NHS Resolution

Safety Action A - Workforce & Capacity

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Royal College of Midwives

RCM

Safety Action A: Workforce and Capacity

Royal College of Midwives: about us

Promote midwifery, quality maternity services and professional standards

Support our members, individually and collectively

Influence on behalf of members and the women and families they care for

50,000 members

UK and international

Professional association

Trade union

RCM 2026

Five Priorities: a downpayment on the future of maternity services

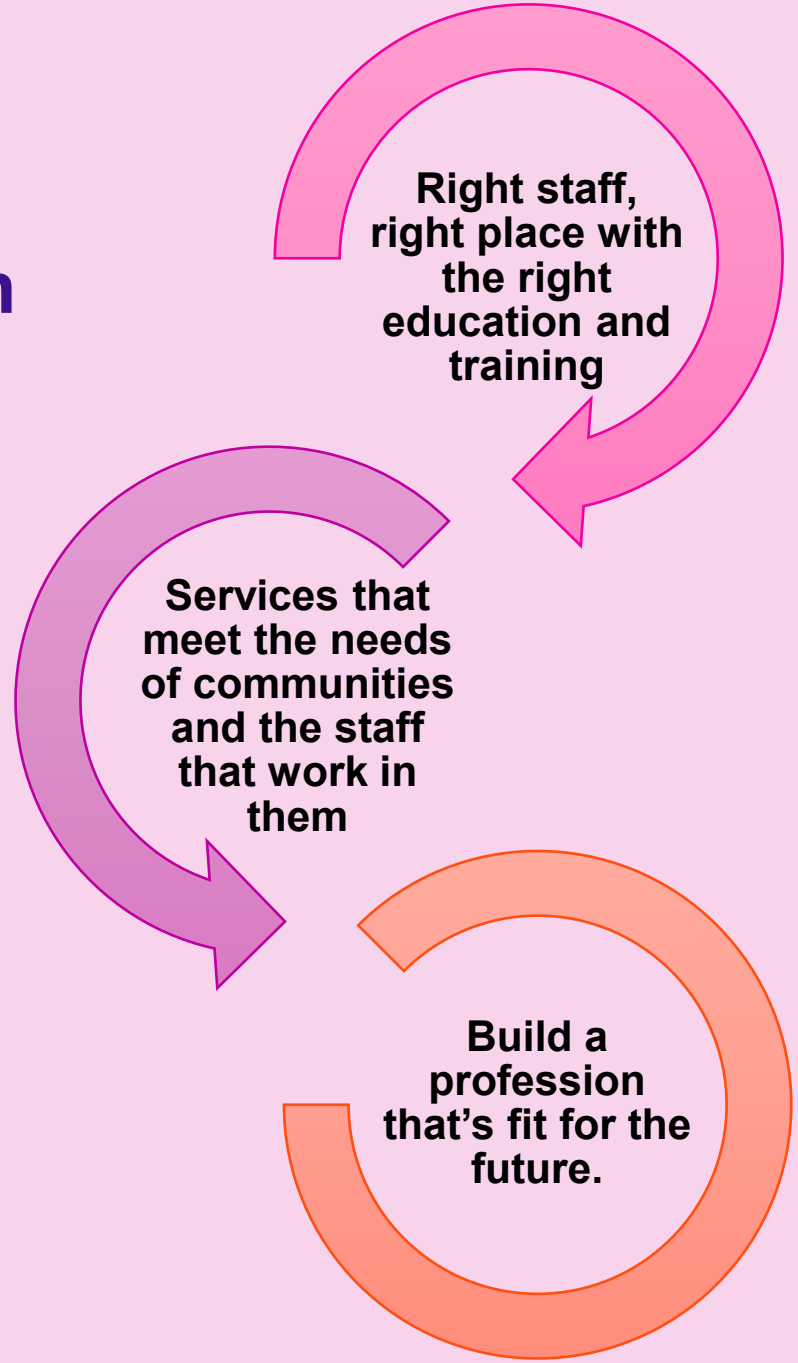
Safe staffing
Dedicated funding for addressing chronic midwife and MSW understaffing

