet the needs of mothers and babies.



Professor Ian Cumming OBE,
Chief Executive, Health Education England



In every part of England, across midwifery clinics, antenatal hubs, birth centres, labour wards, and postnatal visits in our own homes - NHS midwives, doctors and other healthcare professionals are helping women and their families through the journey of pregnancy, birth and the first weeks of life. They are truly amazing people, doing all they can, working long hours and going the extra mile, for those in their care. They witness some of the most special and terrifying moments imaginable, and make the difference between good and bad experiences, sometimes even life and death. We are eternally thankful for their skill and compassion.

In return for this expertise and dedication, we must do more as NHS leaders, managers and planners to give everyone working in maternity services the support and resources they require to deliver high quality care to every woman and family, every time. This is becoming increasingly urgent, as whilst having a baby in England has never been safer, we know there is much more to do to ensure, not only the quantity of maternity workforce, but also the quality and skill mix that we need to make our services more personalised and consistently safe, as the vision in [Better Births](#) so clearly set out for us.

This strategy seeks to provide the support that our staff so desperately need, by commissioning the supply of workforce required, and helping to facilitate teams to work differently and more flexibly in an environment that enables learning and progression. It is only the start of what is needed, as Local Maternity Systems continue to evolve their models of maternity provision, but it is still a major leap forward, and I would like to pay tribute to the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists for the partnership role they have played in getting us to this stage.

Health Education England will develop an accompanying action plan that takes us to 2021, and undertake a longer term strategic review, so we can consider beyond this milestone. I look forward to continuing to work together as we strive to ensure that every maternity service in the country is served by well resourced, high performing teams, with women and babies at their heart.



Sarah-Jane Marsh
Chief Executive, Birmingham Women's and Children's NHS Foundation Trust
Chair of the Maternity Transformation Programme Board, NHS England

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1 The Service Vision: Better Births

The **NHS Five Year Forward View (FYFV)**¹ was published in October 2014, and sets out a new, shared vision for the future of the NHS based around the new models of care. It laid out the decisive steps the NHS will take to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, and between health and social care. It stated four aims:

- **Improving the health of populations**
- **Enhancing the patient experience of care**
- **Reducing the per capita cost of healthcare**
- **Improving the experience of providing care** (including improving the working life of healthcare providers, including clinicians and staff).

In March 2015, Simon Stevens, Chief Executive of NHS England announced a major review of maternity services as part of the FYFV. Baroness Julia Cumberlege was asked to independently lead the review, working with a panel of experts and representative bodies. The scope of the review was to assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies. The resulting report, **Better Births**, was published in February 2016.²

The review found that despite the increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services had improved significantly over the previous decade, thanks to the hard work and dedication of midwives, doctors and other health professionals. However, the review also found meaningful differences across the country, with further opportunities available to improve the safety of care and reduce stillbirths.

“Our 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.”

Better Births: A Five Year Forward View for Maternity Services, 2016.

¹ NHS England et al (2014).

² National Maternity Review (2016).



The review called for care to become safer and more personalised. Importantly, the review recognised, right at the top of its vision statement, the importance of the workforce, and the importance of supporting and nurturing the workforce.

Better Births made the case for the following:

1. **Personalised care** - centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
2. **Continuity of carer** - to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
3. **Safer care** - with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
4. **Better postnatal and perinatal mental health care** - to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
5. **Multi-professional working** - breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
6. **Working across boundaries** - to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
7. **A payment system** - that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

In November 2015, the Government announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England.³ The report published, **Spotlight on Maternity**,⁴ set out five drivers for delivering safer maternity care:

- **Focus on leadership:** creating strong leadership for maternity systems at every level.
- **Focus on learning and best practice:** identifying and sharing best practice, including learning from investigations.
- **Focus on teams:** prioritising and investing in the capability and skills of the maternity workforce and promoting effective multi-professional team working.

³ See: <https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths>

⁴ NHS England (2016).



- **Focus on data:** improving data collection and linkages between maternity and other clinical data sets, to enable benchmarking and drive a continuous focus on prevention and quality.
- **Focus on innovation:** creating space for accelerated improvement and innovation at local level.

Subsequent work has been conducted through the Maternity Transformation Programme Board, which is chaired by Sarah-Jane Marsh, the chief executive of Birmingham Women's and Children's NHS Foundation Trust. This is a multi-organisational programme, which has brought together Health Education England (HEE) with NHS England, the Department of Health and Social Care (DHSC), NHS Improvement (NHSI), Public Health England (PHE), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and other organisations.

The programme has overarching themes of safety and personalisation and is built around nine national work streams in support of 44 Local Maternity Systems (LMS). These work streams bring together clinicians and provider organisations, commissioners, and service users across Sustainability and Transformation Partnership (STP) footprints to plan and deliver local maternity care.

At the heart of our work has been a recognition of the high level of commitment, compassion and skill shown by our staff, who are integral to ensuring high quality maternity services. We recognise staff are facing great pressures to continue delivering safe high-quality care within increasingly stretched services, and that covering existing vacancies and other absences adds to these pressures. Whilst this strategy aims to reduce these pressures and allow us to grow the workforce, for services to continue meeting needs of mothers and babies in the future, we ask of midwives, doctors and other health professionals involved in providing maternity care two things:

We need you to help us make care more personalised around the needs of women, their babies and their families. This will include implementation of continuity of carer – a key recommendation of Better Births – which will involve changes to the way in which some midwives work.

We need you to work and learn together more closely, breaking down barriers between professions and between organisations, to build a learning culture which can ensure care is provided safely and seamlessly around the needs of women, their babies and their families.

We know these changes will not always be easy, and the purpose of this strategy is to support you to do that, whilst ensuring that there is sufficient capacity in the workforce nationally.

To support the vision as outlined above, we know transformation of the workforce will be essential in initiating the changes required to deliver more personalised and safer care.



“We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it”

NHS England, Five Year Forward View, 2014

We appreciate understanding the number and shape of maternity services is challenging, given the needs of women, their babies and their families and our capability to respond are all subject to fast and potentially radical change. It takes typically three to four years to train a midwife, and up to 15 years to train a consultant in obstetrics and gynaecology, during which time, maternity needs may change considerably. For example, since 2009, the number of babies born to teenage mothers has nearly halved, while numbers of babies born to mothers aged over 40 has increased by 10%.⁵

In 2016, the Office of National Statistics (ONS) recorded that there were just over 663,000 births in England.⁶ Overall, we consider that the need for maternity services is likely to remain high and potentially grow, because:

- **The number of births is expected to remain high:**
 - Using 2014 ONS projections, the number of births is expected to be 3% higher in 2020 compared to 2016
 - Using 2016 ONS projections, the number of births is expected to remain at around 660,000 births in 2020⁷



⁵ ONS (2017a).

⁶ ONS (2017a).

⁷ ONS (2017b); ONS (2017c).



- **Women are giving birth later in life:**

- The average age of mothers in England and Wales increased from 27 in 1984 to 30 in 2014.
- The number of births of mothers over 35 increased from just over 139,000 in 2011 to just under 149,000 in 2016.⁸

- **The number of birth complications is increasing** – from just over 237,000 in 2012-13, to just over 336,000 in 2016-17.⁹

- **There is reported historic mismatch between the setting for birth that women say they want and where care is delivered:**

- In 2012, 87% of births took place in an obstetric unit, despite only 25% of women expressing a preference for this setting.¹⁰

HEE will continue to work with partners to carry out more detailed work on forecast levels of need, especially over the longer term. Meanwhile, against the general observation that demand for maternity services is likely to remain high and/or increase, this report sets out actions that can be taken up to 2021 to help alleviate workforce pressures.

The following sections of our strategy consider the current state of play within the key professions and examines where we may be in 2021 all else being equal (i.e. if current trends continue without corrective actions being taken). We then outline possible actions different parties will need to take across the system to secure a net increase in numbers and skills, in order that the system may deliver the vision set out by **Better Births**.

⁸ ONS (2017a).

⁹ NHS Digital (2013); NHS Digital (2017a).

¹⁰ NAO (2013), National Maternity Review (2015).



2 The purpose of this strategy

The purpose of this strategy is to support the multi-organisational Maternity Transformation Programme to deliver the vision for the future of maternity services explained in the first chapter, in particular:

- The vision set out in **Better Births**, the report of the National Maternity Review.
- The ambition of the Secretary of State for Health and Social Care to halve the rate of stillbirth, neonatal death, maternal death and serious intrapartum brain injury by 2030.

It aims to do so by supporting and empowering individual midwives, doctors and other health care professionals and the organisations they work in to deliver that vision, and by ensuring that, overall, the NHS in England has the workforce of the size and skill mix it needs. This reflects the number of recommendations made relating to the maternity workforce, whom **Better Births** recognised needed greater support and empowerment to lead change on the ground in terms of acquiring knowledge and/or skills and in terms of working together to reduce barriers between different professions.

As the lead organisation for the Transforming the Workforce work stream of the national Maternity Transformation Programme, HEE is responsible for developing the Workforce Strategy, working in partnership with other NHS Arm's Length Bodies (ALBs) and Royal Colleges. **Facing the Facts, Shaping the Future** is the draft health and care workforce strategy for England, published in 2018. We have developed this maternity strategy in line with the six principles outlined in **Facing the Facts, Shaping the Future**, which are designed to underpin future workforce decisions:¹¹

- **Securing the supply of staff.**
- **Enabling a flexible and adaptable workforce through our investment in education and training new and current staff.**
- **Providing broad pathways for careers in the NHS.**
- **Widening participation in NHS jobs so that people from all backgrounds can contribute and benefit from public investment in our healthcare.**
- **Ensure the NHS and other employers in the system are inclusive modern model employers.**
- **Ensure that service, financial and workforce planning are intertwined, so that every significant policy has workforce implications thought through and tested.**

¹¹ HEE et al (2018).



These principles have been weaved into the strategy, to ensure we are putting people first and focussing on what works best for the women, babies and families in our care and our staff who support them.

This strategy should be read in conjunction with **Developing People – Improving Care**¹² the national framework, which aims to help NHS and social care staff to develop four critical capabilities in systems leadership; quality improvement; leadership development; and talent management.

Accordingly, this strategy covers the following:

- **The case for change:** the context as set out in the previous chapter, and around **Better Births**.
- **Where we are now:** the overall numbers of our 2016 workforce (as traditionally defined and counted) in maternity services.
- **Where we will be if we take no further action:** we examine 2016 numbers and planned growth to 2021, so that we can see whether the ‘do nothing’ position is likely to result in insufficient staff.
- **How we will ensure delivery:** the implementation and governance arrangements to support implementation of **Better Births** to 2021.
- **What we will do next:** our plans for future change, to develop localised strategies to support **Better Births** and to develop a workforce strategy based on projected activity beyond 2021.

The strategy also reflects some work already undertaken in partnership with both the RCM and the RCOG, specifically:

- Initial work to understand the **size and skill mix of staff involved in delivering maternity services**.
- Follow up work to provide **assessment of demand, identification of gaps between demand and supply, and actions designed to address these gaps up to 2021**.

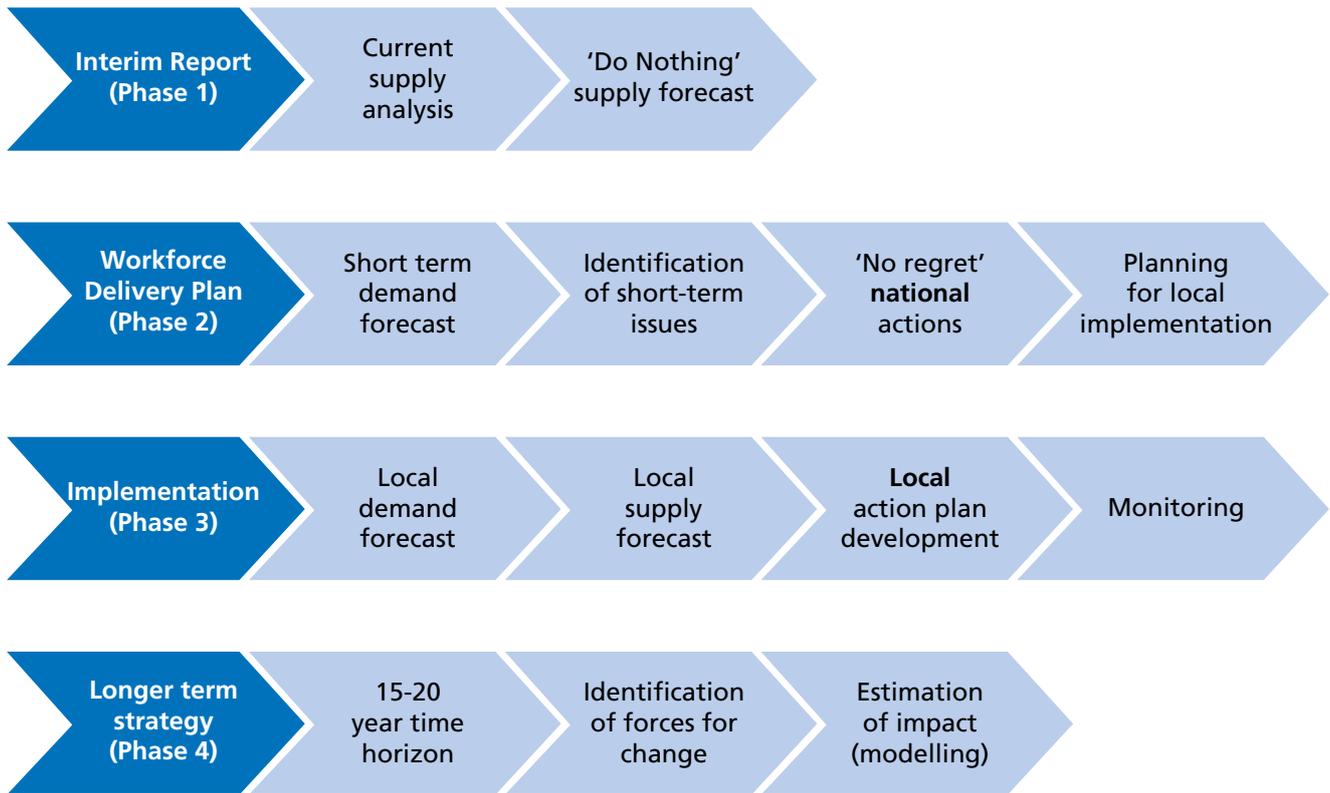
We have designed this strategy to promote local action. Local Workforce Action Boards (LWABs) will lead the development of Local Workforce Action Plans in partnership with local maternity systems.

We will produce localised demand and supply forecasts, and develop local action plans to 2027, as part of the later phases of the work (which will include thinking around how services may need to change over the longer-term).

¹² NHS Improvement (2016).

A summary of how HEE’s work for the Maternity Workforce Strategy (the strategy) links together is provided in **Figure 1 below**. Overall, our intention is that we support maternity services to deliver **Better Births**, and ensure we can respond effectively to emerging issues, both over the short and longer term.

Figure 1 HEE’s Maternity Workforce Transformation Programme





3 Our existing workforce

Our maternity services benefit from the variety of professions and skills required to provide safe and personal care to women within a wide range of settings before, during and after birth. While we can identify the majority of clinical staff who would lead in providing maternity services, we must also acknowledge the contribution of a wide range of workforces who may primarily work in other settings but who nonetheless contribute to providing care to women.

For this reason, we have made a distinction between the core and the wider workforces in line with other areas.

For the purposes of this strategy, we therefore consider primarily the professions that spend a significant proportion of their time on the maternity care pathway:

- **Midwives**
- **Maternity support workers**
- **Obstetricians and gynaecologists**
- **Neonatal nurses**
- **The workforce with competences in sonography** (which includes some AHPs).

