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1. Introduction

1.1 Purpose of Guidance

The Maternity Workload Tool was developed to specifically measure time and complexity of midwifery related care. It is based on an extensive observation study of midwifery activities across Scotland, that covered both hospital and community services. The classification of workload associated with women and babies in the tool is based on vulnerability, social, obstetric and medical / anaesthetic risk. The calculations within the tool are maternity team specific and determined by different level of care and support required by each patient.

The calculation includes an allowance for predicted absence of 22.5% for nursing and midwifery staff. This is then available in a report that can be used by the practitioner and managers to plan the allocation of resources to effectively meet the service or health board’s priorities and to identify any risks that may exist in the service. It is important to remember the maternity report is only one part of the triangulation approach to workload planning and should be considered in conjunction with:

- Funded establishment;
- Professional judgement (please refer to separate guidance for PJ tool);
- Quality indicators and
- Local context.

This document will provide all of the information required to complete the maternity workload planning tool. It will provide detailed information from how to log in to how to finalise and submit data. It will not provide information about the methodologies used to develop the tool or how best to use the reports obtained from the tool. That information can be accessed via the learning resources available on Healthcare Staffing Programme (previously known as NMWWPP) webpages:

http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/

This user guide is available within the maternity workload tool, as are prompts at each part of the tool. To see further information on a section, select the information icon: 

1.2 Background

Nursing & Midwifery workload tools are an essential part of the Health and Care (Staffing) (Scotland) Act 2019 aimed at ensuring health & social care staffing is at the level required to deliver safe, quality focused care to people using the services. The tools are designed to give staff the platform on which to record information about the actual work they do. This is to

1 See Appendix Maternity Dependency Levels for detailed description of each level of care.
collate the activities in a manner that supports decisions about staffing, resource allocation and service design as part of a triangulated process of planning.

To find out more about this, please refer to the HSP website and learning resources: https://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/.

The political commitment in Scotland is that, through application of a common staffing method (Figure 1), health services will be staffed to the level required to provide safe, high quality care. To ensure this, each NHS Board in Scotland and the services therein, are responsible for having effective planning processes, informed by the activities captured through the mandated use of workload tools. The Maternity Workload Tool is one of national workload tools available for this purpose.

*Figure 1 – The common staffing method*
2. Logging In

2.1 Accessing the tools

Once you have been issued with your username and password (via your local SSTS manager) you should use the link provided to go to the login page.

https://workforce.mhs.scot.nhs.uk/eYou/authentication/login.aspx

⚠️ The tools should be accessed via Internet Explorer 11 or Internet Explorer 8. Firefox, Google Chrome or any other browsers are not supported and should not be used.

Enter your username and password as they were provided to you and select ‘Login’:

Passwords are case-sensitive and you will be prompted to change your password the first time you log in.
When you have logged in successfully, you should be presented with this screen. If the details are correct, click Confirm. If the details are not correct, follow the on-screen instructions.

![Image of confirmation screen]

And then select ‘SSTS’:

![Image of SSTS selection screen]

When SSTS opens you will be presented with toolbars at the top of the page and an empty screen underneath it.

![Image of SSTS toolbars]

The information provided include your user name (top left-hand side) and current location name (i.e. roster you have been logged to enter the data for). In the lower line, on the right-hand side, there are three dropdown menus:

- Workload Tools – lists all workload tools available (those you have access to will be in bold);
- My Account – lists option to change password, change username, change working location and change to local area;
- Application – select other application and logout.
2.2 Screen display issues

Some boards have reported issues with the workload tool screens not displaying correctly, for example save buttons being hidden or data entry boxes being misaligned. This is due to compatibility issues following an SSTS update. If you experience display problems, you should first check that you are using either Internet Explorer 8 or Internet Explorer 11. If you are still having problems, please contact your local SSTS Manager, who can advise on local settings and solutions.

Firefox, Google Chrome or any browsers apart from Internet Explorer 8 or 11 are not supported and should not be used.

2.3 Changing Working Location

If you have access to more than one location, you may have to change the roster location to appropriate maternity roster / ward.

Ensure that ‘Current Location’ (at the top of the screen) is the location for which you want to enter data.

If it is correct, ignore the instructions below and skip straight to next step.

If it is not correct, see instructions below:

If you need to change Current Location, select ‘My Account’ and then ‘Change Working Location’:

A screen will then appear containing the ward and clinical areas you have access to:
The ward/area can be searched for by roster location, staff bank, local area or employer. If necessary scroll down to the ward area you that you are going to input the Maternity data into.

