Response to HEE's Facing the Facts, Shaping the Future: health and care workforce strategy for England to 2027

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THE ROYAL COLLEGE OF MIDWIVES

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The Royal College of Midwives' response to Facing the Facts, Shaping the Future

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to comment on the draft Workforce Strategy; before responding to the consultation questions, we thought it useful to begin with some contextual information about the midwifery workforce and some general comments about the draft strategy.

The midwifery workforce

The role of the midwife

The role of the midwife is to ensure that women receive the care they need throughout pregnancy, childbirth and the postnatal period. Much of this care will be provided directly by the midwife, whose expertise lies in the care of women and babies during normal birth and pregnancy. Where obstetric or other intervention is necessary, the midwife continues to be responsible for providing holistic support, maximising continuity of carer and promoting a positive birth experience for the woman.

Whilst this role has remained essentially unchanged for many years, midwives have proved adaptable in responding to changes in the context of their role, and in settings and systems within which midwifery care is provided. This is a welcome development and an important part of providing a service response to the increasingly diverse needs of all communities within the population. It will be most effective where midwives sustain their competency and confidence in core midwifery practice.

The RCM welcomes any development of the midwife's role which enhances her skills and expertise, or which makes midwifery care more accessible and responsive to women's needs. In the context of ensuring that women are able to exercise choice about the care that they receive, it is critically important to ensure that there are midwives in the workforce who are competent to:

- Work in different settings and to address particular needs which impact on maternal and infant wellbeing (for example domestic violence, substance misuse, homelessness, obesity and safeguarding); and
- Work in new ways and partnerships to meet the range of women's needs to, for example, promote seamless care to reduce unnecessary delays or barriers such as distances in accessing care and to learn new skills.

The NHS midwifery workforce in England

The most recent workforce statistics for the midwifery workforce show that, as at October 2017 there were 21,890 full time equivalent (fte) midwives working in the NHS in England in June 2017[1]. This represents an increase of 269 fte midwives from a year earlier. Overall, whilst the number of midwives has risen since 2010, the upward trend has slowed substantially. During the first year of the 2010 Parliament, the midwifery workforce was growing at the rate of 10 midwives per week; the rate of growth is half that for the most recent 12-month period.

The RCM has been demonstrating for a number of years how the total number of qualified midwives employed in the NHS is insufficient to meet the demands on the service (comprising not just the number of births, but the clinical needs of the women using the service). Our current assessment is that the NHS in England is short of around 3,500 fte midwives, sufficient midwives to provide care to around 100,000 women.

This is not a supply issue. Midwifery training places have been maintained in recent years and there has been a small but substantial cohort who could, if conditions were right, return to the NHS. This is a problem of trust finances; many of our hospitals just do not employ sufficient midwives, leading to excessive workloads/caseloads, long hours worked beyond shift, reductions in training and development, high use of agency staff to cover shortages and failure to properly manage peaks of activity.

For women this means that they have a 20% chance of being left alone in labour or shortly after the birth, antenatal care is often disjointed and postnatal care poor. It also means that there are insufficient specialist midwives for women with particular needs and conditions (such as recently highlighted shortages in maternal mental health care) and it means that units close or services are withdrawn because of staffing shortages.

For midwives it means a long hour's culture, where there is little support for continuing professional development and high anxiety caused by continually feeling unable to give of your best. The latest NHS staff survey showed that 47% of midwives report being stressed at work. So the real challenge is that there are not enough midwives and the real solution is recognition that the NHS has to increase the number of midwives working in the NHS in England.

Maternity Support Workers

Maternity Support Workers (MSWs) are non-regulated, non-professional staff members who are able to provide support to midwives, take on some routine tasks and work under

[1] Workforce figures used here taken from *"NHS Workforce Statistics October 2017, Provisional Statistics"*, NHS Digital, https://digital.nhs.uk/catalogue/PUB30189.

delegated authority. In the last 20 years MSWs have proved time and time again their value to the wider maternity team and to women; they provide capacity and skills, they allow for a more flexible deployment of workforce and they allow midwives to spend more time with women who need them most.

MSWs cannot replace midwives and there will always be a limit to the amount of care MSWs can undertake or their numbers in the workforce. However, when used appropriately, they can free up midwifery time. With appropriate training and support they can do many things, such as providing information and guidance on staying healthy during pregnancy (e.g. smoking cessation and healthy eating advice), supporting midwives as a second person at homebirths, giving breastfeeding advice and undertaking postnatal home visits. It would be fair to say therefore, that the RCM does believe there remains considerable scope to expand and develop the MSW workforce.

What concerns midwives about the MSW role and continues to be the concern of the RCM is the wide variation in role, in training and development and in the pay and conditions of MSWs. There is no standard job description for the role in England, no portability of qualifications and experience and no consistent link of role to Agenda for Change (AfC) grades. Nor is there any clear route for career progression. Attempts to introduce consistency have been strongly resisted by the NHS in England; unlike the NHS in Wales, Scotland and Northern Ireland where all have to some extent successfully introduced standard job descriptions, competency frameworks and training programmes. In England by contrast there is a wide range of MSW job descriptions, titles and roles, from cleaning rooms after delivery to processing paperwork, delivering health promotion messages, providing practical parenting assistance (such as bathing) through to breastfeeding support, undertaking routine diagnostic tests and attending home births with midwives. The RCM has evidence of MSWs that have undergone NVQ training to level 4, including apprenticeships, but remain graded at AfC band 2.

Our MSW members continually tell us that what they want is role clarity, respect and recognition for the role and care they provide and to be treated fairly. We have set out in a series of guides what ‘good’ looks like and locally we are influencing and negotiating to try and get these adopted in trusts. Some employers undoubtedly do develop their support worker workforce and employ them appropriately, but without nationally agreed roles, job descriptions and pay, there is a worrying tendency of a race to the bottom. It should also be noted that neither the recent Cavendish nor Carter reviews have done justice to the contribution that MSWs can make to effective healthcare. A level 3 Maternity Support Worker Apprenticeship Standard has been created – the RCM was a member of the Trailblazer Group – but it remains unclear as to how trusts are using this to ‘grow their own’ MSWs.