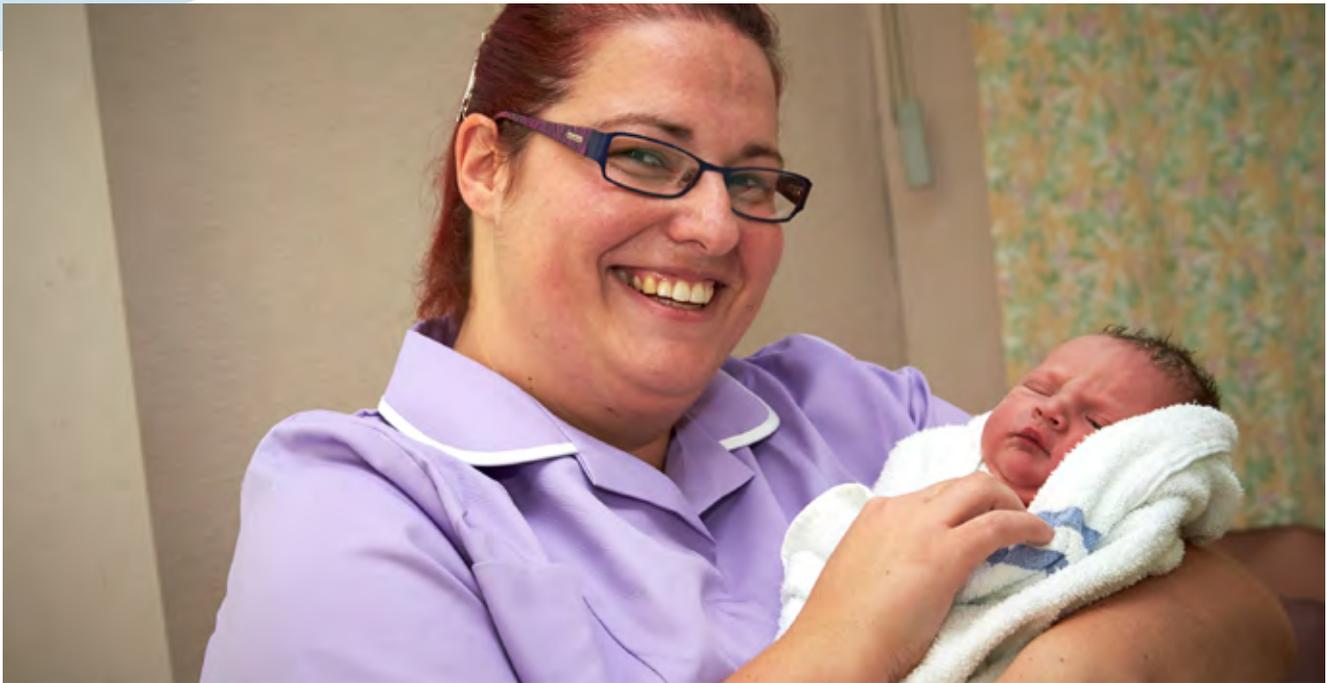
We acknowledge that fact that other professional groups contribute to the maternity care pathway, however we have not included them in analysis and modelling here. This is either through the main part of their role relates to other areas (notably primary care staff) and/or because there is separate work that has been carried out or is underway (notably, those working in neonatal and paediatric care¹³ and in perinatal mental health¹⁴). Workforces in these categories include:

- **Other medical staff who contribute to neonatal and paediatric care** (for example, obstetric anaesthetists, paediatricians and paediatricians specialising in neonatology)
- **Primary care staff, including GPs**
- **Mental health professionals** (who would contribute to perinatal mental health care and provision)
- **Anaesthetists working in obstetrics**
- **Health visitors**
- **Other AHPs.**

We note that skills and knowledge development in many areas of maternity and postnatal services are applicable to these staff groups, and the training resources developed through this strategy should be available to them.

¹³ NHS England, at time of writing, is leading work on **neonatal critical care** through its Neonatal Critical Care Transformation Review. Further work, specifically on the paediatrics workforce, will follow on completion of this project. With the Royal College of Paediatrics and Child Health (RCPCH), we will look to reconcile service and workforce demand models as we develop a separate strategy for paediatrics.

¹⁴ Staff working in **perinatal mental health** are explicitly covered within HEE's Stepping Forward to 2020/21: the Mental Health Workforce Plan, which was published in July 2017. For this reason, we have not repeated a similar analysis. The Mental Health Workforce Plan can be found at the following link: <https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf>



We also acknowledge that many staff who support women in childbirth provide a range of other functions, and that a significant proportion of their time may lie elsewhere. Indeed, a focus on key professional principal workforces must also support complementary work to ensure that we understand the full capacity required in maternity services to deliver **Better Births**. Work is ongoing to understand how our approach could be adapted further in future, to take into account more fully the maternity care pathway.

We also appreciate explicitly that the maternity workforce depends on the support of other colleagues working in health and social care, including medical, clinical and administrative staff. For example, without sufficient paediatricians, opportunities to prevent, diagnose and provide after care for babies may be missed. Without sufficient administrative and technical support, maternity staff may find it harder to do their jobs effectively. While it is impossible to focus on every applicable profession, we recognise and value the wider range of staff delivering maternity services, which will increase as new roles (for example, neonatal practitioners, physician associates) come on board.

The NHS Five Year Forward View (FYFV) states that employers are responsible for ensuring they have sufficient staff with the right skills to provide safe and personalised care. Supported by HEE, this strategy aims to address immediate gaps in key areas, through putting in place new measures to support employers to retain and develop their existing staff, increase productivity and have the most appropriate employment arrangements to enable staff to work across organisational and sector boundaries. HEE will continue to work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new model of care, including the development of transitional plans. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver the new model of care. It will also require awareness of the impact of changes to service delivery, so that any additional demands on staff are mitigated adequately.



Related to the above, we acknowledge that geographic location can be a factor in employment, especially in less densely populated rural communities. Challenges for the rural workforce include recruitment and retention, succession planning, opportunities for career progression, obtaining and maintaining skills and knowledge, as well as the safety of women, maternal outcomes, as well as the financial sustainability of units. We therefore need to reflect on how services in these settings can be delivered to ensure the best possible service to mothers and babies, while ensuring staff can be recruited and retained in these areas. For this reason, we propose to undertake a joint piece of work with system partners to better understand any variation that may exist, and any actions we need to manage this variation (which may include actions to support the opportunities offered by smaller units, including delivery of a wide range of services with a high level of personal responsibility).

Since it takes time to train skilled staff (for example, up to 15 years to train a consultant), maternity needs may change considerably over that period. We also need to consider how we can alter the way in which we plan and train our workforce. HEE is therefore working with statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever women require it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and Shape of Caring Review for the Nursing professions, so that we can future 'proof' the NHS against the challenges to come.

4 Priority areas for action in the short-term to 2021

The vision

HEE has developed this strategy for the delivery of **Better Births** working in partnership with other ALBs and Royal Colleges to deliver the full suite of recommendations. As part of this, HEE is developing a delivery partnership with ALBs and other NHS partners, so that the responsibility for delivering high quality maternity services rests with the whole system.

At its heart, the NHS in England is where people who require care meet those entrusted to deliver it. Implementing the vision set out in **Better Births** will require changes to the composition and deployment of the staff providing maternity care in England. A transformed maternity workforce will improve the quality of service users' experience and outcomes, especially for women with high levels of acuity, such as those with pre-existing medical conditions. It will also support the fourth aim of the FYFV, by improving the working lives of maternity staff.

Previous initiatives

Since the 2016 publication of **Better Births**, HEE has proactively supported the maternity workforce through initiatives including:

- **Increasing midwifery training placements**, with the Secretary of State announcing in March 2018 that we will expand training placement numbers by 25% over four years, with the first



650 places from 2019/20 and up to 1,000 places for a period of three years thereafter. This follows an expansion of the midwifery workforce by at least 7% between 2012 and 2017.¹⁵

- **Expanding the number of trained healthcare professionals capable of providing third trimester obstetric ultrasound services by 200 by mid-2018.** Funding has been provided to support course fees and associated education and training support costs, and the offer has been made available to any relevant healthcare professional who will undertake third trimester scanning within their role.
- **HEE's RePAIR (Reducing Pre-registration Attrition and Improving Retention) programme,** which continues to work with partners to improve retention of trainees, with the objective of reducing avoidable attrition from nursing and midwifery training programmes by one third.¹⁶
- **Leading on making multi-professional training a standard part of professionals' continuing professional development (CPD),** both in routine situations and in emergencies through encouraging appropriate changes to curricula, new systems of midwifery supervision such as A-EQUIP, and HEE's Maternity Safety Training Fund programme, which has distributed over £8.1 million across all NHS trusts to improve the safety of maternity services.

All these initiatives have started the process of implementing **Better Births**. However, we know further initiatives will be necessary to complete this process.

Looking forward

We know that just training more staff will not be sufficient to meet current imbalances between demand and forecast supply in 2021. It takes three to four years to train a nurse or midwife, nine years to train a Speciality Doctor and up to 15 years to train a medical consultant.¹⁷ Further action is therefore required to improve the sustainability of maternity services and support the delivery of the workforce necessary for safer and personal maternity care.

Between now and 2021, increasing numbers working in maternity services will depend on:

- **Attracting and retaining those already in the training pipelines,** including pre-registration courses in midwifery, specialty training for obstetrics and gynaecology, and more recently sonography. Actions in this area may require new funding arrangements, as well as greater support of alternative routes (e.g. post-registration nursing, masters degrees, schemes to upskill maternity support workers for midwifery).
- **Retaining experienced and skilled staff working in or qualified to work in maternity services:** this will be achieved through improved improving deployment, time to care and return to practice, and encouraging everyone who is skilled to work in maternity services – midwives, maternity support workers, doctors in obstetrics and gynaecology, and sonographers – to be able to work at the highest level of their ability. This also requires

¹⁵ HEE et al (2018: 28).

¹⁶ For more information, see HEE (2015).

¹⁷ It is worth noting that numbers of nurses, midwives and allied health professionals are no longer commissioned by the NHS, following changes in funding arrangements through the 2015 Comprehensive Spending Review, which lifted existing caps on places.



closer working with employers and other bodies to recognise increasing trends for part-time and more flexible working arrangements, and where possible ensuring that we support and enable our staff to maintain their contribution to maternity services.

- **Supporting employers to upskill and develop their workforces to work with the Better Births care model, for example through new roles and new ways of working.**

Addressing these challenges requires concerted effort and collaboration, which this strategy aims to coordinate.

In addition to high-level enabling actions for bodies at a national level, local maternity system networks and Local Workforce Action Boards (LWABs) will need to consider the local implementation challenges and priorities for maternity services and work together to ensure delivery of their local workforce plans.

We acknowledge upfront the following steps are required to achieve this at local level:

- **Development of tools to assist geographies with local workforce analysis, workforce modelling and development of local workforce action plans:** This will allow baselines to be established and ensure local workforce plans deliver required numbers through appropriate workforce interventions (for example, upskilling the workforce, new roles and new ways of working). It will also ensure local maternity systems have access to the workforce planning skills to develop strategies that are tailored to both local models and patterns of service provision and national priorities and outcomes.
- Geographic location, particularly rural settings which are more likely to have smaller units, impacts on service delivery including difficulties in recruitment, limited exposure to complex cases and limited opportunities for career progression. Conversely, the educational opportunities afforded by smaller units, particularly in delivering a wide range of interventions with a high personal level of responsibility, may not be fully recognised and appreciated. For this reason, **a joint review will take place to better understand this variation, and identify any actions required to manage this variation.** This should include support for smaller units and stronger links with larger units.

Finally, we have considered below the following workforces, who are core to maternity services through the primary function of their role:

- [Midwives](#)
- [Maternity support workers](#)
- [Neonatal nurses](#)
- [Medical staff \(obstetricians and gynaecologists\)](#)
- [The workforce with competences in sonography \(which includes some AHPs\).](#)



Midwives

Background

Midwives typically work on a rota and are on-call to provide 24-hour care in women's homes as well as in hospital, including in midwifery-led maternity units. Many local maternity systems are seeking to increase the proportion of antenatal services that are provided in a community rather than an acute setting or to provide women with greater choice to give birth outside an obstetric unit. This would lead to increasing amounts of care being provided in women's homes, local clinics, children's centres and GP surgeries.

Midwives play a crucial role in coordinating and navigating maternity care. They are the lead health professional in maternity services and contact for a woman. They support a woman to make informed choices about options and services available throughout pregnancy. This coordinating midwifery role is further accentuated through the introduction of 'continuity of carer'. Continuity of carer means there is consistency in the midwife or clinical team that provides care for a woman and her baby. This enables effective coordination of a woman's care through a named midwife taking responsibility for ensuring the needs of the mother and baby are appropriately met, as well as the building of relationships between the woman and the clinical team providing care.¹⁸ The principal objective is to ensure women see the same midwife or clinical team over the continuum of antenatal, intrapartum and postnatal care.¹⁹

Research studies have linked continuity to improved health outcomes for mother and baby, as well as greater satisfaction with care.²⁰ It is therefore vital that maternity services have the right numbers of people in the right place, with the right competences and expertise to achieve this.

NHS England in their 2017 paper **Implementing Better Births: Continuity of Carer** sets out two models for local implementation of continuity of carer:

- **Team continuity:** a woman has an individual named midwife responsible for coordinating care, who is part of a wider team of four to eight people and where each midwife in the team acts as backup to each other.
- **Full case loading:** each midwife is assigned a certain number of women and arranges work around needs of the caseload, with backup provided by a core midwifery team.²¹

Both models need to ensure sufficient cover for any unscheduled care. NHS England makes it clear that a mix of approaches may be needed to ensure effective implementation, where appropriate. Whatever model is used, a core midwifery staff will be needed on a shift basis to ensure sufficient numbers to maintain services and manage all maternity activity. Midwives will need to work in multidisciplinary teams, with a range of other professionals (including obstetricians, gynaecologists, GPs, health visitors, neonatal nurses and maternity support workers) and in a range of settings.

¹⁸ NHS England (2017).

¹⁹ For example, Sandall J. et al (2013); Sandall (2014).

²⁰ Sandall et al (2013); Sandall (2014).

²¹ NHS England (2017).



Analysis

Number of midwives in the NHS

Midwifery is, by far, the largest profession in the core maternity workforce. The Electronic Staff Record (ESR) at March 2016 indicated that there were **21,763 whole time equivalent (WTE)** midwives in post. We are including an additional **1,012 WTE** midwives, who work in maternity services but in a predominantly management role²² courtesy of their midwifery skills and experience. This gives a total of **22,775 WTE** or, assuming 663,157 births in 2016, one midwife for every 29 births.

However, these 22,775 WTE include staff on long-term leave (for example, maternity leave or long-term sick leave), and therefore not on active assignment. Although these posts are not available to be permanently filled, it creates an additional pressure on services that needs to be addressed through temporary means. Data from NHS Digital suggests that there were 21,038 WTE midwives plus 964 WTE management roles on active assignment – giving a total of **22,002 WTE**, equivalent to one midwife for every 30 births.

Current demand for midwives

Data collected by HEE from NHS providers in March 2016 indicated a demand for 23,388 WTE posts and 965 WTE management posts, providing a total demand of **24,353 WTE** posts. Alternatively, using assumptions based on Birthrate Plus²³ and taking into account a 9% uplift for management, it is possible to estimate a demand for **24,272 WTE**. Both figures suggest a broad ratio of one midwife for every 27 births.²⁴

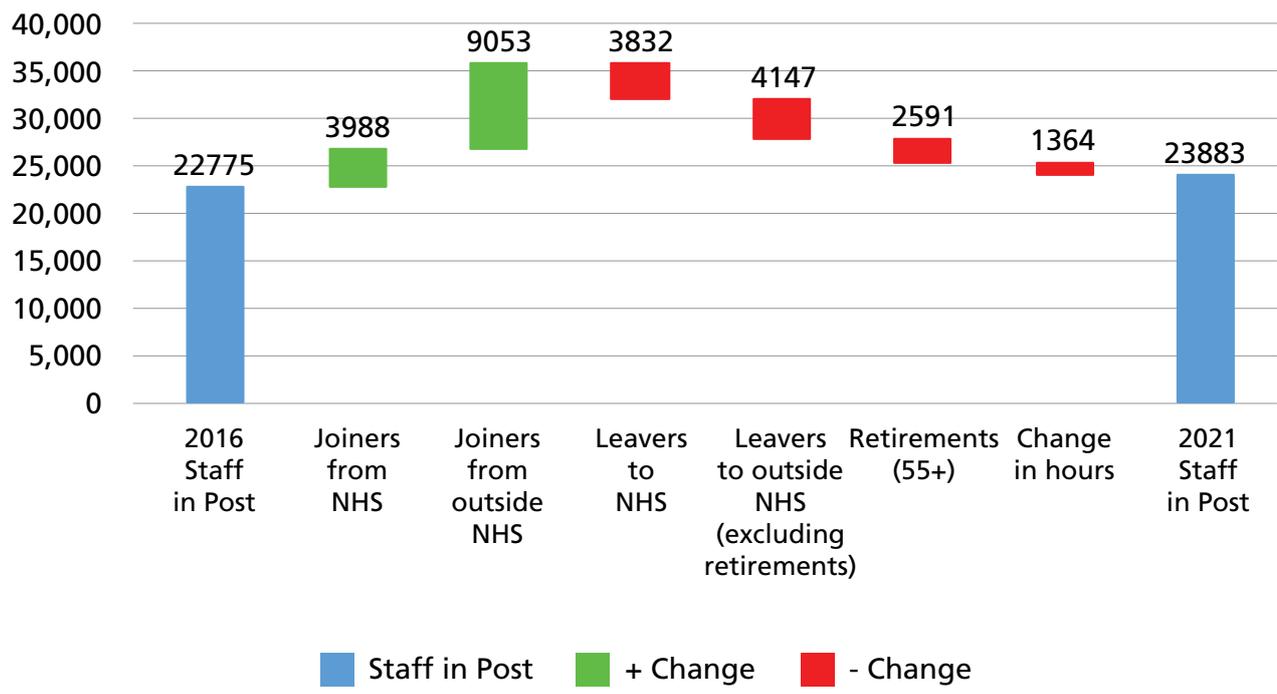
²² These have the following codes in ESR – N0C (Manager), N6C (Other 1st level), N7C (Other 2nd level), NAC (nurse consultant) and NCC (modern matron). NB – these will be midwives rather than nurses; hence, 'nurse consultants' will be the equivalent of 'consultant midwives'. We include those job roles likely to be filled by midwives: these are midwife, midwife-consultant, midwife-manager, midwife-specialist practitioner, modern matron and sister/charge nurse.

