Appendix 4

Stakeholder feedback and response following consultation on the maternity detailed recommendation report

In keeping with duty 12IR of the Health and Care (Staffing) (Scotland) Act 2019, Healthcare Improvement Scotland (HIS) undertook a consultation with named persons prior to the publication of the detailed recommendation report on the Maternity Services Staffing Level Tool v 1.0 to the Scottish Ministers. The below outlines the feedback received and the response from HIS. Please note the section number is referring to the section of the detailed recommendation report for the Maternity Services Staffing Level Tool Version 1.

Feedback from the Royal College of Midwives (RCM)

Section 1.1

The Healthcare Staffing Programme (HSP) sits within Healthcare Improvement Scotland (HIS). HIS was commissioned by the Chief Nursing Officers Directorate (CNOD) to revise the Maternity Staffing Level Tool for use in specific types of healthcare.

Healthcare provision
Maternity are provision by registered midwives including inpatient, outpatient, community services* and specialist and leadership roles

Stakeholder feedback:

There is no mention of integrated care, note specialist and leadership as part of review, yet decision has been made not to include specialist roles.

Response:

This is in relation to Table 1 on page 2 of the report. The healthcare provision refers to the extant maternity tool on Scottish Standard Time System (SSTS). As this is the introduction section it is setting the scene. The word ‘existing’ in 1.1 has been added to ensure it is clear this is in reference to the extant Maternity Staffing Level Tool and not the new Maternity Services Staffing Level Tool.

Section 1.3

HIS recommends the replacement of the 'Maternity Staffing Level Tool Version 3' with a revised staffing level tool 'Maternity Services Staffing Level Tool Version 1'.

Stakeholder feedback:

Are these versions correct as read/appear in wrong order?

Response:

This is not a revision of the existing tool and is a newly built Maternity Services Staffing Level Tool which will be hosted on a new digital platform and therefore is version 1.

Section 2.2

When developing tools, HIS has a duty to consider multi-disciplinary staffing level tools. Due to the nature of the timeline for this tool and the absence of a validated methodology for multi-disciplinary development, it was agreed this tool would remain uni-professional i.e. workload of the midwifery team. Another key factor influencing this decision was that the Royal College of Obstetricians & Gynaecologists (RCOG) had been commissioned by Scottish Government to more accurately quantify the number of obstetricians required in maternity units and a tool describing obstetric and anaesthetic staffing was being developed to support this work. This was discussed with the Scottish Executive Nurse Directors (SEND); NHS Scotland Directors of Midwifery (SDoM), the Royal College of Midwives (RCM) and the Chief Nursing Officer's Directorate (CNOD).

Stakeholder feedback:

Was the RCOG commissioned by Scottish Government? The discussion re RCOG was not around commissioning but for them to share what they were doing in this area.

Response:

This section was entered for information and to support the uni-professional approach to the new tool development. This wording has been amended to the below for additional clarity:

Another key factor influencing this decision was that the Royal College of Obstetricians & Gynaecologists (RCOG) had been commissioned by Department of Health and Social Care (DHSC) to more accurately quantify the number of obstetricians required in maternity units and a tool describing obstetric and anaesthetic staffing was being developed to support this work.

This is topic is expanded upon in section 2.19 of the report.

Section 2.5

The current Maternity Staffing Level Tool covers the following areas of care:

- antenatal ward
- postnatal ward
- labour suite (intrapartum)

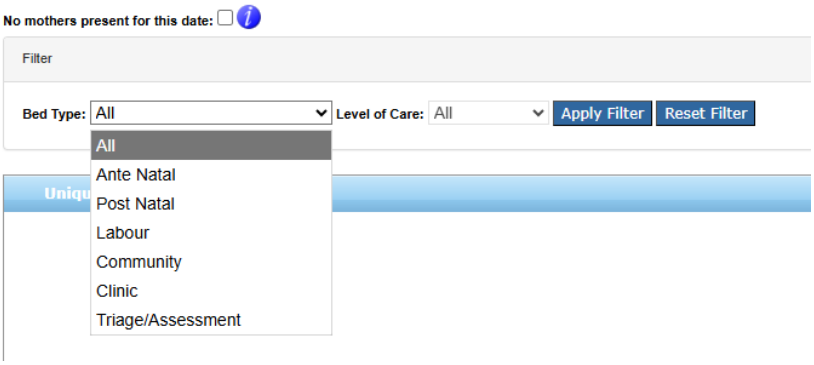
- clinics
- triage
- community

Stakeholder feedback:

Triage was not part of the existing tool.