The RCM supports a career framework and investment in the development of MSWs. Some, but by no means all, do wish to proceed into a career in midwifery and those who meet the entry requirements have successfully applied. The aspiration, set out in the workforce strategy, for the creation of a role that supports, assists and complements the care given by registered professionals, that works within defined principles of practice and is supported by a competency framework, is exactly what the RCM has been calling for, for MSWs. Equally, clear standards and a clear job title, a flexible and portable skill set and appropriate career progression is long overdue for developing the MSW workforce.

During October and November 2017 the RCM and Kings College London undertook research to help inform the national maternity transformation workforce programme. This research was commissioned by HEE. It used a mix of research methods to investigate the following:

- Duties currently undertaken by MSWs
- Progression and development opportunities
- Training of MSWs
- The role of MSWs within current service/staffing models
- Innovation practice related to MSWs nationally
- Key challenges and barriers to the future development of the role
- Education and training opportunities and pathways

Recommendations from the report include clear national guidance to ensure consistency in deployment, training and grading of MSW roles in England. This would bring England in line with Scotland, Wales and Northern Ireland.

The recommendations will be tested out with Heads of Midwifery (HOMs) and other stakeholders in a series of regional roadshows with the objective of seeking consensus on how the MSW workforce should be developed.

General comments about the draft workforce strategy

The RCM welcomes the development of a national workforce strategy; we believe that this should contribute to more effective planning for the future health and social care workforce as well as better integrating workforce planning with financial and service planning. However, the RCM is disappointed with the discussion on midwifery within the draft strategy. In particular the section on the nursing and midwifery workforce (pp105-114) addresses a number of issues relating to recruitment, role development and training for the nursing workforce, which is only of limited relevance to midwifery. In fact this section says next to nothing about the specific workforce challenges facing the midwifery profession.

The midwifery workforce is briefly mentioned in chapter 4 (The workforce response to the Five Year Forward View) in the context of the current maternity transformation programme in England. Reference is made to the Maternity Workforce Strategy, which the RCM has been consulted on and which, at the time of writing, is the subject of ongoing dialogue between HEE and the RCM. The RCM (and indeed the Royal College of Obstetricians and Gynaecologists) is of the view that the strategy does not as yet represent a 'shared understanding' of workforce issues with the maternity professions.
On the midwifery workforce, the issues that we are still trying to resolve with HEE relate to:

- Staff in post: HEE's assessment of the number of midwives in post is based on the Electronic Staff Record (ESR) which gives a figure of 22,305 fte midwives in post in 2016. The RCM has always used NHS Digital's non-medical workforce statistics, which records 21,038 fte midwives in post as at September 2016. Unlike the ESR, the NHS Digital statistics excludes midwives who are on long-term sick leave, maternity leave or other long term absences and who are thus currently unavailable for work. This means that, while we both agree that the funded establishment for this period is 23,512 fte midwives, whereas HEE estimate the number of vacancies to be 1,207 midwives our assessment is that there are 2,474 vacancies.

- Projected workforce requirements: HEE has estimated that by 2021, there will be a need for 23,518 fte midwives (a net increase of 6wte midwives on the current establishment). From what we can see, this projection is largely based on estimates on what the birth rate will be in three years time. The RCM has not made a projection for 2021 but has instead calculated the number of midwives that are needed now, based on data from 2016, the most recent year for which we have both birth and workforce statistics. Our assessment, based on Birthrate Plus, is calculated as follows:
    - There were 663,157 live births in England in 2016.
    - We apply a ratio of 94% births in hospital and 6% births at home or in birth centres to give figures of 623,368 hospital births and 39,789 home/birth centre births.
    - We then apply a ratio of one midwife to every 29.5 births to the 623,368 hospital births to give a figure of 21,131 fte midwives.
    - We apply a ratio of one midwife to every 35 births to the 39,789 home/birth centre births to give a figure of 1,137 fte midwives.
    - To the combined total of 22,268 fte midwives we add a further 9% for managers/midwife specialists (which equals 2004 fte midwives) giving a total midwife requirement of 24,272 fte midwives.
    - When this figure is deducted from the NHS Digital total of 21,038 fte midwives in post as at September 2016, this leaves an identified shortage of 3,234 fte midwives.
- Continuity of carer: the RCM has for some time challenged the assumptions made by HEE about the workforce requirement for continuity. When 50% of midwives work part-time hours it is extremely optimistic to believe that all midwives in continuity teams will be able to work two or three nights a week on call. Moreover, modelling that assumes 100% of women will receive continuity of carer is wildly unrealistic and makes no allowance for staff uplift whilst existing staff are upskilled to work in continuity teams. We are also concerned that HEE has conflated RCM analysis of the number of midwives needed to provide one-to-one care in labour with the number needed to provide continuity throughout the maternity pathway. The reality is that as yet no-one has any definitive evidence that continuity will take more, the same or fewer midwives than are needed to currently provide one-to-one care in labour.
- Training places: the RCM has been discussing with HEE how many training places will be needed to deliver more midwives from 2021. Our view is that whilst there is a clear need to commission more midwife training places, that it is very difficult to assess exactly how many are required particularly now that changes to funding for student midwives have been implemented. We believe that discussions around future training numbers need to be considered alongside a range of other factors, including the development of recruitment and retention campaigns, the development of the MSW role, the changing complexity of women and the impact of continuity of carer.
- Recruitment and retention: the RCM is in agreement with HEE that, in addition to increasing training places, other actions and approaches should be considered as a means of eliminating staffing shortages. These could include, for example: recruitment campaigns; return to practice (RTP) drives; overseas recruitment; flexible employment solutions and the reintroduction of shortened programmes. In particular, flexible employment opportunities would offer scope to significantly improve retention rates and this is something the RCM would welcome further discussion on. We would however caution that there needs to be realistic expectations about the number of additional midwives that can be generated

through routes, such as RTP and overseas recruitment, that to date have only contributed relatively modest numbers to the midwifery workforce.