²³ Birthrate Plus[®] (BR+) is both a service and provider of 'tools' for workforce planning and strategic decision making in midwifery, as well as assessment of real time staffing requirements. For further explanation, please go to the **Appendix**; also see Ball & Washbrook (1996) and Ball & Washbrook (2010).

²⁴ ONS (2017b).

Taking the NHS providers estimate of demand (24,353 WTE), approximately 7% of posts are vacant nationally. When the number of midwives not on active assignment is also considered, this suggests that there are approximately 2,300 WTE or 9.3% of posts where, because of a vacancy, or long-term leave, a permanent midwife is not available to work in the NHS.

Projecting the future supply of midwives



The figure above shows projected numbers broken down into components of supply, assuming 22,775 WTE in 2016. To project 'net' numbers of midwives expected to be working in the NHS by 2021, we look at how many we expect to join versus how many we expect to leave.

We expect an additional 9,053 WTE to join from outside the NHS in England; this will include both new joiners from training, as well as joiners from the rest of the UK and overseas. We also expect a net gain of 156 FTE through staff turnover within the NHS in England, which will also reflect in part transfer from other roles. Significantly, we expect a net loss of 4,147 WTE from the NHS in England, as well as 11% to retire, and a further 6% of capacity to be lost through reduction in hours. Overall, if we take no further action then in 2021 we expect to see **23,883 WTE midwives in post**, a growth of 1,108 WTE or 4.9%. We also need to assume that at least 3.4% of midwives in these posts will not be on active assignment and will therefore need to have their roles covered through temporary or short-term measures. This would mean approximately **23,071 WTE midwives** being on active assignment within the NHS in 2021.



Projecting future demand for midwives

To project future demand for midwives, we will assume that the ratio of midwives per birth required in 2016 is maintained in 2021. Projections on the number of births expected in 2021 are not exact and we are modelling a range of 659,000 – 693,000 births (based on 2016 and 2014 ONS principal projections). This would suggest a requirement for between **24,121 WTE** and **25,457 WTE** posts, which on staff in post would imply a **gap of between 238 and 1,574 WTE**.

To close this gap and deliver flexibility to cover staff who are not on active assignments, we would need 1,050 WTE – 2,386 WTE midwives more than are currently projected to be available to the NHS in 2021.

Therefore, our priorities over the next three years must be to seek and exploit opportunities to further expand the number of midwives training by ensuring:

- Ensure current training pipelines address current vacancies, for example implementing the 25% increase in new training placements announced by the Secretary of State in March 2018 which will provide significant additional midwives for the NHS from 2022 onwards.
- Ensure training pipeline and retention initiatives support access to a wider pool of midwives, to work flexibly and cover non-active assignments, including reducing attrition during training and between training and frontline employment.
- Ensure geographical and rural differentials in ability to recruit are better understood and that initiatives are in place to address these.

It should be noted that expansion of training places may bring its own implementation challenges. We need to ensure that increases in training places accompany similar expansions to training capacity, with appropriate support given to education providers and employers to ensure neither training nor services are compromised. We also need to ensure sufficient take-up of these courses, especially following changes to commissioning and bursary arrangements following the 2015 Comprehensive Spending Review. We will develop an approach to support this growth in training placements which takes into account existing placement capacity and training location with developing workforce planning capacity and capability for local maternity systems at its centre. This may include monitoring placement numbers, as well as alternative routes to placements (for example, through equivalent pre-registration masters courses).

We expect the following actions to have the potential to deliver up at least an additional **750-800 WTE** by 2021, **with a further 2,000 WTE via through training from 2022 to 2026.**



Recommended actions to increase supply

- **Increase midwifery training placements:** in-line with the Secretary of State's March 2018 announcement, HEE proposes to expand training placement numbers by 25% over four years, with the first 650 places from 2019/20 and up to 1,000 places for a period of three years thereafter. This intervention is expected to increase capacity by just over 350 FTE in 2022/23 and just under 550 WTE per year in 2023/24, 2024/25, and 2025/26.²⁵
- **Increase numbers transitioning from training:** we expect about 1,800 WTE new midwives to join the NHS per year between 2016 and 2021. We will aspire to improve completion rates from training to employ 1,850 WTE per year from 2019 onwards to improve on previous years, to increase numbers by potentially 250-300 WTE.

Recommended actions to retain experienced and skilled staff

- **Improve retention:** work is required, across the system from local to national level, starting immediately to improve retention of midwives in the workforce. This will require new approaches to flexible working for staff, stepping down as staff approach retirement and return schemes for staff at different career stages. This will include acting to reduce avoidable staff attrition, both from workplace and training settings, including addressing issues that affect staff welfare. It also means giving due consideration to policies relating to maternity leave, equal pay and flexible working. Local maternity systems will also need to work closely with their midwifery workforce to ensure employment and working conditions reflect the new ways of working to deliver continuity of carer, especially given a significant proportion of the workforce less than full time.

Case study: Liverpool Women's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust piloted a three-stage programme to support midwives with symptoms of Post-Traumatic Stress Disorder (PTSD) with the aim of reducing attrition within midwifery.

Initial findings suggest that the programme to address PTSD risk may be beneficial in terms of reducing sickness and attrition.

- If we **reduce non-retirement attrition from the NHS in England by a sixth** and therefore return attrition rates to what they were in 2012/13 (i.e. down from an average of 3.5% to 2.8-2.9% per year), an additional **750-800 WTE** midwives would be available to the NHS by 2021. This would imply a reduction in such losses from 800-850 WTE per year to about 650-700 WTE per year. Year-on-year retention targets should therefore be established with HEE and NHSI to deliver this improvement by 2021.

²⁵ We assume 20% attrition during training, 15% loss between training and the NHS workforce, and an average participation rate of 0.8 FTE.



- **Return to practice schemes:** to date, small numbers of midwives (less than 50) have undertaken existing return to practice schemes. These courses typically update skills and knowledge, before re-registration on the NMC professional register. This suggests more needs to be done to encourage those eligible to consider these routes, including those registrants who currently do not work in the NHS. This could include making securing of clinical placements easier for people on such schemes. We will examine with system partners the possibility of developing a bespoke scheme **to boost return to practice schemes in midwifery from 50 to approximately 100 per year.**

Recommended actions to support and upskill the workforce

- **Upskilling:** the NMC is reviewing the standards of proficiency for registered midwives to reflect changes to the role of midwifery and the changing needs of mothers and babies. The NMC review intends to ensure that new standards do not quickly become obsolete and will have particular focus on pre-registration requirements, for student midwives. Engagement with key stakeholder groups is currently underway, including with the RCM, the RCOG, the RCGP, the RCPCH, and the RCoA. The NMC expect to consult on new draft standards of proficiency for registered midwives in 2019, with publication and implementation to follow in 2020. These changes to the curriculum will prepare midwives to provide safe and personal midwifery care, in line with the vision of **Better Births.**

We also expect that as midwives provide more women with continuity of carer, additional development needs for midwives will be identified to support them to move across organisational boundaries and work within different teams providing care in different ways. In particular, providers need to adequately support their staff and implement processes to ensure that staff are, and remain, skilled in all areas of maternity care.

HEE proposes that a two-day programme is rolled out to cover ways of working to provide continuity of carer, with appropriate backfill to maintain service delivery.



HEE will therefore work with local maternity systems to develop and deliver an education offer for continuity of carer with view to roll out during 2018/19.

- **Supporting midwives through cultural change and in developing a positive working culture:** NHS Improvement (NHSI) guidance recommends the active involvement of midwives in developing new ways of working, on grounds that **“empowering midwives to develop the model... is likely to result in greater willingness to work within it”**.²⁶

For that reason, the guidance recognises local maternity systems should put in place support for responsible managers, particularly around providing additional training for staff (e.g. around intrapartum care), familiarity with the new environment (e.g. computer systems, equipment), and expectations around duties of midwives and therefore what upskilling is required.

NHSI guidance has also suggested that secondments between teams (to broaden midwives' experience) and analysis of training needs may be useful in supporting transition to new ways of working.

- **Clinical leadership through specialist and advanced practice: Midwifery 2020**,²⁷ a 2010 joint publication by the Departments of Health, strongly advocated maximising the influence of midwives through increased opportunities for specialist and advanced practice for consultant midwives.

Increasing numbers in experienced clinical roles - for example, the role of consultant midwife - will provide important local leadership and practical support for the implementation of continuity of carer. Adoption of these roles will need to be determined locally. HEE, with other organisations, will explore opportunities to further develop and update career frameworks to: enable experienced midwives to provide both strategic clinical leadership and specialist and advanced expertise alongside their core functions; clarify role expectations; set out good employment practice; and describe academic study requirements.

- **Maternity Safety Training Fund:** HEE has distributed more than £8.1 million of DHSC funds to provide multi-disciplinary maternity safety training programmes to 136 NHS trusts. The programmes supported through the fund focussed on leadership, multi-professional team working, and midwifery and obstetric skills. Programmes were due to complete by March 2018. Each participating trust agreed to complete online surveys to report progress and to take part in the independent evaluation commissioned by HEE in 2018.

Initial feedback has been positive. Benefits reported by training leads to date include:

- improved staff morale
- improved team-working and communication
- improved flow of women
- better management of emergencies
- increased enthusiasm for improving safety and culture change.

²⁶ NHS Improvement (2017).

²⁷ DH et al (2010).



- **Deployment of flexible workforce:** Gaps between numbers of established posts and numbers of staff in post should be addressed through recruitment to fill gaps whilst employers also focus on improved retention of the existing workforce to prevent new vacancies arising. Recruitment will also be necessary to be able to backfill for those on long-term absence, for example due to secondment or maternity leave.

Where flexible staffing such as bank or agency staff deployment is approved, service managers should consider where this is used to ensure maximum continuity of carer.

- **Increase numbers of consultant and specialist midwives:** increased numbers of consultant and specialist midwife roles support expansion of the available workforce, as well as introduce additional skills, competences and expertise. This will enable care to be delivered at a level that will allow other regulated professionals to operate at higher levels of their skills and competences. These roles also increase the potential for new innovative models of care to support the capacity of maternity services, as well as for improving the quality of care provided.

Case study: Strategic Lead Midwife role in Surrey Heartlands Health and Care Partnership

A new role emerging in Surrey Heartlands is the role of **Strategic Lead Midwife**. This role developed after local Heads of Midwifery recognised that strategic oversight of maternity services was across the STP footprint. A 0.5 WTE fixed-term post up to 2020 was appointed in early 2018.

The Strategic Lead Midwife, who comes from a head of midwifery background, sets the strategic direction and development of the maternity service across the local maternity system to oversee the implementation of **Better Births**. The post also provides expert advice to partner organisations on related professional issues, and professional leadership as a key member of the local maternity system board and maternity transformation team.

Maternity support workers

Background

Support staff are vital to the smooth running of the maternity sector and work alongside qualified staff. They are split into three broad groups on the Electronic Staff Record (ESR) – ‘support to maternity services/midwives’, ‘support to neonatal nursing/midwives’ (both²⁸ generally operating at Bands 3 and 4) and those providing housekeeping and clerical support (who are in other groupings and generally operate at Band 2). The first two groups are

²⁸ The relevant ‘Support to maternity services/midwives’ codes are N8C (nursery nurse), N9C (nursing assistant/auxiliary) and NFC (nursing assistant practitioner). The relevant ‘Support to neonatal nursing/midwives’ codes are N8L (nursery nurse), N9L (nursing assistant/auxiliary) and NFL (nursing assistant practitioner).



typically referred to as representing the bulk of maternity support workers (MSWs). However, housekeeping and clerical support staff are also key members of the maternity team.

Across the three groups, we estimate that there may be as many as 8,000 FTE support workers in post, of which approximately 2,500 FTE are coded as providing support to maternity services / midwives or neonatal nursing/midwives. Research suggests that many MSWs employed at Band 2 perform Bands 3 and 4 level duties, suggesting that the assumed figure of 2,500 WTE may underestimate the number of staff operating as maternity support workers (MSWs) in the NHS.

The RCM provided guidance in 2011 (with subsequent update in 2016) on how MSWs should be used.²⁹ In response HEE, with support from the RCM is scoping work on standards based on this guidance. This work will look at utilisation, duties undertaken and opportunities for standardised training and development within a nationally consistent curriculum. The standardisation of current training curricula and career frameworks will be the first stage of a new approach to supporting this workforce, as we also look at opportunities for wider access into midwifery training, including through apprenticeship routes.

Estimating required need is challenging for these workforces, as previous collections have tended to focus on overall support to nursing and midwifery, rather than MSWs specifically. The best tool available is Birthrate Plus[®], which recommends that for postnatal care, at least 90% of staff should comprise of registered midwives, while up to 10% can be appropriately trained non-midwifery support staff (i.e. Bands 3 and 4) able to provide direct care.³⁰ This allows some functions previously carried out by midwives to be carried out safely by these support staff. However, Birthrate Plus[®] has not explicitly considered use of MSWs in intrapartum or antenatal care, and so not cannot be applied to those areas. Further work is therefore needed to understand the precise numbers capable of carrying out midwifery functions across the entire maternity care pathway and how MSWs can best support continuity of carer and the vision of **Better Births**.

Given our limitations in estimating demand and supply, we have explicitly assumed that MSWs are those counted in ESR as support to maternity services and neonatal nursing, and that these numbers should, as a minimum, remain in proportion to midwifery numbers. This should be a minimum benchmark, subject to review once the competency framework for MSWs has been developed and established. Any ratio developed must also recognise the existence of other support staff not providing direct care, such as housekeeping and clerical support. They should also consider the evolving role of MSWs, be linked to whatever competences are agreed for MSWs and other associated workforces and be subject to regular review and monitoring.

Number of MSWs in the NHS

The NHS ESR at March 2016 indicated that there were **2,463 WTE** MSWs in post. This is based on counting staff coded as 'support to maternity services/midwives' and 'support to neonatal nursing/midwives' in ESR. Hence, figures given here are indicative, and assume that the staff identified are suitably qualified. It is possible that actual numbers performing functions associated with this role will be higher.

