Safe midwifery staffing for maternity settings

Stakeholder response table

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
22	Birthrate Plus	draft Guideline	8	1-1 care in labour	152	Intrapartum classification should be based clinical indicators of need arising from the process and outcome of labour for mother and infant including any post delivery emergency, together with the length of time care was received in the delivery suite., Using the outcome only does not adequately reflect midwifery workload e.g lengthy labour may result in normal delivery but higher workload for midwife. Also women in higher need groups required more than one midwife during labour e.g resuscitation of an infant, supervising epidural. The Birthrate Plus classification method has been shown to capture these factors	Thank you for your comment. There was insufficient evidence to recommend Birthrate Plus. The guideline recommends a systematic assessment process which considers a variety of data, not just birth outcome. NICE also offers a separate endorsement process to assess whether submitted toolkits for informing staffing requirements comply with the guideline recommendations.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
23	Birthrate Plus	draft Guideline	8	ratios	153	Home birth ratios can be defined on normal antenatal care hours, an assessment of expected hours of labour plus the presence of two midwives for the second stage, together with the subsequent postnatal care. To this is added allowances for travel time according to geography. Also need to record time when midwives escort women into hospital during labour as this can be a notable length of time. Not appropriate to use ratios for antenatal care, as this is split between community and hospital services and can vary a great deal..Better to assess time needed per visit based in Nice guidelines for antentanal care omponents required during pregnancy in community settings and the midwives required per clinic within the hospital setting as these vary a great deal from one service to another	Thank you for your comment. The guideline recommends consideration of a range of factors associated with the woman and baby, environment, staffing, and required care activities in order to assess the midwife time needed to provide safe care.
24	Birthrate Plus	Ev to REc		Allen 2013		This study compared the establishment staffing figure to simulated scenarios of "real-time" activity in a study designerd to track fluctuations in demand. Establishment figures based on long term data are not designed for to day to day activity, That is rather like expecting one's annual salary divided by 12 to match fluctuations of monthly outgoings. The literature review for this study did not refer to the Birthate Plus article on intrapartum acuity tool which indicated how the classification system adapted to a prospective assessment of staffing needs in intrapartum care is the more appropriate method to use. Correpsondence with the	Thank you for this clarification. However, the guideline is only able to consider evidence which was publicly available at the time of development of the evidence review.

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						author acknowledged these issues underlying the study	
25	Birthrate Plus	Ev to Rec		Wartigg and Little	103	Criticism of Birthrate Plus in that the articles (2010) were descriptive and did not provide evidence of changes in staffing or outcomes as a result of undertaking the studies, and that the tool had not been independently evaluated. . The purpose of BR+ is to provide maternity services with a detailed profile of the demands on their service and the staffing and deployment of midwives needed to meet that demand . Our experience is that BR+ has effected change in many of the services where it was applied, and has enabled objective decision making on the numbers and deployment of midwives and other staff. The purpose of these articles was to explore the significant factors and anomalies in staffing which had been identified via BR+, many of which had not been identified before using normal hospital data..	Thank you for your comment. The Birthrate plus articles are high profile and widely cited, but do not address the review questions in this guideline and so cannot be used as evidence on which to base recommendations. The limitations of this evidence at addressing the specific review question were highlighted to support users of the guideline to understand why this evidence cannot be used. We acknowledge that the purpose of the Birthrate plus publications was to explore staffing issues and we recognise the usefulness of this evidence to the midwife staffing debate.

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56	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	General	General	General	There is a need to provide services with clear and appropriate staffing ratios for midwifery staff. It is very positive to see expectation of the staff involved in the monitoring and the outline role of the head of midwifery in staffing and that Trust board should receive information regarding the red flags. However the guideline starts with the concept of individualised care for women and their babies but then assesses the staffing needs not based on the needs of the woman but the timed activity of the midwife. The assessment method is vague and would require a lot of time and audit to make it into a workable model for clinical staff. Even then it would be difficult to explain the rational for staffing to those outside the service eg execs, CCG which means it is open to influence.	Thank you for your comment. The guideline has been amended to make it clearer that staffing calculations should be based on the needs, risk, acuity and dependency of each woman and baby in the service. The process for calculation has also been amended and a diagram of the process has been added to help support implementation of the recommendations.
57	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	8	1.1.1	131	It is good to see the recognition of the need for specialist midwives to support the services in providing care for individualised groups of women. The current staffing model in use in most of the units calculates these specialises outside the general midwifery staffing. It is unclear from the guidance whether that continues and how the requirement for these staff would be calculated.	Thank you for your comment. The recommendations have been amended to make it clear that the establishment calculation should be based on whole time equivalents, but the proportion of time that specialist midwives spend delivering contracted specialist work should not be included.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
58	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	9	1.1.3	157	It's important to reference the time needed for supervision especially given the increased workload for supervisors of midwives regarding quality and safety and supporting staff	Thank you for your comment.
59	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	9	1.1.4	General	This section needs reordering with use of on call staff lowest on the list, on call staff should not be used unless absolutely necessary. It also needs to be made clear whether we are talking about a general on call list or on call for homebirth which would not be utilised for general fluctuation but would be used as part of the esculation to prevent full divert or closure of the unit by suspending the home birth service	Thank you for your comment. The recommendation has been amended in line with your comment. A definition of on-call has been added to the glossary.
60	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	10	1.1.10	General	Positive to see the review at Board 6 monthly but for that to be meaningful to the board there is a need to make the flags true indicators of short staffing not inducators such as genital trauma	Thank you for your comment. The incidence of birth trauma has been removed from the list of red flags and placed in the list of indicators instead. Text has also been added to the guideline to make it clearer that red flag events and indicators are separate and serve different purposes. Red flag events are events that need immediate action now, and that action may or may not involve the allocation of additional midwives to stop the situation getting worse. An indicator is

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							not necessarily caused by midwife staffing, and should be monitored over the long term to assist in future establishment planning. The evidence review underpinning this guideline identified that there was an association between birth trauma and midwifery staffing. The committee felt that the incidence of birth trauma should be reviewed when reviewing midwifery staffing establishments.
61	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	11	1.2.2	General	As previously stated this is based around midwife activity rather than the needs or acuity of the woman. The instruction states that an evidence based tool should be used but does not give details of these tools. Current methodology to assess staffing using the birth rate plus tool has taken Trusts months to undertake and has cost Trusts thousands of pounds as this is provided by the BR + team, However the guideline gives the expectation of collecting the data and analysis it every 6 months	Thank you for your comment. The guideline has been amended to make it clear that the needs, risk, acuity and dependency of each woman and baby is the focus of staffing calculations. Insufficient evidence was available about existing tools to support staffing calculations and so no tool could be recommended. Instead the guideline outlines the process that a tool

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							could use. NICE has a separate endorsement process to evaluate new and existing tools against the guideline recommendations. Any tools that are endorsed will be published on the NICE website.
62	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	12	1.2.3	262	Newly qualified midwives are not supernumery following their induction period which usually lasts no more than 4 weeks. Although they have extra support as preceptee's they are not supernumery	Thank you for your comment. It is outside the scope of this guideline to state how long midwives should be supernumerary. Local and professional guidance should be taken into consideration instead.
63	Bolton Hospital NHS Foundation Trust (HoM)	draft Guideline	14	1.3.7	316	The word 'different from' should be replaced with less than. If the number of midwives was more than those planned escalation plans would not be necessary	Thank you for your comment. The committee considered that the recommendations are also appropriate for situations in which over staffing may have occurred.

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64	Bolton Hospital NHS Foundation Trust (HoM)	Indicators	39	Indicators	744	This should be removed as an indicator of safe staffing as it is affected by too many other factors, type of delivery, position in labour, previous trauma	Thank you for your comment. We were unclear which indicator your comment refers to. The list of indicators was agreed by the safe staffing advisory committee, based on available evidence and knowledge and experience of the committee. An indicator is not necessarily caused by midwife staffing, and should be monitored over the long term to assist in future establishment planning.
65	Bolton Hospital NHS Foundation Trust (HoM)	indicators	43	Staff reported measures	827	Missed breaks should be removed as an indicators, most of the indicators relating to staff ie overtime, breaks morale etc require extensive local data collection on a regular basis as the denominator is the number of midwives in the service this means all midwives would require to be surveyed regularly which is not practical for most services	Thank you for your comment. The committee felt that this was a very important indicator that should be monitored to inform midwifery staffing establishment planning. The committee agreed that difficulty of data collection does not preclude missed breaks being included as an indicator and that systems could be put in place to monitor breaks to minimise the data collection burden.

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246	Bolton NHS Foundation Trust (DoN)	draft Guideline	General	General	General	There is a need to provide services with clear and appropriate staffing ratios for midwifery staff. It is very positive to see expectation of the staff involved in the monitoring and the outline role of the head of midwifery in staffing and that Trust board should receive information regarding the red flags. However the guideline starts with the concept of individualised care for women and their babies but then assesses the staffing needs not based on the needs of the woman but the timed activity of the midwife. The assessment method is vague and would require a lot of time and audit to make it into a workable model for clinical staff. Even then it would be difficult to explain the rational for staffing to those outside the service eg execs, CCG which means it is open to influence.	Thank you for your comment. The guideline recommends that staffing ratios for areas of care other than during established labour, are developed locally if appropriate. This is because maternity services can be very diverse and need to take into account their local circumstances (such as demography, service configuration, needs of women and babies etc.) The guideline has been amended to make it clearer that staffing calculations need to be based on the risk, acuity and a dependency of each woman and baby in the service. The assessment method that has been recommended is to support services to ensure the midwifery establishment is safe. Currently there is no toolkit or other method that could be recommended to

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							support this process, but it is expected that NICE endorsed toolkits will become available after the guideline has published. Any endorsed toolkits will be published on the NICE website.
247	Bolton NHS Foundation Trust (DoN)	draft Guideline	8	1.1.1	131	It is good to see the recognition of the need for specialist midwives to support the services in providing care for individualised groups of women. The current staffing model in use in most of the units calculates these specialises outside the general midwifery staffing. It is unclear from the guidance whether that continues and how the requirement for these staff would be calculated.	Thank you for your comment. The recommendations have been amended to make it clear that the establishment calculation should be based on whole time equivalents, but the proportion of time that specialist midwives spend delivering contracted specialist work should not be included.
248	Bolton NHS Foundation Trust (DoN)	draft Guideline	9	1.1.3	157	It's important to reference the time needed for supervision especially given the increased workload for supervisors of midwives regarding quality and safety and supporting staff	Thank you for your comment.

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249	Bolton NHS Foundation Trust (DoN)	draft Guideline	9	1.1.4	General	This section needs reordering with use of on call staff lowest on the list, on call staff should not be used unless absolutely necessary. It also needs to be made clear whether we are talking about a general on call list or on call for homebirth which would not be utilised for general fluctuation but would be used as part of the esculation to prevent full divert or closure of the unit by suspending the home birth service	Thank you for your comment. The guideline recommends flexible ways of responding to staffing deficits. The most appropriate response will differ for different organisations, and it is the responsibility of individual services to ensure that plans are appropriate and safe. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support.
250	Bolton NHS Foundation Trust (DoN)	draft Guideline	10	1.1.10	General	Positive to see the review at Board 6 monthly but for that to be meaningful to the board there is a need to make the flags true indicators of short staffing not inducators such as genital trauma	Thank you for your comment. Please see response to comment 60.

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251	Bolton NHS Foundation Trust (DoN)	draft Guideline	11	1.2.2	General	As previously stated this is based around midwife activity rather than the needs or acuity of the woman. The instruction states that an evidence based tool should be used but does not give details of these tools. Current methodology to assess staffing using the birth rate plus tool has taken Trusts months to undertake and has cost Trusts thousands of pounds as this is provided by the BR + team, However the guideline gives the expectation of collecting the data and analysis it every 6 months	Thank you for your comment. The guideline has been amended to make it clearer that the focus is on the risk, acuity and dependency of women and babies, not midwife activity. The process that has been recommended is to support services to ensure the midwifery establishment is safe. Insufficient evidence was available to recommend Birthrate Plus or any other approach for supporting this process. It is expected that NICE endorsed toolkits will become available after the guideline has published. Any endorsed toolkits will be published on the NICE website.
252	Bolton NHS Foundation Trust (DoN)	draft Guideline	12	1.2.3	262	Newly qualified midwives are not supernumery following their induction period which usually lasts no more than 4 weeks. Although they have extra support as preceptee's they are not supernumery	Thank you for your comment. The committee agreed that ideally, newly qualified midwives should be supernumerary but it is the responsibility of organisations to agree how long they should be

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							supernumerary for.
253	Bolton NHS Foundation Trust (DoN)	draft Guideline	14	1.3.7	316	The word 'different from' should be replaced with less than. If the number of midwives was more than those planned escalation plans would not be necessary	Thank you for your comment. Please see response to comment 253.
254	Bolton NHS Foundation Trust (DoN)	Indicators	39	Indicators	744	This should be removed as an indicator of safe staffing as it is affected by too many other factors, type of delivery, position in labour, previous trauma	Thank you for your comment. We were unclear which indicator your comment refers to. The list of indicators was agreed by the safe staffing advisory committee, based on available evidence and knowledge and experience of the committee. An indicator is not necessarily caused by midwife staffing, and should be monitored over the long term to assist in future establishment planning.
255	Bolton NHS Foundation Trust (DoN)	indicators	43	Indicators	827	Missed breaks should be removed as an indicators, most of the indicators relating to staff ie overtime, breaks morale etc require extensive local data collection on a regular basis as the denominator is the number of midwives in the service this means all midwives would require to be surveyed regularly which is not practical for most services	Thank you for your comment. The committee felt that this was a very important indicator that should be monitored to inform midwifery staffing establishment planning. The committee agreed that difficulty of data collection does not preclude missed breaks

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							being included as an indicator and that systems could be put in place to monitor breaks to minimise the data collection burden.
55	Bradford Teaching Hospital NHS Foundation Trust	draft Guideline	11	1.2.2	227	More guidance required re the use of evidence based toolkits such as Birth Rate Plus and how to use in conjunction with the calculations in the guidance.	Thank you for your comment. The recommendations included where a NICE endorsed toolkit could be used. Any tools that are endorsed to support this guideline will be published on the NICE website.
301	Buckinghamshire Healthcare NHS trust	draft Guideline	9	Continuity 1.1.3	163	Forward planning references should also include delivery forecasts, booking dashboards, annual activity but also acuity –dependency studies such as Birth rate plus and data on Co-morbidity and Ethnic mix – where this has an impact of midwifery requirements due to language, education or poverty.	Thank you for your comment. The recommendations have been amended to cover the information you have suggested.
302	Buckinghamshire Healthcare NHS trust	draft Guideline	9	Continuity 1.1.4	172	Strongly endorse use of 'on call' hospital midwives (as we do in Bucks.)which should also discourage the use of Community midwives as an on call back up service much less the risk that both Post natal wards and Community are put at risk through inadequate planning by Labour wards	Thank you for your comment.

