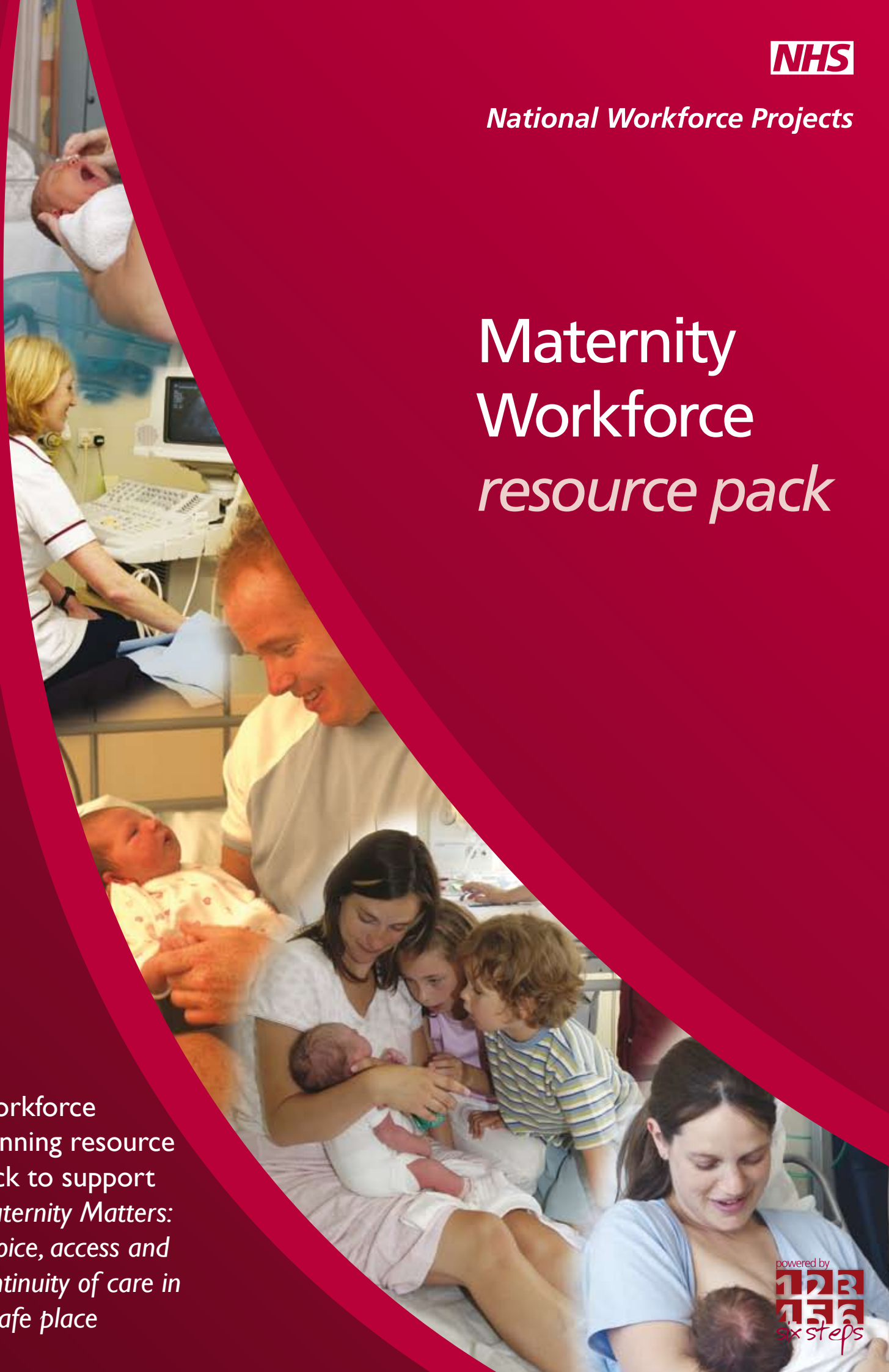
NHS

National Workforce Projects

Maternity Workforce *resource pack*



Workforce planning resource pack to support *Maternity Matters: Choice, access and continuity of care in a safe place*

powered by 123 456 six steps

powered by six steps

Six Steps is a framework for workforce planning developed by **NHS National Workforce Projects**. It is designed to provide an evidence based and effective model that can be adopted by any NHS or partner health and social care organisation. Using a model like Six Steps helps lead to sustainable workforce planning.

For more information on Six Steps and the work of NHS National Workforce Projects see the healthcare workforce portal **www.healthcareworkforce.nhs.uk**.

Contents

Introduction

Maternity services in the NHS are undergoing a period of change. The national service framework (NSF) for children, young people and maternity services and the white paper *Our Health, Our Care, Our Say: A New Direction for Community Services*, have set out a new framework for the delivery of maternity services with an increasing emphasis on choice, access and continuity of care.

This will mean significant changes for services. There is an urgent need for workforce planning principles to be applied to maternity services over the next 12-18 month period so that changes can be made in preparation for the implementation of the new *Maternity matters: choice, access and continuity of care in a safe service* policy in 2009. These changes cannot happen without a carefully planned workforce development programme to ensure that units have the capacity and the skills to deliver services designed around the needs of mothers.

This workforce planning resource pack is part of a range of resources developed by NHS National Workforce Projects (NWP). These resources are aimed at a mixed audience involved in the delivery of these changes which will include clinicians, heads of midwifery and service management staff as well as human resources, service redesign and workforce planning leads. All of these resources are available at the healthcare workforce portal at www.healthcareworkforce.nhs.uk/maternity.

This pack contains workforce planning checklists, together with case studies and frequently asked questions (FAQs) that other organisations have developed to solve common issues. This pack includes examples of good practice and the contact details of teams working in maternity services to enable organisations to follow up any issues raised.

We hope this guide will be used in any or all of the following ways:

- Reference material - to help inform the development of either organisations workforce plans
- To support staff development days in individual departments – to help raise awareness and inform local debate
- Part of a facilitated training programme – to provide reference material and support the sharing of good practice
- A workforce guide for everyday use.

It is not the intention of this resource pack to cover all the work that is currently being undertaken in the development of maternity services. The purpose of this pack is to give some examples of the workforce changes that are currently being piloted or have been implemented, and to act as a signpost to other documents and projects that can be accessed to aid the planning process to support delivery of the maternity policy.

Although this pack focuses on the planning for the new maternity policy it is important that this initiative is not seen in isolation and is developed into an integrated plan that takes into consideration wider workforce issues such as Modernising Medical Careers and Working Time Directive (WTD) 2009.

Section One

Background

The latest policy document *Maternity Matters: Choice, access and continuity of care in a safe service* builds upon the maternity services commitment outlined in *Our Health, Our Care, Our Say* and is an important step towards meeting the maternity standard set out in the NSF for children, young people and maternity services.

The NSF for children, young people and maternity services entitled *Every Child Matters: Change for Children Programme, the National Service Framework for children, young people and maternity services,* was published in September 2004. Its aim was to ensure that all children and young people access services that are age appropriate and accessible, and recognise their needs as different. The new standards were designed to generate a step change in the quality of children's health services. They were based on the existing best practice and were a world first.

In 2005 in *Our Health, Our Care, Our Say,* the Government underlined the importance of providing high quality, safe and accessible maternity care through its commitment to offer all women and their partners a wider choice of type and place of maternity care and birth. Building on this commitment, four national choice guarantees will be available for all women by the end of 2009 and women and their partners will have opportunities to make well informed decisions about their care throughout pregnancy, birth and postnatally.

The policy paper *Maternity Matters: Choice, access and continuity of care in a safe service* was launched in April 2007 and outlines the priority for modern maternity services. The priority is to provide a choice of safe, high quality maternity care for all women and their partners. This is to enable pregnancy and birth to be as safe and satisfying as possible for both mother and baby and to support new parents to have a confident start to family life. For some, especially the more vulnerable and disadvantaged, the outcomes are sometimes

unacceptable. Some women are up to 20 times more likely to die from a pregnancy related complication than other women and infant mortality rates are higher in more deprived areas of the country and in more vulnerable or disadvantaged groups.

Maternity Matters describes a comprehensive programme for improving choice, access and continuity of care and it sets out a strategy that will put women and their partners at the centre of their local maternity service provision. It highlights how commissioners, providers and teams of maternity care professionals will be able to use the health reform agenda to shape the provision of services to meet the needs of women and their families. It emphasises the roles that each can play in providing women focused, family centred services and gives examples of what could be in place to achieve this.

In March 2007 NWP was commissioned by the Department of Health to develop a range of resources to assist in planning the workforce to meet the challenge of the new policy. Details of the NWP maternity project can be found at the healthcare workforce portal at www.healthcareworkforce.nhs.uk/maternity. The maternity section contains a range of tools and resources including access to the maternity workforce planning e-learning CD, details of the maternity workforce planning workshops run in June and July 2007 and a downloadable version of this resource pack. In addition the website contains useful links and an opportunity for you to share your innovations and best practice in your maternity service.

Current policy papers

Maternity Matters: Choice, access and continuity of care in a safe service

Maternity Matters describes a comprehensive programme for improving choice, access and continuity of care and it sets out a strategy that will put women and their partners at the centre of their local maternity service provision. It highlights how commissioners, providers and teams of maternity care professionals will be able to use the health reform agenda to shape the provision of services to meet the needs of women and their families. It emphasises the roles that each can play in providing women

focused, family centred services and gives examples of what could be in place to achieve this.

The aim of health reform in England is "to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare". For maternity services this means providing high quality, safe and accessible services that are both women focused and family centred.

The national choice guarantees described in the maternity matters policy are:

- Choice of how to access maternity care
- Choice of type of antenatal care
- Choice of place of birth – depending on their circumstances, women and their partners will be able to choose between three different options
  - A home birth
  - Birth in a local facility, including a hospital, under the care of a midwife
  - Birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option
- Choice of place of postnatal care.

As well as the choice of local options, a woman may choose to access maternity services outside her area with a provider that has available capacity. In addition, every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.

Commissioning implications of Maternity Matters

Future maternity services must be planned to address current challenges including improving outcomes for more vulnerable and disadvantaged families, the reduction in working hours of doctors as a result of the WTD and demographic and lifestyle changes. At the same time, the principle should be that pregnancy and birth are normal life events supported by midwives.

Commissioners and providers will be able to use a number of the elements of the health reform agenda to facilitate improvements and innovation in the maternity services they offer. The challenge for local commissioners is to ensure that each element is sensitive to the specific nature and requirements of their population and service provision. Individuals and organisations will play a pivotal role in achieving the Government commitment by the end of 2009 and the successful provision of the best possible maternity services. Their enthusiasm, engagement and ownership will drive this forward.