To choose a ward/area of interest, select it from the available list and then click ‘Select’.

The below screen will then appear, select ‘OK’ to proceed:

You will note that the toolbar heading has now changed to the ward you are planning to work on, please check that this information is correct.
2.4 Opening Maternity workload tool

To open the Maternity Workload Tool select ‘Workload Tools’ and then ‘Maternity’:
3. Maternity location types

From May 2015 all mixed maternity rosters should be defined in SSTS as ‘Maternity Services’ (location type). However,

- Midwifery teams working only in community should be assigned to location type: Community.
- Midwifery teams working only at hospital clinics should be assigned to location type: Clinic.

Midwifery Teams working in both community, patient’s homes and hospital (eg BEST START teams) should be assigned to location type: Maternity Services.
Midwifery Teams working in CMU’s should be assigned to location type: Maternity Services.

Entering data for rosters defined as ‘Clinic’ or as ‘Community’ is generally similar to ‘Maternity Services’. Where applicable, differences are marked in the sections below.
4. Creating & editing records in Maternity tool

4.1 Workload calendar screen

The opening screen in Maternity tool has a calendar at the top and list of ‘Event Dates’ underneath it. This list shows recently completed days. You can use the ‘Edit’, ‘Delete’ and ‘Amend Date’ options to modify previously entered dates, as well as change the date without re-keying previously entered data.
4.2 Enter data for new date

To add new data simply select the date you wish to enter data for.

The tool will only let you to select new date within the previous 3 months.

The following screen will appear:

If all the information is correct click on the **Confirm** button to proceed. If the information is not correct click on the **Exit** button to return you to the calendar screen.

‘Number of beds available’ will be displayed also for community and clinic only rosters, that don’t have beds. It is due to a technical issue that has no impact on tool recommendation for clinic and community only rosters.
4.3  Add record for new patient

Before continuing please make sure you have to hand all required information for each patient you are going to record, i.e.

- CHI number (of alternative unique identifier);
- times in/out on the ward;
- dependency (level of care).

4.3.1 Maternity Services

To add patients click on Patients tab. Following screen will appear:

To enter data, click on ‘Add Patient’ to open following screen:
Enter the **Unique Identifier**, if possible this should be patient’s CHI number. However if this is not possible initials, date of birth or any other identifier can be used as long as the staff member is able to track back and identify of the patient. Identifiers are used to ensure that no patient is missed or double counted.

Then select appropriate Bed Type from the dropdown:

- Bed type should represent the ward (or the part of ward) that was responsible for the patient not the clinical category of the mother. E.g. if antenatal mother was seen in hospital clinic, she should be recorded under ‘Clinic’.

After that, select **Level of Care** (dependency) from the dropdown.

- This dropdown is available for ‘Maternity Services’ roster only when Bed Type was selected.

If you need to check definitions behind each level of care, click on the icon to display document with detailed descriptions. Those are also available in appendix at the end of this user guide.

- If bed type selected is ‘Labour’ level of care will automatically default to dependency level 3. Level of care field is mandatory, i.e. not assigning dependency will prevent the record from saving.

Enter a **Time In** and a **Time Out**:
If these fields are left blank then the tool will assume that the mother was present for the whole day (i.e. the patient will be listed as present from 8:00 until 7:59 for that 24hr cycle).

If a “time in” is entered, but not a “time out”, then the tool will assume that that the mother was still present at the end of the date i.e. at 07:59.

If a “time out” is entered but not a “time in” then it will be assumed that the mother was present at the start of the shift i.e. at 08:00.

- If “Community”, “Clinic” or “Triage” bed type is selected it is always necessary to record time in and time out for each patient. Leaving these fields blank would record the patient as if present for 24hr which would be incorrect.

The tool operates on 24hr period, starting at 08:00 am and finishing at 07:59 am. The tool automatically assigns each patient to part of the cycle depending on the times recorded i.e. any activity between 08:00 and 19:59 is counted against a day cycle, and 20:00 to 07:59 against a night cycle. The tool shows error message if recorded times go beyond the 24hr period.

To save the record and add another patient click **Save and add another**.

You can also discard the record by clicking on **Cancel** or just save it by clicking on **Save**. Saving the record will close the Data Entry window and show list of patients recorded and saved for that particular date.

If separate patient’s record is entered for the same date and with the same Unique Identifier as one already in the tool, the tool will assume it is for the same patient and pool those records together, displaying them on the list as one patient under the Unique Identifier.