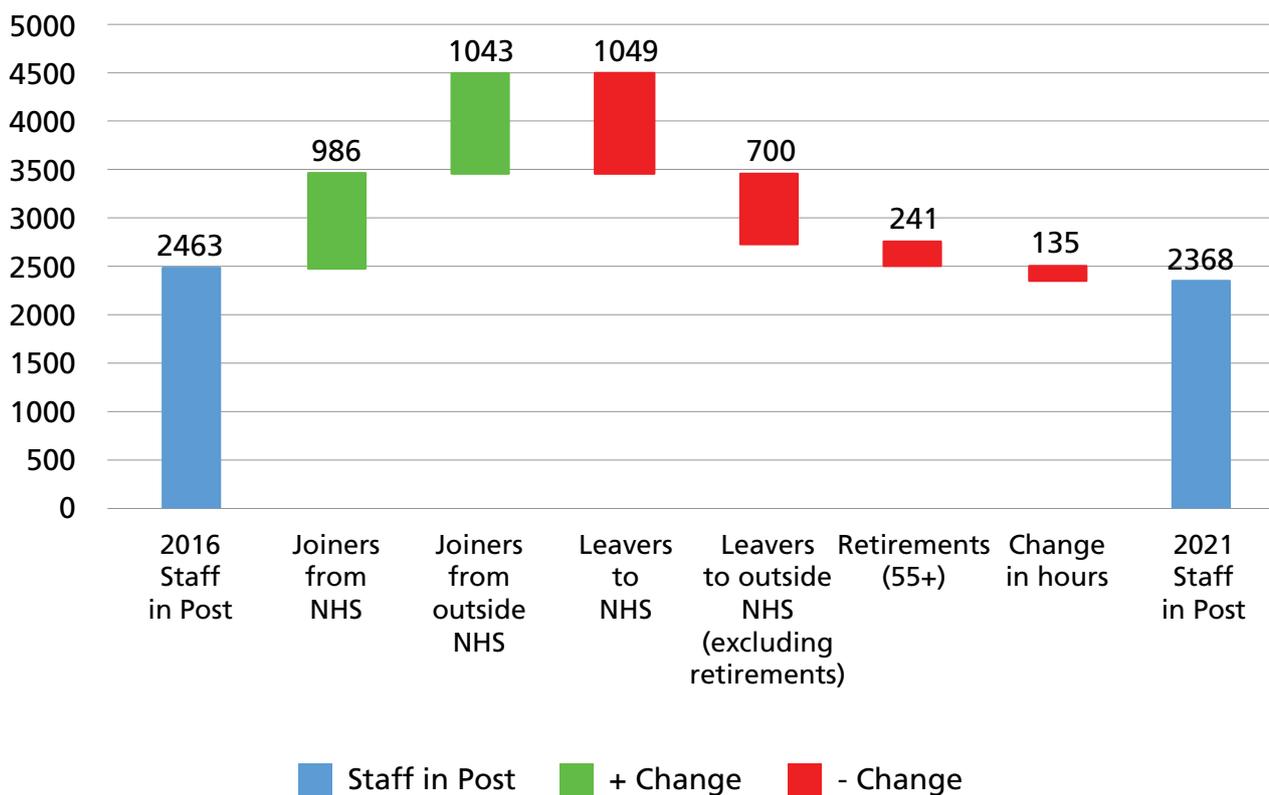
²⁹ RCM (2016a).

³⁰ Ball & Washbrook (2010).

Current demand for MSWs

Compared to demand for 24,272 WTE - 24,353 WTE midwife posts in 2016, the figure of 2,463 WTE MSWs suggests 10 midwives per MSW. As explained above, there are staff members effectively performing MSW roles operating at Band 2, who are not included in this number.

Projecting the future supply of MSWs



The figure above shows projected numbers broken down into components of supply, assuming the MSW numbers above reflect appropriately qualified staff. To project 'net' numbers of MSWs expected to be working in the NHS by 2021, we look at how many we expect to join versus how many we expect to leave. This assumes maintenance of current trends, and that staff numbers reflected here are appropriately trained. We expect an additional 1,043 WTE joiners from outside the NHS (which will include new joiners from England, as well as from the rest of the UK and overseas), but a net loss of 63 WTE through 'churn' within NHS organisations in England (which in part will reflect changes in role). We expect 241 WTE (10%) to retire, and a further 5% (135 WTE) to be lost through reduction in hours. We also expect 700 WTE (28%) to leave the NHS altogether.

Overall, if we take no further action then in 2021 we expect to see **2,368 MSWs in post - a loss of 95 WTE (or 4%)**. However, this assumes no further interventions are taken to redress this balance and that the numbers above reflect all MSWs in scope. Proposed interventions are in hand (see below), disproving the former; we also know that further work is needed to fully clarify and therefore understand trends affecting this workforce.



Projecting future demand for MSWs

- Assuming 23,883 WTE midwives are expected to be in post by 2021, a minimum of **2,582 WTE MSWs in post as defined on ESR** would be required to maintain the same 2016 ratio.
- The range of births predicted for 2021 (based on 2016 and 2014 ONS projections) of 658,000-693,000 suggests demand, as a minimum, would vary between **2,490 WTE and 2,619 WTE MSWs in 2021**.
- Using the Birthrate Plus[®] modelled demand of 24,272 WTE midwives in 2016 gives expected demand, as a minimum, of between **2,482 and 2,611 WTE MSWs in 2021**.

Overall, assuming the coding given above and analysis by NHS England, the RCM, HEE and ONS, we expect demand for appropriately trained MSWs to be between 2,482 and 2,619 WTE. The uncertainty around the number of housekeeping and clerical support effectively operating as MSWs, or the development of guidelines around the ratio of MSWs to midwives in intrapartum or antenatal care may significantly change the number of MSWs required in 2021.

Although supply may fall if no interventions are made, we expect that the interventions already in train below to increase numbers, particularly through efforts to reduce attrition and to provide a stronger career framework for MSWs (and thereby making the MSW role a more attractive one).

Recommended actions to retain experienced and skilled staff

- **Improve retention:** while precise attrition rates for MSWs are unknown, we know approximately 12% of the support workforce to nursing and midwifery currently leave their role every year. HEE will work with the RCM and other stakeholders to support retention of MSWs.

Recommended actions to support and upskill the workforce

- **Upskilling:** MSWs have a key role in supporting midwives to deliver continuity of carer and increase the opportunities for women to have home births.

In line with the Secretary of State's March 2018 announcement, we propose that:

- **MSW guidance:** we will develop the 'Maternity Support Worker' role as a nationally defined role with a national competency, education and career framework. In addition, we will explore new routes to becoming a registered midwife, including via apprenticeships; the review of apprentice standards against revised NMC published curricula expected in April 2020 may also help widen access to pre-registration education.



- **Skills and competences:** the MSW project will develop the skills and competencies for support roles, within a careers framework to attract prospective entrants from broader and more diverse backgrounds
- **Ongoing monitoring:** better data will provide current support worker numbers and duties and thereby inform new guidance on ratios and future competency requirements. We will also consider scoping the possibility of a voluntary register for maternity support workers.

Local maternity systems will need to review existing deployment of MSWs along with local practice frameworks for supervision and delegation. Local maternity systems will also need to consider how best to upskill and train MSWs, for example, potentially through secondments between trusts or access to bespoke training.





Neonatal nurses

This section largely draws on the work of the Neonatal Critical Care Transformation Review, commissioned by NHS England's Women and Children Programme of Care Board. Recommendations to refine the existing model of care and address nurse staffing issues (as well as wider workforce recommendations) will be made by the review team. This section should be read in conjunction with the recommendations of the Neonatal Critical Care Transformation Review.

Background

'Well-organised, effective and sensitive neonatal care can make a lifelong difference to premature and sick new-born babies and their families. Getting this early care right is the responsibility of the NHS at all levels.'³¹ High quality neonatal care is also an important part of achieving the ambition of the Secretary of State for Health and Social Care to halve the rate of neonatal death and serious intrapartum brain injury by 2025.

Neonatal care services are provided in a variety of settings. Approximately 60,000 to 70,000 babies (approximately 10% of all births) per year will receive some type of neonatal care. There are four types of hospital-based neonatal care:

- **Neonatal intensive care units (NICUs)** sited alongside specialist obstetric and fetomaternal medicine services, they provide the whole range of medical neonatal care for their local population along with additional care for babies and their families referred from the neonatal network. Many NICUs in England are co-located with neonatal surgery services and other specialised services.
- **Local neonatal units** provide all categories of neonatal care, but they transfer babies who require complex or longer-term intensive care to a NICU as they are not staffed to provide longer-term intensive care.
- **Special care units** provide special care for their local population and a stabilisation facility for babies who may need to be transferred to a neonatal intensive care unit (NICU); they may also provide some high dependency services.
- **Transitional care** supports resident mothers as primary care providers for their babies with care requirements in excess of normal new-born care, but who do not require care from a neonatal unit.

Neonatal care is commissioned by NHS England's specialised commissioning team which works with eleven Operational Delivery Networks (ODNs). Each coordinate patient pathways between providers over a wide area to ensure access to specialist resources and expertise.³²

³¹ DH (2009).

³² For more information about NHS England's Operational Delivery Networks, please see: <https://www.england.nhs.uk/ourwork/part-rel/odn/>



Local workforce planning and monitoring arrangements are described in **Safe, sustainable and productive staffing, an improvement resource for neonatal care**.³³ In summary:

- Neonatal units must engage with neonatal ODN workforce strategies to ensure that the workforce has the right skills to meet future service requirements.
- Boards of provider organisations should ensure that a strategic multi-professional staffing review takes place at least annually (or more frequently if changes to services are planned or quality or workforce concerns are identified), aligned to the operational planning process. A mid-year review should provide assurance that neonatal services are safe and sustainable.
- ODN boards should receive and discuss regular reports (using quality dashboard models) which map staffing levels to the recommended minimum levels and highlight and quantify any shortfalls. This information should be used to: inform workforce planning and strategy documents; identify training requirements; and ensure that appropriate action is taken.

Staffing requirements: neonatal nurses

Neonatal care is provided by a multidisciplinary team including nurses, neonatologists, AHPs (including dietitians, pharmacists and speech and language therapists), clinical psychologists, nursery nurses and a range of non-clinical support staff (including administrative and housekeeping roles). This section considers the neonatal nursing workforce; the neonatology workforce will be considered in HEE's paediatric workforce strategy (yet to be published).

Neonatal nurses are highly skilled intensive care nurses, caring for babies from 23 weeks gestation up to 44 weeks gestation with a variety of complex needs including intensive respiratory support, complex surgical procedures and ECMO.³⁴ As well as hospital-based care, neonatal nurses also provide care in community settings to support babies after discharge from hospital.

Providers of NHS neonatal care must have a workforce plan, designed to maintain safe, sustainable staffing levels based on the standards set out in '**Safe, sustainable and productive staffing, an improvement resource for neonatal care**'³⁵ and in-line with any predicted increases in birth rate. As set out in NHS England's Service Specification (no. E08/S/a) for neonatal critical care,³⁶ each unit must work towards an agreed plan with commissioners to ensure that nurse staffing reflects the following nurse to baby ratios:

- Intensive Care 1:1
- High Dependency 1:2
- Special Care 1:4.

³³ National Quality Board (2018).

³⁴ Respiratory extra corporeal membrane oxygenation (ECMO) support is used for babies with severe respiratory distress caused by an underlying condition that is reversible. When mechanical ventilation is insufficient, ECMO supports the function of their lungs (and heart, if needed) with an artificial lung and mechanical pump. Further details are available in NHS England's service specification E07/S(HSS)/a.

³⁵ National Quality Board (2018).

³⁶ <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-e/e08/>



For transitional care, the BAPM framework³⁷ recommends nurse to baby ratios of at least 1:4 (in addition to midwifery input).

Safe, sustainable and productive staffing, an improvement resource for neonatal care covers all aspects of neonatal workforce staffing. It recommends that the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity and the results shared with the neonatal ODN. In terms of neonatal nursing, the resource includes requirements that:

- Each shift is led by a supernumerary senior nurse. This nurse is responsible for the unit, ensures that the unit is safely staffed, and that workforce planning is effective.
- There should be a minimum number of registered staff. The resource sets out what this should be, according to the care setting.
- Neonatal outreach teams have their own staffing, additional to that required for the neonatal unit, transitional care and postnatal ward.

Recommendation: NHS Resolution to consider for inclusion in the maternity incentive scheme standards, that providers have a supernumerary senior nurse on each shift who is responsible for the unit and who can ensure that it is safely staffed, and that workforce planning is effective.

From 2018, the National Neonatal Audit Programme (NNAP)³⁸ will report on nurse staffing levels at neonatal unit, network and national level in line with NHS England's Service Specification (no. E08/S/a) for neonatal critical care and the BAPM Service Standards for Hospitals Providing Neonatal Care. The NNAP measures include:

- The proportion of nursing shifts numerically staffed according to guidelines and service specification.
- The proportion of shifts which are staffed according to guidelines and service specification around qualification in specialty.
- The number of additional nursing shifts that are required to meet the guidelines and service specification.

Units need to ensure that they have sufficient capacity to deliver the appropriate service for their booked maternity population. Staffing shortages can result in babies being transferred to other units due to a lack of staffed cots rather than medical need; this puts babies at unnecessary risk and increases the stress placed on families at an already difficult time. The overall approach to staffing should be triangulated; that is, professional judgement is used in conjunction with workforce planning tools and NICE guidance.³⁹

³⁷ BAPM (2017 p.8).

³⁸ Royal College of Paediatrics & Child Health (2017 b).

³⁹ NICE (2010).



“...the very best practice combines professional judgement with professional standards and benchmarking, the use of an appropriate staffing model/dependency tool, robust evaluation of outcomes and feedback from our families to ensure that the staffing approach is working.”

The National Quality Board, *Safe, sustainable and productive staffing, an improvement resource for neonatal care*

Working collaboratively with parents

One of the principles for quality neonatal services is to ensure a family-centred philosophy of care, which ‘puts the physical, psychological and social needs of both the baby and their family at the heart of all care given.’⁴⁰

The **Bliss Baby Charter**⁴¹ supports healthcare professionals in implementing the Toolkit for Neonatal Services to improve the experience of care for babies and their families. Services seeking accreditation under the **UNICEF**⁴² **Baby Friendly Initiative** can count this towards achievement of the charter standards; the initiative enables services to support mothers with feeding and help parents build a close, loving relationship with their baby.

Recommendation: All neonatal services must be supported to seek and acquire accreditation under the Bliss Baby Charter Scheme and under the **UNICEF Baby Friendly Initiative**.

The NNAP⁴³ supports monitoring of the uptake and effectiveness of family-centred care at unit, network and national level, through the measures relating to parental involvement in neonatal care and minimising unnecessary separation of mother and baby.

Family integrated care⁴⁴ is an extension of the principles of family-centred care. It encourages and empowers parents to take control of their baby’s care whilst on the neonatal unit. A multidisciplinary team coaches parents about how to care for their babies, including taking observations, giving medication, feeding and changing. Introducing family integrated care requires a significant change in team working and mindsets; however, these changes can result in significant improvements to clinical quality outcomes.

The neonatal unit at St James’s University Hospital in Leeds found that introducing Family Integrated Care led to:⁴⁵

- breastmilk feeding at discharge rates approximately doubled to nearly 60%;
- length of stay reduced by up to 9 days in babies born up to 10 weeks early; and,
- infections and complications of being born early also seemed to improve.

⁴⁰ DH (2009 p.21).

⁴¹ Bliss (2015 b).

⁴² UNICEF (2018).

⁴³ RCPCH (2017 b).

⁴⁴ Read more about family integrated care here: <http://familyintegratedcare.com/about-ficare/>

⁴⁵ Read more about family integrated care at St. James’ Hospital here: <http://www.leedsth.nhs.uk/about-us/news-and-media/2016/05/20/family-integrated-care-programme-improves-neonatal-care-at-st-jamess-university-hospital>



Every parent that took part in the programme reported feeling more relaxed about their baby's care because they were so involved. It is thought that family integrated care improved attachment between parents and their babies. Family integrated care is not a means of reducing the workforce requirement below the nurse to baby staffing ratios described earlier.

Recommendation: Trusts should support initiatives to develop Family Integrated Care to improve clinical outcomes for babies, promote parental confidence in caring for their baby, and reduce stress and adverse effects on maternal mental health.

Recommendation: NHS England's specialised commissioning team, with support from the ODNs, to establish what models of Family Integrated Care are in operation in England, the coverage of those models, their effectiveness and to consider what further action might be needed to monitor and improve the uptake and effectiveness of Family Integrated Care.

The education and training of neonatal nurses

Neonatal nurses usually train as an adult nurse, a child nurse or a midwife before transferring to neonatal nursing. Approved educational institutions based in health and social care settings provide nurse education and training programmes; courses usually take a minimum of three years. Providing nurses in training with the opportunity to experience neonatal nursing is likely to increase awareness of and interest in the speciality. Training should reflect the importance of building both competence and resilience for what can be both clinically and emotionally demanding work. Therefore, training opportunities should provide graduated exposure to neonatal care settings starting with those babies whose clinical situation is the most stable and least complex.

Recommendation: universities to ensure that adult and children's branch training includes an elective in neonatal nursing. The elective should be designed to provide graduated exposure to neonatal care settings to build the competence and emotional resilience of nurses in training.

A recommendation about pre-registration education for midwives is made under 'Strong multi-professional working and a positive workplace culture', which is later in this section.

After training as an adult or child nurse or a midwife, registrants then train to become 'qualified in speciality' (QIS). At least 70% of a neonatal unit's registered nursing establishment must be QIS.⁴⁶ Individual employers and higher education providers, working in partnership, deliver QIS training. Not all QIS training complies with the elements set out in the core syllabus⁴⁷ (for the curriculum, assessment frameworks and quality of education). This means that QIS nurses may have different skill sets, even within the same ODN area.

⁴⁶ Department of Health (2009).

⁴⁷ BAPM (2012).



Recommendation: the Neonatal Critical Care Transformation Review to make recommendation(s) to ensure that in all ODN areas in England:

- nurses and midwives have access to QIS training (enough that 70% of neonatal units. nursing establishment can achieve and maintain QIS status year-on-year).
- that all QIS training meets the elements set out in the core syllabus 57.
- Improvements in the supply of neonatal nurses should not reduce supply elsewhere in the nursing workforce, particularly in the child nurse branch.

