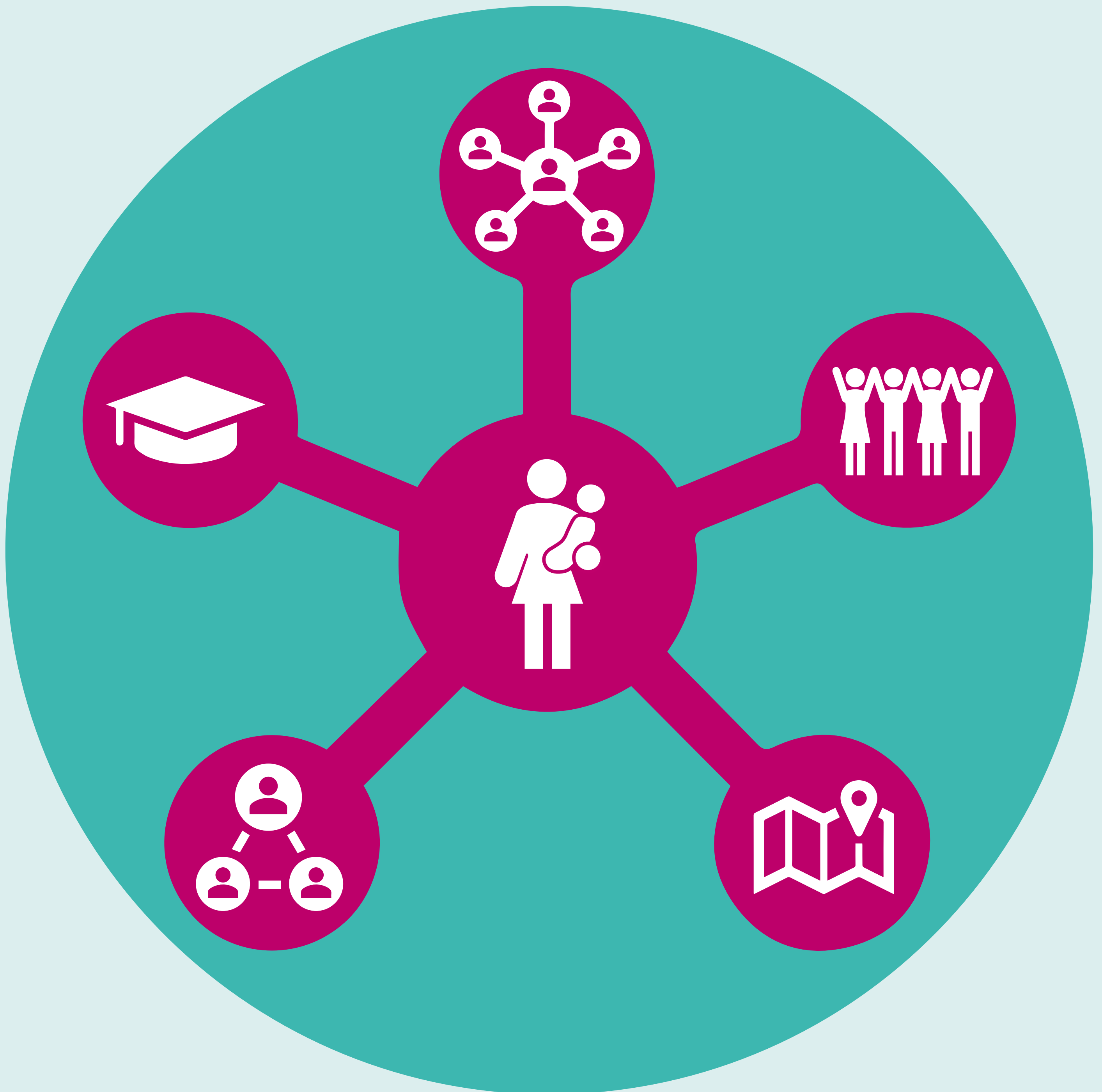
NHS Education for Scotland

The Midwifery Workforce and Education Review for Scotland

March 2021



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Executive summary

NHS Education for Scotland (NES) was commissioned by the Chief Nursing Officer Directorate of the Scottish Government in July 2020 to:

> review the current and future national midwifery workforce and pre-registration education requirements, to ensure that Scotland has the right midwifery workforce, in the right place, with the right skills and competencies to support current and future service reform and sustainability.

The review was led by a Project Team based in NES that was responsible for collating data, consulting with relevant stakeholders, developing recommendations and preparing this report. The Project Team reported to a national Steering Group led by the Chief Midwifery Officer. The methodology for the review was the Six Steps Methodology to Integrated Workforce Planning that has been in place for some time in NHS Scotland and included three stakeholder workshops held virtually between September 2020 and January 2021.

Following on from the evidence collected by the review, it is clear that action is required in the following areas.

- Rapid action is required to **reduce the current and projected shortfall of whole-time equivalents (WTEs) in the midwifery workforce until 2023,** when the effect of the increased graduate outflow will begin to redress the balance. The shortfall can be reduced by increasing retention of the existing workforce and inflow from sources other than newly qualified graduates from Scotland.
- **Service transformation from traditional to continuity of care models should be prioritised** to accelerate achievement of the anticipated benefits of the key Scottish policy on maternity care and services, *The Best Start: a five year forward plan for maternity and neonatal care in Scotland* (referred to in this report as Best Start), which include reduced intervention rates and associated workforce demand, and enhanced job satisfaction for midwives. Effective change management strategies need to be employed to avoid attrition during the transition.
- **The adaptation of the staffing-level tool for the maternity workforce (the Maternity workload tool) needs to be prioritised and accelerated** to ensure it is appropriate for use with continuity of care models to inform safe staffing levels. Further work on the tool is needed to support NHS boards to establish safe and effective staffing levels for core and continuity teams.
- **Education provision should be reviewed** to ensure delivery supports equitable recruitment across all areas of Scotland. This should include consideration of undergraduate, return-to-practice and shortened programmes for registered nurses.

The review's recommendations set a direction of travel for future actions, rather than detailed proposals for activity within defined timelines.

Governance and information

1. **A national midwifery workforce implementation group should be established to co-ordinate and monitor national and local implementation of the review recommendations and their impact on workforce.**

2. **Local midwifery workforce recruitment and retention groups that report to the national group should be established within every NHS board to implement recommendations in this report at local level and collate data to inform student intake planning.**

The national and local groups, working in a co-ordinated and collaborative way and alongside the Best Start Implementation Programme Board, will help to ensure that momentum created by the review is sustained.

3. **NES should provide access to relevant information on the midwifery workforce to support NHS boards and the Scottish Government to plan the workforce.**

These data should be provided through the NES TURAS Data Intelligence service.

Model of care

4. **Transition to continuity of care models should be prioritised, with the Best Start Implementation Programme Board continuing to facilitate shared learning across early adopter boards to inform national transition of service.**

Realising the benefits of person-centred, relationship-based care would reduce dependency levels and consequently workforce demand.

5. **Work to develop the staffing-level tool (the Maternity workload tool) to ensure synchronisation with Best Start aspirations and establish safe staffing should be prioritised and accelerated.**

The impact on workforce demographics of introducing Best Start should be closely monitored to inform the future demand for qualified midwives.

Retention and recruitment of midwives

6. **NHS boards should develop a retention strategy for the midwifery workforce that addresses the eight key areas outlined by the King's Fund in its *The Courage of Compassion* report, prioritising workforce culture and experience.**

The aim of this recommendation is to encourage NHS boards to optimise retention of midwives, increase average WTE contracted hours and facilitate transitions to continuity of care models by making midwives' working experiences more positive, enjoyable, rewarding and productive.

7. **Organisation recruitment policies should be reviewed to ensure they optimise the pace of employment of returning retirees and newly qualified staff.**

A national approach to this would be the preferred option, with the national implementation group best placed to co-ordinate collaboration and co-production.

8. **Return-to-practice options should be reviewed to proactively support a partnership approach between NHS boards, programme providers and Scottish Government to ensure the collaborative employment model is as accessible as possible.**

Ensuring the collaborative employment model is as accessible as possible will help to encourage and support previously registered midwives back into the profession.

9. **Local consideration should be given to options for supporting midwives who are out of clinical practice back into frontline roles to help maintain flexibility in the workforce flow.**

Facilitating transition between roles allows greater flexibility and movement across the career framework, promoting transfer and development of knowledge, skills and experience to create a more robust workforce.

10. **NHS boards should explore strategies to increase recruitment from outwith Scotland. This may include midwives from other areas of the UK and abroad.**

More work needs to be done on understanding the recruitment and retention of qualified midwives from sources other than pre-registration education in Scotland. This may include a co-ordinated national and international recruitment drive.

Regional approaches

11. **A range of supply-side and demand-side measures should continue to be considered to address the specific regional midwifery workforce challenges faced currently by NHS boards.**

There are particular difficulties in recruiting and retaining qualified midwives, but not midwifery support staff, in the North Region that require imaginative and innovative responses.

Student intakes and education provision

12. Responses to current workforce issues should not be based on student intake numbers. The annual student intake process will review necessary numbers in the normal way year on year.

There is no evidence to support an increase in pre-registration midwifery education numbers in Scotland. Such an increase in student intake would result ultimately in an excess of graduates, leading to a reduction in numbers (similar to 2011) in subsequent years.

13. Pre-registration midwifery programmes in Scotland should continue to be provided by the current three higher education institutions.

There is no evidence to support an increase in commissioned providers of the pre-registration programme.

14. The three higher education providers of pre-registration midwifery programmes should review recruitment strategies to ensure a sustainable workforce for partner NHS boards and meet widening-access outcomes.

This recommendation aims to put in place arrangements that will encourage access to, and recruitment of, students from partner NHS boards, including ‘hard-to-reach’ areas, to take account of workforce needs.

15. The three higher education providers should offer a pre-registration midwifery shortened programme for registered nurses to meet specific regional/NHS board workforce needs.

16. NHS boards should commit to seconding registered nurses through an appropriate employment model to ensure the viability of pre-registration midwifery shortened programmes.

The addition of a shortened programme to the suite of midwifery offers from higher education institutions would add increased flexibility to education provision and ensure education capacity is sufficiently responsive to meet current and future service demands.

17. The higher education providers should develop inclusive at-distance learning methods to support rural education provision and recruitment. This should include the use of technology to enable remote learning and provision of local clinical skills teaching.

This recommendation includes education support for the statutory and continuing professional development needs of registered midwives. Partnership agreements between higher education institutions and NHS boards enabling exchange of experience and opportunity will facilitate its achievement.