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303	Buckinghamshire Healthcare NHS trust	draft Guideline	9	Continuity 1.1.6	178	Workforce planning is a discrete skill. The involvement of Nursing administrators, HR professionals and Finance managers should also be referred to – to support not undermine the professional judgement of Midwives.	Thank you for your comment. The guideline does not preclude the involvement of other staff groups who can support the implementation of the guideline recommendations.
304	Buckinghamshire Healthcare NHS trust	draft Guideline	10	Establishment 1.1.9	187	Strongly endorse the need for 6 monthly review at board level	Thank you for your endorsement.
305	Buckinghamshire Healthcare NHS trust	draft Guideline	10	Establishment 1.1.9	191	Strongly endorse the need for consequent changes outside the business planning cycle but also recognise the importance of robust workforce planning, recruitment and retention practice.	Thank you for your endorsement.
306	Buckinghamshire Healthcare NHS trust	draft Guideline	11	Establishment 1.2.2	233	A 2 week sample is completely unreliable – would suggest a minimum of 4-12 weeks	Thank you for your comment. It is expected that maternity services will chose a time period that is appropriate for their local circumstances. The guideline also makes recommendations to check and review the establishment and so an inappropriate sample can be identified and trigger an earlier review.
307	Buckinghamshire Healthcare NHS trust	draft Guideline	13	Skill mix 1.3	277	Please define skill mix- explicit reference should be made to Maternity care assistants – 90:10 ; ratios of Band 6 & 7 and proportions of Clinical Governance midwives and In service Educators	Thank you for your comment. No evidence was available about a safe skill mix, and the committee felt that the

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							required skill mix will vary depending on local circumstances such as needs of women and babies, demographics and service configuration.
308	Buckinghamshire Healthcare NHS trust	draft Guideline	14	Skill mix 1.3.4	299	Unhelpful – see above	Thank you. Please see earlier response.
309	Buckinghamshire Healthcare NHS trust	draft Guideline	14	Skill mix 1.3.4	324	Strongly endorse though box of red flags needs to be embellished see below	Thank you for your comment.
310	Buckinghamshire Healthcare NHS trust	draft Guideline	15	Monitoring 1.4	348	• cancelled clinics • redeployment to labour ward from other settings • missed referral to safeguarding - Suturing delays of >1h - qualify birth trauma – 3rddeg tear is a recognised complication in1% of cases, which is not reflective of staffing – cite evidence base - delays in planned work, e.g. elective c-sections - delays in induction for non clinical reasons • Avoid 'other red flags agreed locally' - this could become a 'cop out' cf. centrally prescribed evidence based red flags.	Thank you for your comment. The red flag events included in this list are examples that were agreed by the committee to be important warning signs that insufficient staff are available. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
311	Buckinghamshire Healthcare NHS trust	draft Guideline	17	Monitoring 1.4	350	Box B should also include - Emergency dept - Gynaecology - Discrete Elective C-Section pathway - Labour ward activity	Thank you for your comment. The box that your comment relates to has been revised substantially for the final guideline. The

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							suggestions you made have been considered and incorporated where appropriate.
312	Buckinghamshire Healthcare NHS trust	draft Guideline	19	Evidence 2	356	The evidence base seems parochial and fails to take account of International work esp. in Australia	Thank you for your comment. The evidence reports that underpin the guideline are published on the NICE website. The reports contain information about the type of evidence that was reviewed. It is unclear what evidence from Australia you are referring to. Please see the evidence reports for further information and the pre-specified inclusion criteria.
313	Buckinghamshire Healthcare NHS trust	draft Guideline	20	Gaps 3	395	This seems perplexing as the NHSLA is v strong on contributory factors	Thank you for your comment. The evidence reports that underpin the guideline are published on the NICE website. The reports contain information about the type of evidence that was reviewed. Please see the evidence reports for further information and the pre-specified inclusion criteria.

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96	City Hospitals Sunderland, NHS Foundation Trust	draft Guideline	9	1.1.6	179	Is there an agreed competency for midwives to be trained in establishment setting	Thank you for your comment. The committee are not aware of a competency in relation to establishment setting, but there are agreed competencies for midwives to develop their knowledge and skills and to enhance safety, which training in establishment setting could be part of.
97	City Hospitals Sunderland, NHS Foundation Trust	draft Guideline	9	1.1.6	180	Wording should read Director of Nursing and midwifery as this is a statutory post on Trust boards	Thank you for your comment. The recommendations have been amended following stakeholder consultation comments.
98	City Hospitals Sunderland, NHS Foundation Trust	draft Guideline	11	1.2.2	227	NICE toolkits are referenced, however, only nursing toolkits are available.	Thank you for your comment. The link to toolkits contains all of the currently available toolkits that have been endorsed by NICE. This is a live link and is updated as toolkits become endorsed. It is anticipated that midwife staffing toolkits will be available after the final midwife staffing guideline is published.

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99	City Hospitals Sunderland, NHS Foundation Trust	draft Guideline	14	1.3.6	314	Professional judgement referenced, this needs clarification to enable consistency	Thank you for your comment. The guideline does not prescribe how professional judgement should be used as it is expected that individuals will make judgments in line with training, advice, and guidance that are appropriate for the local situation.
26	Countess of Chester NHS Foundation Trust	draft Guideline	8	1.1.3	150	This will lead to national variations and inability to benchmark	Thank you for your comment. Maternity services can be highly variable due to differences in needs of the local population and the configuration of services. The recommendations in this guideline aim to support appropriate variation, and reduce inappropriate variation.
27	Countess of Chester NHS Foundation Trust	draft Guideline	11	1.2.2	237	Using booking data to calculate deliveries would not work locally as we have number of women who book with an AQP & we first have knowledge that they are delivering with Acute Trust when they are in labour	Thank you for your comment. We acknowledge that booking data may not be entirely accurate, but committee agreed this information should still be considered when calculating the establishment, and professional judgement

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							used to check its appropriateness.
28	Countess of Chester NHS Foundation Trust	draft Guideline	12	1.2.3	262	Registered m'w with supernumerary status re newly qualified midwives how long are they to be not included in staffing calculation as preceptorship may take 2 years to complete all elements.	Thank you for your comment. It is outside of the scope of this guideline to state how long midwives should be supernumerary. Local and professional guidance should be taken into consideration instead.
117	Department of Health	draft Guideline	General	general	General	There is no mention of the named midwife objective and very little on continuity of care	Thank you for your comment. This guideline aims to ensure organisations are appropriately staffed, however care is delivered. The named midwife initiative and other relevant guidance should be taken into consideration alongside this guideline.
118	Department of Health	draft Guideline	General	general	General	There seems to be nothing to reflect the public health role of midwives, e.g. messaging on smoking, nutrition, etc	Thank you for your comment. The guideline has been amended and box 2 now provides details of key activities. Public health activities are covered generally in the time for antenatal appointments, and more specifically if a midwife is involved in delivering

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							specific training, education or advice.
119	Department of Health	draft Guideline	17	Box 2 - Sub boxes A&D	350	We would like to see perinatal mental health problems and substance misuse included	Thank you for your comment. These suggestions are now included in boxes 1 and 2 of the revised guideline
120	Department of Health	draft Guideline	17	Box 2 - sub box C	350	We would like to see **specialist midwife requirement** included within Pre-conception or antenatal care bullet points	Thank you for your comment. Consideration of specialist midwives is included in the guideline recommendations.
121	Department of Health	draft Guideline	17	Box 2 - sub box C	350	Include **breastfeeding support** in bullet points under care after labour or postnatal care (later in the guidelines breastfeeding is used as an indicator – this would provide consistency)	Thank you for your comment. The box that your comment relates to has been revised substantially. Box 2 in the revised guideline covers the routine antenatal, intrapartum, and postnatal care. Breast feeding education, advice and support was considered to be provided routinely by midwives at all stages of routine care.
122	Department of Health	draft Guideline	31	8	612	We would suggest questions could be altered to reflect " did you have a telephone number for a **NAMED** midwife or midwifery team that you could contact?" (*includes F1*)	Thank you for your comment. The wording is taken directly from the Maternity Services Survey developed by the Care Quality Commission.

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123	Department of Health	draft Guideline	31	8	611	We suggest that the addition of the CQC survey question on 'Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?'	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
234	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	General	General	general	We welcome this guidance on safe staffing in maternity settings, and are particularly pleased that there is a recommendation that safe staffing should be planned and in place in all settings, and not just in the labour ward. However, the guideline then positively endorses using staff from other areas or who are on call to cover areas that are experiencing untoward fluctuation in demand. Clearly there will be the rare situation where this is inevitable but this should very much be seen as the exception and not the rule. Unless the overall midwifery establishment is realistic in terms of an allowance for the periods of fluctuation that are regularly experienced by most maternity services and for which current establishments do not allow this will inevitably lead to areas such as postnatal wards or community services experiencing shortages. It is critical that NICE make it absolutely clear that staffing establishments are planned to ensure there is normally safe staffing across the entire maternity service.	Thank you for your comment and your support for the guideline. The focus of this guideline is to ensure that the establishment is set at a safe level from the outset. It also recommends flexible approaches to respond to unplanned staffing deficits (such as using on-call staff). The most appropriate response will differ for different organisations, and it should be determined locally to ensure that plans are appropriate and safe. The guideline also recommends methods for monitoring and reviewing these plans to ensure that they are appropriate for maintaining a safe midwifery

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							establishment.
235	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	8	1.1.4	general	The proposals for responding to daily fluctuations could result in the depletion of staff in other areas which then leaves those areas with unsafe staffing levels. To cope with daily fluctuations maternity services either have to have an adequate midwifery staffing establishment or a flexible method of getting midwives, which does not deplete other areas. Midwives who are rostered as on call for community services should not be seen as being on call for hospital services unless this has been specifically calculated into the community establishment and their responsibilities to homebirth and community services will not be affected.	Thank you for your comment. The focus of this guideline is to ensure that the establishment is set at a safe level from the outset. The guideline also makes clear that the use of flexible approaches to respond to staffing deficits should not cause red flag events to occur in other areas. The most appropriate response will differ for different organisations, and it is the responsibility of individual services to ensure that plans are appropriate and safe. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support.

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236	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	11	1.2.2	232	The time period selected should be defined by the workforce model that is being used, rather than an arbitrary selection.	Thank you for your comment. The committee discussed all stakeholder comments and guideline has been amended in light of stakeholder comments.
237	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	12	1.2.2	248	This would be an appropriate place to recommend staffing is calculated using acuity and casemix.	Thank you for your comment. Your suggestion is included in the recommendations in section 1.2 in assessing the needs of women and babies and local service configuration.
238	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	12	1.2.3	258	It is suggested that midwifery managers, specialists and consultants (or at least the proportion of time they spend not engaged in providing direct care) should be added to those categories excluded from staffing assessment requirements.	Thank you for your comment. The recommendation has been amended in line with your comment.
239	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	12	1.2.3	262	There should be a defined period (eg 1 month) when newly qualified midwives are excluded from the calculations.	Thank you for your comment. It is outside the scope of this guideline to state how long midwives should be supernumerary. Local and professional guidance should be taken into consideration instead.
240	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	12	1.2.4	265	Whilst the freedom to use 'professional judgement' is welcomed, it is unclear as to what this judgement is based on.	Thank you for your comment. It is not possible for this guideline to prescribe how professional

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							judgement should be used and it is expected that individuals will make judgments in line with training, advice, and guidance that are appropriate for the local situation.
241	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	14	1.3.4	310	It would be helpful if examples of 'Evidence based toolkits endorsed by NICE' could be included.	Thank you for your comment. Evidence about toolkits for calculating midwife staffing requirements was reviewed for this guideline and no evidence meeting the agreed criteria was identified. However, NICE has an endorsement programme that assesses new and existing toolkits for their compliance with the guideline recommendations. Any toolkits that are endorsed will be provided on the NICE website and a link to this information will be provided in the guideline.

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242	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	14	1.3.9	326	The wording of this recommendation is confusing, in that it is unclear how "reviewing the midwife staffing establishment before the planned review" fits with undertaking daily staffing checks. It may be more appropriate to recommend that should there be several red flags then an urgent review should be undertaken ahead of any planned review.	Thank you for your comment. This recommendation has now been moved to the section about monitoring and reviewing the establishment to make clearer how it differs from the daily staffing check.
243	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	24	6	483	It would be helpful to explicitly include 'mandatory training' in the uplift calculations.	Thank you for your comment. This suggested change has been made.
244	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	31	8	611	It is suggested that the following question should be included: 'Were you or your partner left alone during or shortly after labour at a time when it worried you?'	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
245	Guy's & St Thomas' NHS Foundation Trust	draft Guideline	39	8	744	It is unclear as to why 'incidence of genital tract trauma' has been identified as a key indicator for setting safe staffing levels.	Thank you for your comment. The evidence review underpinning this guideline identified that there was an association between birth trauma and midwifery staffing. This association did not indicate causation, but the committee felt that the incidence of birth trauma should be reviewed when

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							reviewing midwifery staffing establishments.
110	Heads of midwifery in Wales Advisory Group	draft Guideline	8	1.1.1	130	The term specialist midwife needs to be specific. What are they relating too in requesting specialist midwives? What area of care is being proposed 24/7 by these specialist midwives?	Thank you for your comment. It is outside the scope of the guideline to include how specialist midwives should provide care.
111	Heads of midwifery in Wales Advisory Group	draft Guideline	14	1.3.9	324	Allocation of additional midwives for times to respond to red flags this maybe challenging in smaller rural areas. Delegation of tasks to MSW's/ GPs. The kings fund research currently being undertaken doesn't appear to support this? Early results are showing that delegation to MSW's particularly in high risk women does not improve outcomes and in some circumstances may make it worse. This maybe an issue with GP's taking on additional capacity/roles especially in rural areas.	Thank you for your comment. It is outside the scope of the guideline to state which staff groups should provide care. Instead, the focus is ensuring that organisations give appropriate consideration to the needs, risk, acuity and dependency of women and babies, and ensure the appropriate midwifery staff are available to meet their needs. In some areas particular staff groups receive appropriate training to support midwives to deliver safe care (for example maternity support workers providing breast feeding support, GPs providing antenatal care), and in other cases midwives may

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							choose to delegate tasks and activities to other staff groups on a case by case basis. The guideline focuses on taking these local circumstances into consideration when determining the number of midwives needed.
112	Heads of midwifery in Wales Advisory Group	draft Guideline	general	general	General	In Wales maternity data is collected on performance indicators set out By the Welsh Government. The majority of the performance indicators mentioned are already collected Health boards in Wales report to Welsh Government at the maternity service Boards every six months. The key indicators that are not already collected can be incorporated however the reasons need to be outlined as this is not clear in the draft recommendations.	Thank you for your comment. The committee chose to include the indicators listed in the guideline based on the evidence that was available and on their knowledge and experience. Individual organisations may choose to use different indicators to the ones provided in the list.
113	Heads of midwifery in Wales Advisory Group	draft Guideline	general	general	General	The guidance is still unclear with a large emphasis on local agreement. This is not national guidance its a local agreement and is disappointing to see	Thank you for your comment. Meeting the needs of women and babies is the focus of this guideline, and these needs can vary dramatically between organisations. Thus it is important to take account of local variation to ensure safe care.

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182	Health Education England	draft Guideline	3	Focus of guideline	22	Suggest use of midwifery as opposed to midwife and repeat this throughout the document	Thank you for your comment. This change has been made throughout the guideline.
183	Health Education England	draft Guideline	4	Focus of guideline	43	There is a major omission from this section. Professional judgement has a role but this must be alongside a workforce planning tool. Suggest wording is amended to: 'However, this guideline does not override the need for, and importance of using evidence based workforce planning tools alongside professional judgement to make decisions appropriate to the circumstances'.	Thank you for your comment. We agree that workforce planning tools have a role, but professional judgement is first and foremost. Although many workforce planning tools are available, insufficient evidence is available to recommend them and so use of workforce planning tools must be alongside professional judgement. Your suggested change has not been included, as it implies that workforce planning tools should come first. Since no accredited workforce planning tools are currently available, professional judgement needs to come first.

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184	Health Education England	draft Guideline	4	Focus of guideline	48	Whilst we agree with the definition of Registered Midwives, the exclusion of Maternity Support Workers from the guideline is a major limitation and does not reflect the current situation on maternity units.	Thank you for your comment. Maternity support workers (MSWs) were excluded from the scope of this guideline. The decision was made because there is no national standard for maternity support workers. Since MSWs are excluded from this guideline, evidence about the role of MSWs has not been reviewed. Thus recommendations specifically about MSW staffing will not be included. However, the availability of other member of MDT such as MSWs and how they affect midwife staffing requirement has been considered by the guideline.
185	Health Education England	draft Guideline	5	Woman and baby centred care	63	How is contact time defined and quantified?	Thank you for your comment. The glossary has been updated to provide a definition of contact time.