- Maternity Support Workers: the RCM supports further development of MSWs roles and recognises that part of the solution to recruitment and retention issues lies in better utilisation of MSWs. Determining how many additional MSWs are required and what the ideal ratio of MSWs to midwives should be part of the programme of work on developing the MSW workforce that HEE will be undertaking.

The RCM remains hopeful that the current discussions we are having with HEE will lead to a consensus on the nature and extent of any shortages and on the measures required to address these gaps in the workforce.

Response to consultation questions

1. **Do you support the six principles proposed to support better workforce planning: and in particular will the principles lead to better alignment of financial, policy and service planning and represent best practice in the future?**

The RCM welcomes the inclusion of the six principles within the strategy and we discuss most of these in more detail in our responses to the following questions.

Enabling a flexible and adaptable workforce

We would however welcome some clarity around principle 2 (enabling a flexible and adaptable workforce) and in particular the following sentence: *"Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions."* It is unclear to us what exactly is meant by 'blending' and the term is not further elaborated on elsewhere in the document. If this is about developing new roles and ensuring that multi-disciplinary teams are configured to include the right roles, then that is to be welcomed. Nevertheless the RCM is concerned that developing new roles has become the default option for tackling skill mix issues, when the more appropriate response may be to make more effective use of staff in existing roles. Moreover, we would question whether new roles which are deemed appropriately for one setting or specialty can automatically be applied to other settings and specialties.

While the RCM has no doubt that more can be done to develop roles, improve skill-mix and promote multi-professional working in maternity care, we would caution against simplistic or 'off the peg' responses to what are often complex issues. Service needs will vary in different localities and with different populations, and the rationale for developing particular roles or substituting roles traditionally undertaken by midwives with other professionals, will vary accordingly. For example, it is probably more efficient and effective for the average sized consultant unit to use professionals other than midwives, such as scrub nurses, to assist in theatre. However in a small obstetric unit it may still be more efficient and effective to use midwifery staff. Equally in a high dependency unit a nurse may be better suited to provide general high dependency nursing care, working alongside a midwife who provides the midwifery care. A rural midwifery unit, by way of contrast, may decide that training midwives in ventouse extraction would make a very real difference to the service's ability to provide accessible, seamless care. In all cases, the rationale for role development should be demonstrable (in terms of maternal and infant health outcomes) and not merely in terms of convenience or professional preference.

The RCM supports some midwives wishing to develop particular skills in order to sustain continuity of carer, allow more women to benefit from midwifery care at home or in midwifery units or otherwise to improve the care available to women and their babies. Good examples of this are perineal repair, cannulation, examination of the newborn and undertaking the six-week postnatal examination. We do not however endorse the extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of, or access to, midwifery expertise. NHS organisations may wish to maximise the flexibility of their workforce, but it is not acceptable to permanently alter midwifery roles to compensate for staffing shortages or changes in doctors' roles (for example, by routinely requiring midwives to assist in caesarean sections).

This kind of response does not resolve the fundamental problem of medical shortages but merely moves the problem onto another profession. Equally, while the RCM appreciates that many midwives may wish to acquire obstetric skills, this needs to be balanced with the value of sustaining the midwifery model of care.

Accordingly, any work to review the skill mix in maternity must be focused on ensuring that women still receive care that is holistic as opposed to task orientated. Other staff can and should be employed in support roles if this leads to greater efficiency, and appropriately educated staff may undertake delegated roles again if this does not undermine the basic principle of women receiving the bulk of their care from an appropriately qualified professional whom they know and trust.

When it comes to assessing the scope for a role in midwifery similar to that of the nursing associate, the first question that arises is whether the workforce challenges facing general nursing are the same as the workforce challenges facing midwifery? And supplementary to that, are solutions that work for general nursing easily transferable to and/or appropriate for midwifery?

Midwifery is a separate and distinct profession to nursing and the role of the practitioner is very different in relation to care provided. Midwifery is very much relationship rather than task or intervention based care. It has its biggest impact on outcomes where midwives are able to provide consistent care over the continuum of antenatal, intrapartum and postnatal care.

Furthermore, midwifery is defined in EU and UK legislation and only a midwife (or doctor) may attend a woman in childbirth. Practically this means that midwives make autonomous decisions without reference to a medical practitioner throughout the pregnancy continuum and that they take full responsibility for their decision making.

The interdependent and interlinked relationship between midwives and MSWs is now reflected in the current practice in maternity units; it does not follow, however, that a higher level of care role would further enhance that relationship. Skills for Health are currently reviewing the MSW level 3 Apprenticeship pathway and we would recommend assessing how this affects workforce planning before moving to create another role. Rather than create an additional role, the RCM believes it would be preferable to put energy and commitment into adapting the principles set out for nursing associate roles, for the existing MSW roles. This would not only increase their productivity and contribution but would also demonstrate a real commitment to developing this element of the NHS workforce.

A similar logic applies to current discussions about the need for an Advanced Practitioner role in general nursing. In midwifery this role already exists – it is called Consultant Midwife and fulfils the need for an experienced clinical expert with a wider sphere of practice. Consultant Midwives make an enormous difference to the clinical leadership, practice development and clinical research within units as well as being the catalysts for change and improvement, often around specialist roles. What maternity services need is more Consultant Midwives, not another new Advanced Practitioner role.

Aligning workforce planning with financial, policy and service planning

The RCM welcomes the recognition within the strategy of the need to better align workforce planning with financial, policy and service planning. This alignment needs to be balanced in a way that ensures that all the different planning elements are accorded equal consideration. Our concern has been that with current funding constraints, financial planning has effectively trumped quality and safety because employers have based their workforce requirements on what can be afforded rather than what service users need.

