The Royal College of Midwives Submission to the NHS Pay Review Body

September 2015
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Executive Summary

The Royal College of Midwives (RCM) welcomes the opportunity to submit evidence to the NHS Pay Review Body (NHSPRB).

The RCM is the trade union and professional organisation that represents the vast majority of practising midwives and maternity support workers in the UK. 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.

Our key arguments are:

- The RCM continues to support the NHSPRB. The RCM is committed to the independent process of the NHSPRB and strongly opposes any moves away from this process.

- The RCM is opposed to decisions relating to pay that have not arisen from the NHSPRB. We are increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after five years of pay freezes or capped 1% uplifts they have announced a 1% cap on public sector pay rises for a further four years. This fundamentally threatens the independence of the NHSPRB.

- Following the Government and employers decision to reject the recommendation of the NHSPRB in April 2014 and stand down the NHSPRB from recommending an uplift for 2015/16 the RCM took industrial action for the first time in our 134 year history. We cannot understate the gravity of our decision to undertake industrial action and the seriousness of our members’ decision to vote for and take industrial action.

- The RCM does not agree with the overall 1% pay increase for Agenda for Change staff. We feel that this is an insufficient reward. Following five years of below inflation awards the value of NHS pay has significantly reduced and to have a 1% uplift for the next four years will further damage the value of NHS pay. The 1% is also falling substantially behind awards in the private sector and wider economy.

- The RCM does not agree that there should be an unequal pay increase across the bands, or ‘targeting’. We feel that there should be the same uplift for all staff. We are concerned about the unintended consequences of a targeted award, in particular the effect on equal pay for work of equal value; the impact on recruitment and retention and potentially causing anomalies in the pay structure.

- The RCM does not agree with arguments made by NHS Employers and Government that incremental progression can act as a substitute for an annual pay increase on basic pay.
Incremental progression represents reward for increased skill and experience as agreed under the Agenda for Change framework. Previously the NHSPRB has taken the position that incremental progression is a separate issue to basic pay and we would like the NHSPRB to confirm that is still their view.

- The RCM, and other NHS trade unions, are in negotiations with NHS Employers and Government about changes to Agenda for Change in England. While we understand the current cost pressures in the NHS there needs to be an understanding that change will only be sustainable if there is investment in the pay structure. Failing this, there must be a realistic timetable. The continuing pay restraint in the NHS makes reaching a solution difficult but we remain hopeful that the discussions will result in positive change for NHS staff.

- The RCM welcomed the NHSPRB’s report on seven day services and were pleased that the PRB considered our evidence demonstrating that unsocial hours payments are necessary to the existing performance of seven days services such as maternity. Midwives have always worked 24 hours a day, 7 days a week and 365 days a year to provide high quality, safe services to women and their families. We made the case that you can't extend services elsewhere in the NHS by undermining hard working midwives and maternity support workers. We are pleased that the NHSPRB made sensible and fair recommendations.

- The evidence in this submission comes from a variety of sources, including official figures from the NHS Information Centre, Stats Wales, the Information Services Division Scotland, and the Health Social Services and Public Safety (Northern Ireland). We conducted our own research, the RCM’s annual Head of Midwifery (HOM) Survey. As the NHSPRB was stood down by the Government we did not submit evidence in September 2014, we therefore include both the 2014 and 2015 HOMs survey in this evidence. The HOMs survey asked questions around staffing levels, recruitment and retention, morale and motivation and budget cuts. HOMs were asked to answer for their Trust/Board as of 1st April 2014 and 1st April 2015. The survey was conducted in June/July 2014 and June/July 2015 and was conducted by email to HOMs across the UK. In 2014 64 HOMs giving a response rate of 38.3% and in 2015 83 HOMs responded giving a response rate of 50.3%.

- There is currently a shortage of approximately 2,600 midwives in England. While the number of midwives has been rising the number of births has risen at a greater pace thus causing a shortage of midwives. Given the additional pressures caused by the increasing complexity of cases; our annual HOMs survey found that maternity units in the UK struggling to meet the demands of the service with HOMs frequently having to redeploy staff to cover essential services; call in bank and agency staff; withdraw services; and close the maternity unit.

- The Francis Report into the failings at Mid Staffordshire Hospital emphasised the importance of organisational culture that promotes high quality care. Many research studies have shown that the more positive experiences of staff within an NHS trust, the better the outcomes for
that trust, both in terms of patient care and in terms of financial performance for the trust, in particular making savings through improving patient outcomes and improving sickness absence rates.

- The RCM believes that maternity units are facing unprecedented challenge. Units are overworked and understaffed. There has been a reduction in training for midwives and maternity support workers and there has been a significant and continued reduction in band 7 posts so there are fewer opportunities for talented midwives to progress and less leadership on the unit; staff are not feeling valued; there are high levels of bullying, harassment and abuse and perceptions of discrimination, particularly in London trusts; staff are redeployed to other areas of work to cover essential services and units rely on bank and agency staff. Improving staff engagement can not only improve the trust’s financial performance through savings on litigation costs and sickness absence rates but staff engagement has a direct impact on patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

- The Government needs to stop considering their pay policy in isolation. They need to have a total strategy for the whole workforce and for service delivery. The RCM is that the Government’s zeal for cutting NHS employees pay, terms and conditions will result in far higher costs to staff engagement and patient outcomes. Investment in NHS staff is an investment in NHS care.
Section One - Government Pay Policy

Introduction

The RCM is increasingly alarmed by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after five years of pay freezes or capped 1% uplifts they have announced a 1% cap on public sector pay rises for a further four years. This fundamentally threatens the independence of the NHSPRB. We are opposed to decisions relating to pay that have not arisen from the NHSPRB. The RCM continues to support the NHSPRB. The RCM is committed to the independent process of the PRB and strongly opposes any moves away from this process.

The RCM was stunned when the Government and employers made the unprecedented decision to reject the recommendation of the NHS Pay Review Body in April 2014 and stand down the NHSPRB from recommending an uplift for 2015/16. The actions by the Government and employers led to the RCM taking industrial action for the first time in our 134 year history. We cannot understate the gravity of our decision to undertake industrial action and the seriousness of our members’ decision to vote for and take action.

The RCM does not agree with arguments made by NHS Employers that incremental progression can act as a substitute for an annual pay increase on basic pay. Nor does it agree with arguments made by the Government that incremental progression is only awarded for ‘time served’. Incremental progression represents reward for increased skill and experience as agreed under the Agenda for Change framework and there are mechanisms that were strengthened in 2013 that allow employers to hold back incremental progression if the expected level of performance has not been met.

This year’s proposed award of 1% is still significantly less than RPI inflation and represents a further decrease in the value of NHS workers pay. The RCM is concerned about the effects that consistently keeping pay below inflation will have on the workforce, the service and the wider economy.

While we feel that a 1% uplift is inappropriate the RCM does not agree that there should be an unequal pay increase or ‘targeting’ across the bands, we feel that there should be a 1% uplift for all staff. We also have concerns that unequal pay increases could disproportionately impact part time staff. We are concerned about the unintended consequences of such a move, in particular the effect on equal pay for work of equal value; the impact on recruitment and retention and potentially causing anomalies in the pay structure with higher pay points on less pay.