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186	Health Education England	draft Guideline	5	Woman and baby centred care	63	Suggest that reference is made to the National Quality Board Guidance 'How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (2013) which applies to all care settings. This highlights the importance of factors other than just numbers of Registered Midwives in safe staffing. Also suggest reference is made to Hard Truths which commits to the publication of staffing data (planned versus actual) with monthly reporting to the Board.	Thank you for your comment, please see response to comment 71.
187	Health Education England	draft Guideline	6	Evidence to recommendations	81	Suggest inclusion of professional consensus as well as experience and expertise	Thank you for your comment. In this guideline term 'consensus' is reserved for situations in which formal consensus techniques (such as the Delphi method) have been used to assist the committee to reach a decision. The terms 'experience and expertise' are used to refer to situations in which decisions were made informally by the committee. As formal consensus techniques were not used in this guideline we have used the phrase 'experience and expertise'.

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189	Health Education England	draft Guideline	7	Recommendations	107	Amend to "The recommendations in this guideline cover all aspects of care provided by a midwife employed to provide NHS funded care".	Thank you for your suggestion. This has been added to the guideline.
190	Health Education England	draft Guideline	8	1.1.1 Focus on care for women and babies	130	Reference should be made to the specific care needs of women and their babies as this will impact upon the midwifery staffing resources required	Thank you for your comment. The guideline has been amended throughout so that it is clearer that the care needs, risk, acuity and dependency of each woman and baby is the starting point for all staffing calculations.
191	Health Education England	draft Guideline	8	1.1.1 Focus on care for women and babies	130	Add 'and their families'	Thank you for your comment. The guideline has been amended in line with your comment.
192	Health Education England	draft Guideline	8	1.1.2 Maintaining continuity of midwife (midwifery) services	141	There is a stage which precedes this section which is about determining planning workforce requirements using evidence based tools. Establishments should be reviewed 6monthly and signed off by the Board. Reference should be made to expectations in NQB staffing guidance and Hard Truths requirements re publication of data. There should be reference to the need for proactive recruitment and retention of midwives based on agreed workforce plans. The education commissioning plan for midwives should be signed off by the midwife responsible for determining the staffing establishment.	Thank you for your comment. The guideline is ordered so that the organisational responsibility comes first, and then the process for determining midwife staffing requirements comes after. This was agreed by the committee to be the most appropriate ordering of the guideline recommendations. It is expected that this guideline will be used alongside existing guidance, including that

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							from the National Quality Board about publishing staffing data. Relevant related documents will be published on the NICE website alongside the guideline.
193	Health Education England	draft Guideline	8	1.1.3 Maintaining continuity of midwife (midwifery) services	147	This section is open to huge variation re how it is interpreted in practice. There is no clarity on role of the midwife versus maternity support worker which is part of skill mix. There are no details re importance / unique role of specialist or consultant midwives. The statement 'provide other locally agreed staffing ratios' is likely to result in huge variation in interpretation and loss of the standardised approach which has been fostered through the wide application of the Birthrate Plus tool in many organisations across England. If staffing levels are to be agreed locally this will defeat the intention of the guidelines. This gives Trusts the opportunity to under establish midwifery in order to meet financial constraints	Thank you for your comment. Please see response to comment 76.

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194	Health Education England	draft Guideline	9	1.1.3 Maintaining continuity of midwife (midwifery) services	155	Suggest revised wording: 'uplift which is sufficient to accommodate requirements for…..' Uplift should also cover continuing professional development, mandatory training, mentorship, preceptorship and absences not covered for example carers leave / compassionate leave etc Supervisory status for the lead midwifery charge nurse should also be considered 155 - It would be helpful to give a figure for uplift as this varies considerably across organisations 157 - 157 We endorse that supervisors of midwives are given the time to undertake this important statutory function. However, the strength of supervision is that it is not part of Trust processes and as such cannot operate alongside organisational management processes. The time required to undertake the supervisory role should not be included in clinical time but should be calculated separately. The LSA Midwifery Officers Forum UK should be consulted in relation to the amount of time needed to undertake the role	Thank you for your comment. The recommendations regarding uplift have been amended to make it clearer what is included. It is outside the scope of this guideline to state how long supervision time should be. Local and professional guidance should be taken into consideration instead.
195	Health Education England	draft Guideline	9	1.1.3	169	This should read redistribute the workload if possible but not in such a way as to compromise other areas.	Thank you for your comment, please see response to comment 78.

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196	Health Education England	draft Guideline	9	1.1.4 Maintaining continuity of midwife (midwifery) services	170	How would 'increasing the number of midwives needed beyond midwife (midwifery) establishment' be assessed – on what basis would decisions be made? And where would the staff come from?	Thank you for your comment. After reviewing the guideline in light of stakeholder comments this recommendation has been deleted.
197	Health Education England	draft Guideline			173	The redeployment of midwives from other areas should be undertaken with caution as this can result in unsafe staffing in other potentially high risk areas.	Thank you for your comment, please see response to comment 81.
198	Health Education England	draft Guideline	9	1.1.4 Maintaining continuity of midwife (midwifery) services	174	Service cancellations are generally not possible due to nature of maternity service requirements	Thank you for your comment, please see response to comment 82.
199	Health Education England	draft Guideline	9	1.1.5 Maintaining continuity of midwife (midwifery) services	176	Senior midwives should be trained in the use of workforce planning tools and roster planning to ensure the effective utilisation of agreed midwifery establishments. Each organisation should have an escalation policy in place to enable staff to seek help and advice when staffing levels fall below planned level or where there are additional service requirements.	Thank you for your comment. The guideline has been amended in line with your suggestions.
200	Health Education England	draft Guideline	9	1.1.6 Maintaining continuity of midwife (midwifery) services	178	Midwives should be trained in the use of evidence based tools for example Birthrate Plus. It is important that there is a consistent approach to establishment setting across maternity services.	Thank you for your comment, please see response to comment 84.
201	Health Education England	draft Guideline	10	1.1.8	186	…..and instigate appropriate action where safe staffing levels are not met. We have concerns that complexity of care is not included for example complicated medical conditions – co morbidity, especially mental health / wellbeing or	Thank you for your comment, please see response to comment 85.

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						safeguarding issues.	
202	Health Education England	draft Guideline	10	1.1.9 Monitor the midwife (midwifery) staffing establishment	187	Suggest that reference is made to the National Quality Board Guidance How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability (2013) which applies to all care settings and requires this 6 monthly review.	Thank you for you comment, please see response to comment 86.
203	Health Education England	draft Guideline	11	1.1.15 Promote staff education and training	214	The time for training, mentoring and preceptorship needs to be included in establishments as these are being planned There is a need to recognise the importance of team working and integrated approach to care with other professions that also contribute to a safe level of care	Thank you for your comment, please see response to comment 87.
204	Health Education England	draft Guideline	11	1.2 Setting the midwife (midwifery) establishment	219	This whole section is a major concern. In the absence of a consistent approach to setting midwifery staffing establishments then there is the potential for huge discrepancies in staffing levels between different midwifery units. It is unclear how this process would work in practice. Section 235-236 'calculate the total midwife hours that are needed over the period of time' – how is it proposed that this will be achieved? How will consistency of staffing levels be assured? This is an oversimplification of a complex assessment which should be underpinned by a consistent evidence based tool / approach. Section 244-246 – it is unrealistic to expect	Thank you for your comment. Differences in approaches to setting staffing establishments are acceptable if they are appropriate and safe. Currently there is no evidence based tool which could support maternity services to set the midwifery staffing establishments. Instead the guideline outlines a process for ensuring the appropriateness and safety of the establishment, and in future a range of NICE

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						local wards / depts to estimate the midwifery time needed and undertake this level of calculation 247 - Allowing staffing ratios for other stages of care to be determined locally is not helpful and does not ensure consistency of care.	endorsed tool kits may be available to support the process. The process outlined in the recommendations in section 1.2 will enable maternity services to calculate the midwife hours of care needed to ensure safe care is being delivered, and a diagram has now been added to the guideline. The committee did not recommend staffing ratios for other areas of care because the needs of each woman and baby and the local situation can vary considerably and there is a risk that setting ratios will inadvertently mask these important differences and could potentially lead to unsafe care.
205	Health Education England	draft Guideline	12	1.2.3 Setting the midwife (midwifery) establishment	260	Registered Midwives undertaking LSA functions need to be added to the establishment numbers to ensure that these functions are funded.	Thank you for your comment. The recommendations are intended to cover situations in which midwives are undertaking local supervisory programmes in the

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							establishment calculation.
206	Health Education England	draft Guideline	12	1.2.4	265	While professional judgement should be applied this does not provide a sound evidence base that will resonate at Board level. This makes the case for an evidence base approach to calculating midwifery establishments for example Birthrate Plus	Thank you for your comment. It is not possible for this guideline to prescribe how professional judgement should be used and it is expected that individuals will make judgments in line with training, advice, and guidance that are appropriate for the local situation.
207	Health Education England	draft Guideline	13	1.3 Assessing differences in number and skill mix	278	As outlined in Hard Truths	Thank you for your comment.
208	Health Education England	draft Guideline	13	1.3.4 Assessing differences in number and skill mix	287	This is not a systematic assessment. This approach is open to varied interpretation. Local midwifery staff do not have the necessary skills, expertise or time to undertake this process in real time as outlined. The suggestion of locally developed staffing ratios support the introduction of wide variations in staffing establishments which is a retrograde step for the midwifery profession and midwifery services	Thank you for your comment. The recommendations in this section have been amended to deal with some of the concerns you raise. The guideline aims to support appropriate variation in midwifery services as the needs of women and babies can vary dramatically between organisations. Following the guideline

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							recommendations should ensure that all services are staffed safely according to their local circumstances.
209	Health Education England	draft Guideline	16	Box 1	347	There is no indication as to who will be collating red flags? There needs to be a clear process for assessing red flags and how these will be acted upon	Thank you for your comment. Please see response to comment 93.
210	Health Education England	draft Guideline	16	Box 1	347	Delay in Induction of Labour should be included in the box rather than agreed locally as this has a big impact on safety for women and their babies and also on complaints. We are unclear where a delay might in washing might occur as this tends to be a MSW/HCA role Should the delays include dealing with a compromised baby?	Thank you for your comment. The red flag events included in this list are examples that were agreed by the committee to be important warning signs that insufficient staff are available. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
211	Health Education England	draft Guideline	17	Box 2 - sub box C	350	Unclear why post labour washing is midwife only care. Need to add administration of medicines Needs to include complex pregnancies	Thank you for your comment. Please see response to comment 94.

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212	Health Education England	draft Guideline	18	Box 3	353	Unclear why the following outcomes are not included: Serious Clinical Incidents; maternal satisfaction surveys. Under staff reported measures, high staff turnover and missed stat and mandatory training due to staffing shortages should be included. Student feedback should be included Outcome measures should read – Booking appointment within 12 +6 weeks of pregnancy The outcome measures should include the normal delivery rate in the unit.	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment that need to be interpreted locally. An indicator is not necessarily caused by midwife staffing, and midwives are not intended to be accountable for them. The examples included in the list were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
213	Health Education England	draft Guideline	general	General feedback	general	Overall feedback received indicates that this guideline is not felt to be a very user friendly document. It was also reported that its vagueness will result in greater opportunity for local variation which is felt to be a detrimental step.	Thank you for your comment. The guideline has been amended taking into account consultation comments, and a diagram of the guideline recommendations has been added to make the document more user

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							friendly. The needs of women and babies can vary dramatically between organisations, so it was considered important to take account of local variation to ensure safe care.
100	National Federation of Women's Institutes	draft Guideline	general	general	General	The NFWI welcomes this draft guideline and the emphasis it places on the link between women and their families' safety and appropriate midwifery staffing. We especially welcome the direction from NICE on calculating the number of midwives needed which will now have to take into account basic aspects of a well-trained, supervised and well looked-after staff, by building in annual leave, breaks and supervision into the midwifery establishment. We also welcome the emphasis on constant monitoring with a view to improvement, and the restating of the Hard Truths Commitment of NHS England which will see staffing reports go to Trust boards every six months. We also welcome the many indicators of safe staffing (Section 8) that must be taken into account, especially those which measure temporary staff reliance, midwives missing breaks, and women who do not birth in their place of choice.	Thank you for your comments and for your support of the guideline.

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101	National Federation of Women's Institutes	draft Guideline	7	Recommendations 1.0	114	We would like NICE to restate the position of NHS England - 'It is first and foremost an employer responsibility to ensure they have enough staff to provide a safe and high quality service for current and future patients' – to make clear that while this guideline will be useful for many people, the ultimate responsibility for implementing it lies with employers (see National Quality Board, '*How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability',* 2013). A similar idea is in Line 144 (on page 8) but it would also be good to have this stated at the outset too.	Thank you for your comment. Links to the National Quality Board Guidance and other related documents will be placed on the NICE website alongside the published guideline, as there are many related documents and some are not specific to midwifery staffing.
103	National Federation of Women's Institutes	draft Guideline	9	1.1.3	157	We would suggest the addition of the word 'statutory' before the word supervision to make clear the relationship to the NMC, as opposed to other forms of supervision which not all midwives have (like LSA Programme supervision).	Thank you for your comment. The committee agreed not to amend the recommendation following committee discussions.
105	National Federation of Women's Institutes	draft Guideline	9	1.1.4	173	The NFWI is concerned that redeploying midwives from other parts of the maternity service is too often seen as a solution to staffing shortages for intrapartum care. We think when staff are redeployed from postnatal or community services, these incidences should be seen as 'red flags', not seen as normal part of dealing with daily fluctuations in demand.	Thank you for your comment. This recommendation has been amended to make it clear than any action in relation to this recommendation should not cause red flags to occur in other areas.
106	National Federation of Women's Institutes	draft Guideline	17	Box 2	350	To section D of Box 2, we would recommend adding in time for midwives to take part in safeguarding cases.	Thank you for your comment. Please note that this box has now been revised

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							substantially. Time for safeguarding has been added to the new box 2 in the revised guideline
107	National Federation of Women's Institutes	draft Guideline	18	Box 3	353	We would suggest adding in the 'ratio of supervisors of midwives to midwives' into the list of Midwifery staffing establishment measures – the recommended ratio is 1:15, and LSAs collect this data.	Thank you for your comment. Although there is professional guidance on this ratio, this is not based on evidence and has not been recommended in the revised guideline.
108	National Federation of Women's Institutes	draft Guideline	45	8 Indicators	general	We welcome the many indicators of safe staffing (Section 8) that must be taken into account, especially those which measure temporary staff reliance, midwives missing breaks, and women who do not birth in their place of choice (and why).	Thank you for your comment.
109	National Federation of Women's Institutes	draft Guideline	45	8 Indicators	872	This paragraph seems to be a repeat from the previous page.	Thank you for your comment. This is intentional as the same data source provides data for both indicators.
214	NHS England	draft Guideline	4	Focus of guideline	43	There is a major omission from this section. Professional judgement has a role but this must be alongside a workforce planning tool. Suggest wording is amended to: 'However, this guideline does not override the need for, and importance of using evidence based workforce planning tools alongside professional judgement to make decisions appropriate to the circumstances'.	Thank you for your comment. Please see response to comment 183.