However, if you try to enter new record with the same unique identifier as a one already recorded for that date, and use the same or overlapping times, the tool will assume it is a mistake or duplication, and will not allow you to save that record. You’ll be presented with following message:

Click **Ok** and correct the data entry.
4.3.2 Community or Hospital Clinic

To add patients to roster defined as a ‘Clinic’ or ‘Community’ click on Patients tab and select Add Patient. This will open following Data Entry window:

There is not an option to select Bed Type, as all the patients are assigned respectively as ‘clinic’ or ‘community’ type.

Record unique identifier, appropriate level of care, time in and time out for the patient, and click Save or Save and add another.

⚠️ If roster is defined as ‘Community’ or ‘Clinic’ it is necessary to always record time in and time out for each patient. Leaving these fields blank would record the patient as if present for 24hr which would be incorrect.

4.4 ‘No mothers present’ option

There is an option in the tool to record dates were no mothers were present for an entire date. This option is available for all maternity roster location types, and would mostly be used by remote and rural areas.

If you tick the ‘No mothers present for this date’ box you will be given a warning message:

If you select Yes you will not be able to enter any more data for the current date, if you select No this will remove the tick and allow you to continue entering data.
4.5 Edit patient’s record

You can edit patient’s record while in the ‘Patient’ tab. Click on the left-hand side of patient’s unique identifier. It will change to and Edit option will appear.

Select Edit to open patient’s record.

In the example above the mother was on the antenatal ward for 24hrs and her dependency was at level 1a for the entire time, or at least for majority of both, day and night, cycles.

You can print list of all recorded patients by clicking button in the right bottom corner of the screen.

4.5.1 Patient’s dependency changed but the same bed type

This will mostly be applicable for rosters defined as ‘Maternity Services’. While it is technically feasible for ‘Community’ and ‘Clinics’, it should not be necessary or required in those settings.

Let’s assume that the mother’s dependency changed and for the bulk of the time during the night cycle her dependency was attributed to level 1b.

Recording the same patient against more than one level of care within the same 12 hr cycle and the same bed type will increase tool’s understanding of the workload for that bed type and result in incorrect whole time equivalent recommendation.

To amend the record, first change the ‘time out’ from ‘07:59’ (end of a 24hr period) to ‘19:59’ (i.e. end of a day cycle) and save the record.
Notice there is now option to ‘Add another level’ available for that patient.

Click ‘Add another level’ to open ‘Data Entry’ window. The Unique Identifier and ‘Time in’ will be automatically populated.

Select ‘Bed type’, ‘Level of care’, add ‘Time out’ and save the record. In this example, selected were antenatal, level 1b and time out ‘7:59’. Amended record looks like this:
4.5.2 Patient moved to different bed type within the same area (same SSTS roster)

If a mother was on a labour ward for part of the 24hr cycle, and then was transferred to postnatal bed/ward, she generated workload against both bed types and this should be reflected in the tool.

First, record and save the mother’s labour stay. From the list of patient records, select the one you want to add another bed type to and click on the left-hand side. Select ‘Add another Level’ option.

In ‘Data Entry’ window select bed type (in this example: postnatal). Select appropriate level of care and time out (note, time in is automatically populated). If the patient was discharged before 8am, record the actual discharge time. If the patient was discharged next morning but after 8am, you can either type ‘07:59’ or leave ‘time out’ empty (i.e. the tool will automatically add end of 24hr cycle).

The time patient spent on a ward after 8am will have to be recorded for next date.

The record after amendments reflects now bed type change and time amendment:

If the patient was in Labour ward and then was transferred to a different ward (different SSTS roster e.g. Postnatal ward), the patient would be recorded as a level 3 for the duration of the stay in Labour Ward. If the patient was in Labour Ward as a Level 3 and had given birth and was still in Labour ward requiring 1:2:1 care, record this patient continually as a level 3 for the full duration of her time in Labour ward.
4.6 Filter patient records

Maternity tool offers functionality to filter entered patients records.

For rosters defined as ‘Maternity Services’, you can filter list of patients by bed type and/or level of care.

![Filter Patient Records](image)

For rosters defined as ‘Clinic’ or ‘Community’, you can filter list of patients by level of care.

![Filter Patient Records](image)

Simply make your selection using the dropdown menu(s) and click **Apply Filter**. The list of patients will change to reflect your selection.

To go back to see all patients recorded for that date click **Reset Filter**.

4.7 Additional activity tab

Additional Activity section should only be used if a rare event occurs, that has a significant adverse effect on the ward/roster resource. Such an event can be related to an adverse weather, vehicle breakdown (note this does not include planned maintenance), inter-hospital transfer or fire evacuation. This section allows you to record type of event, number of staff involved and length of time it lasted.

