Lothian NHS Board

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Date 22/06/2026
Your Ref
Our Ref 11364

Enquiries to Richard Mutch
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Dear

FREEDOM OF INFORMATION – MIDWIFERY SAFE STAFFING

I write in response to your request for information in relation to Midwifery Safe Staffing.

Question:
I am writing to request information under the Freedom of Information (Scotland) Act 2002 relating to Midwifery Safe Staffing and workforce planning for the financial year years 2024/2025 and 2025/ 2026 (up to 31st March 2026)
Specifically, all documentary evidence of application of all aspects of the common staffing methodology as per DL (2024) 05 Health and Care (Staffing) (Scotland) Act 2019 – The Common Staffing Method and Staffing Level Tool Which states that:
'The application of the CSM will support NHS Boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care'
In addition, that account has been taken in workforce planning that the current maternity tool does not cover the full extent of modern maternity services and that '***The use of the Professional Judgement Tool, alongside other elements of the CSM,*** *will enable a more accurate picture of staffing requirements and help mitigate against some of the risks and limitations of the existing Staffing Level Tool.*
For each financial year:

1. Did you run the maternity tool (in line with H&CSA 2019)
2. Did you document all parts of the common staffing methodology?
3. Please share the CSM outcomes that were shared at board level for consideration for midwifery staffing and any associated workforce plan
4. Please share any amendments that were requested to midwifery funded establishment arising from the output from the tool, professional judgement and all other aspects of CSM. (existing establishment and requested)
5. Any amendments that were made to midwifery funded establishment arising from question 4.
6. Please share broken down by registered & unregistered, care setting and skill mix and specialist and leadership roles.
7. Community, acute or integrated broken down by care setting
8. Specific specialist and education roles asked for and WTE approved

9. Specific leadership roles asked for and WTE approved
10. Number of Newly qualified midwives asked for and WTE (and number) approved
11. Pre and post CSM establishments broken down by filled unfilled
12. Share Documents that describes what was asked for and what was approved for recruitment.
13. Share roles not asked for but that you believe is required.

Answer:

FOI Request	2024/25	2025/26	Papers
1. Did you run the maternity tool (in line with H&CSA 2019)	Yes October 2024	Yes March 2026	
2. Did you document all parts of the common staffing methodology?	Yes	Process not yet completed	
3. Please share the CSM outcomes that were shared at board level for consideration for midwifery staffing and any associated workforce plan	Board reports relate to Duties under the Act Shared at Divisional level Funded and actual establishments triangulated with: • Local context including demand and activity • Evidence-based safe midwifery staffing ratios • Outputs from the National Maternity Staffing Level and Professional Judgement tools • Findings and recommendations from an internal Quality of Care Review • Predicted Absence Allowance	See response to Q2	

	• Professional clinical judgement and staff engagement through Midwifery Professional Leadership Group (MPLG) oversight		
4. Please share any amendments that were requested to midwifery funded establishment arising from the output from the tool, professional judgement and all other aspects of CSM. (existing establishment and requested)	Prioritised Staffing Requirements are set out in attached paper	See response to Q2	CMT paper
5. Any amendments that were made to midwifery funded establishment arising from question 4.	See response to Q4	See response to Q2	
6. Please share broken down by registered & unregistered, care setting and skill mix and specialist and leadership roles.	See response to Q4	See response to Q2	
7. Community, acute or integrated broken down by care setting	See response to Q4	See response to Q2	
8. Specific specialist and education roles asked for and WTE approved	See response to Q4	See response to Q2	
9. Specific leadership roles asked for and WTE approved	See response to Q4	See response to Q2	
10. Number of Newly qualified midwives asked for and WTE (and number) approved	Separate work was carried out to determine Prospective Recruitment requirements for NQMs	Separate work was carried out to determine Prospective Recruitment requirements for	Prospective Recruitment Papers for each year

		NQMs	
11. Pre and post CSM establishments broken down by filled unfilled	See response to Q4	See response to Q2	
12. Share Documents that describes what was asked for and what was approved for recruitment.	See response to Q4	See response to Q2	
13. Share roles not asked for but that you believe is required	N/A	See response to Q2	

Question:
B: I am also writing to request information under the Freedom of Information (Scotland) Act 2002 in relation to:
1. predicted absence allowance as defined in Name of measure: predictable absence allowance in maternity in 2024/2025 and 2025/2026.
2. Protected learning time as per NHS Circular: PCS(AFC)2024/1 Protecting learning time for Agenda for Change staff in NHS Scotland statutory and mandatory training as well as the 35 hours every three years for revalidation in addition to further training and development through PDP.

14. Share maternity /paternity leave in each financial year (by grade and setting)
15. Share sick leave in each financial year (by grade and setting)
16. Study leaves in each financial year (by grade)
17. All other leave by grade and setting
18. Total percentage of each absence and total relative to establishment

Answer:

1. predicted absence allowance as defined in Name of measure: predictable absence allowance	21.5%	21.5%	
2. Protected learning time as per NHS Circular: PCS(AFC)2024/1 Protecting learning time for Agenda for Change staff in NHS Scotland statutory and mandatory training as well as the 35 hours every three years for revalidation in addition to further training and development through PDP	See attached excel spreadsheet		Protected Learning Time Paper

14. Share maternity /paternity leave in each financial year (by grade and setting)	See attached excel spreadsheet	See attached excel spreadsheet	NB Data is for Nursing and Midwifery Registered / Non Reg – Cannot be provided at lower level
15. Share sick leave in each financial year (by grade and setting)	See attached excel spreadsheet	See attached excel spreadsheet	
16. Study leaves in each financial year (by grade)	See attached excel spreadsheet	See attached excel spreadsheet	
17. All other leave by grade and setting	See attached excel spreadsheet	See attached excel spreadsheet	
18. Total percentage of each absence and total relative to establishment	See attached excel spreadsheet	See attached excel spreadsheet	

Please see enclosed spreadsheet. Data is the % rate of absence calculated by contracted hours/Hours absence.

Please note for info: Sickness absence we can provide by Sub job family for Midwifery only in the Band groups of 1-4 and 5+ (Please see Sickness absence tab)
Other Leave is only categorised by Job family therefore for all Nursing and Midwifery. Paternity Leave is grouped in the Other leave category.

Please see below response below regarding this data:

Following a review of your request, we are able to provide a summary-level response. However, we are unable to provide the full level of detail requested.

To comply fully with this request would require the extraction, manual review, and collation of information held across multiple systems and records. This would involve a significant level of staff time and resource, exceeding what is considered reasonable under the Freedom of Information legislation.

Under the Freedom of Information Act NHS Lothian is not required to create new records to enable it to respond to your enquiry. This information is not collated or held in aggregate form and it would be necessary to review all case files relating to patients over the period you have requested to assemble the information you seek. Even if NHS Lothian did this – and there would be significant cost implications in doing so – it would be unable to respond in full to your request. The information requested is therefore exempt under section 12.1 – Cost.

That said, we have provided the available high-level information to support transparency, while ensuring that essential resources remain focused on core operational and service-delivery responsibilities.

If you wish to refine or narrow the scope of your request, we would be happy to consider whether additional information could be provided within reasonable resource limits.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, \you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive

Meeting:	**Women's Services CMT**
Meeting date:	**16 December 2024**
Title:	**Midwifery Workforce**
Responsible Executive:	**Alison Macdonald Executive Director of Nursing**
Report Author:	**Fiona Ireland Nurse Director (Corporate)** **Mercedes Perez Botella Director of Midwifery** **Katy Ruggeri Associate Director of Midwifery**

1 Purpose

This report is presented for:

Assurance	☐	Decision	☒
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☒	Performance / service delivery	☒
Legal requirement	☐	Other Corporate Risk Register	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

This paper presents a professional view of the immediate requirements to re-set the Midwifery Workforce model for NHS Lothian to address the current level of activity and current models of care.

It is fully acknowledged that there is further work to be done around the pathways and the re-design of the model of care to improve the delivery of safe, effective, person-centred care and that a detailed workforce plan will be proposed to address any changes arising from the improvement work.

It is also recognised that innovative new roles have been proposed and papers presented, and whilst approved in principle there is no funding currently available to progress these.

This paper addresses recognised and well-known risks and pressures in the current system and highlights roles that have been established without a recurring or dedicated budget which are considered to be core to delivery of safe effective person centred care.

2.1 Situation

The current funded establishment available to deliver the Midwifery services does not enable staffing levels that align with national guidance, recommendations and statutory requirements or adequately meeting the needs of our staff, patients and their families.

Various factors have contributed to the current position, including:
- increased clinical activity
- the expansion of the Midwife's role
- national and local mandatory, clinical and professional training requirements,
- role creep / unfunded roles (e.g. non-recurring / or out of ward funding of the Clinical Educator posts).

The Predicted Absence Allowance is applied inconsistently across the service and the actual levels for maternity leave and sickness are higher than the allocated levels.

Staff have highlighted concerns about staffing levels through various HR routes and directly through engagement sessions with clinical leaders and managers. Following a series of such concerns an independent professional quality of care review was commissioned to consider the findings from all the investigations that had been carried out. The recommendations reported in July 2024 featured workforce solutions in particular in relation to the Obstetric Triage and Assessment Unit. There was a delay in implementing this recommendation, although bank shifts are now being regularly requested.

This paper sets out a series of immediate workforce issues that need to be addressed. It is recognised that further work is needed to refine the model of care / patient pathways to address the changes in the patient population, the complexity of the care required, the changing preferences of women and national strategic direction is required. Reference is made to these developmental posts in this paper, but the focus is on addressing the fundamental shortfall that is affecting the ability to deliver core functions. This paper builds on previous papers taken to the Women's Services Clinical Management Team over the course of 2024.

Under the auspices of the Executive Oversight Group a short life working group has been established to determine models of care for the RIE Obstetric Triage and Assessment service and the antenatal pathways specifically.

It is also recognised that the Establishment Gap HealthCheck work is underway as part of the Nursing and Midwifery Workforce Thematic Efficiency Programme Board and this will make recommendations around building a workforce plan across the Service. The HealthCheck work covers both the RIE and St John's site and was expanded to include the Community teams which has delayed the reporting.

Women's Services Clinical Management Team have had an earlier version of this paper and have agreed to the operational recommendations below relating to reconfiguring the roster for Labour Ward / HDU / Elective Theatres and the reconfiguration of the teams within Labour Ward at RIE.

CMT are invited to

- discuss the staffing proposals in this paper summarised at 2.3.14
- be aware that this paper does not address the HealthCheck work in its entirety but addresses immediate staffing requirements to facilitate improved flow within the department which has been identified as a key risk factor for patient safety
- be aware of the risks of not progressing the recommendations in this paper
- approve the staffing adjustments for Obstetric Triage and Assessment (set out at 2.3.2)
- approve the staffing adjustments for Labour Ward (set out at 2.3.3)
- acknowledge the staffing levels required to deliver the current staffing for HDU and Elective Theatres (set out at 2.3.4 and 2.3.5)
- note that Women's Clinical Management Team have approved the roster reconfiguration for Labour Ward / HDU / Elective Theatres and the further work on the reconfiguration of the teams within Labour Ward
- approve the recommendation to substantiate the Clinical Educator roles (set out at 2.3.7)
- approve further analysis of the essential training for midwives (as set out at 2.3.8) led by the Chief Nurse for Clinical Education
- recognise that the resource to deliver the extended role – routine examination of the newborn – has been absorbed to date by Labour Ward / Post Natal and the revisions to Labour Ward staffing will enable this to continue (set out at 2.3.9)
- approve the additionality to the support team around risk and quality (set out at 2.3.10)
- note the analysis around Community Midwifery Team resources and approve the inclusion of the Complex Social Factors workload without further additionality (set out at 2.3.11)
- approve the additional appointment to the Lead role for LACAS (set out at 2.3.12)
- note the aspirational future workforce issues (set out at 2.3.13)
- note the financial impact of this rebalancing of the midwifery workforce (set out at 2.3.14) and approve the expenditure of £1.496m, set out at table 6, to implement the recommendations above
-

2.2 Background

The provisions in the Health & Care (Staffing) (Scotland) Act 2019 (hereafter referred to as the Act) which came into force on 1 April 2024 include a duty to seek clinical advice, the purpose of doing so being ensuring that operational management have a professional perspective to support appropriate decision making and actions that will ensure the health, wellbeing and safety of patients, the provision of high quality care and the wellbeing of staff.

The Act aims to enable high quality care and improved outcomes for people using services in both health and care by helping to ensure appropriate staffing. The duties under the provisions of the Act set in statute the 12IA duty to ensure appropriate staffing; "that at all times suitably qualified and competent individuals from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients or service users and the provision of high-quality health care."