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215	NHS England	draft Guideline	4	Focus of guideline	48	Whilst we agree with the definition of Registered Midwives, the exclusion of Maternity Support Workers from the guideline is a major limitation and does not reflect the current situation on maternity units.	Thank you for your comment. Please see response to comment 184.
216	NHS England	draft Guideline	5	Woman and baby centred care	63	How is contact time defined and quantified?	Thank you for your comment. The glossary has been updated to provide a definition of contact time.
217	NHS England	draft Guideline	8	1.1.2	143	we suggests adding the words "including in the community" after "in the organisation". This is because there is a tendency to associate the term organisation with a building.	Thank you for your comment. This recommendation has been amended following discussions with the committee of all stakeholder comments to make it clearer that the recommendations are intended for all services.
218	NHS England	draft Guideline	9	1.1.4	169	Clarification is needed as to what is meant by "redistributing the midwife workload". This could refer to, for example, establishing a day assessment unit or it could instead mean substituting midwives in theatre with theatre nurses.	Thank you for your comment. The recommendation has been amended to be clearer.
219	NHS England	draft Guideline	9	1.1.4	170	Clarification is needed as to what is meant by "increasing the number of midwives needed beyond the midwife staffing establishment. Does this to refer to atypical situations rather than daily fluctuations, which should be covered by the midwifery staffing establishment or is this is about calling in bank or agency staff?	Thank you for your comment. After reviewing the guideline in light of stakeholder comments this recommendation has been deleted.

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220	NHS England	draft Guideline	9	1.1.4	172	We not support the recommendation to use on-call staff to respond to peaks in demand, unless it is an on-call rota set up specifically for the purpose of dealing with fluctuations in demand. Furthermore, such staff that are called should not have commitments the next day.	Thank you for your comment. The guideline recommends flexible ways of responding to staffing deficits. The most appropriate response will differ for different organisations, and it should be determined locally to ensure that plans are appropriate and safe. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support.
221	NHS England	draft Guideline	8	Maintaining continuity of midwife (midwifery) services 1.1.2	141	Establishments should be reviewed 6monthly and signed off by the Board. Reference should be made to expectations in NQB staffing guidance and Hard Truths requirements re publication of data. There should be reference to the need for proactive recruitment and retention of midwives based on agreed workforce plans. The education commissioning plan for midwives should be signed off by the midwife responsible for determining the staffing establishment.	Thank you for your comment. The guideline does recommend that the board is responsible for reviewing the midwife staffing establishment at least every 6 months It is expected that this guideline will be used alongside existing guidance, including that from the National Quality Board about publishing staffing data.

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							Relevant related documents will be published on the NICE website alongside the guideline.
222	NHS England	draft Guideline	8	Maintaining continuity of midwife (midwifery) services 1.1.3	147	This section is open to huge variation re how it is interpreted in practice. There is no clarity on role of the midwife versus maternity support worker which is part of skill mix. There are no details re importance / unique role of specialist or consultant midwives. The statement 'provide other locally agreed staffing ratios' is likely to result in huge variation in interpretation and loss of the standardised approach which has been fostered through the wide application of the Birthrate Plus tool in many organisations across England. If staffing levels are to be agreed locally this will defeat the intention of the guidelines. This gives Trusts the opportunity to under establish midwifery in order to meet financial constraints	Thank you for your comment. Please see response to comment 76.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
223	NHS England	draft Guideline	9	Maintaining continuity of midwife (midwifery) services 1.1.3	155	Suggest revised wording: 'uplift which is sufficient to accommodate requirements for…..' Uplift should also cover continuing professional development, mandatory training, mentorship, preceptorship and absences not covered for example carers leave / compassionate leave etc Supervisory status for the lead midwifery charge nurse should also be considered 155 - It would be helpful to give a figure for uplift as this varies considerably across organisations	Thank you for your comment. The recommendations regarding uplift have been amended to make it clearer what is included. It is outside the scope of this guideline to state how long supervision time should be. Local and professional guidance should be taken into consideration instead.
224	NHS England	draft Guideline	9	Maintaining continuity of midwife (midwifery) services 1.1.4	174	Service cancellations are generally not possible due to nature of maternity service requirements	Thank you for your comment, please see response to comment 82.
225	NHS England	draft Guideline	9	Maintaining continuity of midwife (midwifery) services 1.1.5	176	Senior midwives should be trained in the use of workforce planning tools and roster planning to ensure the effective utilisation of agreed midwifery establishments. Each organisation should have an escalation policy in place to enable staff to seek help and advice when staffing levels fall below planned level or where there are additional service requirements.	Thank you for your comment, please see response to comment 199.
226	NHS England	draft Guideline	9	Maintaining continuity of midwife (midwifery) services 1.1.6	178	Midwives should be trained in the use of evidence based tools for example Birthrate Plus. It is important that there is a consistent approach to establishment setting across maternity services.	Thank you for your comment, please see response to comment 84.

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227	NHS England	draft Guideline	10	Monitor the midwife (midwifery) staffing establishment 1.1.9	187	We suggest that reference is made to the National Quality Board Guidance How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability (2013) which applies to all care settings and requires this 6 monthly review.	Thank you for you comment, please see response to comment 86.
228	NHS England	draft Guideline	11	1.1.15	214	We agree with this recommendation but suggests that a minimum period of preceptorship should be stated, as per our suggestions in comment 1 above.	Thank you for your comment. It is not within the scope of this guideline to state how long preceptorship should take. Local and professional guidance should be taken into consideration instead.
229	NHS England	draft Guideline	12	1.2.3	258	We would suggest adding midwifery managers, specialists and consultants (or at least the proportion of time they spend not engaged in providing direct care) to those categories excluded from staffing assessment requirements.	Thank you for your comment. The recommendation has been amended in line with your comment.

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230	NHS England	draft Guideline	11	Setting the midwife (midwifery) establishment 1.2	219	This whole section is a major concern. In the absence of a consistent approach to setting midwifery staffing establishments then there is the potential for huge discrepancies in staffing levels between different midwifery units. It is unclear how this process would work in practice. Section 235-236 'calculate the total midwife hours that are needed over the period of time' – how is it proposed that this will be achieved? How will consistency of staffing levels be assured? This is an oversimplification of a complex assessment which should be underpinned by a consistent evidence based tool / approach. Section 244-246 – it is unrealistic to expect local wards / depts to estimate the midwifery time needed and undertake this level of calculation 247 - Allowing staffing ratios for other stages of care to be determined locally is not helpful and does not ensure consistency of care.	Thank you for your comment, please see response to comment 204.

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231	NHS England	draft Guideline	12	1.2.4	265	While professional judgement should be applied this does not provide a sound evidence base that will resonate at Board level. This makes the case for an evidence base approach to calculating midwifery establishments for example Birthrate Plus	Thank you for your comment. There was insufficient evidence to support Birthrate Plus or any other approach for setting the midwifery staffing establishment. Because of this the guideline recommends that a systematic process is used which is supported by professional judgment. NICE offers a separate endorsement process for toolkits. If Birthrate Plus is submitted for endorsement and approved, this will be published on the NICE website and could be used to support implementation of the guideline in future.
232	NHS England	draft Guideline	13	Assessing differences in number and skill mix 1.3	278	As outlined in Hard Truths	Thank you for your comment.

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233	NHS England	draft Guideline	13	Assessing differences in number and skill mix 1.3.4	287	This is not a systematic assessment. This approach is open to varied interpretation. Local midwifery staff do not have the necessary skills, expertise or time to undertake this process in real time as outlined. The suggestion of locally developed staffing ratios support the introduction of wide variations in staffing establishments which is a retrograde step for the midwifery profession and midwifery services	Thank you for your comment. The recommendations in this section have been amended to deal with some of the concerns you raise. The guideline aims to support appropriate variation in midwifery services as the needs of women and babies can vary dramatically between organisations. Following the guideline recommendations should ensure that all services are staffed safely according to their local circumstances.
66	NHS England (Midlands & East)	draft Guideline	3	Focus of guideline	General	The development of a guideline to support safe staffing in maternity services is very much welcomed and in general terms, adds further value to the NQB safe staffing guidance.	Thank you for your comment.
67	NHS England (Midlands & East)	draft Guideline	3	Focus of guideline	22	Suggest using the term midwifery instead of midwife and repeat throughout the document	Thank you for your comment. This change has been made throughout the guideline.

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68	NHS England (Midlands & East)	draft Guideline	4	Focus of guideline	43	Professional judgement has a role but this must be alongside a workforce planning tool.	Thank you for your comment. The committee agree that workforce planning tools have a role, but professional judgement is first and foremost. Although many workforce planning tools are available, insufficient evidence is available to recommend them and so use of workforce planning tools must be alongside professional judgement.
69	NHS England (Midlands & East)	draft Guideline	4	Focus of guideline	48	The exclusion of Maternity Support Workers from the guideline is a major limitation and does not reflect the current situation on maternity units.	Thank you for your comment. Maternity support workers (MSWs) were excluded from the scope of this guideline. The decision was made because there is no national standard for maternity support workers. Since MSWs are excluded from this guideline, evidence about the role of MSWs has not been reviewed. Thus recommendations specifically about MSW staffing will not be included. However, the availability of other

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							member of MDT such as MSWs and how they affect midwife staffing requirement has been considered by the guideline.
70	NHS England (Midlands & East)	draft Guideline	5	Woman and baby centred care		Contact time needs to be defined and quanitfied	Thank you for your comment. The glossary has been updated to provide a definition of contact time.
71	NHS England (Midlands & East)	draft Guideline	5	Woman and baby centred care	63	Suggest that reference is made to the National Quality Board Guidance *'How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability'* (2013) which applies to all care settings. This highlights the importance of factors other than just numbers of Registered Midwives in safe staffing. Also suggest reference is made to Hard Truths which commits to the publication of staffing data (planned versus actual) with monthly reporting to the Board.	Thank you for your comment. Links to the National Quality Board Guidance and other related documents will be placed on the NICE website alongside the published guideline, as there are many related documents and some are not specific to midwifery staffing.

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72	NHS England (Midlands & East)	draft Guideline	6	Evidence to recommendations	81	Suggest inclusion of professional consensus as well as experience and expertise	Thank you for your comment. In this guideline the term 'consensus' is reserved for situations in which formal consensus techniques (such as the Delphi method) have been used to assist the committee to reach a decision. The terms 'experience and expertise' are used to refer to situations in which decisions were made informally by the committee. As formal consensus techniques were not used in this guideline we have used the phrase 'experience and expertise'.
73	NHS England (Midlands & East)	draft Guideline	8	1.1.1 Focus on care for women and babies	130	Reference should be made to the specific care needs of women and their babies as this will impact upon the midwifery staffing resources required	Thank you for your comment. The guideline has been amended to make it clear that the needs, risk, acuity and dependency of each woman and baby is the focus of staffing calculations.
74	NHS England (Midlands & East)	draft Guideline	8	1.1.1 Focus on care for women and babies	130	Add 'and their families'	Thank you for your comment. The guideline has been amended in line with your comment.

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75	NHS England (Midlands & East)	draft Guideline	8	1.1.2 Maintaining continuity of midwife (midwifery) services	141	It would be helpful to reference the expectations in the NQB guidance and hard truths regarding publication of staffing data..	Thank you for your comment. Links to the National Quality Board Guidance and other related documents will be placed on the NICE website alongside the published guideline, as there are many related documents and some are not specific to midwifery staffing.
76	NHS England (Midlands & East)	draft Guideline	8	1.1.3 Maintaining continuity of midwife (midwifery) services	147	This section is open to interpretation. There is no clarity on role of the midwife versus maternity support worker which is part of skill mix. There are no details re importance / unique role of specialist or consultant midwives. The statement 'provide other locally agreed staffing ratios' is likely to result in variation in interpretation and loss of the standardised approach which has been fostered through the wide application of the Birthrate Plus tool in many organisations across England. If staffing levels are to be agreed locally this will undermine the purpose of this guideline.	Thank you for your comment. The recommendations include that consideration should be given to the availability of other staff groups (such as maternity support workers, GPs, obstetricians) when undertaking staffing calculations, and that midwives can delegate to other trained and competent staff when appropriate. However the focus of the recommendations throughout this guideline is on registered midwives. Furthermore, professional judgement is required when determining the number

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							and skill mix of registered midwives that are required, as this will depend on the case mix and local configuration of services. Since there is a large amount of variation in case mix and local configuration of services, it is important that local service determine their own staffing ratios in order to meet the specific needs of women and babies in the service. If the guideline is followed, any variation in local services should be appropriate and safe. Insufficient evidence was available about Birthrate Plus and so it is unclear if the tool calculates the required number of midwives appropriately, and this is why the tool has not been recommended.

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77	NHS England (Midlands & East)	draft Guideline	9	1.1.3 Maintaining continuity of midwife (midwifery) services	155	Suggest revised wording: 'uplift which is sufficient to accommodate requirements for…..' Uplift should also cover continuing professional development, mandatory training, mentorship, preceptorship and absences not covered for example carers leave / compassionate leave etc Supervisory status for the lead midwifery charge nurse should also be considered We endorse that supervisors of midwives are given the time to undertake this important statutory function. However, the strength of supervision is that it is not part of Trust processes and as such cannot operate alongside organisational management processes. The time required to undertake the supervisory role should not be included in clinical time but should be calculated separately. The LSA Midwifery Officers Forum UK should be consulted in relation to the amount of time needed to undertake the role	Thank you for your comment. The text of the recommendations relating to uplift has been amended to make what is included in study leave clearer. There are separate recommendations about mentorship and preceptorship, and giving and receiving supervision as these factors are not part of uplift. The recommendations about supervision running alongside organisational and management processes has also been amended.
78	NHS England (Midlands & East)	draft Guideline	9	1.1.4	169	This should read redistribute the workload if possible but not in such a way as to compromise other areas.	Thank you for your comment. This recommendation has been amended to make it clear than any action in relation to this recommendation should not cause red flags to occur in other areas.

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80	NHS England (Midlands & East)	draft Guideline	9	1.1.4 Maintaining continuity of midwife (midwifery) services	170	How would 'increasing the number of midwives needed beyond midwife (midwifery) establishment' be assessed – on what basis would decisions be made? And where would the staff come from?	Thank you for your comment. After reviewing the guideline in light of stakeholder comments this recommendation has been deleted.
81	NHS England (Midlands & East)	draft Guideline	9	1.1.4	173	The redeployment of midwives from other areas should be undertaken with caution as this can result in unsafe staffing in other potentially high risk areas.	Thank you for your comment. This recommendation has been amended to make it clear than any action in relation to this recommendation should not cause red flags to occur in other areas.
82	NHS England (Midlands & East)	draft Guideline	9	1.1.4 Maintaining continuity of midwife (midwifery) services	174	Service cancellations are generally not possible due to nature of maternity service requirements	Thank you for your comment. The committee discussed your comment however the recommendation has not been amended as the committee felt that service closures or service suspensions do occur (for example, suspension of home birth service).
83	NHS England (Midlands & East)	draft Guideline	9	1.1.5 Maintaining continuity of midwife (midwifery) services	176	Senior midwives should be trained in the use of workforce planning tools and roster planning to ensure the effective utilisation of agreed midwifery establishments. Each organisation should have an escalation policy in place to enable staff to seek help and advice when staffing levels fall below planned level or where there are additional	Thank you for your comment. The guideline has been amended in line with your suggestions.

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						service requirements.	
84	NHS England (Midlands & East)	draft Guideline	9	1.1.6 Maintaining continuity of midwife (midwifery) services	178	Midwives should be trained in the use of evidence based tools for example Birthrate Plus. It is important that there is a consistent approach to establishment setting across maternity services.	Thank you for your comment. Information about training midwives in establishment setting is provided in the recommendations. Currently there is no evidence based approach to establishment setting that can be recommended. Any evidence based tools that are endorsed by NICE will be published on the NICE website.
85	NHS England (Midlands & East)	draft Guideline	10	1.1.8	186	…..and instigate appropriate action where safe staffing levels are not met. We have concerns that complexity of care is not included for example complicated medical conditions – co morbidity, especially mental health / wellbeing or safeguarding issues.	Thank you for your comment. The guideline has been amended to make it clear that calculations need to be based on needs, risk, acuity and dependency of women and babies in the service, and examples of medical, social and other factors that need to be considered are provided.