Modernising Maternity Care – A commissioning toolkit for England was published in tandem with *Maternity Matters*, to help PCTs and their partners ensure local maternity services meet population requirements and address health inequalities.

Our Health, Our Care, Our Say: A New Direction for Community Services

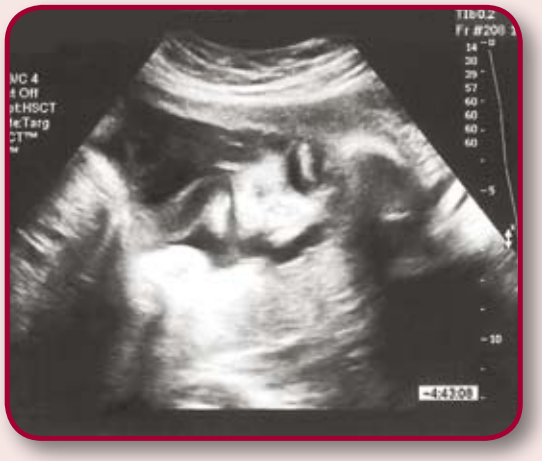
In 2005 the Department of Health conducted two consultations, *Independence, Wellbeing and Choice* and a listening exercise, *Your Health, Your Care, Your Say. Independence, Wellbeing and Choice*, the adult social care green paper, asked for views on how social care services could be improved. The listening exercise, *Your Health, Your Care, Your Say*, allowed the public to speak directly to ministers, health professionals, and each other on how improvements could be made to their local services.

Nearly 143,000 people contributed their views on what they expected from their local social care and NHS services. People wanted their local services to:

- Understand how they live and support them to lead healthier lives
- Help them to live independently if they have ongoing health or social care needs
- Be easy to get to and convenient to use
- Be nearer to where they live, or easily available in the areas they work.

In July 2005 these two consultations formed the basis of a single white paper. The paper outlined how NHS and social care services work together and identified how the delivery of these services could adapt to provide individuals with the health and social care services they need closer to their homes. The proposals in the white paper, *Our Health, Our Care, Our Say* aim to:

- Change the way services are provided in communities and make them as flexible as possible
- Provide a more personal service that is tailored to the specific health or social care needs of individuals
- Give patients and service users more control over the treatment they receive
- Work with health and social care professionals and services to get the most appropriate treatment or care for their needs.



To achieve these aims family doctors, PCTs and local authorities who have direct contact with patients and service users will have more say in how best to plan and buy services for local communities. Public, private, voluntary and charitable organisations will need to work in partnership to put the interests of the public first, ensure health and social care staff receive the right training and make good health and social care services an integral part of local communities.

NSF for children, young people and maternity services

In March 2002 the Department of Health set out major developments in the creation of the first ever NSF for children, young people and maternity services. Leading experts were appointed to help shape policy and the views of children were actively sought to ensure that the NSF had a real impact on children's lives.

Six external working groups (EWG) were established by the Department to help formulate the NSF. Drawing from a wide range of professional expertise, the EWGs tackled specific issues within each of the six modules: maternity, children needing acute/hospital care, mental health and psychological well being, children in need, disabled children and the healthy child and young person. The EWGs involved the expert opinions of those directly affected by a service as well as specialists working in the field. They included representatives from

children's organisations and user groups. In addition, the EWGs used existing networks to talk directly with children, young people and parents.

In April 2003 the Department of Health published the first part of the NSF, which included the *Standard for Hospital Services*, fulfilling the Department of Health's commitment made in response to the Kennedy Report, and an *NSF Emerging Findings* consultation document, which sets out the areas in which work is being taken forward by the EWGs.

Alongside the *Standard for Hospital Services* and the *NSF Emerging Findings*, the Government published *Improving the Patient Experience: Friendly Healthcare Environments for Children and Young People*, *Better Hospital Food: Catering Services for Children and Young Adults*, and the *Neonatal Intensive Care Review* consultation document.

The NSF for children, young people and maternity services was published in September 2004. Entitled *Every Child Matters: Change for Children Programme, the National Service Framework for children, young people and maternity services,* its aim was to ensure that all children and young people get services that are age appropriate and accessible, and recognise their needs as different. The new standards were designed to generate a step change in the quality of children's health services. The standards were based on the existing best practice and were a world first.

A key element of the NSF is that parents of babies and young children can get all the health and other support they need from a local children's centre, cutting out the need for multiple appointments and visits to different agencies.

The NSF must be implemented by NHS trusts and local authorities over 10 years from 2004, although the timing and planning of implementation are local matters. The standards will be delivered locally and monitored by independent bodies including the Healthcare Commission, the Commission for Social Care Inspection and OFSTED. The new *Health and Social Care Standards and Planning Framework* reinforces the importance of planning for children across the whole of health, social services and the voluntary sector. Over the course of the planning period the NHS and local authorities must demonstrate that they are making progress towards achieving the quality of service illustrated in the NSF.

Section two

Workforce planning in maternity services

This resource pack is one element of a number of supporting resources that the Department of Health commissioned NWP to produce in March 2007. The aim was to develop a range of resources to assist in planning the workforce to meet the challenge of the new policy.

The maternity project consists of four main elements:

- Workforce planning workshops across England that will build on the Care Services Improvement Partnership (CSIP) launch events for *Maternity Matters* and help organisations realise the workforce implications of the maternity policy
- An e-learning CD for planning the maternity workforce. This resource builds upon the popular generic e-learning package already developed by NWP
- A workforce planning resource pack to assist organisations to develop an integrated workforce plan for the implementation of the maternity policy aims
- A maternity section on the healthcare workforce portal that will act as a one stop resource for all the workforce planning resources.

Details of the NWP maternity resources can be found on the healthcare workforce portal at www.healthcareworkforce.nhs.uk/maternity.

Planning the workforce

When planning the workforce to develop maternity services it is important to base the workforce plan on a clear vision of the future services, the likely future staffing requirements and the steps needed to be taken to meet that staffing need. The problem with some organisation's workforce planning models is that they concentrate on the workforce numbers in isolation, or vision the future without developing the analysis to check if the workforce numbers will support the vision. Health and social care organisations will have

to develop maternity services at the same time as responding to a range of other initiatives. These organisations will have to identify what the workforce of the organisation will look like following the implementation of a range of initiatives such as WTD, agenda for change, payment by results, improving working lives, practice based commissioning, integrated service improvement programme (ISIP) and the changing workforce initiatives. Often these plans are being taken forward in isolation but the combined effect of these changes in the next five years will markedly change the number, structure and role of the workforce in health and social care.

NWP have developed a six step guide to workforce planning that is outlined later in this document. This guide enables any organisation to develop a robust workforce plan for maternity services that takes account of national and local initiatives. The six step guide is referenced by a range of other NWP resources including the maternity e-learning CD that contains a workforce planning e-learning package based on the six step guide, with links to a further set of tools and techniques to help organisations to develop their workforce plans. Overall there is no formula or fixed number of midwives that will guarantee a quality service, there are extremely useful tools such as Birthrate Plus but these only give a start point to the discussion of the right number of staff and skill mix for a particular unit. Only an integrated plan that takes account of the future changes that will impact on service activity will be successful.

Organisational change

All organisations need to change over time. Organisational change may be necessary for a number of reasons and the way that change is managed will impact on the way the change is received by the people involved.

Organisational change can be an unsettling process for the staff involved and this element is often ignored in the process of redesigning the workforce to meet the changing service needs. The needs of staff are different as are their working styles and reactions to change. These differences must be understood and recognised if there is to be a smooth transition from one way of working to another.

When planning the workforce to meet future service needs it is important that the impact of any changes to traditional roles and ways of working are understood by the organisation and the current workforce. As part of the change management process it is important that staff recognise the reason for the change and the benefits that change will bring. They will need to understand how any changes will impact on them personally and how it will improve patient care. The integrated service improvement programme contains guidance and tools to support organisations to deliver transformation changes (see road map to transformational change www.isip.nhs.uk).

Effective role redesign must follow a set of fundamental principles:

- The changes are based on the use of care systems, pathways and protocols linked to the development and delivery of services
- Any changes must ensure clarity, accountability and safety for the patient
- Assessment of the impact on changing or new roles on other roles and services provided has taken place and wider changes made if needed
- Close links are maintained with other relevant developments in human resources
- All role redesign takes account of the need for continuing personal and professional development and lifelong learning. Experience and training from one post should be recognised and accredited and used for development
- Role redesign builds on the growing evidence and experience of good practice.

It is crucial during the time of change that all parties recognise that role redesign is not a way of getting staff to do more work for less, nor is it a cost cutting exercise. In the current changes facing the NHS, role redesign needs to be used to provide the solution to the widening gap between service demand and delivery, which cannot be met by the current workforce structures and numbers.

For guides on personal and organisational development go to www.institute.nhs.uk/improvementguides.

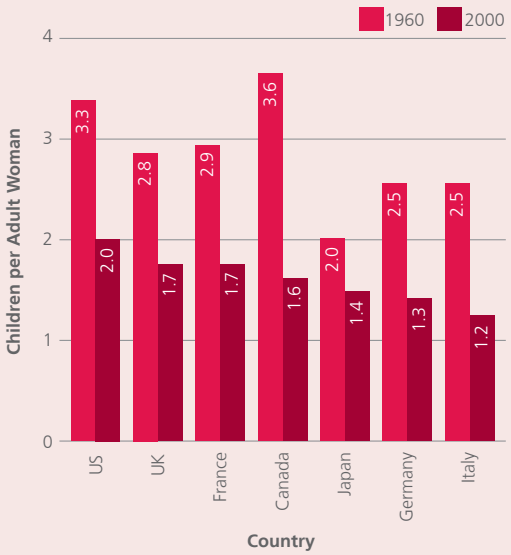


Figure 1: Birth Rates – Total Fertility Rate: 1960 and 2000 (Source: US National Centre for Health Statistics)

Demographic implications for workforce planning

The demographic shape of the western world is changing due to the combination of increased life expectancy, falling birth rates in developed countries and the effect of the baby boom generation coming towards retirement age.

With each generation on average living longer than the last, and this trend continuing for the current generations, UK government actuary figures predict that a child born in 2000 has a life expectancy of 81 years[1]. These figures are by their nature averages and in future years a significant portion of the population will be living well into their 90s and beyond.

The birth rate across most developed countries has been falling consistently since the 1960s. The graph below shows the different fertility rate per adult woman in 1960 compared to 2000. The difference is thought to be that each generation is having fewer children or delaying the age at which they start a family.

