The Royal College of Midwives (The 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 (MSWs) 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 and MSWs. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

Our evidence is divided into two sections: Government Pay Policy and Staffing, Morale and Motivation in Maternity Units.

Our key arguments are:

• The RCM is increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after six years of pay restraint they have announced they will continue with pay restraint until 2020. This fundamentally threatens the independence of the NHSPRB; undermines the integrity of the system; and will cause lasting damage to the morale and motivation of staff, worsening the staffing crisis in the NHS.

• The Government needs to stop considering their pay policy in isolation; they need a total strategy for the whole workforce. The RCM is concerned that the Government’s zeal for cutting pay, terms and conditions for NHS staff will actually result in far higher costs to the NHS in terms of low staff engagement and patient outcomes. Investment in staff is an investment in high quality care.

• The evidence is this submission comes from a variety of official sources. We have also conducted research to inform the NHSPRB about the situation in maternity services; our annual survey of Heads of Midwifery (HOMs) which asks HOMs information about their service for April 2015 – April 2016. The 2016 HOMs survey had a response rate of 53%. The second survey we have conducted is about the reasons midwives give for leaving the NHS. We asked midwives who left the service in the last 24 months or who are intending to leave the service in the next 24 months their reasons for leaving and had 2,719 responses to our survey. We also undertook a freedom of information (FOI) request NHS organisations’ spending on agency, bank and overtime for midwives in 2015. We also present findings from a survey we conducted for our health, safety and wellbeing campaign ‘Caring for You’ about the working conditions that midwives, maternity support workers and student midwives are currently working in.

• The evidence we present shows that there is currently a shortage of nearly 3,500 midwives in the UK. This is caused by the rising birth rate and increased complexity of health needs. The RCM has grave concerns that the planned removal of the bursary and introduction of tuition fees for student midwives and if the nearly 1,200 midwives from other EU countries are not given the right to remain we will see an upsurge in the shortage of midwives in the coming months and years. Additionally, the evidence we present shows that maternity units are struggling to meet the demands of the service, with HOMs frequently redeploying staff to other areas; using bank and agency staff; withdrawing services and closing the unit. Fundamentally, organisations are relying on the goodwill of midwives and maternity support workers to staff the units and this is leading to high levels of stress and burn out and is causing midwives to leave midwifery. The most common reasons that
midwives give for leaving is staffing levels and workload. Maternity services are in a catch-22 situation with many midwives leaving midwifery because of understaffing which further exacerbates staffing levels. However, 80% of the midwives who are intending to leave midwifery in the next two years said that increased pay would encourage them to stay in midwifery.

• The RCM believes that maternity units are facing unprecedented challenge. Maternity units are overworked and understaffed and this has resulted in low levels of staff engagement. Improving staff engagement can not only improve organisations’ financial performance through savings on litigation costs and sickness absence costs but it also improves patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

RCM recommendations

• We would like the NHSPRB’s view on how organisations could make best use of local or regional recruitment and retention premia (RRP) in Agenda for Change to tackle staffing shortages for midwives.

• 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 it is still their view.

• We welcome the introduction of mandatory gender pay gap reporting in the public sector to help to shed light on the impact of long incremental points in the NHS. We would welcome the NHSPRB’s views on the introduction of gender pay gap reporting in the NHS.

• We do not agree with ‘targeting’ of pay awards as this could result in unintended consequences or cause anomalies in the pay structure.

• We believe that the increase to the national minimum wage is part of Government’s social policy and this should be funded in addition to the increase to the pay bill. The RCM believes that the best way to do this is a restructure of bands 1–3 to deliver the living wage.

• We would like to see a return to UK-wide pay structures for the NHS; this would involve re-setting bands 4–9 of the NHS pay structures to the current Scotland rates.