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86	NHS England (Midlands & East)	draft Guideline	10	1.1.9 Monitor the midwife (midwifery) staffing establishment	187	Suggest that reference is made to the National Quality Board Guidance *How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability* (2013) which applies to all care settings and requires this 6 monthly review.	Thank you for your comment. Links to the National Quality Board Guidance and other related documents will be placed on the NICE website instead of within the guideline. This is because these documents are not specific to midwifery staffing, and the list of related documents could be extensive meaning the website is the most appropriate and accessible place for these links to be placed.
87	NHS England (Midlands & East)	draft Guideline	11	1.1.15 Promote staff education and training	214	The time for training, mentoring and preceptorship needs to be included in establishments as these are being planned There is a need to recognise the importance of team working and integrated approach to care with other professions that also contribute to a safe level of care	Thank you for your comment. The recommendation includes midwives having sufficient time for preceptorship and other activities necessary for providing safe care.
88	NHS England (Midlands & East)	draft Guideline	11	1.2 Setting the midwife (midwifery) establishment	219	This section is difficult to follow with text alone and may benefit from a diagrammatic representation to support the various stages. There are more general concerns about whether the process that is described will lead to significant variation across maternity services, particularly in light of the inclusion of locally determined staffing	Thank you for your suggestion. A diagram has now been added to the guideline.

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						ratios for settings other than established labour.	
89	NHS England (Midlands & East)	draft Guideline	12	1.2.3 Setting the midwife (midwifery) establishment	260	Registered Midwives undertaking LSA functions need to be added to the establishment numbers to ensure that these functions are funded.	Thank you for your comment. The recommendations include situations in which midwives are undertaking local supervisory programmes in the establishment calculation.
90	NHS England (Midlands & East)	draft Guideline	12	1.2.4	265	While professional judgement should be applied this does not provide a sound evidence base that will resonate at Board level. This makes the case for an evidence base approach to calculating midwifery establishments for example Birthrate Plus	Thank you for your comment. The evidence review did not identify sufficient evidence to recommend Birthrate Plus. NICE also offers a separate endorsement process to assess whether submitted toolkits for informing staffing requirements comply with the guideline recommendations.
91	NHS England (Midlands & East)	draft Guideline	13	1.3 Assessing differences in number and skill mix	278	As outlined in Hard Truths	Thank you for your comment.

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92	NHS England (Midlands & East)	draft Guideline	13	1.3.4 Assessing differences in number and skill mix	287	The suggestion of locally developed staffing ratios may contribute wide variations in staffing establishments	Thank you for your comment. Variation in staffing establishments may be appropriate to enable organisations to respond to their local case mix and service configuration, as the needs of women and babies can vary dramatically between organisations.
93	NHS England (Midlands & East)	draft Guideline	16		347	There is no indication as to who will be collating red flags? There needs to be a clear process for assessing red flags and how these will be acted upon	Thank you for your comment. Registered midwives in charge of the service are responsible for collating information on red flag events and ensuring appropriate action is taken to address them. The guideline has been amended to make this clearer.
94	NHS England (Midlands & East)	draft Guideline	17	Box 2 - sub box C	350	Unclear why post labour washing is midwife only care. Need to add administration of medicines Needs to include complex pregnancies	Thank you for your comment. The information in this box is about the maternity care needs of women and babies that may be provided by other staff in addition to midwives. Please note that this box has been substantially revised and is now presented as

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							two separate boxes in the revised guideline.
95	NHS England (Midlands & East)	draft Guideline	18	Box 3	353	Suggest the following outcomes are included: Serious Clinical Incidents; maternal satisfaction surveys. High staff turnover and missed statutory and mandatory training due to staffing shortages Outcome measures should read – Booking appointment within 12 +6 weeks of pregnancy The outcome measures should include the normal delivery rate in the unit.	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
297	NHS Trust Development Authority	draft Guideline	General	General	General	The NHS TDA is generally supportive of the approach taken to maternity staffing guidelines. We would ask that the affordability of this guidance is taken into consideration throughout its development. We would also suggest that new roles and support staff to midwives are included in this guidance.	Thank you for your comments and support of the guideline. A resource impact commentary will be produced alongside the guideline.
289	Oxford University Hospitals NHS Trust	draft Guideline	General	General	General	The term 'midwife establishments is incorrect and should be midwifery establishments. The same applies to safe midwifery care, midwifery staffing etc.	Thank you for your comment. Your suggested change has been made throughout the document.

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290	Oxford University Hospitals NHS Trust	draft Guideline	9	1.1.4	167	The use of on call staff unless specifically designated for this purpose should not be advocated. The guideline should make it clear that community midwives are not on call to cover the hospital service as if they are called in this will have a negative impact on the services provided to women and their babies. Other services such as home births and the MLU's may be withdrawn if there are no midwives available. The regular redeployment of midwives from other areas especially postnatal wards is unsatisfactory as women do not receive the appropriate level of support and leave hospital without gaining the skills to care for their baby. The statement relating to closure of services should be much stronger – the statement should be 'service cancellations or closures MUST be considered as a last resort'.	Thank you for your comment. The guideline recommends flexible ways of responding to staffing deficits. The most appropriate response will differ for different organisations, and it should be determined locally to ensure that plans are appropriate and safe. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support. In addition the guideline make recommendations for monitoring and reviewing red flags and indicators which will provide organisations with feedback on whether the planned responses are appropriate and whether alternative responses need to be considered in future.

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291	Oxford University Hospitals NHS Trust	draft Guideline	12	1.2.5	266	It is difficult to understand how the service can flex up and down quickly as it takes 4-6 months to recruit midwives. This could quickly lead to a shortage of midwives in the system.	Thank you for your comment. The guideline recommends that the establishment should be reviewed every 6 months and only changed if the review indicates this is necessary.
292	Oxford University Hospitals NHS Trust	draft Guideline	14	1.3.7	315	Concerns about the situation of calling in temporary staff, in some areas there is not this local provision. Agency costs will escalate if the establishments are incorrect. If maternity services close more often where will women go to have their care?	Thank you for your comment. The guideline is focussed on safe staffing, and regular review of red flags and indicators (including use of temporary staff) is recommended. If agency costs escalate or maternity services close, this should trigger a review and possible revision of the existing establishment.
293	Oxford University Hospitals NHS Trust	draft Guideline	15	1.4.1	337	The continuous monitoring of midwifery establishments is positive. There needs to be an agreed mechanism for presenting and discussing the data at Trust Board.	Thank you for your comment.
294	Oxford University Hospitals NHS Trust	draft Guideline	17	Box 2	350	Concerns about the methodology to determine midwifery establishments, the use of a nationally recognised tool would be helpful.	Thank you for your comment. Currently there is no evidence based national tool to support this guideline. If new or existing tools are submitted and endorsed by NICE to support this guideline, the

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							information will be published on the NICE website.
295	Oxford University Hospitals NHS Trust	draft Guideline	General	General	General	The impact of newly qualified midwives on the establishment needs to be more explicit. They require a period of supernumery status and then need a period of preceptorship including support and supervision especially in areas such as intrapartum care. If this is not in place attrition rates will rise.	Thank you for your comment. The guideline has been amended to acknowledge the impact of newly qualified and recognise the need for preceptorship and supervision.
296	Oxford University Hospitals NHS Trust	draft Guideline	General	General	General	The contribution of specialist roles is very positive and these must include Consultant midwives.	Thank you.
29	Royal College of Midwives	draft Guideline	General	General	General	The RCM welcomes this guideline, much of which is very welcome. It will both add to and reinforce other documents which make recommendations about midwifery staffing. It is particularly welcome that the document takes into account the need to ensure that areas of maternity services other than the labour ward require to be assessed as to appropriate staffing ratios and those ratios regularly monitored and reviewed. The RCM also welcomes the clear intention that Heads of Midwifery (HOMs) must be involved in the process leading to decisions about the correct levels of midwifery staffing and that the Trust Board should be regularly receiving monitoring reports and reviewing midwifery staffing levels against the concept of red flags. However, the RCM is concerned that the philosophical basis for calculating the midwifery workforce in this guideline is not	Thank you for your comment and for the support of this guideline. The establishment calculation recommendations have been amended to make it clearer that the calculation needs to be based on the needs, risk, acuity and dependency of each woman and baby. Other amendments have also been made throughout the document to add clarity to some issues where you have highlighted that the text is vague or contradictory.

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						compatible with the guideline's own acknowledgement that care should be women and baby centred (page 5, lines 63 to67). When it comes to assessing staffing requirements the document always states that the starting point is the activities of the midwife. If care is not to be driven by institutional needs or indeed professional agendas but is to be women centred then it is critical that the philosophical basis for the calculation is the needs of the woman. The highly respected and recent Lancet series (http://www.thelancet.com/series/midwifery) is clear that when thinking about midwives, their role, contribution and hence staffing numbers, we must always start from the needs of the woman and her baby if we are not to distort our conclusions. The RCM is very concerned that at times the document appears to contradict itself and at other times is vague to the point of being unhelpful.	

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30	Royal College of Midwives	draft Guideline	General	General	General	In terms of the most critical contradiction: the document acknowledges the importance of safe staffing ratios in all areas of maternity services provision and indeed indicates that deviations from these ratios should be monitored. However, the guideline then positively endorses using staff from other areas or who are on call to cover areas that are experiencing untoward fluctuation in demand. Clearly there will be the rare situation where this is inevitable but this should very much be seen as the exception and not the rule. Unless the overall midwifery establishment is realistic in terms of an allowance for the periods of fluctuation that are regularly experienced by most maternity services and for which current establishments do not allow this will inevitably lead to areas such as postnatal wards or community services experiencing shortages. The RCM has good evidence from our most recent survey of HOMs that they are regularly depleting less critical areas to cover labour ward. It is critical that NICE make what we believe to be their overall intention crystal clear, that there is normally safe staffing across the entire maternity service. This is not the case at the moment.	Thank you for your comment. The guideline recommendations aim to help organisations to develop a realistic and safe midwifery staffing establishment for all services in all settings, with allowances for time to deliver all midwife activities for direct and indirect care. In addition the committee recommend that that organisations need to have plans in place to respond to any unexpected increases in demand. The revised guideline presents options for organisations to consider when planning responses, and it has been made clearer that responses should not cause red flags to occur in other areas.

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31	Royal College of Midwives	draft Guideline	8	1.1.1	131	In terms of the document being vague, an example of this relates to the issue of newly qualified midwives being supernumerary. Maternity services with a significant turnover and therefore a significant dependency on newly qualified staff will need higher staffing establishments whilst new staff gain experience and this recommendation is very welcome and helpful. However some definition of this would also be helpful. Newly qualified midwives are usually only supernumerary during induction which may last up to a month. The RCM is aware that following induction most HOMs consider a newly qualified needs about a year of preceptorship with obviously some individual variation and midwives tend to report 'feeling experienced' after about two years. However at no point ion this period of between one and two years are new staff supernumerary. Newly qualified midwives probably contribute at a minimum 50% to 75% of an experienced midwife contribution. There is no evidence base around this issue that the RCM is aware of but given that NICE acknowledges that much of this guideline is based on 'experience and expertise' (line 83) it would not be unreasonable to test this with a focus group of HOMs and tighten up this point.	Thank you for your comment. It is not within the remit of this guideline to state how long supernumerary and preceptorship should take. Local and professional guidance should be taken into consideration instead.
32	Royal College of Midwives	draft Guideline	8	1.1.2	143	Finally, the RCM welcomes the concept of the red flag but urges a much wider approach to red flag indicators.	Thank you for your comment. Red flags and indicators serve separate purposes and

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							this has been made clearer in the guideline. The lists of red flags and indicators are not exhaustive and others could be agreed locally.
33	Royal College of Midwives	draft Guideline	8	1.1.3	150	The RCM suggests that the term 'agreed midwifery skill mixes' would make more sense in the context of this recommendation.	Thank you for your comment. The guideline has been updated to incorporate your suggestion.
34	Royal College of Midwives	draft Guideline	9	1.1.4	General	The RCM is concerned that in making recommendations in how to respond to daily fluctuations, the suggested actions will end up depleting other areas, which is effectively endorsing exactly what is currently wrong with how maternity services deal with these situations now. To cope with daily fluctuations maternity services either have to have an adequate midwifery staffing establishment or a flexible method of getting midwives, which does not deplete other areas. Midwives who are rostered as on call for community services should not be seen as being on call for hospital services unless this has been specifically calculated into the community establishment and their responsibilities to homebirth and community services will not be affected.	Thank you for your comment. The intention of the guideline recommendations is as you suggest, to firstly ensure that the midwifery staffing establishment is adequate and then to ensure that there are plans in place to enable services to respond to unplanned deficits in staffing without compromising the safety of care that is delivered in other areas. The recommendations have been amended to make this clearer.
35	Royal College of Midwives	draft Guideline	9	1.1.4	169	Clarification is needed as to what is meant by "redistributing the midwife workload". This could refer to, for example, establishing a day assessment unit or it could instead mean substituting midwives	Thank you for your comment. The guideline has been updated to incorporate your suggestion.

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						in theatre with theatre nurses.	
36	Royal College of Midwives	draft Guideline	9	1.1.4	170	Clarification is needed as to what is meant by "increasing the number of midwives needed beyond the midwife staffing establishment". The RCM would take this to refer to atypical situations rather than daily fluctuations, which should be covered by the midwifery staffing establishment. If instead this is about calling in bank or agency staff then this needs to be made explicit.	Thank you for your comment. After reviewing the guideline in light of stakeholder comments this recommendation has been deleted.
37	Royal College of Midwives	draft Guideline	9	1.1.4	172	The RCM does not support the recommendation to use on-call staff to respond to peaks in demand, unless it is an on-call rota set up specifically for the purpose of dealing with fluctuations in demand. Furthermore, such staff that are called should not have commitments the next day. If they do and they are called, then this is precisely when other service areas suffer and continuity declines as well as quality.	Thank you for your comment. The guideline recommends flexible ways of responding to staffing deficits. The most appropriate response will differ for different organisations, and it should be determined locally to ensure that plans are appropriate and safe. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support.

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38	Royal College of Midwives	draft Guideline	9	1.1.4	173	The RCM strongly opposes the recommendation that midwives are redeployed to and from other areas of care. The danger with this recommendation is that it will perpetuate the practice of repeatedly calling in midwives from postnatal ward or the community to cover shortages on labour ward. The result is that home births are cancelled, birth centres are closed temporarily and the quality and standard of antenatal and postnatal care suffers. This is unacceptable and the concept of ensuring flexibility in staffing numbers needs to be described in a way which does not let this happen. The guideline should make clear that redeployment should only take place in a way that does not deplete other areas, other than in exceptional circumstances. So maternity services need to explore ways of employing flexible groups of staff who have choice over working patterns and who are rewarded appropriately.	Thank you for your comment. This recommendation has been amended to make it clear that action should not cause red flag events to occur elsewhere. In addition, the recommendations outline the examples of flexible approaches that services could consider.
39	Royal College of Midwives	draft Guideline	9	1.1.5	176	The level of training needed to determine midwife staffing requirements should be specified.	Thank you for your comment. It is not within the scope of this guideline to recommend specific details about the training that is required. This should be locally determined.