Recommendation: HEE will identify funding to support QIS training.

The supply of and demand for neonatal nurses in the NHS

Three assessments of the supply of and demand for neonatal nurses are set out below:

- HEE estimates based on engagement with providers
- National Lead Nurse Forum survey about the numbers of funded posts
- The demand for neonatal nurses based on levels of activity

HEE estimates based on engagement with providers

For workforce planning purposes, HEE defines neonatal nurses as those nurses recorded as working in neonatal nursing, excluding those counted as children's nurses or registered midwives.⁴⁸

The NHS ESR at March 2016 indicated that there were **3,874 WTE neonatal nurses in post**.⁴⁹ Care should be taken when interpreting the figures, as the coding and resulting data quality for neonatal nurses has changed in recent years, following the introduction of a new series of codes for neonatal services (which had previously shared a code with maternity services). These numbers also explicitly exclude those counted as children's nurses or registered midwives, as well as those who may remain coded to maternity or paediatric services. We know that in addition to the 3,874 WTE identified above, at least an additional 1,559 WTE nurses and midwives work in neonatal nursing.

Neonatal nurses will already be qualified nurses or midwives and so any flows will primarily reflect this, with the largest flow being those joining from other NHS organisations in England.

HEE engagement with employers in 2016 suggests demand in 2016 was for 4,992 WTE posts. Therefore, this suggests a further 887 WTE neonatal nurses are needed to meet employer demand, representing an **18% vacancy rate**.

⁴⁸ The codes in ESR counted for neonatal nursing are: NAL (nurse consultant); NCL (Modern Matron); NOL (Manager); N6L (other 1st level) and N7L (other 2nd level). We exclude N1L (children's nurse) and N2L (registered midwife), on grounds that in planning terms HEE would count these as children's nurses and midwives respectively in workforce planning.

⁴⁹ When we include the relevant codes for children's nurses and registered midwives, the relevant total is 5,433 WTE, 1,559 WTE higher. Of this 1,559 WTE, 1,405 WTE are children's nurses.



National Lead Nurse Forum survey about the numbers of funded posts

The East of England ODN, on behalf of all eleven ODNs in England, collated survey data for 2017. The survey design aimed to ensure consistency in data collection by: using a common audit form; including instructions with the form; and providing details of a single, named point of contact for queries. All NHS providers of neonatal care submitted a return.

The results of the survey showed that there are **7,132.7 WTE neonatal nurses in post**. The total number of **funded posts is 7,604 WTE**. Therefore, there are 472 WTE vacancies, a **6% vacancy rate**.

The demand for neonatal nurses based on levels of activity

When the demand for neonatal nurses is considered based on activity levels in 2017 and in line with service specification (no. E08/5/a) requirements⁵⁰, **the total number of neonatal nurses that are required to meet activity requirements is 9,395 WTE** (including band 4 healthcare assistants which contribute 271.7 WTE to the total requirement). This means that 1,791 WTE neonatal nurses are required in addition to providers' funded posts to fully staff current activity based on activity levels.

However, it is likely that a significant proportion of activity is avoidable; NHSI⁵¹ states that up to 30% of term baby admissions to neonatal units between 2011 and 2013 were considered avoidable. Evidence shows that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding and long-term morbidity for mother and child.⁵² Therefore, action to avoid admissions (except for compelling medical reasons) is also important when considering workforce requirements.

There are several initiatives to support providers, ODNs and local maternity systems to identify and reduce avoidable admissions and length of stay in neonatal care, including:

- The National Neonatal Audit Programme report⁵³ and the National Maternity and Perinatal Audit report⁵⁴ which identify actions that will not only improve clinical outcomes but are also likely to reduce admissions to neonatal critical care.
- ATAIN (Avoiding Term Admissions into Neonatal Units), described later in this section.
- Monitoring relevant Maternity Services Dataset⁵⁵ (MSDS) metrics; this includes the 'proportion of babies born at term admitted to the neonatal intensive care unit'.
- Giving providers an incentive to keep mother and baby together, where clinically appropriate, through the NHS Resolution maternity incentive scheme⁵⁶ (criteria 3).
- The Commissioning for Quality and Innovation (CQUIN) payment framework, scheme WC5 **Neonatal Critical Care Community Outreach**⁵⁷ which aims to improve community support to allow earlier discharge from neonatal care and prevent unnecessary admissions.

⁵⁰ More information about the review is available at: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-e/e08/>

⁵¹ NHS Improvement (2017 b).

⁵² More information about Atain is available at: <https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/>

⁵³ Royal College of Paediatrics and Child Health (2017).

⁵⁴ National Maternity & Perinatal Audit (2018).

⁵⁵ More information about the MSDS is available at: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set>

⁵⁶ More information about the maternity incentive scheme is available at: <https://resolution.nhs.uk/maternity-incentive-scheme/>

⁵⁷ More information about this CQUIN is available at: <https://www.england.nhs.uk/wp-content/uploads/2016/11/wc5-neonatal-community-outreach.pdf>



Recommendation: providers should act to avoid unnecessary admissions to neonatal critical care and discharge babies from units as soon as clinically appropriate.

Recommendation: HEE, in line with the findings of the Neonatal Critical Care Transformation Review, should provide ongoing monitoring of the future demand and supply for neonatal nurses at both a national and neonatal ODN level. Actions should include consideration of demand for neonatal critical care (and the likely impact of measures to reduce avoidable admissions and length of stay), basing workforce requirements on the Dinning workforce tool and making projections about the supply of neonatal nurses.

Overall, there is a significant shortfall in the number of neonatal nurses in post compared with the number required. Earlier in this section (under 'education and training of neonatal nurses') recommendations were made to increase recruitment – considering nurses and midwives in training and existing registrants. These recommendations centred largely on the availability of training and increasing the awareness of the speciality. As well as these measures, it is also important that potential recruits view neonatal nursing as a rewarding and supportive speciality in which to work and that this is the experience of existing neonatal nurses. To achieve this, there must be sufficient professional development opportunities, alongside strong multi-professional working within a culture that ensures high quality, continually improving and compassionate care.





Professional development

Recommendation: providers of NHS neonatal care must ensure that workforce plans include sufficient resources to allow continuing professional development and to release nurses for educational development (utilising the Dinning Tool), with the support of the NHS trust board.

Recommendation: HEE will work with system partners to set out and implement a clear career structure for neonatal nurses to provide suitably challenging and rewarding careers that improve the quality of neonatal care. This work should build on the recommendations of both the Neonatal Critical Care Transformation Review and **Exploring New Ways of Working in the Neonatal Unit**⁵⁸ (which made a range of recommendations about exploring role development and ways of working).

Strong multi-professional working and a positive workplace culture

Improved working between maternity and neonatal services can happen by encouraging good multi-professional working and joint training at local level.

Many well-run hand overs on the labour ward will have representation from the neonatal intensive care unit (NICU), usually a member of the medical team and a senior neonatal nurse. This helps co-ordinate and manage pending admissions and escalations of care.

Work at a local level can be supported by national initiatives such as ATAIN, which helps healthcare professionals involved in the care of new-borns, both in the hospital and community settings, reduce avoidable causes of harm that can lead to infants born at term being admitted to a neonatal unit. ATAIN focusses on four key clinical areas – respiratory conditions, hypoglycaemia, jaundice and asphyxia. An e-learning programme is available through the NHS ESR system.

Recommendation: providers to incorporate the ATAIN e-learning programme within mandatory training for all those involved in the care of new-borns (midwives and neonatal teams).

Better Births⁵⁹ called for multi-professional training to be a core part of all pre-registration education for midwives and obstetricians. This principle can equally be extended to the care of the neonate by improving pre-registration education for midwives.

Recommendation: universities to consider including the ATAIN e-learning programme within pre-registration midwifery education.

Further recommendations about improving leadership and culture are made elsewhere in this document and apply equally to neonatal critical care.

⁵⁸ Mitra T & Bramwells L (2017)

⁵⁹ NHS England (2016)



Obstetricians and gynaecologists (consultants, SAS and trust doctors, specialty trainees)

Background

Obstetrics and gynaecology (O&G), as a medical specialty is concerned with the care of pregnant women and their unborn children and the management of specific diseases in pregnant women (obstetrics) as well as female reproductive health in non-pregnant women (gynaecology). This includes all aspects of sexual and reproductive health across the life course of a woman.

Most doctors – consultants, specialty and associate specialist (SAS) doctors, trust doctors and specialty trainees whilst working in both obstetrics and gynaecology will have special interests in particular areas of practice. This document focuses on maternity services (obstetrics) rather than O&G as a whole, with little focus on the gynaecology workforce.

Obstetricians and gynaecologists have an explicitly defined role within the provision of continuity of carer, where patients are deemed higher risk. The role of the obstetrician within the **Better Births** model is to support their local service, and especially provide specialist advice and expertise where issues arise. Thus, obstetricians and gynaecologists, like midwives, are critical in ensuring coordinated, joined up care, although midwives tend to have responsibility for 'low risk' women asking the advice of the obstetrician only when they feel it is needed.

To fully understand medical staffing needs in obstetrics and gynaecology, the following key factors merit further discussion:

- **The split between obstetrics and gynaecology**

It is important to note that although the majority of doctors provide both O&G services, a substantial minority provide services in gynaecology only. This split must be taken into consideration when estimating the number of medical personnel required to provide maternity services now and in the future. The RCOG in their 2017 **Workforce Report**⁶⁰ identified the following split:

- 16% of doctors provide obstetrics only services.
- 59% of doctors provide both O&G services during daytime programmed activities.
- 51% of doctors provide both O&G services during out of hours programmed activities.
- 21% of doctors provide gynaecology services only.

In addition, this split changes with seniority and age, as doctors increasingly focus on particular specialisms, with many increasing the proportion of gynaecology work they undertake, as well as potentially reducing their number of programmed activities. Whether this capacity is likely to shift has the potential to affect workforce demand modelling, and so merits consideration.

⁶⁰ RCOG (2017).



We expect the complexity of women's healthcare needs to increase, which will affect all areas of practice. This is due to women becoming pregnant at an older age, as well as increasing obesity in mothers. Given changing population demographics, for example, women living longer, there is likely to be an increase in demand for gynaecological services. All these factors could lead to a change in the priorities in women's healthcare and may reduce the availability of doctors to provide maternity services without decreasing the need.

- **Rota gaps at middle grades**

88% of obstetric units report a gap in their middle grade rota and locum cover is frequently required. The National Maternal and Perinatal Audit reported that in the three months prior to their data collection, 83% of units required some locum cover to staff their rotas.⁶¹ These pressures require further consideration as part of the maternity workforce strategy.

Although an important part of the medical maternity workforce, locum staff at both trainee and consultant level are not only expensive but also potentially lead to inconsistencies in service delivery, as they are often unfamiliar with local systems and need time to acclimatise. This affects team working and potentially patient safety. It is important therefore to address the reasons for rota gaps, to which a number of factors contribute and to which there is no single solution. Attrition from the specialist trainee workforce is a contributing factor, however trainees alone could not fill all the places on a middle grade rota without contributions from SAS doctors, trust doctors and consultants undertaking resident on call at these middle grades.

- **The high rate of attrition from specialty training**

Based on GMC and ESR data, we currently estimate a high rate of attrition from specialty training of approximately 30% (which is likely to continue for the time being). This will reflect both trainees leaving specialty training (either altogether, or to pursue other roles, for example at middle grades), as well as loss between completion of training and entering the NHS workforce.

The 2017 RCOG Trainee Attrition Survey showed that factors behind this high attrition rate included:

- Poor work-life balance
- Rota gaps (which may require additional unexpected cover for maternity units at the expense of other training opportunities)
- More out-of-hours working
- Less supervision
- Fewer training experiences.⁶²

Options to address these issues are already underway, with the RCOG presenting them in their 2017 Workforce Report.

⁶¹ NMPA (2017).

⁶² RCOG (2017).

Consultants

Number of Obstetrics and Gynaecology consultants in the NHS

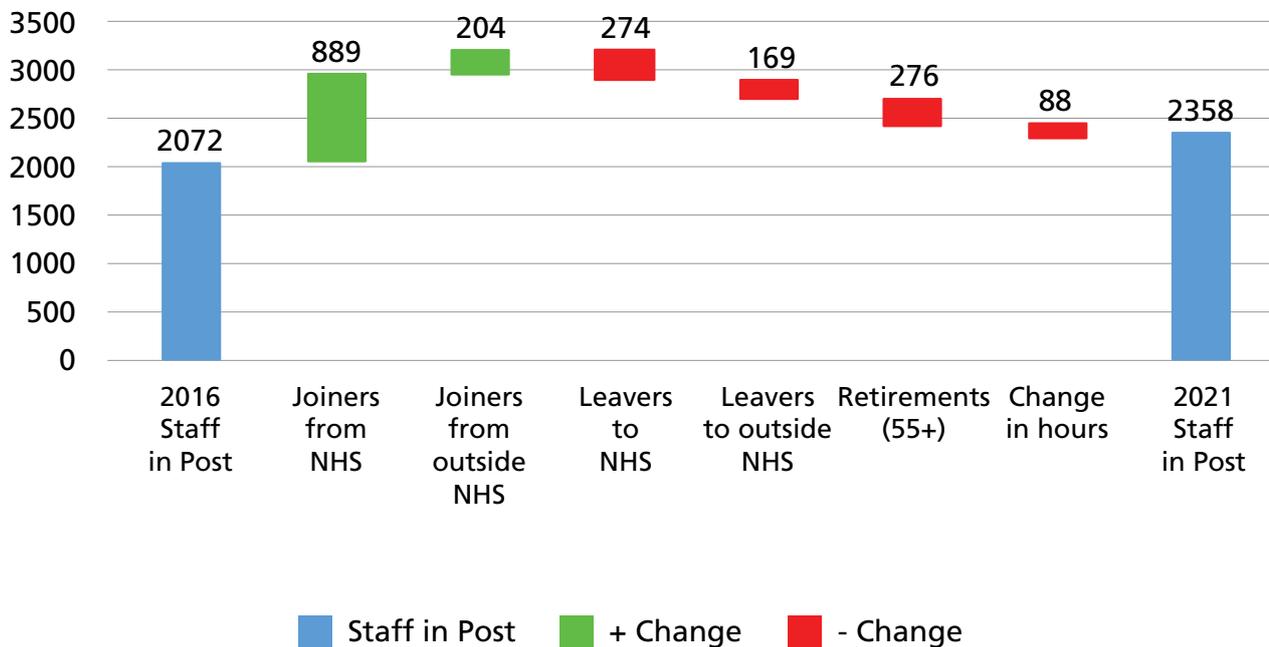
The ESR in 2016 indicated 2,072 WTE in post.

Current demand for O&G consultants

Data collected by HEE from NHS providers at the same date indicated 2,382 WTE available posts, suggesting a vacancy rate of 13%. Assuming 663,157 births, this assumes ideally one consultant in post for every 278 births, or one consultant for every 10.2 midwives.

While using Birthrate Plus® and numbers of deliveries will not provide a fully adequate method of planning future numbers for medical staff (given their focus on complex cases), we have used this method to give a baseline assessment of required 2021 staffing levels. There is no time to train more in the required timeframe, so additional means of estimating appropriate staffing requirements able to ensure increased safety of Maternity Units will be required going forwards.

Projecting the future supply of O&G consultants



The figure above shows projected numbers broken down into components of supply. To project 'net' numbers of O&G consultants expected to be working in the NHS by 2021, we look at how many we expect to join versus how many we expect to leave, assuming maintenance of current trends. We expect an additional 889 WTE joiners from NHS organisations in England. This number will primarily consider people moving between different roles within the NHS, and principally numbers joining from training. We expect 204 WTE to join from outside the NHS in



England; this will include joiners from the other UK nations as well as those from overseas. We expect some turnover, with 274 WTE to leave for other NHS organisations in England (leading to a net gain of 615 WTE, of which the majority will be those completing specialty training and therefore eligible for consultant level roles). We expect 8%, or 169 WTE, to leave the NHS in England; these may go elsewhere in the UK or overseas or leave the profession altogether. We also expect 276 WTE (13%) to leave through retirement, and 88 WTE (4%) of capacity to be lost through changing hours. Overall, if we take no further action then in 2021 we expect to see **2,358 WTE consultants in post**, a growth of 286 WTE or 14%.

