Enabling Safe, Effective Staffing:
An Independent Review of the Birthrate Plus® Methodology

Appendices

birthrateplus

Appendix 1
Thematic analysis of evidence

This appendix sets out the twelve themes that emerged from analysis of evidence gathered through the seven consensus building workgroups, semi-structured interviews, surveys, and wider consultation activity. It reflects what participants consistently told us about the strengths, limitations, and pressures associated with the current Birthrate Plus® methodology. These themes formed the analytical foundation for the findings and recommendations presented in the main body of the report.

1. Increasing administrative and non-clinical workload

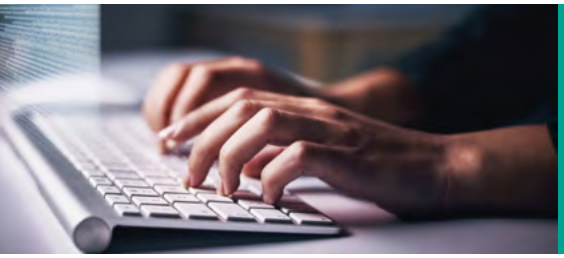
Participants consistently described a significant increase in administrative and non-clinical workload embedded within midwifery practice. This included time spent on digital documentation, electronic patient records, audit activities, incident management, mandatory reporting, policy compliance, and governance processes. Participants also highlighted that the time required to supervise, mentor, assess, and formally sign off students has increased, adding further demands to already pressurised clinical workloads. Many contributors described this work as essential to the delivery of safe care but insufficiently visible within workforce assessments. There was a shared view that administrative work is no longer peripheral to clinical care, and that its impact on workload and capacity is often underestimated.

2. Intrapartum complexity and acuity

Feedback highlighted that intrapartum care has become increasingly complex and resource intensive. Participants described higher levels of maternal co-morbidity, increased intervention rates, increased requirement for oversight of novice midwives and escalation. Many participants felt that existing intrapartum categories do not fully reflect contemporary labour ward acuity or safety requirements, particularly where additional staff are required at key points during labour and birth.

3. Antenatal outpatient, inpatient, and triage

Participants consistently reported growth in antenatal activity outside traditional clinic models, including triage, day assessment, surveillance clinics, interpretation needs, and induction of labour admissions. These pathways were described as becoming increasingly complex, with increased social, mental health and medical issues, needing multi professional and multiagency referral and collaboration. Feedback indicated that this work is not always captured consistently within workforce assessments, leading to concern that antenatal workload may be significantly underestimated in some services.



4. Social complexity, inequality, and personalised care pathways

Social complexity was a strong and recurring theme across all engagement activity. Participants described the increasing time required to support women and families experiencing vulnerability, safeguarding concerns, mental health needs, language barriers, and wider social inequalities. Contributors emphasised that personalised care, continuity, and multidisciplinary coordination significantly increase workload, yet these demands are not always fully reflected within existing workforce models.

5. Newborn care complexity and intermediate pathways

Workshops and workstreams highlighted the expanding role of maternity services in supporting newborn care beyond routine postnatal activity. Participants described increasing involvement in intermediate, enhanced, and transitional newborn care, often for short periods but with high intensity. There was a shared view that this workload is not always clearly visible within workforce assessments, particularly where babies remain under maternity care rather than transferring to neonatal services.

6. Skill mix, delegation, and supervision

Participants discussed the growing use of skill mix, including maternity support workers and other non-midwifery roles, as essential to service delivery. However, feedback highlighted variation in how these roles are used, supervised, and accounted for within workforce planning. Contributors emphasised the importance of clear boundaries around delegation and accountability, noting that non-midwifery roles cannot fully replace registered midwives, particularly in higher-acuity settings.

However, participants provided examples of innovative new roles supporting the wider pathways of care as well as delivering training and contributing to service development.

7. Newly qualified midwives and transitional workforce capacity

Newly qualified midwives were consistently identified as requiring additional support, supervision, and time to consolidate skills. Participants described reduced productivity during preceptorship and the significant contribution of experienced staff to supervision and assessment. There was concern that workforce models do not adequately reflect this transitional capacity, which can impact both safety and retention.

8. Management, leadership, and safety critical functions

Participants emphasised that leadership, management, education, supervision, governance, and quality improvement activities are essential components of safe maternity services. Participants reported variability in how these roles are recognised within workforce calculations, despite their central role in maintaining standards, supporting staff, and responding to incidents and improvement requirements.

9. Specialist midwifery roles

Specialist midwifery roles were widely valued for their contribution to quality, safety, and equity of care. However, participants highlighted significant variation in how specialist roles are defined, particularly in relation to clinical versus non-clinical activity. This variability was seen to create inconsistency in how specialist contributions are captured and understood within workforce assessments.

10. Methodological consistency, technical guidance, and professional judgement

Many participants expressed strong confidence in the underlying principles of the Birthrate Plus® methodology, while also highlighting variation in how it is interpreted and applied. Feedback indicated a lack of clarity around data capture requirements, use of local intelligence, and the role of professional judgement. Participants emphasised the importance of transparency and consistency to maintain confidence in outputs.

