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"A Colossal Failure of Workforce Planning": exploring the 2021 NHS Midwifery Crisis

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***AIMS Campaigns Team comment**: As we go to press, thousands of people – service users, service providers and others – are preparing to protest as part of the nationwide vigils being organised under theMarch With Midwives banner[1]. They are seeking attention for what is being discussed as the worst UK midwifery staffing crisis in living memory. The AIMS Campaigns Team is pleased to publish this piece by Lisa Common, Consultant Midwife, which offers an important perspective on the current situation: how it came to be, the impact it is having on midwives and service users, and how we might move forward together. A shorter version of the piece was originally published as a guest editorial in Roy Lilley's e-letter on 8 November 2021: "It doesn't add up: counting the cost of the midwifery workforce crisis"[2]. We thank Lisa for offering AIMS this excellent briefing, and for giving us permission to share it here with our readers.*

By Lisa Common RM, Consultant Midwife

Giving birth continues to be the most common reason for admission to hospital. In 2020, England and Wales welcomed over 615,000[3] babies into the world. At its best, midwifery is supporting families through pregnancy, birth and into the early days of parenthood. If we agree that every birthing person needs a midwife at their side, why then have midwifery workforce numbers been left to shrink to dangerous levels?

NHSE/I (NHS England and NHS Improvement) refer rather quaintly to 'gaps' in the workforce. This really

does not do justice to the scale of the current recruitment and retention crisis in midwifery. Donna Ockenden, Chair of the review into maternity cases at Shrewsbury and Telford NHS Trust, recently likened the staffing crisis to a bathtub without a plug – seeing midwives disappearing down the plughole and leaving the profession forever. The current numbers of student midwives in training will not be enough to refill the bathtub – or replace the experience and skills of those midwives who have already drained away. We need to put a plug back in.

The workforce supply problem has certainly been exacerbated by the pandemic, but the multitude of challenges that were laid out by the RCM[4] in 2017 warned of a gathering storm. The report highlighted that over a third of midwives were already in their fifties or sixties – signalling a ticking retirement timebomb. At the same time, student finance changes ended student bursaries and introduced tuition fees. The RCM[5] warned that this would impact on application rates. This has now been confirmed by HEE (NHS Health Education England)'s RePAIR Report[6]. We know that applications to become a midwife have decreased (c.35%)[7]. We also know that student midwife attrition has increased (c.31%)[7]. The most common reason students gave for quitting was 'financial'. The Chancellor's latest budget made no mention of funding for HEE, the arms-length organisation that arranges and pays for all the training of new midwives.

In April 2021, NHSE/I announced[8] that maternity units could use a share of their recent £95.9m investment into the service to help recruit 1,000 midwives. Their expectation is that all maternity services will be fully staffed before April 2022 in line with Birthrate Plus[9], the approved safe staffing toolkit. This rings hollow when there are few midwives on the market to recruit and the parliamentary committee (p52)[10] reported in July 2021 that a *minimum* of 1,932 were needed.

Current NHS strategies to cover midwifery workforce 'gaps' commit over £70m annually for agency, bank staff and overtime. The announcement[11] of £4.5m to support the recruitment of 400 international midwives by the end of this financial year has the feel of a sticking plaster solution. There is no global over-supply of midwives. Not only does this raise concerning ethical questions regarding the drain of midwives from where they are needed in their countries of origin, owing to much higher maternal and neonatal mortality and morbidity, it demonstrates a colossal failure in proactively planning for a sustainable midwifery workforce.

Chronic staff shortages have led to despair and burnout. A recent survey[12] of midwives by their Royal College identified that 8 out of 10 felt concerned about staffing levels and over two-thirds were not satisfied with the quality of care they were able to deliver. Midwives want to be able to provide safe and compassionate care, but when some units have midwifery vacancy rates and maternity leave and sickness absence in the region of 20-30%, and shifts sometimes staffed with just 50-60% of what they need to be safe, the system is seriously failing them and the families they care for.