![Additional Activity Tab](image)

⚠️ Development of the Maternity tool was based on detailed observation studies that included all aspects of midwifery workload. Therefore do not use this section to record normal workload activities.
To record additional activity click **Add Additional Activity** to open following window:

![Additional Activity Window]

- Description, time and number of staff information are mandatory.

You can view, edit and delete previously saved additional activity records.

![Additional Activity List]

To print this list click **Print** button in the right bottom corner of the screen.

### 4.8 Incomplete dates

**Incomplete Dates** section lists dates which are not ‘complete’ for that roster.

![Incomplete Dates List]

Date can be left incomplete for legitimate reasons, e.g. all the records have not yet been recorded, therefore please ensure that all information for the day is entered before ‘completing’ the date.

From this screen you can proceed to “Edit” the data or “Delete” if appropriate.
4.9 Editor role

If you have Editor role, you will be able to see list of ‘incomplete’ dates straight after login to SSTS. ‘Warnings’ screen like the one below will appear:

Click ‘Action Item’ to open data view for that date, to view, edit or if applicable to complete the date.

If you do not wish to view/edit the incomplete dates at this time click Close.

4.10 Complete date

Please ensure that all information for the day is entered before completing. Do not press complete date until all data has been entered for the date.

If several people in a team are entering data (e.g. in community or maternity services), do not press ‘Complete date’, until each individual has entered their data, otherwise you will ‘lock’ others out.

When all data has been entered for the date you should click Complete Date.
You will be presented with the following screen:

If you do not want to proceed click **No**. It will allow you to continue to add patients and enter data. Save the data for each patient as you go along.

If you have entered all the patient data for the date click **Yes**. It will ‘lock’ the date, i.e. it won’t be possible to view or edit patient records.

![Unlock Date](image)

If you need to unlock a date to add more data then press the “Unlock Date” button available at the bottom of “Summary Display” tab.

The ‘Unlock Date’ function on the summary screen will allow editors to go back and amend/edit data from the previous 3 months.
5. Summary display

Summary display screen shows the recommended whole time equivalent (rWTE) based on maternity workload recorded for this particular date.

For ‘Maternity Services’ the screen shows number of recorded patients against each available bed type:

For ‘Clinic’ or ‘Community’ screen shows number of recorded patients against respectively, Clinic or community bed type, e.g.:

If you want to obtain rWTE information based on period longer than just one date, please use one of the standard reports for maternity tool available from BOXI.
6. Reporting results

After Maternity data entry into SSTS is complete, please use one of maternity standard reports developed in Business Objects (BOXI) to view and extract information for selected period of time. These reports were created by the national team and have a series of built-in prompts to generate customised outputs locally.

Access to BOXI reports requires login and password, which can be granted by your local SSTS Manager. You will require your Line Manager’s permission and authorisation before contacting your local SSTS Manager.
7. Frequently asked questions

7.1 General information

Q1 What is the background to the Maternity Workload Tool and why we are asked to apply it?

This tool stems from the recommendations of an audit commissioned by the Chief Nurse for Scotland and the Nurse Directors by Audit Scotland. The report, “Planning Ward Nursing - Legacy or Design”, was published in 2005 and led to the ongoing national programme of work. A number of recommendations were made including the need to have a consistent and systematic approach to workforce planning across Scotland, which would include the measurement of nursing workload to calculate staffing requirements.

Much work has been undertaken in Scotland since the publication of the report, under the auspices of the National Nursing and Midwifery Workload and Workforce Planning Programme (NMWWPP), and a suite of workload tools were developed for a number of specialties. In August 2019 it has been agreed that the national team will now be known as Healthcare Staffing Programme (HSP).

Before 2010 Birthrate Plus was utilised to determine staffing levels for maternity services. In 2011 the Maternity Clinical Short Life Working Group was established. The remit of the Group was to develop a workload tool that encompassed the two areas of Maternity Services, hospital and community.

Development of the Maternity Workload Tool involved an extensive exercise undertaken in Scotland of collecting observation data of midwifery activities coupled with patient dependency. Collected data sets allowed development of separate calculators for labour, antenatal/postnatal, triage, hospital clinics and community.

The workload tool was trialled and tested throughout 2013-2014 with final sign off and ratification of the tool in 2015 by Heads of Midwifery. The clinical working group recommended that the tool should be run in each board within both areas of maternity at least 3 times per year, 4 weeks at a time.