11. Reporting, communication, and Board level assurance

Participants described challenges in communicating Birthrate Plus® findings to senior leaders and Boards. While reports were seen as technically robust, contributors felt they were not always accessible or easily interpreted by non-technical audiences. This was perceived as limiting the effectiveness of the methodology as a tool for assurance, decision-making, and investment planning.

12. Digital enablement and future sustainability

Across all engagement activity, participants highlighted limitations associated with manual data collection and reporting processes. There was strong support for digital enablement to improve consistency, reduce burden, enhance transparency, and support integration with wider workforce and safety systems. Digital capability was viewed as essential to the long-term sustainability of the methodology.

Out of scope considerations

Participants also raised a number of issues that were acknowledged but fell outside the scope of the Birthrate Plus® methodology. These included national decisions on headroom or uplift, national guidance on appointment durations and staffing ratios, estates capacity, on-call cover models, and nationally mandated role definitions. These issues are addressed separately as wider system considerations.

Appendix 2

Horizon Scanning for 2025 Birthrate Plus® Review Emma Rose (RM), August 2025

Q1: What is happening now and what are the challenges from a workforce planning perspective?

Many services still only allow for 15-20 minute routine antenatal appointments with midwives, despite ever increasing number of assessments, discussions and referrals required by national guidance, policy and reports. Some of these components of care are discussed in more detail below. In NHS England there also the multiple risk assessments that have come about through Ockenden and the Saving Babies Lives Care Bundle. Women's care requirements have also become increasingly more complex, requiring multiple referrals to the MDT. There has been no quantitative scoping of the time required to deliver all necessary components of routine antenatal care.

Please note, I had limited access to information regarding challenges specific to Northern Ireland and Wales.

a Perinatal mental health (PMH) – early intervention essential and key to preventative approach of 10 Year Plan[1]

One in four women experience mental health issues during pregnancy and up to one year following birth (the perinatal period)[2] .

1 Conditions range from anxiety and depression to severe psychosis and suicide. Incidence is higher in some areas, for example 27.5% in North East England[3] and 31.6% in Wales[4].

All midwives responsible for identification, referral and support during antenatal and postnatal care. This requires additional time in antenatal and postnatal appointments to develop a trusting relationship to facilitate effective screening and to undertake referrals. No national guidance on how long this care requires.

Wales: In addition to universal care requirements[5] and watchful waiting[6] emotional wellbeing visits are part of the Welsh MH policy[7] with an expectation that specialists, including PMH specialist midwives, provide up to six contacts in addition to routine midwifery care.[8] The policy does not state how long these "contacts" should be.

Supervision is an integral part of effective delivery of PMH support[9] and a trauma-informed approach[10] and needs to be factored into job planning so that clinicians can be relieved from clinical duties to attend both clinical and team supervision. Supervision is also recognised for supporting staff retention and reducing burnout. There is no specified number of hours for supervision.

b Trauma informed care – key to preventative approach of 10 Year Plan

NHS England promotes a trauma informed care approach[11] – this requires time for MDT training, longer appointment slots for those women who have experienced trauma, time for staff to have psychological support.

[1] 10 Year Health Plan for England: fit for the future - GOV.UK
[2] Maternal Mental Health Alliance (2024) Maternal mental health statistic. Available at: https://maternalmentalhealthalliance.org/campaign/ [Accessed 21 July 2025].
[3] Office for Health Improvement and Disparities (2025) Estimated prevalence of perinatal mental health conditions in England, 2016 and 2019 - GOV.UK Available at: https://www.gov.uk/government/publications/perinatal-mental-health-condition-prevalence/estimated-prevalence-of-perinatal-mental-health-conditions-in-england-2016-to-2019 [Accessed 22 July 2025].
[4] GIG Cymru / NHS Wales (2024) The women's health plan for Wales. Available at: https://performanceandimprovement.nhs.wales/functions/networks-and-planning/womens-health/the-womens-health-plan-for-wales/ [Accessed 16 July 2025].
[5] performanceandimprovement.nhs.wales/functions/strategic-programme-for-mental-health/perinatal-mental-health/pnmh-docs1/pathway-3-universal-midwives-health-visitors-and-gps/
[6] performanceandimprovement.nhs.wales/functions/strategic-programme-for-mental-health/perinatal-mental-health/pnmh-docs1/pathway-4-watchful-waiting/
[7] Pathways for healthcare professionals - NHS Wales Performance and Improvement
[8] performanceandimprovement.nhs.wales/functions/strategic-programme-for-mental-health/perinatal-mental-health/pnmh-docs1/pathway-5-emotional-wellbeing-visits/
[9] Perinatal mental health - Royal College of Midwives
[10] Best practice recommendations for the integration of trauma-informed approaches in maternal mental health care within the context of perinatal trauma and loss: A systematic review of current guidance - ScienceDirect
[11] NHS England » A good practice guide to support implementation of trauma-informed care in the perinatal period

NHS Wales health policy is supported by a trauma informed framework to address health inequalities.[12]

Current "Birth After Thoughts" or "Postnatal debrief" services are overstretched and under resourced with no nationally agreed standard. The RCM is developing national best practice guidance with stakeholders, due publication by the end of 2025.