The independence of the NHS Pay Review Body

As stated above, the RCM is increasingly alarmed by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after five years of pay freezes or capped 1% uplifts they have announced a 1% cap on public sector pay rises for a further four years. This fundamentally
threatens the independence of the NHSPRB. We are opposed to decisions relating to pay that have not arisen from the NHSPRB and we are committed to the independent process of the Pay Review Body and we strongly oppose any moves away from this process.

The RCM was shocked when the Government and employers made the unprecedented decision to reject the recommendation of the NHS Pay Review Body in April 2014 and stand down the NHSPRB from recommending an uplift for 2015/16. The actions by the Government and employers led to the RCM taking industrial action for the first time in our 134 year history. We cannot understate the gravity of our decision to undertake industrial action and the seriousness of our members’ decision to vote for and take action.

We would like to see a return to the NHSPRB making recommendations based on the evidence presented, rather than seeing the Government constraining the process before it even starts. If the Government want minimal pay uplifts for staff then they should present evidence to demonstrate why that should be the case and let the NHSPRB base their decision on the merits of the evidence. Indeed, in the NHS Pay Review Body’s Twenty-Seventh Report 2013 it states:

“We believe our process has most value when we are able to bring independent and expert judgement to bear on all factors within our terms of reference. The UK Government’s approach not only pre-judged our deliberations but influenced the expectations of staff and effectively set both a ceiling and a baseline to our considerations.”

In the Income Data Services (IDS) publication ‘Pay in the Public Services 2010’ they agree that the Government policy of imposing a pay freeze challenges the independence of the pay review bodies.

“The ever tightening of public sector pay policy towards a pay freeze has longer term implications which need to be considered. In particular, the independence of the Pay Review Bodies has been thoroughly challenged. The Treasury has sought to instruct the Pay Review Bodies to accept Government policy having added affordability and meeting the inflation target to their remit. This has undermined the original remit to set salary levels sufficient to motivate, recruit and retain.”

The RCM remains committed to the independence of the NHSPRB process and would like to see an end to the interference with the Pay Review Body.

**Pay cap of 1%**

The RCM does not agree with the overall 1% pay increase for Agenda for Change staff. We feel that this is an insufficient reward that is out of line with RPI inflation. Following five years of pay freezes and capped 1% uplifts the value of NHS pay has significantly reduced and to have a 1% uplift for the next four years will further damage the value of NHS pay.
This year’s proposed award of 1% is still significantly less than RPI inflation and represents a further decrease in the value of NHS workers pay. The RCM is concerned about the effects that consistently keeping pay below inflation will have on the workforce, the service and the wider economy.

While we feel that a 1% uplift is inappropriate the RCM does not agree that there should be an unequal pay increase or ‘targeting’ across the bands, we feel that there should be a 1% uplift for all staff. We also have concerns that unequal pay increases could disproportionately impact part time staff. We are concerned about the unintended consequences of such a move, in particular the effect on equal pay for work of equal value; the impact on recruitment and retention and potentially causing anomalies in the pay structure with higher pay points on less pay.

Additionally, we believe that the suggestion of ‘targeting’ pay awards is an example of how the Government considers public sector pay policy in isolation and does not have a total strategy for the whole workforce. It is also an example of how the Government considers public sector pay policy in isolation from other policy intentions they have. For example, the Government have just run a consultation on closing the gender pay gap. The document says:

“As a Government we are committed to seeing every person in our nation realise their potential. Greater gender equality will help us to achieve this so tackling the gender pay gap is an absolute priority. Closing the gender pay gap is not only the right thing to do, it is essential for improving our productivity as a nation.”

As Agenda for Change is an equal pay proofed system based on job evaluation we have serious concerns about what the Government intends by ‘targeting’ and how this could be delivered within the principles of equal pay and job evaluation. We feel this contradicts with their commitment to close the gender pay gap.

**Incremental progression and negotiations on Agenda for Change**

The RCM does not agree with arguments made by NHS Employers and Government that incremental progression can act as a substitute for an annual pay increase on basic pay. Incremental progression represents reward for increased skill and experience as agreed under the Agenda for Change framework.

In 2013, the RCM and other NHS Trade Unions agreed to changes to Agenda for Change; Annex W on pay progression sets out that incremental pay progression on all points (in the pay spine) will be conditional upon individuals demonstrating that they have the requisite knowledge and skills/competencies for the role and that they have demonstrated the required level of performance and delivery. Whilst the individual has to demonstrate the application of knowledge, skills and competence in their role there is also a requirement that the employer will have an agreed and fair

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appraisal system in place to assess whether they are meeting the level appropriate to their role. Individual rights are outlined in the Agenda for Change agreement, NHS constitution as well as local policies and procedures.

Therefore, there have already been reforms agreed to incremental progression in the Agenda for Change pay scales that are fair and balanced. We believe that it is fair and reasonable that the agreed changes should be given time to work. However, the Government’s statement in the summer budget says:

“As part of the forthcoming Spending Review, the Government will continue to examine pay reforms and modernise the terms and conditions of public sector workers. This will include a renewed focus on reforming progression pay, and considering legislation where necessary to achieve the Government’s objectives.”

This statement ignores the changes to incremental progression that have already been agreed in the NHS and is an insult to hard working staff that accepted the changes. It is entirely unreasonable to not consider whether there is evidence that further changes are necessary before announcing that further changes will be implemented. We are very alarmed by the statement that threatens to legislate changes rather than negotiating changes through collective bargaining.

The RCM, and other NHS trade unions, are currently in negotiations with NHS Employers and Government about changes to Agenda for Change in England. While we understand the current cost pressures in the NHS there needs to be an understanding that change will only be sustainable if there is investment in the pay structure. Failing this, there must be a realistic timetable. The continuing pay restraint in the NHS makes reaching a solution difficult but we remain hopeful that the discussions will result in positive change for NHS staff.

**Value of NHS pay**

The impact of pay restraint over the past five years has resulted in a real terms decrease in pay for NHS employees and capping pay at 1% for the next four years will further decrease the value of midwives’ pay.

The chart below shows both the Retail Price Index (RPI) and Consumer Price Index (CPI) inflation rates from September 2008 to August 2015.
In April 2010 Agenda for Change staff were awarded a pay increase of 2.25% in the final year of the three year pay deal. However at this time RPI inflation was at 5.3% and CPI inflation was at 3.7% resulting in a real decrease in the value of pay. The pay freeze started in April 2011 at a time when RPI inflation was at 5.2% and CPI inflation was at 4.5%. Both CPI and RPI inflation have stayed fairly consistent at around 2.0% until the middle of last year, resulting in a continued devaluation in the value of NHS employees pay.