A learning profession
52 hours of protected, salaried CPD time

Amplified midwives' voices
A midwifery director and enough consultant midwives in every trust

Improved health and prevention
Funded time for cultural competence training

Our workplace, your birthplace
Clear fixable maintenance backlog for high-quality work and birthplaces



Amplifying members voices

- BR+ methodology
- **MIS ‘compliance’ interpretation**
- **Workforce pressure impact morale and wellbeing**
- Headroom - maternity leave
- Time to deliver personalised care and address inequalities
- Recognition of neonate in admission numbers
- **Planned pressures- triage and theatres**
- Challenges of implementing recommendations and service changes with limited investment in allocation
- Current financial pressures meaning unable to recruit
- **Newly qualified midwives' jobs**

Maternity Incentive Scheme Year 8

- Focus on standards that are **evidence based** and have impact
- Support **reduction in asks** as stress and burnout a significant pressure
- **Perinatal** workforce and capacity essential
- Removal of ‘action plan’
- Strengthened professional judgement
- Planned caesarean capacity pressures including postnatal

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Enabling safe, effective staffing:
An independent review of the Birthrate Plus® methodology

Birte Harlev-Lam OBE
Independent Review Chair

birthrateplus® | Safe Staffing for Maternity Services

Purpose of review

PERIODIC REVIEWS OF – METHODOLOGY (PRACTICE & POLICY) AND DELIVERY NEW GOVERNMENT

FOLLOWS REVIEW OF THE REAL TIME WARD APP

NHSE SMSGG RECOMMENDATIONS

SAFE STAFFING LITERATURE

Expert Advisory Panel oversight

Bring expertise

- Midwifery
- Obstetrics
- Workforce planning
- System knowledge
- Research and evidence
- Policy understanding

Act as a sounding board

- Provide expert challenge and support

Build consensus

- Review findings and research/evidence from topic specific consensus building groups

Ensure relevance

- Outputs are meaningful and relevant for services and workforce planners

Advise on

- Improvements and agree recommendations

Data collection

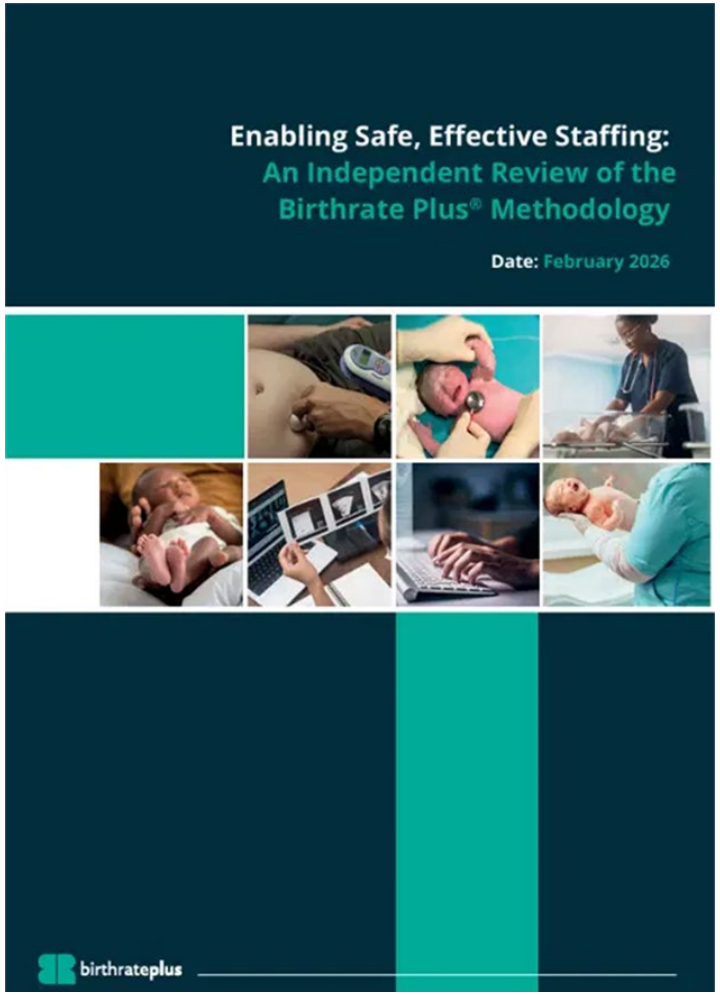
- Scoping: semi-structured one to one interviews
- Setting specific consensus building group workshops x 7
- Consensus building groups survey
- Policy and guidance horizon scanning
- General survey (next steps)

