1. Situation and Background in relation to current staffing and workforce issues in midwifery in Scotland

The RCM’s 2018 ‘State of Maternity Services report – Scotland’ will be published on 12 September 2018, and will be available on the RCM website www.rcm.org.uk.

Key facts:
1) The birth rate in Scotland is gradually falling; only NHS Grampian and Lothian have seen an increase in the number of births.
2) The complexity and care needs of women having babies in Scotland has increased – 51% of women booking for maternity care are overweight and more women over 40 are now having babies than women under 20 – with a 68% increase in women in their 40s giving birth since 2000. Older women and women with a higher BMI have increased risks of a number of complications and so require greater levels of care and surveillance from midwives.
3) The number of student midwife places was radically reduced in 2012 from 200 places each year to 100 in three universities from six. This significantly reduced the number of newly qualified midwives coming into NHS Scotland from 2015 compared to earlier years. This change also reduced the number and proportion of student midwives coming through the system from the North of Scotland and Islands.
4) A new shortened programme for nurses to retrain as midwives is starting in Inverness in January 2019, which will be welcome.
5) With the significant increase in the number of students, there is an increased demand on midwives to provide mentorship and we need to see a commensurate increase in the number of midwifery lecturers.
6) Midwifery has a high proportion of older staff, with 40% of midwives over the age of 50. Around 20% of midwives (509 midwives of a total of 2,400) are over the age of 55 and could therefore choose to retire at any time.
7) We have seen a quadrupling in the number of vacancies open for more than 3 months: from 1.5% to 5% (39 WTE vacancies). This figure is much higher than nursing, where the national average is 1.5%.
8) A higher proportion of midwives work part time than nursing – around 61% of midwives work part time, while in nursing this is less than half. Managers describe a rise in the number of newly qualified midwives choosing to work part time.
9) The North and remote parts of Scotland have a growing number of midwifery vacancies. NHS Highland has the highest vacancy rate – with 19% of posts vacant (11% of posts for more than 3 months); Western Isles have a vacancy rate of 15% and Grampian 7.5%.
10) The Best Start maternity policy signals a radical shift in the way that midwives will be working. Many midwives will be asked to move their main place of work from hospitals to community, providing continuity of carer in small teams. The new way of working is not universally popular with midwives and we do not yet know how many midwives will choose to retire rather than work in new ways or move into other roles that do not require working nights or on calls (such as Family Nurse partnership nursing or health visiting).

2. Do you think the Bill will achieve its policy objectives?

The Royal College of Midwives believes that this legislation may be helpful in establishing a consistent, strategic focus on the staffing of maternity services. However, this legislation
cannot, in isolation, address some of the significant long term challenges relating to the staffing of maternity services. There is a great deal of wider work to be done to ensure that the health professions, including midwifery, are able to attract and retain staff. This work includes factors such as student financial support arrangements, availability and quality of practice placements while studying, flexibility of work patterns, pay and workplace cultures.

The preparations under way for the introduction of the Bill have already led to greater focus on the need to amend and develop the midwifery workforce planning tool and to an increase in the support being provided to Health Boards to successfully run the tool. However, the Bill will not address all of the problems in ensuring safe staffing levels in all areas – the particular challenges faced by maternity services in recruiting and retaining midwives and other members of the multi-disciplinary maternity team in remote and rural areas, will require significant focus.

The SPICE staff survey undertaken earlier this year and also RCM's consultations with its members and Heads of Midwifery across Scotland clearly identify a range of problems with the current midwifery workforce planning tool. These issues have been fed into the appropriate groups and committees at a national level, to inform the development of the Bill's supporting systems including the tool:

1. The tool is considered to be more helpful and accurate when used in large inpatient maternity services. The tool is not considered to be helpful or accurate in measuring the appropriateness of staffing levels in community settings and in smaller more rural maternity units.
2. The tool in its current form does not allow the recording of 24/7 community based services. The assumption of the tool is that midwifery services based in the community only provide care in working hours, which is patently not the case, with home births and births in midwife led units often happening at night.
3. The tool does not reflect different staffing models: for example in some consultant led units, the maternity theatre is staffed by midwives rather than theatre staff.
4. One Head of Midwifery reported reverting to using the English 'Birthrate plus' tool as she did not feel that the Scottish midwifery workforce planning tool was accurate.
5. The IT infrastructure does not support the efficient use of the tool; many experience the data input required as very laborious.

There are some areas in Scotland that have invested significant time and energy into providing dedicated time for completion of the tool and training in the tool. In these areas, there have been some instances where a staff shortfall was identified and then business case was able to be made for more midwifery staff.

The RCM acknowledge the significant amount of national activity that is now underway to ensure that staff are trained to use the tool effectively and given ongoing support with the tool, through the appointment of the policy advisors. We are also engaging with the work to develop escalation guidance to ensure that clear systems and processes are in place to support escalation of concerns. National support is being provided to health boards during September to enable the midwifery tool to be run for two weeks in all areas.

In 2017, the Scottish Government published an ambitious five year plan for radically changing the way that maternity and neonatal services are configured ('The Best Start'). The key challenge for maternity services over the next 2-5 years is a very significant shift in
where and how midwives work. A large number of midwifery staff will move their main place of work from hospital maternity units to working in small, flexible community teams. Staffing will be built around women rather than around staffing wards or units. Labour wards will be staffed by ‘skeleton’ ‘core’ staff, with midwives based in the community working on call to respond to their caseload of women and come into the labour ward as required. If the legislation is to be effective, the midwifery tool and the support systems will require substantial amendment to reflect these new ways of working.

3. What are the key strengths and weaknesses of Part 2 of the Bill?

Overall Part 2 sets out the key elements required, though there will be a key role for supporting guidance to provide greater detail.

A key weakness is the lack of a focus on the multi-disciplinary team. Midwives do not work in isolation, but within the MDT – including AHPs, doctors, support workers and, on occasion third sector organisations. If an unintended consequence of this focus solely on nursing and midwifery, is a reduction in the numbers and strength of staffing of other MDT roles, this could have a very negative impact on the safety and quality of maternity care.

Where there are shortfalls in other professions – such as physiotherapists or ultrasonographers, midwives are often asked to fill the gaps left. We have particularly seen this in the last few years with midwives being encouraged to train as ultrasonographers, and thus reducing the number of midwives further.

The role of non registered staff -maternity support workers and maternity care assistants, is likely to develop and make a significant contribution to the maternity workforce in the coming years. The Bill does not fully address these staff groups.

4. What are the key strengths of: Part 3 of the Bill?

Not relevant for the RCM to comment on this area.