Although the UK shows a similar drop in fertility rates as other developed countries, recent figures and anecdotal evidence from NWP workshops suggests a rise in birthrate in the last 5 years. The graph below shows the total fertility rate for the UK from 1971 – 2005. The graph shows the same decrease in fertility up to the year 2000 but an upward kink from 2000 – 2005, this may be due to a proportion of the population starting a family later in life or the impact of EU economic migrants working and starting families in the UK. This recent increase in birth rate may prove to be a problem as most maternity service projections are based on the decreasing trends prior to the year 2000.

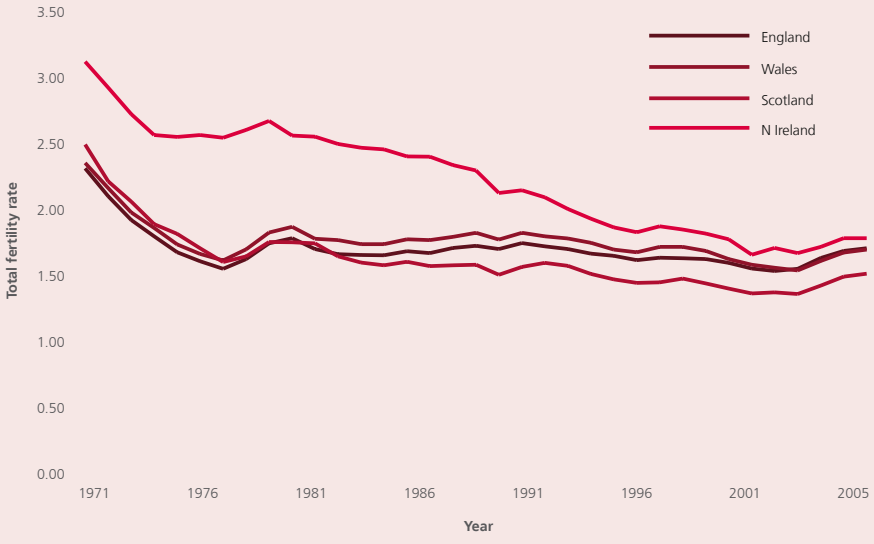


Figure 2: Total fertility rates, UK countries, 1971-2005 (Source: General Register Office for Scotland)

1 Source: Government Actuary Department, UK

In addition the fall in birth rate will provide fewer young workers to the national labour market than in previous generations. This decrease in the available workforce is already having an effect on the NHS with an increase in the age profile of the workforce providing the service. The graph below shows the projected age range of staff providing nursing services changing from 2005 – 2020. Service provision in the future will increasingly rely on midwives that are over 45 and continuing to work past 60. The full effect of this trend has not yet been felt in the NHS partly because healthcare is seen as an attractive career option for people entering universities, but also because of the overall increase in staffing levels in the NHS over the past five years due to the increased investment.

To cope with the impact of all these demographic changes a flexible workforce will be required that can be described in terms of skills and competence, rather than rigid professional boundaries. Organisations will need to consider the appropriate skills mix across maternity services and inter agency collaboration in the community. Other current changes such as agenda for change, IWL and competence frameworks will combine to help organisations create and deliver this flexible workforce. Organisations will require long term plans that map out the effects of all these changes and work through the right skill mix for the delivery of services for the future. This long term plan then needs to inform and shape the workforce commissioning decisions, and local delivery plans within each organisation to bring about the workforce of the future.

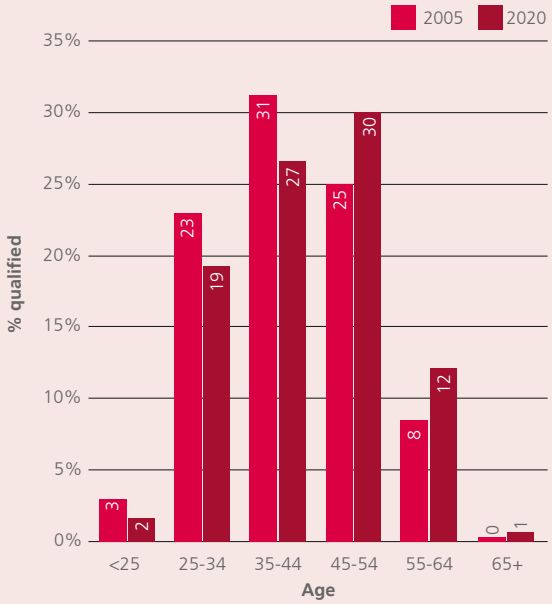
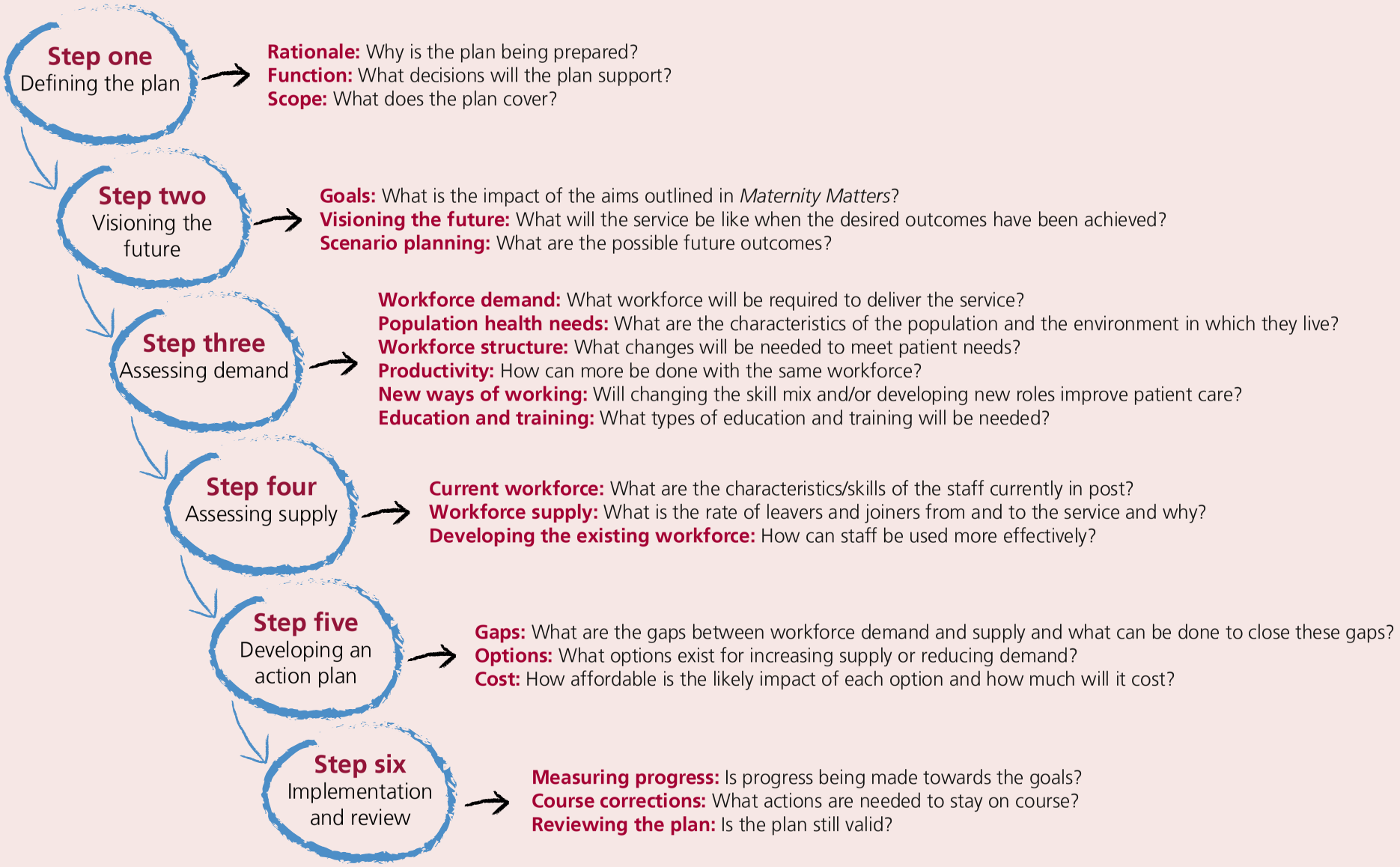


Figure 3: Demographics - age profile of the NHS qualified nursing workforce 2005-2020 (Source: US National Centre for Health Statistics)

Six step guide to planning the workforce



Step one: Defining the plan

- *Rationale: Why is the plan being prepared?*

  This establishes who initiated the planning process, the reasons for initiating the plan, who will be involved in the planning process and what the plan aims to achieve. However, before starting the planning process it is important that organisations know the drivers behind the planning process. Some of the drivers for maternity services can be found in Section One of this pack.

- *Function: What decisions will the plan support?*

  This considers the decisions that need to be made by the planning organisation, and other bodies that may influence the plan, and when these decisions need to be made. A large element of the plan will involve visioning possible scenarios based on an analysis of current trends.

- *Scope: What does the plan cover?*

  The scope defines the structure of the plan, the timescale, client group, geographic area, services and staff which will all need to be included in the planning process to ensure development of innovative solutions. However, although it is important that the plan is not too narrow to avoid missing essential factors, caution also has to be taken to prevent it being too wide and becoming unmanageable.

Step one: What you need to know
Who initiated the plan?
What resources are available for implementation of the plan?
Who will be affected by the plan?
Who needs to be involved in producing the plan?
Is everyone signed up to achieving the goals of the plan?
What outcome is the plan intended to achieve?
What decisions will need to be made by the organisations that are developing the plan?
What decisions, made by others, need to be influenced if the plan is to be successful?
When do decisions need to be made?
What is the timescale for the plan?
What are the characteristics of the population?
What geographic area does it cover?

Step two: Visioning the future

- *Goals: What are the outcomes that the plan is trying to achieve?*

  The central part of the plan is the outcomes: the plan's goals. If the plan is to be successful it will need to have clear and concise goals that all the stakeholders can work towards. Defining the goals will also enable the desired changes to be described in a way that can be clearly identified, monitored and recorded. Identified goals will enable differentiation between intended and other possible outcomes.

- *Visioning the future: What will the service be like when the desired outcomes have been achieved?*

  Visioning the future involves looking at future events, both within and outside of your control, and considering how these events may affect the service to be delivered. If these events are understood at the outset, there will be an opportunity to plan for them by preventing, changing, modifying or supporting the event so that the plan's objectives can be achieved. Developing a vision of what the maternity services/workforce will look like once the desired outcomes have been achieved is generally an excellent way of ensuring engagement from all the stakeholders in the planning process. Gaining stakeholder buy-in to the vision will help in getting everybody working together as a team to help achieve the goals.