18. NHS boards should introduce midwifery-specific practice education posts to support the practice learning environment (delivering education and clinical skills development in practice).

These posts should have a specific focus on supporting midwives through Best Start transitions and ensuring that practice supervisors and assessors are equipped with the knowledge and skills outlined in the updated Nursing and Midwifery Council Standards of Proficiency for Midwives.

19. A nationally agreed preceptorship programme should be developed for newly registered midwives, those returning to practice after re-joining the register or coming to work in the UK from within or outside the European Economic Area and European Union, and those in a new role.

Effective preceptorship outcomes are linked to improved recruitment and retention, but there is no consistent approach to preceptorship across Scotland.

20. A national midwifery career framework, supported by an education framework, should be developed.

A national midwifery career framework, supported by an education framework, would support current and future service reform and sustainable services. It would offer the midwifery workforce opportunities for career progression, supporting the development of future leaders across all areas of midwifery.

Implementing, monitoring and refreshing

21. It is recommended that the national implementation group be co-chaired by the Chief Midwifery Officer and the Director of the Directorate of Nursing, Midwifery and Allied Health Professions of NES.

It will be vital that the national implementation group has leadership from the highest levels representing service, workforce and education interests.

22. The national implementation group should adopt a flexible approach to recommendation implementation that reflects the broader situation caused by the COVID pandemic and the wider roll-out of Best Start.

The pandemic will continue to have serious implications for the delivery of health services, presenting a layer of uncertainty over the short and medium terms to which the implementation group will need to be sensitive and responsive. The ongoing roll-out of Best Start and the adjustments to the staffing-level tool (the Maternity workload tool) that currently are being considered also call for the implementation group to remain flexible and agile.

23. The national implementation group should perform an overall review of progress after 12 months to determine if recommendations need to be revised or refreshed.

It will be important for the national implementation group to monitor closely how recommendation implementation is progressing and, if necessary, amend or adjust recommendations to reflect pressing realities.

Introduction and context

NHS Education for Scotland (NES) was commissioned by the Chief Nursing Officer Directorate of the Scottish Government in July 2020 to:

> review the current and future national midwifery workforce and pre-registration education requirements, to ensure that Scotland has the right midwifery workforce, in the right place, with the right skills and competencies to support current and future service reform and sustainability.

Despite nine successive increases in the midwifery student intake, some NHS boards continue to experience recruitment issues, with a view that output is not keeping pace with vacancies and retirals and that students are not coming from, or taking up posts in, local areas, particularly in the north of Scotland. There is also a view that increasing case complexity and the implementation of a continuity of carer midwifery model following on from the publication in 2017 of the key Scottish policy on maternity care and services, *The Best Start: a five year forward plan for maternity and neonatal care in Scotland*[1] (referred to in this report as Best Start), will require additional midwives to join the workforce. At local level, Best Start is challenging traditional workforce deployment and historical service models. A key challenge is to ensure that local change is based on whole-system redesign, rather than creating additionality by developing continuity of care models alongside the existing service model.

It is these kinds of issues relevant to the midwifery workforce in Scotland (see Box 1) that the commission sought to address.

Box 1. The importance of the midwifery workforce

It is important to consider why the midwifery workforce is important within the context of maternity services. Midwifery as an intervention results in significantly improved outcomes for women and babies. The Lancet Global Health series on midwifery[2] illustrates that having the right number of midwives with the right skills is critical to impacting on key indicators such as maternal and neonatal mortality and morbidity, improving service safety and quality, and producing cost savings. In addition, relationship-based care and midwifery continuity of care models have proven to provide additional benefits for staff, women, babies and families.

The review

The **Midwifery Workforce and Education Review (the review)** set out to ensure that key demographic and workforce characteristics – a relatively static birth rate, increasing co-morbidities such as obesity among pregnant women, an ageing midwifery workforce, increasing retirals and fluctuating vacancy rates, altered working patterns and particular challenges for service delivery in remote and rural areas – were understood and addressed.

Building on the strong foundation of initiatives and efforts that continue to be taken forward in Scotland by NHS boards, higher education institutions and other stakeholders to strengthen and sustain the midwifery workforce across the country, the review has been taken forward in the light of the key underpinning policy in maternity services for Scotland, which is the reform of maternity and neonatal care outlined in Best Start. The Health and Care (Staffing) (Scotland) Act 2019,[3] which will be brought into force as soon as is feasible post-COVID, was also central to the review's context. The Act will place various duties on boards, including requiring the use of workload tools, the common staffing method and other systems and processes.

1 Scottish Government (2017). The Best Start: a five-year forward plan for maternity and neonatal care in Scotland. (https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/).
2 The Lancet (2014). Midwifery (https://www.thelancet.com/series/midwifery).
3 Health and Care (Staffing) (Scotland) Act 2019 (https://www.legislation.gov.uk/asp/2019/6/contents/enacted).

The review methodology

The methodology for the review was the Six Steps Methodology to Integrated Workforce Planning[4] that has been in place for some time in NHS Scotland:

1. **Define the plan**
2. **Map service change**
3. **Define the required workforce**
4. **Understand workforce availability**
5. **Develop an action plan**
6. **Implement, monitor and refresh.**

The review was led by a Project Team based in NES (see Annex 1) that was responsible for collating data, consulting with relevant stakeholders, developing recommendations and preparing this report. The Project Team reported to a national Steering Group led by the Chief Midwifery Officer (see Annex 1).

The work of the review was carried out in two phases.

- The first stage was to develop a shared understanding with a diverse range of stakeholders on the current and future registered midwifery workforce requirement, and to form a consensus on whether current workforce planning is meeting, and will continue to meet, this requirement.
- The second phase was to consider what action is required in light of both current and future population and workforce need across Scotland.

To support this endeavour, a series of stakeholder workshops was held virtually between September 2020 and January 2021 (see Box 2).

Box 2. Review stakeholder workshops

The review hosted three stakeholder workshops, chaired by the Chief Midwifery Officer, at which participants were enabled to listen to high-quality presentations from workforce experts, ask questions and seek answers, and get together in groups and in plenary sessions to discuss key issues for the midwifery workforce now and in the future. Participants included the NES Project Team and other NES personnel, and representatives from the Scottish Government, higher education institutions and NHS board-level education services, workforce planning services in NHS boards, lead midwives from NHS boards, the Scottish Executive Nurse Directors group, the Scottish Funding Council, Health Improvement Scotland and the Royal College of Midwives.

4 Skills for Health (2021). The Six Steps Methodology to Integrated Workforce Planning (https://skillsforhealth.org.uk/info-hub/six-steps-methodology-to-integrated-workforce-planning/).

The workshops focused on the following areas:

- Workshop 1: consideration and review of evidence and trends presented by NES and recent national reviews of midwifery workforce elements
- Workshop 2: consideration of areas in which recommendations should be developed, reflecting the accumulated evidence
- Workshop 3: review, amendment and approval of draft recommendations.

Complementary work

The review also recognised and utilised the findings of two other important pieces of national work that had recently been taken forward in Scotland:

- a national run of the maternity workload planning tools (the Maternity workload tool and the Professional Judgement tool (see page 15, Box 6))
- a Best Start Deep Dive (see page 13, Box 4).

The national run of the maternity workload planning tools and the Best Start Deep Dive played a key part in shaping the review's thinking and guiding its decisions as it worked through the six-steps methodology to produce this review report.

This report

This report is presented in three sections:

1. Background and context
2. **Evidence and trends**, based on the first five steps of the Six Steps Methodology to Integrated Workforce Planning and setting out current and future trends in relation to the midwifery workforce in Scotland
3. **Recommendations and the way forward**, defining practical actions that will have precision impact on the development of the midwifery workforce of the future and putting in place mechanisms to implement, monitor and refresh the recommendations.

Evidence and trends

Defining the plan

The Health and Care (Staffing) (Scotland) Act 2019, when brought into force, will place a duty on heath boards to ensure that **at all times** suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in numbers appropriate to the provision of high-quality care. The legislation will apply to all healthcare professionals, including registered midwives (see Box 3), who since September 2013 have been defined in the Official Statistics for NHS Scotland in six sub-categories. In this report, the term "midwives" refers to **registered neonatal and non-neonatal midwives providing direct and indirect care and who are employed in NHS Scotland on Agenda for Change (AfC) bands 5–9.**

Box 3. Midwifery education in Scotland

Midwives have to be registered with the Nursing and Midwifery Council (NMC) to practise in the UK. Registration depends on whether the midwife was trained in the UK, the European Union (EU) or outside the EU.

Pre-registration midwifery education is regulated on a UK-wide basis by the NMC. The approved midwifery programmes in Scotland commissioned by the Scottish Government currently are: 36-month BSc pre-registration midwifery and 36-month MSc pre-registration midwifery programmes at the University of the West of Scotland and Edinburgh Napier University; and a 36-month Bachelor of Midwifery programme at The Robert Gordon University.

Currently, all three education providers are preparing for reapproval of their programmes in line with the new NMC education standards published in 2020. They have been encouraged by the Scottish Government to provide a mixed economy of provision in terms of mode of provision, length of programme (including shortened programmes) and staggered graduations to better meet specific workforce demand needs, with a particular focus on widening access to applicants across the whole of Scotland.

The Chief Nursing Officer Directorate of the Scottish Government makes recommendations to the Scottish Funding Council on the target number of pre-registration nursing and midwifery student places to be commissioned each year, based on workforce projections and advice from stakeholder organisations. NES supports this process through expert advice and the provision of data on nursing and midwifery student numbers, progression and completion. Due to changing workforce projections and demand, the number of student midwifery places commissioned by the Scottish Government has increased steadily over the past nine years, from a target intake of 97 in 2011 to 270 in 2020 (including students on the pilot shortened programme at the University of the Highlands and Islands).

The University of the Highlands and Islands commenced a pilot shortened (20-month) midwifery programme for registered nurses in January 2019 to address geographical recruitment challenges in the midwifery workforce, and a second intake commenced February 2020 (due to complete in August 2021).

There is also a return-to-practice[5] programme currently available at The Robert Gordon University for midwives whose registration has lapsed. Glasgow Caledonian University will commence a return-to-practice programme for midwives in September 2021.

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5 NMC (2019). Standards relating to return to practice (https://www.nmc.org.uk/standards-for-education-and-training/standards-relating-to-return-to-practice/return-to-practice-courses/).

Mapping service change

The Strategic Review of Maternity and Neonatal Services in Scotland produced Best Start, which focuses on creating a refreshed model of care and approach to maternity and neonatal services and examining choice, quality and the safety of those services in light of current evidence and best practice. Among its recommendations is that:

> Every woman will have continuity of carer from a primary midwife who will provide the majority of their antenatal, intrapartum and postnatal care and midwives will normally have a caseload of approximately 35 women at any one time … Midwifery and obstetric teams should be aligned around a caseload of women and should be co-located for the provision of community and hospital-based services.