Over 2024 there has been a lot of work in parallel considering a range of issues across Women's Services. The Clinical Management Team have had previous reports (in April and July 24) relating to staffing levels, at the same time the Nursing and Midwifery Thematic Efficiency Programme Board was developing the plan to carry out Establishment HealthChecks across all in patient areas.

The more recently convened Midwifery Professional Leadership Group (MPLG), which first met in September 2024, has a remit to
"provide the professional oversight for the N&M Workforce Review across the entire service using the Common Staffing Methodology / "Establishment Healthcheck" and to "explore the shape of the workforce, including considering enhanced roles / advanced practice and opportunities for skill mix and make recommendations to Women's CMT and the N&M Workforce Programme Board".

The HealthCheck work will report in February 2025 and may bring forward further analysis of the overall position and the work that has been agreed to review the midwifery rotational programmes will also provide a more robust framework for the management of the staffing deployment across midwifery services going forward.

Other workstreams within the Executive Oversight Group are considering other aspects of the workforce such as the medical staffing model in relation to the provision of safe, effective and person-centred care across Women's Services.

It is under the auspices of the remit of the MPLG that this paper is being brought forward to highlight immediate pressures in the Women's service staffing position predominantly in RIE however it is recognised that addressing these issues may relieve the pressures on the St John's site through reducing the redirection of patients when staffing levels do not meet service requirements in RIE.

2.3 Assessment

2.3.1 Workforce Position / Funded Establishment

The underlying staffing establishment (from the HR Workforce Dashboard) for Nurses and Midwives across Women's Services was 682.4 wte in September 681.9 wte in November

with an in post 687.4 wte in September, 678.3 wte in November. The finance stated position is marginally different at 684.48 wte with an in post of 697.40 wte in September.

In the period between September and November work by Finance to better align establishment and in post has resulted in small movements.

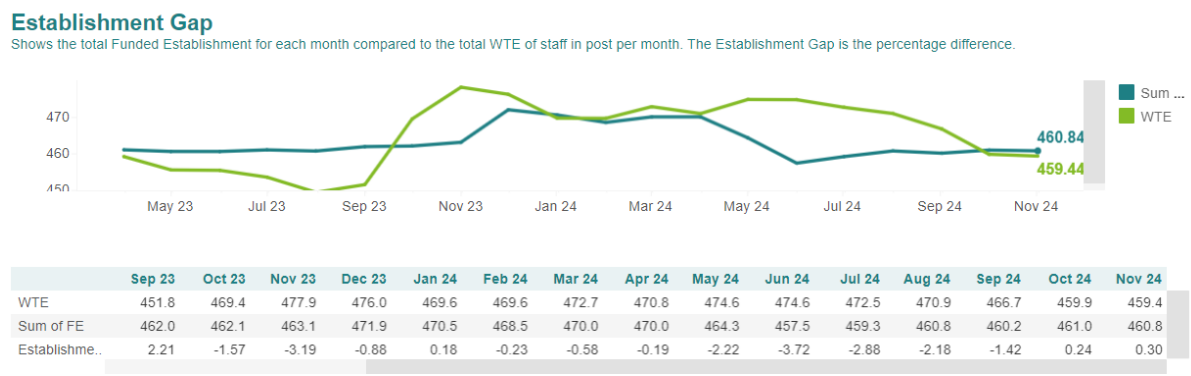
The breakdown as at September and November 2024 is illustrated in table 1 below and figures 1 & 2 set out the in scope areas for the content of this section (2.3.2 to 2.3.4) of the paper. For the purposes of this paper the Neonatal, Gynae and EFREC workforce has been excluded giving a working funded establishment of 460.8 wte and an in post of 459.4 wte but the focus for this paper is on three clinical areas – RIE Obstetric Triage and Assessment Unit, RIE Labour Suite and the Community Teams as well as Directorate wide roles of Clinical Educator and the Risk Team. As previously stated other areas are all pending the outputs from the HealthCheck work. The mis-match between funded establishment and in post at a cost centre level is largely down to the mechanism of the current rotational programme which is subject to separate review. This paper addresses the underlying funded establishment and will need operational management of the workforce to deploy the in post appropriately.

Table 1 Funded & In Post from the HR Workforce Dashboard

	Funded Establishment (wte)		In Post (wte)	
	Sept 24	Nov 24	Sept 24	Nov 24
Community	137.8	138.2	142 .9	138.2
Rep Health RIE	396.1	395.1	388.9	388.6
Rep Health St J	129 .1	129.2	134	132.1
Womens Admin	19.4	19.4	21.66	19.46

Figure 1 In scope Areas

Figure 2 Current Funded Establishment and In post – In scope areas



	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
WTE	451.8	469.4	477.9	476.0	469.6	469.6	472.7	470.8	474.6	474.6	472.5	470.9	466.7	459.9	459.4
Sum of FE	462.0	462.1	463.1	471.9	470.5	468.5	470.0	470.0	464.3	457.5	459.3	460.8	460.2	461.0	460.8
Establishme..	2.21	-1.57	-3.19	-0.88	0.18	-0.23	-0.58	-0.19	-2.22	-3.72	-2.88	-2.18	-1.42	0.24	0.30

Predicted Absence in November for this cohort of wards and teams is 25.92% down from 29.45 % in September and 33.95% in July but higher than the nominal allowance of 21.5% in in patient settings.

The “healthcheck” review of the establishment across all in patient parts of the service is underway as part of the Nursing and Midwifery Workforce Thematic Efficiency Programme of work. This work has been delayed as there was a view that the community teams, as well as the in patient areas, should be included (this is contrary to the project brief).

This paper sets out priority areas that need to be addressed prior to the conclusion of the “healthcheck”.

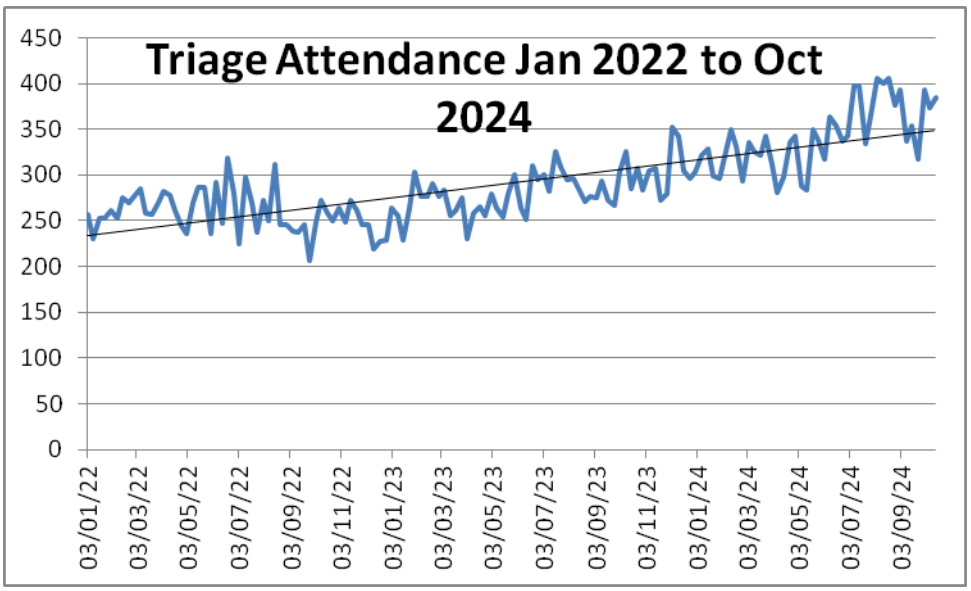
The healthcheck work will help drill out the application of the predicted absence allowance across the service. The disbandment of the Willow and Aspen and reallocation of the resources across the team is believed to have created an element of predicted absence allowance in the community teams.

This paper takes the November position for the in-scope areas as the basis for the analysis that follows.

2.3.2 Obstetric Triage and Assessment Unit

Obstetric triage is the front door to Midwifery services. Activity in the Triage Unit has increased by 20% over the past twelve months, as illustrated in figure 3 below.

Figure 3. Triage Attendance



The Midwifery funded establishment for the Obstetric Triage and Assessment Unit is 25.10 wte and the in post at November is 26.26 wte. (The in post includes an off-ward Band 7 SCM, therefore it is accepted that the in post will be 1 wte greater than the required funded).The current predicted absence is 21.56%. There is an additional 3.5 wte funded establishment for admin with 2.5 wte in post.

The current funded establishment is insufficient to deliver the current agreed staffing level for the Obstetric Triage and Assessment Unit. Funded establishment (midwifery and admin) 28.6 wte, required 30.08 wte to service the current agreed staffing numbers, assuming a PAA of 21.5% across all the staff as the admin element of the service must be maintained.

The findings of the internal Quality of Care Review specifically recommended an increase in staffing to manage the increase in activity during peak activity hours by deploying an additional Midwife for Triage on the late shift and an additional Clinical Support Worker to support the service 24/7. As an interim measure Staff Bank is being used to support this additionality in Triage staffing, but the uptake over the initial period was less than 50%.

Whilst the fundamental problems are recognised as flow into and out of the Obstetric Triage and Assessment Unit and the requirement to review the antenatal pathways is recognised there is a recommendation on the grounds of safety to enhance the staffing level. The later in the day that a woman attends, the longer she is likely to stay which creates an increasing volume of women requiring ongoing midwifery care & medical reviews and a backlog in triage for attending women adding further pressure in the later part of the day. Adequate staffing levels will decrease delays in the ongoing journey from medical review to transfer to Ward 119 and labour ward. Most of the delays are reported to be due to lack of staff rather than lack of beds.

Table 2 Current and Proposed Staffing Level & Funded Establishment for Obstetric Triage and Assessment Unit

	Current Requirement		Proposed Requirement		Current Funded Establishment
	Day		Day		
Charge Midwife	1 wte		1wte		
	Long Day	Night	Long Day	Night	
Midwife (Telephone)	1	1	1	1	
Triage Midwife	1	1	1 1 Late	1	
Ongoing Care Midwife	2	1	2	1	
Subtotal incl PAA	*18.5 wte*		*20.23 wte*		**19.62**
Clinical Support Worker	1	1	2	2	
Subtotal incl PAA	*5.29 wte*		*10.57 wte*		**5.48**
Total Required incl PAA	*24.79 wte*		*31.8 wte*		
wteReceptionist (Admin Role)	1	1	1	1	
Admin Total Required incl PAA	*5.29 wte*		*5.29 wte*		**3.54 wte**
	30.08 wte		*37.09 wte*		**28.64 wte**

Applying the recommendation from the Quality of Care review requires an adjustment to the funded establishment as set out in the proposed staffing in table 2 above, and an investment in the funded establishment of 8.45 wte (as set out in table 6).

Further work is being taken forward to consider pathways of care in the antenatal period. A SLWG has been established but this will require time and increases in midwifery staffing are required in the interim to take the funded establishment to the agreed staffing level or to adopt the recommendations of the Quality of Care review and to enhance the staffing levels to the proposed level.

There is an additional workstream under the Executive Oversight Board to review the medical model for Triage. Any changes in the medical staffing will be designed to impact positively on the activity and flow through the service, this will affect the number of patients having ongoing care which is currently exceeding the number of spaces available. The changes proposed here are to ensure that during the busiest times the BSOTS principles can be achieved as there will be two midwives assigned to achieving the 15 minute triage and that there is CSW support in both the Triage and Ongoing care areas to ensure that the Midwifery staff are not being diverted to non-registered duties.

The risks of not increasing the staffing establishment for Triage are:

- continued risk of delays in transferring patients to antenatal / labour ward with subsequent risk of significant adverse events arising from staffing shortfalls
- continued lack of compliance with the BSOTS
- poor patient experience owing to delays in care
- continued inability for staff to take meal breaks
- rising sickness levels (sickness in OTAU is currently 8.6%)

2.3.3 Labour Suite

The RIE roster for Labour Suite is currently constructed across 5 teams

1. Band 7 Senior Charge Midwife
2. Charge Midwife Co-ordinators
3. Elective Theatre
4. Maternity High Dependency Midwives
5. Labour Ward
    i. Registered Midwives
    ii. Band 4 MCA
    iii. Band 3 CSW
    iv. Band 2 Ward Clerk

The Band 7 Senior Charge Midwife role is a non-clinical / admin position.

The remaining band 7 Charge Midwives on the Co-ordinator team provide senior cover into the Labour Ward and also, on occasion, to the Unit, although this role may be taken by SCMs from other wards.

The Registered Midwifery staffing and non registered assigned to the Maternity High Dependency and Labour Ward are used interchangeably. The Midwifery theatre roster is dedicated to the Theatre environment.

The current funded establishment for Labour Suite is 77.52 wte (HR Workforce Dashboard) with an in post of 73.95 wte in November. It is not currently possible to breakdown the funded establishment across the component parts of the Labour Suite. The roster assignments account for 67.15 wte in post (roster beginning 9th Dec) across all of the teams in Labour Suite. The roster assignments (as an in post equivalent) are adequate to provide the currently agreed staffing level which requires 64.44 wte to deliver care and provide the co-ordination roles.