- *Scenario planning: What are the possible future changes?*

  Once the goals have been identified and a vision of the future created, these can be used to create a range of scenarios or 'what if?' pictures of the future. It is best to keep these scenarios relatively simple at this stage, adding complexity will involve lengthy debate but not improve the overall plan.

Step two: What you need to know
What will the maternity service and/or workforce be like once the desired outcomes have been achieved?
What will be improved by the plan?
How will improvement be measured?
What are the priorities for the desired outcomes?
What are the main events that will impact on the service?
How effectively can these events be controlled?
How are these events likely to work?
Has a range of scenarios been developed that captures all the possible future changes?

Step three: Assessing demand

Workforce demand means the numbers and types of people needed to deliver the planned service and the skills and competences they need to possess.

As discussed at the start of Section Two, planning workforce demand cannot be carried out in isolation. It needs to be an integral part of the wider service and financial planning process. Workforce demand will be driven by the planned delivery of services but the workforce is also a limited resource, which may constrain the services that can be delivered.

Demand numbers cannot be identified by looking forward from the current structures; this will restrict the demand to today's model of working. Demand will need to be worked up from the visioning of scenarios identified in step 2 and would bring together information on:

- Activity data from maternity services
- How this translates into demand for services
- The planned provision of services to meet these needs which will be informed by national and local policy on the quality of provision
- The service models that are planned to deliver these services
- Ways of working including current staffing models, new roles, skill mix and productivity changes.

- *What are the characteristics of the population and the environment in which they live?*

  Community mapping data will be needed to enable identification of the characteristics of the population and a description of the environment in which they live. This process will also establish whether any up to date data currently exists concerning the maternity services. The data should include:

  - Demographic statistics such as population, ethnicity, deprivation and unemployment data
  - Information regarding the use and capacity of services from service providers and service users ie activity data including caesarean section rates and birth per midwife rates.
  - A community map highlighting all relevant services in the locality as well as local knowledge relating to the accessibility and use of these services.

- *What is the treatment need the service is expecting?*

  Once a picture has been formed in relation to the characteristics of the population and the services they can easily access, it will be possible to identify the treatment need the service is expecting.

  The service will be faced with a heterogeneous mix of people both in terms of numbers and needs. It will therefore be necessary to understand the requirements of delivering treatment to this mix of people. It can be helpful to mind map the configuration of services around this mix of people before developing service pathways. Once service pathways have been established for the population, an opportunity is given to see if the pathways can be improved or made less complex. In other words, an opportunity is provided to look at redesigning the service to more appropriately meet the needs of the population.

- *How can more be done with the same workforce?*

  Productivity improvement is about achieving more service activity for a given level of workforce input. Increasing productivity is commonly misunderstood as trying to make people work harder. While improved motivation will, no doubt, produce some productivity improvements, the significant gains come through using a scarce workforce resource more effectively.

- *Will changing the skill mix and/or developing new types of workers improve patient care?*

  One way of improving the productivity of a specific staff group is to use the skills of that group more effectively by transferring tasks to other groups of workers. Staff at any level typically spend a large part of their time undertaking tasks that do not require their level of training or skill. These tasks can often be successfully transferred to other workers. Where these are existing staff, this is often referred to as changing the skill mix; in other cases the transfer may require the development of new roles. This provides the opportunity to envisage the service being delivered by new types of workers such as maternity support workers and specialised administrative staff. Examples of these roles can be found in the case study section of this document.

- *How many and what kind of staff are needed to meet this treatment need?*

  The number of staff required in each function within the service and the skill mix of the staff necessary to fulfil the activities can now be planned. However, it is vital that only the skills, knowledge and competences required by the service are identified at this stage by developing a profile of what is needed for the service pathways. There are a range of commercial modelling tools on the market such as Birthrate Plus that will act as a good starting point for these discussions. However, the focus should remain on the needs of the patient and the development of the appropriate skill mix to deliver a safe affordable quality service. Only when this has been achieved should the number and type of maternity professionals

needed to deliver the service be identified based on the profile information. This should also identify the training needs of the whole maternity service and ensure that all members can continue developing their skills, knowledge and competence.

Step three: What you need to know
What services will be needed to meet the patients' needs and how are they likely to change?
What is the treatment need these services will be expecting?
Can ways of working be adapted, including current staffing models, new roles, skill mix and productivity changes to meet these needs?
What are the financial implications?

Step four: Assessing supply

Many people with different working patterns and a diverse range of skills could be involved in delivering a maternity service. These people make up the staffing profile. To achieve workforce planning effectively, you need to understand the composition of the current workforce and be able to forecast future potential supply.

Some of the future demand for maternity services may be adequately met by current staff, some may not. Estimates can be made for the future supply requirements of a maternity workforce to deliver the service by considering a number of key questions:

- *What are the characteristics of the staff currently in post?*

  The starting point for assessing supply is the workforce that is in post now. This not only informs how current demands are being met but will also form the core of the future workforce. Developing the skills of this workforce is as important to the supply strategy as recruitment and training of new staff.

- *What is the rate of leavers and joiners from and to the service?*

  An important characteristic of workforce supply is the flow of workers into and out of the organisation. An understanding of this flow is needed in order to control workforce supply and forecast the future workforce. The number of workers at any point in time will be a balance between the leavers and the joiners.

- *How can staff be used more effectively?*

  In step three, new ways of working to modify demand was explored. New ways of working can also be used to enhance supply. However, this considers more radical solutions such as total restructure of the workforce when more simple and straightforward options will not bring about sufficient change.

Step four: What you need to know
Have options been analysed and costed for increasing the workforce supply?
Have the options for working differently been analysed and costed?
Has data relating to current workforce numbers/competence/career aspirations been collated and analysed?
Has the potential of the current workforce been maximised?
Can intrinsic rewards of posts be improved?
Have all possible sources of maternity workforce supply been considered?
Are there untapped new pools of potential recruits to maternity services such as the voluntary/ independent sector?

Equipment officer, neonatal unit

The neonatal unit at the Royal Victoria Infirmary, Newcastle is the regional referral centre for neonatal intensive care. We have approximately 600 admissions a year and attend to over 400 retrievals in and out of the region.

Primarily we offer respiratory care for sick preterm infants however we support care for infants with cardiac and surgical problems.

The unit is extremely busy and resources are used to their full potential. To assist the nursing and medical team within their roles we employed an equipment officer.

The equipment officer's role primarily is to ensure that all equipment is clean, correctly stored and kept in working order. She maintains all the ward stock to ensure that we are never depleted and keeps a check on orders coming in and out of the department. She alerts senior staff to any discrepancies early so that we can plan for any problems that may occur and prevent this affecting the efficiency of the service.

This is an extremely important role within the unit. It not only frees nursing and medical time that can be spent providing a quality care to the infant and family but also ensures that the resources required to run the service are always available.

Step five: Developing an action plan

Steps three and four gave a picture of how the demands for the workforce, and the supply available, are likely to change over time. If the two forecasts are compared, a picture will be established of the difference between them, the gaps, which are likely to occur over the period of the plan. Gaps can occur in the overall availability of people to deliver a service and also in the skill mix that a group of people have. Remember, workforce planning is about getting the right people with the right skills and competences available at the right time.

- *How big is the impact on service of each gap likely to be?*

  Once the supply and demand assessments have been put together, it is likely that a number of gaps will have been identified. On development of the action plan, actions will need to be prioritised so that the gaps that present the highest risk receive the greatest focus. One way to think about this is in terms of hot spots and cold spots. Hot spots are gaps that are likely to have a major impact on service delivery whilst, in contrast, cold spots are areas where there is under utilisation of skills or scope for flexibility.

  It is possible to turn hot spots into cold spots. For example, if an important clinical skill is only possessed by a single professional group, it may be possible to train a wider group of people to safely carry out the activity.

- *What options exist for increasing supply or reducing demand?*

  If a gap has been identified between supply and demand, it will need to be closed by increasing supply, reducing demand or a combination of both. The options available will depend heavily upon the service area. The following are some things that should be considered:

  - Increasing the number of people in education and training
  - Reducing demand by reviewing the traditional staffing patterns and challenging the way care is delivered
  - Increasing productivity
  - Upskilling the current workforce.

- *How big is the likely impact of each option and how much will it cost?*

  Once a list of options for increasing supply or reducing demand has been established, it will be necessary to assess these for the likely impact each could have on the outcome of the plan. It will also be necessary to consider the cost for the proposed solutions. It may be that some solutions incur additional costs, but it is possible that some may avoid further investment by maximising on the investments previously made in the workforce.

Once completed, a highly flexible robust plan should be established that will allow adjustments to be made in response to the influencing factors that will inevitably be present.

To test the plan a number of scenarios should be used. If the scenarios are chosen well, they can be very useful testing tools for the plan or strategy to see if it will stand up to different circumstances. Scenarios cannot test for every eventuality; they will however show which strategies appear more able to cope with different challenges.

Step five: What you need to know
How well does the plan stand up to different scenarios?
Have the workforce demand and supply figures for each scenario been compared?
Has a gap analysis for each scenario been undertaken?
What are the gaps between staff supply and demand and what can be done to close these gaps?
Have the hot spots/cold spots been identified?
Have the options been costed?
What are the best options to put into the action plan?
Are there any other tools available that can be used to assess workforce supply or demand?
What steps need to be taken now as part of the action plan?

Step six: Implementation and review

Strong plans are flexible plans that can be changed and adapted as new circumstances arise. This flexibility will allow adaptation and change to meet the challenges encountered during the implementation process.

- *Is progress being made towards the goals?*

  At the beginning of the planning process, the plan's goals were defined. At that stage, goals should have been picked that had measurable outcomes. Now that the plan has been implemented, it is necessary to ensure that the progress towards the goals is actually measured. This will ensure that if the plan deviates from the desired goals something can be done about it.

- *What actions are needed to bring the plan back on course?*

  It can be assumed that, realistically, no plan is likely to be perfect given the number of uncertainties that are being dealt with. If the monitoring processes are effective, however, they will provide early warnings of when the plan strays from the intended course of achieving the goals. When these warnings are received it is important to review the plan and identify a set of actions to bring the plan back on course.

  If the problem has been spotted early enough, it may still be possible to adjust the action within the workforce plan to put things back on course. Corrective action can be taken or some of the other actions on the action list adjusted. For example, in more complex areas, such as the introduction of new ways of working, an underestimation may have been made concerning the level of resistance to change in the organisation and additional organisational development activities may need to be invested in to win acceptance for the change. Corrective action can only be taken so far. If the scale of the problem is such that adjustments cannot be made to bring the plan back on course, the only option is for a radical review.