Response:

There is an option for triage on the extant Maternity Staffing Level Tool on SSTS. However, the option is referred to as 'Triage/Assessment'. See screenshot below from SSTS.



The HSP recognise the extant Maternity Staffing Level Tool on SSTS does not reflect the developments that have taken place within maternity triage services since the tool was developed.

Section 2.19

In January 2022 the HSP were made aware of work being undertaken across NHS Scotland to develop a staffing tool for Obstetricians with NHS Boards requested to submit a range of data to the Royal College of Obstetricians & Gynaecologists (RCOG) to support the development of this tool. The Department of Health and Social Care commissioned the RCOG to more accurately quantify the number of obstetricians and obstetric anaesthetists required in maternity units in England, taking into consideration factors such as existing staffing levels and predicted population changes. The priority for this tool was following the recommendations from the Health and Social Care Select Committee Inquiry in 2020/21, which examined the ongoing safety concerns with maternity services.

This work was extended to include Wales and Scotland with funding being secured from Scottish Government to support this expansion. The purpose of the tool was to describe the summary characteristics and demand for obstetric and anaesthetic staffing on an annual basis in NHS Trusts and Boards providing maternity services across England, Wales and Scotland. Meetings between the HSP and external stakeholders in CNOD, Royal College of Midwifery (RCM) and the RCOG took place to understand and identify opportunities to incorporate or align the Scottish Maternity Staffing Level Tool development with the RCOG Tool development going forward. The RCOG tool does not capture the Midwifery staffing and therefore hasn't impacted on HIS's planned redevelopment of the Maternity Staffing Level Tool.

Stakeholder feedback:

The issue was potential variation in acuity definitions.

Response:

Noted. The RCOG do not utilise levels of care (LoC). Therefore, would not impact on the NHS Scotland LoCs for the new Maternity Services Staffing Level Tool. It is believed that they utilise the number of births to inform obstetric and anaesthetic staffing and workforce modelling.

Section 2.22 (please note this section has multiple elements of feedback)

A collaborative meeting with the Health and Care Staffing Team, Health Improvement Scotland, Royal College of Midwifery and the Chief Midwifery Officer representing NHS Board Heads of Midwifery agreed that while it would not be possible to include all areas noted above, the ability to record travel time and time spent on triage phone calls would be a welcome addition to the existing SLT ahead of enactment.

Stakeholder feedback:

The RCM was not in agreement with all aspects of this discussion, that all those above areas should not be included. I take it this means that as a stopgap that these areas were added prior to enactment.

Response:

Yes, this was pre-enactment as the meeting took place in 2022 and was in relation to additional improvements to the existing staffing level tool while the new build was in progress. The text has been amended to:

A collaborative meeting with the Healthcare Staffing Programme team, the Royal College of Midwifery and the Chief Midwifery Officer representing NHS Board Heads of Midwifery. It was **established** that while it would not be possible to include all areas noted above, the ability to record travel time and time spent on triage phone calls would be a welcome addition to the existing staffing level tools ahead of enactment.

Noted within the RCM response to this section there is still outstanding aspects of care delivery within the new tool, as detailed below.

Stakeholder feedback:

Transitional care was not widespread when tool developed thus generating concern that mum and baby are not identified individually.

Response:

Transitional care also sits within the neonatal tool and is not widespread within maternity services in Scotland for all boards. In the new maternity tool, it falls within a complex level of care and has a multiplier of 1.80 care hours per patient day (CHPPD) based upon intelligence gained from observation studies. Compared to the British Association of Perinatal Medicine (BAPM) standards

that suggests 1.55 CHPPD which is utilised within the current neonatal tool. The HSP is exploring capacity to review the neonatal staffing level tool within the next financial year (2026/27).

Stakeholder feedback:

Increased travel resulting from Best Start implementation within integrated teams. Increased travel was not only arising from Best Start/integrated teams – it was about capturing real time travel reflective of geography.