The parliamentary report into the safety of maternity services[10] investigated how the under-investment in workforce was contributing to an exponential rise in the cost of clinical negligence claims to NHS Resolution (p.46)[13] for obstetric harm. In 2020-21 this accounted for a whopping 59% of the £7.1

billion total, up 9% from last year.

So, what does a maternity unit in distress look and feel like?

Midwives feel increasingly fearful that they cannot deliver against the professional standards detailed in the NMC Code[14].

There are not enough staff to manage the demands on the service, meaning women getless time and care from midwives.

There is a lack of capacity to ensure women living in areas with high levels of socialdeprivation, or women from Black, Asian or ethnic minority backgrounds, arereceiving the level of care needed to prevent worse outcomes for them and their babies[15].

Units find they must close temporarily more often as there aren't enough staff or beds,which means women are asked to travel further to get to a unit that can provide care.

Midwives, under workload pressures, struggle to give one-to-one care during birth, meaning opportunities to spot the early signs of deterioration and avert a disaster mightbe missed.

Home birth services get suspended, depriving women of this choice (see editor's note).[16]

There are delays for women trying to speak to a midwife when they are worried aboutthemselves or their babies, leaving them feeling frightened, alone and at risk.

Changes to services during the pandemic have led to a rise in anger and aggression towards staff[17] who already feel despair and that they are letting families down.

Services are being stripped down to basics, meaning vital antenatal education - thathelps prepare parents for the emotional and physical demands they can expect when anew baby arrives - is sparse.

Capacity to deliver public health priorities - such as supporting smoking cessation or breastfeeding, or ensuring women receive appropriate mental health support - becomespatchy.

Midwives not having enough time to do home visits - visits where they can spot warningsigns that families are struggling emotionally or financially or if there may be any threatsto safety in the home.

More parents leave maternity care having experienced trauma and being left withsymptoms of PTSD, leaving individuals to deal with the fall-out of anxiety and depression andpotentially contributing to family breakdowns.

Vulnerable families fall through the cracks that can lead to Adverse Childhood Experiences (ACEs)[18] that cast a long shadow over the lives and life chances of babies borntoday.

What may help change all this? Here are my top five suggestions:

1. A sharper focus on the retention of existing midwives. Data from the past decade[19] shows a real-

terms fall in midwife pay of £1,813 pa. Pay midwives what they are worth. Commit to offering flexible working patterns to midwives who need more support during the menopause or as they approach the end of their careers.

2. Given the impact that changes to student finance have had on student midwife applications and retention, why not scrap tuition fees and re-introduce bursaries to help widen participation? Or even forgive student debt once a midwife has served at least five years?

3. Mandate best practice for preceptorships[20] so that we close the 'flaky bridge'[21] and ease the transition from student to newly qualified practitioner[22] with better support.

4. We could diversify the maternity workforce by accelerating implementation of theMaternity Support Worker (MSW) Career Development Framework[23] to improve workforce capacity at pace.

5. Why not task universities and NHS trusts to work together to offer themidwifery degree apprenticeship?[24] This has the potential to create a sustainable pipeline of staff who could use the apprenticeship framework for MSWs to progress to Assistant Practitioners and onto a midwifery degree apprenticeship.

A nationwide grass-roots initiative has emerged to help facilitate the organisation of vigils around the country and to establish a network of allies to share their outrage at this growing national calamity in maternity services. Visit the March With Midwives UK Facebook page[25]. Midwives cannot keep consuming their own smoke[26] – they need birthing people, parents, grandparents and advocates to amplify their voices.

The NHS is failing midwives. They are burnt-out, fearful, angry, and abandoning the profession as a result. In turn, this means that the NHS is also failing too many birthing people, babies, and families: putting them in harm's way. This is not the type of service that midwives can tolerate providing any longer. We all deserve better.