In March 2017, the RCM conducted a freedom of information request with NHS trusts in England about the extent to which they were implementing the NICE safe staffing guideline for midwives working in maternity settings. What was apparent from the responses to the FOI was that where trusts have conducted a proper assessment of their staffing needs, that trust boards have generally been receptive to requests to recruit more midwives and/or MSWs. This indicates that where robust workforce planning is undertaken that it is highlighting differences between the staffing establishments that have been set according to available funding and the staffing requirements identified by the workforce planning tool.

It is also important to ensure that the workforce implications of all policy decisions and service reorganisations are properly thought through. Policy decisions taken in isolation from workforce considerations can lead to unintended consequences. For example, in the absence of an overarching workforce strategy, the implementation of recruitment drives for particular professional groups (health visitors five years ago, sonographers now) has resulted in the effective poaching of midwives, thereby exacerbating existing staffing shortages. We hope that by better aligning workforce planning with other elements of planning, there will be an end to 'robbing Peter to pay Paul'.

2. **What measures are needed to secure the staff the system needs for the future; and how can actions already underway be made more effective?**

Demands on the midwifery workforce

It is important to emphasise the need that there is for more midwives.

In the four most recent years for which the Office for National Statistics has released figures, the number of live births in England was: 664,517 in 2013; 661,496 in 2014; 664,399 in 2015; and 663,157 in 2016. This is up 100,000 on the number born in 2001. Based on the latest birth figures, the RCM estimates that the NHS in England is short of around 3,500 full-time midwives.

The complexity of the midwife's workload exacerbates this problem. Modelling by NHS Improvement on the maternity pathway tariffs has identified a significant increase in the

number of women allocated to the intermediate and intensive antenatal pathways since 2013 because of their health needs. These pathways require more midwifery time and skills.

In October 2017, for all women for whom height and weight were recorded at their booking appointment, 48% were either overweight (27%) or obese (21%). This was one point higher than the number whose weight was recorded as being in the normal range (47%). This is very slightly higher than the first month for which figures were published, March 2016, when 46% were overweight (26%) or obese (20%). These rates have remained stubbornly high.

Like obesity, smoking prevalence has been consistent too. In March 2016, amongst women whose smoking status was recorded at their booking appointment, 12% were smokers; in October 2017, it was 11%.

Women with greater health needs, including those who are obese and/or smokers, will require more care and support. Higher BMI scores and rates of smoking prevalence increase still further the demands placed on the service.

One big impact of these pressures and the shortage of midwives has been the amount the NHS in England is spending on short-term solutions, like agency and bank midwives and those working overtime. This amount rose 20% between 2015 and 2016, from £72.7m to £87.3m, according to an RCM report based on figures obtained under the Freedom of Information (FOI) Act[2].

Midwifery workforce supply

Whilst pressures on the service remain, the midwifery profession is ageing. Between October 2010 and October 2017, the proportion of NHS midwives in England aged 50 or above rose from 27.9 % to 31.6 %, according to NHS Digital. With many now fast approaching retirement - 1,162 were in their sixties or seventies by 2017 - we need to replace these older, typically more experienced midwives with new midwives in good time, so that their replacements are able to build up their level of experience before their older colleagues leave the profession.

It is important to note that in September 2017, in the NHS in England, there were 1,388 midwives who had a nationality recorded as being from one of the 27 other EU member states, according to NHS Digital. This constituted the equivalent of 1,219 full-time midwives. Despite warm words, these individuals do not yet have legal certainty about their continuing right to live and work in the UK. Whilst December 2017's Joint Report between the UK Government and the European Union set out a plan for them to acquire "settled status" or at least to be on a pathway to securing it, this could still not materialise if talks collapse and there is no exit deal. In any event, post-Brexit, these midwives will be free to leave the UK, but the route through which future EU midwives can replace them will almost certainly be harder than now.

EU-trained midwives may also simply not want to come to a country if they have been made to feel unwelcome by the vote to leave the EU in June 2016. Indeed, the latest figures from the Nursing and Midwifery Council (NMC) show that in the 12 months to September 2017, whilst just 51 EU-trained midwives joined the register as a midwife, 237 left the register - a net loss of 186 registered midwives able to work in the NHS in the UK.

[2] RCM (2017) Agency, Bank and Overtime Spending in Maternity Units in 2016 https://www.rcm.org.uk/tags/agency-spending

The good news in terms of addressing this lack of midwives is that there is no shortage of people wanting to be midwifery students. Figures from UCAS show that in 2017, 14,625 people applied to midwifery courses in England, with 2,605 accepted. There is clearly scope to expanding the number of places on traditional midwifery courses.

The scale of the need to bring new midwives into the profession is illustrated by comparing the number of new students each year with the net effect on the workforce. Despite around 2,500 starting their midwifery studies each autumn, in the most recent 12-month period (the year to November 2017) figures from NHS Digital show that the full time equivalent NHS midwifery workforce in England rose by just 219. So, the number by which the workforce is rising is less than a tenth of the input into our universities.

Recruitment and retention solutions

What is to be done? What improvements could ameliorate the current situation? There are many actions that can be taken without the need to undertake lengthy reform of routes into the profession.

It has become clear to the RCM through surveys we have conducted that the lack of availability of flexible working options contributes to midwives deciding to leave the profession. This is felt most keenly by midwives in the 35-44 age bracket, often juggling the demands of parenthood and the care needs of elderly parents.

Our 2017 survey of heads of midwifery (HOMs) found that:

- 85% of HOMs found accommodating requests to reduce the number of night shifts difficult or very difficult;
- 88% of HOMs found accommodating requests to reduce the number of weekends difficult or very difficult; and,
- 91% of HOMs found accommodating requests to fix their shifts (i.e. no rotation of shifts) difficult or very difficult.

