Royal College of Midwives

getting the midwifery workforce right

2: Workforce planning

Workforce planning

Midwives are autonomous practitioners that can make decisions within their scope of practice and refer to wider professional team when required. Therefore midwives assume full responsibility for the decisions they make and can delegate certain aspects of care to support workers and others.

At the same time, midwives lead on supporting women to plan and make decisions about the nature of their care, as well as providing 'hands-on' care. These are central to the role of the midwife. Midwifery provides holistic, person-centred care that supports safe physical, psychological, social, cultural, and spiritual needs. It is most effective when midwives can provide consistent care throughout the pre-pregnancy, pregnancy, labour and birth, and postnatal continuum to promote positive outcomes and to anticipate and prevent complications. To deliver this continuum successfully, there must be sufficient staff with appropriate skills, competence and expertise to minimise the number of different contacts that a woman will be required to have during her pregnancy, birth and the early postnatal period.

This section will cover the following:

- The right staff in the right place at the right time – with the right skills
- Recruitment and retention
- How to define the right number of staff

The right staff in the right place at the right time – with the right skills

An effective and safe maternity service requires an appropriately staffed and skilled multi-professional team to provide care.

The RCM supports the concept of the right staff in the right place at the right time with the right skills. Midwives work alongside other staff groups who form part of the wider maternity workforce. This includes (but is not limited to) maternity support workers/maternity care assistants (MSWs/MCAs), obstetricians, neonatologists, anaesthetists, allied health professionals, nurses in specialist roles eg, theatre nurses, health visitors and GPs.

Multidisciplinary teams are central to maternity care, with all members of the maternity team having a role to play in contributing to safe and high-quality care. Safe, effective and high-quality maternity care can require flexibility on the part of all members of the maternity team, and careful consideration of an appropriate skill-mix for different maternity settings. Staff must be engaged in any staffing evaluation process and informed of outcomes.

Any work to review the skill-mix in maternity must be focused on ensuring that women receive care that is holistic, rather than task-oriented. Other staff can and should be employed in delegated, support roles if this is consistent with the principle that women receive the majority of their care from an appropriately qualified professional they know and trust. This makes it even more important to sustain a clear definition of the role of the midwife, to ensure consistency in standards of care and the continued advancement of a defined midwifery body of knowledge.

Guiding criteria for the development of midwives' roles should be considered across the entire maternity pathway, and should address:

- The impact on core midwifery care and associated standards (for example, the ability to provide one-to-one care in labour).
- The availability of funding to resource associated education, development, monitoring and audit.
- Acceptability to women and to midwives.

Recruitment and retention

The RCM has continually raised concerns about the shortage of midwives across the UK. These historic shortages have been compounded in recent years by the increasing number of midwives leaving the NHS.

A parliamentary report in October 2022[1] exposed the consequences of staffing shortages in maternity and neonatal services in England. Maternity staff find it challenging to assist women, provide timely updates and compensate for the lack of senior colleagues. This creates high risks and leaves women feeling uncertain and unsupported. Exhausted staff are frustrated by a system that hinders their ability to perform at their best, and they fear making grave mistakes. Professional development and safety training are also limited due to staffing shortages.

But there is hope. Birth numbers have fallen across the UK in recent years, easing some of the pressure. At the same time an increase in student midwife numbers means there are more midwives entering the workforce. However, applicants for 2024 have dropped 10% in the past year and is the lowest number of applicants in the last six years. (Universities and Colleges Admissions Service (UCAS) 2024).

Additionally, there are challenges to stem the number of midwives leaving the NHS. NHS midwives in England are working over an estimated 118,000 unpaid hours of overtime each year, according to an RCM survey in 2024 and it is a similar picture across the UK. It is therefore not surprising that so many midwives experience burnout, are struggling to juggle the demands of work and family life or just generally feel unsupported and cared for at work. Retention of skilled maternity staff must become a higher priority if we are to improve the safety and experience of women and families. Ensuring midwives and MSWs are valued, both in terms of pay and conditions and in the way they are treated within the NHS workforce, must be a priority for policy-makers across the UK..

