

Safe staffing position statement

June 2026

Safe staffing means that we have the right number of staff, with the right skills, available at the right time to provide safe, equitable and personalised care for women and babies. This can only happen with effective workforce planning, continuous learning, and sustainable midwifery leadership. It requires a healthy working environment with a positive culture and a sense of psychological safety, with staff breaks protected in dedicated spaces and shift patterns that allow for recovery and sleep.

The nature and intensity of midwifery work has changed significantly in recent years, with rising clinical acuity, increasing social and psychological complexity, expanded safeguarding and public health responsibilities, more complex care pathways, and substantially increased administrative and governance workloads.

Expectations around personalised care, informed choice and reproductive rights have rightly increased. Yet the evidence continues to show that maternity services are operating with insufficient staffing.¹ Staff are overstretched, increasing the risk of burnout, and making it harder to provide the safe, personalised care that women, babies and families need. The consequences are felt across maternity services, contributing to delays in care, reduced choice, poorer experiences and increased risk for families and staff.¹

The RCM position

- **Safe staffing is fundamental to safe maternity care.** Unsafe staffing levels are associated with an 11% increase in avoidable maternity incidents.² Midwives and maternity staff who are tired, overstretched and overworked in inadequately staffed services cannot provide the safe, compassionate care that women and babies need.
- **Babies must be accounted for within care provision and recognised as individuals requiring assessment, monitoring and clinical care in their own right.** Neonatal care requires dedicated midwifery and maternity staff time, skill and expertise, and should be explicitly addressed within workforce planning models.

- **Workforce modelling must reflect the needs of today's maternity service users.** Planning must move beyond whole time equivalent (WTE) calculations and birth numbers alone. Workforce models should reflect the time required to provide safe, personalised care, and the demands of acuity, case mix, continuity of care, supervision, leadership responsibilities and quality improvement activity. All workforce models should include adequate provision for staff absence due to sickness, maternity leave, learning and development and for non-clinical responsibilities including management responsibilities, student supervision and facility time for partnership working with trade unions and professional associations.
- **Learning must be protected.** The RCM recommends a minimum 52 hours of protected, salaried learning time per midwife per year.^{3,4,5} This is essential to adhere to NMC revalidation requirements, mandatory employer training and to ensure the workforce is equipped to deliver evolving evidence-based, rights-based care. Staff should not be required to undertake this in their rest time.
- **Boards and commissioners must be held accountable for safe staffing.** Senior leaders must be responsible for monitoring staffing levels, ensuring safe minimum standards are met and planning is based on acuity, not just funded posts. Persistent staffing deficits should trigger formal escalation, risk assessment and recovery planning.
- **Equitable access to wellbeing and psychological support services for staff.** The service provides valuable support for workforce wellbeing, resilience, retention and return to practice. Ensuring consistent access for all professional groups would support a healthier workforce and demonstrate a commitment to parity of support across the NHS.
- **Good workforce planning should ensure that on-call scheduling supports safe and compliant rest periods,** including a minimum of 11 hours of uninterrupted rest within each 24-hour period, in line with Working Time Regulations. Rotas should be designed to avoid rostering on-call time directly after long shifts or on scheduled days off, giving staff recovery time, reducing fatigue-related risk and supporting sustainable staff levels.
- **Trust and Health Boards should receive a six-monthly board report on staffing,** led by the perinatal leadership team, setting out planned versus actual staffing levels, associated risks and mitigations. The report should be made publicly available to ensure transparency and strengthen board accountability for workforce planning and safe staffing oversight.

Background, context and analysis

Staffing pressures

The evidence is clear that current maternity staffing is inadequate to provide safe, compassionate care across the UK.² This has been a recurrent theme of numerous investigations and reviews into maternity services. Staff are regularly asked to work above their contracted hours while being unable to take breaks, leaving them tired and burnt out¹.