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40	Royal College of Midwives	draft Guideline	10	1.1.12	198	The RCM welcomes this recommendation because if midwives have to be redeployed it implies that there would need to be some acknowledgement that another area would then be short of staff. If this was expressed more firmly and also as a red flag then this would help to ensure that other parts of the maternity pathway would not be routinely depleted of staff in order to cover for shortfalls on labour ward. However, even then it's a case of how often are red flags acted on – it is only after a six month review and then takes further time to action, it is possible to envisage a situation where it could take a year or more to alter the establishment and get midwives in post. So while this is a good recommendation, it highlights that issues need to be red flagged and red flags need to be reviewed and acted on much more often.	Thank you for your comment. The guideline has been amended to clarify the purpose and intent of red flags and indicators. Red flags require immediate action and should not wait until after a 6 month review. Indicators on the other hand are longer term measures of the service. The recommendation has been amended to make it clearer that the occurrence red flag events could trigger a review of the midwife staffing establishment before the planned 6 month review.
41	Royal College of Midwives	draft Guideline	10	1.1.13	207	This recommendation is helpful as it again mitigates against the problem of midwives being pulled from the community/postnatal ward to cover shortages on labour ward. It is however then a question of getting the red flags right.	Thank you for your comment. The committee discussed which red flags should be included in the guideline and also included that additional red flags could be locally defined.
42	Royal College of Midwives	draft Guideline	10	1.1.14	211	The RCM has two reservations about this recommendation. Firstly, by amending an assigned location there is increased likelihood of causing red flags in other parts of the service. Secondly, we do not believe	Thank you for your comment. The committee discussed your comment and employment contract

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						that amending employment contracts is an appropriate response to midwife red flags.	has been removed from the recommendation and the recommendation has been amended accordingly.
43	Royal College of Midwives	draft Guideline	11	1.1.15	214	The RCM welcomes this recommendation but suggests that a minimum period of preceptorship should be stated, as per our suggestions in comment 1 above.	Thank you for your comment. It is not within the scope of this guideline to state how long preceptorship should take. Local and professional guidance should be taken into consideration instead.
44	Royal College of Midwives	draft Guideline	12	1.2.3	258	The RCM recommends adding midwifery managers, specialists and consultants (or at least the proportion of time they spend not engaged in providing direct care) to those categories excluded from staffing assessment requirements.	Thank you for your comment. The recommendation has been amended in line with your comment.
45	Royal College of Midwives	draft Guideline	12	1.2.3	263	While the RCM welcomes the suggestion that newly qualified midwives should not be included in the staffing assessment calculation, we believe there should include a defined period, for example for the first month of their first midwifery post. Otherwise there will be considerable variation in how this is interpreted.	Thank you for your comment. It is outside the scope of the guideline to state how long midwives should be supernumerary. Local and professional guidance should be taken into consideration instead.

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46	Royal College of Midwives	draft Guideline	12	1.2.5	268	The RCM would suggest adding that a change in community workload due to changing boundaries should be included as a reason for reviewing the staffing establishment more frequently than every six months.	Thank you for your comment. The guideline has been revised and now provides examples for when the establishment should be reviewed more often than every 6 months. For example, when local services are reconfigured, or when there is unexpected variation in demand.
47	Royal College of Midwives	draft Guideline	13	1.3.1	279	The wording of this sentence is clumsy. We suggest deleting "'for each maternity service in all settings" with "in each area of maternity services, including community".	Thank you for your comment. This recommendation has been slightly amended following consultation which we hope makes the wording clearer.
48	Royal College of Midwives	draft Guideline	14	1.3.5	312	The RCM recommend that calculations be based on whole time equivalents (wte) rather than hours.	Thank you for your comment. This text has now been updated.
49	Royal College of Midwives	draft Guideline	14	1.3.7	317	The RCM has serious reservations about this recommendation. If activities can be delegated to other staff then this should have been actioned as part of the calculation of the skill mix. Of course on very rare occasions a service might for example ask a neonatologist to undertake examinations of the newborn rather than the midwife but this can only work on an exceptional basis without neonatal work suffering unless the neonatal rotas have taken the need for such delegation into account.	Thank you for your comment. It is intended that this action will take place in exceptional circumstances, as other recommendations in this guideline should ensure that the midwife staffing establishment is adequate, and that the required number and skill mix of midwives needed on a day to day

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							basis is identified.
50	Royal College of Midwives	draft Guideline	14	1.3.7	318	The RCM would want to reiterate its reservations here about the use of on-call staff, namely that this is only acceptable if it is specifically for dealing with fluctuations and should not involve staff that have commitments to women choosing to have a homebirth or to women receiving community based services the next day. With regards to use of temporary staff, the RCM is unclear who this refers to. If it relates to bank and agency staff then this needs to be clearly stated.	Thank you for your comment. It is intended this action will only take place in exceptional circumstances, individual services will locally determine plans for responding to staffing deficits are appropriate and safe. For some organisations existing on-call teams may be developed to provide on-call cover elsewhere in the service without being detrimental to the provision of other services. Temporary staffing is now added as a bullet point in the recommendation, and it is the responsibility of individual services to determine how to source temporary staff.
51	Royal College of Midwives	draft Guideline	14	1.3.7	319	Regarding service cancellations and closures, the RCM would suggest that this recommendation needs to acknowledge that sometimes it is better for women to go somewhere else, if there are clear policies in place and if women understand the circumstances in which this may be	Thank you for your comment. It is intended that this action will take place in exceptional circumstances, as other recommendations in this guideline should ensure

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						necessary. This is sometimes the safest way of dealing with rare and unexpected major fluctuations.	that the midwife staffing establishment is adequate, and that the required number and skill mix of midwives needed on a day to day basis is identified.
52	Royal College of Midwives	draft Guideline	14	1.3.9	326	The wording of this recommendation is confusing, in that it is unclear how "reviewing the midwife staffing establishment before the planned review" fits with undertaking daily staffing checks.	Thank you for your comment. This recommendation has now been moved to the section on monitoring and evaluating the establishment to make clearer how it differs from the daily staffing check.
53	Royal Surrey County Hospital Foundation Trust	Draft guideline	14	1.3.4	310	the endorsement of tools such as Birthrate Plus may support capturing this activity	Thank you for your comment. Any tools that are endorsed to support this guideline will be published on the NICE website
54	Royal Surrey County Hospital Foundation Trust	Draft guideline	16	1.4.2	348	Please can you explain the example given around incidence of birth trauma as midwives cannot be held accountable for delay in these repairs as they are obstetric driven and about theatre availability and not midwife time.	Thank you for your comment. The incidence of birth trauma has been removed from the list of red flags and placed in the list of indicators instead. An indicator is not necessarily caused by midwife staffing, and midwives are not intended to be accountable for them. The evidence review

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							underpinning this guideline identified that there was an association between birth trauma and midwifery staffing. This association did not indicate causation, but the committee felt that the incidence of birth trauma should be reviewed when reviewing midwifery staffing establishments.
124	Shelford Group	draft Guideline	21	5	413	A list of NICE guidance is provided; however, Public Health guidance relating to care in pregnancy is not. For example, '*Quitting smoking in pregnancy and following Childbirth'*, has implications for workload in relation to CO monitoring and referral to stop smoking services, brief interventions throughout pregnancy etc. Furthermore, '*Weight management before, during and after pregnancy*' also has implications for staffing, with regards to information-giving, brief interventions and appropriate referral.	Thank you for your comment. Related NICE guidance will now be available by links on the NICE pathway. All relevant clinical, public health and other NICE guidance will be included on the pathway.
125	Shelford Group	draft Guideline	24	6	483	Does uplift include 'carers leave' and 'special leave'?	Thank you for your comment. The recommendation provides examples of types of leave that are included in uplift and is not exhaustive; other types of leave may be included in uplift as

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							agreed locally.
126	Shelford Group	draft Guideline	31	8	611	There is a key question missing here: 'Were you left alone in labour at a time when it worried you to be alone?'	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
127	Shelford Group	draft Guideline	37	8	708	What about antenatal attendances (triage and day care)? And telephone calls taken to hospital and community triage.	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
128	Shelford Group	draft Guideline	39	8	746	It is unclear why genital tract trauma is an indicator regarding staffing. Additionally, the definition of perineal trauma should include 'episiotomy'.	Thank you for your comment. The evidence review underpinning this guideline identified that there was an association between birth trauma and midwifery staffing. This association did not indicate causation, but the committee felt that the incidence of birth trauma should be reviewed when reviewing midwifery staffing establishments.

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129	Shelford Group	draft Guideline	General	8	General	Compliance with SDRs needs to be addressed.	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
130	Shelford Group	draft Guideline	General	8	General	Measures to account for complexity, e.g. BMI of population, medical conditions, Intra uterine transfers/admissions, smoking at delivery, VTE positive screening, need to be addressed. Furthermore, the proportion of women in a range of tariffs, and this bearing upon workload, needs to be taken into consideration.	Thank you for your comment. The committee considered these suggestions and incorporated them into the guideline when appropriate.
131	Shelford Group	Linking evidence	General	General	General	The impact of calling in community midwives to cover shortfalls in staffing or increase in activity on other pathways normally covered by that midwife (ie. antenatal and postnatal care in the community) needs to be considered. Is there any evidence regarding the implementation of escalation policies and or supervisor on call? Escalation policy needs to mitigate for problems faced by midwives wanting to escalate when the person they would normally escalate to might be the same person who has taken staff from their area of work.	Thank you for your comment. Appendix 1 outlines the committee's considerations and the evidence used to inform each recommendation. The specific details of escalation policies would be locally determined.
132	Shelford Group	draft Guideline	9	1	163	The meaning of this sentence is unclear.	Thank you for your comment. This sentence has been amended to be clearer.

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133	Shelford Group	draft Guideline	12	1	248	There is no mention of risk/acuity and staffing needs	Thank you for your comment. The guideline has been amended to make the focus on risk and acuity clearer.
134	Shelford Group	draft Guideline	12	1	265	What is 'professional judgement' based on in this case?	Thank you for your comment. It is not possible for this guideline to prescribe how professional judgement should be used and it is expected that individuals will make judgments in line with training, advice, and guidance that are appropriate for the local situation.
135	Shelford Group	draft Guideline	42	8	820	It is unclear why the genital tract trauma rates are included in this section on place of birth.	Thank you. This has been corrected.
136	Shelford Group	draft Guideline	9	1.1.4	174	The following should be considered as an addition: (Service cancellations and closures should only be considered as a last resort and should only be agreed by the Trust Board.)	Thank you for your comment. The committee discussed your comment however the recommendation has not been amended as the committee felt that service closures or service suspensions do occur (for example, suspension of home birth service).
137	Shelford Group	draft Guideline	9	1.16	178	Where it says "trained in establishment", it should say "experienced in establishment setting".	Thank you for your comment. The recommendations have

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							been amended in light of stakeholder comments.
138	Shelford Group	draft Guideline	11	1.2.2	233	The defined period of time for 6 months should be changed from 24 weeks to 26 weeks.	Thank you for your comment. The committee discussed all stakeholder comments and guideline has been amended in light of stakeholder comments.
139	Shelford Group	draft Guideline	12	1.2.2	254	Including national recommendation for uplift in place of locally determined uplift should be considered.	Thank you for your comment. It is outside the remit of this guideline to set an uplift figure. Instead recommendations have been made about what should be considered when determining uplift locally.
140	Shelford Group	draft Guideline	12	1.2.3	258	The following in the calculations - for non-clinical aspects of roles e.g. education, governance, coordinator, does not need to be included.	Thank you for your comment. The guideline has now been amended to make it clear that the proportion of time that specialist midwives who are part of the establishment spend delivering contracted specialist work should not be included in the calculations.

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141	Shelford Group	draft Guideline	17	Box 2	349	The following should be considered: · Including the initiation breastfeeding in care provided by a midwife · Including neonatal IV antibiotics · Including the presence of a second midwife at the birth, receiving a baby in theatre, and the fresh eyes approach to foetal wellbeing	Thank you for your comment. The red flag events included in this list are examples that were agreed by the committee to be important warning signs that insufficient staff are available. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
142	Shelford Group	draft Guideline	18	Box 3	353	Including breastfeeding at discharge under outcome measures should be considered.	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.

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143	Shelford Group	draft Guideline	4	Focus of guideline	48	We do not understand why Maternity Support workers (MSW) are excluded from this guideline? They provide an essential support to midwives, allowing them to provide increased face-to-face expert care for mother and baby, and currently are an essential element of all maternity care staffing.	Thank you for your comment. Maternity support workers (MSWs) were excluded from the scope of this guideline. The decision was made because there is no national standard for maternity support workers. Since MSWs are excluded from this guideline, evidence about the role of MSWs has not been reviewed. Thus recommendations specifically about MSW staffing will not be included. However, the availability of other member of MDT such as MSWs and how they affect midwife staffing requirement has been considered by the guideline.
144	Shelford Group	draft Guideline	5	Woman and baby centred care	66	What is meant by 'contact' time? This needs to be clearly defined/made explicit.	Thank you for your comment. The glossary has been updated to provide a definition of contact time.

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145	Shelford Group	draft Guideline	8	1.1.3	152	In community/homebirth, situations need to have 2 midwives to 1 woman in established labour, to provide for emergency care.	Thank you for your comment. No evidence was identified about the safety of home births and the committee agreed that decisions about increasing staffing for situations when more than one midwife is required should be taken locally depending on care needs, demography and local configuration of services as there may be other situations (not just in home births) where more than one midwife is required.
146	Shelford Group	draft Guideline	8	1.1.3	153	'Locally agreed' staffing ratios renders the intentions of the guidelines as obsolete, allowing organisations to set establishments according to their financial situation.	Thank you for your comment. The recommendations of this guideline are focused on ensuring safety and to do this requires consideration of local information that can vary dramatically between organisations (such as case mix, demography and service configuration). Setting national staffing ratios in this guideline would not take these local factors into

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							consideration and could lead to unsafe care being delivered. Section 1.1 of the guideline details the responsibilities of organisations to ensure safe care is being delivered.
147	Shelford Group	draft Guideline	8	1.1.3	155	It would be helpful to have at least the 'MIMIMUM' figure for uplift, as this varies between organisations, and set too low may negatively impact on availability of midwives whilst allowing organisations to work within their 'locally set' financial purse.	Thank you for your comment. It is outside the scope of the guideline to stipulate an uplift figure. Instead recommendations have been made about what should be considered when determining uplift locally.
148	Shelford Group	draft Guideline	9	1.1.4	157	Supervision of midwives is an NMC requirement, and therefore should be included in the uplift	Thank you for your comment. Supervision has not been included in uplift, but as separate bullet point in the recommendation for time for supervision to be taken into account.
149	Shelford Group	draft Guideline	9	1.1.4	170	Does this mean employ temporary staff? If this is mid-way through a shift, where will these come, from other than line 173?	Thank you for your comment. The term temporary staff has been added to the glossary.
150	Shelford Group	draft Guideline	9	1.1.4	173	Should add caveat of 'whilst still ensuring safe staffing in all areas'.	Thank you for your comment. The committee discussion all stakeholder comments

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							and made amendments in light of stakeholder comments.
151	Shelford Group	draft Guideline	9	1.1.6	178	Should add using evidence-based staffing tools to this section.	Thank you for your comment. The recommendations in the guideline include where the committee agreed a NICE endorsed tool kit could be used.
152	Shelford Group	draft Guideline	10	1.1.12	195	Red Flag reporting: This adds to the risk to patient safety significantly. At a point where staff are fully committed to delivering care. We are pulling them away from this to complete lengthy reports. They should be escalating their concerns to their seniors rather than filling out paperwork. This needs to be included in the 'uplift' when determining the establishment. Overall comment on this section: Agree that these are all essential elements to include when determining midwifery establishments. However, we would suggest that the advice to the reader is that when considering an evidence-based tool, all these elements would be essential considerations to be included. As it reads here, it is confusing and complex to understand (as determining establishments without evidence-based tools are), and not realistic to suggest ward teams undertake this level of calculation.	Thank you for your comment. The guideline has been amended to make it clear that the occurrence of a red flag event should trigger immediate action and reporting to the senior midwife in charge. It is not expected that this activity should require lengthy report writing.