The finance in post figure of 73.95 wte should not differ from the eRostered staffing. It is assumed that owing to rotations not being aligned there are either staff working in Labour Suite who are not on the Labour Suite roster but are aligned to the cost centre or staff who are aligned to the cost centre who are no longer working in Labour Suite and are aligned to another roster. The work to reconfigure the Labour Suite rosters will address this mismatch and on an ongoing basis the grip and control procedures being promoted by the Nursing and Midwifery Workforce Thematic Efficiency programme provide operational managers with a toolkit to prevent future divergence.

There are currently 12 members of registered midwifery staff (11 out of hours) assigned to each labour ward shift in the RIE across bands 5 to 7. One of these midwives is assigned to

the HDU unit, 2 are assigned to the Elective Theatre lists for Caesarean sections. One acts as unit co-ordinator, and one acts as labour ward co-ordinator, the remainder (7) are allocated to Labour Ward.

The sickness absence rates across the services delivered from the Labour Ward resource have been higher than the average across Womens Services since April 2024 as set out in figure 4.

Figure 4 Sickness and Total Absence Levels

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 2
Womens Services														
Sick Leave	8.2	8.7	7.8	7.3	7.4	7.6	8.1	7.7	8.5	8.5	7.6	8.6	10.9	8.3
Total Leave Parameter	29.26	29.27	29.31	31.14	31.84	32.37	29.76	28.25	29.09	33.95	28.96	29.46	32.37	26.88
Labour Suite														
Sick Leave	8.8	12.1	8.0	7.7	6.5	7.3	9.9	9.3	7.4	10.0	9.8	11.9	14.4	8.6
Total Leave Parameter	28.67	34.12	27.02	30.91	28.96	31.00	31.21	27.04	27.09	34.28	28.97	30.56	36.08	25.48

2.3.4 Labour Ward

The staffing levels in Labour Ward RIE do not currently meet 2015 NICE guidelines for safe midwifery staffing for maternity settings which recommend a minimum safe staffing ratio for labour ward environments.

The NICE guidelines recommend that Labour Ward has:

- A registered midwife in charge of the shift or service to take appropriate action in relation to midwifery red flag events
- one-to-one care during established labour / more than one-to-one care during established labour if circumstances require it

Additionally, the guidelines recommend that midwives have time for:

- participating in continuing professional development, statutory and mandatory training, and supervision
- receiving training, mentoring and preceptorship
- providing training and mentoring for student midwives or other maternity service staff
- supervising and assessing the competencies of other midwives and maternity support workers
- taking part in indirect care activities such as clinical governance, safeguarding, administration and liaison with other professionals

and the guidelines require that the locally defined rate of uplift (allowance for annual leave, maternity leave, paternity leave, study leave, special leave and sickness absence) are applied to the staffing establishment – the Predicted Absence Allowance (PAA).

The staffing arrangement described above deploying the available staff on the Labour Suite roster leaves seven midwives available to deliver care to women in the 13 beds in labour ward which equates to 54% of the required capacity to deliver 1:1 care to women in active labour.

It is recognised that not all the Labour Ward beds require 1:1 staffing, equally it is recognised that the current staffing levels impacts on the departmental ability to provide one to one care in labour and to transfer patients into labour ward with resultant flow issues affecting the ability to manage the patients from antenatal pathways. There is also an impact on the ability to schedule staff breaks, whilst maintaining safe patient care – this is a reported concern from staff which is having a direct impact on their wellbeing.

Using the National Maternity Workforce Tool the recent analysis of RIE labour ward staffing demonstrated an average of 68% occupancy in labour ward beds requiring 1:1 care. This level of occupancy does not reflect that patients are awaiting entry to the Labour Ward (mainly from Triage and patients having induction of labour) owing to staffing shortfalls which would increase the utilisation of Labour Ward capacity if staffing was available.

The proposal is to staff Labour Ward to deliver a 1:1 ratio in Labour Ward for 75% of the capacity. Table 3 sets out the Labour Ward element of the Labour Suite roster disaggregated from the staffing required for co-ordination, HDU and Elective Theatres.

Table 3 Current and Proposed Staffing Level & Funded Establishment for Labour Ward

	Current		**Proposed**	
	Day	Night	Day	Night
Admin Charge Midwife	1 wte		1wte	
Charge Midwife **Unit Co-ordinator**	1	1	1	1
Total Required incl PAA	*6.29 wte*		*6.29 wte*	
LABOUR WARD				
Charge Midwife **(Labour Ward Co-ordinator)**	1	1	1	1
Total Required incl PAA	*5.29 wte*		*5.29 wte*	
Band 7 Totals Required	*11.58 wte*		*11.58 wte*	
Band 7 Current in post (Roster)	11.52 wte			
Labour Ward Midwives	7	7	10	10
Subtotal incl PAA	*37.00 wte*		*52.87 wte*	
Current in post (roster)	37.54 wte			
Clinical Support Worker	3	3	3	3
Subtotal incl PAA	*15.86 wte*		*15.86 wte*	
Current in post (roster)	7.43 wte			

Labour Ward Total Required incl PAA	*64.44 wte*	*80.30 wte*

The current structure of the "team" arrangement in Labour Ward could be reviewed formally, pending the recommendations below regarding disaggregation of HDU and the Elective Theatres and it is recommended that this is pursued.

2.3.5 Maternity HDU

The pregnant population in Scotland is presenting with increasing complexities, more high-risk women are becoming pregnant with more pre-existing complex medical history and social factors. This has led to an increase in demand for HDU beds.

The Kings Fund published "Critical Care Services in the English NHS" in 2020, this document defines the levels of care. Level 2 care is provided in HDU environments, the definition of level 2 care is "patients requiring more detailed observation or intervention, including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care". The Kings Fund document references the national service specifications which set out an expectation that there is one nurse for every two patients for level-2 (high dependency) patients.

The Maternity HDU has 3 beds. As described in 2.3.3 the Labour Suite resource provide the staffing into HDU. The current staffing in HDU is 1 Midwife and 1 MCA (band 4) for up to 3 patients and 3 babies.

The average occupancy of the HDU is 1.7 mothers and 1.5 babies therefore it is recommended that the dedicated staffing level should be set at one Midwife and one MCA at all times. On occasion when the capacity increases staffing, with the HDU skill, can be deployed from Labour Ward and backfill into Labour Ward could be managed via Staff Bank.

The workforce model needs to ensure that there is a supply of HDU trained midwives. The staffing level of 1 Midwife precludes upskilling of Midwives to work in HDU as trainees would be required to have supervision. The training programme is provided within women's services "on the job by the anaesthetic and Clinical Education team. It comprises of 4 short theoretical days with a further day release in ITU to gain competencies. Over previous years two cohorts of 5 – 8 midwives have gone through the training programme each year. This has been managed from within the funded establishment and will have depleted the availability of staff to be deployed to the care needs of patients across the Labour Suite

It is recommended that the staffing resource for Maternity HDU is increased by 1 wte (with no PAA) over the required and that this is used to fund the trainee posts in Maternity HDU. This would also provide additional capacity for an increased HDU population. The training roles would be open to competitive interview on an annual basis.

The roster for HDU is a separate team on the Labour Ward roster. It is recommended, in order to provide the legal documentation of who worked where when in the roster, that the HDU funded establishment is disaggregated from Labour Ward staffing, that a band 7 is assigned (from the existing cohort, the band 7 will continue to deliver Co-ordinator function as currently) and that the HDU forms part of the revised rotation proposals in its own right. Whilst the findings of the Rotation option appraisal is not known, one consideration would be that HDU is a sub rotation from Labour Ward to ensure the maintenance of skills.

The current HDU Registered Midwifery staffing level exceeds the required level but as all of the staffing is deployed across the Labour Suite this surplus needs to be netted against the requirements for Labour Ward. There is however a deficit in the non-Registered resource allocated to the Maternity HDU.

The proposal is to staff HDU to manage 2 beds and 2 cots consistently according to the Kings Fund good practice is set out independently of the other Labour Suite resources in table 4, together with the capacity for training as described above.

Table 4 Current and Proposed Staffing Level & Funded Establishment for Maternity HDU

	Current		Proposed	
	Long Day	Night	Long Day	Night
Maternity HDU Midwife	1	1	1	1
Trainee HDU Midwife			1 wte (no PAA)	
Subtotal Required incl PAA	*5.29 wte*		*6.29 wte*	
Current in post (roster)	8.38 wte			
Band 4 Maternity Care Assistant	1	1	1	1
Subtotal incl PAA	*5.29 wte*		*5.29 wte*	
Current in post (roster)	0.92 wte			
Maternity HDU Total Required (incl PAA as appropriate)	10.57 wte		11.57 wte	

In the event that HDU is not occupied the HDU midwife and non-Registered support worker would be deployed within the service depending on need.

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2.3.6 Maternity Elective Theatre

Within RIE the dedicated Theatre Midwives provide cover to the 6 theatre lists each week delivering the elective C Section workload. The Theatre Midwife supports the management of the delivered baby and the post operative recovery period. DATCC staff are allocated to and responsible for the anaesthetic, scrub and floor roles – i.e the procedure.

There are 6 elective section lists each week, one each day Monday to Thursday and a double list on Friday. Two midwives are allocated to the Theatre staffing each day to maintain theatre activity flow. The currently deployed midwives, according to the roster, is inadequate to meet the staffing needs for the 6 lists.

The roster for the Maternity Elective Theatre HDU is a separate team on the Labour Suite roster, and whilst this team are dedicated to the Theatre environment it is recommended, in order to provide the legal documentation of who worked where when in the roster, that the Maternity Elective Theatre funded establishment is disaggregated from Labour Ward staffing and that a band 7 is assigned (from the existing cohort) to provide leadership to this team. The band 7 will continue to deliver Co-ordinator function as currently.

Whilst this team have been recruited specifically to do theatre duties and are not part of the rotation, this arrangement needs to be considered in the review of rotation processes, in order to ensure a pipeline of theatre skilled midwives. Midwifery staffing for the second theatre where emergency C sections are performed is provided from the Labour Ward staff cohort, the Midwife essentially follows through with the 1:1 care into theatre. Consequently, the Labour Ward staff need to have midwifery theatre skills.

Table 5 sets out the current requirements and proposed unchanged staffing of 2 Midwives covering the 6 theatre sessions for elective C Sections. The current in post assigned to the Elective Theatre is insufficient to deliver the current 6 session arrangement.

Table 5 Current and Proposed Staffing Level & Funded Establishment for Elective Theatres

Maternity Theatre Staffing	Current	Proposed
Registered Midwife	2 Mon – Fri Day	2 Mon – Fri Day
Subtotal Required incl PAA	*2.46 wte*	*2.46 wte*
Current in post (roster)	1.36 wte	1.36 wte
Maternity Theatre Total Required (incl PAA as appropriate)	2.46 wte	2.46 wte

2.3.7 Clinical Educators

Across NHS Lothian Clinical Educator roles have been created to support the retention of staff through the local delivery of local support, education and training.

During 2024 there has been a professional agreement across Nursing and Midwifery to standardise the role descriptor for and to agree a governance framework within which the Local Clinical Educators will operate.

Women's Services have created 6 band 6 roles (totalling 4.42 wte).

The post holders in these roles have been appointed on a fixed term arrangement to the Clinical Educator position but have underlying substantive permanent contracts. The post holders are aligned to the Womens Services Management roster. The Women's Services Admin cost centre has the other positions aligned to the Women's Services Management roster (Associate Director, Clinical Midwifery Managers, 3 Band 5 midwives (Shortened Midwifery Trainee roles), Specialist Midwives, band 5 Admin Roles and an undefined band 6 role).

3.27 WTE of recurring funding has been identified by the service. However, all of the posts have been provided with fixed term contracts due to funding not being identified for the full 4.42 WTE's required.

Given the current shortfall in Triage and Labour Suite and the likelihood of recruiting from the newly qualified midwifery cohort into these gaps, together with the extent of the work to be done across the service to support staff it is recommended that funding is aligned to the Management budget to retain the Education Co-ordinator roles, the posts are substantiated and that this is prioritised.

It is further recommended that work is carried out to understand whether or not the underlying substantive posts of these post holders are being held as vacancies in their respective departments.

2.3.8 Training

The Act requires, under duty 12II, the organisation to ensure that employees have appropriate and relevant training, to ensure that they are suitably qualified and able to maintain competence in their role.

Under the AfC reform there is work being taken forward to consider the essential training required.

The extent of the mandatory training / essential training for the Midwifery role is extensive, particularly in the first year with 132 hours of training to be achieved and an average annual commitment of a further 26 ½ hours per member of staff. The level of study leave included in the PAA is 1% or 16.28 hours per annum per wte. However, for part time staff the commitment remains at 26.53 hours but the allowance will be proportionately less.