High level common themes

- Highly valued, recognised and trusted workforce tool but…….
  - Needed to better reflect modern maternity services including:
- Digitalisation/Administrative burden
- Underrepresentation of increasing complexity incl social complexities and mental health
- Skill Mix and Experience (students and NQM)
- Changing face of what is required in the maternity workforce 2026
  - Policy and guidance
  - Safety reports

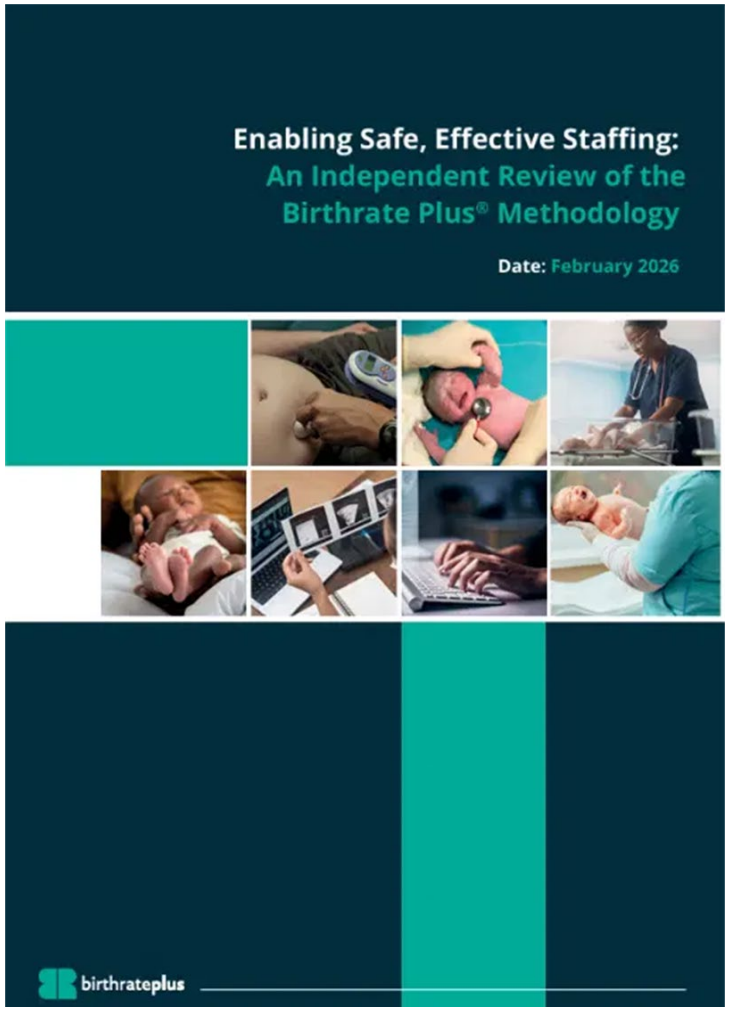
Short term developments for BRP

- Technical Guidance
- Workforce report redesign
- Language and terminology
- board template