Best Start goes on to recommend that early adopter NHS boards should be identified to lead the change in practice, with implementation ensuring that appropriate education, training, development and realignment of resources is achieved within five years for all boards. A Best Start Deep Dive was conducted in these early adopter boards (see Box 4).

Box 4. The Best Start Deep Dive

The Deep Dive carried out in the Best Start early adopter board areas focused on recommendation 1 from Best Start on the idea of continuity of carer. It aimed to: map the woman's journey through the lens of delivering continuity of care and carer; develop an understanding of the experience and learning of the early adopter boards; test different models with scenario modelling (working with the University of Stirling); consider stretch aims; review the midwifery staffing position (current and in relation to modelled requirements); and understand the supply of midwives over the next five years.

The Deep Dive found that:

- there seems to be correlation between returns from early adopter boards and the national picture on funded establishments
- early adopter boards are testing different models for providing continuity of carer, dependent on local circumstances, and that the models being tested are able to deliver on the continuity aims
- there appears to be sufficient workforce to implement the continuity model, but this depends on the size of the core team retained, how midwifery staffing is distributed across the service and NHS boards, and local population demographics and geography.

Reform will be essential at local level to redeploy the clinical midwifery workforce to deliver continuity of care with a reduced core hospital team.

Defining the required workforce

The Health and Care (Staffing) (Scotland) Act 2019 will require a common staffing method to be applied when determining the number of staff required in certain healthcare settings, which are specified in the Act. Since the use of a workload staffing-level tool is an integral part of the common staffing method, the healthcare settings in which the common staffing method must be used will initially match those settings for which a staffing-level tool currently exists. As further staffing-level tools are developed for new healthcare settings, so the requirement to follow the common staffing method will be extended to those settings.

The common staffing method takes account of a range of factors, including output from the specialty-specific workload staffing-level tools, professional judgement, local context and quality measures. It also requires NHS boards to seek and have regard to professional advice on decisions relating to staffing, including, where appropriate, from the nurse or medical director, and that the views of staff should be taken into account in decision-making (see Box 5). When brought into force, the requirement to apply the common staffing method will replace the current mandate to NHS boards to use the suite of existing specialty-specific workload tools.

Box 5. Determining appropriate staffing levels in midwifery

The staffing-level tool for maternity services in Scotland is the **Maternity workload tool**,[6] which is supported by the Healthcare Staffing Programme at Healthcare Improvement Scotland. This tool uses historical data across a wide range of maternity services to determine workload, taking account of levels of dependency of women during different aspects of their maternity journey to calculate a recommended whole-time equivalents (WTEs) required to deliver a quality service. The dependency levels are:

- 0 for women who do not require increased midwifery care
- 1a for women who require a minimal increase in midwifery care
- 1b for women who require an increase in care from the multi-disciplinary team but minimal midwifery care
- 2 for women or babies who require a moderate increase in midwifery care
- 3 for women who require one-to-one midwifery care.

Other things being equal, a higher degree of dependency implies a higher recommended WTE. In November 2019, the percentage of patients in Levels 0, 1a, 1b, 2 and 3 was 24.2%, 33.6%, 10.2%, 22.6% and 9.4% respectively, and the recommended WTE from 14 NHS boards (excluding Best Start early adopter boards) was 2448.55.

The Maternity workload tool is based on traditional models of service delivery. Work is underway to revise the tool to reflect current practice and implementation of Best Start. Additional information relating to some community aspects, transitional care, triage and theatre provision was collected during the 2019 national run of the tool to inform this review.

It is very important that the output of the Maternity workload tool is not seen in isolation and that all aspects of the common staffing method are applied when determining appropriate staffing levels.

6 Healthcare Improvement Scotland (2020). Maternity tool (http://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools/maternity_tool.aspx).

Box 5. Determining appropriate staffing levels in midwifery – continued

The **Professional Judgement tool**[7] allows professional judgement to be applied to actual workload and local context during the time the workload tools are being applied. It can include workload that is not included in the specialty-specific tool, where appropriate. The output from the Professional Judgement tool can then be triangulated with output from the specialty-specific tool and other aspects of the common staffing method to inform decision-making. In November 2019, the Professional Judgement tool assessment for 14 NHS boards resulted in 2656.44 WTE.

A national run of the maternity workload planning tools (the Maternity workload tool and the Professional Judgement tool) was carried out late in 2019, the data from which have fed into the review process (see Box 6). The national run also included collection of additional information designed to reflect feedback from heads of midwifery to inform any future review of the Maternity workload tool.

Box 6. National run of the maternity workload planning tools

The maternity workload planning tools (the Maternity workload tool and the Professional Judgement tool) were run in all NHS boards for four weeks in November–December 2019. The aims were to identify: recommended staffing requirements based on the workload tool and professional judgement tool outputs; current funded establishment; and actual absence during the national run. A dashboard was developed to enable collection and analysis of data.

The run showed:

- rosters aligned to traditional models of care reported little variance between the funded establishments and Professional Judgement tool WTE, but there was significantly greater variance between funded establishment and professional judgement for the rosters of the continuity of care models
- amendments to the maternity workload tools are required (this is already in train)
- any second-generation tools should strive for e-enablement and be based on multidisciplinary approaches.

Another measure of **establishment** (see Box 7) is reported in the Official Statistics for the NHS Scotland workforce.[8] Each quarter, NHS boards report information on **staff in post** – that is, funded and filled posts – and **vacancies** – funded and unfilled posts.

Box 7. Establishment

Establishment is the total number of funded posts – the sum of posts that are funded and filled, and posts that are funded but unfilled. Establishment should therefore represent the outcome of the common staffing method, which accounts for the demand for midwives arising from the staffing-level tool (the Maternity workload tool) and the Professional Judgement tool, which in turn account for the complexity of cases and local factors.

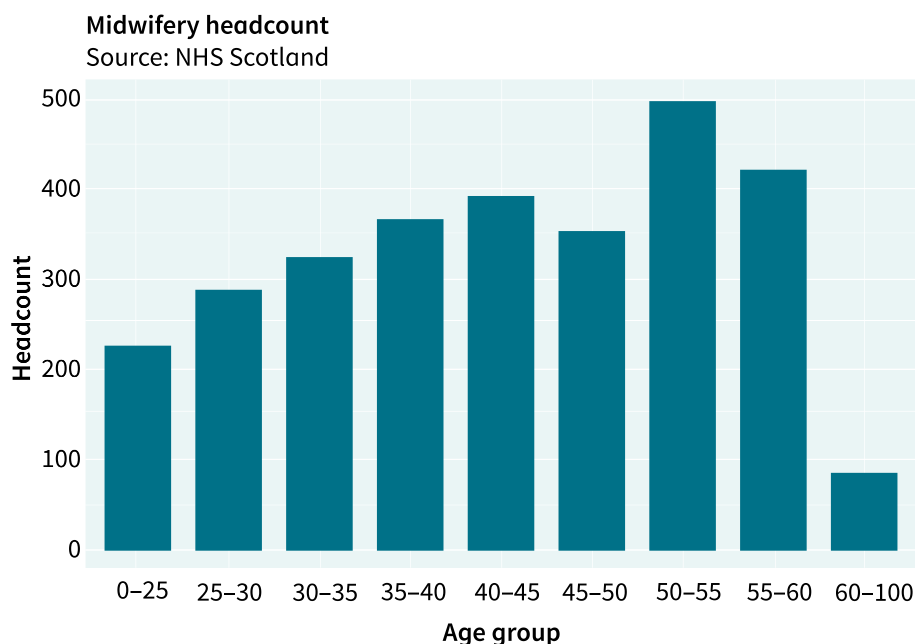
7 Healthcare Improvement Scotland (2020). Professional Judgement tool (http://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools/pj_tool.aspx).

8 NES (2021). Turas Data Intelligence (https://turasdata.nes.nhs.scot/workforce-official-statistics/nhsscotland-workforce/publications/01-september-2020/dashboards/nursing-and-midwifery/).

Understanding workforce availability

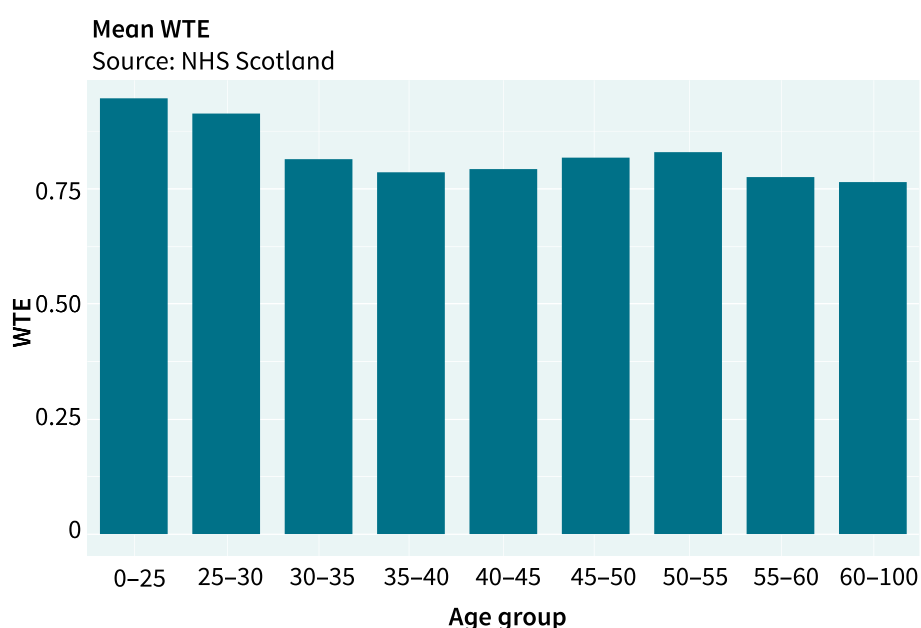
The headcount by age distribution of **the current workforce of midwives in NHS Scotland** is shown in Figure 1.

Figure 1.



There has been relatively little change in either the headcount or WTE of midwives since 2015. At the lower end of the age distribution, mean WTE is close to one (full-time). The mean WTE of midwives older than 30 is about 0.8 (four days a week) (Figure 2).[9]

Figure 2.



9 The WTE of the current workforce is a function of the number of staff in each age group and the mean WTE in each age group.

The future workforce of midwives in Scotland depends on the current workforce and future flows in and out of the workforce.