It is recommended that the Chief Nurse for Clinical Education leads work to review the current essential training requirements and the mode of delivery to make recommendations on the impact this is having on the workforce.

It is proposed that the review of the essential training is played into the AfC reform findings for the Protected Learning Time.

2.3.9 Extended Role – Routine Examination of the Newborn

Routine examination of the newborn is an important part of the care of all babies. It offers an opportunity to detect congenital abnormalities and identify problems which can be treated or avoided by prompt intervention. It is generally undertaken within the first 72 hours of life and has traditionally been performed by junior medical staff.

Midwives have taken on this role over the last five years without any additional resource. This duty is carried out in Labour Ward prior to the discharge of Mum / baby or in Post Natal and having the Midwives carrying out this check can expedite discharge and positively impact on flow. Approximately 75 % of all births would be eligible for Midwife REN, with consultant Neonatologists carrying out examinations for babies with a complex medical history.

There is an educational programme for the midwives carrying out this extended role with a requirement for regular competency assessments. This will be included in the review of essential training described in 2.3.8.

The resource required to carry out the checks for 75% of 7000 births is 5250 checks being carried out by Midwives on the basis of 40mins per check requires 3500 hours (1.8 wte) of midwifery time. The proposed additionality in Labour ward would be able to absorb this activity as part of the 1:1 care being provided.

2.3.10 Maternity Risk Team

The maternity risk team provide support for the co-ordination, investigation, identification of learning and ensuring implementation of actions arising from Significant Adverse Event Reviews (SAER) in maternity, gynaecology, neonatology and Child Death reviews.

Following a review of maternity risk teams across Scotland by the Perinatal Network in 2023, several recommendations arose, including local recommendations for NHS Lothian. Perinatal SAERs represent the largest workload component of the Board's SAER.

It was recognised that for the size of maternity services within our Board, the reliable, equitable and sustainable delivery of SAER in line with national recommendations needs additional local operational, governance and multidisciplinary workforce infrastructure (i.e. midwifery, obstetrician and neonatology). Benchmarking work has confirmed that the current NHS Lothian team is disproportionately low for the size of the Board.

The service have invested in fixed term appointments without recurring funding to provide some capacity. This outline plan is based on the advice from the national perinatal network review from 2023 and it relates only to midwifery requirements. Neonatal and medical requirements will need to be further scoped and proposed on a separate paper.

The proposal below would require to be further worked up through a formal Organisational Change process. This will provide opportunity to clarify the new role and develop the job description for the new Clinical Lead role for evaluation.

Table 6 Maternity Risk Team Current and Proposed Staffing (no PAA)

Maternity Risk Team	Current	Proposed
Registered Midwife Clinical Lead indicative Band 8A	0	1 wte
Registered Midwife B7	1 wte	1 wte
Registered Midwife B6	1 wte (FT 18/12)	2 wte
Midwifery Subtotal (excl PAA)	*2 wte*	*4 wte*
Admin Support B5	2.6 wte	2.6 wte
Risk Team Total	*4.6 wte*	*6.6 wte*

2.3.11 Complex Social Factors

The Best Start Implementation Board has a clear directive from the Scottish Government and evidence-informed recommendations from NHS Lothian Public Health and Health Policy to prioritise women with complex social factors in our next phase of implementation of the continuity of carer model.

The adoption of this model across the Community Teams will require additional input to specific groups of pregnant women, for which purposes the community staff will have additional training. The enhanced pathway of care was approved by the Best Start Implementation Board in summer 2024 but not progressed owing to funding constraints.

This represents a risk in our aim to reduce avoidable harm and reduce inequalities and it is further impacting on midwives ability to comply with requirements to provide woman centred care at the expense of their wellbeing and job satisfaction.

In the interim the Best Start teams have been disbanded and the resources redistributed, see table 7. The in post exceeds the core community midwifery funded establishment and the difference was “adopted” as an 11½% PAA, in an opportunistic way. Across NHS Lothian no other community teams currently have any allowance for PAA.

Analysis of the prevalence of the complex social factors across the caseloads of community midwifery teams and the additionality required to support this work being absorbed by the current teams is set out in table 7 above. The additional staffing required is calculated on the basis of a proportionate uplift across the team aligned to the % of the caseload that will fall into the CSF category.

Analysis of the current funded establishment and in post, set out in table 7 below, demonstrates that the redistribution of Best Start resource has effectively applied the additionality required to manage the complex social factors workload in the community workforce.

The current in post and the funded establishment that would be required to accommodate the complex social factors workload are equal (117.03 wte in post against 116.98 wte revised establishment to include complex social factors workload). Retaining the 11½% PAA would require a further investment of 13.45 wte, however this is contrary to the position across other community nursing teams and is therefore not recommended.

It is recommended that as a priority the training needs are incorporated for Community Midwifery Teams and the SLWG engage with the staff around adopting the pathway changes into their core duties without any further additionality.

The HealthCheck work underway will consider the underlying establishment for the provision of the community midwifery service but the work undertaken for the purposes of determining the requirements for ensuring that the complex social factors additional input does not indicate a requirement for any additional resources for that purpose.

Table 7 Community Midwifery Teams – Analysis of Funded Establishment / In Post and Additionality for CSF (*Workforce Dashboard data)

Community Team	Women with 3+ CSF*	Proportion of Caseload 3+ CSF	*Current Funded Establishment	CSF Uplift Required	Revised FE Current + Uplift	*In post	Difference between Revised FE / In Post	Revised FE with PAA applied at 11.5%
Leith	66	16%	10.88	1.3	12.18	12.04	0.14	13.58
Pennywell	44	10%	9.64	0.9	10.54	8.71	1.83	11.75
Stewart	17	4%	9.8	0.3	10.1	10.8	-0.7	11.26
Rowan	40	10%	11.81	0.8	12.61	13	-0.39	14.06
Sighthill	50	12%	9.21	1	10.21	8.23	1.98	11.38
Tollcross	23	5%	10.51	0.5	11.01	10.14	0.87	12.28
East Lothian	30	7%	11.82	0.6	12.42	18.39	-5.97	13.85
ML	43	10%	12.51	0.8	13.31	12.31	1	14.84
WL1	56	13%	13.13	1.1	14.23	14.29	-0.06	15.87
WL2	52	12%	9.37	1	10.37	9.12	1.25	11.56
Total	421		**108.68**	**8.3**	**116.98**	**117.03**	-0.05	**130.43**

2.3.12 Lothian Accredication and Care Assurance Standards (LACAS) Lead Midwife for Quality Improvement

The introduction of NHS Health Improvement Scotland Quality of Care inspections from January 2025 has added a level of urgency to establishing a formal set of standards for midwifery care. The MPLG are progressing the development of the LACAS standards and Person Centred Audit Tool (PCAT) equivalent for Women's Services.

Across Lothian the appointment of Lead Nurses over the last 5 years has been key to the improvement work being taken forward to drive standards up across a range of key patient outcome indicators.

It is recommended that a Lead Midwife for Quality Improvement is appointed to expedite the development of the LACAS standards, training across the Directorate and to support the improvement work that will be identified from local "mock" and formal HIS Inspections of Care.

2.3.13 Future Workforce Issues

There are a series of workforce issues related to the delivery of services for specific client groups, routine pathways for patients or aspirational developments. These need to be further developed, reviewed and considered by CMT separately. Some of these have already had papers taken to the Executive Oversight Board and these projects will be considered by the MPLG and progressed through the appropriate governance channels.

These include:

- Specialist roles
- Fetal Wellbeing Midwife
    - Bereavement Support
    - Perinatal Mental Health Support
- Provision of Vaccinations during pregnancy
- Bereavement Support
- Reflections Clinic
- Birth Choices Clinic
- Community Hub

Additionally, the MPLG are providing professional input to the Directorate review of leadership and management arrangements for Women's Services and are working of a radical overhaul of the rotation programmes that apply to band 5 and band 6 midwives.

2.3.14 Summary of the Impact of the Staffing Proposals

Table 6 sets out a summary of the funded establishment, in post and current and proposed staffing levels being brought forward in this paper.

Table 6 Analysis of Workforce Funded, In Post, Current Requirement and Proposed (wte)

		Funded Est.	In Post	Current Requirement	Proposed Requirement	Investment / (Disinvestment) Wte (Proposed v Funded Estab)	Investment Required £'000
Obstetric Triage	RM	19.62	18.28 +1.00	19.5	21.23	1.61	*105*
	NR	5.48	6.98	5.29	10.57	5.09	*196*
	Ad	3.54	2.5	5.29	5.29	1.75	62
Sub Total		**28.64**	**28.76**	**30.08**	**37.09**	**8.45**	**363**
Labour Ward	B7	77.52	11.52	11.57	11.57	16.82 wte	(70)
	RM		37.54	37.01	52.87		535
	NR		7.43	15.86	15.86		366
Maternity HDU	RM		8.38	5.29	6.28		0
	NR		0.92	5.29	5.29		0
Elective Theatre	RM		1.36	2.46	2.46		0
Sub Total		**77.52**	**67.15**	**77.48**	**94.34**	**16.82**	**831**
Clinical Educators	B6	3.27	4.42	4,42	4.42	1.15	75
Sub Total		**3.27**	**4.42**	**4,42**	**4.42**	**1.15**	**75**
Risk Team	B8A	0	0	0	1	1	81
No PAA	B7	1	1	1	1	0	0
	B6	1 (non rec)	1	1	2	1	65
	B5	2.6	2.6	2.6	2.6	0	0
Sub Total		**4.6**	**4.6**	**4.6**	**6.6**	**2**	**146**
LACAS	B8A	0	0	0	1	1	81
Subtotal		**0**	**0**	**0**	**1**	**1**	**81**
Totals		**114.03**	**104.93**	**116.58**	**143.45**	**29.42**	**1,496**

The community complex social factors workload does not require any additionality and is therefore not included in above but is set out in summary below.

		Funded Estab	In Post	Current Requirement	Proposed Requirement	Investment / (Disinvestment) Wte (Proposed v Funded Estab)
Community (Complex Social Factors)	RM	108.68	117.03	108.68	116.98	(0.05)
Sub Total		**108.68**	**117.03**	**108.68**	**116.98**	**revised to 0**

2.4 Recommendation

CMT are invited to

- discuss the staffing proposals in this paper summarised at 2.3.14
- be aware that this paper does not address the HealthCheck work in its entirety but addresses immediate staffing requirements to facilitate improved flow within the department which has been identified as a key risk factor for patient safety
- be aware of the risks of not progressing the recommendations in this paper
- approve the staffing adjustments for Obstetric Triage and Assessment (set out at 2.3.2)
- approve the staffing adjustments for Labour Ward (set out at 2.3.3)
- acknowledge the staffing levels required to deliver the current staffing for HDU and Elective Theatres (set out at 2.3.4 and 2.3.5)
- note that Women's Clinical Management Team have approved the roster reconfiguration for Labour Ward / HDU / Elective Theatres and the further work on the reconfiguration of the teams within Labour Ward
- approve the recommendation to substantiate the Clinical Educator roles (set out at 2.3.7)
- approve further analysis of the essential training for midwives (as set out at 2.3.8) led by the Chief Nurse for Clinical Education
- recognise that the resource to deliver the extended role – routine examination of the newborn – has been absorbed to date by Labour Ward / Post Natal and the revisions to Labour Ward staffing will enable this to continue (set out at 2.3.9)
- approve the additionality to the support team around risk and quality (set out at 2.3.10)
- note the analysis around Community Midwifery Team resources and approve the inclusion of the Complex Social Factors workload without further additionality (set out at 2.3.11)
- approve the additional appointment to the Lead role for LACAS (set out at 2.3.12)
- note the aspirational future workforce issues (set out at 2.3.13)
- note the financial impact of this rebalancing of the midwifery workforce (set out at 2.3.14) and approve the expenditure of £1.496m, set out at table 6, to implement the recommendations above

3 List of appendices

The following appendices are included with this report:

Nil

NHS Lothian

Meeting:	**Corporate Management Team**
Meeting date:	
Title:	**Nursing & Midwifery Vacancies**
Responsible Executive:	**Alison Macdonald, Exec Nurse Director**
Report Author:	**Catherine Crombie, General Manager**
	Fiona Ireland, Nurse Director (Corporate)

1 Purpose

This report is presented for:

Assurance	☐	Decision	☒
Discussion	☒	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe] Workforce	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

As a result of a very positive recruitment campaign during 2024 NHS Lothian has a Nursing & Midwifery establishment gap of 4.11% (February 2025). This is a healthy position, less than the target of 5% gap and equates to 343 wte vacancies.

Based on previous years turnover between April 24 and February 25 it is anticipated a further 428 wte Registered Nurse positions will become vacant over the 2025/26 financial year.

Work is underway to assess the extent of the additionality that will be required to support service delivery as a consequence of the impact of the Reduced Working Week (RWW).