A 2016 survey of midwives who had either left midwifery or were considering leaving midwifery found that:

- 76% of midwives who had left would be very or quite likely to return if there were opportunities to work flexibly; and
- 70% of midwives who are considering leaving midwifery would be very or quite likely to stay if there were opportunities to work flexibly.

Our recommendation is for the NHS to be more open to flexible working. Whilst this can be challenging for a service already short-staffed, inflexibility only threatens to make the situation worse by encouraging those in post to leave and discouraging those who have left to re-join.

The RCM is also firmly of the view that midwives and MSWs, as well as other NHS professionals, need and deserve a pay rise. By 2017, the value of a typical midwife's pay had fallen by over £6,600 compared to 2010; and 94% of HOMs responding to a 2017 RCM survey said that pay restraint had had a negative impact on both morale and motivation in their maternity unit. Additionally, in our 2016 survey of those who had left midwifery or were thinking of leaving midwifery, 80% said that better pay would encourage then to stay in the

profession. It has the potential to be a key intervention to staunch the loss of midwives from the NHS.

In the evidence the RCM presented to the independent NHS Pay Review Body, we argued that it is clear from the current and growing staffing crisis in midwifery that the numbers of new recruits and student places must increase. The pay structure and annual uplift that we see for 2018/19 must be good enough to attract new staff into the NHS and students into viewing the NHS as an attractive career option.

We are therefore pleased to report that the RCM and other health unions have agreed in principle a three year pay package with the Government for NHS staff on the AfC pay structure. This framework agreement will result in staff receiving a minimum increase of 6.5% during this period, with many seeing their pay increase by between 9% and 29%. There will also be quicker progression through the pay bands as these have been shortened and overlaps between pay bands have also been removed, resulting in better starting salaries. Crucially, this agreement will be fully funded by the Government and will not come out of existing NHS funding.

The RCM is also pleased that the agreement includes recognition of the need to care for NHS staff, with a commitment to improve productivity through greater emphasis on staff health and wellbeing.

We believe that this agreement sends out a positive message and represents both a start to valuing the contribution of NHS staff and a good basis for improving the recruitment and retention of midwives and MSWs. The RCM will now be consulting our members on the agreement with a recommendation that they accept it.

There are other interventions that have the potential to ensure staff are used more efficiently. It is sensible to focus on how midwives' time is spent rather than just how many midwives the NHS employs.

Take, for example, the issue of where women give birth. The more births that take place outside of obstetric units, the fewer the number of medical interventions that occur and the number of midwives needed reduces. Whilst the number of women who need to give birth in an obstetric unit is increasing, the proportion of women who do so (86% according to the NMPA audit[3]) includes a significant number of women who would be suitable to give birth at home or in midwifery-led facilities. Moreover, evidence from a study by the NCT and Women's Institute[4] indicates that when it comes to place of birth, women whose first choice is to birth in an obstetric unit are far more likely to do so than women who have chosen to give birth at home or in a midwife-led unit which, per birth, are cheaper and on average provide women with better experiences of care. So in our view there is significant scope to encourage more women to give birth in non-obstetric settings, such as in midwife-led units. Additionally, providing a full-spectrum maternity service, e.g. choice of birth in an obstetric unit, midwife-led unit, or at home, as well as antenatal and postnatal care offered in the community, would allow midwives to work in the setting that suits them best, whilst offering

[3] NationalMaternity and Perinatal Audit (2017) Clinical report 2017 http://www.maternityaudit.org.uk/pages/home

[4] NCT/NfWI (2013) Support Overdue: Women's experience of maternity services https://www.nct.org.uk/press-release/wi-and-nct-report-finds-women-unsupported-and-midwives-pushed-their-limits

women greater choice over their care. This is more likely to keep them happy and keep them working in the NHS.

Additionally, the NHS should look at some of the work that midwives currently undertake and whether it would be better done by other staff. We have previously referred in this response to ways in which MSWs can be deployed to free up midwifery time through, for example, providing advice and guidance on staying healthy during pregnancy or supporting midwives as the second person at the homebirth.

There is much discussion across the NHS about the potential expansion of apprenticeships as one way that organisations can grow their own local workforce, while also allowing people to gain skills and experience in order to progress their careers. However the current framework for midwifery education effectively precludes apprenticeships from being a helpful development within midwifery. Not only are all candidates for midwifery education required to have completed 12 years of secondary education, but there is no accreditation for prior learning in midwifery.

Moreover, a curriculum for midwifery apprenticeships cannot be drawn up until the current review of the wider midwifery curriculum is concluded by the NMC. It is only once that is finished, the apprenticeship curriculum is created, and at least one consortium of employers steps forward to take the idea forward that we can progress this route. Even in the best case scenario, this is some way off. So MSWs or others who have achieved a foundation health degree, still need to undertake a full midwifery education programme.

RTP courses represent another route (back) into midwifery, for those who have been midwives previously but have been out of practice for some time. However the present reality is that very few midwives are coming back into the workforce via RTP programmes. The RCM conducted an FOI survey of UK higher education institutions (HEIs) looking at the 2015/16 academic year and found that out of a total of 7,944 individuals at some point of their midwifery studies across the 47 HEIs that responded, there were just 41 RTP students in nine universities, equivalent to around 0.5%of all students. The principal barrier to opening up RTP to more applicants would appear to be the difficulty that former midwives encounter in securing clinical placements. It may be worth looking again at RTP and its potential, but as of now it is not providing a significant route into the midwifery workforce.

3. How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

Pre-registration midwifery education

The draft workforce document currently makes no reference to midwifery education and HEE will need to factor in the new proficiencies for qualified midwives and requirements for midwifery education providers when these are published by the NMC in January 2020. In setting the scene for the future education of the maternity workforce, our report of the RCM/RCOG colloquium on the implications of the Lancet Series on Midwifery may be of interest as it touches on a number of issues raised already in our response[5].