Outflows are calculated by identifying qualified staff who were in the NHS Scotland workforce in one year, but not the following year. Outflows may reflect midwives **taking career breaks, finding employment outside NHS Scotland, reducing their hours of employment** or **retiring**. The proportion of outflows increases towards the upper end of the age distribution as midwives approach retirement.

Inflows tend to come from:

- **outside NHS Scotland**: this consists mainly, but not exclusively, of new registrants completing their pre-registration midwifery programmes, mostly from programmes in Scotland (see Box 8), and registered midwives from the rest of the UK and elsewhere
- **support staff**: this is calculated by identifying qualified staff who had previously worked as midwifery support staff and then completed a pre-registration midwifery programme (with a tendency towards people from the lower end of the age spectrum)
- **midwives returning to practice**: this includes midwives who left and subsequently returned to the workforce, of which a relatively large proportion are in the upper end of the age distribution; they tend to represent a small total number overall.

Box 8. Completion probabilities

The number of midwives who qualify in Scotland depends on intakes into Scottish higher education institution programmes and the probability that students complete their programmes; this is referred to as **completion probabilities**.

Completion probabilities are used to look forward and estimate how many students will complete their programmes (and when) but can also enable planners to look backwards to estimate the intake required to ensure that a given number of students will complete within a certain interval.

Completion probabilities vary among the three higher education institutions providing midwifery undergraduate education in Scotland, but completion tends to be high. Based on 2012–2016 cohorts, midwifery students on 36-month programmes consistently show the highest completion probabilities at any given time. Based on these cohorts, over 65% completion is seen at three years. It is estimated that a further 20% complete in the interval between three and four years, bringing the overall percentage to about 85% at four years. By five years, completion is around 87%. It should be noted, of course, that not all graduates completing their programmes choose to work full time or, indeed, work in NHS Scotland.

The final source of flow is **staff increasing their WTE**. These staff neither enter nor leave the service but amend their hours of working either by increasing or decreasing them (see Box 9).

Box 9. Retention of staff

Findings from an NMC survey[10] asking why nurses and midwives left the permanent register, carried out before the COVID pandemic took hold, showed the top reason cited for leaving (after retirement) was too much pressure leading to stress and/or poor mental health. This finding is replicated in a survey of midwives carried out by the Royal College of Midwives in England.[11]

Research evidence highlights the significant impact the working environment has on staff retention. Work by the King's Fund[12] identifies eight key areas on how nurses' and midwives' workplaces can be transformed to prioritise workforce culture and experience and enable nurses and midwives to flourish and deliver high-quality care, thereby increasing retention probabilities: authority, empowerment and influence; justice and fairness; work conditions and working schedules; teamworking; culture and leadership; workload; management and supervision; and learning, education and development.

Exploration of strategies to retain an ageing workforce carried out by NES (unpublished report) highlight supportive leadership, positive workforce culture and job satisfaction as key factors in retaining staff. Reported outcomes of transition to continuity of care models include increased levels of autonomy, job satisfaction and enhanced work-life balance, but the transition period poses a risk of attrition that could compound existing establishment gaps if the service change is not effectively managed to help to minimise work-related stress and prevent sickness absence.

Developing an action plan

The task is to ensure **that employment of qualified midwives is the same as establishment**. The top panel of Figure 3 shows total establishment and staff in post (the dotted line signifies that incomplete data were received from boards over the period, a direct result of the COVID pandemic), and the bottom shows vacancies (both in WTE).

The demand for midwives, as measured by establishment, has increased during recent years. Currently, there is a relatively large stock of vacancies.

Figure 4 shows the trend in vacancies by region during the sample period. The vacancy rate for qualified midwives in NHS boards in the North are higher than in the East and West regions during the sample period. This suggests that there are particular difficulties in recruiting qualified midwives in the North Region of Scotland.

From this, it is possible to begin to **project future demand for midwives**.

Demand for midwives is a function of many factors. The precise relationship between these factors and the demand for midwives is difficult to determine but is likely increasingly to be affected by **births** and **complexity** (see Box 10).

10 NMC (2020). What do the latest figures from the NMC register tell us? (https://www.nmc.org.uk/news/news-and-updates/nmc-register-data-march-2020/).

11 Royal College of Midwives (2017). The gathering storm: England's midwifery workforce challenges (https://www.rcm.org.uk/media/2374/the-gathering-storm-england-s-midwifery-workforce-challenges.pdf).

12 The King's Fund (2020). The courage of compassion: supporting nurses and midwives to deliver high-quality care (https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives).

Figure 3.

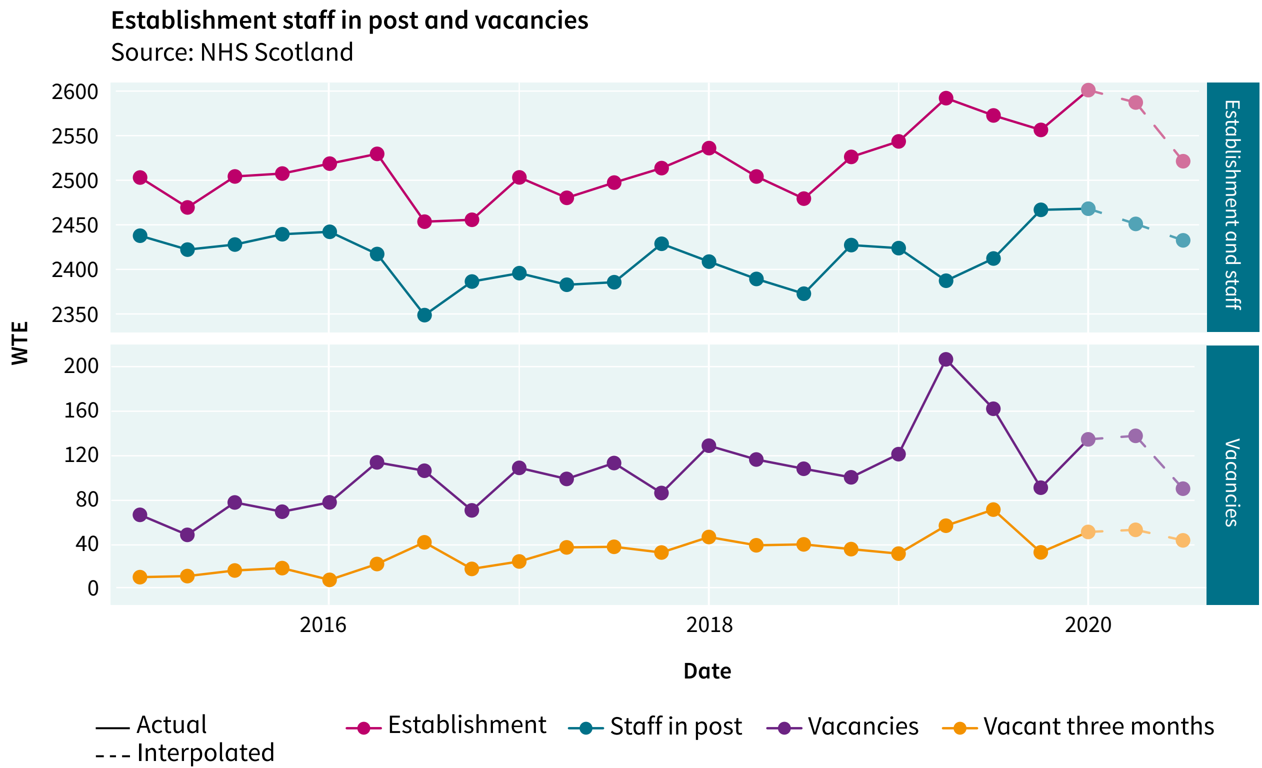
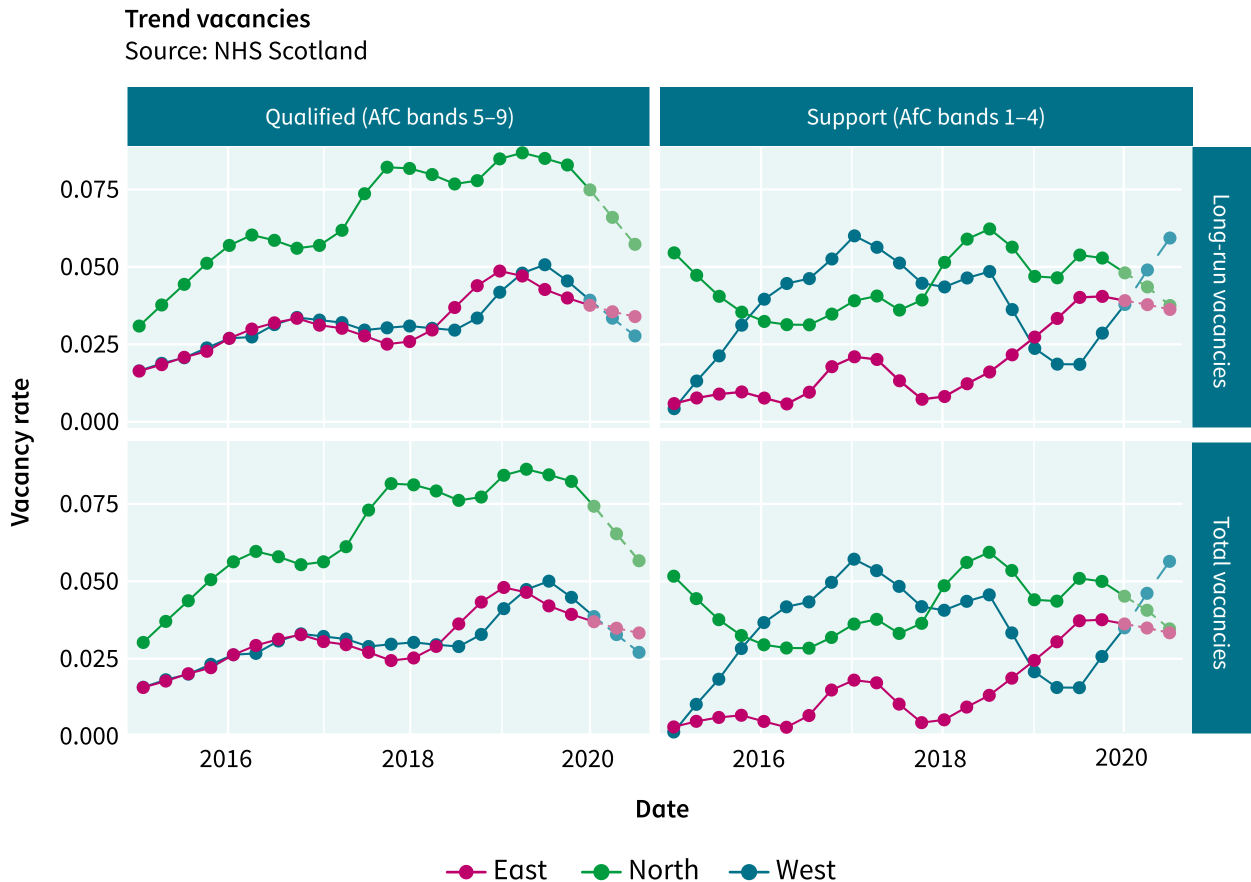


Figure 4.