There are 1001 eligible newly qualified Registered nursing (NQRN) applications as a result of NHS Lothian annual NQN campaign. This is the primary source for recruitment year-round. This group of graduates will be available to start employment between May / June (QMU / University of Edinburgh) and September / November (Edinburgh Napier University).

CMT is being asked to support the approval for prospective recruitment authorisation within the Business Units, in order to secure staffing for future months from the cohort of applications currently being processed.

Specifically CMT are invited to:

- Support the decision that Business Units should approve and submit a RAF for all current and prospective Registered Nurse gaps as set out in table 2.
- Support the Generic Recruitment Team to proceed to recruit to these positions making unconditional offers of employment to
    - Specific Vacancies as currently available
    - A Site / Partnership - with subsequent placement of these candidates to be co-ordinated as actual vacancies arise and RAFs are submitted through normal processes
    - Over recruitment to support the estimated requirement to provide cover for the impact of the reduced working week as set out in table 3. These staff would be the recruits seeking the latest start dates (December to February).
- Support Business Units to consider any workforce requirements aligned to additional funding streams and to submit RAFs at as early a point as possible to ensure supply.

2.2 Background

NHS Lothian is unable to recruit to prospective positions due to the current manpower approval process, whereby each Recruitment Authorisation Form (RAF) requires a named individual for whom the post is being vacated by. This process delays the active recruitment of registered nurses and has the potential to result in the available pool of graduates taking posts in other Boards which in turn will lead to an over reliance of supplementary staffing to cover gaps later in the year, adding increased costs to the organisation.

NHS Lothian have an annual recruitment campaign to attract & recruit NQRNs with large volumes of applications being received from student nurses and midwives from across Scotland. The numbers applying to NHS Lothian are high this year, against a backdrop of declining numbers NQRNs in future years.

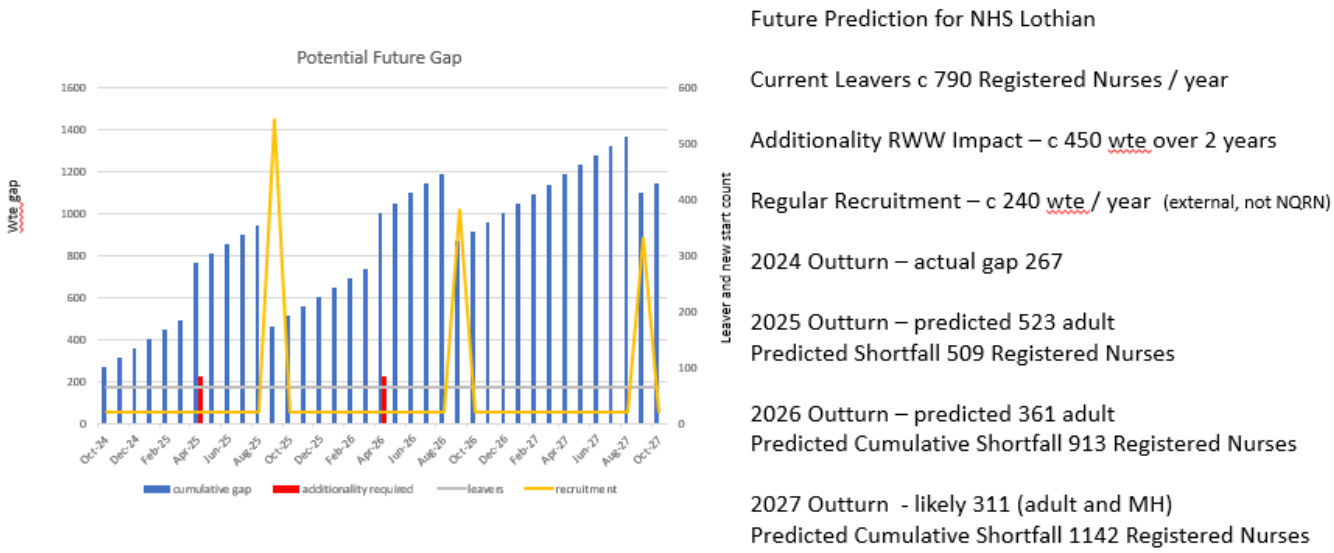
NHS Scotland is experiencing a steady decline in the number of nursing graduates entering the workforce. Southeast Scotland Universities are producing fewer graduates due to lower attrition rates, faculty shortages, or program limitations. At the same time, the demand for nursing staff is increasing due to an aging population, higher patient volumes, and growing service needs. The NES Workforce Team have identified the number of entrants and graduates from Nursing & Midwifery training programmes is set to reduce significantly year on year over the next 3 years. Their estimates are based on the university course specific intakes and course specific completion probabilities.

The local impact of this on NHS Lothian from the Edinburgh HEIs is set out in Table 1and Figure 1 below.

Table 1 Impact of 2024/25 Intake on 2027 outturn

	Intake hard target AY 24/25	Intake soft target AY 24/25	Actual number of students indexed numbers to 12/11/24	Overall Difference Index to Hard Target	Indicative January intake number	Overall Difference including Jan intake
Adult						
Edinburgh	64	50	43	33% gap	0	33% gap (count 21 short)
ENU	440	319	206	54% gap	35	45% gap (count 199 short)
QMU	88	75	69	22% gap	0	22% gap (count 19 short)
Mental Health						
ENU	134	110	61	55% gap	15	43% gap (count 58 short)
CYP						
ENU	101	101	103	Over supply	0	Oversupply
Learning Disabilities						
ENU	60	30	20	67% gap	0	67% gap (count 40 short)
Midwifery						
ENU	109	109	82	25% gap	28	Oversupply

Figure 1 Future Prediction for NHS Lothian



2.3 Assessment

Generic Recruitment act as the hiring manager for NHS Lothians Nursing & Midwifery workforce at band 2 to 5 (and band 6 non promoted roles in Midwifery / District Nursing).

On an annual basis they hold a bespoke recruitment campaign to attract and recruit NQRNs into the organisation, primarily from the Southeast region. More recently interest has come from further afield, including the West of Scotland and NHS England. The campaign promotes the Nursing and Midwifery Strategic Plan and branding and offers opportunities for potential recruits to visit sites and meet staff on “awareness” sessions.

This year we have seen unprecedented numbers of applications within 1001 applications being received, of which 907 are eligible to proceed to matching. There are 620 adult branch, 158 mental health branch, 28 Learning Disability. The 101 for child branch will be interviewed as this number exceed the likely demand.

The advert for new graduate midwives is due to be opened on 12th May. The numbers of applicants are not therefore known and a further position statement on midwifery will be provided in future.

NHS Lothian have made significant progress in the recruitment and retention of registered nurses over the past 2 years and have been instrumental in the reduction of the establishment gap from 7.17% in April 2024 to 3.87% in March 2025 and it is imperative that we continue to build on our success and reputation.

Table 2 below demonstrates by site the February 25 establishment gap and the prospective number (headcount) of leavers anticipated over the next 10 months.

Table 2 Establishment Gap

Site/Partnership	Registered Nurse Establishment Gap Feb 25	Registered Nurse Establishment Gap wte	Registered Nurse Leavers (April 24 -Feb 25)	Total Predicted Registered Nurse Vacancies
NHS Lothian				
RIE	**1.43%**	19	97	116
WGH	5.05%	44	48	92
STJ	9.21%	44	50	94
ATCC	-2.10%	0.08	25	25
OPD	3.13%	3.8	3	7
RHCYP	-3.44%	-23.9	16	-8
WOMEN'S	0.34%	-1.9	21	19
REAS	8.04%	62.6	60	123
EDINBURGH	10.30%	87.5	35	123
EAST	8.39%	40.1	37	77
MID	4.73%	11.5	14	26
WEST	8.57%	38	22	60
Total	**4.47%**	**324.78**	**428**	**753**

2.3.1 Quality/ Patient Care

With fewer Registered nurses available, there is a detrimental impact on patient-to-nurse ratios. This can lead to delays in care, missed care and reduced time for patient interaction — negatively impacting patient outcomes and satisfaction. Prospective recruitment will reduce if not prevent such impacts on patient care and outcomes.

2.3.2 Workforce

Whilst there has been improved retention rates within the nursing workforce over the past 2 years, it is essential to build upon these successes by ensuring we provide stability within the nursing workforce numbers.

It is recognised that increased Establishment levels may impact on existing staff, particularly if staff are required to work extended shifts or take on additional responsibilities, leading to fatigue, burnout, and ultimately, higher turnover rates. This creates a cycle that further deepens the staffing shortage.

Across NHS Lothian the workforce profile has an increasing number of registered nursing nearing retirement age (800 over the age of 60 of which 180 of these are over the age of 65). The modelling for anticipated turnover does not include a higher proportion of this staff group opting for retirement that have done so in previous years. A change in that position would impact on the overall position

2.3.3 Financial

The financial risk is one of balance as failure to recruit from the outturn of NQRNs will result in an increasing establishment gap which will require supplementary staffing to maintain services, via Staff Bank, extra hours or overtime hours. In extremis this may also require the re-engagement with agency suppliers. It is important that the Board's recruitment actions do not derail the reduction in agency spend over 2025/26, every effort will be required to sustain these reductions in spend, particularly in light of the National Task and Finish Group being disbanded.

The proposed prospective recruitment we will see the majority of NQNs joining the organisation in a phased period with the majority joining the organisation between September and November.

Throughout the year there is a reliance on supplementary staffing for staffing shortfalls. In the unlikely event that the NQRNs cannot be allocated against an actual vacancy they would be deployed to cover shortfalls reducing the cost of Staff Bank.

Project Workstreams require additional nursing resource and normally come with associated funding. The requirement for nursing to support is essential, prospective recruitment/over recruitment into some positions will allow for easier backfill and release staff to undertake bespoke project streams.

The RWW requirements are yet to be calculated but can be estimated to be in the region of 298 wte for Registered Nursing alone, based on current in post, as set out in Table 3.

Table 3 Estimates for Reduced Working Week (Registered Nurses and Midwives only)

Site/Partnership	Reg Nurse Funded Establ wte	Registered Nurse In Post wte	4% of In Post wte	Predicted Reg Nurse Vacancies	Potential Total Gap
RIE	1352	1331	53	116	169
WGH	856	814	33	92	125
STJ	480	433	17	94	111
ATCC	925	943	38	25	63
OPD	113	117	5	7	12
RHCYP	693	714	29	-8	21
WOMEN'S	553	563	23	19	42
REAS	780	719	29	123	152
EDINBURGH	810	766	31	123	154
EAST	466	422	17	77	94
MID	231	234	9	26	35
WEST	442	406	16	60	76
Total			**298**	**753**	**1051**

2.3.4 Risk Assessment/Management

The proposed risk mitigation is aimed at preventing a significant increase in the establishment gap that will result in an adverse impact on activity.

Recruiting to only the current 324.78 wte gap will likely see the establishment gap increasing to >10% by March next year. Given the known reduction in student outturns in subsequent years this will be a very difficult position to recover.

2.3.5 Equality and Diversity, including health inequalities

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

The Nursing and Midwifery Workforce position is a key agenda item at all professional forum. The current position and potential for mitigating any worsening of the current staffing has been discussed at the following meetings;

- Nursing & Midwifery Workforce Programme Board
- Nursing & Midwifery Thematic Efficiency Programme Board
- Nurse Directors Operational Group
- Acute Nursing Workforce Governance Group
- Community & Primary Care Workforce Group
- Recruitment (Sub-Group) of N&M Workforce Programme Board

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups set out above have either supported the content, or their feedback has informed the development of the content presented in this report.

2.4 Recommendation

CMT are invited to:

- Support the decision that Business Units should approve and submit a RAF for all current and prospective Registered Nurse gaps as set out in table 2.
- Support the Generic Recruitment Team to proceed to recruit to these positions making unconditional offers of employment to
  a) Specific Vacancies as currently available
  b) A Site / Partnership - with subsequent placement of these candidates to be co-ordinated as actual vacancies arise and RAFs are submitted through normal processes

c) Over recruitment to support the estimated requirement to provide cover for the impact of the reduced working week as set out in table 3. These staff would be the recruits seeking the latest start dates (December to February).

d) Consideration to the likely staffing requirements arising from HealthCheck work, particularly in mental health units.

- Support Business Units to consider any workforce requirements aligned to additional funding streams and to submit RAFs at as early a point as possible to ensure supply.