• Following re-setting of the NHS pay structure to the Scotland rates for bands 4–9 and the living wage restructure for bands 1–3 there should be an annual pay award determined for the NHS. The RCM believes that the NHSPRB needs to break the public sector pay restraint and should recommend an appropriate pay award to ensure that NHS organisations are able to recruit and retain staff in the NHS. We believe that retail prices index (RPI) is the most appropriate measure for the cost of living and therefore an award of 1.9% based on the July rate of RPI should be applied to the re-set pay structure to determine salaries for 2017/18.
Section One – Government Pay Policy

The RCM is increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after six years of pay restraint they have announced they will continue with pay restraint until 2020. This fundamentally threatens the independence of the NHSPRB; undermines the integrity of the system; and will cause lasting damage to the morale and motivation of staff, worsening the staffing crisis in the NHS. Section two of this report will give evidence about morale, motivation and staffing while this section deals with our concerns about the independence of the NHSPRB and the integrity of the pay system in the NHS.

The Government needs to stop considering their pay policy in isolation; they need a total strategy for the whole workforce. The RCM is concerned that the Government’s zeal for cutting pay, terms and conditions for NHS staff will actually result in far higher costs to the NHS in terms of low staff engagement and patient outcomes. Investment in staff is an investment in high quality care.

The RCM would like to see the NHSPRB make an unfettered recommendation on pay and our view is that the pay award for 2017/18 should be a resetting of the pay structure to the Scotland rates; a restructure of bands 1–3 to deliver the living wage; and an uplift for staff based on RPI inflation (1.9% as of July 2016).

The independence of the NHS Pay Review Body

As stated above, the RCM is increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after six years of pay restraint they have announced they will continue with pay restraint until 2020. This fundamentally threatens the independence of the NHSPRB; undermines the integrity of the system; and will cause lasting damage to the morale and motivation of staff, worsening the staffing crisis in the NHS.

In 2014 the Government and employers made the unprecedented decision to reject the recommendation of the NHSPRB 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. Fundamentally, this act, by the Secretary of State, weakened the trust and confidence that NHS staff have in the pay structure and, added to the ongoing political interference in NHS pay, the integrity of the system has been undermined.

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 NHSPRB’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.”

The RCM remains committed to the independence of the NHSPRB process and would like to see an end to the political interference with the NHSPRB.
Negotiations on Agenda for Change and incremental progression

Following the resolution of the 2014 pay dispute the RCM, and other NHS trade unions, agreed to enter into discussions around the pay structure to ensure that it is fair and fit for purpose.

The RCM has engaged in talks for the past year and a half, and will continue to engage in talks around the pay structure. We believe that there are issues that could be resolved, mainly that if there are fewer incremental points in the pay bands midwives, maternity support workers and other NHS staff can reach the top of the band, which is the true rate of the job, in a more appropriate period of time. This is particularly important given the equalities impact of long incremental scales and we welcome the introduction of mandatory gender pay gap reporting as this could help to shed light on the impact of long incremental points in the NHS. We would welcome the NHSPRB’s views on the introduction of gender pay gap reporting in the NHS.

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 it is still their view.

The RCM is concerned by the on-going dispute over the junior doctors’ contract. In particular, we are concerned by the imposition of changes to their contract; we do not want to see moves away from the good partnership working in the NHS, and urge the Government to negotiate with the BMA. We made the case that services cannot be extended elsewhere in the NHS by undermining hard working midwives and maternity support workers. We were pleased by the recognition in the NHSPRB’s report that the main barrier to providing extended services is because of staffing levels.

While we understand there are 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.

Government imposition

As discussed above, the RCM is concerned by the way the Government has continued to restrain the NHSPRB and interfere with the independence of the recommendations of the NHSPRB and by the imposition of the junior doctors contract of employment.

Moreover, we are concerned by the announcement on 26th September 2016 about the changes to redundancy payments that the Government wish to impose on the NHS. There is already a redundancy agreement in Agenda for Change that has been negotiated by the NHS trade unions, including the RCM, with employers. By announcing that it will legislate change and not allowing trade unions and employers to negotiate change is a cynical move by the Government that undermines the trust and confidence that staff have in the NHS Staff Council.
Value of NHS pay

The impact of pay restraint over the past six years has resulted in a real terms decrease in pay for NHS employees and capping pay at 1% until 2020 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 January 2010 to July 2016.