During the RCM’s pay campaign last year we created an infographic (below) which shows the change in a salary of band 6 midwife since 2010 and what their salary would be if it had risen by inflation. This shows that as of 2014 the difference between the actual salary and a salary that increased by inflation for an average midwife was £4,045.
Taking this forward, by using the forecast inflation rates in the Summer Budget\(^2\), and assuming that there is a consolidated 1% pay increase awarded to all NHS staff from 2016 - 2019 the difference would increase to £5,180 (as shown in the graph below). This means that in nine years the value of a midwife’s salary has decreased by 15%.

\[\text{Salary in line with CPI inflation} \times 1.01^n - \text{Actual Salary} \times 1.01^n = \text{Difference}\]

\[\text{Difference} = 5,180\]

The RCM has substantial concerns about the impact of nine years of pay restraint and a midwife’s salary losing value of over £5,000 on the attractiveness of midwifery as a career. This is a retrograde step to the time when NHS careers, particularly female dominated professions such as midwifery, were poorly paid and poorly valued.

\(^2\) HM Treasury Summer Budget 2015, July 2015
Comparisons to other professional groups

Midwives fit into the Income Data Services’ description of professionals. To register with the Nursing and Midwifery Council (NMC) students must first earn a qualification in Midwifery at degree level. Midwifery training involves a mixture of academic study and supervised Midwifery practice in hospitals and the community. The degree is a three year course, although qualified Nurses can take a shortened programme which lasts for 18 months. On completion of their degree students are awarded both an academic and professional qualification. During their career Midwives are responsible for keeping their knowledge up to date in order to remain on the professional register.

The Government’s pay policy for the past five years and the next four years does not appear to be a sufficient reward for obtaining professional qualifications nor does it appear to be a sufficient reward for the years of hardship suffered and the debt incurred while at University. If the rewards are not seen to be sufficient this could have the effect of deterring students from choosing Midwifery as a career.

Comparisons to private sector pay awards

Pay settlements across the economy have been running at between 2% and 2.5% over most of the last year. Since April 2010, a growing gap has opened up between private and public sector settlements. While the public sector has experienced a pay freeze followed by a 1% pay cap, average private sector settlements have frequently been running at 2.5%. Private sector rates are predicted to return to rates double that of the public sector over the coming year, with private sector employers expecting settlements of 2% over 2015 while public sector rates are forecast at 1% to March 2016.

As strong demand and a tight labour market puts upward pressure on pay in the rest of the economy and a return to positive inflation once again starts to erode the buying power of NHS wages, there is a very real risk to recruitment and retention. As Simon Stevens, Chief Executive of NHS England has acknowledged:

“NHS staff have made a huge sacrifice during this period of global economic recession and austerity. But the health service has for the most part continued to perform incredibly well during that period… Over the medium term, the NHS has to pay in line with pay rates across the rest of the economy if we’re going to be able to continue to attract some of the best and most committed staff for nursing

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3 Pay forecasts for the private sector, February 2015, XpertHR
4 Nursing Times (2014) Nurses will quit without ‘competitive’ pay, concedes Simon Stevens, 23 October 2014 www.nursingtimes.net/home/specialisms/leadership/nurses-will-quit-without-competitive-pay-concedes-simon-stevens/5076080.article
jobs and other jobs across hospitals and primary care in England... We know there are more pressures and people are working incredibly hard and that’s why we’ve got to change.”

Other changes

In addition to falling wages midwives and maternity support workers have seen increases in reductions from their pay. For example, Midwives have also seen their pension contributions rise substantially, with the majority of midwives seeing their contribution rise from 6.5% to 9.3% from 2012 to 2015. Additionally, the changes to the second state pension will result in increases to national insurance contributions for members of the NHS pension scheme by 1.4%. This is expected to start in 2016. Additionally, midwives have seen increases of over 30% to their Nursing and Midwifery Council (NMC) registration fees. Midwives must pay their fees to legally work as a midwife.

Furthermore, there are proposed changes to tax credits that it is highly likely will affect most maternity support workers and likely to affect some midwives, particularly if they work part time and are the sole earner in the household. The effect of the cut will depend on personal circumstances but could be in the region of several thousand pounds. This will have a huge impact on those members of staff and the attractiveness of remaining a member of NHS staff.

Conclusion

The RCM is committed to the independent process of the PRB and strongly opposes any moves away from this process. We believe that this year’s proposed award of 1% is still significantly less than inflation and represents a further decrease in the value of NHS workers pay.

While we feel that a 1% uplift is inappropriate the RCM does not agree that there should be an unequal pay increase or ‘targeting’ across the bands, we feel that there should be a 1% uplift for all staff. We are concerned about the unintended consequences of such a move, in particular the effect on equal pay for work of equal value; the impact on recruitment and retention and potentially causing anomalies in the pay structure.

The RCM is concerned about the effects that consistently keeping pay below inflation will have on the workforce, the service and the wider economy. In particular, we are very concerned that this sustained attack on the value of midwives pay will damage the attractiveness of midwifery as a career.
Section Two – Staffing, Morale and Motivation

Introduction

There is currently a shortage of approximately 2,600 midwives in England. While the number of midwives has been rising the number of births has risen at a greater pace thus causing a shortage of midwives. Given the additional pressures caused by the increasing complexity of cases; our annual Heads of Midwifery (HOMs) survey found that maternity units in the UK are struggling to meet the demands of the service with HOMs frequently having to redeploy staff to cover essential services; call in bank and agency staff; withdraw ‘non essential’ services; and close the maternity unit.

The Francis Report into the failings at Mid Staffordshire Hospital emphasised the importance of organisational culture that promotes high quality care. Many research studies have shown that the more positive experiences of staff within an NHS trust, the better the outcomes for that trust, both in terms of patient care and in terms of financial performance for the trust, in particular making savings through improving patient outcomes and improving sickness absence rates.

The RCM believes that maternity units are facing unprecedented challenge. Units are overworked and understaffed. There has been a reduction in training for midwives and maternity support workers and there has been a reduction in band 7 posts so there are fewer opportunities for talented midwives to progress and less leadership on the unit; staff are not feeling valued; there are high levels of bullying, harassment and abuse and perceptions of discrimination, particularly in London trusts; staff are redeployed to other areas of work to cover essential services and units rely on bank and agency staff. Improving staff engagement can not only improve the trust’s financial performance through savings on litigation costs and sickness absence rates but staff engagement has a direct impact on patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

2014 has also seen the publication of the Kirkup Report in relation to failings at University Hospitals of Morecambe Bay NHS Trust. The findings and recommendations of the report have been accepted in their entirety by the RCM. We are working alongside others to implement its recommendations.

The Government needs to stop considering their pay policy in isolation. They need to have a total strategy for the whole workforce and for service delivery. The RCM is that the Government’s zeal for cutting NHS employees pay, terms and conditions will result in far higher costs to staff engagement and patient outcomes. Investment in NHS staff is an investment in NHS care.

The shortage of midwives

The RCM recommends that the correct minimum staffing level for maternity units should be determined using Birthrate Plus. Birthrate Plus suggests the number of whole time equivalent (WTE)
midwives required should reflect, amongst other things, the complexity of case mix and the number of births.

Midwifery is a physically demanding profession given the unpredictable nature of the maternity unit; providing emergency care; operating a 24-7 service; and working long shifts in particular on calls. Additionally in recent times there has been an increasing complexity of cases due to rising rates of obesity and older mothers.