Response:

The reference to travel time within 2.12 was amended as follows:

- Increased travel resulting from Best Start implementation within integrated teams and geographical locations of maternity services within NHS Scotland

Increased travel associated with geographical variance across NHS Scotland and Best start can be captured accurately through the additional task function. This was deemed the best approach in recognition of the variability across Scotland.

Stakeholder feedback:

Theatre activity not included in current tool.

Response:

Through discovery work undertaken early in the tool development process, the HSP identified significant variation across Scotland relating to theatre activity and the associated workforce within theatres. A Once for Scotland approach to support maternity services workforce planning for theatres would prove challenging due to the different models of care delivery. For example, some theatres were staffed by non-maternity services staff while other Boards used a mixed approach. This was therefore put on hold so as not to delay the staffing tool availability for the other aspects of maternity care. Staff can capture when a midwife/s accompanies a patient to theatre as this would be included within the intrapartum multiplier. Further work will be undertaken to scope whether developing a multiplier for theatres would be viable in 2026/27.

Stakeholder feedback:

Intrapartum work undertaken by community continuity / integrated midwife recorded in labour ward and not community teams.

Response:

Intrapartum work undertaken by community midwives can be recorded by community teams in the new maternity tool but will be a local board decision how they configure this.

Stakeholder feedback:

On-call provision not included.

Response:

Providing an on-call does not lend itself to recommending a whole-time equivalent within a staffing level tool. The reports from the tool will be explicit that the outputs do not reflect on call arrangements. It is up to the boards to ensure there is sufficient resource to meet this need and make suitable arrangements, adhering to working time directives. Staff would be able to record any actual workload undertaken as part of their on call role and capture the required appropriate staffing through the professional judgement tool and application of the common staffing method.

Stakeholder feedback:

Recording of high risk antenatal and maternity day assessment workload

Response:

This activity would be captured via the outpatient multipliers within the new tool.

Stakeholder feedback:

The other tools described; emergency care, small wards (Community Midwifery Units in our case) are not addressed.

Response:

The HSP are currently looking to address the issue of ensuring appropriate staffing for small wards within maternity services for the staffing level tool. We have reached out to boards several times to provide us with the information we require to progress this work but to date have had minimal feedback. A further request has been issued to Boards with the proposal to have a minimum staffing statement/output within the reporting function.

Section 2.25

A Director's Letter (2024) 05 was issued to NHS boards acknowledging the limitations of the extant Maternity Staffing Level Tool but emphasising that it must be run alongside the professional judgment tool as part of the health boards requirement to follow the common staffing method for this type of healthcare

Stakeholder feedback:

Can the link be added so quite clear that the results should not be relied on?

Response:

Link now added to the report.

Section 4.2.4

*In accordance with the National Institute for Health and Care Excellence (NICE) guidelines, women in established labour should have 1:1 care and support from an assigned midwife.

1:1 care needs to be based on a calculation and not observation studies to ensure an accurate output. This allows for a standardised approach to 1:1 care ensuring staffing level tools attribute sufficient care hours for patients at this level. The proposed multiplier is based on the recommended

calculation that attributes 26 hours of paid care to a patient on 1:1 care over a 24-hour period as detailed below.

24 hours + 60min handover period + 60min personal time = 26 hours of care required

Annex B (time tasked method):

- hospital outpatients
- community/integrated areas
- specialist midwives
- leadership roles

Stakeholder feedback:

Whilst accepting this as a **minimum** there will regularly be episodes that require greater than 1:1 care. It should be acknowledged that this is a **minimum** and robust professional judgement is therefore required in the absence of level of care multipliers to take account of this. Additionally, the risk of staffing to a median when fluidity of activity can mean that the ward can run at full for e.g. 30% of shift and then 35% capacity for 40% etc. There must be 1:1 staffing available for all peaks otherwise there simply won't be safe staffing.

Response:

The 'calculation' is based on the outcomes of evidence-based practice for 1:1 care and, as in the point above about transitional, is also applicable here.

The variability in the number of staff present did not support development of a Once for Scotland multiplier. In recognition that more than one member of staff may be required, core and enhanced intrapartum levels of care will allow teams to record additionality using the patient task function.

The HSP are also looking to undertake further work in 2026/27 in recognition that these ratios are minimum staffing levels and seek to understand what additional resource is required. The HSP chose not to delay the launch of the new tool for another 6-12 months while this work was being undertaken while this work is being undertaken and re-emphasise the importance of using professional judgement and the common staffing method alongside the tool outputs when undertaking workforce planning.