National runs of the maternity tool, when all maternity rosters in Scotland are asked to participate and record their workload during the same time period, enable development of a structured approach and contribute to a detailed process, as well as ensure that there is nationally accurate and consistent use of the maternity workload tool. As with all the other workload tools, centrally preformed data analysis and collection of evidence and feedback from clinicians inform any further modifications and enhancements to the tool.

Q2 When and where will I find out the results from the tools?

Please see Chapter 6 Reporting results for detailed explanation.
Q3  How frequently should the tool be run?

The national team recommends checking with your local Head of Midwifery/Chief Midwife and workforce team for detail about when the tool has been scheduled for the local area. However, the tool can be used as often as an individual/team or health board wish.

The clinical working group recommended that the tool should be run in each Board within both areas of maternity at least 3 times per year, 4 weeks at a time.

Q4  Will the use of the tool result in fewer midwife posts?

The aim of the Healthcare Staffing Programme is to provide workload tools to help staff and organisations recognise staffing needs in relation to workload. Decisions will be made locally on the information as part of the triangulation process. That is why it is recommended that staff are familiar with the tool and the information it provides in order to be able to use that information most effectively.

7.2 About the Maternity Workload Tool

Q5  What do I need to do before I start using the tool?

You need to make sure you are familiar with how to capture your workload and apply the appropriate levels of care within the workload tool. Please read through the user guidance provided.

Q6  What is the unique identifier required to complete the tool?

Please see section dedicated to recording Unique Identifier in Chapter 4.3.1 for detailed explanation.

Q7  SSTS has the 24 hour time scale as 08.00 - 07.59 hours, is this correct? I thought that it would have been 00.00-23.59 for inpatient areas.

Please see section dedicated to ‘Time in’ and ‘Time out’ recording in Chapter 4.3.1 for detailed explanation of how the 24hr cycle works in the tool.

Q8  Do we need to enter the ‘Time out’ if the mum is still in the ward at the time of data collection on the data collection form?

Please see section dedicated to ‘Time in’ and ‘Time out’ recording in Chapter 4.3.1 for detailed explanation.

Q9  What happens if the patient is in the ward for e.g. 48hrs, does this mean that the patient has to be entered into the tool AGAIN for each day they are in the ward?

The tool operates on 24 hour cycles, so if a patient is in the word for 48 hours, she will have to be entered separately for every 24hr period.
Q10  The tool does not capture all aspects of my work.

The tool has been based on intensive observation studies and developed by midwives across Scotland who have agreed that it broadly represents what they do.

In addition, see Chapter 4.7 Additional activity tab and refer to separate guidance on Professional Guidance tool.

Q11 What level of dependency has to be recorded for each mum? Is it the highest dependency at the time of recording (real time) or the highest level of care in the previous 12hrs?

Please see Chapter 4.5 Edit patient’s record for detailed explanation.

Q12 If a 20 bedded ward has a significant throughput and the number of beds is increased to record this (e.g. 32) does the ward then appear to be a 32 bedded ward?

No. The tool calculators recognise that this is increased throughput.

Q13 Why does the tool ask for number of beds for community rosters that have no beds?

This is a legacy related issue, as within the previous version of the maternity tool, staff did record data against the bed number. When the tool was amended, this validation hasn’t been changed. Therefore when configuring community rosters bed numbers are still required, and any number other than zero should be entered to avoid an error message. But please be reassured that the entered number of beds does not impact on WTE calculation in community setup.

Q14 How are telephone calls captured?

These do not need to be recorded separately as telephone calls have been captured in all areas during the observation studies and included in the calculator.

For Triage: Telephone calls require a series of questions for completion of a telehealth record. Any extensive telephone call extending beyond the record completion should be considered when recording required staffing numbers in the Professional Judgement Tool.

Q15 Once the complete date button is pressed is it possible to edit the maternity tool data?

Please see Chapter 4.10 Complete date for detailed explanation.

Q16 If a labour ward team also have an incorporated function of triage and assessment in their workload, can they add this work in against the mum as one of their patients by ‘increasing the beds’ or will this impact the calculators?

All wards should be assigned to the Maternity Services tab and the appropriate bed type selected from the drop down list which includes triage.
Q17 Should maternity theatre teams be included? Working hours 5 core 8-4 weekdays and 2 overnight and at weekends.
No. Maternity tool doesn’t apply to theatres.

Q18 Should babies who attend ward based clinics for hearing screening be included in the additional activity area?
No. This activity has been captured in the observation studies and is included in calculations.