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Solutions

It is therefore vital to seize the opportunity to eliminate national midwifery shortages. There is a growing consensus, encompassing Royal Colleges, trade unions, think tanks and politicians from all parties, on the measures needed to turn this situation around. These include:

- Increased investment, in line with recommendations made by the House of Commons Health and Social Care Committee (2021) and the Ockenden Review (2022) , along with more robust workforce planning. In this context, the publication, in June 2023, of the NHS long-term workforce plan for England is a step in the right direction and has been welcomed by the RCM.
- Utilising additional funding to employ specialist midwives, who not only provide direct specialist and expert care to women who need it, in areas including mental illness, bereavement, diabetes and safeguarding, but also advice, guidance and expertise to colleagues. In many parts of the country these specialist midwife posts do not exist, meaning women are going without specialist care and midwives are not able to access knowledge and expertise that would improve the quality of care they are able to provide.

1. Staffing shortages - APPG report, Oct 22 (final).pdf (sands.org.uk)

2. The safety of maternity services in England - Health and Social Care Committee - House of Commons (parliament.uk); Findings, conclusions and essential actions from the indepedendent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report (publishing.service.gov.uk)
3. NHS England » NHS Long Term Workforce Plan

Practical example

Specialist midwife roles are crucial to effective perinatal mental health care. They are at the heart of forming and leading local care pathways, providing training of staff and support for other maternity teams. The leadership embodied with the role provides for quality improvement relating to how services are delivered and reduces the gaps through which vulnerable women can fall. 'Strengthening perinatal mental health', the RCM's roadmap for perinatal mental health services, recommends that every Trust/ Health Board employs a minimum of one whole-time equivalent band 7 Specialist Midwife in perinatal mental health, supported by a team, which may include MSWs/MCAs, and necessary administrative support.

- The organisation of working patterns, working conditions and working arrangements, underpinned by a focus on the health, wellbeing and welfare of midwives and MSWs. This should include facilitating more flexible working opportunities, so that staff are able to work the hours that fit with their work/life balance and commitments outside of work. Midwives and MSWs should be encouraged to take their breaks and not work beyond their contracted hours. Any additional hours worked must be fairly remunerated.
- Developing a supportive working environment and a culture that values and respects staff and has zero tolerance for discrimination, bullying and harassment and other unacceptable behaviours. These are not only intrinsic to staff wellbeing and retention — they are essential building blocks for high quality and safe maternity services.

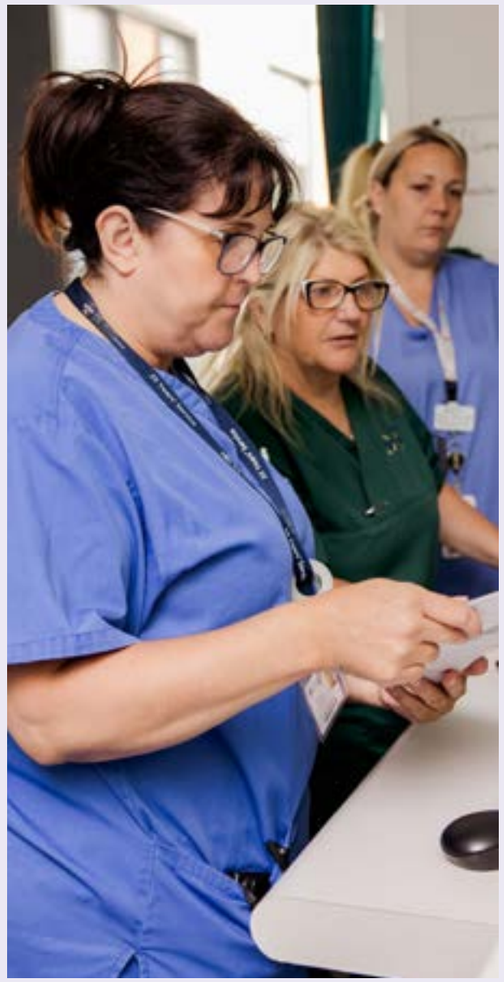
Practical example

The 'any hours' scheme developed by Lewisham and Greenwich NHS Trust, supports staff to cover the hours that fit in with their work-life balance, while picking up extra hours when they can. By enabling staff to work the hours that suit them, it has kept them in post and on the register when they might otherwise have left. The scheme has also supported older, more experienced staff needing a change in pace. Even when it has not been possible to cover an entire shift, the scheme has helped to cover breaks and ensure that colleagues are able to work safely.