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153	Shelford Group	draft Guideline	12	1.2	247	Need to be either advised of a ratio for all areas or none at all. It is not acceptable to 'locally' determine for some aspects of care. If adamant that this is to be approach, then a prototype risk assessment must be given which may assist in minimising local bias driven by a finite financial situation.	Thank you for your comment. No evidence was identified to recommend a safe staffing ratio for areas of care other than established labour. The needs of each woman and baby and the local situation can vary considerably and the committee felt that setting ratios could inadvertently mask these important differences and could potentially lead to unsafe care.
154	Shelford Group	draft Guideline	13	1.3	287	The majority of these elements are locally determined, such as who/what the registered midwife delegates to, and therefore this is not a systematic approach to utilise. Again, it states a ratio for established labour in a hospital setting; is this the same in a home birth situation? As such, the guideline is not holistic.	Thank you for your comment. As holistic care requires consideration of the individual needs of each woman and baby, as well as the consideration of local circumstances which can vary between organisations, the recommended approach aims to take these factors into consideration when determining the midwifery staffing establishment.

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							The guideline recommends a minimum of one midwife to one woman during established labour in any setting, including home. The guideline also recommends increasing the ratio of midwives to women if needed.
155	Shelford Group	draft Guideline	16	Box 1	347	Red flag: Delayed or cancelled time-critical activity because of midwife staffing issues (for example, identifying pre-eclampsia, or malposition, screening appointments) - I think this should be malpresentation, as we don't worry about malposition antenatally. Safeguarding cases inappropriately discharged home. Other red flags may be agreed locally –it is difficult to attribute to midwifery staffing as the cause of red flags – it is more likely to be the result of poor communication.	Thank you for your comment. The red flag events included in this list are examples that were agreed by the committee to be important warning signs that insufficient staff are available. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.

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156	Shelford Group	draft Guideline	18	Box 3	353	Safe staffing indicators: Many of the indicators around experience of women would be influenced by continuity of carer, rather than unavailability of midwives. Additionally: Adequacy of meeting mothers breastfeeding support – this may be entirely attributed to the skills and ability of the midwife rather than the number of midwives available. Adequacy of meeting mother's postnatal needs (Postnatal Depression and Post Traumatic Stress Disorder (PN PTSD)) – this is difficult to attribute to midwifery staffing, as it is more likely to be rooted in pre-existing history, lack of support in home, etc. Midwives only provide care routinely of up to 10 days, so this is not a great measure for midwifery staffing. Antenatal/postnatal admission - this decision to admit is medical. Furthermore, would a high number of admissions mean good midwifery staffing in hospital, or poor midwifery staffing in community? Birth trauma – this doesn't occur because women doesn't get one to one care (Also refer to 1.1.8 line 186) Birth place of choice - change in place of birth – this is rarely driven by midwifery staffing, but often changes to woman's risk status or epidural request. The closure of a birth centre or declined admissions due to staffing would be a better measure/indicator of staffing. Staff reported measures – midwife overtime work; this is frequently driven by	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment that need to be interpreted locally. An indicator is not necessarily caused by midwife staffing, and midwives are not intended to be accountable for them. The examples included in the list were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.

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						the individual midwife based on their own financial situation; therefore, this is a poor measure of adequacy of staffing Missed statutory mandatory training/increased staff turnover as a more useful indicator Midwifery staff establishment measures: 'Planned'- staff – this is a flawed principle as it depends on how this was determined. Is the determination based on patient requirements using evidence-based tool, or is it based on local financial situation? This must be stipulated. Compliance with mandatory training – local determination weakens this significantly and therefore makes it a poor indicator	
157	Shelford Group	Overall feedback	general	general	general	Key points from 'Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour' by RCOG not considered or included here, such as: 1. The need for continuous care means that labour ward staffing must not be considered in isolation or separated from total maternity services establishments. However, throughout this guideline, recommendations are made for ratios for established labour, whilst recommending locally set ratios for all other aspects of maternity care 2. The use of midwives for theatre staffing - i.e. scrub; should explicitly say this should not be done from intrapartum staffing 3. Numbers of consultant midwives 6 monthly completion of birth rate plus -	Thank you for your comment. Guidance by the Royal College of Obstetricians and Gynaecologists is not considered as primary evidence and so was not eligible for inclusion in the reviews underpinning this guideline.

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						£5k per time plus a midwife to do data collection full-time for 6 months a year - financially that would be tough in current climate.	
314	Sherwood Forest Hospitals NHS Foundation Trust					There are no suitable tools or guidance to enable services to define staffing levels for each maternity service and until the current tariff payment is reviewed it would be difficult to justify and conflicts with the expectation in the How to guide produced by NHS England.	Thank you for your comment. NICE has an endorsement programme that assesses new and existing toolkits for their compliance with the guideline recommendations. Any toolkits that are endorsed will be provided on the NICE website and a link to this information will be provided in the guideline.
315	Sherwood Forest Hospitals NHS Foundation Trust					Contradiction from line 229 and 237 in how to inform or predict future staffing needs as in actual activity against bookings	Thank you for your comment. The recommendations have been amended.
316	Sherwood Forest Hospitals NHS Foundation Trust					is this too rigid in todays financial climate and should we add in something around escalation and risk assessment as even if investment/de investment is achievable the time lag could be significant.	Your comments were considered by the committee and the guideline has been amended.
256	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	General	general	general	We welcome the opportunity to comment on this guidance	Thank you for your comments.
257	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	8	1.1.1	140	We welcome the recommendation that women and babies should receive the same standard of care regardless of time	Thank you for your comment.

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						or day	
258	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	8	1.1.3	150	We ask that 'bereavement midwives' be included as an example	Thank you for your comment. Bereavement midwives are specialist midwives and are therefore included by the term specialist midwives.
259	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	9	1.1.3	162	We ask that 'and bereavement support to families and staff' be added to the end of the sentence	Thank you for your comment. This was intended as a list of examples and is not an exhaustive list; therefore we have not included all possible examples.
260	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	10	1.1.10	189	Please move the note to see box 1 from line 196 to line 189 after the first mention of midwife red flags	Thank you for your comment. The guideline text has been edited and amended.
261	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	11	1.1.15	214	We welcome the recommendation regarding training and note that 'safe' should extend to emotional as well as physical care, and thus training should include bereavement care training	Thank you for your comment. It is outside the scope of this guideline to include what type of training should be undertaken.
262	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	13	1.3	General	We urge the inclusion of midwives with bereavement and mental health specialisms in all considerations of skills mix	Thank you.
263	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	14	1.3.7	319	While we acknowledge that the guidance specifies a lack of evidence linking safety outcomes with staffing, we consider that the safety of women and babies should be paramount in all decisions regarding the cancellation or closure of services	Thank you for your comment.

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264	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	14	1.3.4	305	Typing error: Assess (not asses)	Thank you. This has been corrected.
265	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	17	Box 2 - sub box C	350	For 'individual advice or support', please add as an example 'previous birth-related bereavement or trauma'	Thank you for your comment. The box that your comment relates to has been revised substantially for the final guideline. The suggestions you made have been considered and incorporated where appropriate.
266	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	18	Box 3 Patient-reported outcome measure	353	Change 'measure' to 'measures' for consistency The Friends and Family Test may give a broad indication of service users' satisfaction with staffing	Thank you for your comment.
267	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	18	Box 3 Outcome measures	353	While we acknowledge that the guidance specifies a lack of evidence linking safety outcomes with staffing, we strongly urge the guidance developers to consider how SUIs and outcomes captured for MBRRACE-UK and/or the maternity safety thermometer could be considered as indicators of clinical safety and reviewed in light of staffing allocation	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
268	Stillbirth & Neonatal Death Charity (Sands)	draft Guideline	31	8 Adequacy of communication with midwifery team	611	We acknowledge that these questions are taken from the Maternity Services Survey developed by the CQC. However, we draw the developers' attention to the following question, which is based on the findings of the NPEU's Listening to Parents report, which looked at the experiences of parents whose babies were stillborn or died neonatally: During pregnancy, labour and the postnatal period, did staff listen to and take your concerns seriously?	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
288	The Royal College of Anaesthetists	draft Guideline	17	1.4.2 Box 2 - sub box B	350	In Box B, "Availability of other staff": would this section include Obstetric Physiotherapists as they are not specifically mentioned?	Thank you for your comment. The box that your comment relates to has been revised substantially for the final guideline. The list of other non-midwifery staff that may be involved in maternity care is not exhaustive. It provides examples only and therefore does not preclude the inclusion of other staff groups not specifically mentioned.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
158	The Royal College of Nursing	draft Guideline	3	Introduction	20	Recommend adding links to toolkits. The Berwick Report also had some comments about staffing. Would it be relevant to include reference to this here as well?	Thank you for your comment. This section of the guideline provides a brief introduction about why the guideline was developed. The links to toolkits are provided in the section 'Toolkits to support this guideline'. The introduction section does not intend to be an exhaustive list of reports about staffing. The Berwick report does not specifically mention midwives in it which is why it has not been included.
160	The Royal College of Nursing	draft Guideline	4	Introduction	47	Regional workforce planning groups are key actors in facilitating safe staffing levels. Are there plans to engage with this group? There is a Spelling error (Asses) should be (Assess).	Thank you for your comment. Standard stakeholder engagement is used during the development of NICE guidelines. Regional workforce planning groups, if registered as a stakeholder for this guideline, will be engaged with on the same principles as all other stakeholders. Thank you for highlighting the spelling error. This has now

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
							been corrected.
162	The Royal College of Nursing	draft Guideline	4	Introduction	49	Safe staffing implies that there are appropriate numbers of registered midwives and also adequate numbers of support and other staff to provide safe and high quality care. How will overall staffing numbers be determined? We recommend that the boxes on pages 17 onwards appear as appendices or indexed for easy reference	Thank you for your comment. Whilst we acknowledge that safe, quality care requires adequate numbers of staff overall, it is beyond remit of this guideline to include other staff groups other than registered midwives. However, the guideline does consider how the availability of other staff affects midwifery staffing requirements. Safe staffing guidance for other staff groups may be developed in future.
164	The Royal College of Nursing	draft Guideline	8	1.1.2 Organisational strategy Maintaining continuity of midwife services	141	This guideline does not appear to address continuity of care by a midwife, only adequate midwife numbers. Continuity of care by a known midwife is highly valued by women and improves outcomes	Thank you for your comment. No evidence was available about the safety of continuity of care by a known midwife. Existing guidance exists about the named midwife initiative and it is expected that this guideline will be used in conjunction with any other relevant guidance.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
165	The Royal College of Nursing	draft Guideline	8	1.1.3 Organisational strategy Maintaining continuity of midwife services	150	Is this midwifery skill mixes?	Thank you for your comment. The text has been amended to 'locally agreed midwifery skill mixes'.
166	The Royal College of Nursing	draft Guideline	9	1.1.3 Organisational strategy Maintaining continuity of midwife services	155	Does study leave include annual mandatory training? If not it should as midwives are often taken out of mandatory updating if the service is busy. There needs to be some allowance made for this	Thank you for your comment. The recommendation has been amended to make it clear that uplift should take into account study leave including mandatory training and continuing professional development.
167	The Royal College of Nursing	draft Guideline	9	1.1.5 Organisational strategy Maintaining continuity of midwife services	176	The staffing needs of obstetric theatres needs addressing as well	Thank you for your comment. The scope of this guideline is to provide recommendations that are applicable to all maternity services where midwives work (including obstetric theatres). It is not within the scope of this guideline to make recommendations for other staff groups (such as obstetricians or theatre nursing staff).

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
168	The Royal College of Nursing	draft Guideline	10	1.1.14 Organisational strategy Monitor and respond to changes	211	Changing the skill mix is likely to be a high risk strategy. How would changing the skill mix resolve shortages in midwifery staffing, unless non-midwives are undertaking midwifery duties?	Thank you for your comment. This recommendation provides a range of examples that an organisation may wish to consider, depending on the outcome of the red flag review. Safe staffing is not always about increasing staffing numbers, but ensuring the staff with the right skills are available at the right time.
169	The Royal College of Nursing	draft Guideline	11	1.2 Organisational strategy Setting the midwife staffing establishment	219	This needs to include a time allowance for registered midwives to train others e.g. midwives who are sign-off mentors for student midwives	Thank you for your comment. The guideline included time for training others is included in the recommendations in section 1.1 organisational strategy.
170	The Royal College of Nursing	draft Guideline	11	1.2.2 Organisational strategy Setting the midwife staffing establishment	238	'next few months' is too vague	Thank you for your comment. We are unclear which text your comment relates to as the line number or page number referenced does not correspond with the quoted text. The guideline does not include the term 'next few months'.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
171	The Royal College of Nursing	draft Guideline	11	1.2.2 Organisational strategy Setting the midwife staffing establishment	239	How will the 'maternity care activities for which midwives are responsible be defined? There needs to be a national consensus	Thank you for your comment. The committee agreed that the maternity care activities for which midwives are responsible will be locally determined depending on local population needs, skill mix, training and commissioning arrangements.
172	The Royal College of Nursing	draft Guideline	12	1.2.2 Organisational strategy Setting the midwife staffing establishment	245	'trained and competent staff' requires definition	Thank you for your comment. It is outside the scope of this guideline to define the training and competencies that staff require. Judgements about the necessary training and about competencies should be made in line with local and national policies, procedures, codes of conduct and other relevant guidance.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
173	The Royal College of Nursing	draft Guideline	16	1.4.2 Monitoring and evaluating midwife staffing requirements Box 1 Midwife red flags	347	It needs to be clear that this is not an exhaustive list. For example failure to undertake a vaginal examination when required and failure to undertake a full clinical examination on admission would both be red flags	Thank you for your comment. The red flag events included in this list are examples that were agreed by the committee to be important warning signs that insufficient staff are available. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate, and the box includes wording stating that other midwifery red flags may be agreed locally.
174	The Royal College of Nursing	draft Guideline	17	1.4.2 Monitoring and evaluating midwife staffing requirements Box 2 Factors to consider when determining the number and skill mix of midwives needed Column D	350	Home birth needs adding to Column D 'Staffing'	Thank you for your comment. Preferred place of birth has been added to box 2 in the revised guideline.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
175	The Royal College of Nursing	draft Guideline	18	1.4.2 Monitoring and evaluating midwife staffing requirements Box 3 Safe Midwife staffing indicators Outcome Measures	353	Outcome measures needs to include other morbidities for example readmission of mother or baby after discharge, wound infection, other infection, urinary tract disorders such as urinary retention post delivery and mental health problems such as depression or PTSD	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment. These examples were drawn from evidence and from committee knowledge and expertise. The suggestions you made have been considered and incorporated where appropriate.
176	The Royal College of Nursing	Ev to Rec	19	2. Evidence	356	Evidence from the King's Fund appears not to have been used	Thank you for your comment. The evidence reports that underpin the guideline are published on the NICE website. The reports contain information about the type of evidence that was reviewed. Evidence from the King's Fund was identified but it did not meet the pre-specified inclusion criteria. Please see the evidence reports for further information.