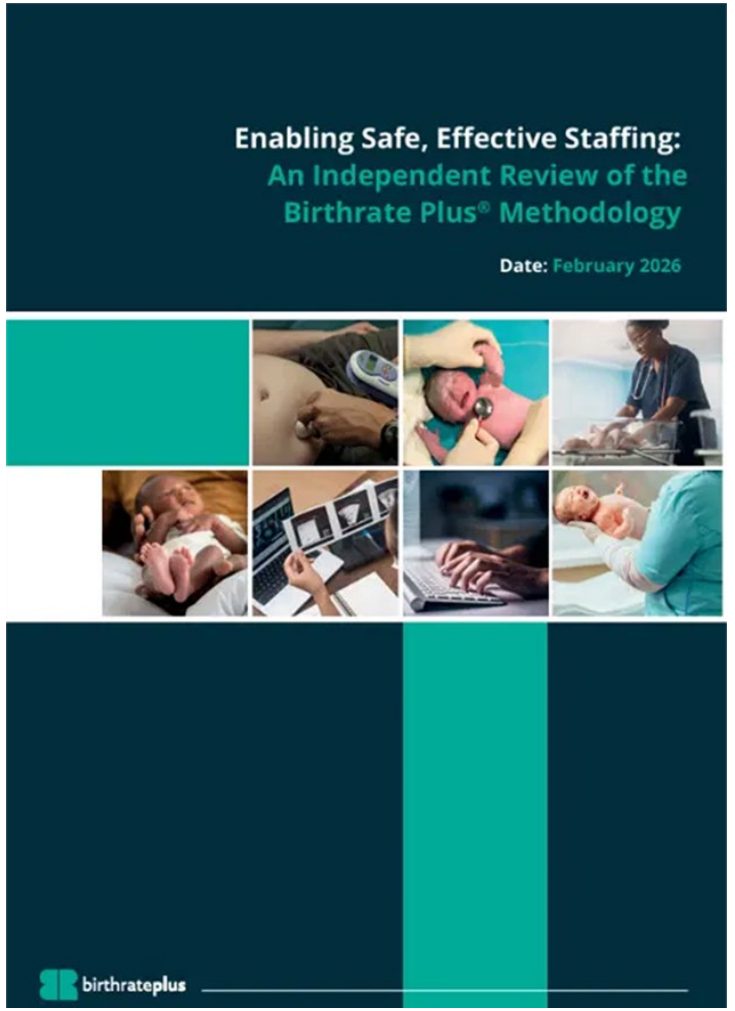
Medium and long term developments for BRP

- Antenatal outpatient and inpatient activity
- Social complexity and pathway approach
- Newborn care complexity & intermediate pathway
- Skill mix (non-midwives)
- Newly qualified midwives & transitional workforce capacity
- Management and leadership
- Specialist Midwives
- Digital Platform



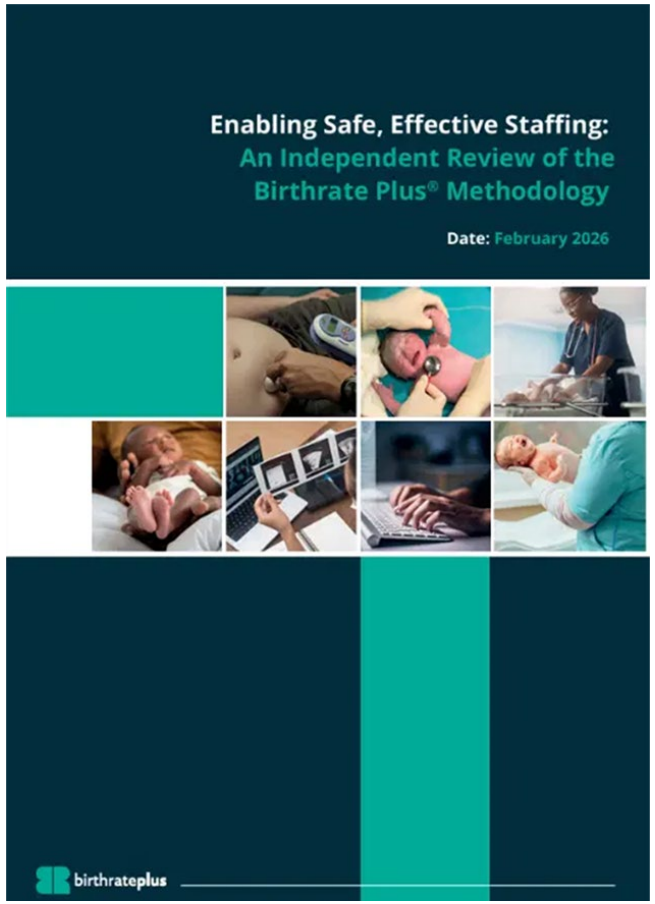
Review recommendations for the wider system