Developing personalised care and support plans[13] require a trauma informed care approach.

There is no policy or guidance on how much time is needed within appointments to ensure meaningful trauma-informed approach.

c Safeguarding – early intervention essential and key to preventative approach of 10 Year Plan

Consider time required to holistically and fully assess care needs and to plan for personalised care and support plans as per RCM Maternity Disadvantage tool (MatDAT) RCM launches tool to tackle high levels of maternity disadvantage - Royal College of Midwives This tool has been evaluated and MBRRACE-UK and policy-makers have highlighted its value, however, not yet in national policy recommendations. There is no quantitative assessment of how much time is required to fully utilise the MatDAT.

Complexity of women's social and medical needs have increased as evidenced by recent MBRRACE-UK reports [14], including that 1 in 4 births were to women born outside the UK[15]. Being of a migrant population increases multiple needs relating to access to care and for example potential for previous trauma, experiences of racism, and language needs. This places significant increased need for time and resource during perinatal care, particularly at antenatal and postnatal outpatient appointments.

Birth companions have highlighted research demonstrating the impact of children's social care involvement when care is disjointed and women lack continuity of care: BC_Spotlight_MBRRACE_CSC_FINAL.pdf Birth companions are working to develop national policy for a framework of care for the first 1001 days for women with social care involvement.

d Infant feeding – a key role of midwifery public health role and essential to preventative approach of 10 Year Plan as impacts future generation health

Time for infant feeding support needs to be reviewed during immediate postnatal 1:1 care. Consideration needs to be made regarding the competing demands of immediate PN care: complexity of care needs with a higher risk population; document requirements ever increasing; pressure to maintain patient flow and prevent bed blocking; and for those women who have a preterm birth or whose baby is admitted to the NICU, the need to initiate hand expression within 2 hours of birth.[16] This BFI requirement is a standard required for BFI accreditation for hospitals.

Must also consider protected time for skin-to-skin contact (BFI and NICE standards of care[17]). UNICEF advocate for at least 60-90 minutes of skin to skin contact.

[12] Trauma-Informed-Wales-Framework.pdf
[13] NHS England » Personalised care and support planning
[14] Saving Lives, Improving Mothers' Care 2025 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23 | MBRRACE-UK | NPEU
[15] Perinatal Confidential Enquiry: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death | MBRRACE-UK | NPEU
[16] Expressing milk for your baby on the neonatal unit - Baby Friendly Initiative
[17] Quality statement 7: Skin-to-skin contact | Intrapartum care | Quality standards | NIC

e A second midwife or maternity care assistant during 2nd and 3rd stages of labour: "Birth buddies"

This isn't in national policy or clinical guidance, but a common safety practice within services is to have a 2nd attendant at birth to support this complex stage and prevent deterioration of the mother and infant. During the 2nd and 3rd stage of labour midwives have multiple, complex tasks and have to maintain constant situational awareness during the most high-risk time of perinatal care. Additionally, they go from having a single patient to two patients to support during this time.

It is recognised best practice that a second midwife or skilled maternity support worker or care assistant is available during the 2nd and 3rd stages of labour and the immediate PN period. They play a key role in perineal care[18] [19], PPH prevention and management, recognition and escalation of concerns, as well as supporting safe skin to skin contact, infant feeding, drawing up of medications, psychological support and supporting with timely documentation.

A second midwife at home births is also widely supported by Trust policies from a lone worker perspective, for the above reasons and to ensure emergency care can be effectively provided. Home birth staffing needs to account for 2nd midwife presence or experienced MSW[20] .

Capacity for units to provide this support during the end stage of birth and immediate postnatal period requires review.

f Vaccinations

Increase in number of vaccinations offered that require discussion and administration in the AN period. Evidence shows discussion and administration by midwives is more effective for uptake. Currently variation in administration – undertaken at midwife-led clinics and by GP practice nurses.

Flu (seasonal) – offered as early as possible

RSV – new in 2025 – offered at 28 weeks

Whooping cough – offered 16-32 weeks, usually at 20 weeks (common to have clinics attached to 20 weeks scan appt timing)

Possible future GBS vaccine: Pfizer Announces New England Journal of Medicine Publication on Group B Streptococcus (GBS) Maternal Vaccine Candidate | Pfizer

g GBS screening

Currently services follow NICE guidance nationally for risk-based screening.[21]

Awaiting results of GBS3 Trial looking at universal screening in UK: Home UKNSC will then consider options for universal screening. Unlikely to change practice immediately but current risk-based screening approach isn't factored into antenatal appointment time for collection of swabs at 35-37 weeks.

