midwifery model and skill mix

for sustainable island services

Report from workshops facilitated by RCM Scotland and NHS Education Scotland

Royal College of Midwives
Scotland

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Sustainable island services: Midwifery model & skill mix

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Island Boards: A Midwifery Model and Skill mix for sustainable services

Introduction

Women and families across the Scottish islands of Orkney, Shetland and the Western Isles need access to high quality maternity care within the unique challenges of their remote location. Local planned care services sustain the community and inward migration. With the distance from additional clinical support, there is also a need to provide access 24/7 to emergency obstetric and midwifery care, based not on caseload but on a sustainable and safe service provision. The safest way to do that for the workforce and the women is to build this on a sustainable model of planned care.

Through a series of meetings and workshops facilitated by RCM Scotland and NHS Education Scotland (now Public Services Delivery), midwives from across the three island boards and their midwifery leadership identified the workforce, skill mix, and development opportunities that all three boards agreed were key to sustainable midwifery services for our island communities. This covered the knowledge, skills and development required to facilitate a sustainable midwifery model, across islands, to meet the population health needs, succession planning and to support an attractive career structure across all pillars of practice from band 3-9 and links clearly to the aspiration and recommendations from of the Nursing and Midwifery Taskforce.

The agreed priorities and way forward were summarised as:

A shared model and clear career structure, with strong links to universities, is essential in advocating for what is required within an island setting, sharing learning and ensuring sustainability. Aligning some of this work with non-island rural settings may be helpful if looking at sustainable career development for rural midwifery.

Midwives are reflecting roles with advanced levels of practice and need an advanced level of education for sustained and consistent care in rural and island Scotland. There is strong innovation, but sustainability requires recognised programs and roles and recognition which support innovative approaches to learning and the additional workforce to lead, role model and educate the next generation while ensuring succession planning. Further work with the multidisciplinary team would be helpful.

Key action points

1: For Leadership sustainability: a Deputy Director of Midwifery (suggested Band 8c) with an operational manager or quality and improvement band 8a would support succession planning, sustainability and delivery on all quality and improvement measures.

2: Understanding variation: There is quite a variation in IOL and SVB for a low-risk population, this would be good to explore further and to share learning.

3: Preceptorship: Individualised supernumerary time with shadowing more experienced midwife on nights and on call while developing confidence in unscheduled care and arranging and supporting air ambulance transport and pre-transport care is essential when new to role.

4: Learning and Development: Midwifery Educator/Practice Education Facilitator (PEF) roles and strong links to universities are essential to support the learning culture and support educator career opportunities and widening access to midwifery.

5: Safe Staffing: Need for skill mix to include advanced level of practice as a generalist across 4 pillars & proficiencies

6: Learning and Development: Time and development opportunities to be available for some of team to develop specific areas of practice required for meeting service needs.

7: Learning and Development: Advanced education programs to ensure the skill mix is maintained for rural generalist midwife

8: Learning and Development: there is a need for modules/education to be available to meet population needs e.g. for aspects of women's health, educators, safeguarding among others

9.Workforce planning: Establishments need to reflect time off island for development and clinical exposure

Background

The three island boards (Orkney, Western Isles and Shetland) have embedded broadly similar obstetric supported models that have developed to meet the unique needs of the women and families and island populations within their own contexts. All have a planned hybrid model, supporting the core maternity service provision and additional care, for women requiring local obstetric input and coordination of care with the tertiary consultant-led unit (CLU) for those women with requirements for more complex care.

The service provided by the multidisciplinary team (MDT) includes the full scope of practice of a midwife with some specific and potential role extensions to ensure that women can access care locally.

Context

There will always be a need to provide unplanned and emergency obstetric and midwifery care on these islands due to population needs and distance from additional clinical support. This requires the ability to provide a full 24/7 service that is not predicated on caseload size but on maintaining a sustainable and safe service provision.

There is also a need to provide local planned services to sustain the community and inward migration. The safest way to do that for the workforce and the women is to build this on a sustainable model of planned care. This fits within the policy context, anchor institutions, and realistic medicine.