Practical example

The Maternity Wellbeing Committee at Hywel Dda Health Board has been established as part of the maternity service's commitment to the health, safety and wellbeing of all staff and students. Jointly chaired by a senior midwife manager and the RCM's health and safety rep, the work of the committee has been crucial to understanding the pressures of individuals and of the staff as a whole. The committee has planned numerous activities to support and promote wellbeing, including Wellbeing Wednesdays, a rounders team, mindfulness walks and events to celebrate St David's Day and MSW Day. Since the committee was established, there has been a significant fall in the number of staff leaving.

A supportive working environment is intrinsic to staff wellbeing



Practical example

Newcastle upon Tyne Hospitals 'New to Post Bootcamp' is a rostered eight-day programme aimed at midwives within their first six weeks of joining the Trust. The programme consolidates all training requirements aligned with the National Preceptorship Framework, Saving Babies Lives, Unicef BFI and Ockenden Essential Actions. All attendees have reported that the programme prepared them well for their preceptorship and provided clarity around what is expected of them. Completion of the programme as a cohort helps to cultivate relationships, peer support and a sense of team as well as enabling integration within the workforce – a key contributor to retention.

- Protected learning time, both for mandatory training but also the education opportunities necessary to support professional learning and development.
- Better support for students and newly qualified staff, including more investment in mentoring, preceptorship, continued professional development and career progression.
- Diversifying entry routes into midwifery, such as expanding education programmes for nurses to become midwives and apprenticeship programmes for MSWs and incentives for newly retired staff to return to support students and early career midwives.
- Better pay and conditions, both immediately and, longer-term, to redress the cumulative loss of earnings over the last decade.

How to define the right number of staff

The current shortages in maternity services, and the negative impact that these are having on women and families, and on staff, only serve to underline the importance of regular and rigorous workforce planning.

Workforce planning is essentially about determining 'the right staff, with the right skills in the right place' and should underpin decisions about maternity staffing at every level:

- For Directors and Heads of Midwifery, deciding how best to staff services, taking into consideration the needs of women, local geography and demography, and patterns of care.
- For Health Boards and trusts to assure themselve that staffing levels are sufficient to provide safe, high-quality services that maximise productivity and efficiency.
- For commissioners of maternity services and devolved governments, comparing staffing, skill mix and models of care between local providers.
- For regional/national planners, providing workforce projection data to determine required intake numbers of students.

The RCM continues to support Birthrate Plus™ as the most credible and robust workforce planning tool for midwifery services. It is based on an assessment of clinical risk and the needs of women and their babies during pregnancy, labour, birth and the immediate postnatal period, utilising the accepted standard of one midwife to one woman in labour, to determine the total midwife hours, and therefore staffing required, to provide midwifery care across the whole maternity pathway. Birthrate Plus™ provides insights and intelligence to inform decisions about staffing numbers, staff deployment, models of care and skill mix, enabling midwifery leaders to deploy staff in line with their local demographics. It has long been used by midwifery leaders in England, Wales and Northern Ireland to measure the work and time involved in providing high-quality maternity care and translating this into the requisite numbers of midwives and MSWs. It is endorsed by the National Institute for Health and Care Excellence (NICE) as a workforce planning tool that can be used in conjunction with implementation of the safe staffing guideline (NICE 2015) for midwifery staffing in maternity settings.

As with any evidence-based tool, Birthrate Plus™ requires periodic updating to reflect current midwifery practice and to take account of recent developments, such as the role of midwives in safeguarding and child protection or the implementation of midwifery continuity of carer. Accordingly, the RCM supported the recommendation in the Ockenden Review for a national review of the feasibility and accuracy of the Birthrate Plus™ tool and associated methodology.