[18] The effect of two midwives during the second stage of labour to reduce severe perineal trauma (Oneplus): a multicentre, randomised controlled trial in Sweden - The Lancet
[19] Women's experiences of being assisted by two midwives during the active second stage of labour: Secondary outcomes from the Oneplus trial - ScienceDirect
[20] Task shifting Midwifery Support Workers as the second health worker at a home birth in the UK: A qualitative study - ScienceDirect
[21] Recommendations | Neonatal infection: antibiotics for prevention and treatment | Guidance | NICE

h Saving Babies Lives Care Bundle (v3.2) in England[22] continue to place increased demands on antenatal appointment time and resource as services must show compliance against the tool in order to meet safety action 6 of the maternity incentive scheme (MIS). Most notably impacted:
Fetal growth restriction – increased demands on ultrasound departments for additional US for those not suitable for routine SFH monitoring.

RFM - Recurrent reduced fetal movement pathways (also RCOG23) place increased pressure on maternal day assessment units and ultrasound departments.

Fetal monitoring – antenatal discussions regarding option for fetal monitoring (also supported by NICE24).

Commitment to preterm birth prevention clinics require specialist midwifery input.

Type 1 and 2 diabetes – standardised requirement for one stop service and specialist midwifery input.

i Induction of labour (IOL)
Nationally induction rates have increased: England, Scotland and Wales were similar (33.7%, 36.1% and 33.6% respectively) and there was wide variation between maternity care providers (as high as 39%). The first NMPA annual report IOL rate was 28.5% (2015/16)[25]. This places significant increased pressure on antenatal and intrapartum care, and given associated risks also results in longer postnatal admissions.

Some services have created a midwife induction of labour coordinator role to ensure induction of labour flow is safe and effective, to ensure inductions are appropriate and to provide patient information via workshops.

Two key changes in clinical guidance by NICE[26] for indications to offer IOL have led to an increased rate – reducing post-dates offer to 41 weeks and the offer of induction for women with reduced fetal movements as a single reason from 39+6 weeks onwards. 32% of women would usually spontaneously labour between 40+0 and 40+6, and 16% between 41+0 and 41+6 weeks, but a significant proportion of these women are now offered IOL and this is evident in the reducing numbers of births occurring in midwife-led settings.

Furthermore, NICE recommend commencement of oxytocin immediately after rupturing of membranes during the IOL process meaning 1:1 care is required earlier.

NICE IOL guidance now also recommends that membrane sweeps are offered from 39 weeks to all women – this doesn't fit with the standard antenatal care pathway (38 and 40 weeks for primips / 38 and 41 weeks multips) and there is no guidance on frequency of membrane sweeping. Therefore many services are now offering additional appointments to accommodate this. Previously membrane sweeps were offered at 40 weeks (primips) and 41 weeks (multips).

[22] NHS England » Saving babies' lives: version 3
[23] Reduced Fetal Movements (Green-top Guideline No. 57) | RCOG
[24] Overview | Fetal monitoring in labour | Guidance | NICE
[25] NMPA State of the Nation reports: Clinical Audit Publications
[26] Overview | Inducing labour | Guidance | NICE

j **Number of unplanned maternal readmissions need to be accounted for in staff planning:** In 2018-19 the postnatal readmission rate (within 42 days of birth) was higher following a caesarean birth compared with a vaginal birth in both England (4.3% vs 2.9%) and Wales (4.7% vs 3.3%)[27]. In 2024 the overall rate was 3.08% across England and Wales, with the rate higher in Wales (4.14%) than England (3.05%), and rates varied by provider (IQR: 2.57–5.02% in Wales; 2.14–3.59% in England).[28]

- Antenatal education – provision in a setting that meets women's needs[29]. Workforce planning needs to include the time required for planning and practical set-up, not just the hours with service user contact.

- National preceptorship programmes – workforce planning needs to account for supernumery time, protected training/reflection hours, and the roles of those delivering the preceptor programme. [30] [31] [32]

Q2: What recent and upcoming policies and guidance exist which may impact midwifery care provision?

Scoping revealed limited information regarding policy or guidance changes within all three nations (Scotland not scoped).

- **NHS Wales Strategic Perinatal Workforce Plan (2025-2028)[33] – horizon scanning within this report highlights the complexity of perinatal care and challenges with workforce planning.**

- **NHS England's 10 year plan[34]** Shift to community-based care and "neighbourhood health services" is well suited to the midwifery model of care. Will this present new opportunities for midwifery continuity of care? This remains a part of CORE20PLUS5 and the key evidence-based recommendation for reducing health inequalities but has not been fully realised since Ockenden's recommendations re staffing and continuity. A future workforce would have continuity built into minimum staffing numbers but needs to consider how this operates in tertiary services where a larger core of hospital-based staff may still be needed.

- Includes move to a genomics healthcare service which will start universal genomic sequencing at birth. The scope of the midwife role in this is currently unclear and potentially complex requiring specialist knowledge and training, even for basic consent-seeking. Does the future include genomics family counsellors or will there be specialist midwives working in this field?