Dr Lisa Common, Consultant Midwife

Disclaimer: All views expressed in this article are my own and not those of my employingorganisation or their affiliates

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[1] March With Midwives Facebook page: www.facebook.com/groups/marchwithmidwivesuk. See also the AIMS Statement concerning the nationwide March With Midwives vigils, taking place on 21 November 2021, published on 15 November 2021

[2] Common, Lisa (2021) 'It Doesn't Add Up' First published as a guest editorial in Roy Lilley's e-newsletter, 8 November 2021 https://files.constantcontact.com/9bc520cb001/fb926a15-0388-4716-

84ca-d072526289e9.pdf [last accessed 9/11/21]

[3] Office for National Statistics (ONS) Provisional births in England and Wales: 2020 and Quarter 1 (Jan to Mar) 2021. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/articles/provisionalbirthsinenglandandwales/2020andquarter1jantomar2021

[4] RCM (2017) The Royal College of Midwives - The gathering storm: England's midwifery workforce challenges. www.rcm.org.uk/media/2374/the-gathering-storm-england-s-midwifery-workforce-challenges.pdf

[5] Siddique H. (2015) Midwives' body condemns plan to make students pay for training. The Guardian. www.theguardian.com/education/2015/oct/02/midwives-body-condemns-plan-to-make-students-pay-for-training

[6] NHS Health Education England. (2020-2021) Reducing Pre-registration Attrition and Improving Retention. www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention

[7] Astrup J. (2018) Blown off course. RCM. https://www.rcm.org.uk/news-views/rcm-opinion/blown-off-course

[8] May R., Chief Nursing Officer, England (2021) Investment in Maternity Workforce and Training. Personal communication. www.england.nhs.uk/wp-content/uploads/2021/04/B0532-investment-in-maternity-workforce-and-training-letter.pdf

[9] Birthrate Plus: https://birthrateplus.co.uk

[10] UK Parliament (2021) Safety of maternity services in England. https://committees.parliament.uk/publications/6578/documents/73151/default/

[11] NHS Workforce Alliance (2021) International Recruitment funding for midwives and hotel quarantine costs. https://workforcealliance.nhs.uk/ir-funding-midwives-and-quarantine

[12] RCM (2021) RCM warns of midwife exodus as maternity staffing crisis grows. www.rcm.org.uk/media-releases/2021/september/rcm-warns-of-midwife-exodus-as-maternity-staffing-crisis-grows

[13] NHS Resolutions (2021) Annual report and accounts. https://resolution.nhs.uk/wp-

content/uploads/2021/07/Annual-report-and-accounts-2020-2021-WEB-1.pdf

[14] NMC (2018) Read The Code Online. www.nmc.org.uk/standards/code/read-the-code-online

[15] NPEU (2021) MBRRACE Reports. www.npeu.ox.ac.uk/mbrrace-uk/reports

[16] Editor's note: While it feels this way in practice, AIMS reminds women that home birth is still a legal and human right and that no one (with rare exception) can be made to give birth in hospital. What has always been a choice is whether or not to be attended by a midwife at home, and some women are currently being denied this choice. Home birth suspension coerces women into hospital.

[17] RCM (2020) Seven out of 10 midwives experience abuse from women and partners during pandemic, says RCM. www.rcm.org.uk/media-releases/2020/november/seven-out-of-10-midwives-experience-abuse-from-women-and-partners-during-pandemic-says-rcm

[18] Violence Prevention Unit Wales (2021) Adverse Childhood Experiences (ACEs). www.violencepreventionwales.co.uk/research-evidence/adverse-childhood-experiences-aces

[19] The Health Foundation (2021) How has NHS staff pay changed over the past decade? www.health.org.uk/news-and-comment/charts-and-infographics/how-has-nhs-staff-pay-changed-over-the-past-decade

[20] Editor's note: The Nursing and Midwifery Council (NMC) defines a preceptorship as 'a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further'.

[21] Editor's note: 'flaky bridge' is a term that has been used to describe the transition between training and qualified practice.

[22] Ashforth K., Kitson-Reynolds E. (2019) Fairy tale midwifery ten years on: facilitating the transition to newly qualified midwife. BJM Vol 27 Issue 12. www.britishjournalofmidwifery.com/content/literature-review/fairy-tale-midwifery-ten-years-on-facilitating-the-transition-to-newly-qualified-midwife

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[25] March With Midwives (2021) Facebook page. www.facebook.com/groups/463781921584006

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