The additional work being undertaken by HSP in 2026/27 will include reviewing percentiles for the tool outputs.

Stakeholder feedback:

The study from 2013 warns against staffing to a median occupancy (as for birthrate plus) as this leads to being understaffed 37% of the time -advises being staffed to 90th percentile.

Response:

The additional work being undertaken by HSP in 2026 / 27 will include reviewing percentiles for the tool outputs.

Stakeholder feedback:

Regarding Annex B, it should be noted that this is only inclusive of roles where direct clinical care/intervention is delivered, therefore will not capture all specialist and additional roles essential to delivering safe midwifery care.

Response:

The HSP team met with RCM colleagues on the 8 May 2025, to explain the rationale in the methodology for excluding these roles. This was then shared with the EWG on 10 June 2025 with no objections to this noted in the minutes.

Sections 4.2.4/4.2.10/4.2.11

4.2.5 Observation studies are an established methodology developed by Dr Keith Hurst where observers shadow an inpatient midwifery team for the duration of their shift and record each activity observed at 10-minute intervals. Data gathered is then used to develop acuity-based multipliers for each of the different levels of care by sub-specialty i.e. Antenatal, Postnatal Mother, Postnatal Baby.

4.2.10 Operational processes were developed to support Annex A and Annex B including the creation of a quality audit to ensure the findings are reflective of areas that are delivering high-quality care.

4.2.11 When completing the quality audit some clinical areas were unable to achieve the required threshold to evidence high quality of care. These clinical areas were excluded from Annex A and Annex B with the sampling revisited to identify further areas across NHS Scotland. This is an iterative process.

Stakeholder feedback:

While the evidence regarding tools remains weak, the evidence regarding continuity of care is strong, yet the tool continues to follow the building rather than the woman. We have continued to say that observation should have followed the pathway of care across level of acuity and the woman rather than the shift.

Response:

HIS have developed a staffing level tool which will reflect the establishment required to deliver continuity of care. In practical terms, it would not have been possible for the observers to follow a particular woman's journey, from booking appointment into the postnatal period. However, the tool captures all aspects of workload associated with delivering continuity of care including the additional travel time which will be reflected through the additional tasks function. Teams will be able to apply a variation of multipliers e.g. ante / postnatal, triage and community to a single roster reflecting their workload across the patient care continuum. It should also be noted that tool outputs should not be used in isolation but are part of the triangulation process required in applying the common staffing method which is a duty within the legislation.

Stakeholder feedback:

It should be noted that this approach has limitations in that it 'assumes' that the safest high-quality care is being delivered during the observation period when in fact we know that the quality audit did not guarantee this as current staffing is subjective as was the self-completion (by midwife in charge) with a 70% (I think) threshold.

Response:

This appears to be referring to the initial quality audit that is undertaken prior to observation studies. Following feedback from the RCM during the tool development process an additional quality assurance tool was completed at the time of the observation studies to ensure any data included in the studies reflected high-quality care. This was done in addition to the nurse in charge completing the professional judgment tool.

Sections 4.2.6/4.3.3

4.2.6 Activities are grouped into 4 main categories:

- direct care
- indirect care
- associated work
- personal.

4.3.3 b = breaks = *percentage to allow for breaks/unproductive time*

Stakeholder feedback:

Please describe these categories (in 4.2.6) and relation to the term: unproductive time in calculation (in 4.3.3).

Response:

A glossary will be added with descriptors for direct, indirect, associated and personal categories. The reference to 'unproductive' is within the development of the multiplier section (old terminology). The text has been amended to the below:

b = breaks = percentage to allow for breaks

Stakeholder feedback:

The issue of unpaid breaks is unresolved.

Response:

The issue of breaks is currently under review for all the staffing level tools. A proposal for how paid and unpaid breaks should be addressed will be shared with the Scottish Terms and Conditions Committee to seek feedback. The redeveloped staffing tool only removes 8% which is the amount of time attribute to the 'unpaid breaks' element, when staff are not expected to be available to provide care. This is considerably less than the actual breaks recorded as follows:

Breaks Recorded

Days: 11.7%

Nights: 15.5%

% of breaks overall: 13.2%

% Removed (unpaid breaks): 8%

Section 4.2.8

The application was developed by HSP Analysts supported by a Short Life Working Group (SLWG). Members included the HSP Project Team as well as Community and Specialist Midwives from across NHS Scotland. Improvements were made to the data collection application following feedback from the project team and EWG /SLWG colleagues. Thereafter, a small test of the application was completed by midwives from across 4 NHS boards. Access to the application was via a dedicated MS Teams channel with a link provided by the HSP.