What happens when a plan has been developed, implemented (with a set of measures to monitor progress) and reviews and course corrections have been carried out - but the goals of the plan are still not going to be achieved? At this point a more radical revision of the plan may be required. If the workforce plan has been built following the guidance in this toolkit, a clear systematic approach to the development of the document will have been undertaken. This, therefore, makes it relatively easy to review each step to find out which part of the planning process was flawed, insufficiently robust or has been impacted on by an previously unforeseen problem.

The review process is not simply about producing an updated plan (the plan may need no changes) but is also a learning exercise. By undertaking a methodical approach in the review of the plan, a better understanding will be achieved concerning what worked well and what did not. This learning can be transferred when developing a modified plan or the knowledge used in the next planning exercise.

Step six: What you need to know
How often will progress be measured?
Who will review progress?
How will progress be measured?
What will progress reports look like and how will they be produced?
Have all the actions within the plan been implemented?
Is the plan still valid? If not, what needs to change?

Full details of the Six Step Guide to Workforce Planning together with an e-learning programme based on these six steps can be found at www.healthcareworkforce.nhs.uk. This portal offers practical tools and resources, shares best practice, acts as a networking forum and provides up to the minute information that can support health and social care managers deliver smart workforce solutions to changing healthcare needs. Some useful workforce planning tools that can be found on the portal include:

- Supporting Maternity Matters E-learning Programme
- NHS Benchmarking Database
- UK Wide Workforce Planning Competence Framework
- Labour Market Information and Intelligence Guide for NHS Planners
- Workforce Productivity Briefing Paper
- Children's Workforce Briefing Paper
- Education Workforce Briefing Paper
- Working Time Directive projects

Visit www.healthcareworkforce.nhs.uk to access free copies of the above resources.

Workforce planning checklists

The following checklists are for guidance only. Some of the questions may not be relevant to your level of workforce planning.

	YES	NO	ACTION REQUIRED
Strategy			
Does the SHA/PCT have a maternity services strategy? If so:			
• Has it been endorsed by appropriate boards?			
• Does the strategy take account of service provider/corporate/ voluntary sector involvement in provision of services?			
• Does the strategy embrace the implications of new approaches to the management of maternity services?			
• Does the strategy address workforce issues throughout?			
Leadership			
Does the SHA/PCT have a maternity workforce development steering group? If so:			
• Does the board/group include local authority representation?			
• Does the board/group include representation from the service provider/voluntary/corporate sector?			
• Does the board/group include workforce lead or have other direct links to SHA?			
Operational policies			
Have the specifics concerning type of activity, location and volume been addressed in the following:			
• In the maternity service which is to be reshaped?			
• Does the planned service include new types of workers?			
• Has the capacity of existing providers to deliver services been assessed?			

	YES	NO	ACTION REQUIRED
Controls			
Does the strategy align with financial plans/assumptions in the local delivery plan (LDP)?			
Does the strategy align with financial plans/assumptions in multiprofessional education and training (MPET)?			
Is the implementation of the maternity services strategy subject to local performance management mechanisms?			
Commissioning education and training			
Have local stakeholders proposed changes to commissioning patterns for 2007/2008 to accommodate a new maternity service strategy?			
Have the deanery/service provider/corporate/voluntary sectors been involved in making decisions about commissioning of education for the maternity workforce?			
Have the deanery/service provider/corporate/voluntary sectors approached local education providers about training the future maternity workforce?			

Workforce training and development checklist

	YES	NO	ACTION REQUIRED
Does the strategic workforce plan include staff development and training?			
Has any training and development been commissioned around the area of maternity workforce development?			
Are you aware of any training commissioned by local authorities or PCTs in your area to support maternity workforce development?			
Are service users involved in the development and/or delivery of training to support maternity workforce development?			
If no training is currently being delivered, are there plans for this area?			
Is support available to make the commissioning process easier?			
Have funds been identified to support additional training?			

Section Three

Case studies

Case study one

Development of the maternity support worker (MSW) role

Contact details

Name: Julie Estcourt

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Lead organisation

Stockport NHS Foundation Trust

SHA region

North West

Date

June 2005

Project summary

Following a full review of the maternity service provision in the High Peak area, the new integrated model of care was introduced in June 2005. The Corbar Birth Centre (stand alone) is staffed overnight by two MSWs with two on-call midwives. The MSWs completed in house training sessions to equip them with the required skills, for example breast feeding training, neonatal resuscitation, telephone/communication, vital signs, and have annual updates. All MSWs are able to work to achieve NVQ level 3.

About the local area

The Corbar Birth Centre is situated in Buxton in the High Peak area and is approximately 17 miles from Stockport NHS Foundation Trust.

Introducing the project/work

The MSW role has resulted in effective use of resources and allowed the midwives to be able to work more flexibly in order to meet the needs of women and their families. They are valuable members of the teams in the High Peak and contribute to the provision of a quality service.

Learning from the project/work

It is important to have clearly defined boundaries of practice and accountability. The role has continued to evolve and develop and now provides administrative support to the birth centre.

(cont.)

Outcomes

- Positive feedback from women and their families
- Job satisfaction for MSWs
- Appropriate use of staff resource - most cost effective way of providing the service
- Reduced length of stay in the birth centre.

Case study two

New role of floating community midwife- to support community midwives in the provision and expansion of the home birth service

Contact details

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Lead organisation

North Bristol NHS Trust

SHA region

South West

Date

July 2007

Project summary

The suggestion for the role of the floating midwife in the community emerged following a home birth discussion forum attended by all community midwives. The home birth rate at North Bristol NHS Trust is 4.6 percent with some areas having a higher rate of 10–12 percent.

About the local area

The role of floating community midwife covers the catchment area of North Bristol NHS Trust which includes Bristol, South Gloucestershire and North Somerset PCTs. This includes both inner city and rural areas, encompassing a wide range of cultural diversity and social and public health need.

Introducing the project/work

The home birth discussion forum was arranged to allow joint discussion and sharing of ideas about how best we could address some of the difficulties that traditional community midwives face when supporting home births in addition to fulfilling the demands of a busy caseload during the normal working day.

The idea of a floating midwife, flexible and mobile across the community and in a position to cover their workload the day after being out at night at a home birth was felt to be the best solution. When consulting community midwives as to how they best felt the role would support them, the following were agreed:

(cont.)

- Cover the workload during the day, particularly antenatal clinics, when the midwife has been out overnight
- Provide early labour assessment at home to women during the day if on call midwife busy at an antenatal clinic
- To relieve the on call midwife at an antenatal clinic in order for her to perform labour assessment to women at home
- To perform the role of second midwife at home birth
- To collect home birth equipment
- To support community midwife in any aspect of midwifery care as required.

Additional funding for this new role was obtained as a consequence of a Birthrate Plus assessment and a midwife was appointed in July 2007.

The role is believed to be crucial to the traditional community model of care as, for the most part, they have less flexibility due to the organisation of the way in which they work. As this is a new role a communication pathway was developed to clarify the process for accessing the support of the floating midwife.

It is also recognised that at certain times, for example times of unexpected sickness, study leave, family leave, the midwives feel additional pressure in fulfilling the increased workload and covering additional on calls and by utilising an experienced midwife with community knowledge they can make their commitment to home birth a priority knowing that their additional work will be taken care of.

Once agreed, the purpose of the role and the communication pathway was disseminated to all community midwives via email and letter and a visit by the floating midwife to the bases once the role went live. Having a flexible, committed, knowledgeable and experienced midwife is crucial and is the key to the success of this role, as from one day to the next it is not known where and in what capacity she may be required.

Learning from the project/work

The main aim of the role of the floating community midwife was to support the home birth service. However what has been identified is the enormous need for this role in more general terms of support to traditional community midwives. The impact of holidays, sickness, family leave and study leave has a huge impact on the service provided to women and increases the stress and pressures of those midwives who pick up the additional workload. The role has certainly been able to relieve some of those pressures. There is great potential for the role to be expanded and rolled out further in the future in order to offer the service more widely, as one midwife can only provide so much support at any one time. In addition, more community based care which currently is only available in a hospital setting, for example early labour assessment at home for more women, could be offered within the flexibility of this role, enabling the traditional community midwives to continue to offer continuity and the highest quality of care to the women on their caseload in addition to a choice for woman regarding place of care at this time.

Outcomes

As the role is a new development there are currently limited measured outcomes to assess its effectiveness. However in the first month, 60 percent of calls were to directly support midwives in the provision of home births and the feedback from midwives has been extremely positive. Data is being collected on a monthly basis and an audit will take place six months into the role.

Case study three

Polish antenatal care project

Contact details

Name: Chris Poyzer

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Lead organisation

Worcestershire Royal Hospitals NHS Trust

SHA region

West Midlands

Date

August 2007

Project summary

The PANC-ap Polish Antenatal Care Project commenced in October 2006.

Due to the increasing Polish population in recent years there has been a huge impact on the case load in Worcestershire. Young families were often unable to communicate adequately with the medical and midwifery profession and were posing a significantly higher risk assessment. This could potentially lead to mismanagement and increased risks in providing safe and individualised care. The purpose of this project is to allow delivery of a high standard of care. Polish families will have a vastly increased understanding of the care pathway in the UK, ensuring they have the ability to make an informed choice and receive individualised care depending on their needs.

About the local area

Worcestershire is a mix of mainly rural with urban areas. Within the rural areas there is a huge amount of fruit and agricultural farming with seasonal employment either picking or processing. The young Polish community are mainly congregated in these areas.

Introducing the project/work

A Polish midwife employed by the trust, identified the need for developing a service when undertaking her scan clinics in the Evesham area, where the Polish women were increasing in numbers and had very limited understanding of the English language.

The project midwife sees the woman at booking, 28 weeks and around 34-36 weeks of pregnancy. There are communications between the project midwife and the community midwives especially as the woman is seen in between times by the community midwife.

The work included:

- Translation of information on procedures and tests that may be used during the antenatal, intranatal and postnatal period. This is to enable informed choice about, for example, blood tests, scenarios such as induction of labour, cot death information, Vit K, BCG, breast feeding information and ideas of what to bring into hospital

(cont.)

- Development of key terms for the antenatal ward, delivery suite, postnatal ward and community midwifery service to assist in communication when an interpreter is not available. This enhances communication and encourages informed choice around key areas for example, CTG, FBS, FSE, Emergency LSCS, ARM, cannulation and other topics.