- Includes advance practice (AP) role development – supported by NMC[35]. These need to be factored into future midwifery workforce as standard and with appropriate B8 banding as currently they are rare across maternity services and often working at B7 level. Opportunities for midwife APs across triage, postnatal wards, mental health, and maternal medicine.

[27] Ref 336 NMPA Clinical Report_2022.pdf
[28] Ref 545 SON 2023 data_VF.pdf
[29] Overview | Antenatal care | Guidance | NICE
[30] NHS England » National preceptorship framework for midwifery
[31] hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/preceptorship-policy-for-newly-qualified-nurses-and-midwives/
[32] Preceptorship Framework NI | NIPEC
[33] heiw.nhs.wales/files/strategic-perinatal-workforce-plan1/
[34] 10 Year Health Plan for England: fit for the future - GOV.UK
[35] Principles for advanced practice - The Nursing and Midwifery Council

Midwives are key to providing public health interventions which are key to the government's 10 year plan for moving to preventative health care – ranges from lifestyle and smoking cessation support, to pelvic health and perinatal mental health early intervention, to reproductive health, including contraceptive advice and provision of LARC. Fundamental to future generation health is the provision of infant feeding support which at present is under-resourced within basic postnatal care in the hospital and community. Provision of specialist support varies greatly across the country, including access to specialist feeding drop-ins and tongue tie clinics.

- **NHS England's maternal care bundle** is anticipated at the end 2025. Proposed to include elements on VTE prevention, postpartum haemorrhage prevention and management, maternal mental health, and management of neurological conditions. Not yet known what additional resource will be needed for this.

- **Patient engagement – new NHSE policy (2025)[36]** – co-design and do-production in maternity take time and people resource. This needs to be built in job plans for ward managers, matrons and specialists so that they can effectively improve their services with women and families genuinely at the heart. This is also important for those team members who are responsible for investigating and responding to incidents and complaints to ensure women and families are heard. People and time resource for PMRT[37] (including representation at across organisations as external providers) and PSIRF[38] need to be factored into job plans and reflect the local service demands. Again, time needs to be factored in for trauma informed approaches to this engagement.

- Midwife-led IV iron clinics are increasingly being run within maternal medicine clinics and align with NHSBT's draft strategy (not yet published) which includes a focus on prevention within maternity and recommendations for use wider use of preventative techniques such as use of IV iron to treat anaemia in pregnancy thereby reducing impact of anaemia at birth.

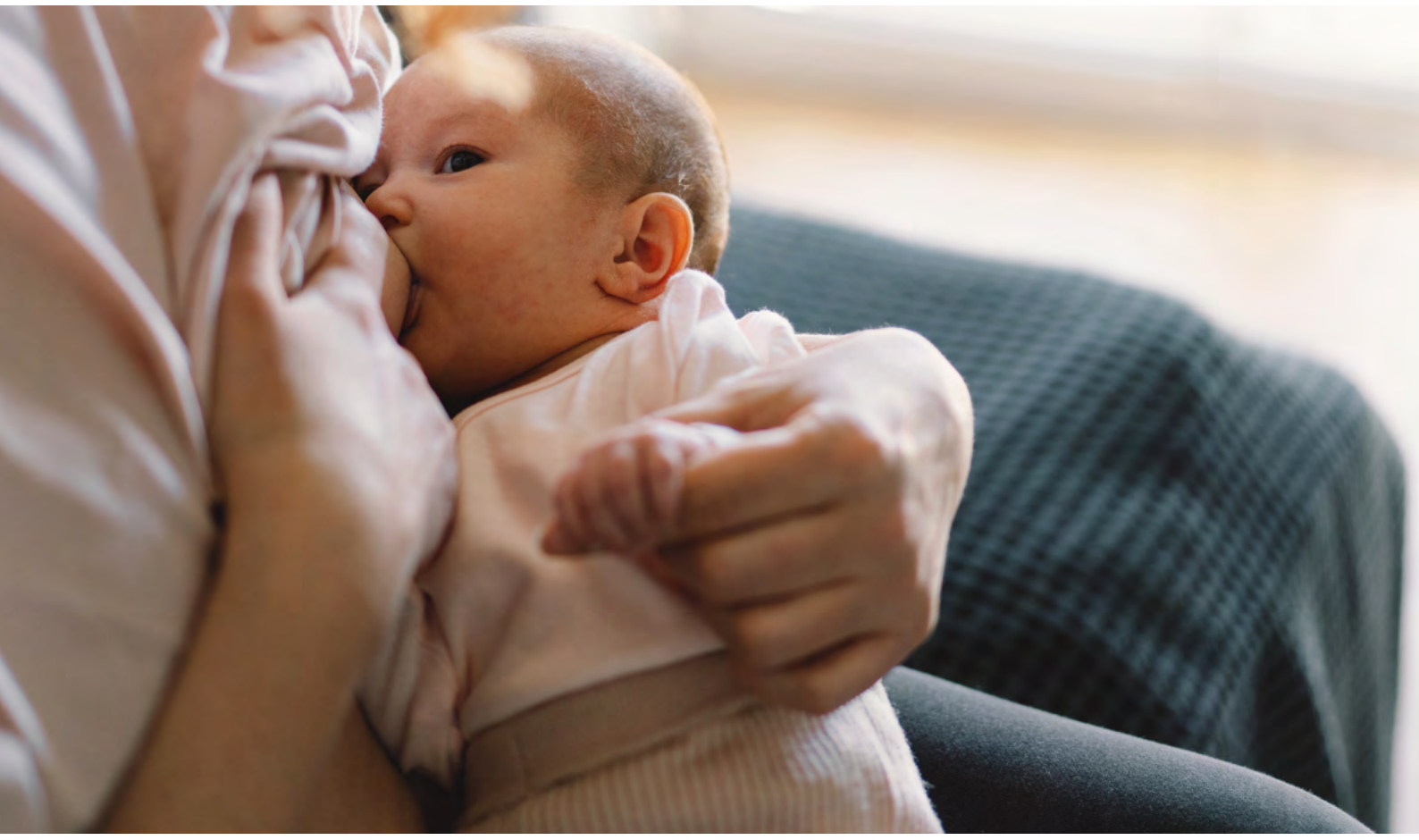
- **Martha's Rule[39]** within maternity – due to be launched in maternity care too. Potential to save time as incidents and complaints may reduce due to hearing patient/family concerns and thereby preventing harm and worse outcomes.