Q19 If a baby requires more input does the mother take on the babies dependency score?
No. This work is incorporated in the dependency scores e.g. level 1a includes mild jaundice in a neonate, or a neonate who is slow to feed; level 2 includes neonate with significant feeding problems, a cold neonate, and neonate of a diabetic woman. So the woman would be scored according to that category. We are not scoring babies.

Q20 Should I record postnatal readmissions?
Yes. These patients should be entered on the system as per normal, with time in/out and dependency.

Q21 When we have a CMU that has all the staff on the same roster location for both the inpatient and community based care, where will the delivery room data be entered and where will the community data be entered as it is all one off duty?
Your SSTS Manager should set you up to use the Maternity Services tab. This gives you all the options e.g. community, labour, clinic, antenatal, postnatal and triage. Enter each patient in the appropriate category with their level of care.

Antenatal and postnatal refer to inpatients only.

Q22 As a part of GIRFEC, midwifery teams spend a high percentage of their working day communicating referrals and writing the required reports for multiagencies. How to best record this workload or is this calculated within the tool?
This workload has been captured within the observation study and included within the calculator. However, this workload should also be considered when completing the Professional Judgement Tool.

Any excessive workload for a patient that impacts on a midwive’s planned work in a day being realigned should therefore be captured in the Professional Judgement.

Q23 How should community staff record attendance at a case conference or social work meeting?
Please record ‘time in’ and ‘time out’ of the case conference or social work meeting. Use patient’s CHI number as unique identifier. Level of care / patient’s dependency should be L1b (see Appendix 1 – Maternity dependency levels).
Q24 Our infant team work 6 days per week and regular hours, we had thought about collecting their data under the community tab and my question relates to the weekend calculators as they only work one day. These are a team of 3 WTE.

Capture your workload using community bed type. Use ‘Maternity Community Roster Report’ to view your results. This report shows WTE recommendation based only on Mon-Fri day activity. Any weekend activity is provided separately in the appendix at the end of the report.

Q25 What information needs to be collected by Community Midwives (roster defined as COMMUNITY)?

Details of all patients they see whether in clinic or home visit. For each patient CHI, ‘Time in Time out’ and dependency is required.

Q26 How should community staff record: Waste visits and clinic DNAs; travel time; handover to the Health Visitor?

Everything in the above list has been captured as part of the observation studies and is included in the calculator. The sample included both remote/rural and urban areas

You are also able to capture this within the Professional Judgment tool.

Q27 How should community staff record parentcraft / groupwork / education classes?

Do not record all participants of the session separately. Instead, please create one record, with ‘time in’ & ‘time out’ matching the length the session. Use appropriate description e.g. “parentcraft” or “group session” as Unique Identifier. Level of care / patient’s dependency should be set at L0 (i.e. routine midwifery care).

Q28 If a woman visited 3-4 days out of 10 does all the data have to be inputted for every visit if they are not seen on consecutive days? If the same entry is used is there capacity to change the criteria of a visit say from 2 to 1b from day to day?

The tool captures data on a 24hr cycle. Therefore if the same patient attended numerous days, all those visits will have to be captured separately for each day.

Q29 How are joint community visits recorded?

During the observation study midwives recorded their own individual workload but did not specifically highlight visits as assisted or joint. In order to capture that workload, both midwives should record the patient in the tool. However, one of them should enter in brackets “(assist visit)” after the CHI number (to avoid system error message).

This way of recording will allow the team leader to identify how many assist visits took place and what impact it had on staffing levels.
Q30 Some Maternity Care Assistants within community are involved in lots of admin duties (non patient related) how is this recorded?

General administration was captured within the observation studies and is therefore included in the calculator; no need to record is separately in the tool. If increased staffing required because of that work, then this should be captured in the Professional Judgment tool.

⚠️ Any clinical activity carried out by maternity care assistants should be recorded in the tool as normal.

Q31 Is there capacity to document vehicle breakdown?

Yes. You can document this using the “additional activity” tab. See Chapter 4.7 Additional activity tab for more details.

Q32 What maternity location type should be used for Best Start teams?

From May 2015 all mixed maternity rosters should be defined in SSTS as ‘Maternity Services’ (location type) (see Chapter 3 Maternity location types). This allows Best Start midwives to capture activity under labour, clinic, community, triage, antenatal and postnatal.

⚠️ Antenatal and postnatal should only be used if an inpatient.

Q33 What locations should we use for early pregnancy units, maternity assessment units and sonography departments etc.?

These are hospital clinics, therefore use clinic location. If you are unsure discuss with your local workload co-ordinator or ask the national team for advice.

Q34 Who do I contact if I can’t find an answer to my question(s)?