Aims of the Polish antenatal clinic are:

- To give a high standard of care alongside the consultant, midwife and GP
- To obtain accurate information and undertake the booking process
- To explain the care pathway in the UK during pregnancy and the postnatal period
- To obtain informed consent for ultrasound scans, screening tests and procedures
- To enable the woman/partner to discuss their fears and anxieties in their mother language
- To sign post them in the right direction with queries not relating to their pregnancy
- To provide a resource for the Polish families on pregnancy information.

Learning from the project/work

So far the feedback has been very positive from the clients and health professionals. The project is supported by the chief executive of the trust and senior management within the maternity service.

- The project is helping to provide safer, high standard care and is bridging the communication gap between the Polish speaking community and the maternity healthcare professionals
- The numbers using the service has increased more than was anticipated
- Initially clinics were set up in the three hospital sites, but the project is now moving out to children's centres as well
- Over ambitious ideas of how many women could be seen at a clinic needed to be refined as the project has developed
- Initially community midwives referred all Polish women to the project - it was clarified that it is just the non English speaking women that are to be referred.

Outcomes

- Project is reviewed every three months, increased resources are being given to the midwife to enable the project to continue
- A patient satisfaction survey in Polish is being undertaken with the clients using the service. Clinical governance with the Polish midwife have developed this and will provide the report
- The need for further translation of information has been identified
- The Polish midwife has been contacted as a resource to translate the West Midlands Perinatal Institute antenatal and postnatal booklets in to Polish.

Case study four

Development of the MSW role in discharge

Contact details

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Lead organisation

Stockport NHS Foundation Trust

SHA region

North West

Date

June 2007

Project summary

Stockport NHS Foundation Trust took part in the first wave of the MSW programme. We undertook a pilot study to evaluate the role to work as a focused discharge team working closely with the midwife to provide a quality service, and provide a smooth transition from hospital to home. This pilot was conducted at Stepping Hill Hospital and involved 2.80WTE MSW posts.

About the local area

Stockport NHS Foundation Trust maternity service has approx 3600 births per annum.

Introducing the project/work

The focused discharge team of MSWs has demonstrated a reduction in delayed discharges from the ante/postnatal ward.

Learning from the project/work

It is important to have clearly defined boundaries of practice and accountability. The role has continued to evolve and develop and now provides administrative support to the birth centre.

Outcomes

Baseline data demonstrated that 38 percent of midwives time could be saved by the introduction of this role. Delayed discharges were reduced dramatically.

Case study five

Willow community team (specialist team for vulnerable women)

Contact details

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Lead organisation

Ealing Hospital NHS Trust

SHA region

London

Date

August 2007

Project summary

The vulnerable women's case loading team was set up in September 2006, in response to a range of policies. A team of three band 7 and three band 6 midwives were recruited and the team initially had no guidelines, care pathways or connections.

The team leader appointed set about identifying a referral process from the community professionals and GPs, establishing links with police, mental health and sure start. The team promote referral to the team by 16 weeks.

About the local area

The London boroughs of Ealing and Southall are a diverse multi ethnic population, high areas of social deprivation and areas of wealth.

Introducing the project/work

Women are referred to the team and following their antenatal booking they are offered early bird education sessions. Contact and communication with the vulnerable women is undertaken via text and mobile phones, thus alleviating the potential for missed appointments or loss of contact.

All women are referred to Connexions and health visiting services, the team also access psychologists, mental health and drug services, and the police in cases of domestic violence.

Learning from the project/work

Women suffering domestic violence would not always attend appointment or they attended appointments with their abusers. The police now inform the midwives if there have been two reports from the woman's home of a disturbance.

The team set up clinics in the community in association with Sure Start, facilitating women to access services early and the opportunity to self refer.

The team review all women on their case load prior to discharge from hospital and ensure care plans are in place and discharge professionals meetings have taken place.

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Outcomes

The team are presently collating audit data, a parent education workshop for postnatal mothers indicated an 80 percent normal delivery rate amongst our teenagers, and 80 percent of these teenagers were breastfeeding at six weeks post delivery.

The number of referrals has been much greater than anticipated and case loads continue to expand. Currently the team have a case load of 1:31.

Case study six

Providing *Maternity Matters* facilitators in local maternity services

Contact details

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Lead organisation

South East Coast SHA

SHA region

South East Coast

Date

August 2007-July 2009

Project summary

A business case was submitted to the SHA by the local supervising authority midwifery officer (LSAMO) to support the implementation of *Maternity Matters* within the local maternity services in trusts within the South East Coast SHA region. The bid asked for funding to develop a *Maternity Matters* facilitator post within each maternity service in local acute hospital trusts. These posts are part time seconded midwifery posts (band 7). Funding was also requested for a part time programme lead (15 hours per week) to coordinate the programme across the SHA (band 8a).

About the local area

South East Coast SHA covers a population of approximately 4.5 million people across Surrey, Sussex and Kent. There are 12 acute hospital trusts and 19 maternity units supporting over 50,000 births a year. Implementation of *Maternity Matters* is occurring against a background of the NHS South East Coast's 'Fit for Future' programme which is driving changes in the configuration of services – including maternity.

Introducing the project/work

Each maternity service has been asked to submit a job description for the facilitator post and an outline plan of the planned developments in line with *Maternity Matters* (units are asked to have this programme plan signed by the head of midwifery, the obstetric lead and the chair of the maternity services liaison committee to demonstrate engagement and commitment).

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Learning from the project/work

Across the SHA there are variations in-home birth rates, caesarean section rates, CNST levels, breast feeding initiatives. This project is in its infancy but it is hoped that by having a coordinated programme of implementation that individual successes can be celebrated and that lessons learned from the high performers in a particular area can be spread effectively to other services.

Outcomes

From the outline programme plans submitted the expected benefits are:

- To deliver a 1 percent point reduction per year in the proportion of women continuing to smoke during pregnancy, particularly focusing on smokers in disadvantaged groups
- To maintain the 2006 breastfeeding initiation rate each year
- To deliver a 2 percent points increase in the number of women who continue to breastfeed at postnatal day 10
- To ensure that all women have a choice in where and how they have their baby and which pain relief they wish to use, depending on their individual circumstances
- To form and maintain strategic links with a widened variety of community settings to improve accessibility and promote early integration with other services, focussing especially on women from disadvantaged groups
- To promote awareness of geographical variations in clinical outcomes that cannot be fully explained by local demography, and to suggest alternative models of maternity service provision which may reduce these inequalities in outcome
- To promote the contribution that high quality maternity care can make to equipping mothers and fathers to be confident and caring parents.

Case study seven

Reducing caesarean section rates in Wolverhampton

Contact details

Name: Tracy Palmer

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Lead organisation

Royal Wolverhampton Hospitals NHS Trust

SHA region

West Midlands

Date

August 2007

Project summary

The caesarean section rates in Wolverhampton have decreased gradually and significantly over the last three years.

This has been achieved by midwives, consultant obstetricians and medical staff working in partnership. The result has been that our caesarean section rate is now falling in line with the national average of 23 percent.

Learning from the project/work

Focus on keeping pregnancy and birth normal
In 2004 we developed a midwifery led steering group to identify leaders / change agents, review normal care pathways and develop guidelines to support normality. This group has embedded and devised a sustainable model of good clinical practice, with the focus on normality (low risk birth pathway).

Active birth workshops
Active birth workshops for midwives supported this care pathway and these were successfully facilitated by our specialist midwife in parent education and have been evaluated positively. The emphasis has been to educate and develop midwives in the concept of active birth and normality thus empowering midwives to provide choice and support for women during their birth experience. Women are now encouraged to remain active and adopt alternative birthing positions.

Avoidance of unnecessary intervention for low risk women
Promoting intermittent auscultation of the fetal heart using a hand held sonic aid. Continuous electronic fetal monitoring is associated with increase likelihood of caesarean section (NICE, 2004).

Risk assessments
Continual risk assessment at every contact with the woman and maintaining midwifery led women within low risk status. Documentation has been updated to support this concept and has been reinforced as part of the intra partum study day that is mandatory for staff.

Introduction of alternative methods of pain management
The last two years has seen the introduction of our water birth facility – the focus is on

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movement and active birth in deep water, aquagesia, aromatherapy/ massage and wheat bags which are used to provide heat to specific areas of discomfort ie back, abdomen. These therapies offer a positive and supportive alternative to medical pain relief and assist in keeping women within the 'normal' parameters of midwifery remit.

Room décor
Ensuring that the décor of the birth room is homely with clinical equipment out of sight – this enables the woman to feel more at ease and the midwife to keep the focus on normality.

Promotion of vaginal birth after caesarean section
Standardised information is now used to enable an informed choice for women requesting vaginal birth after caesarean section.

Training
Robust multiprofessional training programmes have been developed to address CTG interpretation. This has been conducive to a standardised and consistent approach in managing women who have abnormal CTG traces. This has influenced our perinatal morbidity and mortality rates positively. Training is delivered in-house on a rolling programme which meets the criteria for twice yearly CTG training as recommended by NICE.

Fetal blood sampling
The appropriate use of this diagnostic test and the development of a robust clinical guideline has resulted in women who have suspicious/pathological fetal heart traces being allowed to continue in labour if the foetus shows no sigh of fetal acidosis. This means that caesarean sections are not being performed inappropriately.

Visible consultant and senior midwifery presence on the delivery suite
Provision of senior clinical leadership has played an essential part in the reduction of caesarean section rates. This partnership has led to a robust review of training and clinical practices for medical and midwifery staff through intrapartum/antenatal committee groups.

Review of equipment
Our unit ceased to use the Kiwi cup for instrumental delivery in 2006. This was resulting in failed instrumental deliveries which would then proceed to unnecessary caesarean section in some instances.

Outcomes

Annual percentage of caesarian sections over the last 3 years 2004 – 2007

2004 28.0 percent

2005 26.7 percent

2006 25.3 percent

2007 24 percent to date

Staffing

One of the key influencing factors for reducing the caesarean section rates has been improved staffing levels on the delivery suite. This has enabled midwives to deliver one to one care in labour 80 percent of the time in line with the *Towards Safer Childbirth* 2007 recommendation. Support for women in established labour is a fundamental factor in ensuring a reduction in caesarean section rates, the need for medical pain relief and positive birth outcomes.