Box 10. Complexity

The relationship between the demand for midwives and the complexity of patients is difficult to measure, but vitally important. The following factors are among those that will have an impact on demand for midwives.

Method of birth: a lower proportion of spontaneous births and an associated increase in the proportion of births requiring increased intervention is likely to result in an increase in the proportion of Level 1a women. Between 2014 and 2019, there was a reduction in the proportion of Level 0 women (who do not require increased midwifery care) and an almost equal increase in Level 1a women, who require a minimal increase in midwifery care.

Deprivation: measures of deprivation of mothers by Scottish Index of Multiple Deprivation[13] quintiles between 2010 and 2018 show there has been relatively little change in the proportion of mothers who live in the most deprived areas of Scotland. Social risk factors are indicators for inclusion in Level 1b, which is for women who require an increase in care from the multi-disciplinary team but minimal midwifery care.

Maternal weight: maternal body mass index (BMI) over 35 is one of the factors that would increase the dependency of a woman from Level 0 to Level 1a. The proportion of mothers classified as obese by having a BMI of over 29 is increasing, which may help to explain the reduction in the proportion of Level 0 women and the increase in Level 1a women observed through the workload tools.

Maternal age: there is no specific risk factor related to maternal age in the maternity dependency levels. Women aged 16–40 are classified as Level 0. There has been a slight increase in the proportion of mothers aged over 40, but it remains relatively small.

Figure 5 shows the actual number of births[14] (a key determinant of demand for midwives) from 1990 to 2020 and projections of births based on high, low and principal fertility rates over the next 10 years or so.[15] Other things being equal:

- an **increase in the projected number of births** implies **an increase in the demand for midwives**
- a **decrease in the projected number of births** implies **a decrease in the demand for midwives.**

As can been seen, there is considerable variation between the high and low fertility projections; by 2025, for instance, the difference is 10,023 births.

Figure 6 shows the WTE establishment required to maintain the 2019 birth-to-establishment ratio.

13 Scottish Government (2020). Scottish Index of Multiple Deprivation 2020 (https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/).

14 National Records of Scotland (2020). Births Time Series Data (last updated: 23 June 2020) (https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/births/births-time-series-data).

15 Office for National Statistics (2019). Zipped population projections data files, Scotland (release date 21 October 2019) (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z5zippedpopulationprojectionsdatafilesscotland).

Figure 5.

Actual and projected births
Source: National Records of Scotland; Office for National Statistics

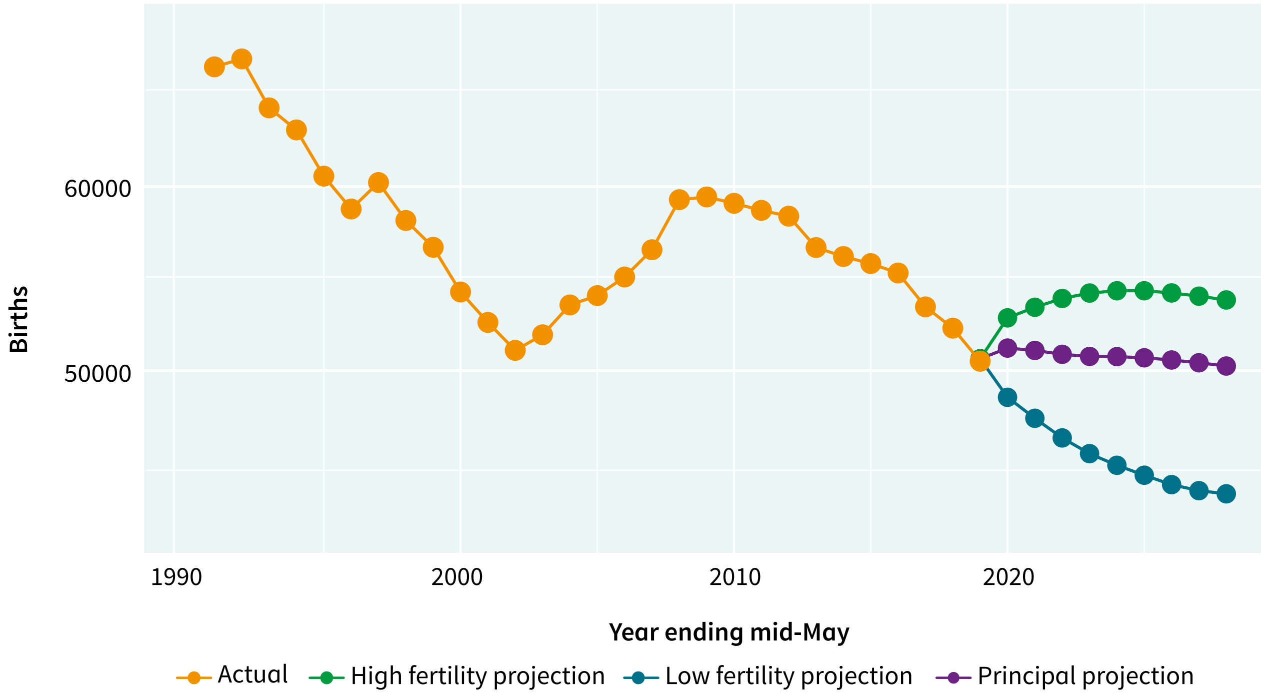
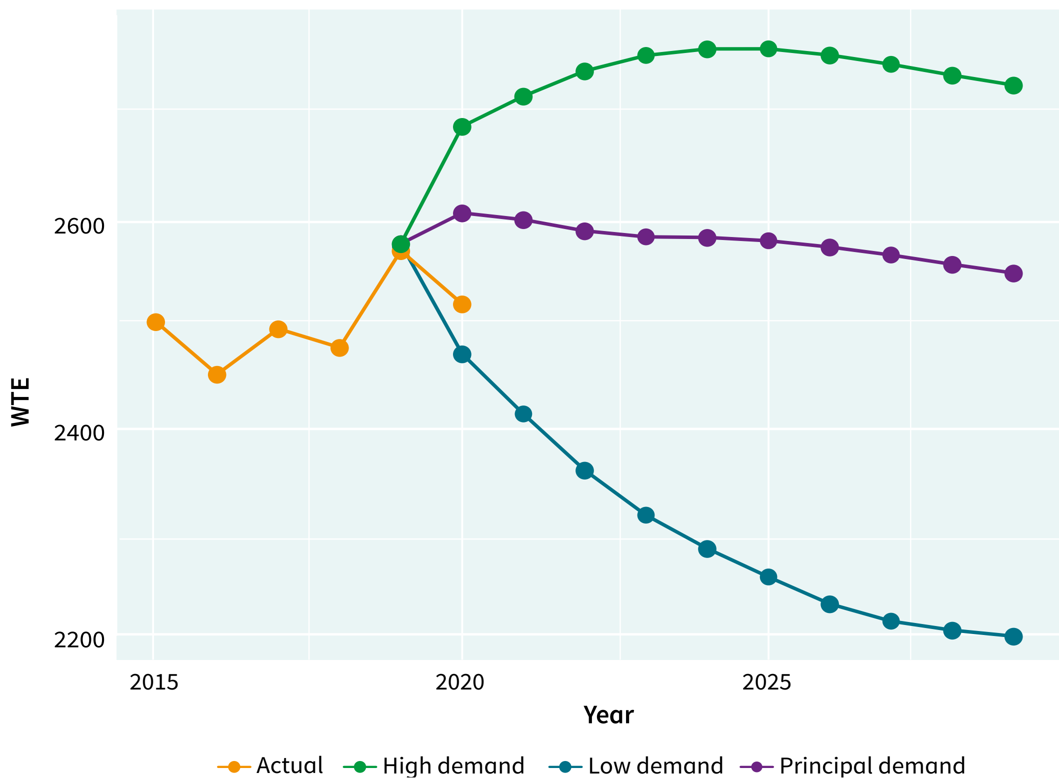


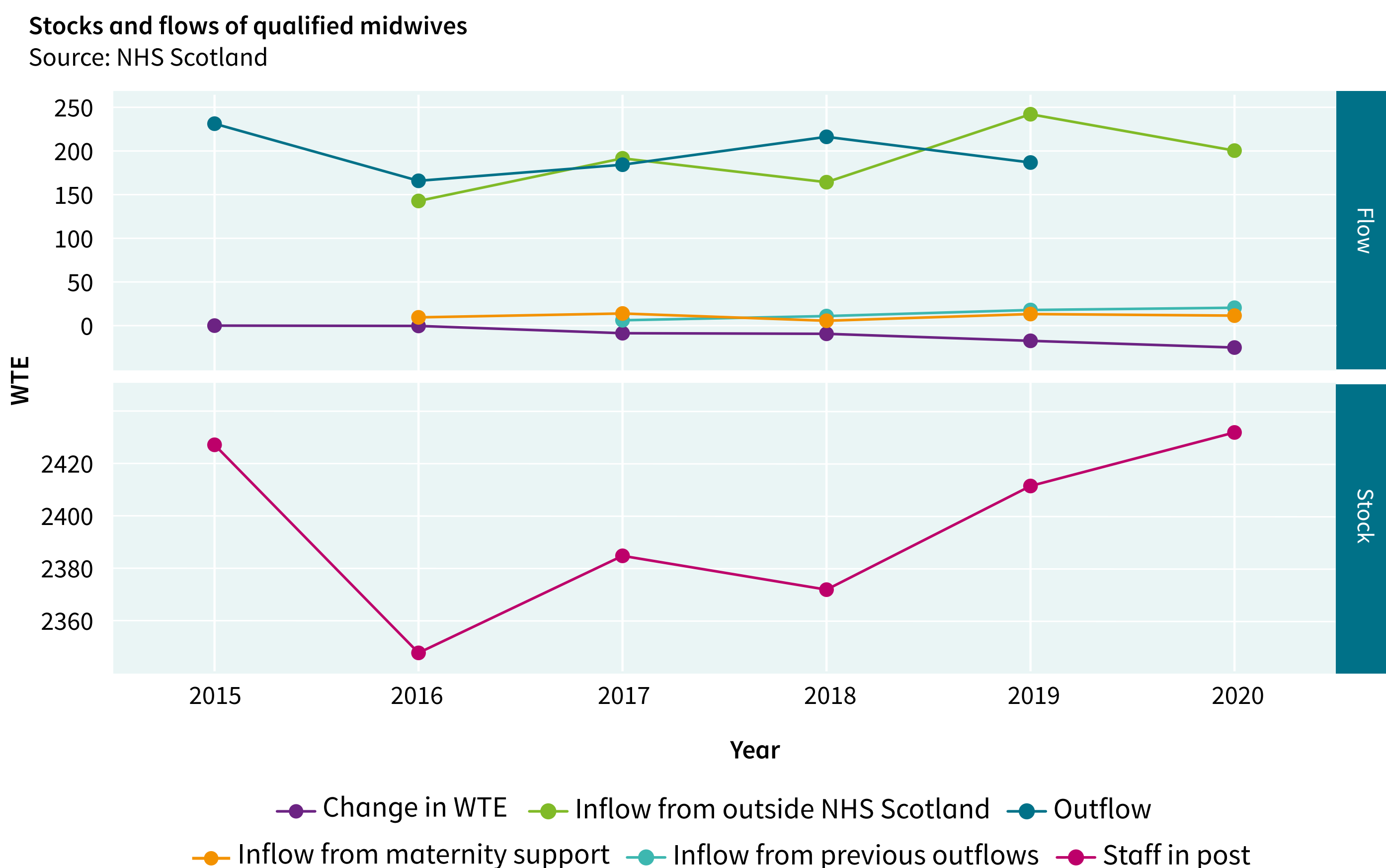
Figure 6.