5 https://www.rcm.org.uk/sites/default/files/Implications%20for%20the%20UK%20of%20The%20Lancet%20Series%20on%20Midwifery%20A4%2036pp%202016_3.pdf

As part of the review of the current standards work the NMC has held a series of listening events during 2017/early 2018 with the profession, members of the public including maternity service users and others with an interest in the maternity services. The RCM has also been a member of the NMC Thought Leadership Group and the debates have been wide ranging. Of particular note in these early discussions is the use of the Lancet series on midwifery as a framework for the development of the new proficiencies as well as the challenges posed by the length of the programme. The increasing expansion of the midwife's role has meant that whilst midwives may be competent at the end of the programme they lack experience particularly with regard to leadership, management, provision of complex care and decision making. Early discussions have raised the issue of either extending the programme to four years as is the case in a number of European and Scandinavian countries or alternatively adopting the medical model by having a foundation year following initial qualification and registration, with UK-wide post-registration education and training requirements set by the regulator.

Availability and funding of post-graduate pre-registration midwifery education

New regulations have recently been announced by the DH and HEE in relation to the future funding of post-graduate pre-registration education and training for nurses, midwives and AHPs in England. Currently one of the routes into midwifery is via a post-registration programme for those who are adult nurses on the NMC register (minimum 18 months/3000 hours full time, this equates to an 80 week programme in the UK). Up until now these students have been supported through not having to pay course fees and have a salary replacement equivalent in most cases to entry level Band 5. New arrangements recently announced by HEE include a requirement that nurses wishing to undertake midwifery as a second qualification will have to apply for a student loan. Whilst they may also be eligible for a 'training grant' to compensate for the loss of salary, the mechanism for accessing this is unclear and we have had to seek clarification from HEE with regard to this arrangement. However, given the financial circumstances of nurses and midwives referred to earlier, qualified nurses are unlikely to burden themselves with significant loans of this nature which may be in addition to a pre-existing loan. The resultant fall in applications, as has been seen with the three year programme following the introduction of student loans, is likely to contribute to further loss of viable programmes in England and a drop in post-registration student midwife numbers. Ultimately, this will impact on the number of student midwives exiting programmes in any one year thus further depleting the workforce – it is not evident from the workforce predictions outlined by HEE in the strategy that this has been factored in.

Availability and funding of post-registration education and training/CPD

The RCM is particularly concerned about the impact of the cuts on CPD funding for nurses, midwives and AHPS. For 2016/17 this funding in England has been the subject of cuts of up to 45%, often without much warning and with little evidence of strategic planning at national level whilst funding for postgraduate medical education has continued to be protected[6]. We are in agreement with the Council of Deans of Health findings and recommendations.

With regard to CPD in maternity settings HOMs report that they struggle to identify the post registration education and training budget for the trust and how this can be accessed. BabyLifeline collaborated with the University of Hull to investigate training in maternity

[6] https://www.councilofdeans.org.uk/wp-content/uploads/2016/09/19092016-A-False-Economy-CPD-cuts-in-England-2016-17-.pdf

settings provided by trusts in England. A report of their findings was published in October 2016[7].

Of the 125 trusts who responded:

- Over half of trusts provided 4 days or less of in-house mandatory maternity training every year, with evaluation of training programmes often being poor or non-existent.
- There was no consistency between trusts in relation to which areas of maternity care are classed as requiring 'mandatory' training.
- Only 50 trusts identified newborn screening as part of their CPD training programme.
- Less than a quarter of trusts highlighted teamwork and communication in obstetric emergencies as being part of mandatory training.
- Training was delivered in different ways from trust to trust, with no clear standardisation of topics, duration of training, method of delivery, frequency or assessment.

Medical colleagues' mandatory training is aligned to foundation year training requirements, but there is no sensible, equivalent approach for mandatory midwifery training. Given that midwives and obstetricians work closely alongside each other in maternity units and care for women within a multi-disciplinary team approach, this is particularly unfortunate. The RCM is aware that, following the publication of the Morecambe Bay Investigation[8], that there has been an increase in multidisciplinary training both for students and newly qualified midwives. However this is often focused on skills and drills and dealing with emergencies. What has become increasingly apparent is the role that human factors and situational awareness have to play on a daily basis in assuring the quality and safety of care in maternity settings, particularly in the labour ward environment.

There are new, beneficial, innovative learning and teaching methodologies including gamification, e-learning, use of simulation labs and QI science within maternity settings. However, there remains the fundamental problem of variability in the access, funding and protected time to engage in these activities within trusts in England.

4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

Aside from the issues we have identified in response to question 3, the career structure for all staff needs to focus on four main areas of practice: clinical, managerial, education and research. The later two areas are particularly poorly addressed except where trusts are linked to Academic Health Science Centres. We would like to see more opportunities for staff to be supported in undertaking a clinical academic career or one in education and the creation of joint appointments with trusts and HEIs. Again there is variation in relation to the education and research opportunities available to medical practitioners in contrast to nurses, midwives and AHPs. We have also identified limitations in access to leadership education and training opportunities and access to senior 'nursing' positions within trusts. For example, the person who is the Director of Nursing within a trust and has responsibility for midwifery and

[7] http://babylifeline.org.uk/home/wp-content/uploads/2017/06/BBL-The-Training-Gap-FINAL-report.pdf. See also the infographic http://babylifeline.org.uk/home/wp-content/uploads/2017/06/Mind-the-gap-Infographic-web-May-17.pdf

[8] https://www.gov.uk/government/organisations/morecambe-bay-investigation

allied health is often required to be nurse but not a midwife or AHP thus creating a 'glass ceiling' for those professions. We are currently developing a career framework for midwifery and maternity support workers roles; as part of this we are recommending that every trust has in place a Director of Midwifery equivalent to a Director of Nursing. This would not only improve the quality of care provided to women and their families but also raise the profile and accountability of the profession.