Case study eight

Universal care pathway for antenatal and postnatal care

Contact details

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Lead organisation

Dudley Group of Hospitals NHS Trust

SHA region

West Midlands

Date

August 2007

Project summary

A pathway for midwives to use as a resource tool for antenatal and postnatal care, indicating the optimal time for screening and referral. The pathway also includes the use of pre-conceptual care information and encouraging women to take up early access to the maternity services (posters have been developed with partners and users of the service and disseminated widely throughout the borough). The posters aim to improve women's access to the maternity service, encourage women and their partners to prepare for pregnancy and the pathway promotes the implementation of consistent care based on NICE and the National Screening Committee recommendations.

About the local area

The trust's maternity service has worked with users, Dudley PCT, Dudley Maternity Services Liaison Committee and children's centres to review recommendations of the NSF for children, young people and maternity services and *Maternity Matters* to promote women to gain early access to services.

Introducing the project/work

The project was launched to staff and primary care colleagues via an information letter and pack, feedback was very positive. The pathway will be reviewed as part of clinical audit and updated accordingly.

Learning from the project/work

Multidisciplinary working can be both productive and effective but can also make progress very slow.

Outcomes

The posters and pathway are newly implemented and audit of the outcomes has not yet been undertaken, however, all partners involved in the project are committed to effective implementation for the good of the women and families within the borough.

Case study nine

Changes to the parent education service

Contact details

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Lead organisation

Royal Wolverhampton Hospitals NHS Trust

SHA region

West Midlands

Date

2006 - 2007

Project summary

One of our priorities was to completely revamp the parent education sessions, and to provide midwives with equipment needed to offer a modern approach to parent education. It was necessary to standardise the classes to ensure that women were receiving consistent information wherever the classes were held.

The information received needed to be relevant to every person in the room.

The standard now is for three classes facilitated by the midwife:

1. Active birth (labour). This includes practical demonstration of the pelvis and positions using the birthing ball
2. When things do not go to plan and pain control. This is a game facilitated by the midwife, but led by the women or couples
3. The first few days with a baby. This is a quiz which deals with many of the problems that the community midwife has to deal with in the first visits.

Introducing the project/work

Booking and choosing classes

At the initial contact with the community midwife the woman is given a booklet. This contains all information needed re classes available for the women. If it is the woman's second baby she may only want to attend for active birth or a breast feeding class. As a result the course can now be tailored for the individual.

All day classes are also an option and have proven to be very popular on a Saturday or Sunday, all four sessions are done on the same day, this suits the busy life styles of some of our clients.

Venues

It is vital to take the classes out into the community to make them easily accessible to all women. Joint working with children's centres is also a positive step and we have used these wherever possible.

(cont.)

Learning from the project/work

Breast feeding
Wolverhampton has been awarded the certificate of commitment from Baby Friendly and has a specialist midwife for infant feeding.

To support this and to ensure that the women are all receiving the same information all breast feeding sessions are delivered by a specially trained midwife.

Day classes
Though evening classes are of utmost importance they have taken over from day classes and have become very much for couples - many of them well educated and motivated - and it has never been a problem getting these people through the doors of classes.

Previously day classes traditionally supported women and helped them meet new friends. Currently there are wider groups of women that services need to target including teenagers, ethnic minorities, asylum seekers and single women.

To reach these groups classes are now run during the day at the children's centres, these are operating with the help of the family support workers. We are able to offer a 10 week course to support these women and once engaged antenatally at the centres they continue to access services postnatally.

Previously, teenage girls have had separate classes with some input from midwives. The attendance at these sessions was patchy and many times this was a waste of a midwife's valuable time. Now the girls are part of the main group this means that the girls are not made to feel that they are different, they also have a positive interaction with others in the group.

Asylum seekers attend the children's centres for support and we have had several come to the group. The group has also been key to me being able to book or give antenatal care to women who have had domestic violence or have concealed their pregnancy for whatever reason.

Outcomes

- This has been a very popular service and the feedback from the couples very positive
- The rate of caesarean section has been reduced together with the use of epidural
- Women are likely to labour at home longer
- They describe positive birth experiences and feel more confident postnatally
- Partners have benefited and feel that they were able to offer confident support in labour as they have a better awareness of the birth process.

Case study 10

The impact of a vaginal birth after caesarian section (VBAC) clinic

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Lead organisation

Worcestershire Acute Hospitals Trust

SHA region

West Midlands

Date

August 2007

Project summary

The elective LSCS rate was causing concern, therefore, an elective LSCS audit was performed. Due to the findings of the audit a VBAC clinic was initiated as a pilot project.

About the local area

The caesarean section rate in Worcestershire is one of the highest within the West Midlands region.

Introducing the project/work

The elective LSCS rate was causing concern and following discussion at the labour ward forum meeting it was decided to perform an elective LSCS audit.

The audit was retrospectively performed across the county, collating data over May-July 2005. 67 sets of medical notes were reviewed. The reason for 55 percent (37 out of 67) of elective LSCSs was due to having had a previous LSCS, 40 percent (15 out of 67) were due to the woman's choice.

The information given to these women was extremely poor. 97 percent (35 out of 37) of these women were not given sufficient information to make an informed choice of their options for mode of birth. There was also evidence of poor decision making relating to 'large for dates' babies and women whose babies were breech presentations. Two out of six women who had a breech presentation were not offered external cephalic version (ECV), one woman was offered it but it wasn't booked, so she had a LSCS.

Learning from the project/work

Due to the findings of the audit a VBAC clinic was initiated in October 2005 at the Alexandra Hospital, Redditch, as a pilot project to see if was successful. The aim being to reduce the amount of elective caesarean sections being performed, which may be due to women not having adequate information to make an informed choice about their birth options. The clinic is run by the consultant midwife.

All women that have had a previous LSCS are given an appointment to the clinic. The woman and her birth partner have the opportunity to discuss the previous birth and resolve any issues they may still have from that time.

(cont.)

The risks of VBAC and the risks of LSCS are equally discussed. Information is given about both options both verbally and in written form. The woman and her birth partner are then able to make an informed choice.

Outcomes

Prior to the clinic commencing only 22 percent of women wanted VBAC, 100 percent of them had a LSCS.

From December 2005 to December 2006:

- 66 percent elected to have VBAC.

Out of the women who decided on VBAC:

- 66 percent had a vaginal birth (52 percent normal birth)
- 34 percent had an emergency LSCS.

Positive feedback has been gained verbally from the women via the community midwives.

From the VBAC clinic has stemmed a VBAC pathway and a VBAC checklist which has been developed by the consultant midwife, this has been accepted by the guidelines group and a VBAC guideline developed with the lead obstetrician and clinical specialist midwife. A VBAC information leaflet has been developed by a midwife on labour ward at WRH and has been accepted by the guideline group for use.

The pathway, guideline, checklist and should then give a clear direction on the information given by medical staff and midwives and opens up a referral route to the consultant midwife for women who are undecided.

Case study 11

Reducing perinatal and infant mortality projects

Contact details

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Lead organisation

West Midlands SHA

Heart of Birmingham tPCT

SHA region

West Midlands

Date

Interim report January 2007 - ongoing project

Project summary

Focusing on enhanced community midwifery services within targeted wards with highest perinatal/infant mortality and deprivation. Data collection on key performance indicators (KPIs) for all births in the area. Confidential case reviews and maternal experience survey.

(cont.)

About the local area

West Midlands SHA has the highest perinatal mortality rate in the country. This project specifically targets wards with the highest deprivation and perinatal/infant mortality rates.

Introducing the project/work

The project was designed to enhance community midwifery services by developing KPIs around early booking in pregnancy, continuity of carer, detection of intrauterine fetal growth restriction, smoking and breast feeding. The project involved data collection on the KPIs, confidential case review and maternal experience survey.

Alongside this project, Heart of Birmingham (HoB) tPCT were awarded NRF funding to fund additional midwifery posts to reduce in the caseload in the most deprived wards within Birmingham. The community midwifery service will work to a service specification designed to target those with the highest medical and social risk, providing additional support. The service specification includes the KPIs outlined above.

In addition, a consultant midwife in public health will provide the clinical leadership and support to achieve the aims of the project, which is to reduce perinatal and infant mortality. A social enterprise organisation has been funded to provide additional pregnancy support workers, specifically employed to provide support to those with the high social risk.

Learning from the project/work

- A targeted approach is required to tackle inequalities in care when resources are limited. This relies on extensive data to identify the greatest need
- Workforce planning should use a population and needs based approach
- Additional funding is required to reduce the high community midwifery caseloads
- Data collection clerks are essential to achieve additional data collection
- Pump priming projects require sustainable funding to achieve any long term gains.

Outcomes

The KPIs are designed to enhance community midwifery services.

HoB tPCT have committed to continue the funding for the additional staff to ensure the work to reduce perinatal and infant mortality rates continues.

NHS West Midlands have included the reduction of perinatal and infant mortality rates as a target in its future work, now under consultation with stakeholders.

Case study 12

Enabling informed choice for women and user led services

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Lead organisation

Barnet and Chase Farm NHS Hospital Trust

SHA region

London

Project summary

In accordance with government policy and best practice evidence, the overall aim of the project is to ensure that our maternity service is women focused and that women are empowered with the appropriate information to make informed choices about their care and are involved in any decisions with respect to the strategic direction of our maternity service.

About the local area

Barnet and Chase Farm NHS Hospitals Trust provides maternity services to approximately 6,700 women who reside within the catchments areas of Barnet, Enfield, Haringey and Hertsmere. Maternity services within the trust are provided across the community, children's centres and within community hospital settings and two acute hospital site settings.

Introducing the project/work

Initial priorities were to agree for the purpose of our local strategy

- What a woman centred maternity service would comprise of
- What information was required to support informed choices
- How that information should be developed and made accessible to all women

Our initial priorities were to implement the necessary infrastructures to support women having access to the midwife as the lead professional, to strengthen the provision locally for choices with respect to place of birth including the provision of birth in midwifery led units or birth centres in addition to ensuring that women and staff had access to supporting information.

A systematic and collaborative approach was adopted which included the establishment of a strategic midwifery forum and involving and engaging all key stakeholders. User involvement was through the maternity service liaison committee.

Initial goals and objectives focused on the development of evidenced based guidelines to support the delivery of midwifery led care in addition to changes in the structure and processes within maternity services that enabled the midwife to be identified as the lead professional for low risk women and refer appropriately to members of the multidisciplinary team. These required changes to the trust's information systems with the acceptance

(cont.)

of a code that would enable women identified for midwifery led care to be entered, the development of direct referral pathways for midwives to other agencies such as the ultrasound department, obstetricians, and dieticians as required.

Options for place of birth were reviewed in order to ensure that local women had real choices. Provision for birth in midwifery led units and our stand alone birth centre was increased. As a result we have established three midwifery led units, two integrated and one standalone with each having the capacity to provide intrapartum care for approximately 800 women per year.