Previous papers[1] have indicated that existing workforce planning tools least serve small services and that centralisation does not lead to better experiences for families. Currently, maternity workforce planning tools are found often not to be helpful for island health boards that deliver fully integrated midwifery services as they fail to capture the complex, variable, and multirole nature of day-to-day practice in island settings. As a result, staffing requirements, on-call pressures, travel time, acuity fluctuations, and the need for 24/7 resilience are underestimated, leading to outputs that do not accurately support safe service planning or the sustainability of rural & island maternity services. There is an overreliance on professional judgement as there is no definition of minimum service levels for rural & island services.

Risks

- **Team demographics: -** The age demographic of the current leadership across the islands raises this imminent risk with a limited leadership career structure that supports recruitment or succession planning.
- **Current leadership structures**, implemented across the mainland, risk creating a disconnect and disparity with the island leadership structures, with the essential role and experience of the Island Midwifery leadership not being recognised due to title variation.
- **Variation in services: -** from mainland boards (e.g. sexual health advice, lab support, accommodation) impacts island service provision.
- **Sustainable communities**: Without a full maternity service (including holistic women's health) young people may not return and increase the risk of depopulation.
- **The lack of alternative models of midwifery education: -** such as shortened course, workplace learning/earn as you learn routes, risk losing potential midwifery staff to the mainland.

Leadership Structure

Currently the services on the islands are led by three heads of Midwifery sitting at band 8b or 8c with one band 7 in each team. This is an issue in terms of succession planning and attraction of future leaders, with the potential for island midwives not being eligible to apply for roles in future due to the lack of development opportunities and differences in leadership structures/banding.

The RCM have successfully advocated for Directors of Midwifery[2] in Health Boards as part of safe care and board assurance however this sits within the three Cs of Context, Capacity and Capability. To that end we recognise that for smaller boards that may be achieved by an associate or Deputy Director role with an additional operational manager with the proviso that that leadership role reports directly to the Executive Nurse Director to ensure access to the board and succession planning.

The island boards are required to deliver on the same policy, regulatory and quality standards as all boards and manage the same risks with the additionality of travel challenges and with a smaller workforce. Therefore, there is no rationale or justification for attributing lower levels of practice to the roles. The expectations, responsibilities and professional standards remain equivalent, and the complexity of practice is often heightened by the unique demands of remote and rural care.

The island model is unique in that it supports care for all women, local birth for women suitable for midwifery led care and the additional obstetric care for several

women without medical complexity. The leadership model requires close interdisciplinary team working.

Strong leadership on island is essential and requires close networks with regional centres to facilitate effective pathways for care and repatriation. While honorary contracts support ease of clinical exposure when identified in personal development plans (PDP) and development reviews, the practicalities of this remain challenging (travel, backfill, accommodation and time on the mainland). Scottish maternity policy has recognised the need for a broader skill set for rural and island care settings and the need for opportunities for specialist exposure, to ensure the workforce is equipped and confident to deliver safe, sustainable care across all acuity levels.[1]

The addition of an 8a operational manager role would allow the deputy director to deliver on the strategic role while supporting the operational manager with a remit for risk and improvement to ensure all parts of the quality management system are implemented, to develop across identified portfolio of work and to deputise for the deputy director enabling succession planning.

Key action point 1: Deputy Director (suggested Band 8c) with Operational Manager or quality and improvement band 8a to ensure succession planning, sustainability and delivery on all quality and improvement measures.

Service Model

Stage 1: Desktop exercise with the Heads of Midwifery to define what services are currently provided across the island boards

Firstly, it was identified that not all aspects are provided in each board but that a level of consistency with allowance for contextual variation was welcome.

'Like the farmers we need to diversify'

1.Core/universal maternity: integrated

- All antenatal care as per pathways of care
- Intrapartum: low risk with additional access to obstetric support for planned and emergency Caesarean section.
- Induction of labour, low risk.
- Vaginal Birth after Caesarean section (dependant on primary cause)
- Postnatal care up until day 10 however flexibility to day 28.