- No concrete policy changes yet following Renfrew report. Minister announces development of Nursing & Midwifery Career Framework | Department of Health. (Northern Ireland)

[36] NHS England » Policy on working in partnership with people and communities
[37] The PMRT Tool | PMRT | NPEU
[38] NHS England » Patient Safety Incident Response Framework
[39] NHS England » Martha's Rule

What we still don't know

- What midwifery time is needed to ensure informed consent is supported?
- How many women are birthing outside guidance – significant additional resource often needed to support this group of women but monitoring of numbers is unreliable and not collected nationally.
- How long should appointments be when using interpreters? Conversations are 3-way so therefore usually it is recommended to have double-length appointments but this isn't factored into clinic capacity or midwife numbers. Issue is also that data on language needs is poor. It is known that use of and quality of interpreters is sub-optimal.[40]
- Scope of virtual wards within maternity and whether this will reduce pressures on maternity care: NHS England » Virtual wards. Examples of maternity hypertension virtual wards (CUH NHS FT) and hyperemesis maternity wards (Norfolk & Norwich). The hyperemesis virtual ward evaluated positively by service users – potential to reduce complaints, incidents and clinician time.



[40] Perinatal Confidential Enquiry: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death | MBRRACE-UK | NPEU

Appendix 3
Workforce tools comparison grid

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Primary purpose	Determines nursing staffing establishments in adult acute inpatient wards. Focus on medical and surgical wards. (Separate SNCTs are in place for acute children's wards, Acute Adult Assessment Units, Emergency departments and Mental Health)	Determines midwifery staffing requirements across all maternity inpatient and community areas (antenatal, intrapartum, postnatal). Additionally calculates establishment for specialist midwives and senior midwifery management. "The tool can also be used in conjunction with 'real time' ward and intrapartum Apps that gather data over four hour periods". Both Apps are used in over 80% of maternity services	Determines midwifery staffing levels across maternity inpatient and community areas in Scotland, as part of the Common Staffing Method (statutory).
Scope/ clinical setting	Adult acute wards only. Excludes maternity, paediatrics, MH (see above).	All maternity care settings. Includes specialist midwifery and senior management roles.	All maternity care settings.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Policy status	NICE - endorsed; widely used in England; not statutory.	NICE endorsed. Not statutory but referenced in Department of Health and Social Care guidance. Widely used across England, Wales, Northern Ireland. Additionally used in Republic of Ireland and Australia. The tool was assessed as part of a PhD study in terms of its validity and applicability to the Netherlands, leading to a current project to consider wider implementation – the outcomes of which were published in the British Journal of Midwifery (https://www.britishjournalofmidwifery.com/content/research/measure-to-improve-a-pilot-study-of-birthrate-plus-in-the-netherlands)	Mandated by the Health and Care (Staffing) (Scotland) Act 2019). Statutory reporting required.
Underlying methodology	Uses acuity/dependency scoring. Each level corresponds to a defined number of nursing minutes per patient per day	Uses five labour and birth categories, antenatal, postnatal and newborn care categories. Each category has a time multiplier added to the midwifery workload task, identifying staffing requirement. Categories aggregates complexity (need from the perspective of the woman and baby) into staffing requirement.	Uses activity-based time measurement across the care pathway. Observes time spent on a wide range of midwifery tasks. Aggregates complexity and demand into staffing requirements.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Care delivery assumptions	Assumes average workload per acuity level; uplift added separately.	Based on the 1:1 midwife–woman care in active labour, coordinating midwife role, indirect care time. Postnatal mother and baby care requirements based on labour category (need). Takes account of the multiple needs of women and babies and the factors impacting on staff time.	Assumes midwifery workload is multi-faceted and non-linear; designed to reflect true activity rather than episode-of-care categories.