- Partnership working for workforce planning
- Consistent agreed workforce uplift
- National guidance and standards for maternity practice
- Alignment of NICE guidance with workforce requirements – updated guidance
- Standardised clinical care hours
- National guidance for specialist midwife roles



Link to report:

https://birthrateplus.co.uk/wp-content/uploads/2026/01/Birthrate-Plus-Methodology-Review-REPORT.pdf



birthrateplus® | Safe Staffing for Maternity Services

CODP
College of Operating Department Practitioners

Workforce and Capacity
The Perioperative Component

Bill Kilvington FCODP, FRCA

Patient Safety Lead

Anaesthetic workforce

Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.

When calling the Anaesthetist – bleep the ODP!

- Safe anaesthesia relies upon the anaesthesia team – the anaesthetist and trained anaesthetic assistant (ODP or Anaesthetic Trained Nurse).
- Until now, not all units could call upon a dedicated trained assistant who could attend immediately.

Planned caesarean capacity

Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward).

- Competing demands upon operating theatre and perioperative staff capacity can limit timely access for women booked for a planned caesarean birth.
- Maternity services managing theatre bottlenecks day to day can mask very real impacts upon safe care, meaning Trust Boards may be unsighted.

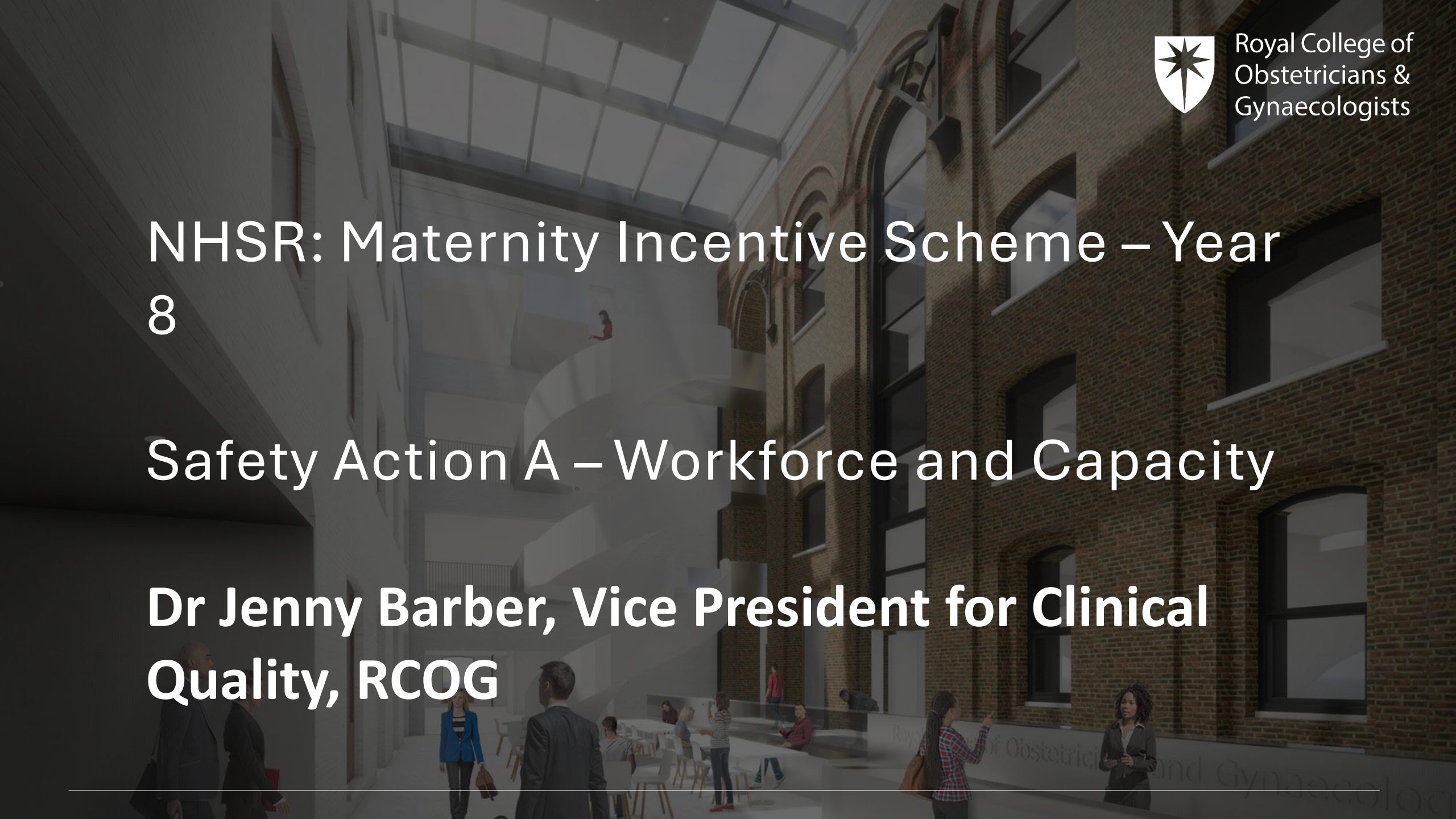
Planned caesarean capacity 2

- This safety action aims to shine a light upon what has become a significant concern for many maternity services, enabling Trust Boards to understand and plan appropriately

“Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it"
H. James Harrington

You are not alone!

- Theatre demand and capacity planning should be the bread and butter of the theatre management team – THEY should be working in partnership with the maternity service to deliver this Safety Action.
- ODPs are trained in anaesthesia, surgery and post anaesthetic care. The role in maternity can enhance the capacity of midwives to focus upon the care they are uniquely qualified to provide.



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NHSR: Maternity Incentive Scheme – Year 8