We are unclear as to why there is a particular emphasis on reforms to medical education given that the GMC has recently undertaken a review of the outcomes of medical education and training[9] and are due to publish a new version of the outcomes during 2018.

5. How can we better ensure the health system meets the needs and aspirations of all communities in England?

To be able to provide a truly inclusive service and an NHS which treats all service users with respect, dignity and compassion, NHS workplaces need to be inclusive and the workforce needs to be treated with respect, dignity and compassion.

Investing in a diverse NHS workforce, one which ensures that NHS organisations recruit and retain a workforce that is representative of the communities that they serve, allows the NHS to deliver a more inclusive service and improve the quality and safety of care for service users.

In terms of recruitment, this means widening participation in education and careers in the midwifery profession to a wider section of the population. Unfortunately, the ending of the bursary for student midwives and its replacement with tuition fees and loans risks making the future midwifery workforce less, not more, representative of the communities that midwives serve. Prior to the removal of the bursary, there was wide participation and a varied demographic in relation to people embarking on midwifery programmes.

The RCM has obtained data from UCAS on the number of applications and acceptances to midwifery education providers in England, for the period 2013-17. This shows that whilst the number of applications to midwifery courses in England has fallen in every year since 2013, the introduction of self-funding has accelerated this decrease. So whereas applications fell by 4% in 2014, 9% in 2015 and 7% in 2016, total applications in 2017 decreased by a staggering 21%. To some extent this decline has been masked by the fact that the number of available training places during this period has remained relatively stable and for applicants this has significantly increased their chances of a successful application. Nevertheless the ratio of applicants to acceptances has fallen from 10:1 to 5.6:1 and, if this trend continues, will raise concerns about the available talent pool for midwifery programmes. It should also be noted that the drop in applications is most acute for applicants aged 21 and over (down by 45% between 2013 and 2017) with the result that most students on midwifery programmes for this year are school leavers rather than mature people from varied backgrounds who wish to either embark on a new career as a midwife or change careers. These trends are supported by anecdotal reports from our members who are designated Lead Midwives in Education in universities in England.

[9] https://www.gmc-uk.org/education/undergraduate/undergrad_outcomes.asp

The evidence thus far confirms our view that this decision is fundamentally flawed; the RCM has continually warned the Government about the wide reaching implications of removing the student midwifery bursary given the existing crisis in our maternity services. We are particularly disappointed that the Government has ignored the advice of the RCM and other health unions and professional bodies to make any loans forgivable if students then go to work in the NHS.

In order to address this issue and provide a solution a number of education providers linked with NHS Employers to develop an apprenticeship standard for midwifery. Unfortunately, HEE and Skills for Health have decided that this work should be deferred until after the NMC have published the new pre-registration midwifery proficiencies in 2020. Whilst this is understandable, it does mean that there will be a delay in processing this work aside from the difficulties/confusion in relation to implementing health professional apprenticeships within the NHS, to which we have already referred.

Concerning retention, we must ensure that all sections of the workforce feel valued, able to progress in their career and to feel that they can give of their best. These are reasonable expectations and should be underpinned by equality and diversity policies. Since 99% of the midwifery workforce are women, it will be particularly important to ensure that policies relating to pregnancy and maternity rights, equal pay and flexible working are fully implemented, monitored and evaluated. Similar requirements will apply to older workers (more than half of midwives who are aged over 45), in respect of policies relating to, for example, shift working, access to training and development and retirement policies.

It is therefore of considerable concern that the NHS staff survey for 2017 records an increase in staff reporting that they experienced discrimination at work (from 11.8% in 2016 to 12.6% in 2017) and that fewer staff believe that their organisation provides equal opportunities for career progression or promotion (from 87.5% in 2013 to 84.2% in 2017). Ethnicity was cited as the most common grounds for discrimination and this accords with our own evidence of the experience of BME midwives and MSWs in the NHS. In particular, RCM analysis of the outcome of disciplinary proceedings in London[10] found that BME midwives were disproportionately more likely to face disciplinary action and far more likely to be dismissed than their white colleagues. Indeed, of the 38 midwives dismissed by London trusts between 2010 and 2015, 37 were from a BME background. This and other reports suggest there is discrimination in the NHS which must be tackled and stopped.

The NHS staff survey also highlighted that discrimination on the grounds of age or gender is increasing which is of particular concern for maternity services, given the demographic characteristics of the midwifery and MSW workforce. In this respect, it is worth noting that one of the principle reasons that midwives leave the NHS is because they are not granted opportunities to work flexibly. As we refer in our answer to question 2, HOMs have reported increased difficulty in accommodating requests to work flexibly or to reduce the number of shifts or unsocial hours worked.

The inability of the service to agree to requests to work flexibly is frustrating and demoralising for the very many midwives who have childcare and other caring commitments for whom opportunities to work flexibly are so important. This is also bad for retention and, we believe, a significant factor in the fall in the proportion of the midwifery workforce aged

[10] RCM (2016) BME midwives, disciplinary proceedings and the workplace race equality standard https://www.rcm.org.uk/equality-and-diversity

35-44 years; and it is ultimately detrimental to quality of care that maternity services provide for women and families. While the NHS staff survey records a slight increase in the proportion of staff who feel satisfied with opportunities for flexible working (up from 51.7% in 2016 to 51.8% in 2017) it is clear that the NHS could do more to help staff to juggle work and family commitments.

As we have argued elsewhere in this response, the RCM believes that midwives and MSWs should be supported in working flexibly and be offered a variety of working patterns, so that they can manage their responsibilities to their own families and to their personal work life balance. Moreover career structures and ongoing training and development (including a commitment from the employer to give staff protected time) should form part of the package of support that modern employers are able to offer to staff.