The table below shows the number of births in England compared to the number of WTE midwives from 2001 to 2014. While the graph below does show that the numbers of midwives has increased since 2001 and that in the last two years the birth rate has fallen slightly the increase in midwives has been at a far slower pace than the increase in births. There is a current shortage of 2,600 midwives in England.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Midwives</th>
<th>Number of Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>21,000</td>
<td>370,000</td>
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<tr>
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<td>430,000</td>
</tr>
<tr>
<td>2014</td>
<td>34,000</td>
<td>435,000</td>
</tr>
</tbody>
</table>

The HOMs survey found that:

- 29.5% (2014) and 29.6% (2015) of HOMs said their funded establishment was not adequate for their organisation.

Additionally, in the HOMs survey we asked about the complexity of births:

- 96.9% (2014) and 91.3% (2015) of HOMs said their unit is dealing with more complex cases than last year;
• When asked what types of complex cases have they seen more of in the last year HOMs reported: Overweight/obese women; social factors e.g. domestic violence; older women; long term health conditions; drugs/alcohol abuse; safeguarding/child protection issues; and mental health issues.

When asked about the complexity of cases HOMs said:

“The birth rate may have reduced so there are fewer births but the increasing complexity absorbs any small gains in terms of activity as more time is needed to care for women with additional health/social needs. This is not reflected in the workforce tools for midwifery establishment.”

“The maternity tariff does not appear to take into consideration some of the complexities which require additional care and time to provide an effective service to the woman and baby e.g. mental health issues only equate to an intermediate tariff.”

“Staffing is and will remain a safety issue and financial pressure. The level of pressure everyone is feeling is now palpable. Worrying times.”

Service delivery

Given the shortage of 2,600 midwives and an increasing complexity of cases the HOMs survey asked questions about how HOMs were managing service delivery under increased pressure. There were reports of some cuts to services, including closing the maternity unit, although some HOMs also reported that they were asked to take on more services (but not given the extra budget). In the main it would appear that existing staff are being relied upon to cover the gaps in the service through being redeployed to other areas (normally the labour and delivery suite), missing their breaks and working late. There is also a reliance on using bank and agency staff. The HOMs reported that:

• 21.3% (2014) and 14.6% (2015) of HOMs said their budget had decreased in the last year;

• 10.9% (2014) and 11.0% (2015) of HOMs reported that they had to decrease services in the last year;

• The most common services that HOMs report having to reduce in both 2014 and 2015 were specialist midwives; parent classes; bereavement support; and breast feeding support;

• 32.8% (2014) and 41.5% (2015) of HOMs reported that they had to close their unit during the year because they couldn’t cope with the demand;

• The average number of times a unit had to close their doors was 6.6 separate occasions (2014) and 4.8 separate occasions (2015). The most times a single unit closed in a year was 33 times (2014) and 23 times (2015);
75% (2014) and 75.9% (2015) of HOMs said they had to redeploy staff to cover essential services either very or fairly often;

HOMs were asked which areas staff were redeployed to and from, overwhelmingly in both 2014 and 2015 HOMs reported that staff were redeployed from the community and the postnatal service to the labour and deliver suite;

65.6% (2014) and 64.6% (2015) of HOMs answered that on call community staff have to be called in to cover the labour and delivery suite and 26.2% (2014) and 35.8% (2015) of HOMs said this restricted the home birth service;

67% (2014) and 72.8% (2015) of HOMs answered they had to call in bank and/or agency staff very or fairly often (very often - nearly every day, fairly often - a few times a week); and

59.4% (2014) and 61.3% (2015) of HOMs said that it was difficult/very difficult to ensure that staff take their breaks and leave on time.

When asked about service delivery HOMs said:

“The majority of staff prefer to work long days which means there is no 'overlap' when breaks can easily be taken. There is a great deal of 'goodwill' where unpaid work is done.”

“Activity can be high at times and breaks are missed or not completed. Since e-rostering was introduced these unpaid breaks cannot be compensated for.”

“I am very concerned about the state of the NHS. How is it possible to continue providing high levels of individualised quality care year on year with high cost reductions, cuts to training budgets and more women with complex needs? Stress in the workplace directly affects women's care. The pressure all grades of staff are experiencing is palpable. As a head of service I feel powerless to affect change. More staff is not always the answer but staff who have the knowledge and skills to do their job is essential. Staff who do not have time to train, develop professionally and do not feel valued will struggle to provide safe, high quality compassionate care. There is a dissonance between the outcomes being measured and their relevance in clinical care. Women will continue to remain our focus and we will endeavour to listen and respond to their needs. The impact on the staff providing the service with the endless financial, physical, emotional and professional challenges is deeply concerning.”

“Excessive activity and workload for staff. 12 hour shift patterns impact on break cover so staff have to stay late to do any emails, closure report information, student assessments etc.”

“Midwives have to work as flexibly as possible - on call working overnight and call outs impact on routine daily workload. Clinics/appointments may need to be rescheduled if midwives require
compensatory rest if they have been working overnight. This adds pressure on the rest of the team for that day and midwives miss lunch, work over hours and service user appointments have to be cancelled or rescheduled.”

“I feel staff are feeling the pressure of austerity with the major drive to bring down costs within the NHS. This trust has a duty to look at all services and to keep staff informed of the measures we need to take. This is a new world for many midwives who probably do not have finance as a driver in how they want to deliver care.”

“All staff including non clinical based roles are under extreme pressure with many of us working c.60 hours per week on 37.5 hours contracts for no additional pay and still not keeping up. When struggling, the response from the top floor is to delegate; to whom I ask? Everyone is too busy.”

“The continued pressure of adding services to the midwives portfolio without extra funding, because the service is apparently in tariff, this is not sustainable.”

“Since my appointment into this role substantively in 2015 I have already had other specialist areas added which provides a challenge in being able to focus on midwifery issues. The current trust focus is on the financial pressures being faced which proves to be a constant challenge when the quality and safety of care to women and babies cannot be compromised. Increased numbers of complaints/litigation cases is becoming a worrying factor and the public’s perception of what they perceive they should receive as ‘care’ is often unachievable within the resources available.”

“The gross under funding of maternity services makes it very difficult for senior leaders in the service to implement changes especially with development specialist posts. We used to be able to move posts around and effect changes in a timely manner now this is difficult as there are so many hoops from a financial perspective to get through this slows down service development. Heads of Midwifery need to be able to be responsive to changes and needs of pregnant service users not to be held back by bureaucracy. Financial considerations are of course important but they should help not hinder progress if services are to be responsive to individual needs.”

“I have been a HOM for less that one year and I struggle with a tiny management structure and being able to articulate the differences and difficulties that midwifery faces as opposed to nursing. The CQC reports have been very negative and the staff are very demoralised as well as having to wait for a year for any decision regarding the outcome of the reports. I work ridiculous hours to not even stand still. I am passionate about midwifery services but we need more support from the Government.”