Birth-to-establishment ratio
Source: NHS Scotland; Office for National Statistics



This projected demand needs to be set alongside a forecast of employment of midwives. Figure 7 shows numbers of registered midwives in NHS Scotland at December 2020. The change in numbers of midwives is driven by inflows and outflows (see 'Understanding workforce availability' section above). In Figure 7, the blue line represents outflow of midwives from NHS Scotland and the green line is inflow.

Figure 7.



The task now is to **try and forecast how these flows will look in future**.

Most inflow into the NHS workforce comes from midwives graduating from pre-registration programmes in Scotland (see Box 11). Figure 8 shows the actual intakes up to 2019 and the target intakes thereafter against the actual number of graduates emerging from pre-registration programmes, again with forecast numbers from 2020. It demonstrates that while in 2019 there were 150 graduates emerging from programmes, NHS Scotland's intake of midwives that year was 262 (see Figure 7). Inflow therefore is not simply determined by the number of graduates – external recruitment also plays a significant part.

Figure 8.

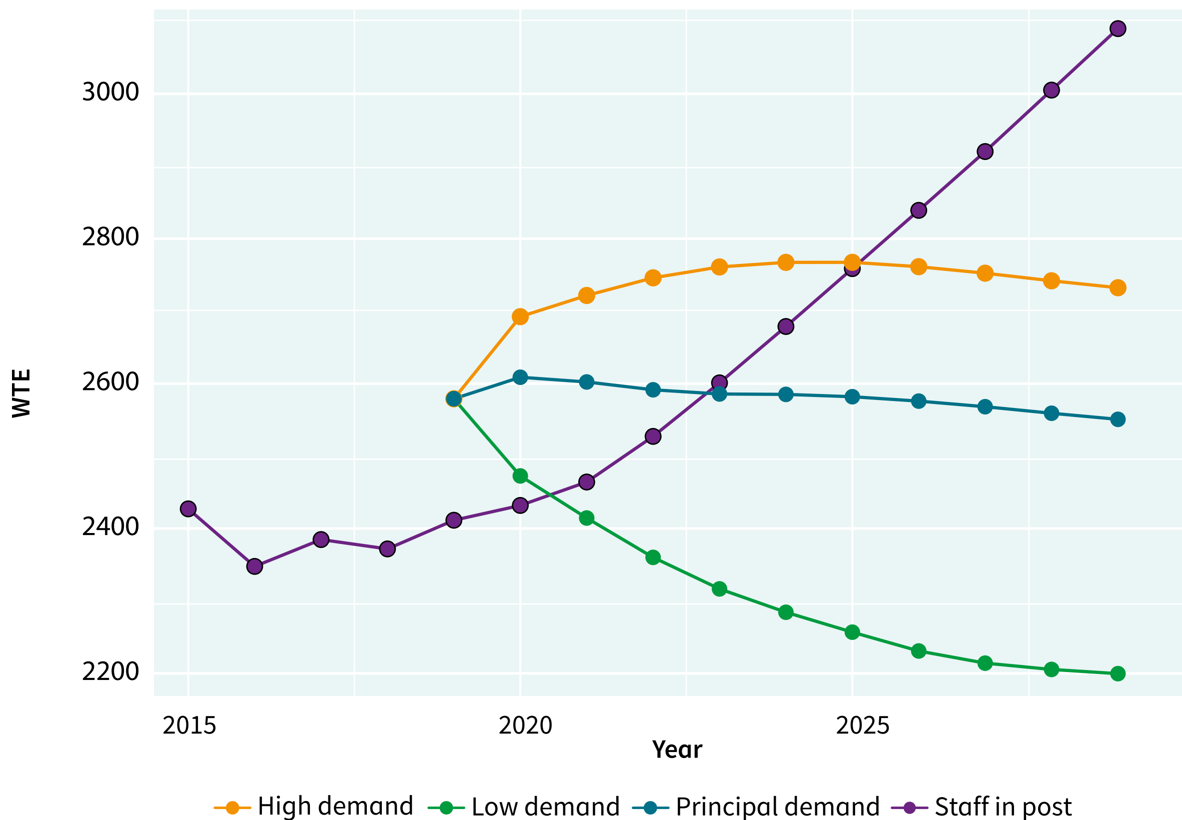
Bringing these data on forecast demand and employment together provides an opportunity **to consider how any gaps can be closed**.

Box 11. Student intakes

It is recognised that the reduction in student numbers in 2011 and regionalisation of higher education providers for pre-registration midwifery in 2011 may have contributed to current workforce challenges in the North Region of Scotland because local workforce needs for some NHS boards were not addressed by the education model. Student intake numbers nevertheless have increased since then every year and are expected to be 225 by 2025, the highest output of graduates ever (see Figure 8).

Figure 9 compares forecast employment with the three demand forecasts. The demand forecasts reflect the demand for qualified midwives associated with the high, low and principal fertility projections. The employment forecast accounts for assumed outflows and inflows based on past trends. Inflows from outside NHS Scotland consist of the expected number of graduates from pre-registration midwifery programmes in Scotland and registered midwives from the rest of the UK and elsewhere.

Figure 9.



This suggests that:

- if the demand for midwives in post is **based on the low demand forecast**, the current workforce is appropriate for current and future demand; there is a small short-term gap between demand and employment that is closed in 2021
- if the demand for midwives in post is **based on the principal demand forecast**, there is a slightly larger gap in 2021 and 2022 that is closed in 2023
- if the demand for midwives in post is **based on the high demand forecast**, the gap in 2021 is even larger but closes in 2025.

It is clear that short-term measures to close the forecast gaps from the principal and high-demand levels cannot include changing student intake numbers, which take at least three years to come into effect. It would be possible, though, to consider:

- increasing direct recruitment from outside the NHS
- reducing outflow from NHS Scotland
- increasing the contracted WTE working hours of midwives (the current average days worked by midwives entering the service are around 4.5 – increasing this to 5 would have an impact in the longer term).

Crucial to any effort to align demand and supply, however, is defining which demand forecast seems the most appropriate – high, low or principal demand? For practical reasons, the principal assumption seems most sensible: adopting the high-fertility demand might lead to oversupply, and the low-demand to undersupply.

Recommendations and the way forward

Following on from the evidence presented in the previous chapter, it is clear that action is required in the following areas.

Rapid action is required to **reduce the current and projected shortfall of WTEs in the midwifery workforce until 2023,** when the effect of the increased graduate outflow will begin to redress the balance. The shortfall can be reduced by increasing retention of the existing workforce and inflow from sources other than newly qualified graduates from Scotland.

Service transformation from traditional to continuity of care models should be prioritised to accelerate achievement of the anticipated benefits of Best Start, which include reduced intervention rates and associated workforce demand, and enhanced job satisfaction for midwives. Effective change management strategies need to be employed to avoid attrition during the transition.

The adaptation of the staffing-level tool for the maternity workforce (the Maternity workload tool) needs to be prioritised and accelerated to ensure it is appropriate for use with continuity of care models to inform safe staffing levels. Further work on the tool is needed to support NHS boards to establish safe and effective staffing levels for core and continuity teams.

Education provision should be reviewed to ensure delivery supports equitable recruitment across all areas of Scotland. This should include consideration of undergraduate, return-to-practice and shortened programmes for registered nurses.

Governance and information

1. **A national midwifery workforce implementation group should be established to co-ordinate and monitor national and local implementation of the review recommendations and their impact on workforce.**
2. **Local midwifery workforce recruitment and retention groups that report to the national group should be established within every NHS board to implement recommendations in this report at local level and collate data to inform student intake planning.**

The national and local groups, working in a co-ordinated and collaborative way and alongside the Best Start Implementation Programme Board, will help to ensure that momentum created by the review is sustained, that improvement work is appropriate to local needs and effective in achieving the review recommendations, and that co-ordinating measures are taken to prevent over- as well as under-supply of midwives.

3. **NES should provide access to relevant information on the midwifery workforce to support NHS boards and the Scottish Government to plan the workforce.**

These data should be provided through the NES TURAS Data Intelligence service and should include NHS board birth projections, NHS board staff in post, vacancy and establishment information, stocks and flows of qualified midwives, pre-registration midwifery intake targets and completion probabilities by higher education institutions, transitions between higher education institutions and NHS boards, turnover of staff with and between NHS boards, and Universities and Colleges Admissions Service (UCAS) information on applications to midwifery programmes in Scotland.

Model of care

4. **Transition to continuity of care models should be prioritised, with the Best Start Implementation Programme Board continuing to facilitate shared learning across early adopter boards to inform national transition of service.**

The anticipated benefits of person-centred, relationship-based care, as prescribed in Best Start, include reduction in intervention rates, preterm births, fetal loss before and after 24 weeks and neonatal death. Realising these benefits would reduce dependency levels and consequently workforce demand (see Box 5, page 14). The reduction in demand is unlikely to be observed before 2023, but the long-term effect could be significant, particularly if the benefits of health promotion/harm prevention and increased breastfeeding rates (as envisaged by Best Start) are realised.