Data collection requirements	≥20 days of data twice yearly; trained scorers required; can be electronic or paper.	Collects annual activity plus case mix data usually collected over 3 months; requires midwives trained in correct Birthrate® Plus categorisation; area-based workload capture. Data validation is undertaken between service and Birthrate Plus®.	Annual (minimum) data collection; uses standardised national templates; may require observation studies to measure activity/time.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Skill and training requirements	Ward nursing teams trained to classify patients consistently; calibration recommended.	Midwives trained in Birthrate® Plus categorisation; local maternity leadership oversight required for workforce studies. Specific workforce training available via NHSE CNO Safe Staffing Fellows programme in England. Written guidance also available along with the direct support of Birthrate ® Plus staff.	Staff trained via Healthcare Staffing Programme; structured national training with consistent definitions and templates.
Outputs	Required nursing WTE per ward; skill mix guidance; indicators of safe staffing.	Required midwife to birth ratio; Identifies recommended WTE for inpatient, outpatient and community care. Can model service redesign or birth-rate changes. Supports NHS Resolution Maternity Incentive Scheme (Safety Action 5) requirements.	Required midwifery WTE integrated into the Common Staffing Method; supports statutory assurance and reporting.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Granularity of output	Ward-level.	Area-level (labour/ postnatal/antenatal/ community) and organisationwide as includes skill mix, special-ist midwives and senior midwifery management establishment. Can be utilised across systems comprising separate services.	Area-level with detailed breakdown of actity-based workload.
Triangulation expectations	Strongly recommended with professional judgement + outcomes data.	Strongly recommended with safety incidents, escalation levels, acuity trends. Uses professional judgement via head of service.	Mandatory triangulation with professional judgement + quality indicators under statute.
Validity – content	Strong: widely accepted acuity framework; professionally developed.	Strong: foundation in observational activity research and activity analysis; categories reflect clinical complexity. Periodic reviews with expert groups.	Strong: designed with Scottish mid-wifery input; reflects modern maternity activity patterns.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Validity – outcome evidence	There is a recognised lack of research studies investigating optimum and safe workforce planning in healthcare and assessments of tools This is a challenge for all tools and effective workforce planning more generally. A 2020 review of the SNCT based on four units identified inconsistent results because the tool does not take account of local factors such as layout and specialities. The study noted that "estimated establishments may always be imprecisely estimated" (Griffiths et al, 2020: 10).	There is a recognised lack of research studies investigating optimum and safe workforce planning in healthcare and assessments of tools This is a challenge for all tools and effective workforce planning more generally. Whilst a literature review of published studies considering the efficacy of BR found few reliable studies had, in fact, been published, it noted that the "absence of evidence is not evidence that the tool does not work" (Griffiths et al, 2024: 323). The same study did report evidence that midwives understood the methodology and a ppropriately recorded data and that the categories reflected the increased needs of women which "leads some support to the validity of the tool" (Griffiths et al., 2024:323)	There is a recognised lack of research studies investigating optimum and safe workforce planning in healthcare and assessments of tools This is a challenge for all tools and effective workforce planning more generally. There was no published evidence on the efficacy of the tool at the time of this review

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Strengths	Simple; rapid scoring; reasonable evidence base; widely understood; useful for trend monitoring.	Established maternity tool; explicit 1:1 labour care modelling; covers all maternity areas and reflects wide range of midwifery activity across the whole pathway. Independent validation of data. Used by all maternity services in England, Wales and Northern Ireland, as well as internationally.	Statutory tool; highly structured QA; reflects wide range of midwifery activity; aligned to national staffing legislation.
Limitations	Not suitable for highly variable pathways like community nursing and maternity; may miss peak demand; scoring accuracy varies.	Limited independent research evidence; may under-represent postnatal and community workload.	No external studies; more resource-intensive to implement; method still being refined.
Governance & QA	Overseen by Shelford Group; local calibration and audits essential; triangulation recommended but optional.	Overseen by Birthrate Plus®; requires local QA audits; triangulation strongly recommended; often scrutinised in maternity governance.	Overseen by Healthcare Staffing Programme (HIS); mandatory QA cycle, mandatory triangulation, statutory annual reporting to Boards and Government.