Safety Action A – Workforce and Capacity

Dr Jenny Barber, Vice President for Clinical Quality, RCOG

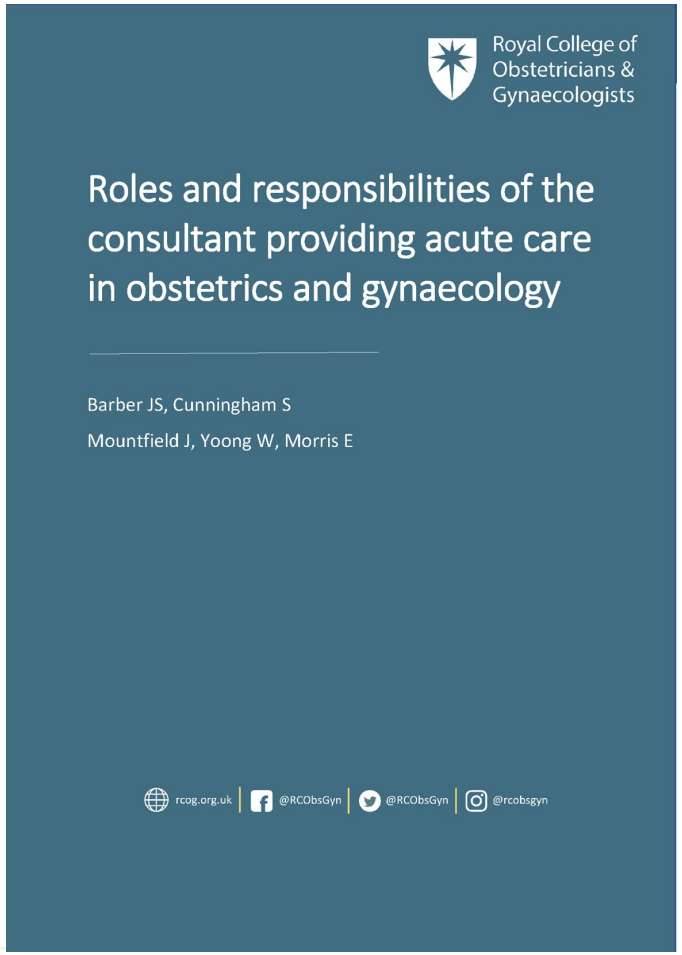
Improving perinatal outcomes: Right people, right place, right time

Royal College of Obstetricians & Gynaecologists

Safe care
Timely escalation
Effective decision-making

1. Escalation to the consultant

- Trusts must demonstrate 80% compliance with ensuring that certain clinical scenarios are escalated to the consultant on-call