Stakeholder feedback:

Do you have the results of the test as we heard a lot of negatives around the use of app (e.g. access, logging in)?

Response:

Access to the application was via MS Teams. The HSP provided a link for colleagues to join. The application could also be accessed via mobile devices if MS Teams was installed. An MS Teams 'Testing' channel was created where colleagues could ask any questions, submit requests for support, share any learning so everyone using the application would see comments. The also enabled the HSP to respond to any questions or issues in real time.

The data collected during the test will not be utilised or shared anywhere; the exercise was undertaken simply to seek user feedback on the below questions.

- Did the application allow them to record their workload?
- Is it user friendly and intuitive?

Thirty-two shifts were entered on the application across 4 boards. NHS Forth Valley, NHS Highland, NHS Tayside & NHS Greater Glasgow and Clyde across the period of testing. Early review of this data demonstrated staff being able to enter their direct and indirect activity. There was initially some delay in testing due to service capacity and access issues which were supported by a HSP analyst. Overall, the test went well as outputs from this allowed the HSP to make any amendments to Annex B in preparation for data capture.

There were some technical issues during the actual data collection period and tight timelines which may have contributed to the negative feedback mentioned. Training was provided for undertaking quality audits and how to use the application. A user guide was circulated prior to starting data

collection and the MS Teams channel was available during data collection period to enable rapid responses to issues or queries raised.

Section 4.2.9

A statistical technique of sampling was undertaken for all clinical areas within Maternity services across NHS Scotland. The objective was to identify the clinical areas where the observation studies and completion of the data collection app were to be conducted. The aim of this sampling exercise was to ensure a representative cross-selection of specialties and geographic areas across NHS Scotland from remote and rural to urban cities.

Stakeholder feedback:

Specialties? Is it this or types / levels of care?

Response:

This term reflects **aspects** of maternity care. Text has been amended to the below.

A statistical technique of sampling was undertaken for all clinical areas within maternity services across NHS Scotland. The objective was to identify the clinical areas where the observation studies and completion of the data collection application were to be conducted.

Section 4.2.12

Stakeholder feedback:

We disagreed with the fact that quality assessment does not reflect whether care in the right place e.g. in terms of care experience, it may be good care but person unhappy as meant to be induced or in labour ward for example.

Response:

As previously mentioned, there was a quality assurance checklist completed at the end of each shift where observation studies were undertaken. The examples provided would be considered under the quality measures section of the common staffing method e.g. patient feedback, Excellence in Care measures etc. This is a staffing level tool and any additional multifactorial care is picked up in professional judgement and common staffing method triangulation.

Section 4.2.13

Observation studies were undertaken in 35 clinical areas across a range of subspecialties. Shifts were a combination of day and night as well as weekends.

Stakeholder feedback:

Subspecialties, what do you mean?

Response:

This term reflects **aspects** of maternity care. Text has been amended to the below.

Observation studies were undertaken in 35 clinical areas across various aspects of maternity care. Shifts were a combination of day and night as well as weekends.

Section 4.2.19

The Annex B specialist midwives who completed and were on boarded to the application is as follows.

Stakeholder feedback:

BBV should be written in full.

Response:

Report updated to reflect blood born viruses.

Section 4.2.20

Following analysis of the data the data the decision was taken not to include the specialist midwives within the tool due to low numbers and variation across roles, preventing the ability to develop a Once for Scotland multiplier.

Stakeholder feedback:

There is a significant gap – it should therefore be noted that robust CSM is required to ensure overall compliance with the act.

This is not acceptable, just because small numbers do not mean essential. The RCM disagree on this. This is about safe staffing and specialist roles ensure workforce have up to date guidance and education therefore impact on safe care.

Response:

There is significant variance across Scotland in the use and roles of specialist midwives. The data collected demonstrates that the development of a Once for Scotland multiplier for this group of staff is not a viable option. In recognition of how valuable these posts are, the HSP is exploring the potential of undertaking additional work during the 2026/27 financial year to explore a different approach for this staff group. This may include development of workforce standards to accompany the staffing level tool.