6. What does being a modern, model employer mean to you and how can we ensure the NHS meets these ambitions?

High-quality care requires high-quality workplaces. People perform better when they are confident and motivated a modern, model employer should be positively supporting employees' health safety and wellbeing so they can perform to the best of their ability. Much is said about increasing productivity across the NHS this cannot be achieved where staff feel overworked and undervalued. Many midwives and MSWs are feeling under intense pressure to be able to meet the demands of the service reporting and, as a consequence, experience increased stress and burn out. They have never felt so challenged in their ability to provide the high quality safe care they have been trained to give.

Over recent years there have been many reviews and initiatives to improve the health and wellbeing of NHS staff. In 2009, Dr Steve Boorman was commissioned by the Department of Health to review of the health and wellbeing of NHS staff. The RCM welcomed the resulting recommendations. But piecemeal initiatives, as evidenced from surveys of our members, show that little headway has been made. The increasing demands are having a significant impact on their health safety and wellbeing.

The strong relationship between levels of staff wellbeing and clinical outcomes is well known. Research shows that when staff wellbeing is supported, employee involvement increases and outcomes for women improve. Investment in staff is an investment in care for women and their families. We know the impact that poor culture has on staff and patient care but also that workplace culture does significantly improve where employers take positive action.

There have been some ground-breaking and innovative programmes that are having a positive impact on the experience of midwives and MSWs. For example, the programme for the prevention of posttraumatic stress disorder in midwifery (POPPY©) followed a large scale investigation of UK midwives' experiences of traumatic stress. One in six midwives experienced events whilst providing care to women that they personally perceive as traumatic. The POPPY study, undertaken at Liverpool Women's Hospital, evaluated an educational package aimed at creating a 'trauma aware workforce' and improving the psychological wellbeing of midwives by:

- Raising awareness about work related trauma and normal responses to these.
- Providing guidance on self-care after a traumatic event.
- Ensuring that all midwives can access peer support and trauma-specific psychological therapy where needed.

At the end of the study midwives reported increased job satisfaction, sickness absence was reduced from 12% to 5% and fewer midwives reported considering leaving the profession.

The RCM Caring for You Campaign[11] survey of members in March 2016, and repeated in December 2017[12], does show improvement in those organisations who signed our campaign charter and committed to improve health, safety and well being of staff working in maternity. As part of the campaign, a study carried out by the University of Cardiff in collaboration with Griffin University will make recommendations for employers to improve the psychological health and wellbeing of midwives.

However there are still some worrying concerns for the RCM following the subsequent survey in 2017, which indicated that maternity units are still struggling, that midwives and maternity support workers continue to experience feelings of stress and burn out and that, in some cases health, safety and wellbeing has worsened over the last eighteen months.

In the NHS staff survey 2017[13] there is little change from the 2016 survey with staff still reporting high levels of work related stress, pressure to attend work even when unwell, however staff do report an improvement in organisational response to health and wellbeing issues. More staff report feeling discriminated at work and fewer staff believe that their organisation provides equal opportunities for career progression or promotion. Workplace culture, bullying and undermining behaviours has seen no improvement which is also reflected in the RCM's member surveys, members reported an increase in bullying, harassment or abuse from managers, and other colleagues. However more members said they would report bullying now. We know the impact poor culture has on staff and patient care, encouragingly workplace culture does improve significantly where employers take positive action.

Moreover, a survey of nearly 2,000 midwives carried out in May 2017 for the Work, Health and Emotional Wellbeing of Midwives (WHELM) study[14], has indicated that the psychological health and wellbeing of UK midwives compares poorly to that of midwives from Australia, New Zealand, Sweden and Finland.

We should also consider the responsibility we all have in supporting student midwives and other trainees who midwives help to support and educate. The high rate of attrition amongst student midwives is a concern and RePAIR (Reducing Pre-registration Attrition and Improving Retention) offers interventions for organisations to support students whilst training but also as newly qualified members of the team.

Outstanding high performing organisations are those who value, engage and support their most valuable asset their staff. It is clear that where organisations, working in partnership with the RCM, have put steps in place to improve the health safety and well being of midwives and maternity support workers there have been improvements. There are very clear benefits to doing this which in turn improves patient experience and outcomes.

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[11] https://www.rcm.org.uk/sites/default/files/Caring%20for%20You%20-%20Survey%20Results%202016%20A5%2084pp_5%20spd.pdf

[12] https://www.rcm.org.uk/sites/default/files/Caring%20for%20You%20-%20Survey%20Results%20Midwives%20Working%20in%20Education%20A5%2020pp_1_FINAL.pdf

[13] http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/

[14] The results of the WHELM study will be published shortly

7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

The best way to support midwives and MSWs to maximise their contribution to caring for women and families is to empower them to make full use of their knowledge, expertise and commitment. Midwives and MSWs greatest commitment is to the women and families who they care for and so part of the solution is to implement maternity policies that place women and families at the centre of care.

Accordingly, the RCM supports the vision for maternity services set out in *Better Births,* the report of the National Maternity Review, and has actively engaged with the subsequent maternity transformation programme in England. The intention of delivering continuity of carer, of each pregnant woman seeing as few different health staff as possible, is central to the Maternity Transformation Programme. This is because of the wealth of evidence that shows continuity of care provided by a midwife is linked to the best clinical outcomes for women. Any discussion about the implications of the workforce strategy for the maternity workforce must therefore start from a clear understanding that the primary objective must be to have sufficient staff of sufficient skills/competence/expertise, to minimise the number of different contacts a woman will be required to have during her pregnancy, birth and early postnatal period.

However, whilst the RCM is supportive of the aspirations underpinning maternity transformation, we are equally clear that this cannot be delivered by simply relying on the goodwill of midwives and MSWs alone. It will also require a commitment from the Government, arms length bodies, commissioners and NHS employers to commit the necessary resources to maternity services and to invest in, support, engage with and value midwives and MSWs. In other words it is about implementing the measures that we have referred to in our answers to the preceding questions, such as: recruiting and retaining sufficient midwives and MSWs; investing in their training and development; treating them equitably and fairly and improving their health, safety and wellbeing.

The Royal College of Midwives
March 2018