- If escalation does not occur, a reason should be documented and unit review should be undertaken to develop action plans and strategies to reduce recurrence.



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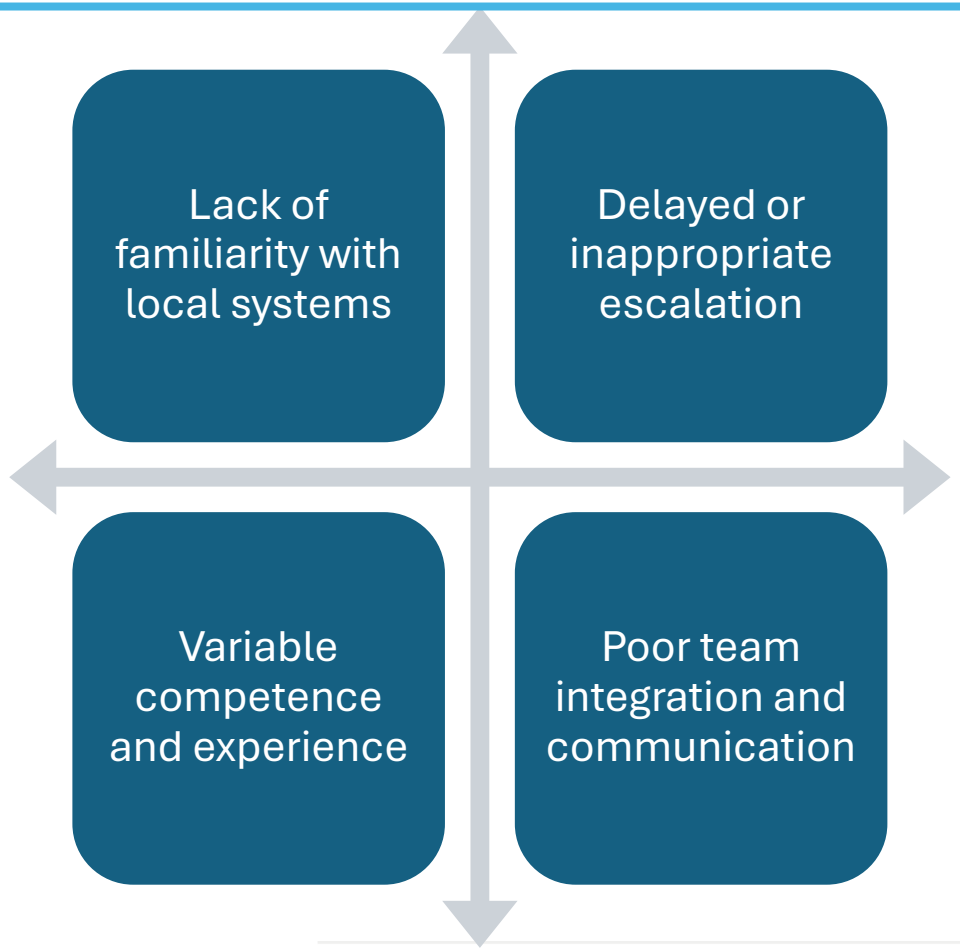
Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
GENERAL
Any patient in obstetrics OR gynaecology with an EBL >1.5litres and ongoing bleeding[#]
OBSTETRICS
Trial of instrumental birth
Vaginal twin birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
GYNAECOLOGY
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