Ensuring that women had access to appropriate evidence based information was critical for the successful implementation of our vision. Evidence based information was developed for women on the different options available to them, including place of birth and choices with respect to their pregnancy, labour and postnatal care. In addition to the provision of written information, the hand held maternity records were redesigned to be more women focused incorporating reminders to them of the choices available and in promoting their ongoing involvement in their maternity care. The maternity website was also developed to include appropriate information to women.

Learning from the project/work

- Important to set key objectives and regularly monitor implementation of agreed objectives
- Support/mentor all staff in relation to them achieving their set goals
- Networking and planned, facilitated time out is invaluable in achieving service changes with the staff involved in the provision of care changes
- Senior midwifery leadership, motivation, drive and support for staff is vital in any major strategy change process.

Outcomes

Prior to the implementation of the project less than one percent of women were booked with a midwife as the lead professional, currently approximately 60 percent of women are booked for midwifery led care.

Choices with respect to place of birth has increased and last year approximately 20 percent of all women booked in the trust gave birth in one of our three midwifery led units.

Giving women choice and information about the options available to them and empowering them through active birth workshops and antenatal care have been pivotal in enabling them to make an informed choice. The evidence based practice guidelines together with the ongoing education programmes have meant that midwives feel more empowered to utilise their skills and expertise fully. This has also facilitated local recruitment and retention of midwives. Enabling midwives to utilise their full skills and expertise has meant that consultant obstetrician time is released to be available to care for women requiring specialist services.

Section Four

Frequently asked questions

Q What are the key deliverables for the policy through to its implementation in 2009?

A The detail of what the policy sets out to achieve is contained within the Department of Health policy paper *Maternity Matters.* Each health economy will have to demonstrate progress towards the implementation deadline of December 2009. Details of the policy and the workforce planning implications are available on the healthcare workforce portal at www.healthcareworkforce.nhs.uk/maternity.

Q How will the Department of Health support the NHS in delivering the maternity matters policy?

A The Department of Health, together with key partners, will work with the NHS to overcome the challenges involved in delivering the aims of *Maternity Matters.* Best practice and case studies of innovative practice will be shared on the stakeholder websites such as the Department of Health, CSIP and the healthcare workforce portal.

Q How does the policy fit with the wider system reform plans?

A For mothers the policy offers a guaranteed choice in the birth of their baby. These guarantees are further supported by the choice agenda outlined in *Our Health, Our Care, Our Say.* This reform creates more choice by:

- Offering independent sector provision
- Extending foundation trust status, creating extra flexibility for hospitals to expand and develop services
- Rewarding hospitals through payment by results, for treating extra patients and enabling them to invest in extra capacity.

Q How can engagement across a wide range of organisations and groups be managed effectively?

A Each of the SHAs recognised the need for a strategic framework that supports engagement. This can take the form of strategic workforce modernisation teams into which new ways of working projects and developments are fed. Programme boards can also be influenced by clinical reference groups that engage lead clinicians to contribute to the development of clinical outcomes and patient and service user forums to provide the patient perspective and advice on patient focused outcomes.

Q What relationships are required with workforce planners across healthcare?

A Each SHA has recognised the need to work closely with workforce planners to ensure that modernisation of the workforce can be captured. Some authorities have arranged events with sectors in social care, including the independent sector to try to encourage a better sharing of knowledge. Others are discussing how joint training across health and the independent sector can provide potential shared learning opportunities.

Q What developments are required and which are underway in the commissioning and delivery of education and training for new ways of working in the maternity matters policy?

A Each SHA is committed to the need to work differently given the predicted trends in workforce growth. To sustain these developments, however, they are trying to encourage consistency of approach in education and training by mapping roles against existing national occupational standards and national competency frameworks. Some SHAs have developed good collaborative working relationships with further and higher education providers so that they are influenced by the changing needs of the service. Others find this is an area in which they need national support to change cultures within the education sector.

Q What skills and competency frameworks are being utilised to support new/extended roles?

A Wherever possible, SHAs are using national competency frameworks developed with Skills for Health to support the development of new ways of working. All maternity services will need to review their staff skill mix and map it against the expected activity to ensure that the staff roles meet the needs of the local population. Work is being undertaken to map job descriptions against national frameworks, locally developed frameworks, the knowledge and skills framework and agenda for change.

Q What resources are available to support the implementation of *Maternity Matters?*

A Each of the maternity units will be able to access a range of national and local support to develop their workforce plans. Workforce planning resources, such as this resource pack, are available nationally. In addition case studies from service demonstrate how other organisations have developed their departments' competences and skill mix.

In many cases workforce skill mix redesign can be achieved within the current budget levels, in other cases maternity units have successfully developed a business case for increasing levels of staffing to meet the maternity matters policy. In all cases a robust workforce plan depends on a clear vision of future activity and good baseline data on which to make decisions.

Section Five

Useful contacts/ resources

Care Services Improvement Partnership (CSIP)

The Care Services Improvement Partnership supports positive changes in services and in the wellbeing of vulnerable people with health and social care needs.
www.csip.org.uk

Children Act 1989 (c.41)

www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

Child Health and Maternity Services Self Assessment and Benchmarking Tools

This website provides access to four tools which are designed to help commissioners and local health economies assess their progress toward implementation of the the NSF for children, young people and maternity services, including the baseline assessment which is required for *Maternity Matters*.
www.childhealthmapping.org.uk/pct.self.assessment/

Innovations Matter: Examples of Support Workers in Maternity Services

This recent CSIP document is designed to assist maternity services with the development of skill mix outlined in *Maternity Matters*.
www.healthcareworkforce.nhs.uk/innovationsmatter

Maternity support workers: Enhancing the work of the maternity team (Large Scale Workforce Programme)

This report illustrates ways in which the support worker role is helping the maternity workforce provide the improved access, quality and flexibility of care needed to deliver choice by increasing the capacity of the maternity team.
www.healthcareworkforce.nhs.uk/maternitysupportworkers

NSF for children, young people and maternity services (Department of Health)

The NSF, published on 15 September 2004, sets standards for children's health and social services, and the interface of those services with education.

CSIP Children, Young People and Families Programme - The tools on this website will support commissioners and providers of maternity services to develop their services to meet national policy recommendations.
www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childrenservicesinformation/index.htm

Department of Health

Providing health and social care policy, guidance and publications.
www.dh.gov.uk

Every Child Matters

Every Child Matters: Change for Children is a new approach to the well-being of children and young people from birth to age 19. Over the next few years, every local authority will be working with its partners, through children's trusts, to find out what works best for children and young people in its area and act on it.
www.everychildmatters.gov.uk/aims/

NHS North West

NHS North West has agreed to coordinate the implementation of *Maternity Matters* across strategic health authorities and will be working in partnership with the Department of Health, CSIP and NWP. More information and access to examples of best practice from across the country can be found on the NHS North West website.
www.northwest.nhs.uk

Royal College of Midwives (RCM)

The RCM is the professional organisation and trade union run by midwives for midwives. It is the voice of midwifery, providing excellence in professional leadership, education, influence and representation for and on behalf of midwives.
www.rcm.org.uk

Royal College of Obstetricians and Gynaecologists (RCOG)

The RCOG is dedicated to the encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology.
www.rcog.org.uk

Skills for Health

Skills for Health is the Sector Skills Council (SSC) for the UK health sector. We help the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare. The website includes a series of online tools which help an organisation collate a set of competences for a service or a role.
www.skillsforhealth.org.uk

Support workers in Maternity Services: a national scoping study of NHS Trusts providing maternity care in England 2006 (King's College London)

This study aimed to provide a systematic overview of the numbers, scope and range of practice, levels of training, skill mix and service model arrangements of support workers working in maternity services in England.
www.kcl.ac.uk/content/1/c6/02/16/41/SupportWorkersinMaternityServicesREVISED.pdf

Yorkshire and Humber Public Health Observatory

This contains a basic selection of relevant contextual and outcomes data for your region. They have been produced by Yorkshire and Humber Public Health Observatory (as lead national PHO for child health), and show examples of the type of routine data that is currently available, and could be incorporated within the needs assessment tool for maternity services. It is important to note that the development of the tool will also feed into and link closely with other national work around the development of metrics for maternity services.
www.yhpho.org.uk/maternity.aspx

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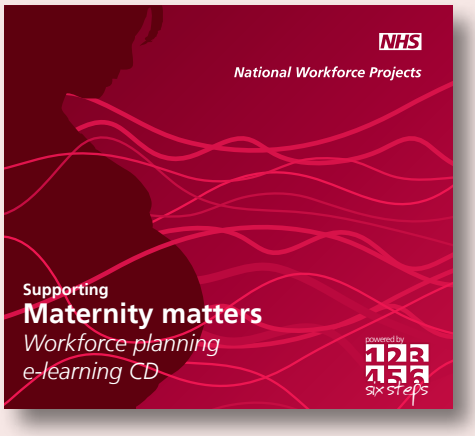
Supporting resources from NHS National Workforce Projects

Supporting Maternity Matters workforce planning e-learning CD

The *Supporting Maternity Matters workforce planning e-learning CD* is an interactive learning programme that gives you a guide to effective workforce planning. At its simplest, workforce planning ensures you will have a workforce of the right size, with the right skills and competences delivering services in the right place and at the right time. The guide aims to help all those involved in maternity services and workforce planning gain an understanding of how to work through the maze of information to support the *Maternity Matters choice agenda*.



This educational package will assist and guide you through the workforce planning process using the Six Step Guide to Workforce Planning, featuring expert speakers accompanying each step:

Professor Sabaratnam Arulkumaran, president of the Royal College of Obstetricians and Gynaecologists

Rachael Charlton, director, NHS National Workforce Projects

Mike Farrar, chief executive, NHS North West

Dr Gwyneth Lewis, national clinical lead for maternal health and maternity services, Department of Health

Jon Skewes, director of employment relations and development, Royal College of Midwives

Jenny Thomas, director of strategy and corporate governance, West Kent PCT

John Wolfe, interim director of workforce, NHS South West

Healthcare workforce portal

The maternity section of the healthcare workforce portal is an integrated series of resources to help maternity units plan their future workforce. The portal contains downloadable versions of this resource pack, resources from each of the maternity workshops and access to the e-learning CD. In addition the portal contains a range of links to other useful maternity resources and websites as well as case studies of practical solutions to workforce planning issues from across the maternity service. Staff interested in maternity issues can post questions and join the dialogue in the maternity forum via the portal.

The healthcare workforce portal is available at www.healthcareworkforce.nhs.uk/maternity.

Notes

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