2. Additional

- Fertility services: Initial referral from GP, coordination of care, ultrasounds for baseline fertility scans, follicular tracking, endometrial thickness tracking prior to IVF
- Termination of pregnancy (TOP): 1 stop clinic
- Scanning (full service)
- Miscarriage care & ongoing bereavement support
- Family planning/post-natal contraception/sexual health
- Forensic aftercare: Lord Advocate has now approved midwife model (previously examiner may come from long distance away, some areas are travelling across board for care breaching human rights)
- After care TOP
- Ongoing stabilisation of the unwell neonate & co-ordination of retrieval
- Outpatient - gynaecology
- Transitional care - completed neonatal modules Napier
- Virtual ward- Neonatal outreach

(PLGF provision reviewed care for past 5 years - no cases that would have been cared for differently.)

Board Comparisons

44,383 maternities in Scotland in 2023/24 with 0.6 of these being in the three island boards (approximately 266). Nationally there was a 41.8% caesarean section rate.

Key action point 2: There is quite a variation in induction of labour (IOL) and spontaneous vaginal birth (SVB) data shared for a low-risk population, this would be good to explore further and to share learning.

2024	Average gestation at booking	Number of pregnancies in total	IOL 23/24*	SVB on island	CS planned /unplanned on island	Births locally
Western isles	8.6	177 +25 social gynae +miscarriage 20 approx.	42.3%	68	65	139 includes twins (78%)
Orkney	8.2	147	27.5%	72	39	111(75.5%)
Shetland	8.6	178	12%	57	32	89(50%)
Scotland	9.7	44383[2]	35.9%			-

27 births in other boards for NHS Orkney in 2024[4]

39 birthed off islands (mainly to Glasgow) from Uist and Barra in 2024 /74 births in Boards other than NHS Shetland in 2024

Establishment Sep 25[5]

Board	WTE-registered	Nonregistered	headcount	vacancies
Western Isles	15	4.7	19 registered 6 nonregistered	0.8 (3.9%)
Orkney	12.2	5.2	17 registered 8 nonregistered.	0
Shetland	12.5	4.1	16 registered 6 nonregistered	0

Therefore, broadly similar workforces.

Stage 2: Workshop with the three island boards facilitated by RCM and NES

This workshop took place on the 29th of August with input from 20 midwives and MCAs, from all three island boards, to explore the skills required to practice and sustain the services described above. The workshop was split into 4 sections with the responses being collated on Padlet in three breakout rooms for collation and analysis.

The first part explored the core/universal skills required by all midwives with part two describing the additional skills and levels of practice/skill mix required by some or all the team. The final two parts explored the education requirements and any gaps in provision with a final session on future opportunities for development, challenges and opportunities in accessing development.

1.Preceptorship and the newly qualified midwife (NQM).

In discussing core skills, the first is clearly those required of all registered midwives at point of registration. This is the full role and scope of a midwife as described on page 5 and 6 of the proficiencies of the Midwife[6] and across all 6 domains.

This generated discussion on how to support newly qualified midwives, or new to role, when they first come to work on the island. The experience varied depending on whether the Midwife had undertaken placements on the island during their education, which was seen as a benefit. There remains support for an earn as you learn route into practice as a key way of supporting succession planning in the team. The lack of a Midwifery practice education facilitator (PEF) was identified as a challenge, with two Midwives who had previously undertaken this role in two of the boards no longer funded to provide this. Throughout the workshops the need for education to support all levels of practice and linked to universities was highlighted.

There was variation in how preceptorship was supported across the islands, but the key theme was that this would be individualised to the person, their needs and their experience to date this reflects the Midwifery preceptorship framework[7] and the finding of the RCM Early career midwives 2025 publication on the experience of preceptorship.[8] The standout requirement in this period was to support the transition to on call and nights, where the responsibility is for all unscheduled maternity care out of hours on the island.

The variation in supernumerary time was from 4 months to one year with no nights or on call. It was recognised that there is a need to transition out of that by working alongside another more experienced midwife until confident.

Key action point 3

Individualised supernumerary time with shadowing more experienced midwife on nights and on call while developing confidence in unscheduled care and arranging and supporting air ambulance transport and pre-transport care is essential.

Key action point 4

Midwifery Educator/PEF roles and strong links to universities are essential to support learning culture and support educator career opportunities and widening access to midwifery.