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3 List of appendices

There are no appendices are included with this report

NHS Lothian

Meeting:	**Corporate Management Team**
Meeting date:	
Title:	**Prospective Recruitment to Nursing & Midwifery Vacancies**
Responsible Executive:	**Alison Macdonald, Exec Nurse Director**
Report Author:	**Fiona Ireland, Nurse Director (Corporate)** **Catherine Crombie, General Manager**

1 Purpose

This report is presented for:

Assurance	☐	Decision	☒
Discussion	☒	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe] Workforce	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

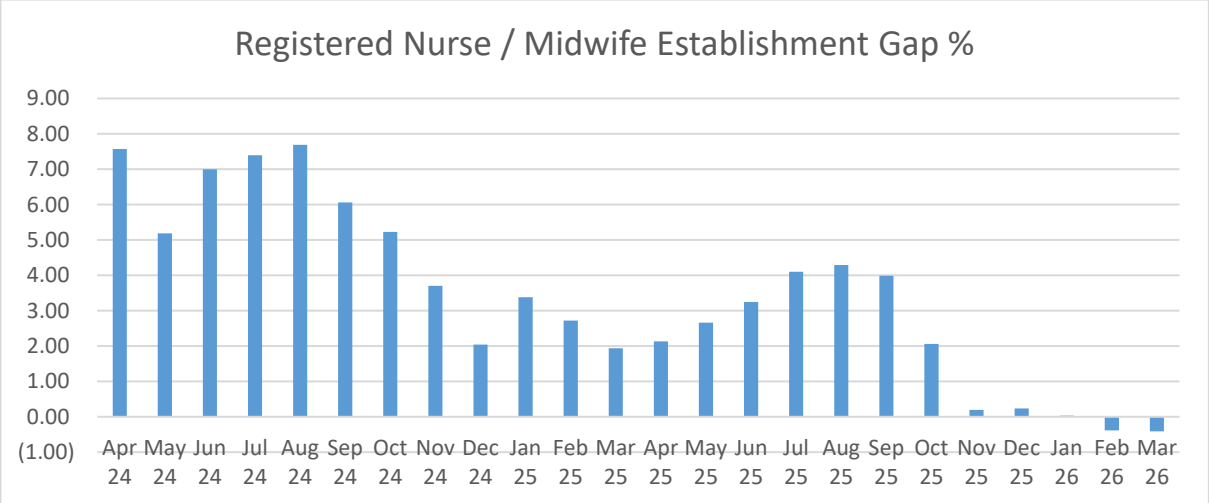
2.1 Situation

As a consequence of the annual outturn of newly qualified Registered Nurses (NQRN) recruitment activity is highly competitive across Health Boards. NHS Lothian's Nursing and Midwifery Generic Recruitment Team's 2026 campaign is underway with 1025 eligible applications received from Scottish HEIs. The new graduate nurses will predominantly be in a position to take up posts between September 2026 and January 2027.

The current generic recruitment process matches successful applicants to actual vacancies with appropriate approval through the authorisation processes (RAF). The current number of vacancies will increase through normal turnover over coming months but this does not align to the availability of potential new recruits. To overcome the risk of losing candidates to other Health Boards NHS Lothian adopted a position of prospective recruitment in 2025. Successful candidates were made unconditional offers of employment following the review of applications in May / June against a prospective RAF and were subsequently aligned to specific vacancies (as processed through RAF approvals by local service areas) prior to indicative start dates. This prospective agreement enabled earlier and better engagement with candidates, improved conversion rates (ie successful applications resulting in an appointment) and contributed significantly to the reduction in the overall establishment gap.

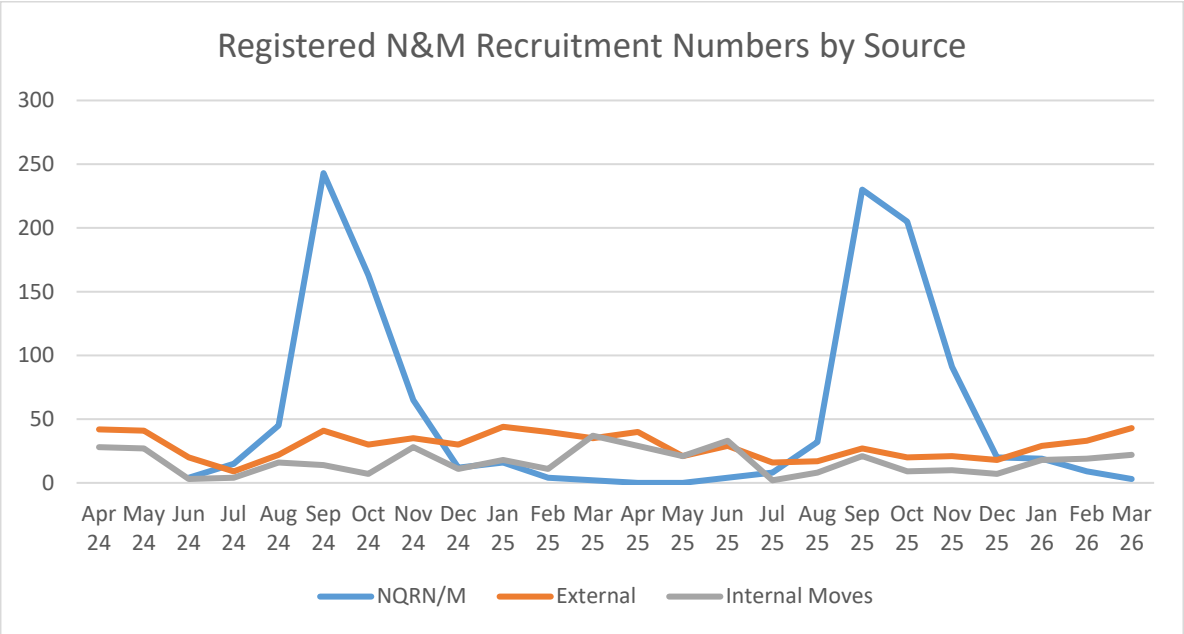
The success of the 2025 prospective recruitment approach has been instrumental in reducing the establishment gap for Registered Nurses & Midwives and improving workforce stability (see figure 1). As a consequence of this position the Nursing and Midwifery workforce risk has been taken off the Corporate Risk Register and continues to be monitored at Divisional risk level.

Figure 1



The new graduate recruitment peak in September / October addresses the vacancies that had arisen over prior months, together with the underlying recruitment resulted in a net over staffing in February and March 2026 (as illustrated in fig 1). The reliance on newly qualified Registered Nurses and Midwives is evidenced in figure 2 which shows band 5 recruitment from external sources and internal moves alongside the annual peaks from University outturns.

Figure 2



Considering the success of the prospective recruitment in 2025, it is proposed that NHS Lothian adopts a similar prospective recruitment approach for the 2026 campaign, enabling early offers and pipeline recruitment aligned to predicted vacancies and service demand.

CMT is therefore asked to support the continuation of this approach to ensure the organisation can maximise recruitment from the current cohort and mitigate future workforce risks.

Specifically, CMT are invited to:

- Support the corporate approval of a RAF for the prospective recruitment campaign of 693 newly qualified nursing and midwifery staff, signed off by the Director of Finance and the Executive Nurse Director (this allows the recruitment process to proceed through the various business systems) as set out in table 2.
- Require Business Units to review all vacancies under active recruitment, approve and submit a RAF for all Registered and Non Registered Nurse gaps without RAFs in play and to promptly complete and submit RAFs as staff leave.
- Support the levelling off of staffing in areas with an over establishment (as set out in table 2) in all areas except Women's Services, where the additionality must be sustained to maintain Neonatal, Labour Ward and Triage staffing levels as approved by CMT in January 2025.

- Support the Generic Recruitment Team to proceed to recruit to the prospective positions making unconditional offers of employment to
    - Specific Vacancies as available (netting off against a prospective position)
    - A Site / Partnership - with subsequent placement of these candidates to be co-ordinated as actual vacancies arise and RAFs are submitted through normal processes – with a focus on areas of greatest need (i.e. those areas with a residual gap following the 2025 recruitment campaign)

2.2 Background

As a result of a very positive recruitment campaign in 2025/26 NHS Lothian has a Nursing & Midwifery establishment gap of 2.43% (March 2026), the lowest establishment gap for many years and below the 5% operational target.

However, the Non-Registered gap has been high for the last 12 months, currently 9.53% and this accounts for 313 wte.

The position for Registered Nurses and Midwives is an over establishment currently of 0.41% (34 wte) pan Lothian, although there is a range from a high of 6.25% gap in Edinburgh H&SCP to an overstaffing of 9.29% in RHCYP (see table 2 below for detail).

Based on turnover between April 2025 and March 2026, it is anticipated that a further 616 Registered Nurse positions will become vacant over the 2026/27 financial year.

The numbers of entrants for Nurse training is not achieving the targets set by the Scottish Government for Adult Acute, Mental Health or Learning Disabilty branches. Midwifery, whilst not meeting the target intake has an adequate or over supply for local needs but Childrens Nursing is over populated. Table 1 illustrates a prospective outturn position based on the numbers currently in each year of training (these numbers will go down) for each of the Nurse training branches (data is not available for midwifery).

Table 1 Nurse Training Potential Graduate Numbers versus Scottish Government Target

	Hard Target	Soft Target	Potential Graduate 2026	Potential Graduate 2027	Potential Graduate 2028	Potential Graduate 2029
Adult – Edin	64	50	34	27	27	48
Adult - ENU	440	319	296	218	186	
Adult - QMU	88	75	47	58	50	48
Mental Health	134	110	86	63	78	
LD	60	30	31	26	22	
Childrens	101	101	82	91	103	

2.3 Assessment

Generic Recruitment act as the hiring manager for NHS Lothian's Nursing & Midwifery workforce at band 2 to 5 (and band 6 non-promoted roles in Midwifery / District Nursing).

On an annual basis they hold a bespoke recruitment campaign to attract and recruit NQRNs into the organisation, primarily from the Southeast region. More recently, interest has come from further afield, including the West of Scotland and NHS England. The campaign promotes the Nursing and Midwifery Strategic Plan and branding and offers opportunities for potential recruits to visit sites and meet staff at "awareness" sessions.

The prospective recruitment campaign in 2025 resulted in 907 eligible applications resulting in recruitment of 704 Registered nurses and Midwives (495 adult branch, 101 mental health branch, 15 Learning Disability. 62 Children and 32 Midwifery).

The 2026 campaign is underway. The advert for new graduate Registered Nurses closed on 13th April 2026, with 1025 eligible applications. The new graduate Midwifery advert is due to go live in May 2026. The level of applications is indicative of the strength of the recruitment process and positive reputation NHS Lothian has as an employer of newly qualified Registrants.

Given the known reduction in future graduate supply from 2027, on the basis of intake and year on year numbers being lower than the target, alongside increasing service demand, there is a strong strategic case to repeat and embed the prospective recruitment approach for 2026. Table 1 above illustrates that the local HEIs are not recruiting sufficient adult acute or mental health nurses to meet the Board's normal turnover of staff in future years.

Repeating the 2025 recruitment model will allow NHS Lothian to remain competitive, secure high-quality candidates, and sustain workforce gains already achieved. The matching process for 2026 will require to focus on the areas with a remaining establishment gap – particularly the partnerships and mental health where the gap remains higher. This will ensure that the Board is in an optimum position in future years when the supply of nurse graduates is reducing.

Whilst in some areas there has been an over recruitment in the Registered line the proposal in this paper is to reset to the funded establishment therefore there needs also to be local action taken to reinstate the non registered workforce to the funded establishment number (see table 3).

2.3.1 Quality/ Patient Care

With fewer Registered nurses available, there is a detrimental impact on patient-to-nurse ratios. This can lead to delays in care, missed care and reduced time for patient interaction — all of which can negatively impact patient outcomes and experience. Prospective recruitment will reduce, if not prevent, such impacts on patient care and outcomes.

2.3.2 Workforce

Registered

Whilst there has been improved retention rates within the nursing workforce over the past 3 years, it is essential to build upon these continued successes by ensuring stability within the nursing workforce numbers. It is recognised that increased establishment gap levels may impact on existing staff, particularly if staff are required to work extended shifts or take on additional responsibility. This can lead to fatigue, burnout, and ultimately, higher turnover rates, creating a cycle that further deepens staffing shortfalls.

Across NHS Lothian the workforce profile has a significant number of registered nursing nearing retirement age (411 over the age of 60 of which 93 of these are over the age of 65). The modelling for anticipated turnover does not include a higher proportion of this staff group opting for retirement that have done so in previous years. A change in that position would impact on the overall position.

Taking account of the current gap, predicted leavers and supported over establishment position in maternity table 2 sets out the proposed recruitment numbers to maintain a workforce position of sub 5% establishment gap.