Projecting future demand of O&G consultants

- Assuming 23,883 WTE midwives in 2021, **2,336 WTE** O&G consultants would be required (+21%) to maintain the preferred 2016 ratio between midwives and O&G consultants.
- Using the range of births predicted for 2021 (based on 2016 and 2014 ONS projections) of 658,000- 693,000 suggests demand could vary between **2,367 WTE and 2,490 WTE** O&G consultant posts.
- Using the Birthing Plus[®] modelled demand for midwives of 24,272 WTE in 2016, and maintaining the ratio between midwives and O&G consultants, gives expected demand of between **2,359 and 2,482 WTE consultant posts in O&G**.

Overall, given the above we expect demand for O&G consultants to be between 2,336 and 2,490 WTE.

SAS and trust doctors

In obstetrics and gynaecology, two distinct groups of doctors are neither consultants nor officially 'in training':

- **SAS grade doctors** – Specialty and Associate Specialist (SAS) doctors have at least four years of postgraduate training, at least two of those being in the relevant specialty. They are not on a specialty training scheme but employed on nationally agreed contracts and have the same appraisal and revalidation requirements as consultants. This is a highly varied group, with doctors often performing highly specialised roles but with a narrower remit compared to consultants. Senior SAS doctors can be experienced, autonomous, decision makers within provider organisations, and in many units are members of the senior team. A number of publications have supported the development of the SAS workforce over the years by various groups in employing and supporting specialty doctors – for example, **A guide to good practice in April 2008** and more recently the publication of the SAS Charter. Associate Specialist posts are now "closed", so it is no longer possible for SAS Doctors to progress to this senior SAS Grade position, which is currently being lost as people retire.
- **Trust grade doctors** – These doctors have a variety of titles and are employed on local contracts by employing trusts. They are often employed on short term contracts and may have stepped out of formal training programmes at some stage (often between F2 and ST3-4, meaning that they will hold a full GMC license to practice).

Number of SAS and trust doctors currently working in the NHS

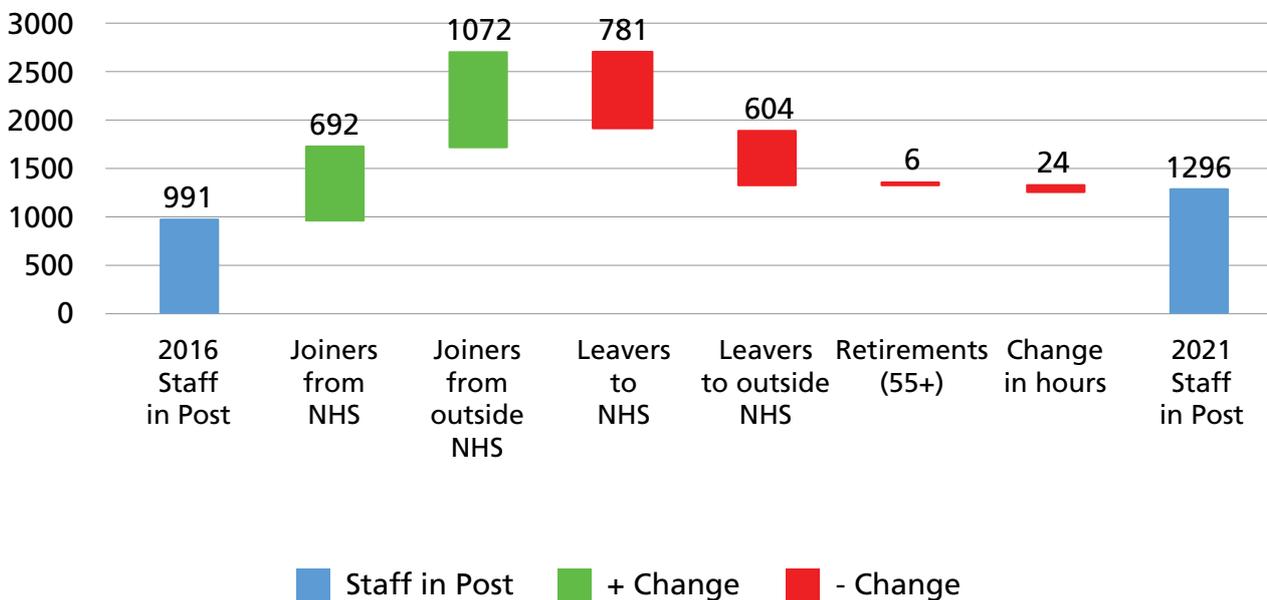
O&G services are reliant on the significant contribution of SAS doctors and Trust grade doctors. These staff constituted 991 WTE in England in 2016, according to the ESR.⁶³ Although precise figures do not exist, engagement with the system suggests that no more than half would be SAS Doctors. Therefore, the numbers below must be treated with some caution.

Within this group of doctors, there is significant turnover, with around 11-12% leaving the substantive NHS workforce in England in any given year, and about a sixth moving into either Consultant posts or post-graduate training posts in the NHS.⁶⁴ However, leaver rates for speciality doctors are likely to be lower than for trust doctors, as advantages of the former include permanent contracts with national terms and conditions, geographical stability, and potential for job plans with regular, fixed on-call without prospective cover.

Active interventions to retain, reskill and upskill these experienced staff would increase available workforce supply and the skills within that supply.

Assuming 991 WTE SAS and other doctors, this assumes roughly that in 2016 one such doctor was needed for every 2.1 consultants.

Projecting future supply of SAS and trust doctors



Although these figures need treating with some caution due to significant variation in this workforce, the figure above shows projected numbers broken down into components of supply. To project 'net' numbers of O&G SAS and trust doctors expected to be working in the NHS in England by 2021, we look at how many we expect to join versus how many we expect to leave, assuming maintenance of current trends.

⁶³ In addition, there will be approximately 1,000 trainees a ST3 or beyond who provide additional capacity.

⁶⁴ It is worth noting that turnover of trust doctors tends to be far lower than figures reported. Hence, much of the turnover will be in career posts.



We expect an additional 692 WTE joiners from NHS organisations in England. This figure will include specialty trainees stepping off training, as well as existing staff taking on new posts. We expect 1,027 WTE to join from outside the NHS in England. This figure will primarily count joiners from overseas, as well as specialty trainees joining from the rest of the UK and returners to the profession. This suggests dependence on people joining from outside England. We expect 781 WTE (15%) to leave for other NHS organisations in England. This will include both people taking on consultant and specialty training posts and people taking on new posts at this grade. We expect 604 WTE (12%) to leave the NHS in England altogether, either to elsewhere in the UK or overseas. By contrast, we expect to lose on current trends far fewer through retirement (6 WTE) and through change in hours (24 WTE). These lower numbers may reflect, in part, assumptions made for leavers, especially for those retiring – with retirements assumed as the main cause for leaving the NHS in England altogether for those aged 55 or over in those specific roles.

It is possible that those retiring or reducing their hours are reflected through other routes – for example, those currently under 55 may in fact be counted as ‘leavers to outside NHS’. Similarly, those reducing their hours but remaining in the NHS may be counted as ‘leavers to NHS’ (where they change employer) or ‘change in hours’ (where they remain with the same employer).

Overall, if we take no further action then in 2021 and assuming current trends only we expect to see **1,296 WTE SAS and trust doctors in post**, a growth of 305 WTE or 31%. However, this is entirely reliant on maintenance of current trends, which in turn will depend on several factors: for example, the final agreement reached on the UK’s exit from the EU and government decisions relating to the availability of visas for medics, and decisions from individual trusts on employing them. We also acknowledge observed rates of retirement have been very low for this section of the profession and may well increase.

Projecting future demand for SAS and other doctors

- Assuming 2,358 WTE O&G consultants in 2021, **1,128 WTE O&G SAS and other doctors** would be required (+21%) to maintain the 2016 balance with O&G consultants;
- Using the range of births predicted for 2021 (based on 2016 and 2014 ONS projections) of 658,000- 693,000 suggests demand could vary between **985 WTE and 1,036 WTE posts**.
- Finally, projecting forward using the Birthrate Plus® modelled demand of 24,272 WTE midwives in 2016 gives an expected demand of between **982 and 1,032 WTE SAS and other doctors**.

Given the above analyses, we expect demand for SAS and trust doctors in obstetrics and gynaecology will be between 982 and 1,128 WTE. However, greater thinking in this area will be necessary around the appropriate split between specialty and trust doctors, not least to assess the extent to which these staff can be integrated into existing training programme arrangements.



Overall, the above suggests that we will likely require an increased number of consultants on top of projected supply, with the precise amount required dependent on the number of births to 2021. While the evidence suggests that there should be sufficient SAS and trust doctors, this is highly dependent on maintaining current rates of joiners – by no means guaranteed, as the UK's exit from the European Union and decisions on visa availability may affect numbers. Moreover, we are also aware of reported gaps in middle grade rotas, and the fact that many trust doctor roles are the responsibility of employers, who tend to employ them on a short-term basis.

Actions designed to address existing and future workforce challenges are already underway, with many presented by the RCOG in their 2017 O&G Workforce Report.⁶⁵ These are outlined below.

Recommended actions to increase supply

- **Increased flexibility in specialty training programmes:** this includes introducing ST3 entry, which has been introduced in some specialties and would allow those leaving in ST1 and 2 to be replaced.
- **Improved awareness of complexity in workforce planning:** assessment of complexity is a pivotal component of future workforce planning. HEE and the RCOG will consider future further work to assess the workforce needed to deliver O&G services over the next 5 to 15 years, including and assessment of acuity. This will consider questions such as the complexity of workload, and the impact of age of mothers, presence of obesity and socio-economic status among other factors. Initial thinking is underway, and once complete this work will be essential for longer-term strategic planning.

Recommended actions to retain experienced and skilled staff

- **Understanding the causes of attrition:** we know that 30% of O&G trainees do not transition to the NHS workforce. This high attrition impacts on future consultant numbers, affects the quality of training in the specialty and puts services under further pressure.

Overall, we currently expect just under 180 WTE per year to join the consultant workforce from the NHS between 2016 and 2021. Not all of these will be new joiners from training, as this number will also reflect turnover in staff. Key to increasing numbers joining the profession will be improving understanding of workload and reasons for people leaving, **as well as provide greater support to SAS and trust doctors.**

To ensure any targets for new joiners and return to practice are appropriate, we will establish a Medical Workforce Steering Group to undertake work that is more detailed.

- **Return to training:** we know for doctors who take time out of practice for maternity/ paternity leave or out of programme experience, returning to the workplace can be a daunting prospect. In response, the RCOG is developing an accelerated return to training toolkit, which is currently in development for trainees (funded by a grant from HEE). We envisage encouraging returners to practice through a similar route, by potentially 5-10 people per year to 2021.

⁶⁵ RCOG (2017).



- **Increased resident consultant working:** for resident consultant roles to be successful, they must be professionally satisfying with opportunities and support equal to non-resident roles. If not, then we may witness increased attrition in another part of the O&G workforce (see job planning below).

Not all units require 24/7 resident cover of labour wards by consultants. All need specialist covers all the time, but this may be provided by experienced trainees or SAS/trust doctors with consultant cover within easy reach should it be required. A large unit with a high number of complicated patients will often require resident consultant input and this must be factored into the workforce planning at a local level. In their 2017 O&G Workforce Report, the RCOG made clear that rather than make recommendations on consultant presence based on delivery numbers, it is for each individual maternity unit to determine the best way of providing care, with emphasis on 24/7 safe care for women and appropriate capacity to provide that care.⁶⁶

- **Employers' job planning:** the RCOG encourages a transparent and professionally satisfying approach to job planning and provides guidance to employers on the creation of job plans that not only meet the needs of the department but also of the role holder. Linked to the above, we advise that employers follow guidance around developing appropriate job roles (as required by local needs).
- **Redeployment of retiring consultants:** as consultants near the age of retirement, many consider reducing their number of sessions, resulting in the loss of much needed skills and experience from the workforce. The RCOG is looking at options to retain this important and much needed group of doctors, for example, encouraging a 'retire and return' model whereby doctors considering retirement are employed on a part-time basis, with an adapted job plan that supports activities such as conducting clinics, ward rounds, time on labour ward and teaching.

Recommended actions to support and upskill the workforce

- **Upskilling:** the RCOG is currently undertaking a review of the core O&G curriculum and expect to implement this in 2019. Work on the review is focusing on several areas including development of a new draft curriculum and assessment blueprint.

Both aim to reflect new GMC standards for curricula and assessment (including Generic Professional Capabilities⁶⁷) with all Royal Colleges required to submit updated curricula by 2020. There will also be a new ePortfolio process, to better support continuous professional development with an emphasis on multi-professional working in the new curriculum, and close working with the NMC.

⁶⁶ RCOG (2017).

⁶⁷ Generic Professional Capabilities cover nine broad areas of professional practice, including professional skills, values, behaviour and knowledge; health promotion; leadership; patient safety; safeguarding, and research. These are being introduced into post-graduate medical curricula by the GMC, following findings that most concerns about doctors' performance fall within nine areas. It is hoped that through introducing these within curriculum standards, these will embed common generic outcomes, skills and content across all curricula.



- **Resources to better support new consultants:** we will support and develop further resources and networks to ensure new consultants feel better supported, equipped and confident to carry out their roles. This will include particular focus on the non-clinical aspects of consultant roles, including effective leadership, management and team working.
- **Resources to better support existing doctors:** ensuring a supportive, effective and positive working culture and environment within O&G services will also be vital in improving retention and creating the culture described in **Better Births**. In response, the RCOG has established the Supporting Our Doctors Task Group to prevent, minimise and manage workplace stress experienced by doctors. Outputs include a service to support doctors and their employers to manage more workplace conduct and practice challenges locally, as well as providing information on how to manage workplace challenges. This work should continue and be developed further over time.
- **New role of obstetric physician:** we will fund the development of an additional training pathway for obstetric physicians, with plans to pilot this for both established consultants and doctors in training in 2018/19.

Obstetric physicians are post-CCT physicians with additional subspecialty training who specialise in the care of women with pre-existing or new onset medical problems during pregnancy. In addition to providing additional service and expertise on these issues, they will also provide leadership within local maternity systems (alongside an obstetrician) in a networked model across England.

Development of a curriculum is complete, with training to take place over six months via supervised clinic and labour ward experience and a final viva. Over time, we will seek opportunities to work with the GMC to have this training credentialed and accredit the competencies relevant to obstetric medicine (e.g. diabetes and endocrinology, nephrology and rheumatology).

- **Redesigning the consultant model for the future:** working with the RCOG and other bodies, HEE will develop a future consultant model which addresses:
 - Growing subspecialisation and subsequent impact on the consultant model and training curricula (e.g. obstetric anaesthesia).
 - Changing work expectations at different career stages (e.g. decreasing amount of obstetric work and programmed activities as consultants get older).
 - The role of SAS doctors within the workforce, their future education and training requirements and their contribution to service delivery.

Linked to retention, a key priority will be to ensure skills are retained wherever and whenever possible – this may be through ‘return to work’ routes whereby people that choose to ‘step off’ specialty training are supported and encouraged to continue providing capacity, potentially through a Staff and Associate Grade role.



- **Recognition of competences acquired through training:** most doctors leaving training in the first three years go into general practice. In response and linked to the above point around future consultant models, HEE is working with the GMC to find ways for these doctors to have their O&G skills recognised within general practice.
- **Developing the role of SAS and trust doctors:** SAS doctors tend to have long-standing experience in O&G, often running clinics and theatre lists alone. However, the turnover of doctors in these posts can be very high.

Through its SAS Lead and advisory group, the RCOG is looking at improving recognition and providing the career development and support needed to retain, reskill and upskill these experienced staff, which in turn would increase workforce supply. Such development is crucial, given rota gaps observed within middle grades in obstetrics and gynaecology. Acknowledgement of these doctors as an essential part of the workforce with their own career structure, and as **“different grades not middle grades”**, will be especially important. This acknowledgement may help stabilise supply further, as may promotion of these posts as a potential alternative to consultant posts and looking at “step out/in” training/SAS post options for trainees who may otherwise leave the specialty. Given the geographical stability and regular hours possible with a SAS post, these posts may appeal to many doctors.

Alongside this RCOG initiative, we propose to bring together stakeholders to coproduce a workforce strategy for SAS doctors, focusing on areas such as education, development and career structure. This will review the support provided and investigate potential interventions to enhance the working lives of these doctors in line with our draft Workforce Strategy,⁶⁸ which committed to explore better support for this workforce. For trust grade doctors our Medical Education Reform Programme will lead work to encourage better retention and stability within this workforce, as well as enable improved flexibility and attractiveness of such careers.

The RCOG will work with our SAS doctors development group to develop a strategic approach to SAS doctor development and funding reform reporting in late 2018.

⁶⁸ HEE et al (2018).