5. **Work to develop the staffing-level tool (the Maternity workload tool) to ensure synchronisation with Best Start aspirations and establish safe staffing should be prioritised and accelerated.**

The impact on workforce demographics of introducing Best Start should be closely monitored to inform the future demand for qualified midwives.

As was explained in the 'Evidence and Trends' chapter, the future demand for qualified midwives is the establishment set out by NHS boards, which is informed by the common staffing method (see page 14). The common staffing method is a function of several factors over which there is considerable uncertainty.

Retention and recruitment of midwives

6. **NHS boards should develop a retention strategy for the midwifery workforce that addresses the eight key areas outlined by the King's Fund in its *The Courage of Compassion* report, prioritising workforce culture and experience (see Box 9, page 18).**

The aim of this recommendation is to encourage NHS boards to optimise retention of midwives, increase average WTE contract hours and facilitate transitions to continuity of care models by making midwives' working experiences more positive, enjoyable, rewarding and productive. The recommendation is in line with Scotland's Fair Work Framework,[16] which sets out a vision that by 2025, people in Scotland will have a world-leading working life where fair work drives success, wellbeing and prosperity for individuals, businesses, organisations and society. The improvement work required to secure its achievement should be undertaken in conjunction with service transition to continuity of care models to support effective management of staff experience throughout the change.

7. **Organisation recruitment policies should be reviewed to ensure they optimise the pace of employment of returning retirees and newly qualified staff.**

During the stakeholder events, some boards reported successful recruitment solutions to long-term vacancies that included recruitment of recent retirees and final-year students. Other boards, however, suggested local human resource policies hindered adoption of such strategies and welcomed the suggestion of support to develop more facilitative policies.

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16 Scottish Government (2016). Fair Work Framework 2016 (https://www.fairworkconvention.scot/wp-content/uploads/2018/12/Fair-Work-Convention-Framework-PDF-Full-Version.pdf).

There was general agreement during the stakeholder events that a national approach to this would be the preferred option, with the national implementation group best placed to co-ordinate collaboration and co-production. NHS Scotland's 'Once for Scotland' update of existing Partnership Information Network (PIN) policies demonstrates this approach, creating simplified, standardised policies that are used consistently across NHS Scotland.

8. **Return-to-practice options should be reviewed to proactively support a partnership approach between NHS boards, programme providers and Scottish Government to ensure the collaborative employment model is as accessible as possible.**

Ensuring the collaborative employment model is as accessible as possible will help to encourage and support previously registered midwives back into the profession.

Financial and time investments to support readmission to the register are significantly smaller than the funding and time required for undergraduate training. In addition, the historical profile of return-to-practice midwives is consistent with the age group who are more likely to work full-time. Uptake, programme completion and retention trends on return-to-practice programmes nevertheless are disappointing, pointing to the need for greater focus on this area to yield more positive results.

The Scottish Government supports those wishing to return to the NMC register and has introduced a new funding model through which candidates can apply to an NHS board for a returner vacancy. The Scottish Government will fund programme fees for candidates employed under certain conditions. NES manages the funding for the current return-to-practice programmes in Scotland at The Robert Gordon University and Glasgow Caledonian University.

9. **Local consideration should be given to options for supporting midwives who are out of clinical practice back into frontline roles to help maintain flexibility in the workforce flow.**

Midwives who are out of clinical practice are those who are still on the register but have moved away from direct clinical care to undertake other essential roles such as education, research or management. Some of these midwives may wish to return to frontline care but lack confidence without opportunity to refresh and update their practice, as they do not qualify for the support available through Return to Practice. Facilitating transition between roles allows greater flexibility and movement across the career framework, promoting transfer and development of knowledge, skills and experience to create a more robust workforce.

10. **NHS boards should explore strategies to increase recruitment from outwith Scotland. This may include midwives from other areas of the UK and abroad.**

Probably the largest inflow into the NHS Scotland midwifery workforce is from pre-registration education programmes in Scotland. The number of graduates from pre-registration education in Scotland is expected to continue to increase to almost 225 a year by 2025. This is not, however, the only source of inflow. Additional inflow from other sources has been considerable during the recent past and accounted for more than half of the inflow into employment in 2019.

Future inflow from these other sources is uncertain. More work needs to be done on understanding the recruitment and retention of qualified midwives from sources other than pre-registration education in Scotland. This may include a co-ordinated national and international recruitment drive. It will also be supported through an annual linkage of pre-registration education and employment data, which would allow qualified midwives trained inside and outside Scotland to be identified.

Regional approaches

11. A range of supply-side and demand-side measures should continue to be considered to address the specific regional midwifery workforce challenges faced currently by NHS boards.

NHS boards, particularly in the North Region of Scotland, currently face specific workforce challenges. NHS boards in the North have systematically higher total and long-run vacancy rates for qualified midwives than those in the East and West Regions, accounting for 35% of the vacancies in Scotland (September 2020 figures). This suggests that there are particular difficulties in recruiting and retaining qualified midwives, but not midwifery support staff, in the North Region that require imaginative and innovative responses.

Student intakes and education provision

12. Responses to current workforce issues should not be based on student intake numbers. The annual student intake process will review necessary numbers in the normal way year on year.

As is explained in the 'Evidence and Trends' chapter, forecasts indicate there is likely to be a short-run gap between employment and the demand for qualified midwives. These short-run gaps cannot be filled by increasing educational capacity because of the duration of pre-registration education programmes, but could instead be addressed by reducing outflow, increasing WTE per midwife and increasing the inflow of registered midwives from outside Scotland (see 'Retention and Recruitment of Midwives' section above). The forecasts do not indicate a gap between demand and employment from 2023 onwards, so there is no evidence to support an increase in pre-registration midwifery education numbers in Scotland. Such an increase in student intake would result ultimately in an excess of graduates, leading to a reduction in numbers (similar to 2011) in subsequent years. Future student intake planning will need to take account of future workforce planning associated with Best Start in light of ongoing implementation and realised outcomes.

13. Pre-registration midwifery programmes in Scotland should continue to be provided by the current three higher education institutions (see Box 3, page 12).

There is no evidence to support an increase in student intake or commissioned providers of the pre-registration programme. It is recognised, however, that regionalisation of higher education providers for pre-registration midwifery in 2011 may have contributed to current workforce challenges in the North Region of Scotland, as local workforce needs for some NHS boards were not addressed by the education model.

14. The three higher education providers of pre-registration midwifery programmes should review recruitment strategies to ensure a sustainable workforce for partner NHS boards and meet widening-access outcomes.

Statistical data indicate the vast majority of midwifery graduates currently seek to secure employment within the NHS board areas in which they completed their programme of study. This recommendation aims to put in place arrangements that will encourage access to, and recruitment of, students from partner NHS boards, including 'hard-to-reach' areas, to take account of workforce needs. In addition, the three providers of undergraduate midwifery programmes have the same single exit point in the year, which significantly limits NHS board recruitment between January and September.

15. **The three higher education providers should offer a pre-registration midwifery shortened programme for registered nurses to meet specific regional/NHS board workforce needs.**

16. **NHS boards should commit to seconding registered nurses through an appropriate employment model to ensure the viability of pre-registration midwifery shortened programmes.**

The addition of a shortened programme to the suite of midwifery offers from higher education institutions would add increased flexibility to education provision and ensure education capacity is sufficiently responsive to meet current and future service demands.

17. **The higher education providers should develop inclusive at-distance learning methods to support rural education provision and recruitment. This should include the use of technology to enable remote learning and provision of local clinical skills teaching.**

This recommendation includes education support for the statutory and continuing professional development needs of registered midwives. Partnership agreements between higher education institutions and NHS boards enabling exchange of experience and opportunity will facilitate its achievement.

18. **NHS boards should introduce midwifery-specific practice education posts to support the practice learning environment (delivering education and clinical skills development in practice).**

The stakeholder event participants identified the need for midwifery-specific practice education roles that focus especially on supporting midwives through Best Start transitions and ensuring that practice supervisors and assessors are equipped with the knowledge and skills outlined in the updated NMC Standards of Proficiency for Midwives.[17] The Scottish Access Collaborative Flying Finish initiative[18] endorses the approach of utilising experienced staff at the latter end of their career within such roles.

19. **A nationally agreed preceptorship programme should be developed for newly registered midwives, those returning to practice after re-joining the register or coming to work in the UK from within or outside the EEA or EU, and those in a new role.**

A positive preceptorship experience is reported to result in newly registered midwives having increased confidence and sense of belonging, feeling valued by their employer, and having greater professional and team identity. Effective preceptorship outcomes are linked to improved recruitment and retention.[19] Although the Flying Start NHS® programme[20] continues to support newly registered midwives in their first NHS posts, there is no consistent approach to preceptorship across Scotland.

17 NMC (2019). Standards of proficiency for midwives (https://www.nmc.org.uk/standards/standards-for-midwives/standards-of-proficiency-for-midwives/).

18 NES (2021). Scottish Access Collaborative Flying Finish (https://learn.nes.nhs.scot/16972/scottish-government-health-and-social-care-resources/scottish-access-collaborative-making-connections-for-staff-and-patients/endorsed-challenges/flying-finish).

19 NMC (undated). Principles of preceptorship (https://www.nmc.org.uk/standards/guidance/preceptorship/).

20 NES (2017). Flying Start NHS®. The definitive guide to the programme (https://learn.nes.nhs.scot/1915/flying-start-nhs/flying-start-nhs-definitive-guide-to-the-programme).

20. **A national midwifery career framework, supported by an education framework, should be developed.**

While there is limited data on why midwives in Scotland leave the profession, anecdotal evidence suggests that the reasons include limited career opportunities. This has been highlighted by the number of midwives recently transferring into other professions to take up band 7 posts, which are limited in opportunity within midwifery and rarely come without management responsibilities.

A national midwifery career framework, supported by an education framework, would support current and future service reform and sustainable services. It would offer the midwifery workforce opportunities for career progression, supporting the development of future leaders across all areas of midwifery. A nationally consistent approach would mitigate against varied and short-term solutions to ensure developments are underpinned by the necessary knowledge and skills across all pillars of practice: clinical practice; facilitation of learning; leadership; and evidence, research and development.

Education and research roles, both in academia and practice, are essential to quality care and sustaining an appropriate workforce flow. Succession planning for these vital roles needs to be taken forward in a reciprocal partnership between NHS organisations and higher education institutions to enable the release of staff for development opportunities.

Implementing, monitoring and refreshing

This is the final step in the six-step methodology, and enables the review to provide suggestions for the way forward with the recommendations.