Table 2: Registered Nurse / Midwife Establishment Gap March 2026 position

	% Establishment Gap	Wte Establishment Gap	Predicted Leavers	Prospective Recruitment Numbers
RIE	-3.01%	-40	128	88
WGH	2.58%	23	60	83
St J	1.21%	7	35	41
DATCC	0.39%	4	67	71
OPAS	3.39%	4	12	16
RHCYP	-9.29%	-62	41	0
Women's Services	-6.24%	-37	47	47
*Neonatal **	*-5.63%*	*-8*		
*RIE Midwifery Labour Ward**	*-23.12%*	*-28*		
*RIE Triage Assessment**	*-10.79%*	*-2.3*		
REAS	2.9%	23	63	86
Edinburgh	6.25%	51	56	107#
East Lothian	3.95%	18	39	57#
Midlothian	2.5%	6	28	34#
West Lothian	5.15%	23	40	63#
Overall Position**	**-0.41%**	**- 34**	**616**	**693**

*figures for specific wards are included in the overall total for the Directorate

**overall position includes areas not on table e.g corporate teams, research teams and nursing staff in primary care

proportion of registrant positions for Adult Acute / Mental Health and LD to be established by service areas, not exceeding total prospective recruitment

Non Registered

The Non Registered nursing gap is currently 9.53%. Generic recruitment are recruiting to RAFs as they are processed but analysis of the actual gap against the number of RAFs in the system has a discrepancy of 252 posts currently not filled. Table 3 below shows this by information by business unit. REAS recruited to additional Non Registered posts to support the reduction of agency.

Table 3 Non Registered Establishment Gap / RAFs in Generic Recruitment

	% Establishment Gap	Wte Establishment Gap	RAFs under Recruitment
RIE	9.53%	55	6
WGH	13.88%	52	7
St J	7.14%	18	7
DATCC	13.82%	38	5
OPAS	12.38%	9	4
RHCYP	17.16%	34	5
Women's Services	6.51%	9	0
REAS	-3.09%	-14	3
Edinburgh	12.83%	31	6
East Lothian	12.26%	41	8
Midlothian	20.26%	32	1
West Lothian	10.28%	19	9

2.3.3 Financial

The financial risk is one of balance, as failure to recruit from the outturn of NQRNs will result in an increasing establishment gap which will require supplementary staffing to maintain services via Staff Bank, extra hours or overtime hours. In extremis this may also require the re-engagement with agency suppliers. It is important that the Board's recruitment actions do not derail the reduction in agency spend over 2025/26. Every effort will be required to sustain these reductions, particularly in light of the National Task and Finish Group being disbanded.

The proposed prospective recruitment we will see the majority of NQNs joining the organisation in a phased period with the majority joining the organisation between September and November 2026, with a tail of recruitment into January 2027.

Throughout the year there is a reliance on supplementary staffing for staffing shortfalls. In the unlikely event that the NQRNs cannot be allocated against an actual vacancy they would be deployed to cover shortfalls in specific areas reducing the cost of Staff Bank.

There are proposals to establish firmer controls around the use of additional duties and to add a further layer of approval to bank shift requests, as part of the Nursing and Midwifery Thematic Efficiency programme. These controls are designed to ensure that prospective recruitment is not creating an additional financial pressure in the system and that where staff are deployed the equivalent bank use is reduced.

2.3.4 Risk Assessment/Management

The proposed prospective recruitment is designed as risk mitigation, aimed at preventing a significant increase in the establishment gap that will result in an adverse impact on patient outcomes and activity.

Failure to recruit to prospective gaps when the new graduates are seeking employment will result in NHS Lothian missing the opportunity to secure the very best of the graduate nurses and midwives and will risk an increasing gap if the supply is consumed into other Boards.

2.3.5 Equality and Diversity, including health inequalities

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

The Nursing and Midwifery Workforce position is a key agenda item at all professional forums. The current position and potential for mitigating any worsening of the current staffing have been discussed at the following meetings.

- Nursing & Midwifery Workforce Programme Board
- Nursing & Midwifery Thematic Efficiency Programme Board
- Nurse Directors Operational Group
- Acute Nursing Workforce Governance Group
- Community & Primary Care Workforce Group
- Recruitment (Sub-Group) of N&M Workforce Programme Board

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups set out above have either supported the content, or their feedback has informed the development of the content presented in this report.

2.4 Recommendation

CMT are invited to:

- Support the corporate approval of a RAF for the prospective recruitment campaign of 693 newly qualified nursing and midwifery staff, signed off by the Director of Finance and the Executive Nurse Director (this allows the recruitment process to proceed through the various business systems) as set out in table 2.
- Require Business Units to review all vacancies under active recruitment, approve and submit a RAF for all Registered Nurse and Non Registered Nurse gaps without RAFs in play and to promptly complete and submit RAFs as staff leave.
- Support the levelling off of staffing in areas with an over establishment (as set out in table 2) in all areas except Women's Services, where the additionality must be sustained to maintain Neonatal, Labour Ward and Triage staffing levels as approved by CMT in January 2025.
- Support the Generic Recruitment Team to proceed to recruit to the prospective positions making unconditional offers of employment to
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3 List of appendices

There are no appendices are included with this report

HIS Evidence: Protected Learning Time for Midwifery Staff

1. Context and Purpose

NHS Lothian ensures that midwifery staff have protected learning time formally rostered within HealthRoster. This provides clear, transparent and auditable evidence that staff are given dedicated time within contracted hours to maintain the skills, competence and confidence required to deliver safe, high-quality maternity care.

Protected learning time supports mandatory training, role development and supervised practice, and is recognised as a key enabler of workforce safety, sustainability and staff wellbeing.

2. Alignment with HIS Standards

This approach provides assurance against HIS Domain 4.3-24 (Ensuring Staff Competence and Development) by demonstrating that staff development and release for education is systematically planned, recorded and supported.

HealthRoster records provide objective evidence that midwives are enabled to maintain the knowledge and skills required to deliver safe and consistent care, with learning time protected as part of normal working patterns.

3. Ensuring Staff Are Appropriately Trained

To meet this requirement, the service ensures that protected learning time is rostered for all midwifery staff. Training and education shifts are clearly coded within HealthRoster, providing assurance that staff are released for mandatory and developmental training as part of their working hours.

This enables oversight at local and senior management level and supports compliance monitoring and inspection readiness.

4. Local Review and Risk-Based Decision Making

Prior to any decision to cancel or defer planned learning time, a local safety huddle review is undertaken. This review considers current staffing levels, clinical acuity, demand and available mitigations.

Options such as reallocation of staff, deployment of additional support or temporary adjustments are explored to maintain training safely. Cancellation is considered only where patient safety would otherwise be compromised.

5. Workforce Context and Senior Staff Development

The service recognises that a high volume of newly appointed staff has required a focus on induction, preceptorship and mandatory training in the short term, while maintaining compliance for all staff groups.

Senior Charge Midwives continue to engage with the Senior Management Team to highlight the importance of development opportunities for experienced Band 6 midwives. This supports resilience, leadership capacity and succession planning and has been recognised and supported by the Corporate Management Team.

6. Evidence and Assurance

Attached data from RIE Labour Ward demonstrates the number of shifts allocated to training and supernumerary support over the last six months.

- The chart shows weekly fluctuations in training shifts (green) and supernumerary shifts (blue) on Labour Ward between October and March.

- Supernumerary shifts demonstrate ongoing support and supervision for staff alongside clinical delivery. Processes relating to supernumerary periods have been reviewed and continue to be monitored to ensure they remain person-centred.
- Training activity is more variable, with peaks and troughs reflecting the timing of courses delivered across the year, corporate induction, NQM essential training, scheduling, staff availability, and service pressures.
- Overall, the data demonstrates a sustained commitment to supernumerary support, even during periods when formal training activity is reduced.

HealthRoster exports provide auditable evidence of the department's ongoing commitment to protected learning time, supervised practice and the maintenance of a skilled and competent midwifery workforce.

NHS Lothian

Meeting:	**Women's CMT**
Meeting date:	**17th March 2026**
Title:	**Midwifery and Obstetric Mandatory Training Requirements**
Responsible Executive:	**Justine Craig, Professional Midwifery Lead & Corinne Love, Associate Medical Director**
Report Author:	**Assistant Service Manager**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☒
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☒
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☒	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

The purpose of this paper is to seek CMT approval of the proposed professional mandatory training pathways for midwifery and obstetric staff.

2.1 Situation

There is a need to identify appropriate professional mandatory training pathways for midwifery and obstetric staff that ensure knowledge and expertise are kept up to date whilst not inappropriately overburdening staff with training requirements. The mandated requirement was laid out in the 2018 Scottish Government directive letter (SGDL 2018).

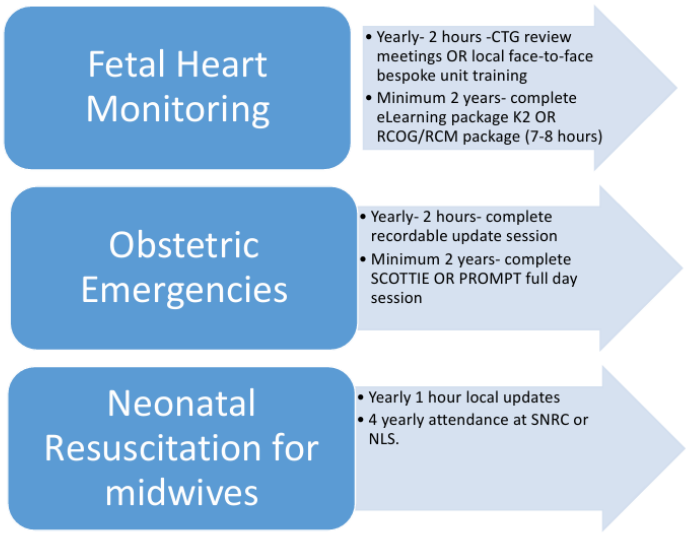

Figure1. Summary of Core element of mandatory update training for midwives and obstetricians as per 2018 Scottish Government directive letter (SGDL 2018).

2.2 Background

At present, every two years all midwifery and obstetric staff are required to complete:

- Full K2 e-learning package, totalling 10h 5 mins of learning
- In-house Maternity Mandatory Update Day (MMUD) training day, totalling 7h 30mins of learning (including a 2hr update on fetal wellbeing training with a competency test and 1hr local neonatal resuscitation update)
- In-house PROMPT or COMET training day, totalling 7h 30mins of learning

In addition, all midwifery and obstetric staff are required to undertake 2x one-hour face-to-face multidisciplinary CTG meetings every year and all midwifery staff are also required to undertake Neonatal Resus training (Scottish National Resuscitation Council) every 4 years (7h 30mins) and annual local updates every year (1h).

The learning pathways and time-to-complete is currently as follows:

- Year 1: K2 e-learning, PROMPT/COMET study day, 2x one-hour meetings: 19h 35mins
- Year 2: MMUD study day, 2x one-hour meetings: 9h 30mins

The cycle then repeats, with staff required to complete around 30hours of mandatory training every two-year period. In addition, midwives are also required to undertake full neonatal resuscitation training every 4yrs (7h 30mins).

There are challenges associated with enabling staff to attend/take time back for this volume of training, and there are currently insufficient face-to-face training sessions to facilitate full compliance with training requirements.

2.3 Assessment

2.3.1 Quality/Patient Care

Following a review of the current level of mandatory training for all obstetric and midwifery staff, it has been concluded that in its current form it is in excess of the requirements set out by the Scottish Government (2018). This paper will outline appropriate learning pathways recommended to ensure safe, high-quality care is provided to patients and service users by well-trained staff.

2.3.2 Workforce

Mandatory training pathways for midwifery and obstetric staff require amending based on the review to ensure:

- They meet the needs of the Service in terms of updates to evidence-based care, and developing well trained staff to delivery quality care
- They meet the requirements of the Scottish Government directive
- They are valued by the workforce, allowing them to keep up to date with training needs without unnecessary burden.

Fetal Heart Monitoring- e-learning

The SGDL 2018 states staff should complete the RCOG/RCM e-LFH or K2 PTP e-learning programmes. At present, NHS Lothian completes the K2 PTP programme.

Whilst it provides rich background detail, much of the K2 e-learning package contains modules which review basic information that is not of benefit to re-visit every two years and are covered in the face-to-face MMUD training. Since the letter was written there have also been additional modules added to the K2 package; some of which are not relevant to staff working in areas where they will never use CTG interpretation, e.g. core community midwives.

The Fetal Blood Sampling module is not relevant to staff within NHS Lothian as fetal blood sampling is not practised locally and therefore can be removed from all learning pathways.