Anaesthetists working in obstetrics

Background

Anaesthetists working in obstetrics play an essential role in the maternity pathway. They provide a range of functions, including labour ward analgesia, anaesthesia for caesarean section, instrumental delivery, placement and removal of cerclage, manual removal of placenta, perineal repair and external version. They are vital for the resuscitation of the mother, on occasions the neonate, and are responsible for the care and transfer of the critically ill.

In addition to these acute roles, anaesthetists see patients in outpatient clinics, preparing them for delivery, counsel women before and after delivery and provide teaching for a variety of healthcare workers.

Number of anaesthetists supporting maternity services in the NHS

Unfortunately, although we can identify numbers of anaesthetists in ESR, we cannot reliably identify anaesthetists working in obstetrics, without crude assumptions having to be made. This reflects existing and known limitations of information held in the ESR.

Existing evidence suggests suggests that maternity services do involve a significant proportion of the anaesthetic workforce. The 2015 RCoA census suggested that 9% of job planned consultant PAs and 16% of job planned SAS and other programmed activities were allocated for use in Obstetric anaesthesia.

Assuming those splits, and assuming 6,114 consultant FTE and 1,956 SAS and other in 2016, this suggests that approximately **550 consultant FTE and 313 SAS and Other FTE** of anaesthetist capacity is used by obstetric services.

This suggests one consultant anaesthetist working in obstetrics was required for every 41 midwives, and 0.6 SAS and other FTE were required for every consultant FTE.

Projecting future demand of anaesthetists working in obstetrics in the NHS

We do not know the precise contribution required for anaesthetists working in obstetrics. The best estimate is from a survey of clinical directors in 2017, which suggested that vacancies were at around 5% for obstetric anaesthesia posts, compared to 4% overall for anaesthetics.

Assuming 5% vacancies in 2016 suggests demand for obstetric anaesthesia would have been approximately **578 consultant FTE and 330 SAS and other FTE** – 0.6 SAS and other for every consultant FTE, and one consultant FTE for every 42 FTE midwives.

Based on above, we can make some high-level assumptions:

- Assuming 23,883 WTE midwives expected to be in post by 2021, a minimum of **567 consultant WTE and 324 SAS and other FTE** would be required to maintain the same 2016 ratio



- The range of births predicted for 2021 (based on 2016 and 2014 ONS projections) of 658,000-693,000 suggests demand, as a minimum, would vary **between 574 and 604 consultant WTE, and between 328 and 345 SAS and Other FTE in 2021**
- Using the Birthrate Plus® modelled demand of 24,272 WTE midwives in 2016 gives expected demand, as a minimum, of between **572 and 600 consultant WTE and between 327 and 343 SAS and other FTE in 2021.**

These suggest an indicative growth of between three and 10% may be required for this workforce as a minimum to meet possible demand by 2021.

Even this growth may be challenging, given expected retirements of anaesthetists over the long term (retirements are expected at 280 consultants per year, or potentially up to 25 FTE of capacity for obstetric anaesthesia), and that demand for anaesthesia has historically grown at 2% per year and is expected to grow potentially as much as two to 5% annually.

Recommended actions to retain experienced and skilled staff

Increasing anaesthetic trainee numbers is a desirable but difficult long-term solution. In the meantime, the development of job plans more suitable to the ageing anaesthetic workforce, encouraging senior colleagues to delay retirements may reduce some of the workforce pressure. The use of physician's assistants within a department will release anaesthetists to be redeployed to the labour ward. In addition to staffing numbers, organisational factors will need to be considered such as ensuring that local maternity systems develop service models that take into consideration their available anaesthetic workforce.

In summary, service planning for specialties dependent on anaesthesia needs to recognise that there may be significant workforce issues in the future, and close collaboration between all the specialist groups will be required.

Sonography

Background

Sonographers are health professionals (typically radiographers) who use high frequency sound waves (ultrasound) to produce images of body structures and organs to identify the source of a disease or exclude any pathology. Ultrasound is used extensively to examine pregnant women, as a means of establishing the health of unborn children.

As sonography is not a regulated profession in the UK, it is difficult to use the ESR to identify staff skilled in this area and therefore estimate demand. Engagement with the professions suggests an increasing demand for additional scans throughout pregnancy. We believe this is driven by an increase in the number of complex and high-risk pregnancies, as well as national ambitions to reduce levels of stillbirth and neonatal mortality. More complex modelling would need to consider case mix of women.



There is no nationally led education programme for this occupation. Sonographers train in other areas before transferring to sonography (with the training specific training modules delivered in partnership between individual employers and higher education providers). Coding on the ESR is inconsistent, with no occupation code due to not being a regulated profession. **For this reason, future projections have not been provided.**

Number of sonographers supporting maternity services in the NHS

The most recent data available for this profession is from 2015,⁶⁹ with an estimate that there were approximately 4,300 sonographers, with 28% of the workforce assigned to obstetrics or early pregnancy. This gives approximately 1,200 WTE sonography staff working specifically in maternity in 2015. Assuming 22,627 WTE midwives in 2015, this suggests approximately one maternity sonographer for every 19 WTE midwives.

Projecting future supply of sonographers in the NHS

HEE's model for sonography forecasts an increase in the available sonography workforce to 2021.⁷⁰ Assuming a simple 28% proportion of the workforce (those whose main ultrasound area is obstetrics or early pregnancy) gives us a forecast increase in the maternity sonography workforce of between 400 and 700 people, from 1,200 in 2015 to between 1,600 and 1,900 by 2021.

Projecting future demand for sonographers

- Using the range of births predicted for 2021 (based on 2016 and 2014 ONS projections) of 658,000- 693,000 suggests demand could vary between **1,283 WTE and 1,350 WTE** posts.
- Using the Birthrate Plus® modelled demand of 24,272 WTE midwives in 2016 and maintaining the ratio between midwives and sonographers gives expected demand for sonography posts of between **1,279 and 1,346 WTE**.



⁶⁹ CfWI (2017).

⁷⁰ CfWI (2017).



This suggests a demand in 2021 of between 1,279 and 1,350 WTE Sonographers. However, given the increasing demand for scans the NHS is experiencing, **we believe it remains prudent to plan for between 1,600 and 1,900 WTEs in 2021.**

Recommended actions to retain experienced and skilled staff

- **Increase supply:** HEE will train 200 healthcare professionals in third trimester obstetric ultrasound by September 2018 to improve the safety of maternity care, including implementation of NHS England's 'Saving Babies Lives Care Bundle'. Training has been staggered: the first cohort began around September 2017, with three more training cohorts in February, May and September 2018. Trainees have been recruited from a range of professional groups, including midwifery, radiography and sonography.

Overall, it will be important to monitor numbers, both to ensure delivery of obstetric ultrasound services and that increases in this occupation do not lead to reductions elsewhere.

Leadership, culture and productivity

This section covers broader themes and actions relating to all staff, specifically around local leadership, culture and productivity.

An emphasis on leadership

Better Births outlines a clear vision for leadership in maternity services:⁷¹

“Front line teams do not operate in a vacuum; leadership is the key determinant of the organisational culture in which front line teams operate. In maternity services, where there are clear leadership roles and channels for both midwifery and obstetric professionals, it is vital that there is collective leadership to create a multi-professional and learning culture.

Midwives and obstetricians, including their management and leadership, must work together as part of a single team focussed on the needs of the women and babies in their care.”

It is the responsibility of boards of provider organisations to ensure the provision of excellent maternity care and to monitor the quality of the care provided. To support this work, every maternity provider should nominate a board-level Safety Champion and local midwifery and obstetric safety champions; more detail about these three roles and their responsibilities is set out in **A guide to support maternity safety champions.**⁷²

⁷¹ National Maternity Review (2016: 72).

⁷² NHS Improvement (2018).



Recommendation: NHS providers to enable, support and empower their maternity safety champion to be able to fulfil their roles so that the:

- Board-level maternity safety champion ensures a board-level focus on improving safety and outcomes as part of improving maternity services.
- Obstetrician and midwife maternity safety champions can make appropriate links with the board, the local maternity clinical network and the maternal and neonatal health safety collaborative in their region.

The safety champion roles may be held by those already holding key leadership roles for clinical care in maternity services. These roles are usually the **Clinical Director for Women's Health** (the professional lead for Obstetrics and Gynaecology) and the **Director of Midwifery** (the professional lead for midwifery). Both roles need to work closely together to ensure high quality, compassionate care while increasing productivity and facilitating clinical engagement across directorates and multi-professional teams.

Leadership development

HEE is working with the NHS Leadership Academy⁷³ and maternity system partners to assess the leadership needs of the maternity workforce and develop a bespoke programme to support local cultural change, as well as ensuring as effective workforce deployment and skill mix as possible. This will take into account:

- Three of the four critical capabilities set out in **Developing People – Improving Care**,⁷⁴ the national framework for developing staff in NHS-funded services. The capability not included is around improvement skills (as staff development in this area is already underway through the Maternal and Neonatal Health Safety Collaborative). The three capabilities are:
 - Systems leadership skills: to help leaders to build trusting relationships, agree shared system goals and collaborate across organisational and professional boundaries.
 - Compassionate, inclusive leadership skills: to create just, learning cultures where improvement methods can engage colleagues, patients and carers, deliver cumulative performance improvements, and make health and care organisations great places to work.
 - Talent management: to fill current senior vacancies and leadership pipelines with the right numbers of diverse, appropriately qualified people.
- The wide range of leadership 'readiness' within the senior leadership of local maternity systems and therefore the importance of reflecting a range of training needs.
- The diverse demographic and geographical challenges faced by local maternity systems and the differing skills leaders might need.
- For those leaders with clinical responsibilities, recognition of seasonal operational pressures, ensuring that development activities reflect this where practicable.

⁷³ NHS Leadership Academy will transfer from HEE to NHS Improvement from 1 April 2019.

⁷⁴ NHS Improvement (2016).



- The need to equip the workforce to co-produce service developments and quality improvement initiatives with women, families and carers, for example through Maternity Voices Partnerships.⁷⁵

Recommendation: HEE, together with the NHS Leadership Academy, to develop a leadership programme for local maternity system leaders.

An emphasis on culture

One of the enablers to support the delivery of the vision of local maternity systems is to promote a culture that puts women at the centre of care, supports multi-professionalism and values learning.

Better Births sets out six key elements of cultures that ensure high quality, continually improving and compassionate care is the norm, that is, 'the way we do things around here'.

These are:

- Prioritising an inspirational vision and narrative – focused on care quality and compassion
- Clear aligned goals and objectives at every level
- Good people management and employee engagement
- Continuous learning and quality improvement
- Team-working, cooperation and integration
- A values-based, collective leadership strategy.⁷⁶

There are three national surveys that can help providers and local maternity systems assess culture and track the efficacy of initiatives to improve culture.

- **The NHS staff survey**⁷⁷ can be analysed at occupational group level (including midwives, but not other maternity-related job roles) by providers. The survey's core questionnaire includes questions relevant to safety culture; providers may opt in to further questions about 'leadership and development' and 'health and safety' (which includes more detailed questions about safety culture).
- **The General Medical Council's trainee surveys**⁷⁸ consider a range of indicators about staff experience; the results can be viewed by post speciality within a trust. This survey therefore provides data about the experience of obstetrics and gynaecology trainees.
- **The SCORE survey** provides an insight into a team's safety culture to help the team identify strengths and weaknesses and start to drive improvement. SCORE provides an overview of team culture and detail in areas such as team working, communication and staff burn out. Produced by **Safe and Reliable Healthcare**, the survey forms part of NHS Improvement's Maternal and Neonatal Health Safety Collaborative.⁷⁹

⁷⁵ NHS England (2017). Annex B emphasises that these partnerships should "Provide leadership to ensure that the service user voice co-produces both Local Maternity System transformation plans and provider level operational plans".

⁷⁶ National Maternity Review (2016: 74-75).

⁷⁷ Results from the 2017 NHS Staff Survey can be found here: <http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/>

⁷⁸ Results from GMC surveys can be found here (to members only): <https://webcache.gmc-uk.org/analyticsrep/saw.dll?Dashboard>

⁷⁹ More details about NHSI's programme can be found here: <https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/>



Practical tools to support providers and local maternity services improve culture include the employer-led model of midwifery supervision called A-EQUIP (Advocating for Education and Quality Improvement). The aim of the A-EQUIP model is that, through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone's job, every day in all parts of the system. Professional Midwifery Advocates (PMA) lead implementation of A-EQUIP within their organisations.

Considering the findings from **Better Births** that 'Maternity staff report higher levels of perceived stress and a less supportive work environment than other NHS staff',⁸⁰ the 'undermining toolkit'⁸¹ (produced by the RCOG and the RCM) is a tool that helps maternity services improve workplace behaviours and the effectiveness of team working.

Recommendation: NHS providers, alongside Local Maternity Systems, to engage with staff to improve leadership and culture in their organisations, including taking action to address the findings of the NHS staff survey, GMC's trainee survey and, for those trusts who are part of the Maternal and Neonatal Health Safety Collaborative, the SCORE survey.

Multi-professional working

One of the seven themes of **Better Births**, good multi-professional working breaks down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies. To do this:

- Multi-professional learning should be a core part of all pre-registration education for midwives and obstetricians, so that they understand and respect each other's skills and perspectives.
- Multi-professional training should be a standard part of continuous professional development, both in routine situations and in emergencies.
- Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they should release their staff to be part of these reviews.

Safe, Sustainable and Productive Staffing – an Improvement Resource for Maternity Services describes the need for organisations to ensure robust mandatory training, development and education programmes for multidisciplinary teams. Organisations should therefore enable multi-professional teams to come together from across the organisation and work flexibly.

Improved data and information systems also support better multi-professional working, ensuring information sharing between professionals and organisations to support safe, personalised care; this work forms a separate and distinct part of the Maternity Transformation Programme.

⁸⁰ National Maternity Review (2016: 29).

⁸¹ More details about work in this area can be found here: <https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/undermining-toolkit/>



The Maternity Safety Training Fund supported every provider trust in England to access multi-disciplinary training to improve the safety of maternity services alongside the range of other resources already mentioned in this chapter. However, there is still more HEE and others in the system can do to ensure the maternity workforce is enabled and supported to develop a culture which puts women at the centre of care and supports multi-professionalism and values learning.

Recommendation: HEE to publish an evaluation of the maternity safety training fund.

Continuity of carer models

There are four main principles that need to underpin the provision of continuity of carer:

- Provide for consistency of the midwife or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods.
- Include named midwife who takes on responsibility for co-ordinating a woman's care throughout the antenatal, intrapartum and postnatal periods.
- Enable the woman to develop an ongoing relationship of trust with her midwife.
- Where possible, be implemented in both the hospital and community settings.⁸²

⁸² NHS England (2017).



This means that services that provide continuity over the antenatal and postnatal periods, with the exception of the intrapartum period, do not meet continuity of carer requirements.

As well as the NHS England (2017) guidance referred to above (and other support co-ordinated by the National Safety Champion), HEE will provide additional support, such as appropriate education and training packages, tools and techniques development, best practice guidance, behaviour and competency assessment, and development and support to local maternity systems in implementation. The precise nature of this support will be developed following development of this strategy.

Recommendation: HEE to create a support offer for local maternity systems around the implementation of continuity of carer.

Workforce productivity

Workforce productivity is key to NHS services, as outlined in the draft workforce strategy **Facing the Facts, Shaping the Future**. Based on current trends, we expect an additional 190,000 posts across the whole NHS in England by 2027 but only an additional 72,000 staff – meaning improving the capability of services to deliver activity will be necessary.⁸³ Central to this will be ensuring the right mix of skills and competences within individual services, and ensuring the right staff undertake the right tasks.

NHSI⁸⁴ outlines how trusts should improve workforce productivity in maternity services. Firstly, providers should collect data at clinical area level and organisation level to monitor how staffing levels affect clinical quality, the use of resources and staff experience. Next, providers should engage staff to study the data (presented in a local maternity dashboard) and make changes to improve productivity and clinical quality.

The introduction of continuity of carer for most women by March 2021, with 20% of women booking from March 2019 receiving continuity is one of the key 'asks' of local maternity systems. Continuity of carer is not only what women want, but it also improves clinical quality outcomes and, whilst it is a challenge to implement, implemented well continuity of carer empowers midwives – it enables midwives to build a relationship with the women they care for, helps them manage their own working lives and provides greater job satisfaction.⁸⁵ Continuity of carer models, when implemented well, should result in a better match between women's needs and staff deployment together with better clinical outcomes for women and greater job satisfaction for staff.

Building on the key themes throughout this strategy, HEE and its system partners will work with organisations providing NHS-funded care to ensure supportive and open working environments to benefit both staff and service users. The NHS Health and Well-being Review made '**clear links between staff health and well-being and... service quality**'.⁸⁶ Investment in staff is an investment in care for women and families.