In September 2014 Income Data Services (IDS) conducted a survey for staff side to accompany our evidence to the Pay Review Body. The graph below shows some of the key results from the survey that show worryingly high numbers of staff do not feel supported; do not feel they have the time and resources available to do their job to a high standard; and have seriously considered leaving the NHS.
The information from both the 2014 and 2015 HOMs surveys show that maternity units are facing unprecedented challenge. Units are overworked and understaffed. Staff are working through their breaks and beyond their hours to cover the demands of the service and units are increasingly reliant on bank and agency staff. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

**Unsocial hours payments and seven days services**

We were pleased to read in the NHSPRB’s report ‘Enabling the Delivery of Healthcare Services Every Day of the Week - the Implications for Agenda for Change’ that the NHSPRB identified that unsocial hours payments are fit for purpose and enable the NHS to provide a seven days service:
“However, the national Agenda for Change pay system presents no contractual barrier to the delivery of seven-day services; seven-day working is already well established for a number of core staff groups; and has been used at seven-day case study and early adopter sites across the United Kingdom... In overall terms therefore, whilst some adjustments could be made, we have not found enough evidence to support wholesale changes to unsocial hours definitions and premia in isolation from the wider Agenda for Change pay system.”

We had started to conduct the 2015 HOMs survey before the NHSPRB’s report was published so had included some questions on unsocial hours payments in the survey. The HOMs said:

“The removal of unsocial hours payments will have] a huge impact as the staff work really hard and they will be tempted to work for agencies if they are not given due consideration for the difficult job they do really well on a daily basis. I am amazed at how supportive my teams are in going the extra mile to deliver excellent care for women and this would really feel like the straw that broke the camels back.”

“I think staff will be extremely unhappy about this, as historically they've always received these payments. It will impact on retention of the most experienced staff, and will make it more difficult to recruit.”

“I think staff will request flexible working for weekday hours and then work bank or agency during unsocial hours. If unsocial hours aren't to be paid monthly then basic salary must increase to accommodate the loss of earnings.”

“There will be a huge impact, staff won’t want to work the unsocial hours and the safety of the service would be compromised.”

We believe the NHSPRB have made a sensible and fair decision about unsocial hours payments and are pleased that the NHSPRB listened to arguments put forward by the RCM and the other NHS Trade Unions.

**Productivity and agency midwives**

Improving productivity is increasingly becoming a pivotal issue in the NHS. Not least because productivity is a key issue across the economy but because of the significant funding challenges facing the NHS combined with an increased demand for services due to the increasing birth rate and increasing complexity of cases. We believe that the best way of improving productivity is by utilising the existing workforce. This does not mean continuously relying on the goodwill of staff but rather:

- incentivise staff to work bank and overtime shifts rather than relying on agency staff; and
• improve sickness absence by implementing the findings of the Boorman report.

It is clear that the Government and NHS organisations are not investing in NHS staff and this is negatively impacting on productivity. The Government and NHS organisations need to change their approach to NHS staff because an investment in NHS staff is an investment in improved productivity and improved care.

The cost of agency staffing in the NHS has substantially increased in the last few years with 2014/15 seeing NHS providers spend £3.3billion on agency staffing. As discussed above, in our HOMs survey 67% (2014) and 72.8% (2015) of HOMs answered they had to call in bank and/or agency staff very or fairly often (very often - nearly every day, fairly often - a few times a week).

During the summer the Department of Health instructed Monitor to introduce a mandatory cap on the hourly rates paid for agency staff and an annual ceiling for agency spending for each trust; however both of these caps will only apply to nursing, midwifery staff and health visitors. While the RCM agrees that the use of agency staff in the NHS has reached inappropriate levels and should be controlled we do not believe that Monitor’s proposals will do this in a safe and sustainable way. We believe there are two safe, sustainable and effective ways to reduce agency spending, first, to eliminate the staff shortages and second, to incentivise existing staff to work bank or overtime.

We were pleased to read in the NHSPRB’s report ‘Enabling the Delivery of Healthcare Services Every Day of the Week - the Implications for Agenda for Change’ that the NHSPRB identified that the main barrier to expansion of services is the numbers of staff. We agree with the NHSPRB that without the appropriate numbers of staff to deal with the rising demand for services there would be an increase in the cost of agency staff:

“If changes are introduced without the appropriate workforce planning then the short-term impact on staff levels could see agency costs increase. We note that those responsible for workforce planning and commissioning of training are not yet fully linked into local plans for seven-day services. Given the number of years it takes to train suitably skilled and qualified staff we believe a substantial barrier to the expansion of seven-day services could be insufficient numbers of appropriately trained staff”

In the meantime, we recommend that as a short term solution trusts could reduce their agency spending by using their own staff and incentivising staff to work overtime or on the bank rather than using agency staff. There is a single harmonised rate of overtime set out in Agenda for Change (time and a half for all overtime apart from public holidays which is double time). We understand that it is difficult to get authorisation to pay overtime rates and that bank rates are too low. By not authorising overtime or paying bank at a fair rate the result is that trusts have to use agency staff, which costs them more money.
Indeed, the ‘Review of Operational Productivity in NHS Providers’\(^5\) report by Lord Carter of Coles identified that bank staff are not remunerated in a way to attract them from moving from agencies.

We would like to reiterate the comments made by the NHSPRB in their report on seven day services:

“The pay structure should work to support and incentivise behaviours to ensure that shifts are scheduled principally around the needs of the patient rather than skewed by rules around shifts and payments.”

The RCM would be interested to understand the NHSPRB’s views on agency spending in the NHS, in particular to understand the data employers have about the use of agency staff. For example, the cost per hour, the cost of agency fees, variations by region, variations by day of the week, variations by time of the day, variations by different professional groups etc. The data can then be analysed to work out if there are particular causes for the increased agency spend rather than putting a crude cap on the agency spend, as Monitor wish to do. In particular, the staff side are interested in the cost of fees to agencies, rather than the total amount of agency with the fees to agencies combined with the wages paid to staff.

Additionally, the Boorman Report (November 2009)\(^6\) sets out key recommendations to improve the health and wellbeing of the NHS workforce, including the cost savings that can be gained from investing in staff health and wellbeing. The Boorman report found that organisations that prioritised staff health and well being performed better, with improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence. The report estimated that the NHS could reduce current rates of sickness absence by a third and this would mean an additional 33.4 million working days a year for NHS staff equivalent to 14,900 WTE staff with an estimated annual direct cost saving of £555 million.

The Health and Social Care Information Centre’s latest report\(^7\) into NHS sickness absence rates shows that between January and March 2015 the average sickness absence rate for the NHS in England was 4.44%, an increase from the same period in 2014 and nursing, midwifery and health visiting staff were one of the staff groups with the highest average sickness rates (5.19%).

Indeed, in our HOMs survey HOMs reported:

“We have a very high sickness rate which is the biggest reason for use of bank staff.”

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“The unit currently has high number of young midwives and a high number of older midwives so maternity leave is consistently around 4% and age related ailments contributes to the sickness rate which puts pressure on remaining staff and has an impact on morale.”

