birthrateplus® | Enabling Safe, Effective Staffing

Birthrate Plus® supports safe and effective maternity care

Workforce Planning and Decision Making

To ensure the maternity service provide safe, effective and responsive care to women, service leaders need to understand the clinical needs of women receiving care - and this is where Birthrate Plus can help.

Workforce planning

Birthrate Plus® workforce planning and real time staffing acuity tools use validated methodology to support the delivery of safer maternity care.

Birthrate Plus® is a midwifery-specifict tool that gives the intelligence and insights needed to be able to model midwifery numbers, balanced workforce including newly qualified midwives & support staff and deployment and to inform decision making about safe and sustainable services. Birthrate Plus® is based on staffing and clinical data that has been collected over many years.

Endorsed by the UK National Institute for Health and Care Excellence (NICE) and aligned with international maternity care standards (WHO 2018, 2020)

A consistant methodology since 1988

Birthrate Plus® is a workforce planning and decision-making system for assessing the needs of women for midwifery care throughout pregnancy, labour, and the postnatal period both in hospital and community settings.

The methodology has been in constant use in the UK since 1988. It calculates the required number of midwives to meet all the needs of women and babies in relation to defined standards and models of care, whilst incorporating local workforce planning factors. Not every woman requires the same level of care nor the same amount of midwifery time during her pregnancy, labour and postnatal period. Using Birthrate Plus® supports service leaders to match their staffing requirement to the clinical needs of women.

How it works

To undertake a Birthrate Plus® assessment several specific datasets are collected, and the appropriate method applied to each. The main task is to provide the number of births within the service and place of birth eg midwife-led birth settings (hospital-based or community-based). The percentage of adjustments for staffing requirements to take account of planned and unplanned staff absence, is built into the funded establishment.

The Intrapartum classification system

The methodology is centred upon the Birthrate Plus® Intrapartum Classification System.

The score system is based upon clinical indicators of need during labour, birth and post-delivery. Each indicator is given a score and the total score is used to place the mother and infant(s) into one of five distinct categories. The birth outcome category also predicts the postnatal care needs for mother and infant.

The standard of care derived from the Short Report of 1980 (and confirmed by recent National Institute for Health and Care Excellence publications) is that a minimum of one to one care from a midwife throughout labour for all women. International evidence indicates workforce requirements increase with clinical complexity and intervention. Birthrate Plus® provides increased ratios of midwife care for those in the higher need categories where more than one midwife is needed at some stage in the labour process.

A further classification is used for other women who require care in the delivery area but do not give birth at that time.

Other areas are also included such as midwife-led birth settings (hospital-based or community-based).

Intrapartum Services

The complexity and clinical needs profile of women receiving care is collected from three months of births within the obstetric delivery suite. Each woman is assessed, and a Birthrate-Category assigned.

Validation of a sample of data is completed to ensure correct scoring and classification. Using this data, the overall casemix for the unit is ascertained. Births in the midwife-led birth settings (hospital-based or community-based) are scored and added to the delivery suite data to provide a complexity and clinical needs profile of women receiving care for community services.

Annual data is gathered on the number of antenatal cases requiring care in the delivery suite, planned birth interventions such as labour induction, postnatal readmissions, escorted transfers out and non-viable pregnancies.

If there is a dedicated Triage, this is included and if the activity is seen on the delivery suite instead, the annual number is required.

Maternity Wards

Antenatal activity: This includes the number of antenatal admissions, if any ward attenders and if planned birth interventions such as labour induction are carried out on the ward.

Postnatal activity: Annual number of postnatal women generally from delivery suite and some from the Alongside midwifery units, ward attenders, readmissions, newborn and infant physical examination completed by midwives, tongue ties seen by midwives, babies requiring extended care over seventy two hours (within the maternity ward area, not neonatal intensive care unit).

Outpatient Services

This includes day unit, maternity assessment unit and usually covers planned activity. A typical weekly profile of hospital based clinics is completed and records details of sessions rather than number of women attending with professional judgement on the appropriate staffing by midwives and support staff.

Community Services activity

The number of women having antenatal (AN) and/or postnatal (PN) care will include women who have their community antenatal and postnatal care within the service, but who have birthed elsewhere (imports) and those who birth within the service but have antenatal and postnatal care in another area (exports).

The methodology considers women who are booked in community with adjustments being made if bookings are carried out in hospital clinics. Also, all services have an attrition rate of women who will see a midwife in early pregnancy but either have a pregnancy loss or who move out of area. Furthermore account will be taken of the proportion of women with a significant safeguarding need and additional time added accordingly.

Annual home births are also considered and whether midwives go out to born before arrival (BBA) or the women are transferred into hospital. In addition, the time spent travelling within the community is also included and this will show variations between different units due to local geography as well as models of care.

The approach we use ensures all activity that impacts staffing is captured.

Specialist Midwifery Roles

Each maternity unit will have a requirement for specialist and managerial roles in addition to the clinical roles required. Birthrate Plus® takes this into account and suggests an appropriate number of such non-clinical roles to ensure the safe operational delivery of the service.

I'm being asked why we still need the same number of midwives even though our birth rate has dropped®

How do I explain this?

In order to provide an accurate determination of the number of midwifery staff required to provide a safe and effective maternity service, there are a number of factors to consider.

Women who access maternity services have a wide range of medical, physical, social and psychological needs. Some will require significant midwifery input to ensure care is given in line with the latest evidence-based recommendations. These needs are noted during all stages of the pregnancy journey.

International evidence indicates workforce requirements increase with clinical complexity and intervention, as first described in the Short report (1980), supported by National Institute for Health and Care Excellence (2015) and further recommended in the Ockenden report (2022). However, some women require the input of more than one midwife during labour, due to complexity or intervention such as fresh eyes review of Fetal monitoring, checking of medication, second midwife during a complex or multiple birth, all of which need to be accounted for in the establishment setting.

Changes to national guidance and policy have resulted in an increasing number of women having intervention or additional care and monitoring during pregnancy, labour and following the birth of their baby. There has also been an increase in the number of babies requiring observation during the early postnatal period, all of which increases the midwifery time required to provide care.