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178	The Royal College of Nursing	draft Guideline	37	8. Indicators for Safe Midwife Staffing	730	Should include reason for readmission of mother or baby in the postnatal period	Thank you for your comment. Your suggestion was considered by the indicators team and this section of the guideline has been amended.
180	The Royal College of Nursing	draft Guideline	39	8. Indicators for Safe Midwife Staffing	744	The indicators need to be much more comprehensive as indicated above in comment 15	Thank you for your comment. The list of indicators was agreed by the safe staffing advisory committee, based on available evidence and knowledge and experience of the committee. The list is for example only and should not preclude the collection and review of other data that is considered important for assuring maternity services' safe staffing arrangements.
298	The Royal College of Obstetricians and Gynaecologists	draft Guideline	11	1.2.2	226	Should mention adjustments needed for acuity which is mentioned in the next section.	Thank you for your comments. The recommendations have been amended to make it clearer that the calculation should be based on needs, risk and acuity of women and babies in the service.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
299	The Royal College of Obstetricians and Gynaecologists	draft Guideline	13	1.3.1	278	Would it be appropriate to mention the NPSA Intrapartum scorecard as a tool that is widely available for calculating the numbers of midwives required against the actual number available?	Thank you for your comment. No evidence was found in relation to the intrapartum score card. If the intrapartum scorecard is submitted to NICE and is endorsed for use alongside this guideline, this information will be published on the NICE website.
300	The Royal College of Obstetricians and Gynaecologists	draft Guideline	General	General	General	We are encouraged by the focus on women centred care and the emphasis on ensuring that women have choice and information. Reference to patient involvement toolkits is helpful in the guidance provided. Women have told us that they want continuity of care, focus on mother and baby and have strong views on the need for all staff, including midwives, to demonstrate that they can provide the highest quality care. This must be supported by maintaining skills and provision of up to date evidence and guidance to women about choices and care.	Thank you for your comments.

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1	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	4	INTRODUCTION	48	Should MSWs be included if they are conducting roles previously done by midwives e.g neonatal screening tests and if their contribution is acknowledged what is a safe ratio of qualified to unqualified staff per area?	Thank you for your comment. Maternity support workers (MSWs) were excluded from the scope of this guideline. The decision was made because there is no national standard for maternity support workers. Since MSWs are excluded from this guideline, evidence about the role of MSWs has not been reviewed. Thus recommendations specifically about MSW staffing will not be included. However, the availability of other member of MDT such as MSWs and how they affect midwife staffing requirement has been considered by the guideline.
2	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	8	1.1.1	131	We need to have ratios of how many specialist midwives per service per woman e.g screening	Thank you for your comment. The committee agreed that setting staffing ratios outside of the intrapartum care phase would not be practical. This is because of the lack of evidence and the way local services are

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							configured varies and the individual needs, risk and dependency of women and babies need to be considered. Please see appendix 1 for further information on the committee discussions.
3	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	8	1.1.2	141	Where are we measuring continuity community intrapartum postnatal or do we mean consistency of the service availability not necessarily the same midwife?	Thank you for your comment. This heading has been amended to reflect that the recommendations refer to the boards accountability for the midwife establishment.
4	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	8	1.1.3	149	Preconception care is not in the current maternity tariff how can a service be provided if its not commissioned?	Thank you for your comment. Although preconception is not currently included in the maternity tariff, some maternity services do provide preconception midwife care. It is important that maternity services include all services provided in their staffing calculations so that all areas of care are safely staffed. Therefore we have included preconception care in the guideline recommendations.

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5	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	8	1.1.3	150	Local agreement of specialist midwives makes comparative data difficult there should be some consistency of minimal specialists with local agreements to reflect demographic data.	Thank you for your comment. No evidence was available about what a 'safe' number of specialist midwives is and the committee did not feel it was appropriate to recommend a minimum number. Instead, the committee felt that the guideline will enable local organisations to identify the required number and skill mix of midwives, and this number may differ between services depending on their local service configuration and demography.
6	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	8	1.1.3	152	Allow for increased agreed ratios for complexity and tertiary centres	Thank you for your comment. The committee agreed not to provide examples of situations in which increased staffing ratios may be appropriate (for example in tertiary centres or complex cases) as it was felt that there are a range of situations in which increased staffing ratios may be necessary. The recommendations

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							outline that other midwife staffing ratios could be agreed locally.
7	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	9	1.1.3	155	The uplift should reflect the increased training requirements and statutory supervision requirements for midwives	Thank you for your comment. The recommendation has been amended to make it clear that uplift should take into account study leave including mandatory training and continuing professional development. The recommendation also makes clear that allowances also need to be made for the supervision requirements for midwives.
8	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	9	1.1.3	165	Predictions of demographics and patient choice predictions are very inaccurate and difficult build an argument for a workforce plan, the current increase in birth-rate and immigration issues was poorly predicted by OPCS.	Thank you for your comment. The recommendation has been amended to make it clear that organisations need to ensure that maternity services have capacity to enable them to deal with fluctuations in demand. Recommendations have also been amended to make it clear that local records of demands for

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
							midwifery services should be used to inform future plans (rather than national projections)
9	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	9	1.1.4	171	Increasing midwives beyond the staffing establishment is difficult to achieve when the NHS has challenging budgetary constraints.	Thank you for your comment. This text has now been removed from the guideline.
10	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	9	1.1.4	172	Use of the On Call to support staffing depletes the home birth choice . The RCM have surveyed midwives and an on call model is unpopular form a work life balance perspective.	Thank you for your comment. The guideline recommends flexible ways of responding to staffing deficits. The most appropriate response will differ for different organisations. For example, some localities may choose to develop their homebirth on-call team to provide on-call cover elsewhere in the service without being detrimental to the provision of homebirth support.
11	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	10	1.1.9	187	Review of staffing is achievable monthly/ 6 monthly but amending the Workforce plan is difficult with trust budget setting and annual cohorts of midwifery students	Thank you for your comment. The recommendation says that the establishment should be reviewed every 6 months and should be changed if it is indicated this is

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							necessary.
12	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	10	1.1.13	206	There needs a clear calculation of what conditions trigger more than 1 to 1 care and to what level of uplift 1.2 or 1.4	Thank you for your comment. The committee agreed not to include what factors should trigger more than 1:1 care during established labour. This is because the needs of each woman and baby will be different and how the service is configured locally will be different.
13	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	11	1.1.15	215	Recognition of student mentorship and newly qualified preceptorship is important	Thank you for your comment. The recommendation emphasises the need for midwives to have sufficient time for preceptorship and other activities necessary for providing safe care.
14	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	11	1.1.16	216	Involve midwives and Supervisors in policies relating to staffing and escalation	Thank you for your comment. Your comment was considered by the committee. Supervision is no longer a statutory requirement for midwives and so the recommendation has been amended to reflect this recent change.

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15	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	11	1.2.2	237	Bookings are a crude indicator of activity the pressure on the service is from peaks in activity and high dependency in maternal and neonatal groups.	Thank you for your comment. The committee felt using booking data alone, or historical data alone would not be appropriate for calculating the establishment. The committee felt the best way of calculating the establishment is to use booking and historical data together and then estimate the risk, acuity and dependency of women and babies. This has been included in the recommendations.
16	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	12	1.2.2	248	Local ratios are too vague and will not give comparative data there is a need to specify ratios for clinical conditions	Thank you for your comment. No evidence was identified to recommend a safe staffing ratio for areas of care other than established labour. The needs of each woman and baby and the local situation can vary considerably and the committee felt that setting ratios could inadvertently mask these important differences and could potentially lead to

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							unsafe care.
17	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	12	1.2.3	261	Local programmes are not predictable therefore consider some level of inclusion of this potential in the establishment	Thank you for your comment. The recommendations include situations in which midwives are undertaking local supervisory programmes.
18	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	14	1.3.4	299	Need to specify safe ratios for community, admission areas , ward areas and birth centres	Thank you for your comment. As no evidence was available about safe midwifery staffing ratios for community, admission areas, ward areas, or birth centres and the needs of each woman and baby and the local situation can vary considerably, the committee felt that setting ratios could inadvertently mask these important differences and not constitute safe care in all circumstances.

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19	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	14	1.3.9	234	Is this not the use of an escalation policy green amber then hopefully avoid red?	Thank you for your comment. The guideline recommends that escalation policies are developed in order to respond to situations in which more staff are needed. Escalation policies may contain different levels of action required to address different situations, and should aim to avoid potentially unsafe staffing situations getting worse.
20	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	15	1.4.1	339	This should be reported on the Maternity Dashboard	Thank you for your comment. The guideline recommends recording information about whether the midwifery staffing establishment is meeting the needs of women. This may or may not be reported on the maternity dashboard.
21	University Hospital of North Staffordshire NHS Trust (UHNS - soon to be UHNM)	draft Guideline	23	6	462	Is the preceptor ship not 2 years as per Agenda for Change	Thank you for your comment. It is outside the scope of the guideline to specify the duration of preceptorship.

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114	University Hospital South Manchester NHS Foundation Trust	draft Guideline	9	1.1.3	157	Should there be an agreed time regarding supervision rather than local agreement	Thank you for your comment. It is outside the scope of this guideline to state how long supervision time should be. Local and professional guidance should be taken into consideration instead.
115	University Hospital South Manchester NHS Foundation Trust	draft Guideline	12	1.2.3	262	Should there be an agreed preceptorship period for newly qualified midwives.	Thank you for your comment. It is outside the scope of this guideline to state how long the preceptorship period should be.
116	University Hospital South Manchester NHS Foundation Trust	draft Guideline	16	Box 1	348	Would be useful to provide inclusive list. Unclear how incidence of 3rd and 4th degree tear relates directly to safe staffing.	Thank you for your comment. The incidence of 3rd and 4th degree tear has been removed from the list of red flags. The list provided in the guideline contains examples and organisations may wish to add additional items to this list if appropriate.

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269	West Hertfordshire Hospitals Trust	Draft guideline	General	General	general	This draft guideline is the most disappointing draft I have ever been given the opportunity to comment on. It is not helpful It focuses on quality indicators not safety ones (ie babies damaged in utero) It will not assure boards that their establishment is correct It will not enable Heads of Midwifery to set establishments that are safe in workforce planning It will not assist commissioners It will not build on the comprehensive four country programme midwifery2020 workforce workstream. It fails to test the only validated workforce planning tool – birthrate plus , which sets the minimum staffing levels for clinical midwifery care, and which Financial Consultants manipulate to try and bring efficiency savings to reduce the funded establishments that are already very concerning in some units.	Thank you for your comments. Your comments were considered and discussed by the committee and the guideline has been amended in light of stakeholder comments.
270	West Hertfordshire Hospitals Trust	draft Guideline	3	Introduction	20	Recommend adding links to toolkits. The Berwick Report also had some comments about staffing. Would it be relevant to include reference to this here as	Thank you for your comments. Please see response to comment 158.

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						well?	
271	West Hertfordshire Hospitals Trust	draft Guideline	4	Introduction	47	Regional workforce planning groups are key actors in facilitating safe staffing levels. Are there plans to engage with this group? There is a Spelling error (Asses) should be (Assess).	Thank you for your comment. Please see response to comment 160.
272	West Hertfordshire Hospitals Trust	draft Guideline	4	Introduction	49	Safe staffing implies that there are appropriate numbers of registered midwives and also adequate numbers of support and other staff to provide safe and high quality care. How will overall staffing numbers be determined? We recommend that the boxes on pages 17 onwards appear as appendices or indexed for easy reference	Thank you for your comment. Please see response to comment 162.
273	West Hertfordshire Hospitals Trust	draft Guideline	8	1.1.2 Organisational strategy Maintaining continuity of midwife services	141	This guideline does not appear to address continuity of care by a midwife, only adequate midwife numbers. Continuity of care by a known midwife is highly valued by women and improves outcomes	Thank you for your comment. Please see response to comment 164.
274	West Hertfordshire Hospitals Trust	draft Guideline	8	1.1.3 Organisational strategy Maintaining continuity of midwife services	150	Is this midwifery skill mixes?	Thank you for your comment. The text has been amended to 'locally agreed midwifery skill mixes'.
275	West Hertfordshire Hospitals Trust	draft Guideline	9	1.1.3 Organisational strategy Maintaining continuity of midwife services	155	Does study leave include annual mandatory training? If not it should as midwives are often taken out of mandatory updating if the service is busy. There needs to be some allowance made for this	Thank you for your comment. The recommendations regarding uplift have been amended to make it clearer what is included.

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
276	West Hertfordshire Hospitals Trust	draft Guideline	9	1.1.5 Organisational strategy Maintaining continuity of midwife services	176	The staffing needs of obstetric theatres needs addressing as well	Thank you for your comment, please see response to comment 167.
277	West Hertfordshire Hospitals Trust	draft Guideline	10	1.1.14 Organisational strategy Monitor and respond to changes	211	Changing the skill mix is likely to be a high risk strategy. How would changing the skill mix resolve shortages in midwifery staffing, unless non-midwives are undertaking midwifery duties?	Thank you for your comment, please see response to comment 168.
278	West Hertfordshire Hospitals Trust	draft Guideline	11	1.2 Organisational strategy Setting the midwife staffing establishment	219	This needs to include a time allowance for registered midwives to train others e.g. midwives who are sign-off mentors for student midwives	Thank you for your comment, please see response to comment 169.
279	West Hertfordshire Hospitals Trust	draft Guideline	11	1.2.2 Organisational strategy Setting the midwife staffing establishment	238	'next few months' is too vague	Thank you for your comment, please see response to comment 170.
280	West Hertfordshire Hospitals Trust	draft Guideline	11	1.2.2 Organisational strategy Setting the midwife staffing establishment	239	How will the 'maternity care activities for which midwives are responsible be defined? There needs to be a national consensus	Thank you for your comment, please see response to comment 171.
281	West Hertfordshire Hospitals Trust	draft Guideline	12	1.2.2 Organisational strategy Setting the midwife staffing establishment	245	'trained and competent staff' requires definition	Thank you for your comment, please see response to comment 172.

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282	West Hertfordshire Hospitals Trust	draft Guideline	16	1.4.2 Monitoring and evaluating midwife staffing requirements Box 1 Midwife red flags	347	It needs to be clear that this is not an exhaustive list. For example failure to undertake a vaginal examination when required and failure to undertake a full clinical examination on admission would both be red flags	Thank you for your comment. Please see response to comment 173.
283	West Hertfordshire Hospitals Trust	draft Guideline	17	1.4.2 Monitoring and evaluating midwife staffing requirements Box 2 Factors to consider when determining the number and skill mix of midwives needed Column D	350	Home birth needs adding to Column D 'Staffing'	Thank you for your comment. Please see response to comment 174.
284	West Hertfordshire Hospitals Trust	draft Guideline	18	1.4.2 Monitoring and evaluating midwife staffing requirements Box 3 Safe Midwife staffing indicators Outcome Measures	353	Outcome measures needs to include other morbidities for example readmission of mother or baby after discharge, wound infection, other infection, urinary tract disorders such as urinary retention post delivery and mental health problems such as depression or PTSD	Thank you for your comment. The indicators included in this list are examples that were agreed by the committee to be important measures of the midwifery staffing establishment that need to be interpreted locally. An indicator is not necessarily caused by midwife staffing, and midwives are not intended to be accountable for them. The examples included in the list were drawn from evidence and from committee knowledge

Comment number	Stakeholder	Document	Page No	Section heading or para	Line No	Comments	Developer's response
							and expertise. The suggestions you made have been considered and incorporated where appropriate.
285	West Hertfordshire Hospitals Trust	Ev to Rec	19	2. Evidence	356	Evidence from the King's Fund appears not to have been used	Thank you for your comment. Please see response to comment 176.
286	West Hertfordshire Hospitals Trust	draft Guideline	37	8. Indicators for Safe Midwife Staffing	730	Should include reason for readmission of mother or baby in the postnatal period	Thank you for your comment, please see response to 286.
287	West Hertfordshire Hospitals Trust	draft Guideline	39	8. Indicators for Safe Midwife Staffing	744	The indicators need to be much more comprehensive as indicated above in comment 15 (line 353 in guideline)	Thank you for your comment. Please see response to comment 180.