6. https://www.rcm.org.uk/media/5524/rcm-position-statement-midwifery-continuity-of-carer-mcoc.pdf
7. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

In practice: How to flex your workforce

1. Upskill and maximise the potential of MSWs and MCAs. This could include:

- breastfeeding support
- maternal or neonatal phlebotomy
- providing support to women and families with specialist needs,

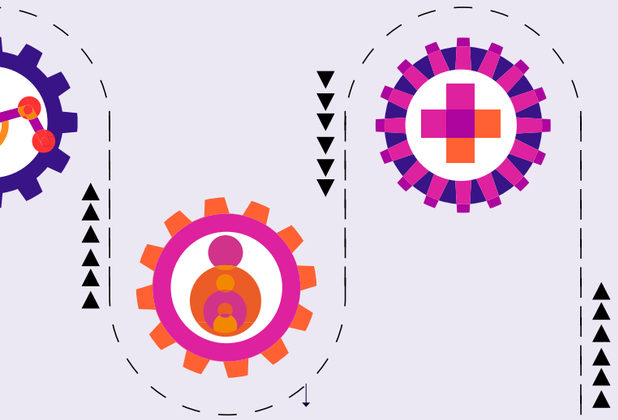
2. Use other services effectively. This could include:

- Transfer routine cleaning of rooms to housekeeping teams
- Delegate healthcare records maintenance to admin teams

Practical example

At Wigan and Leigh NHS Foundation Trust, MSWs are employed to support the midwives in a 1:1 care setting in an area of high deprivation, providing care for women with mental health issues, substance misuse, safeguarding and domestic violence . This includes practical parent education, support groups, home visits and neonatal screening to encourage engagement with maternity services.

The MSW homebirth team at Birmingham Women and Children's Trust provides support to the midwife leading care as the second attendant at homebirths. Completion of a foundation degree in health and social care (maternity pathway) and training in obstetric emergencies are prerequisite for joining the teams and the MSWs are also the dedicated feeding champion. This role ensures women receive continuity of care, access to additional support in the postnatal period and is well received by mothers using the service. Midwifery capacity is released alongside career development for MSWs.



Midwifery continuity of carer

The policy of women receiving dedicated support from the same midwifery team throughout their pregnancy – midwifery continuity of carer (MCoC) – reflects the distinct contribution that midwives make to the care of women.

It is supported by a wealth of evidence linking continuity of midwifery carer with positive outcomes for women and infants. It is most effective when midwives can provide consistent care throughout the pre-pregnancy, pregnancy, labour and birth, and postnatal continuum to promote positive outcomes and to anticipate and prevent complications. To deliver this continuum successfully, there must be sufficient staff with appropriate skills, competence and expertise to minimise the number of different contacts that a woman will be required to have during her pregnancy, birth and the early postnatal period.

While this level of support is something to which midwives and maternity services aspire, the chronic shortage of midwives across the UK has a significant impact on the ability to roll it out universally. Levels of staffing are compromising the quality and safety of care being provided to women and infants, even in more traditional care delivery.

Getting the midwifery workforce right is predicated on recognising that midwives, like the women and families they support, have differing needs. With a majority female workforce, and with caring responsibilities generally falling to women, there needs to be diversity of approach in ensuring shifts are appropriately staffed. So, while some midwives genuinely enjoy and derive satisfaction from working in continuity teams, the strict application of MCoC may not work for all. Successful implementation of this model is not therefore just about having enough midwives; it is also about taking into account the needs and rights of all staff and implementing change in a way that is not to anyone's detriment. One size will not fit all.

The RCM's position (2018), which aligns with the recommended actions in the Ockenden Review, is that:

- Where services are unable to provide safe staffing levels, it will not be possible to safely introduce or expand continuity of carer teams.
- Services that can provide good levels of antenatal and postnatal continuity for most women should not be required to discontinue this approach to provide antenatal, intrapartum and postnatal continuity for a smaller number of women.
- Any changes to working practices and conditions must be undertaken in partnership with maternity staff and their representatives. Employment regulations and Agenda for Change must be adhered to, and no midwife should suffer detriment to their pay or conditions as a result of a change to providing midwifery continuity of carer.

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