In first instance, please contact your local workload co-ordinator.
## Appendix 1 - Maternity Dependency Levels

### Level 0 - Require routine midwifery care

<table>
<thead>
<tr>
<th>Level 0 Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who do not require increased midwifery care: Healthy term baby who requires only routine midwifery care when woman is able to care for baby independently:</td>
<td>● A healthy woman at low risk  ● Age 16 – 40 years inclusive  ● Parity less than a para 5  ● BMI 18 – 35 inclusive  ● Singleton pregnancy  ● SVD</td>
<td>● Woman requires routine midwifery care as per KCND green pathway  ● Routine parenthood education  ● General supervision and assessment  ● General assistance with feeding and baby care</td>
</tr>
<tr>
<td>● No risk factors identified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Level 1a - Require minimal increase in midwifery care

<table>
<thead>
<tr>
<th>Level 1a Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who require minimal increase in midwifery care: Potential obstetric/neonatal medical/ anaesthetic risks which require further assessment and/or referral to other healthcare professionals by the midwife.</td>
<td>Obstetric / neonatal risk factors  ● Reduced foetal movement  ● Urinary Tract Infection  ● Minor ante partum haemorrhage  ● Previous pregnancy loss needing assessment and counselling in EPAS*  ● Any woman who requires counselling from midwives during her pregnancy from midwives with regards to screening in pregnancy and post birth which goes further to diagnostic testing</td>
<td>Additional midwifery care:  ● Increased blood pressure checks  ● Organisation of additional growth scans  ● Organisation and follow up of additional investigations where results are normal e.g. GTT, PIH bloods, ultrasound scans, CTG for reduced foetal movement  ● Requires abdominal or perineal wound care  ● Requires catheter care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1a Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women who need support with BMI &lt;18 and &gt; 35 with nutrition, exercise</td>
<td>Requiring assistance due to limited mobility</td>
</tr>
<tr>
<td></td>
<td>RH negative with counselling re – prophylactic anti D</td>
<td>4 hourly maternal or neonatal observations</td>
</tr>
<tr>
<td></td>
<td>Mild jaundice in neonate</td>
<td>IV fluids</td>
</tr>
<tr>
<td></td>
<td>Increased observation of neonate</td>
<td>IV access for potential risk</td>
</tr>
<tr>
<td></td>
<td>Potential pregnancy induced hypertension</td>
<td>Regular medication</td>
</tr>
<tr>
<td></td>
<td>Poor past obstetric history</td>
<td>Enhanced discussion relating to screening programmes, rhesus factor</td>
</tr>
<tr>
<td></td>
<td>Potential intra uterine growth retardation</td>
<td>Enhanced midwifery intervention relating to diet, exercise etc.</td>
</tr>
<tr>
<td></td>
<td>Initial low neonatal temperature</td>
<td>Monitoring of suspected neonatal jaundice</td>
</tr>
<tr>
<td></td>
<td>Neonate who is slow to feed</td>
<td>Monitoring of neonatal temperature for up to one hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased assistance with feeding for up to three hours in a 12 hour period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One off SBR where result is normal</td>
</tr>
</tbody>
</table>

Medical/anaesthetic risk factors
- BMI high over 35
- Woman who has diabetes
- Woman with thyroid disease
- Woman requiring thromboprophylaxis
- Woman who is HIV positive
- Needle phobia
- Any woman with previous anaesthetic drug reaction
- Any other significant medical history
- Previous failed epidural
- Spinal headache

Medical/anaesthetic care:
- Referral to anaesthetic team / physicians
- Enhanced discussion relating to medical condition in pregnancy
- Advice re managing condition during pregnancy
- Enhanced counselling re lifestyle
- Fact finding re impact of condition on pregnancy
- Increased antenatal clinic visits
## Level 1b - Require increased but minimal increase in midwifery care