- The Nursing and Midwifery Council reported in February 2026:⁶
 - 68% reported working above their contracted hours at least once a week
 - Almost one in four midwives (39%) reported struggling with their workload
 - 30% of midwives are at high risk of burnout, higher than the 23% of all NMC registered professions
 - Almost three-quarters of midwives (72%) reported finding it difficult to take breaks due to the intensity of their workload at least once a week
- In addition, the RCM found that midwives work an estimated 100,000 unpaid hours every week.⁷
- Break spaces are inadequate, with staff reporting it is difficult to secure access to food, drink and a rest area, and that breaks frequently cannot be taken, are interrupted, or they are unable to leave the workspace to take their breaks.⁸
- Planned staffing levels are often insufficient to provide one-to-one care of women in active labour. As a result, staffing is prioritised towards care in labour, frequently leaving antenatal, postnatal, assessment wards and community services under-resourced.⁸ For women and families this can mean delays in care, reduced opportunities for preventative support, less continuity of care and fewer choices about place of birth. Home birth and birth centre services are often suspended to maintain labour ward staffing. The situation is now so critical that some parts of maternity services are closing for long periods or even permanently.⁸
- Unlike other health services, maternity care is both highly unpredictable and reliant on a small number of skilled professionals; namely midwives and obstetricians. This means when staff levels are inadequate and/ or there are peaks in activity, there is not the same level of flexibility of wider operational support available.
- Despite recent workforce growth in parts of the UK, midwifery staffing levels have not kept pace with increasing complexity and workload.⁹ While shortages have historically been most acute in England, maternity services in Northern Ireland, Scotland and Wales are also experiencing escalating pressures.¹⁰ Across the UK, staff shortages are compounded by poor workplace experiences and limited opportunities for career progression and flexible working, reducing the attractiveness of midwifery as a career.
- The midwifery workforce is 99.7% female, and in recent years has become younger overall.¹¹ This creates a higher need for maternity leave cover, flexible

working arrangements and family-friendly rostering. Workforce planning models that fail to account for this adequately, result in services left understaffed

- Midwives must have access to timely and meaningful support when experiencing moral distress, burnout, or mental ill health. Supporting staff wellbeing is essential to both workforce retention and the delivery of safe, high-quality maternity care.

Changing nature of clinical need

- Maternity care across the UK has changed significantly in the past 20 years, according to a Birthrate Plus analysis in 2026.⁹ A well supported maternity service should recognise and plan for the increasing workload complexity of midwifery practice, with growing demands arising from multiple long-term conditions, complex social circumstances, safeguarding responsibilities and mental health needs. This has contributed to an expansion in the scope and intensity of midwifery practice, with increased involvement in multi-disciplinary decision making and a corresponding rise in medical interventions.
- National reports have highlighted disparities in outcomes and experiences for women and babies because of inequalities in maternity care. Workforce tools and modelling must consider the needs of the local population but also the requirements of care to meet these needs including through targeted and continuity-based models of care.
- Babies are presenting with increasingly complex needs, including prematurity and early term births (37-38 weeks), partly due to rising intervention rates and maternal health and social complexity. Many require ongoing clinical observations, feeding support and close monitoring. Mothers, too, often arrive on postnatal wards with greater clinical complexity. Caesarean birth rates have risen significantly and women recovering from major abdominal surgery need additional care and support. Despite this, midwives are routinely expected to care for an average of 13-16 women and their babies at a time, a level of understaffing that is rarely reflected in staffing models.

Changing nature of health service delivery

- **Implementing recommendations.** Responding to the findings of reviews and investigations into maternity care quality requires sufficient staffing, and those staff need the time, skills and support to deliver safe and compassionate care.
- **Commitments to care improvement.** National maternity policies in all four UK countries place increasing emphasis on safety, personalised care, continuity, public health and reducing inequalities.^{12, 13, 14, 15} Delivering these commitments requires additional time, skills and leadership capacity and workforce investment, and cannot be achieved safely within static or under-resourced staffing models.