2. Certificate of Eligibility to Locum (CEL)



Recommendations from Regulation 28 Reports

2. Certificate of Eligibility to Locum (CEL)

- Applies when trusts employ doctors for short-term locums (less than 2 weeks duration) to work on tier 2 and 3 (middle-grade) rotas.
- Requires doctors to have documented evidence of competency at a range of common obstetric procedures, CTG training and multi-disciplinary team working.
- It is the responsibility of trusts to ensure that locum doctors hold a CEL
- A CEL is currently not required for doctors holding a CCT / CESR.
- Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

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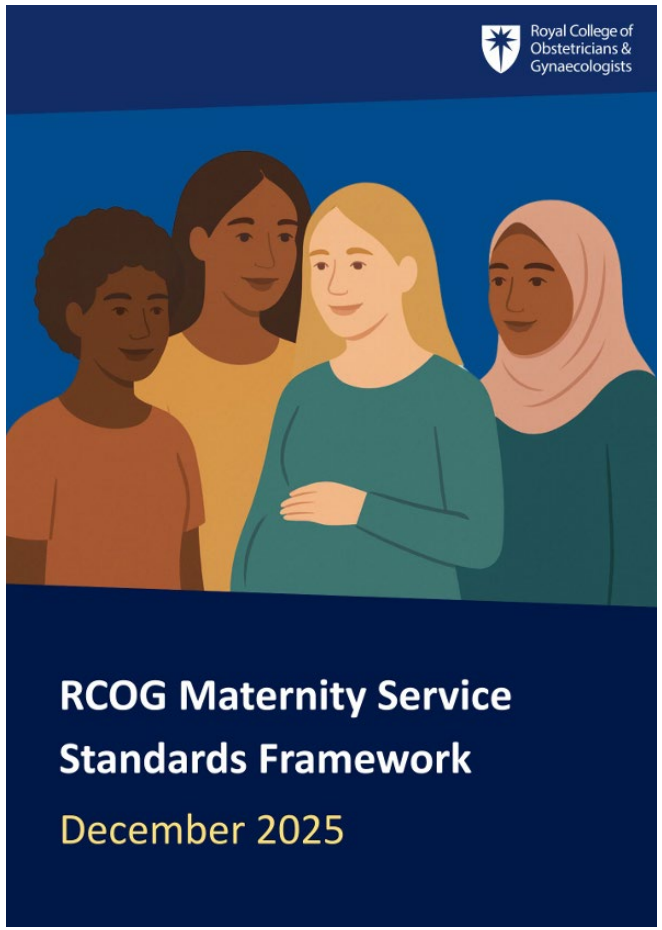
3. Mapping of planned caesarean birth



Coming Soon!

RCOG Good Practice Paper – Planned Caesarean Birth

- Good practice standards for delivering a caesarean birth service including antenatal care and counselling, intrapartum and postnatal care.