K2 Module	Time	Current Staff Requirement	Future Staff Requirement	Rationale for Change
Fetal Physiology	1h 40mins	All staff - 2 yrly	All staff – once only	Content covered in 2yrly MMUD training
Antenatal CTG	15mins	All staff - 2 yrly	All staff - 2yrly	n/a
Intrapartum CTG	4h	All staff - 2 yrly	All hospital staff – 2yrly Not required by Core Community Midwifery Staff	Not required for community as not used in homebirth setting.
Cord Blood Gas	1h 35mins	All staff - 2 yrly	All staff – once only	Content covered in 2yrly MMUD training
Errors and Limitations	1h 25mins	All staff - 2 yrly	All staff – once only	Content covered in 2yrly MMUD training
Intrapartum Intermittent Auscultation	10mins	All staff - 2 yrly	All staff - 2 yrly	n/a
Fetal Blood Sampling	1h	All staff - 2 yrly	Not mandated	Fetal Blood Sampling not practised in NHSL
NHSL Competency Test		All staff - 2 yrly	All staff - 2 yrly (aligned to MMUD)	To assess understanding of relevant training delivered through MMUD teaching

This would reduce the training duration for midwifery and obstetric staff as follows:

- At point of employment – reduced by 1 hour
- Hospital based staff, two-yearly refresher – reduced by 5 hours 40mins
- Community based staff, two-yearly refresher – reduced by 9 hours 40mins

Currently e-learning modules are undertaken on an ad hoc basis across all staff groups, resulting in difficulty with compliance monitoring as various modules fall due at different times. With the proposed refresh in e-learning required, the expectation would be that all K2 e-learning would be undertaken in a single sitting, with staff being asked to, either, evidence their K2 e-learning is in date at the point of employment or undertake the full requirement within the 2-week supernumerary period for midwifery staff and 2 week induction period for medical staff.

Obstetric Emergencies - Face-to-face training

Both midwifery and obstetric staff will be asked to complete the PROMPT or COMET course within three months of employment. This would then be alternated each year with the MMUD study day which would act as an update for fetal wellbeing training for all and a local neonatal resuscitation update for midwifery staff.

At present, the following number of spaces are available at each training day each year:

- MMUD (all staff) spaces available per year:
  - 330 spaces per year
  - 11 sessions, 30 spaces per session
- PROMPT (hospital-based staff) spaces available per year:
  - 286 spaces per year
  - 11 sessions, 26 spaces per session
- COMET (community-based staff) spaces available per year:
  - 120 spaces per year
  - 6 sessions, 20 spaces per session

At present, there are ~584 staff requiring face to face training with the following headcounts applying for different groups of employed staff members:

- Total Midwifery staff headcount: 460 (taken from Healthroster)
  - Core community midwives: 109 (COMET)
  - Core hospital-based midwives: 234 (PROMPT)
  - Early careers midwives: 117 (PROMPT)
- Obstetric staff (ST2+) headcount: 74 (taken from Healthroster) (PROMPT)
- Bank staff headcount: ~50 regular bank staff without substantive posts (based on information from Staffbank, May 2025) (PROMPT)

In addition, there is currently ~20 WTE vacancy at present, which could translate to ~30 headcount of staff as well as anaesthetic colleagues who are also required to attend the same face to face training sessions if working within the maternity unit(s).

Training spaces required per year, assuming 50% of each staff group attends in alternating years:

- ~600 MMUD spaces needed every 2 years= 300 spaces needed per year **(sufficient capacity)**
- ~490 PROMPT spaces needed every 2 years = 245 spaces needed per year **(sufficient capacity)**
- ~110 COMET spaces needed every 2 years = 55 spaces needed per year **(sufficient capacity)**

Whilst there are currently sufficient training spaces to ensure all face-to-face training is delivered to all staff, this assumes an attendance rate at MMUD sessions of 90.9% and at PROMPT of 85.6%, and leaves little flexibility for staff absence, changing Service needs or cancellation due to clinical pressures.

Assuming an 80% attendance rate at each MMUD and PROMPT session would be more realistic and allow more flexibility throughout the year but would require the following number of training places for MMUD and PROMPT each year:

- MMUD = 375 spaces (300÷0.8)
    - 13 sessions of 30 spaces each required annually
- PROMPT = 307 spaces (245÷0.8)
    - 12 sessions of 26 spaces each required annually

This represents an increase of two MMUD and one PROMPT session per year to cover this mandatory training.

Fetal Heart Monitoring- MDT CTG meetings

All hospital obstetric and midwifery staff and any early career midwives within the community would additionally need to attend 2x one-hour multidisciplinary CTG meetings in the years which do not align to MMUD attendance.

Consideration as to whether a second, shorter MMUD day could be facilitated on the alternating years to address this shortfall is currently underway.

Neonatal Resuscitation Training for Midwives – Face to Face Training

All registered midwifery staff are required to undertake a full neonatal resuscitation training day (Scottish National Resuscitation Council) every four years (7h 30mins) and a local update annually (1h). Whilst staff are, in the main, compliant with the four yearly training aspect and receive the local update on the years aligned to MMUD attendance. There is currently no update being provided on the years falling out with the 4 yearly SNRC course or 2 yearly MMUD attendance.

There is potential to include this in the second, shorter MMUD day on alternating years.

Learning pathways

We would recommend staff complete the following learning pathways:

Staff group	Fetal physiology	Antenatal CTG	Intrapartum CTG	Cord Blood Gas	Errors and Limitations	Intrapartum Intermittent Auscultation	PROMPT or COMET	MMUD	Neonatal Resus Training (SNRC)	Neonatal Resus update	MDT CTG meetings	Learning pathways and duration
Time	100mins	15mins	240mins	95mins	85mins	10mins	7.5hrs	7.5hrs	7.5hrs	1hr	2hrs	
	e-learning/K2 module						Face-to-face training		Face-to-face training		MDT learning	
Obstetric staff ST2 and above	Once only	Every 2 years	Every 2 years	Once only	Once only	Every 2 years	PROMPT every 2 years	Every 2 years, to include a fetal wellbeing competency assessment	Not required	Not required	Every year	**At point of employment:** e-learning/K2: 545 mins (9h 5mins) Face-to-face training (PROMPT): 7h 30mins MDT CTG meetings: 2h **TOTAL: 18h 35mins** **Alternating years thereafter:** **Year 1:** Face-to-face training (MMUD): 7h 30mins MDT CTG meetings: 2h **TOTAL: 9h 30mins** **Year 2:** e-learning/K2: 265mins (4h 25mins) Face-to-face training (PROMPT): 7h 30mins MDT CTG meetings: 2h **TOTAL: 13h 55mins**
Early career midwives Core and rotational hospital midwives (established career pathway)	Once only	Every 2 years	Every 2 years	Once only	Once only	Every 2 years	PROMPT every 2 years	Every 2 years, to include a fetal wellbeing competency assessment and neonatal resus update	Every 4 years	Every 2 years (alternating with MMUD)	Every year	**At point of employment:** e-learning/K2: 545 mins (9h 5mins) Face-to-face training (PROMPT or COMET): 7h 30mins Face-to-face training (SNRC): 7h 30mins MDT CTG meetings: 2h **TOTAL: 26h 5mins** **Alternating years thereafter:** **Year 1:** Face-to-face training (MMUD): 7h 30mins MDT CTG meetings: 2h **TOTAL: 9h 30mins**

Staff group	Fetal physiology	Antenatal CTG	Intrapartum CTG	Cord Blood Gas	Errors and Limitations	Intrapartum Intermittent Auscultation	PROMPT or COMET	MMUD	Neonatal Resus Training (SNRC)	Neonatal Resus update	MDT CTG meetings	Learning pathways and duration
												Year 2: e-learning/K2: 265mins (4h 25mins) Face-to-face training (PROMPT or COMET): 7h 30mins Face-to-face training (NNR update/SNRC every 4th yr): 1hr/7.5hrs MDT CTG meetings: 2h **TOTAL: 14h 55mins (increased to 22h 25mins every 4th yr)**
Core community midwives (established career pathway)	Once only	Every 2 years	Not required	Once only	Once only	Every 2 years	COMET every 2 years	Every 2 years, to include a fetal wellbeing competency assessment and neonatal resus update	Every 4 years	Every 2 years (alternating with MMUD)	Not required	**<u>At point of employment:</u>** e-learning/K2: 305 mins (5h 5mins) Face-to-face training (COMET): 7h 30mins Face to face training (SNRC): 7h 30mins **TOTAL: 20h 5mins** **<u>Alternating years thereafter:</u>** **Year 1:** Face-to-face training (MMUD): 7h 30mins **TOTAL: 7h 30mins** **Year 2:** e-learning/K2: 25mins Face-to-face training (COMET): 7h 30mins Face-to-face training (NNR update/SNRC every 4th yr): 1hr/7.5hrs **TOTAL: 8h 55mins (increased to 16h 25mins every 4th yr)**

2.3.3 Financial

Fetal Heart Monitoring- e-learning

The SGDL 2018 states staff should complete the RCOG/RCM e-LFH or K2 PTP e-learning programmes. At present, NHS Lothian completes the K2 PTP package which costs approximately £18,000pa excl. VAT to licence to our staff. This package was chosen due to the ability to centrally report on compliance of training.

Whilst NHS Lothian currently uses K2, the RCOG/RCM endorsed e-LFH programme offers a more condensed package of learning, taking approximately 1 hour to complete, free of charge. The service is exploring this option ahead of the K2 contract expiring in July 2026 and are working with colleagues in the Clinical Education Team to investigate what options there might be for reporting compliance directly from this platform.

Obstetric Emergencies - Face-to-face training

There is a need to increase the number of MMUD and PROMPT study days each year to ensure staff can attend in a timely fashion both upon starting employment with NHS Lothian and when training falls due. Acknowledging that there is currently no job planned time within the obstetric faculty to deliver this training as it stands, there may be a cost uplift associated with increasing face-to-face training sessions.

Fetal Heart Monitoring- MDT CTG meetings

There may be a cost uplift associated with releasing staff to attend MDT CTG meetings if this cannot be facilitated within rostered shifts and a second, shorter MMUD training day needs to be introduced on alternating years.

Neonatal Resuscitation for Midwives - Face-to-face training

There may be a cost uplift associated with releasing staff to attend the mandated 1hr local updates if this cannot be facilitated within rostered shifts and a second, shorter MMUD training day needs to be introduced on alternating years.

2.3.4 Equality and Diversity, including health inequalities

Following consideration of the statutory duties, an Equality and Children's Rights Impact Assessment (ECRIA) is not required. The proposal does not introduce new services, change eligibility criteria, alter referral pathways, or reduce/withdraw any existing services for patient groups.

2.3.5 Route to the Meeting

23/02/26 – discussion between Fetal Wellbeing Midwife, Fetal Wellbeing Consultant Lead and Assistant Service Manager
10/03/26 – discussion between Fetal Wellbeing Consultant Lead, Professional Midwifery Lead, Associate Medical Director and Assistant Service Manager

2.4 Recommendation

- **Decision** - We are seeking CMT approval to progress the revised learning pathways outlined in section 2.3.2 above.
- **Information** - We are making CMT aware that there may be additional costs associated with delivering additional face-to-face training.

Midwifery Band 1-4	April	May	June	July	August	Septembe	October	November	December	January	February	March
2024/25	19.88	15.52	15.12	11.66	13.42	17.85	21.79	13.82	16.02	10.07	9.71	14.45
2025/26	15.47	8.05	10.81	13.41	14.06	13.49	15.41	16.40	16.81	17.66	13.32	14.66

Midwifery Band 5+	April	May	June	July	August	Septembe	October	November	December	January	February	March
2024/25	5.96	6.25	7.00	8.11	7.55	9.02	10.42	7.53	9.05	8.36	8.04	7.74
2025/26	7.29	7.20	7.94	7.42	6.68	7.95	8.09	8.12	6.76	6.81	6.82	7.21

Nursing Midwifery	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
COVID-19 Related (Special Leave)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Leave	2.69	2.43	2.25	3.02	2.62	2.18	2.58	2.48	2.31	2.38	2.39	2.24	2.61	2.32	2.44	2.98	2.64	2.33	2.60	2.57	2.68	2.49	2.49	2.52
Study Leave	1.66	1.69	1.38	0.85	1.21	2.00	2.03	2.07	1.25	1.47	1.67	1.68	1.78	1.71	1.50	1.04	1.33	2.33	2.15	2.47	1.53	1.62	1.78	1.99
Maternity Leave	2.82	2.59	2.45	2.81	2.44	2.64	2.75	2.51	2.77	2.56	2.59	2.68	2.83	2.52	2.87	2.86	2.50	2.91	2.45	2.40	2.70	2.15	2.26	2.42
Annual Leave	13.19	11.94	12.69	17.12	13.25	13.68	13.36	10.31	16.30	13.99	15.06	15.83	14.04	11.48	13.31	16.37	12.79	14.34	12.40	10.15	16.28	13.65	15.44	16.59
Sick Leave	7.2	7.0	7.1	7.6	6.9	7.1	7.5	7.2	8.1	7.6	6.8	6.5	6.9	6.5	7.1	7.1	6.7	7.4	7.3	7.5	8.4	7.2	7.0	6.6
Total Leave Parameter	27.59	25.62	25.88	31.36	26.40	27.61	28.23	24.60	30.73	28.02	28.51	28.90	28.15	24.50	27.19	30.35	26.01	29.35	26.89	25.06	31.60	27.11	29.00	30.15