Section 4.2.21

The HSP plans to review alternative options to inform workforce planning for these roles.

Stakeholder feedback:

What is the plan as these are key roles and where does consultant fit in?

Response:

Further work to be undertaken in 2026/27 which may include development of maternity workforce standards to accompany the staffing level tool and/or the development of a multiplier for some

specialist roles e.g. sonographers. This requires further scoping to understand how viable this would be.

Section 4.3 (title)

Development of the multiplier

Stakeholder feedback:

Multiplier

Response:

Possibility this comment means it should this be multipliers (plural) rather than single as there are varying multipliers within the new tool. This has now been rectified.

Section 4.3.2

The HSP analysts discovered that there was insufficient quantity of quality data for 3 specialties i.e. antenatal, postnatal and triage. Further observation studies took place in these areas between March to November 2025.

Stakeholder feedback:

Antenatal and postnatal are not specialties they are aspects of midwifery care.

Response:

This term reflects **aspects** of maternity care. Text has been amended to the below

The analysts discovered that there was insufficient quantity of quality data for 3 aspects of maternity care i.e. antenatal, postnatal and triage. Therefore, further observation studies took place in these areas between March to November 2025

Section 4.3.3

Methodology developed by Dr Keith Hurst was used to calculate the inpatient multiplier for one patient at each level of acuity by subspecialty over a 24-hour period using the following calculation.

Stakeholder feedback:

The level of care should be stated.

Response:

Calculation methodology states dependency/acuity to level of care. Document outlining levels of care now included in the appendices of the detailed report.

Section 4.3.7

Please note the content of this paper, including the above calculations. The calculation and multipliers are the intellectual property of HIS. Please see Creative Commons Attribution statement

on page 2. See staffing level tool methodologies and multipliers (an updated document will be published on the HIS Website when the report goes live).

Stakeholder feedback:

We would want to see the multipliers before this goes live. Table 5 currently and those planned for new tool.

Response:

Please see HSP-SLT-Methodologies-and-Multipliers-January-2026.pdf published on 8 January 2026. This was shared with the expert working group on 13 January 2026.

Section 5.11

The consensus from the senior charge midwives on the new Maternity Staffing Level Tool in SafeCare was that it was: "less time consuming to complete overall, which is a positive improvement in terms of usability and workflow efficiency"; "It was concise and user-friendly"; "easier to access and update", "the individual midwives found it easy to complete". There was significant informal feedback of a much-maligned Maternity Staffing Level Tool on Scottish Standard Time System (SSTS) being replaced with a more contemporary and relevant Maternity Staffing Level Tool.

Stakeholder feedback:

Does not reflect the feedback from our representatives, is there a report?

Response:

The HSP sent a survey to NHS boards participating in the national evaluation with 20 responses across different boards. The report is available and has subsequently shared with the RCM.

Section 6.5

The HSP collaborated with Dr Keith Hurst to ensure the evidence-based methodology for the development of the staffing tools was adhered to and any improvements were done in collaboration with him.

Stakeholder feedback:

Evidence of tool use or impact on safety and quality of care?

Response:

The HSP will continue to monitor tool usage and impact on quality and safety in accordance with HIS staffing functions.

Section 6.8

The HSP collaborated with trade unions and professional bodies representative of midwifery teams via the expert working group.

Stakeholder feedback:

Collaborated but we did not agree with all parts as we continue to say: maternity is integrated and follows the woman (Renfrew 2025). The tool was updated as Directors of Midwifery stated it did not have the staff to provide continuity, but the tool has not measured what is required - minimum ratios, time to lead, time for supervision etc.

Response:

HIS have developed a staffing level tool which will reflect the establishment required to deliver continuity of care. In practical terms in would not have been possible for the observers to follow a particular woman's journey, from booking appointment into the postnatal period. However, the tool captures all aspects of workload associated with delivering continuity of care including the additional travel time which will be reflected through the additional tasks function. Teams will be able to apply a variation of multipliers – e.g. ante / postnatal, triage and community to a single roster reflecting their workload across the patient care continuum. It should also be noted that tool outputs should not be used in isolation but are part of the triangulation process required in applying the common staffing method which is a duty within the legislation. The staffing level tool reflects current practice across NHS Scotland in relation to any associated workload staff undertook while rostered on shift e.g. time to lead, protested learning time and supervision. Work is ongoing as part of the Ministerial Scottish Nursing and Midwifery Taskforce with any recommendations attributed to protected learning time, time for supervision and time to lead being reflected as a future revision to the staffing tools.

