The Royal College of Midwives

Statement

Staffing Standard in Midwifery Services

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This statement has been produced to assist maternity service providers and commissioners when they are reviewing their midwifery staffing levels.

The need for this statement arises from the fact that midwifery staffing numbers are variable throughout the UK. Yet we have clear evidence that an adequate ratio of midwives to births impacts on both the safety and quality of maternity services and mothers satisfaction (HCC 2008, Hartem et al 2008, Gardosi et al 2007, Ball 2006, McCourt 1996).

The Royal College of Midwives supports a minimum ratio of 1 midwife per 28 births per year. This is based on the requirements placed on midwives in the documents referenced in Appendix 1. Falling outside this ratio is a strong indication that a service should undertake a thorough workforce review. This ratio may need to be improved upon in particular circumstances (see Appendix 2).

Midwives working in caseload practices, giving total care and attending the majority of their births should have a caseload of 1:35 women.

Midwives should be supported in practice by appropriately qualified support workers and administrative staff.

Future guidance on this paper will be issued,

Endorsed by the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health

References

Health Care Commission (HCC) (2008) *Towards better Births*. London: Health Care Commission.

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Gardosi J, Clausson B, Francis A (2007) The use of customised versus population-based birthweight standards in predicting perinatal mortality. *BJOG* **114**(10): 1301-2.

Ball JA. *Factors which have impact upon recruitment and retention of midwives identified in Birthrate plus data from 54 maternity units in England in 2003/2004*. Nottingham: Birthrate Plus Consultancy Ltd

McCourt C, Page L (1996) *Report of the evaluation of one-to–one midwifery*. London: Thames Valley University.

Appendix 1

In order of published date:

Darzi, A (2008) *High quality care for all: NHS Next Stage Review Final Report.* Norwich: The Stationery Office

National Institute for Clinical Excellence (NICE) (2008) *Antenatal Care: Routine care for healthy pregnant woman.* London: NICE

RCOG, RCM, RCOA, RCPCH (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in labour.* London: RCOG Press

Department of Health (2007) *Maternity matters: choice, access and continuity of care in a safe service.* London: Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

Department of Health (2007) *Health Inequalities Unit, Review of the Health Inequalities Infant Mortality PSA Target.* London: TSO

National Health Service Litigation Authority (NHSLA) (2007) *CNST Maternity Clinical Risk Management Standards (revised set of standards piloted 2008/09)* http://www.nhsla.com/NR/rdonlyres/A2A885C8-562E-474E-893D-1D942ED7802A/0/CNSTMaternityStandardsPilotJune2008.doc Accessed on 19th December 2008.

NICE (2007) *Intrapartum care: care of healthy women and their babies during childbirth.* London: NICE

Shribman, S (2007) *Making it better: for mother and baby: clinical case for change.* London: Department of Health

Department of Health (2006) *Our health, our care, our say: a new direction for community services.* London: TSO

NCT, RCM, RCOG (2006). *Modernising Maternity Care: A Commissioning Toolkit for England, 2nd ed.* http://www.rcog.org.uk/resources/public/pdf/mmc_toolkit_06.pdf Accessed on 19th December 2008

NICE (2006) *Routine postnatal care of women and their babies: quick reference guide.* London: NICE

COI Communications (2005) *Access to maternity services: research report.* London: Department of Health

Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services: Maternity services.* London: Department of Health

Appendix 2

- Where a service is experiencing higher than average levels of sickness absence or maternity leave.

- Where particular education and training is needed to enable service development e.g. midwives observing a different service model prior to its local introduction.

- Where a service is substantial 'gainer' of births (does not undertake antenatal and postnatal care for women who give birth in the unit). Cross boundary flows may be due to clinical needs, but are more often due to social and geographical factors.

- Where a service caters for a population with extraordinary social or medical needs, such as very deprived areas with high ethnic minority populations.

- Where community midwives cover very rural areas and have high mileages. Nationally mileage averages at 17.5 % of each wte community midwives' time.

- Where models of care are significantly different to NICE guidance.