“Staff are pressured when there are sickness/vacancies in the team as this then makes it very difficult to cover local births/on call service. Little time for development or new initiatives. Also difficult to release staff for training or give hours for additional study or courses that midwives might want to undertake. The bed numbers have been reduced drastically to allow areas of general nursing to expand and develop. This has resulted in a quicker turn around and discharge of postnatal women”

It is clear that there is still work to be done to reduce sickness absence rates in the NHS, and given the huge potential for savings the recommendations of the Boorman Report should be implemented across the NHS.

**Vacancies, recruitment and retention**

Despite there being a shortage of midwives there are still vacancies across the UK. The HOMs survey found that:

- 76.6% (2014) and 76.5% (2015) of HOMs have vacancies in their unit; and

- 57.3% (2014) and 50.9% (2015) of the vacancies were for band 6-9 midwives.

While we are pleased that the Health and Social Care Information Centre have now started to collect vacancy data again but we are concerned about the vast number of caveats they put on the use of the data. We would like to see full and consistent vacancy data collected in the future.

As of March 2015 the NHS Vacancy Statistics publication\(^8\) record there are 555 positions in maternity advertised on NHS Jobs which is a long way short of the 2,600 midwives needed in England.

The HOMs survey revealed that maternity units are increasingly facing issues with recruitment and retention, particularly of experienced midwives (band 6 and above). HOMs said:

- 32.8% (2014) and 47.6% (2015) of HOMs said they have trouble recruiting to some/all posts and 18.8% (2014) and 28.4% (2015) of HOMs said they have trouble with retention to some/all posts; and


\(^8\) [http://www.hscic.gov.uk/catalogue/PUB18102](http://www.hscic.gov.uk/catalogue/PUB18102)
and 8 (2015) applications per vacancy for a band 7 midwife; and 3 (2014) and 5 (2015) applications per vacancy for a band 8/9 midwife.

HOMs said:

“We have huge problems recruiting experienced midwives (Band 6 or above). We have only succeeded in recruiting 3 external Band 6 candidates in the past 12 months to in excess if 30 vacancies overall. Community midwifery posts are exceptionally difficult to recruit - we only ever succeed in recruiting newly qualified staff who require an extended preceptorship period before they can be released into the community, these midwives then quickly move on to posts which become vacant in the unit or to other external unit based posts. We have one point of qualification from our provider universities (September), this makes it very difficult to fill vacant positions outside of this timeframe with all other units competing for candidates from the same pool. I have been a HOM for over ten years and I have never experienced difficulties as in the last three years.”

“Band 6 midwives are the most difficult group to recruit to, we develop our Band 5 midwives through a robust preceptorship programme. We have applicants for these posts from other UK trusts who are already employed as a Band 6 midwife however we cannot employ them at a Band 6 as they do not fulfil our competencies.”

“Not attracting experienced community midwives to posts and not always possible to support newly qualified midwives into remove community midwives teams - issues re: lone working, on call and lack of experience. On call commitment for home birth/local birth when working in community and CMUs - not attractive, not well paid.”

“Problems with retention of community based staff - only able to attract NQ midwives to these posts and there is a high degree of attrition to unit based posts even with a robust preceptorship package. We work in an area of very high deprivation, with a population who experience very complex health and social care needs. This makes the challenges for community midwives extremely demanding.”

There does appear to be issues with the recruitment and retention of midwives in band 6 and above and we do feel local RRPs could help local trusts. However, we feel that this would be a sticking plaster and not a long term solution. The HOMs survey is showing the effects of the Government’s pay policy which is leading to a long term impact on the attractiveness of midwifery and the NHS as a career. Given that there is such a large shortage of midwives maternity units are in a vulnerable position.

Skill mix

HOMs were asked to give the numbers of WTE staff in the maternity unit by pay band. The table and graph below shows the results from the last six years HOMs surveys:
The most significant result is the steady decline in the proportion of band 7 posts from 18.3% in 2010 to 13.8% in 2015, declining by about 1% each year.

When asked about downbanding staff, HOMs said:

- 9% (2014) and 9.8% (2015) of HOMs had to downband staff during the year; and

- 59% (2014) and 70.6% (2015) of HOMs reported that the downbanded midwives were in band 7.

The RCM believes that the significant reduction in band 7 posts in the last six years will have detrimental impact on the attractiveness of midwifery as a career as there are fewer opportunities for talented midwives to progress and less leadership on the unit.
Age profile of midwives and flexible working

The table below shows the ages of midwives working in England in September 2014 which shows that 48% of midwives in England are 45 or over.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Midwives</th>
<th>Proportion of Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>1197</td>
<td>4.6%</td>
</tr>
<tr>
<td>25-29</td>
<td>2920</td>
<td>11.2%</td>
</tr>
<tr>
<td>30-34</td>
<td>3233</td>
<td>12.4%</td>
</tr>
<tr>
<td>35-39</td>
<td>3065</td>
<td>11.7%</td>
</tr>
<tr>
<td>40-44</td>
<td>3199</td>
<td>12.2%</td>
</tr>
<tr>
<td>45-49</td>
<td>4435</td>
<td>17.0%</td>
</tr>
<tr>
<td>50-54</td>
<td>4577</td>
<td>17.5%</td>
</tr>
<tr>
<td>55-59</td>
<td>2507</td>
<td>9.6%</td>
</tr>
<tr>
<td>60-64</td>
<td>827</td>
<td>3.2%</td>
</tr>
<tr>
<td>65+</td>
<td>177</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

The graph below shows the age profile of midwives in England from 2002-2014, not only does it show that midwives in England are getting older, but it also shows a dip in the numbers of midwives aged between 35-45. We believe that the number of midwives aged 35-45 has been declining due to fewer opportunities to work flexibly. Opportunities to work flexibly are important given that over 99% of midwives are female and so many need to be supported with childcare arrangements.

Source: The Health and Social Care Information Centre
In the 2015 HOMs survey we asked questions about the impact of working longer and the ability of HOMs to be able to support flexible work arrangements. They reported that:

- 83.1% of HOMs said they felt staff would struggle to work in the labour and delivery suite after the age of 60;
- 79.7% of HOMs said they found accommodating requests to reduce the number of night shifts difficult/very difficult;
- 80.8% of HOMs said they found accommodating requests to reduce the number of weekends difficult/very difficult;
- 91.3% of HOMs said they found accommodating requests to fix their shifts (so no rotation of shifts) difficult/very difficult.

When asked if they could accommodate requests to work flexibly if the number of requests increased many HOMs reported that they were only just managing now and they would not be able to cope with more requests to work flexibly and some HOMs were reporting that they already had to decline requests to work flexibly:

“This [requests to work flexibly] has substantially increased over the last year to a point now where it is more difficult to grant requests as the consequence/impact to full time staff to provide decent off duty. At times it is difficult to populate the off duty and has an impact on mentorship.”

“We can normally accommodate requests but may have to move the staff member to a different area e.g. if they want to work fixed shifts. Reducing the number of night shifts is the most difficult challenge - in some cases the request has been accommodated for a fixed period and then reviewed.”

“No, the duty rota is almost crippled the fixed pattern working of staff.”