2. Core/universal skills required by all midwives.

The table below indicates the skills that the midwives felt every member of the team requires therefore would all require to be covered to an enhanced level during the preceptorship period. Working from the baseline of the provision of '*skilled knowledgeable respectful and compassionate care for all women and families throughout the continuum from pre-pregnancy to early weeks of newborn life. ……. optimising normal physiological processes and support safe physical, psychological, social, cultural, and spiritual situation working to promote positive outcomes and anticipate and prevent complications. Making a vital contribution to quality and safety of maternity care'.*[6:5]

However, some of the skills indicated, specifically HDU level care, which would require advanced clinical assessment, and pre-transport stabilisation and medicines administration indicates a preference for independent prescribing skills that would be expected as an advanced generalist that maps to the PG cert level of the rural advanced practice MSc.[9]

For all to attain these skills to an enhanced level would require some of the team to have not only the knowledge and skills to an advanced level but also the level of knowledge across the four pillars to lead, teach and evaluate practice. It is also a given that there needs to be development of knowledge & skills across the four pillars of the proficiencies to support all to develop and to continue to improve.

In terms of these essential skills all require some of the team to be able to lead, evaluate and with knowledge of the community drive improvement. These reflect the domain descriptors in the Rural advanced practice capability framework as well as the NHS Education England advanced practice framework for midwives.[10] (While there is the generic NES framework[11] the work from England is helpful from a midwifery perspective.)

	Essential Skills	**enhanced**	**advanced**	**Links to core capabilities (NHS England) and NES (rural)Domain 4**	**comments**
1.	**Adult and neonatal**	**All team**	**Teaching and leading**	**C1, C2, C4**	**Practice and theory ALS**

	resuscitation skills		**in these skills**		
2	**Deteriorating neonate stabilisation**	**All team**	**Some of the team; supporting, leading, and teaching,**	**C1, C2, C4**	
3.	**Neonatal care**	**All team**			**Required as no NN nurse or paediatrician**
4.	**Pre transport and transfer care adult and neonate**	**All team**		**C1, C2, C3, C4, L1, L5**	
5.	**Cannulation**	**All team**			
6.	**Medicines administration**	**All team**	**Prescriber: some of team**	**C4**	**Need in depth skill set and theory**
7.	**HDU level care:**		**Some team advanced**	**C1, C2, C3, C4, L1, L5**	**All need Identification of deterioration and provide initial care**
8.	**Early pregnancy care and management of loss**	**All team**		**C1, C2, C3, C4, L1,**	
9	**Supporting and mentoring team**	**All team**	**Lead and drive learning culture and improvement**	**E1, E2, E3, E4, R1, L1, L2, L3, L4, L5, L6**	
10	**Miscarriage care**	**All team**		**C1-C4**	

Key action point 5

Need for skill mix to include advanced level of education as a generalist across 4 pillars & proficiencies.

3. What additional skills/opportunities do most of the team need?

This generated much discussion with many examples of the breadth of development required to provide services that meet current and emerging population and policy needs and requirements. As a microcosm of any larger service, while delivery is divided between a smaller team, you are also able to also see what a service needs to deliver more clearly. It was clear that all midwives need to develop as generalists but that there was opportunity for all to develop areas of interest that would be covered by a specialist midwife in a larger board and indeed need to be developed for the board to deliver required care. Some of those may include advanced education level.

In addition, there were some skills that are within scope of a midwife but are developed beyond what may be expected of all midwives in a mainland central board but are required to meet the population needs; extended neonatal support, extended reproductive and sexual health, public health and population health. These align more to advanced practice in competence and capability both reflecting those described in the Midwifery core capabilities[12] and the rural core capabilities.[13]

Some skills were needed by the service but not for all midwives: scanning including fertility and hip scanning in one board, the development of this service also reflected a number of the leadership and management advanced capabilities (L1, L4) as well as the research capabilities (R1, R4). This is also the case for forensic services. In addition, overall education /practice development is required to facilitate this and ensure sustainability.

Gynaecology and women's health, while described within the advanced primary and community care nursing framework,[12] this was identified as an essential area of practice for maternity in all island boards and indeed in many of the non-island rural services this may be part of care. Midwives already at point of registration are expected to develop care that is responsive to population health needs. Moreover, the NMC (2019) proficiencies[6] (5:16-5:18) support the midwife to continue to identify and develop skills and knowledge to develop practice. However currently there is a lack of modules to support this.