Feedback from Associate Director of Midwifery in a territorial board

Stakeholder feedback:

I would like to highlight an observation I raised at the national level regarding the allocated absence allowance of 22.5%. Within our board this allowance is 21% for all nursing and midwifery staff. This discrepancy has been noted at the board level. To ensure equity across all boards, it is important to document this variance so that boards deviating from the standard are aware, as it impacts the staffing required to provide the service.

Response:

The 22.5% predicted absence allowance was mandated by the Scottish Government back in 2007 (Cel6 (2007) - CEL(2007)6 - Implementation of nursing and midwifery workload and workforce planning tools and methodologies) therefore should not vary between Boards. The 22.5% is added to all of the recommended WTE outputs from the Nursing and Midwifery staffing tools. It is recognised that the 22.5% is insufficient to ensure appropriate staffing across nursing and midwifery therefore Scottish Government have committed to reviewing this as part of the recommendations from the Ministerial Scottish Nursing and Midwifery Taskforce. This work will progress over the course of 2026 therefore further strengthening the position from Scottish Government to NHS boards on the requirement to ensure sufficient predicted absence is built in to Nursing and Midwifery establishments.

Feedback from Executive Nurse Director in a territorial board

Stakeholder feedback:

The 26 hours for 1:1 care in labour stated in the document, although an increase, is based around 12-hour shifts only and does not account for the mixed economy of shift patterns which our staff undertake.

Response:

The HSP emphasise the importance of using the common staffing method along with staffing level tool outputs and professional judgement to inform workforce planning.

Additional work is planned for all 1:1 care service models and associated workforce resource required to staff units/departments where 1:1 ratios are used to ensure the ratios are reflective of appropriate staffing e.g. inclusive of any coordinator, support worker etc. and will encompass maternity units who operate a 3 shift or mixed shift roster.

Stakeholder feedback:

Only unpaid breaks are accounted for.

Response:

The issue of breaks is currently under review for all the staffing level tools. A proposal for how paid and unpaid breaks should be addressed will be shared with the Scottish Terms and Conditions Committee to seek feedback.

Stakeholder feedback:

The document appears to be based on larger boards and does not take into consideration community midwifery, island settings, or smaller health boards.

Response:

Appendix 1 reflects all boards and services who participated in the observation studies and the national evaluation. These are inclusive if smaller and island health boards and community teams.

Stakeholder feedback:

The professional judgement tool will need to be approved and fit for use in all settings prior to adding context to the report. Currently, the outputs remain acute based.

Response:

The new Professional Judgement Tool is now available on SSTS and was tested across a range of services, including maternity services, prior to being launched. Feedback from maternity teams is that the tool is fit for purpose across maternity services. A further evaluation of the new professional judgment and maternity services staffing level tool will take place over the course of their first year of deployment.

Feedback from the maternity expert working group

Stakeholder feedback:

There are usually two midwives at a home birth, can this be captured within the new tool?

Response:

Yes. This would be recorded as a patient task, and each midwife would input into the tool the total time they spent supporting a home birth. The HSP will be developing data capture sheets to support midwives in capturing this activity.

Stakeholder feedback:

In the community section, where you have care hours assigned to a home visit, is that the length of time you would expect a visit to take?

Response:

Yes, but this also includes associated workload like preparation, forward referrals and updating records. Also, if you were visiting a mother and baby these activities would be added together to make a total time.

Stakeholder feedback:

On call provision isn't addressed within the tool.

Response:

See previous answer regarding on call within this document under section 2.22.

Stakeholder feedback:

The issue of continuity of care isn't address within the tool.

Response:

See previous answer regarding continuity of care within this document under section 4.2.5/ 4.2.10/ 4.2.11.

Stakeholder feedback:

How do you capture women who need transferred to another hospital and needs accompanied by an escort?

Response:

This could be captured as an additional task as a one to one out of hospital transfer and would not end until the midwife had returned to base and is able to undertake other duties.