“No, there is only so much adaptation to working practices that the service can provide. We always try to accommodate changes wherever possible however these opportunities will lessen as these posts are filled.”

“Staff are under a lot of pressure outside of work and sometimes this effects how they behave at work. Many of the staff are the main earners and the main carer- of children and elderly parents so have a lot to juggle. Other work places do not allow carers leave so maternity often has to carry more such request - which is now being managed more tightly, so added stress to staff.”

In addition, the Family and Childcare Trust’s annual Childcare Costs Survey 2015 found that the costs of sending a child under two to nursery part time (25 hours) is £115.45 per week or £6,003 per year,
which is a 5.1% rise since 2014. They calculate that the cost of a part-time nursery place for a child under two has increased by 32.8% in the last five years.

We believe that as the opportunities to work flexibly decline and the costs of childcare increase, at a time when midwives are seeing a real terms cut in their pay this will create a significant problem with retention and increase the shortage of midwives. Midwives must be supported with childcare arrangements by being able to work flexibly and by getting a real terms pay increase so that they can afford childcare.

**Morale and motivation**

Morale and motivation continue to be a big issue for midwives and maternity support workers, as does bullying and harassment. The HOMs survey found that:

- 29.7% (2014) and 27.5% (2015) of HOMs said that morale and motivation had decreased in the last year;
- 35.9% (2014) and 29% (2015) of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from other staff members;
- 25% (2014) and 29% (2015) of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from service users;
- 31.3% (2014) and 29% (2015) of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from other friends/family users.

HOMs said:

“Staff morale is about as low as I have observed. The number of births in the unit is low but the complexity has risen.”

“Social media is a growing concern with inappropriate posts form members of the public taking photos of staff at work and posting with abusive or inappropriate comments.”

In the 2015 HOMs survey we asked HOMs about their feelings about how well they were performing and how maternity was perceived by their organisation’s Board. There were some quite alarming findings:

- 19.2% of HOMs disagreed/strongly disagreed with the statement 'maternity is a priority in my organisation';
- 19.2% of HOMs disagreed/strongly disagreed with the statement 'I am able to influence the Board in my organisation';
• 31.2% of HOMs disagreed/strongly disagreed with the statement 'I am able to do my job to a standard I am personally happy with'; and

• 62.3% of HOMs disagreed/strongly disagreed with the statement 'I am able to meet all the conflicting demands on my time at work'.

These results show that all levels of staff, including Heads of Midwifery, are feeling pressurised and that is affecting their morale and motivation and their ability to give high quality, safe care.

Staff engagement and training

The Francis Report into the failings at Mid Staffordshire Hospital emphasised the importance of organisational culture that promotes high quality care. Many research studies have shown that the more positive experiences of staff within an NHS trust, the better the outcomes for that trust, both in terms of patient care and in terms of financial performance for the trust. A key way of improving productivity is to improve staff engagement.

In the Kings Fund research ‘Employee Engagement and NHS Performance’ (2012) the authors analyse the data from the NHS Staff Survey which indicates employee engagement and how it is linked to a variety of individual and organisational outcome measures, including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates. The results from their research clearly found that the more positive the experiences of staff within an NHS trust the better the outcomes for that trust. Engagement has significant associations with patient satisfaction, patient mortality, infection rates, Annual Health Check scores, staff absenteeism and turnover. They conclude that the more engaged staff members are, the better the outcomes for patients and the organisation more generally.⁹

An important factor in engagement scores is creating a safe working environment. Research has found that in trusts were there are high levels of physical violence, bullying, harassment, abuse and discrimination this creates poorer outcomes in terms of staff turnover, absenteeism and patient satisfaction. As detailed above, there is a large number of HOMs that report bullying, harassment and abuse in their unit.

In 2009 a report was published by the Aston Business School that linked NHS staff survey data to patient survey data and found that the staff survey item that was most consistently linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background. They found that high levels of bullying, harassment and abuse against staff related to negative patient experiences. The RCM has previously published information about the disproportionate number of black and minority ethnic (BME) midwives who face disciplinary proceedings. In our

⁹ Employee Engagement and NHS Performance Michael A West and Jeremy Dawson, The Kings Fund 2012
In research conducted by West and Dawson they found that good staff management is a key factor in engagement. This includes having well-structured appraisals setting out clear objectives and ensuring the employee feels valued by the employer. This is followed through in team working, so the team have a good understanding of their shared objective and work interdependently to meet those objectives. The research has shown that good, supportive line management is key. Conversely, high levels of work pressure and stress can lead to dissatisfaction and disengagement. All these factors were linked to patient satisfaction, patient mortality and staff absenteeism and turnover, and better performance on the Annual Health Check.

Another factor that was important is training and development. Where employees received training, learning and development that is relevant to their job there were better outcomes, in particular health and safety training and equality and diversity training were important. In their research West et al conclude that:

“By giving staff clear direction, good support and treating them fairly and supportively, leaders create cultures of engagement, where dedicated NHS staff in turn can give of their best in caring for patients. Such steps produce high quality and improving patient care along with effective financial performance.”

Indeed, the report by the Treasury ‘Fixing the foundations: creating a more prosperous nation’ highlights a key way to improve productivity is the need to improve skills.

The 2014 NHS Staff Survey found that 83% of staff had an appraisal. Of those to receive an appraisal, only 54% said it helped them improve how they do their job, and only 78% felt the appraisal helped them to agree clear objectives for their work. Worryingly, only 62% said it left them feeling that their work is valued by their organisation. This indicates that effective appraisals are far from widespread in the NHS.

HOMs were asked questions about appraisals, training and development and they said:

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10 NHS Staff Management and Health Service Quality – Results from the NHS Staff Survey and Related Data – Michael West, Lancaster University Management School and the Work Foundation. Jeremy Dawson, Lul Admasachew and Anna Topakas, Aston Business School
11 NHS Staff Management and Health Service Quality – Results from the NHS Staff Survey and Related Data – Michael West, Lancaster University Management School and the Work Foundation. Jeremy Dawson, Lul Admasachew and Anna Topakas, Aston Business School
12 NHS Staff Management and Health Service Quality – Results from the NHS Staff Survey and Related Data – Michael West, Lancaster University Management School and the Work Foundation. Jeremy Dawson, Lul Admasachew and Anna Topakas, Aston Business School
• 42% (2014) and 43% (2015) of HOMs said they were able to conduct appraisals with all midwives in their unit once a year;

• 39.1% (2014) and 39.7% (2015) of HOMs said they were able to conduct appraisals with all the MSWs in their unit once a year;

• 81.2% (2014) and 79.5% (2015) of HOMs felt they were given enough training to conduct appraisals;

• 68.8% (2014) of HOMs felt confident in the appraisals process;

• 9 HOMs (2015) have held a member of staff back from incremental progression in the last year and in total 12 members of staff have been held back; and

• 21.9% (2014) and 20.3% (2015) of HOMs had to reduce training in the last year.

HOMs said:

“[In the appraisal process it is] not always possible to support staff aspirations for professional or personal development.”