	Additional skill	enhanced	advanced	comments
1	Multidisciplinary team working	All team	L1, L2, L3, L4, L6	This is necessary for all team members with leadership in this area to maintain.

2	Skill mix essential			Depending on scenario and ability to support less experienced
3	Time off island built into WTE			For development, relationships, and clinical exposure
4	Special Interest ‘champion’	Individual team members	Individual team members C1, C2, C4	Each midwife has an area of special interest - Diabetes, teaching, Fertility, Vulnerabilities, Sonography, public protection, Baby Friendly, Mental Health, Early Pregnancy, Bereavement etc (other staff can ask for help or advice from the "Champions")
5	Generalist: need to develop across a wide range of skills and need to be able to pivot across all areas.	All	Part of skill mix Across all capabilities	Midwives need to wear lots of different hats - SPSP, Digital Midwife, Risk Management etc
6	Sonography		Individuals C1, C2, C3,C4, L1,L2, L3, L4, L6,E4, E1, R1	Essential to reduced unnecessary travel for community - covers all screening and care from fertility to EPU to postnatal. Recent development of hip scanning on one island with

				high cost saving to island.
7	TOP/MTOPFA		Potential development if change in law	With medical colleagues
8	Contraception			As above
9	Forensic			As above
10	Aqua natal and complementary care			
11	Bereavement care			
12	Detailed examination of newborn			Requires experienced level to support
13.	Educator: practice educator/development/PEF	Team member	Team member E2, E3, E4	Requires development of one team member at least currently acting as a champion
14	Advocacy	team	Skill mix C1,C2, C3, C4 L1, L2, L3, L4 ,L5, L6,E1, E2, E3, E4, R4	How to support and advocate from women who have made a decision which may involve the need to manage risks- other professionals trying to pressure different decisions, misunderstand it is the woman's choice not the midwife. Care outside guidance
15	Population health: identify and meet population health needs and contingency planning	all	R1, R4, E2, E3, L2, L3, L4, L5L6	Identify changing and emerging health needs and adapt service to meet.

16	Technology enabled care	all	L1, L4, E2, E3, E4R4	Remote consulting and advocating for woman
17	Public protection	all		Managing child protection/public protection scenarios with local resource and support- encapsulates substance misuse etc.
18	Maintaining confidentiality in a small population	all		

Key action point 6: Time and development opportunities to be available for some of team to develop specific areas of practice required for meeting service needs.

Key action point 7: Advanced education programs to ensure the skill mix is maintained for rural generalist midwife

4. Current Education needs and gaps in provision.

Some of the education and training are those already described in the DL[14] describing the core mandatory training for all staff working in maternity care. For this to be sustained requires an educational role and local trainers. It is notable that some of the midwives have developed skills and experienced in teaching and education but there is no opportunity for their development in this area.

The nursing and midwifery taskforce recommendations make clear the need for a learning environment across Scotland's boards that supports midwives to continue to develop throughout their career but also to develop as educators. This is essential for innovation and future proof education models.

Orkney had already developed a compliance aid for training and education which they agreed to share with other boards.

For sustainable provision E1-4 and R1-R4 are all relevant capabilities also reflecting capability 7 or the rural framework.[13]

Key Gaps: - Safeguarding training at level 3 and MARAC training as well as the functioning of the links with SW/HV both locally and in Aberdeen. Women's health training: It is essential that women can access gynae care and midwives are involved in this care in a generalist capacity. Educator development and networking

Face to face training is valued to enable more in-depth critical thinking and application to the local context

	Current education needs and gaps.	Comments and GAPS
1	Neonatal transitional care-ENU/DEOTN	Full training and competency signed off
2	K2/CTG	
3	SMMDP: Scottie, SNRC, Reacts, PROMPT, pre-transport care, non-maternity care providers	Requires local trainers to maintain drills and make courses sustainable
4	Safeguarding/child protection	GAPS- safeguarding aspects difficult to access at level 3 which is multiagency, MARAC training- limited spaces for island boards Working with MDT; Social work, Health visitors and links to Aberdeen can be a challenge
5	BBV	
6	HDU training	
7	Perinatal mental health	While there is some funding, access to education is a challenge
8	Trauma informed care	
9	Forensics	
10	Midwifery scanning	
11	Contraception: requires some of team to be sexual health trained to support wider team	IUD and implant insertion
12	Academic courses for wider development	
13.	Diabetes	
14	Complex health needs and comorbidities Obesity	
15	Electronic record and TEC	Tech is a huge issue for us. There is so much more we could do. i.e. Badgernet and Trak linked, CTGs linked. This would help with remote viewing of CTGs out of hours and

		reduce the need to have paper copies of CTGs.
16	Teaching and education role	Need some members to be developed
17		
18		