<table>
<thead>
<tr>
<th>Level 1b Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who require minimal increase in midwifery care;</td>
<td>Social/vulnerability risk factors;</td>
<td>Social/vulnerability care;</td>
</tr>
</tbody>
</table>
| ● Potential vulnerability social risk factors identified | ● History of gender based violence  
● Involvement with the sex trade  
● Women who conceived in difficult circumstances and/or as a result of rape  
● Woman leaving ‘looked after’ services (16 or over) or working with leaving care services (e.g. Blue Triangle Housing)  
● Disclosure of female genital mutilation (FGM)  
● Failed or destitute asylum seekers or illegal entrants  
● Women who have been trafficked into UK  
● Women who have been victims of torture/imprisonment  
● Woman who smokes  
● Criminal justice activity not related to child protection | ● Increased number of antenatal appointments with midwife present  
● Enhanced discussion with women relating to benefits, housing, health promotion and parenting  
● Enhanced monitoring of social and vulnerability risks of individual and family  
● Discussion with other health or social care workers to gain information relating to the family |
<table>
<thead>
<tr>
<th>Level 2 Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women or baby who require moderate increase in midwifery care;</td>
<td>Obstetric risk factors:</td>
<td>Additional midwifery care:</td>
</tr>
<tr>
<td>• Obstetric / neonatal / medical/ anaesthetic / social / vulnerability risks factors identified which require further midwifery intervention and / or liaison with other agencies by the midwife.</td>
<td>• Any pregnancy requiring frequent foetal/maternal assessment e.g. twin pregnancy, pre term SROM</td>
<td>• Blood pressure profile</td>
</tr>
<tr>
<td></td>
<td>• Minor ante partum haemorrhage</td>
<td>• Further action from abnormal growth scan results e.g. increased antenatal clinic visits, regular CTG monitoring, liaison / referral to obstetrician</td>
</tr>
<tr>
<td></td>
<td>• Women with significant limitation to mobility</td>
<td>• Organisation and follow-up of additional investigations where results are outwith normal limits and require additional clinic visits, regular additional intervention, liaison / referral to obstetrician eg. Requires abdominal or perineal wound care</td>
</tr>
<tr>
<td></td>
<td>• Unstable BP/preeclampsia</td>
<td>• Requiring 2-4hrly hly assessment of TPR, fetal wellbeing, fluid balance, urinalysis, PV loss checks, CTG interpretation, fundal height checks</td>
</tr>
<tr>
<td></td>
<td>• Induction of labour using prostaglandins for priming</td>
<td>• Neonate having phototherapy in ward</td>
</tr>
<tr>
<td></td>
<td>• Suspected pre term labour</td>
<td>• Incubator / care in ward area</td>
</tr>
<tr>
<td></td>
<td>• Any woman who requires significant wound care i.e. regular wound dressing or input from tissue viability team</td>
<td>• 1hrly BM, temperature, observation check of neonate</td>
</tr>
<tr>
<td></td>
<td>• Women in prolonged latent / hesitant phase of labour</td>
<td>• Increased assistance with feeding for three to 6 hours in a 12 hour period</td>
</tr>
<tr>
<td></td>
<td>• Unstable diabetic women</td>
<td>• Complex, prolonged, intensive discussion with women child or adult support and protection with women and their families and other health and social care workers</td>
</tr>
<tr>
<td></td>
<td>• Women mobilising in early labour</td>
<td></td>
</tr>
<tr>
<td>Level 2 Description</td>
<td>Inclusion criteria</td>
<td>Examples of care required</td>
</tr>
<tr>
<td>--------------------</td>
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<td>---------------------------</td>
</tr>
</tbody>
</table>
| Medical/anaesthetic risk factors | • Unstable diabetic  
• Women made immobile due to spinal tap | |
| Social/vulnerability risk factors; | • Woman who has or whose partner have current and/or past involvement with the criminal justice system involving child protection issues (e.g. schedule 1 offender)  
• Adult with learning disability  
• Significant mental health issues impacting a woman’s ability to parent a child  
• Late booker (over 20 weeks) with additional concerns +/- concealed pregnancy  
• Complex under 16’s  
• Unaccompanied asylum seeking children  
• Woman in care (under 16)  
• Homeless families Woman with unsupported home circumstances  
• Woman with alcohol addiction  
• Women with drug addiction | |
### Level 2 Description

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
</table>
| • Child protection involvement either current or previously identified issues (including children previously in care or on child protection register)  
• Women disengaged from mainstream maternity services (such as recurrent defaulter, or women with difficulties registering with GP) | |

### Level 3 - Requiring intensive and/or continuous 1:1 midwifery care

<table>
<thead>
<tr>
<th>Level 3 Description</th>
<th>Inclusion criteria</th>
<th>Examples of care required</th>
</tr>
</thead>
</table>
| Women who require one to one midwifery care. | • All women in established labour, at delivery and 2 hours following delivery  
• Significant ante partum or post partum haemorrhage  
• Eclamptic woman  
• Bereaved families  
• Baby in ward when woman not present  
• Puerperal psychosis | • Continual midwifery assessment  
• At least hourly observation of TPR, BP, PV loss, uterine activity  
• Continuous infusion of magnesium sulphate, lobetalol, atasobian  
• Emotional / psychological and physical care and support for bereaved parents  
• One to one observations of women with puerperal psychosis |