- **Support for student midwives.** Midwives require protected time to support student learning in practice settings, including fulfilling supervision, assessment and educational responsibilities.
- **Investment in specialist and leadership roles must be protected.** Consultant midwives, specialist midwives, and professional midwifery advocates contribute significantly to safety, quality improvement, staff support and improved clinical outcomes. These roles must be funded separately, not counted within core clinical staffing numbers.
- **Administrative and governance support are essential components of safe maternity care.** Without dedicated support staff, midwives carry increasing responsibility for data reporting, audits, investigations and regulatory compliance, reducing the time available for direct care.
- **Investment in clinical academic pathways is vital to improve quality and strengthen evidence-based practice.** Clinical academic roles for midwives should be embedded within workforce planning and sustainably funded to support research, innovation and service improvement.
- **Multi-professional approach.** Safe maternity care depends on the contribution of the wider multidisciplinary team. Workforce planning must account for the roles and interdependencies of obstetricians, anaesthetists, GPs, neonatal staff, maternity support workers and allied health professionals including sonographers, alongside midwives.
- **Safe staffing also depends on culturally competent services, fit-for-purpose physical infrastructure, and leadership** with the capacity to anticipate and manage risk. Service redesign or new policy initiatives should not be implemented without ensuring staffing levels are sufficient to deliver them safely.

Changing nature of the workforce

- For many years, Birthrate Plus⁸ has been the primary midwifery-specific workforce planning tool, trusted by the RCM and endorsed by NICE, to model midwifery numbers, skill mix and deployment in England. However, it does not fully account for emerging pressures, including administrative burden, governance requirements and the growing complexity of maternity care.
- Headroom in staffing, often referred to as ‘uplift’, is a budgeted workforce allowance added into establishments to maintain safe and consistent staffing accounting for predictable absences such as annual leave, sickness, maternity leave and time allocated for education and training. Inadequate headroom reduces staffing available for clinical practice and increases the risk of unsafe staffing levels.
- The amount of headroom applied varies considerably across organisations and UK nations.¹⁶ Further work is urgently needed to ensure workforce planning is informed by evidence and best practice, reducing unwarranted variation and supporting safer outcomes.

- Workforce planning, establishment setting, monitoring and review should align with relevant statutory and policy frameworks across the four UK nations. These include:
 - The Working Time Directive,¹⁷ including the requirement for 11 hours of uninterrupted rest within each 24-hour period
 - Agenda for Change¹⁸
 - NICE guidance on safe midwifery staffing (England and Wales)¹⁹
 - The Health and Care (Staffing) (Scotland) Act 2019²⁰ including duties relating to professional judgement, escalation and staff wellbeing
 - The Nurse Staffing Levels (Wales) Act 2016²¹
 - Regional governance and accountability arrangements in Northern Ireland.²²
- While workforce planning arrangements differ across the UK, the underlying principles of safe staffing, professional judgement, acuity-based planning and organisational accountability remain consistent across all four countries.

Conclusion

- **Safe staffing is critical to deliver high quality maternity care.** All members of the maternity team should feel able to raise concerns when staffing levels compromise safety, quality or individualised care. Concerns should be recorded, escalated appropriately, and addressed locally wherever possible without destabilising staffing elsewhere or limiting women's choice of place of birth.
- **Trust and Health Board leadership hold legal responsibility for safe staffing.** Senior leadership should receive regular assurance through up-to-date information on workforce metrics, staffing tool compliance, the impact of staffing levels on clinical and personalised care and staff wellbeing, and any associated risks or mitigations.
- **Commissioner and national responsibility.** Regional and national bodies have a responsibility for workforce planning. Planning must reflect the wider strategic direction of health services and maternity care, along with workforce intelligence including retirements profiles, staff turnover, sickness absence and attrition rates from university programmes. Robust workforce planning is essential to ensuring a sustainable supply of registered and non-registered staff to deliver safe maternity services.

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Other resources

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