The review's recommendations set a direction of travel for future actions, rather than detailed proposals for activity within defined timelines. The review envisages that implementation, including monitoring workforce changes such as sharp inflows and reductions in completion probabilities from higher education institution programmes, will be taken forward by a national implementation group working with local focal points (see Recommendation 1).

The national implementation group therefore becomes central to progress against the recommendations. While it will be for the implementation group to set its own terms of reference, appoint its own members and determine specifically how the recommendations should be taken forward, it is likely that it will play a vital role in:

- supporting the establishment of local midwifery workforce recruitment and retention groups
- ensuring all relevant stakeholders are represented in the national and local groups' structures and activities
- co-ordinating actions nationally, regionally and locally
- ensuring the recommendations are applied consistently across Scotland in line with the 'Once for Scotland' approach,[21] but also supporting adaptation of the recommendations as necessary to reflect local needs.

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21 The vision of the 'Once for Scotland' workforce policies is to 'promote NHS Scotland as a modern, exemplar employer, showcasing our core values, and promoting consistent employment policy and practice that supports the implementation of the Staff Governance Standard and effective recruitment and retention.'

21. It is recommended that the national implementation group be co-chaired by the Chief Midwifery Officer and the Director of the Directorate of Nursing, Midwifery and Allied Health Professions of NES.

To meet these aspirations across the country, it will be vital that the national implementation group has leadership from the highest levels representing service, workforce and education interests.

At the time of writing this report, Scotland was in the midst of the COVID-19 pandemic. The country had experienced almost a full year of unprecedented disruption to economic and social activity, extraordinary pressure on health and care services, and devastating levels of morbidity and mortality. COVID-19 had disturbed the delivery of normal health services in a way that no other public health crisis had hitherto come close to replicating.

22. The national implementation group should adopt a flexible approach to recommendation implementation that reflects the broader situation caused by the COVID pandemic and the wider roll-out of Best Start.

At this point, it seems inevitable that the pandemic will continue to have serious implications for the delivery of health services and the education, health and wellbeing of health professionals, including midwives and midwifery students. This presents a layer of uncertainty over the short and medium terms to which the implementation group will need to be sensitive and responsive. In addition, the ongoing roll-out of Best Start and the adjustments to the staffing-level tool (the Maternity workload tool) that currently are being considered will call for the implementation group to remain flexible and agile in its approach to taking its work forward.

23. The national implementation group should perform an overall review of progress after 12 months to determine if recommendations need to be revised or refreshed.

In view of the ongoing uncertainty caused by the pandemic and the potential of new issues being raised by the Best Start roll-out, it will be important for the national implementation group to monitor closely how recommendation implementation is progressing and, if necessary, amend or adjust recommendations to reflect pressing realities.

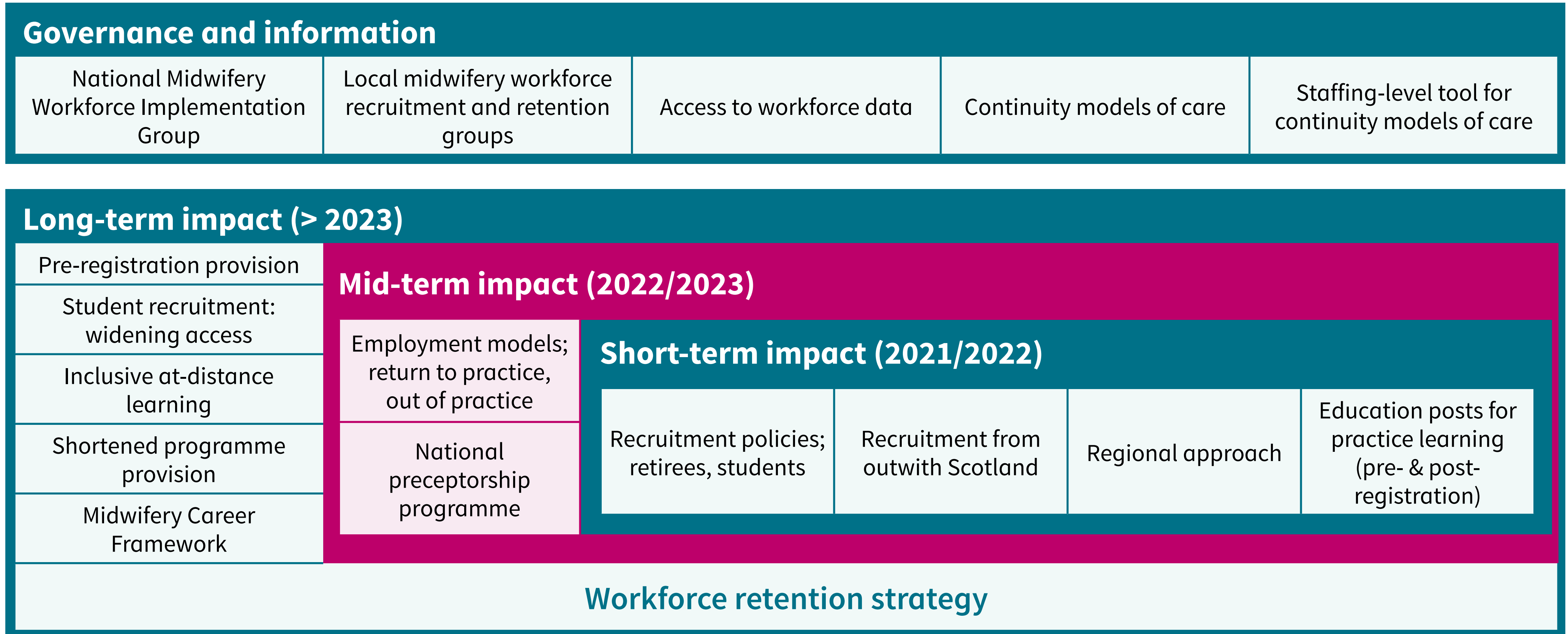
It is important that all the review's recommendations are taken forward together in a consistent and co-ordinated way. It nevertheless seems likely that impacts on the workforce will be evident earlier for some recommendations than for others; for instance, taking measures to create education posts to promote practice learning and to adopt recruitment policies for new registrants and retirees can be taken forward immediately to deliver short-term impacts, while others, like developing the midwifery career framework, will take longer to put in place and will have longer-term effects. Meanwhile, work on retaining the current workforce will go on consistently over the short, mid and long terms.

Figure 10 attempts to represent diagrammatically this relationship between short-, mid- and long-term impacts on the midwifery workforce of the recommendations over 2021–2023 within the overall governance and information structure.

The recommendations are summarised in Annex 2.

This report marks the end of the review, but it is not the end of the journey. The work to implement the review's recommendations now begins, leading to a stronger, more sustainable and better supported midwifery workforce in Scotland that in turn will enable even higher standards of care for women, babies and families.

Figure 10. Workforce impacts of recommendations over time



Annex 1. Group memberships and acknowledgements

The NHS Education for Scotland (NES) Project Team

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The NES Project Team would like to thank the Events Team at NES who facilitated the three stakeholder workshops that were so vital to the process of reviewing the evidence and formulating the recommendations, members of the Project Steering Group and the many other stakeholders who contributed to the review process. Editorial support to the NES Project Team was supplied by Alex Mathieson.

Annex 2. Recommendations

Governance and information

1	A national midwifery workforce implementation group should be established to co-ordinate and monitor national and local implementation of the review recommendations and their impact on workforce.
2	Local midwifery workforce recruitment and retention groups that report to the national group should be established within every NHS board to implement recommendations in this report at local level and collate data to inform student intake planning.
3	NHS Education for Scotland (NES) should provide access to relevant information on the midwifery workforce to support NHS boards and the Scottish Government to plan the workforce.

Model of care

4	Transition to continuity of care models should be prioritised, with the Best Start Implementation Programme Board continuing to facilitate shared learning across early adopter boards to inform national transition of service.
5	Work to develop the staffing-level tool (the Maternity workload tool) to ensure synchronisation with Best Start aspirations and establish safe staffing should be prioritised and accelerated.

Retention and recruitment of midwives

6	NHS boards should develop a retention strategy for the midwifery workforce that addresses the eight key areas outlined by the King's Fund in its *The Courage of Compassion* report, prioritising workforce culture and experience.
7	Organisation recruitment policies should be reviewed to ensure they optimise the pace of employment of returning retirees and newly qualified staff.
8	Return-to-practice options should be reviewed to proactively support a partnership approach between NHS boards, programme providers and Scottish Government to ensure the collaborative employment model is as accessible as possible.
9	Local consideration should be given to options for supporting midwives who are out of clinical practice back into frontline roles to help maintain flexibility in the workforce flow.
10	NHS boards should explore strategies to increase recruitment from outwith Scotland. This may include midwives from other areas of the UK and abroad.

Regional approaches

11	A range of supply-side and demand-side measures should continue to be considered to address the specific regional midwifery workforce challenges faced currently by NHS boards.

Student intakes and education provision

12	Responses to current workforce issues should not be based on student intake numbers. The annual student intake process will review necessary numbers in the normal way year on year.
13	Pre-registration midwifery programmes in Scotland should continue to be provided by the current three higher education institutions.
14	The three higher education providers of pre-registration midwifery programmes should review recruitment strategies to ensure a sustainable workforce for partner NHS boards and meet widening-access outcomes.
15	The three higher education providers should offer a pre-registration midwifery shortened programme for registered nurses to meet specific regional/NHS board workforce needs.
16	NHS boards should commit to seconding registered nurses through an appropriate employment model to ensure the viability of pre-registration midwifery shortened programmes.
17	The higher education providers should develop inclusive at-distance learning methods to support rural education provision and recruitment. This should include the use of technology to enable remote learning and provision of local clinical skills teaching.
18	NHS boards should introduce midwifery-specific practice education posts to support the practice learning environment (delivering education and clinical skills development in practice).
19	A nationally agreed preceptorship programme should be developed for newly registered midwives, those returning to practice after re-joining the register or coming to work in the UK from within or outside the European Economic Area or European Union, and those in a new role.
20	A national midwifery career framework, supported by an education framework, should be developed.

Implementing, monitoring and refreshing

21	It is recommended that the national implementation group be co-chaired by the Chief Midwifery Officer and the Director of the Directorate of Nursing, Midwifery and Allied Health Professions of NES.
22	The national implementation group should adopt a flexible approach to recommendation implementation that reflects the broader situation caused by the COVID pandemic and the wider roll-out of Best Start.
23	The national implementation group should perform an overall review of progress after 12 months to determine if recommendations need to be revised or refreshed.

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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