“Very little [confidence in the appraisal process]- it is a generic process that has little value for staff.”

In September 2014 Income Data Services (IDS) conducted a survey for staff side to accompany our evidence to the Pay Review Body. The graph below shows some of the key results from the survey that show worryingly high numbers of staff are not given training, development and appraisals. This is particularly disturbing given that we know that the key to improving productivity in the NHS is going to be through valuing and engaging the existing workforce and equipping them with the skills and resources they need to provide quality NHS services.
It is clear that the Government and NHS organisations are not doing enough to engage with staff, value them and equip them with the skills and resources they need. The Government’s approach to the NHS and the NHS workforce involves the continued pay freeze and cap; pension changes; NHS restructures; continued references to the ‘burden’ of public sector workers on taxpayers; undermining collective bargaining e.g. rejecting the recommendations of the Pay Review Body and threats to legislate around capping redundancy payments; and attacks on the right to strike with the Trade Union Bill. This has contributed to a culture that does not value staff and negatively impacts on productivity. The Government and NHS organisations need to change their approach to NHS staff because an investment in NHS staff is an investment in improved productivity and improved care.

Conclusion

The RCM believes that maternity units are facing unprecedented challenge. Units are overworked and understaffed. There has not only been a reduction in training but also there has been a reduction in band 7 posts so there are fewer opportunities for talented midwives to progress and less leadership on the unit; staff are not feeling valued; there are high levels of bullying, harassment and abuse and perceptions of discrimination, particularly in London trusts; staff are redeployed to other areas of work to cover essential services and units rely on bank and agency staff. Improving staff engagement can not only improve the trust’s financial performance through savings on litigation costs and sickness absence rates but staff engagement has a direct impact on patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

The Government needs to stop considering their pay policy in isolation. They need to have a total strategy for the whole workforce and for service delivery. The RCM is that the Government’s zeal for cutting NHS employees pay, terms and conditions will result in far higher costs to staff engagement and patient outcomes. Investment in NHS staff is an investment in NHS care.
Conclusion and Summary

We have welcomed the opportunity to submit evidence to the NHSPRB.

Our key arguments are:

- The RCM continues to support the NHSPRB. The RCM is committed to the independent process of the NHSPRB and strongly opposes any moves away from this process.

- The RCM is opposed to decisions relating to pay that have not arisen from the NHSPRB. We are increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after five years of pay freezes or capped 1% uplifts they have announced a 1% cap on public sector pay rises for a further four years. This fundamentally threatens the independence of the NHSPRB.

- Following the Government and employers decision to reject the recommendation of the NHSPRB in April 2014 and stand down the NHSPRB from recommending an uplift for 2015/16 the RCM took industrial action for the first time in our 134 year history. We cannot understate the gravity of our decision to undertake industrial action and the seriousness of our members’ decision to vote for and take industrial action.

- The RCM does not agree with the overall 1% pay increase for Agenda for Change staff. We feel that this is an insufficient reward. Following five years of below inflation awards the value of NHS pay has significantly reduced and to have a 1% uplift for the next four years will further damage the value of NHS pay. The 1% is also falling substantially behind awards in the private sector and wider economy.

- The RCM does not agree that there should be an unequal pay increase across the bands, or ‘targeting’. We feel that there should be the same uplift for all staff. We are concerned about the unintended consequences of a targeted award, in particular the effect on equal pay for work of equal value; the impact on recruitment and retention and potentially causing anomalies in the pay structure.

- The RCM does not agree with arguments made by NHS Employers and Government that incremental progression can act as a substitute for an annual pay increase on basic pay. Incremental progression represents reward for increased skill and experience as agreed under the Agenda for Change framework. Previously the NHSPRB has taken the position that incremental progression is a separate issue to basic pay and we would like the NHSPRB to confirm that is still their view.

- The RCM, and other NHS trade unions, are in negotiations with NHS Employers and Government about changes to Agenda for Change in England. While we understand the current cost pressures in the NHS there needs to be an understanding that change will only
be sustainable if there is investment in the pay structure. Failing this, there must be a realistic timetable. The continuing pay restraint in the NHS makes reaching a solution difficult but we remain hopeful that the discussions will result in positive change for NHS staff.

- The RCM welcomed the NHSPRB’s report on seven day services and were pleased that the PRB considered our evidence demonstrating that unsocial hours payments are necessary to the existing performance of seven days services such as maternity. Midwives have always worked 24 hours a day, 7 days a week and 365 days a year to provide high quality, safe services to women and their families. We made the case that you can't extend services elsewhere in the NHS by undermining hard working midwives and maternity support workers. We are pleased that the NHSPRB made sensible and fair recommendations.

- The evidence in this submission comes from a variety of sources, including official figures from the NHS Information Centre, Stats Wales, the Information Services Division Scotland, and the Health Social Services and Public Safety (Northern Ireland). We conducted our own research, the RCM’s annual Head of Midwifery (HOM) Survey. As the NHSPRB was stood down by the Government we did not submit evidence in September 2014, we therefore include both the 2014 and 2015 HOMs survey in this evidence. The HOMs survey asked questions around staffing levels, recruitment and retention, morale and motivation and budget cuts. HOMs were asked to answer for their Trust/Board as of 1st April 2014 and 1st April 2015. The survey was conducted in June/July 2014 and June/July 2015 and was conducted by email to HOMs across the UK. In 2014 64 HOMs giving a response rate of 38.3% and in 2015 83 HOMs responded giving a response rate of 50.3%.

- There is currently a shortage of approximately 2,600 midwives in England. While the number of midwives has been rising the number of births has risen at a greater pace thus causing a shortage of midwives. Given the additional pressures caused by the increasing complexity of cases; our annual HOMs survey found that maternity units in the UK struggling to meet the demands of the service with HOMs frequently having to redeploy staff to cover essential services; call in bank and agency staff; withdraw services; and close the maternity unit.

- The Francis Report into the failings at Mid Staffordshire Hospital emphasised the importance of organisational culture that promotes high quality care. Many research studies have shown that the more positive experiences of staff within an NHS trust, the better the outcomes for that trust, both in terms of patient care and in terms of financial performance for the trust, in particular making savings through improving patient outcomes and improving sickness absence rates.

- The RCM believes that maternity units are facing unprecedented challenge. Units are overworked and understaffed. There has been a reduction in training for midwives and maternity support workers and there has been a significant and continued reduction in band 7 posts so there are fewer opportunities for talented midwives to progress and less
leadership on the unit; staff are not feeling valued; there are high levels of bullying, harassment and abuse and perceptions of discrimination, particularly in London trusts; staff are redeployed to other areas of work to cover essential services and units rely on bank and agency staff. Improving staff engagement can not only improve the trust’s financial performance through savings on litigation costs and sickness absence rates but staff engagement has a direct impact on patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

- The Government needs to stop considering their pay policy in isolation. They need to have a total strategy for the whole workforce and for service delivery. The RCM is that the Government’s zeal for cutting NHS employees pay, terms and conditions will result in far higher costs to staff engagement and patient outcomes. Investment in NHS staff is an investment in NHS care.