Dimension	Safer Nursing Care Tool (SNCT) for acute adult wards	Birthrate Plus® (BR plus)	Scottish Maternity Staffing Level Tool (MSLT)
Uplift	Uplift applied separately (leave, training, sickness etc.).	Some uplift embedded (indirect activities, coordination), others applied locally to reflecting local context.	Uplift applied through national Common Staffing Method rather than within tool alone.
Sensitivity to variation	**Moderate** – may not fully capture high turnover or pressure spikes.	**High** – workload shifts with category mix; intrapartum calculations sensitive to complexity.	**High** – activity-time basis better captures multitasking, peaks, and unpredictable demand.
Overall applicability	Best for stable acute wards with predictable patterns.	Best for maternity services requiring detailed modelling of intrapartum, antenatal & postnatal midwifery care needs.	Best for Scottish maternity services needing statutory assurance and modern, activity-based modelling.

Appendix 4
Feedback from semi-structured interviews

1. Interviewee Roles

Feedback was gathered from a range of senior stakeholders across maternity services, including:

- Chief Midwifery Officers
- Chief Executive Officers (CEOs)
- Digital midwives
- Directors of Midwifery (DoMs)
- Directors of Nursing
- Shelford Group
- Heads of Midwifery (HoMs)
- Frontline midwives
- Country Workforce Leads
- Educationalists
- Digital Lead Midwives
- NHSE Maternity Improvement Leads

2. Strengths and benefits of Birthrate Plus®

General support

- Overwhelming support for retaining Birthrate Plus® with improvements.
- Only a very small minority feels the tool is no longer useful or fit for purpose.

Purpose and recognition

- Recognised as the primary workforce planning tool for midwifery.
- Endorsed by NICE and included in Maternity Incentive Scheme in England.
- Used country wide as government directive in Wales
- Midwifery-specific and responsive to local context/demographics.

Acuity and app value

- Most commonly used acuity tool in maternity care.
- Useful for short, medium, and long-term planning.
- Captures key acuity triggers.
- Categories for labour and early postnatal care are well designed.
- App used alongside workforce assessment provides persuasive evidence for Boards

3. Challenges and limitations identified

Credibility, transparency and communication

- Tool lacks credibility among some senior maternity and executive leadership groups.
- Staffing requirements change when DoMs intervene, undermining trust.
- Feels like a “black box” – users can’t see how results are calculated.
- Methodology and calculations not clearly explained; hard to communicate to Boards.
- Executives struggle to understand how outputs are derived.

Interoperability and language alignment

- Tool terminology does not align with Trust/ Health Board safety language.
- Not linked to other key tools (e.g., SafeCare acuity tool).
- Acuity app and workforce planning tool needs better integration.
- Terminology should shift from "births to midwife ratio" to WTE (Whole Time Equivalent) to match Board-level metrics and daily "bed state and safety meetings".

Methodology and Calculations

- Community acuity not clearly calculated or reflected.
- Current tool doesn't account for policy shifts (e.g., longer booking times, increased mandated specialist roles).
- Fails to consider new demands like increasing social and medical complexity, safeguarding, translation time, BSOTs and triage.
- Specialist midwives and Band 7 managers should not be included in clinical staffing calculations.
- Management requirements should not be calculated as a percentage of clinical staffing numbers.
- Doesn't incorporate emerging models like LDRP rooms and "New Hospital" builds.

Community, Postnatal and Complexity Gaps

- Poorly determines and represents community workload. Lacking sensitivity to increased time dealing with safeguarding and perinatal mental health demands.
- Postnatal complexity and antenatal ward demands are underrepresented.
- Doesn't fully reflect workload increases from women choosing care outside guidance.
- Limited ability to account for debriefing, PMA/ supervision, complaints, and enhanced postnatal care.

4. Suggested improvements to the Birthrate Plus® tool

Structure and scope of workforce modelling

- Introduce a national, standardised uplift model, including additional mandated training time for maternity.
- Separate staffing into clear categories:
  1. Direct hospital clinical care (antenatal, intrapartum, postnatal)
  2. Community care (including safeguarding, social complexity)
  3. Mandated specialist roles
  4. Management requirements (coordinators, Band 7, etc.)

Model adjustments

- Allow for more nuanced skill mix: distinguish newly qualified vs. experienced midwives.
- Address the difference between Band 3 roles in skillmix and Band 2 support roles.
- Explicitly remove Band 7 managers and specialist midwives from clinical numbers.

Terminology and reporting

- Move away from "birth to midwife" ratios – considered misleading.
- Shift to WTE-based metrics for better Board engagement.
- Improve tool transparency – share evidence and formula openly.

Pathway and complexity inclusion

- Recognise pregnancy as a continuum of care, with different care level pathway considerations. Incorporate:
    1. Clinics, travel, visits
    2. Social/mental health complexity
    3. Triage, maternity assessment units
    4. Theatre/recovery/HDU staffing
    5. Debriefing, PMA/supervision, complaint resolution roles
- Provide interim self-service functionality between full assessments.

5. Summary

The Birthrate Plus® tool remains a valued and widely recognised asset in midwifery workforce planning. However, in its current state, it does not fully reflect the complexities, evolving care demands, and structural realities of modern maternity services. Stakeholders advocate for a refreshed, transparent, and modular version that aligns with operational language, clinical models, and policy direction.

Appendix 5
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Notes

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