⁸³ HEE et al (2018).

⁸⁴ NHS Improvement (2018a, 34).

⁸⁵ NHS England (2017).

⁸⁶ Boorman (2009).



Support provided to local maternity systems for workforce transformation

To drive workforce transformation, HEE and partners will develop a programme of support to Local Maternity Systems for integrated workforce planning and analysis, as well as tailored support based on each local maternity service's needs. We will work locally and regionally – including through local systems, STPs and Integrated Care Systems (ICSs) to support the following areas:

- **Workforce demand and supply modelling tools:** we will develop tools to assist geographies with local workforce analysis, workforce modelling and the development of local workforce action plans through Local Workforce Action Boards and Local Maternity Systems to ensure sustainability in capability in this area for the future;
- **Workforce strategy development:** we will work with system partners to support the development of local maternity system workforce demand plans, through workforce planning and analytic support by December 2018 to inform commissioners plans for 2019/20.

We will work with local leaders and Regional Maternity Boards to understand individual and team leadership needs to help develop the programmes and overarching approach to development.

Support offer to local maternity services for workforce transformation

In practical terms, HEE, alongside the NHS Leadership Academy, proposes to offer the following:

- **Organisational development tools:** these will allow local boards to look at behaviours, values and organisational development with a team, and thereby inform future actions.
- **A transformation lead linked to each STP:** these leads will work with colleagues to develop and deliver organisational development plans.

This offer will need to vary across England, depending on local needs and priorities.



5 Implementation and Review

This strategy has aimed to identify the size and shape of the current workforce, and to assess expected future demand and workforce supply. In response, it has outlined possible actions to support the workforce in meeting the vision of **Better Births**.

For ease, we have provided the recommendations for the health care system below, with reference to each workforce and theme.

Actions relating to specific workforces

Midwifery

- **Increase midwifery training placements:** in line with the Secretary of State's March 2018 announcement, HEE proposes to expand training placement numbers by 25% over four years, with the first 650 places from 2019/20 and up to 1,000 places for a period of three years thereafter. This intervention is expected to increase capacity by just over 350 FTE in 2022/23 and just under 550 WTE per year in 2023/24, 2024/25, and 2025/26.⁸⁷
- **Improving retention rates:** a target of increasing midwife numbers by 750-800 WTE midwives between now and 2021. This means reducing numbers leaving the NHS altogether from between 800-850 WTE per year to 650-700 WTE.
- **Increase numbers transitioning from training:** Between 2016 and 2021, we expect that just under 1,800 WTE to join the NHS in England per year, either from training in England, from the rest of the UK, or from overseas. We will look to improve completion rates from training and employ 1,850 new WTE per year. This could increase numbers of newly qualified midwives entering the workplace by 250-300 WTE over the period.
- **Increase numbers joining through return to practice schemes:** We will look to boost participation in return to practice schemes in Midwifery from 50 to approximately 100 per year.
- **Increase capacity for clinical leadership:** HEE, with other organisations, will explore opportunities to further develop and update career frameworks to: enable experienced midwives to provide both strategic clinical leadership and specialist and advanced expertise alongside their core functions; clarify role expectations; set out good employment practice; and describe academic study requirements.

⁸⁷ We assume 20% attrition during training, 15% loss between training and the NHS workforce, and an average participation rate of 0.8 FTE.



Maternity support workers

- **Improve retention:** we know that approximately 12% of the support workforce to nursing and midwifery currently leave their role every year. HEE will work with the RCM and other stakeholders to support retention of MSWs.
- **Upskilling:** HEE will work with system partners to progress the MSW project; with the following expected deliverables:
 - Develop and publish the MSW Competency, Education and Career Development framework (February 2019)
 - Develop and implement a higher level MSW role (April 2019 - March 2020)

The review of apprentice standards against revised NMC published curricula, expected in April 2020, may also help widen access to pre-registration education.

Neonatal nursing

- **Neonatal Critical Care Transformation Review:** NHS England's Women and Children Programme of Care Board have commissioned the Neonatal Critical Care Transformation Review. The Model of Care Workstream will bring together the work of the review to date and develop recommendations to refine the existing model of care. It will include recommendations to address the issues that exist around nurse staffing (as well as wider workforce recommendations). Therefore, the recommendations of the review team should be read in conjunction with this document.
- **Requirements for safe staffing:** NHS Resolution should consider for inclusion in the maternity incentive scheme standards the requirement that providers have a supernumerary senior nurse on each shift who is responsible for the unit and who can ensure that it is safely staffed, and that workforce planning is effective.
- **Promote family-centred care:** All neonatal services must be supported to seek and acquire accreditation under the Bliss Baby Charter Scheme and under the UNICEF Baby Friendly Initiative.
- **Promote family integrated care:** trusts should support initiatives to develop family integrated care to improve clinical outcomes for babies, promote parental confidence in caring for their baby, and reduce stress and adverse effects on maternal mental health.
- **Review the adoption of family integrated care models:** NHS England's specialised commissioning team, with support from the ODNs, will establish what models of family integrated care are in operation in England, the coverage of those models, their effectiveness and to consider what further action might be needed to improve and monitor the uptake and effectiveness of family integrated care.



- **Education and training:** universities should ensure that adult and children's branch training includes an elective in neonatal nursing. The elective should be designed to provide graduated exposure to neonatal care settings to build the competence and emotional resilience of nurses in training.
- **Qualified in specialty training**
 - The Neonatal Critical Care Transformation Review will make recommendation(s) to ensure that: nurses and midwives have access to QIS training (enough that 70% of neonatal units' nursing establishment can achieve and maintain QIS status year-on-year) and that all QIS training meets the elements set out in the core syllabus.
 - HEE will identify funding to support QIS training.
- **Safe, sustainable neonatal care:** providers should act to avoid unnecessary admissions to neonatal critical care and discharge babies from units as soon as clinically appropriate.
- **Monitoring of future demand and supply:** HEE, in line with the findings of the Neonatal Critical Care Transformation Review, should provide ongoing monitoring of future demand and supply for neonatal nurses at both a national and neonatal ODN level. Actions should include consideration of demand for neonatal critical care (and the likely impact of measures to reduce avoidable admissions and length of stay); basing workforce requirements on the Dinning workforce tool; and making projections about the supply of neonatal nurses.
- **Professional development:** providers of NHS neonatal care must ensure that workforce plans include enough resources to allow continuing professional development and to release nurses for educational development (utilising the Dinning Tool), with the support of the NHS trust board.



- **Career structure:** HEE will work with system partners to set out and implement a clear career structure for neonatal nurses to provide suitably challenging and rewarding careers that improve the quality of neonatal care. This work should build on the recommendations of both the Neonatal Critical Care Transformation Review and **Exploring New Ways of Working in the Neonatal Unit**⁸⁸ (which made a range of recommendations about exploring role development and ways of working).
- **Support for multi-professional working (registrants):** providers to incorporate the ATAIN e-learning programme within mandatory training for all those involved in the care of new-borns: midwives and neonatal teams.
- **Support for multi-professional working (pre-registration):** universities to consider including the Attain e-learning programme within pre-registration midwifery education.

The medical workforce

- **Understanding the causes of attrition:** for Obstetrics and Gynaecology medical staff, HEE will establish a Medical Workforce Steering Group to undertake further work into the causes of attrition and thereby ensure subsequent targets for new joiners and returners to practice are appropriate.
- **New role of obstetric physician:** HEE will fund the development of an additional training pathway for obstetric physicians, with plans to pilot this for both established consultants and doctors in training in 2018/19.
- **Developing SAS Doctors:** HEE will work with its SAS doctors development group to develop a strategic approach to SAS Doctor development and funding reform, reporting in late 2018.
- **Improving recruitment to training:** for obstetrics and gynaecology, we expect just under 180 WTE per year to join the consultant workforce from training between 2016 and 2021. We will look to increase this to 195 WTE per year, which could increase numbers by 75 WTE.
- **Redesigning the consultant model for the future:** HEE will work with system partners to progress work to improve retention within the O&G training pathway and better understand the extent of subspecialisation within O&G.⁸⁹
- **Return to training schemes:** HEE will look to boost participation in return to training schemes in Obstetrics and Gynaecology by approximately five to 10 per year between now and 2021.

Sonography

- **Increasing supply:** HEE will work with system partners to progress the wider sonography training project, with a view to increasing the pipeline to 1,750 by 2021.

⁸⁸ Mitra T & Bramwells L (2017).

⁸⁹ HEE has counted all obstetrics and gynaecology staff in its calculations, as they follow a common training programme and therefore have potential to provide capacity in maternity – in practice, not all will work in maternity.



Actions relating to leadership, culture and productivity

Leadership

- **Maternity safety champions:** NHS providers should enable, support and empower their maternity safety champion to be able to fulfil their roles, so that the:
 - board-level maternity safety champion ensures a board-level focus on improving safety and outcomes as part of improving maternity services
 - obstetrician and midwife maternity safety champions can make appropriate links with the board, the local maternity clinical network and the maternal and neonatal health safety collaborative in their region
- **Leadership development:** HEE, together with the NHS Leadership Academy, will develop a leadership programme for local maternity system leaders.

Culture and Productivity

- **Improving organisational culture:**
 - NHS providers, alongside local maternity systems, to engage with staff to improve leadership and culture in their organisations, including taking action to address the findings of the NHS staff survey, GMC's trainee survey and, for those trusts who are part of the Maternal and Neonatal Health Safety Collaborative, the SCORE survey.
 - HEE and its system partners will also work with organisations providing NHS-funded care to ensure supportive and open working environments to benefit both staff and service users.
- **Assessment of the Maternity Safety Fund:** HEE will publish an evaluation of the maternity safety training fund.

Continuity of Carer

HEE to create a support offer for local maternity systems around the implementation of Continuity of Carer.

Workforce planning

- **Supporting development of local maternity systems:** HEE will work with system partners to support the development of Local Maternity System workforce demand plans, through workforce planning and analytic support by December 2018 to inform commissioners plans for 2019/20.
- **Development of workforce planning tools:** HEE will develop tools to assist geographies with local workforce analysis, workforce modelling and the development of local workforce action plans through Local Workforce Action Boards and Local Maternity Systems to ensure sustainability in capability in this area for the future.



- **Improved awareness of complexity in workforce planning:** HEE will consider future further work to assess the workforce required to deliver O&G services over the next five to 15 years, including and assessment of acuity.

Workforce Intelligence

- **Rural services:** HEE will undertake joint research with appropriate stakeholders to better understand variation in delivery of rural services, and any required actions to better manage this variation.
- **Performance reporting:** HEE will develop dashboards for performance reporting incorporating the proposed measures of maternity transformation by September 2018.
- **Data quality:** HEE will work with system partners to explore and agree solutions to current data gaps (most significantly the sonography workforce).
- **Dissemination of good practice:** HEE will populate the Workforce Transformation Star⁹⁰ to provide examples of maternity workforce transformation projects for wider dissemination.
- **Development of a longer-term workforce strategy:** HEE will work with system partners to develop a longer-term maternity workforce strategy considering demographic and service changes to 2027.

Workforce development

- **Development of a leadership offer:** HEE will develop with appropriate stakeholders a leadership offer for local and regional leaders that supports implementation of new models of care and optimal workforce productivity and skill mix, as well as leadership skills for the future. As part of this, HEE will work with local leaders and Regional Maternity Boards to develop programmes and approaches to implementation that consider specific circumstances;
- **Upskilling to deliver continuity of carer:** HEE will develop appropriate opportunities for upskilling current staff delivering continuity of carer, including through supporting the findings of existing NMC and RCOG reviews for midwifery, MSWs and obstetrics and gynaecology and developing appropriate programmes to promote supportive, effective and positive ways of working. HEE proposes that a two-day programme is rolled out to cover ways of working to provide continuity of carer and will therefore work with local maternity systems to develop and deliver an education offer for continuity of carer with view to roll out during 2018/19.

All these actions, and progress of these actions, will need regular review.

HEE will develop a detailed action plan that will set out timescales for this work, with the Maternity Workforce Steering Group overseeing the plan.

HEE will also work with partners to develop a shared model of workforce demand beyond 2021.

⁹⁰ The HEE Star can be viewed here: <https://hee.nhs.uk/our-work/hee-star>



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Appendix

Resources available to support planning

There are many useful resources available to trusts and service planners looking to assess their maternity workforce requirements. Boards are accountable for assuring themselves that NICE recommended tools such as Birthrate Plus® are used to assess staffing requirements for maternity services. A brief explanation of the main resources is provided below.

Safe, Sustainable and Productive Staffing: an improvement resource for maternity services

NHS Improvement has developed safe staffing improvement resources for several care settings, including maternity services. Initial results were published in summer 2017.⁹¹ This resource took into account existing staffing guidance from bodies such as NICE, the RCOG, Anaesthetics (RCoA) and Midwives (RCM), instructs provider boards to ensure they are using NICE endorsed tools such as Birthrate Plus® - **(see below)**. The guidance takes a multidisciplinary approach to staffing, and reviews the best available evidence on safe, sustainable staffing, including an economic impact assessment.

NICE guidelines: safe midwifery staffing for maternity services

NB - Please note that since publication, this guidance has been superseded by the Safe Staffing Maternity Improvement Guidance above.

The NICE guideline 4 (NG4) covers safe midwifery staffing in all maternity settings. The guidelines make recommendations about safe midwifery staffing, based on the best available evidence. The guidelines focus on the pre-conception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including at home, in the community, in day assessment units, in obstetric units and in midwifery-led units.

The NG4 is written for organisations that provide or commission services for NHS service users. It recommends minimum staffing ratio for women in established labour and is available on the NICE website.⁹²

Birthrate Plus®

Birthrate Plus® is both a service and provider of tools for workforce planning & strategic decision making, as well as assessment of real time staffing requirements. BR+ has developed a method of real time assessment to analyse the numbers of midwives required to safely operate maternity intrapartum and ward services. The tool is based upon a well-established workforce planning methodology for midwifery services.⁹³ The tools compare acuity and the intensity of need arising from the number and clinical status of women and the infants during labour and delivery, with numbers of staff available, highlighting risk and times when this occurs. The ward tool continues this assessment into the postnatal services and includes antenatal women as inpatients, outpatients and inductions.

⁹¹ NHS Improvement (2017).

⁹² NICE (2017).

⁹³ Ball & Washbrook (1996).



Work is underway to align Birthrate Plus[®] with the aspirations of **Better Births**, including continuity for care. Birthrate Plus[®] has been endorsed by NICE for Workforce Planning in line with the safe staffing guidelines and more information about the methodology is available on their website.⁹⁴

The birth to midwife ratios aligned with Birthrate Plus[®] recommendations adopted within the NHS England modelling were:

- A mean national ratio of 36 births per WTE continuity midwife, which is aligned with Birthrate Plus[®] guidance for homebirths and FMUs
- A ratio of 42 births per WTE hospital midwife, which is aligned with Birthrate Plus[®] recommendations for a District General Hospital with greater than 50% of mothers in acuity categories IV and V.
- A ratio of 96 births per WTE community midwife, which is aligned to Birthrate Plus[®] recommendations for community services activity only (not involving birth).

Six steps methodology to integrated workforce planning

The **Six Steps Methodology to Integrated Workforce Planning** is a practical approach to planning that ensures a workforce of the right size with the right skills and competences. The methodology identifies those elements that should be in any workforce plan, considering the current and future demand for services, the local demographic situation, the impact on other services, and any possible financial constraints. More information about Six Steps can be found on the Skills for Health website.⁹⁵

WrAPT

WrAPT is a web based, strategic workforce planning tool for health and social care. It facilitates the collection, analysis and modelling of workforce information for health and social care. It is a flexible tool to link workforce capacity and service activity and includes a mechanism for holding data to support comparison of demand and supply forecasts. WrAPT can produce guidance around staffing levels into a numeric scenario for comparison with the current workforce.

WrAPT was commissioned by HEE and led by a team hosted by Lancashire Care NHS Foundation Trust in partnership with GE Healthcare Fennimore. More information is available on the WrAPT website.⁹⁶

⁹⁴ See BR+ website for more information: <https://www.birthrateplus.co.uk/>

⁹⁵ Skills for Health (2017).

⁹⁶ The WRaPT website can be found here: <https://www.wrap.org.uk/>



Office of National Statistics data

Historical data of numbers of live births, fertility rates and the demographics of mothers is available from Office of National Statistics (ONS) reports on Live Births.⁹⁷ The ONS also publishes projections of future population trends for regions, local authorities and clinical commissioning groups in England, as well as national projections. These projections are widely used for workforce planning, both in health and beyond.⁹⁸

⁹⁷ More information can be found here: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths>

⁹⁸ More information can be found here: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections>



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