Key Point 8: there is a need for modules/education to be available for aspects of women's health, educators, safeguarding, among others.

5 Barriers/Challenges & Future opportunities

Finance is clearly a challenge, and a travel ban raised real concerns where links to tertiary centred and development are key for sustainability of services. Workforces need to be sufficient to cover care as well as the backfill for the additional training required for working in these settings. A good skill mix both within the team and in the wider MDT is key and there is a need for courses to support that development across all pillars in a structured way if services are to be sustained

The solutions and opportunities reflect a structured development and education across all four pillars from band 2-9 to enable advanced level education to support the rural midwife skill mix and for a small number of those specialist roles with opportunities for enhanced services to meet women's health needs with some midwives potentially working at that level already. Advancing education across the four pillars will also support shared learning, evaluation, and research into rural and island practice

	Barriers/challenges	Comments
1	Backfill	
2	Finance	
3	Travel bans	
4	Skills of Wider team	
5	Decreasing birth numbers	
6	Keeping care local	Local induction service has increased local births
7	Recruitment and retention	
8	Skill mix	How to develop
9	Voice of Midwifery at board level	Person dependant rather than structural currently
10	Lack of midwifery PEF or educator	
11		

	Opportunities	
1	Earn as you learn for MCA to Midwife	Requires university to provide and infrastructure and educator on island
2	Advanced, consultant and deputy or associate director roles	Clear development leadership and succession plans
3	Educational qualification for educators	Required to support earn as you learn and ongoing development linked to university
4	Protected time for evaluation/research/supervision	
5	Development and Succession planning 5-9	
6	Midwives and champions of women's health/population health including pelvic health and sexual health	
7	Cross board networking and peer support	Shared learning and reduce isolation
8	Opportunities to develop additional skills /roles for greater population benefit and job satisfaction	
9	Leadership skills for all	Midwives offered place on LEO course and have attended RCM courses
10	Increase local births e.g. VBAC	Often person dependant at Obstetric level.

6 Multidisciplinary team (MDT)

In terms of MDT, the makeup of the team has a marked impact. The presence of a paediatrician in one board had an impact on neonates remaining on the island from 35 weeks. There was large variation in the way that obstetricians worked both in terms of time on island as well as promotion of local care. Further work is required to understand the skills required by the whole MDT. The last time this was defined was in Appendix 3 of the EGAMS report in 2002.[15]

Summary

A shared model and clear career structure with strong links to universities will be helpful in advocating for what is required within an island setting and for sharing learning and ensuring sustainability. Aligning some of this work with non-island rural settings may be helpful if looking at program development. Midwives are providing an advanced level of practice in rural and island Scotland. There is a prominent level of innovation, but sustainability requires recognised programs and roles which support innovative approaches to learning and the additional workforce to lead, role model and educate the next generation while ensuring succession planning.

Key action points

1: For Leadership sustainability a Deputy Director Band 8c with Operational Manager or quality and improvement band 8a would support succession planning, sustainability and delivery on all Quality and improvement measures.

2: Understanding variation: There is quite a variation in IOL and SVB for a low-risk population, this would be good to explore further and to share learning.

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4: Learning and Development: Midwifery Educator /PEF roles and strong links to universities are essential to support learning culture.

5: Safe Staffing: Need for skill mix to include advanced level of practice as a generalist across 4 pillars & proficiencies

6: Learning and Development: Time and development opportunities to be available for some of team to develop specific areas of practice required for meeting service needs.

7: Learning and Development: Advanced education programs to ensure the skill mix is maintained for rural generalist midwife

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9.Workforce planning: Establishments need to reflect time off island for development and clinical exposure.

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Midwifery model & skill mix for sustainable island services

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