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 2015 when there was a dip in RPI inflation, although levels seem to have returned to around 2% with the July RPI inflation figure at 1.9%. This has resulted in a continued devaluation in the value of NHS employees’ pay.

The chart below shows the actual pay for a midwife at the top of band six from 2010–2016 and the pay if there had been increases to their salary in line with RPI inflation. In 2016 the value of pay for a midwife at the top of band six has decreased by over £6,000.
Taking this forward, using the Treasury’s average of independent forecasts of RPI inflation rate, and assuming that there is a consolidated 1% pay increase awarded to all NHS staff from 2016–2020 the difference between the actual salary of a band six midwife and if their salary increased by RPI inflation would be over £9,000 (as shown in the chart below). This means that in ten years the value of a midwife’s salary will decrease by over 25%.

**Comparison of Projected Actual Pay for a Band Six Midwife to Projected Pay Including RPI Inflation Uplifts 2010–2020**

The RCM has substantial concerns about the impact this will have on the attractiveness of midwifery as a career. The next section will present evidence about the impact the decreasing value of pay is having on recruitment and retention of midwives and the impact this then has care for women and their families. This is a retrograde step back to the time when NHS careers, particularly female dominated professions such as midwifery, were poorly paid and poorly valued.

**Comparisons to other professional groups and pay awards**

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.

According to the latest figures by the Labour Research Department (LRD) pay settlements across the economy stand at 2%. The Chartered Institute of Personnel Development (CIPD) expect that settlements will centre at around 2% and the Office of Budget Responsibility (OBR) forecast average earnings growth of 2.6% during 2016 and then 3.6% in 2017, where it is set to remain until 2020.

As other pay awards continue to improve 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 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."

We further explore recruitment and retention issues in maternity units in the next section.

Other changes to income

In addition to falling wages midwives and maternity support workers have seen other reductions in their take home 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 resulted in increases to national insurance contributions for members of the NHS pension scheme by 1.4% from 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, ongoing changes and restraint to tax credits are likely to affect most MSWs and some midwives, particularly if they work part time and are the sole earner in the household. This will have a huge impact on those members of staff and the attractiveness of remaining a member of NHS staff.

Pay restraint and the RCM’s pay claim for 2017/18

As stated above, the RCM is increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after six years of pay restraint they have announced they will continue with pay restraint until 2020. This fundamentally threatens the independence of the NHSPRB; undermines the integrity of the system; and will cause lasting damage to the morale and motivation of staff worsening the staffing crisis in the NHS. The RCM would like to see the NHSPRB make an unfettered recommendation on pay and our view is that the pay award for 2017/18 should be a resetting of the pay structure to the Scotland rates; a restructure of bands 1–3 to deliver the living wage; and an uplift for staff based on RPI inflation (1.9% as of July 2016).

The RCM does not agree with the overall 1% pay increase for Agenda for Change staff. We feel that this is an insufficient reward and will not be adequate to relieve the very real recruitment and retention pressures that there are in the NHS. As we shall explore in the next section, there is a growing shortage of midwives and the ongoing pay restraint in the NHS is causing increased recruitment and retention difficulties. We would like the NHSPRB’s view on how organisations could make best use of local or regional recruitment and retention premia (RRP) in Agenda for Change to tackle staffing shortages for midwives.

The RCM does not agree that there should be an unequal pay increase across the bands, or ‘targeting’. We are concerned about the unintended consequences of a targeted award, in particular the consequences for equal pay for work of equal value, the impact on recruitment and retention, and causing anomalies in the pay structure. However, the former Chancellor, George Osborne, MP’s announcement that the national minimum wage should increase to £9 by 2020 will start to impact on the lower bands by 2017 in Northern Ireland and 2018 in the rest of the UK. This will mean that in order to be complaint with the national minimum wage lower paid staff will need to have an
increase of higher than 1%. We believe that the increase to the national minimum wage is part of Government’s social policy and this should be funded in addition to the increase to the pay bill. The RCM believes that the best way to do this is a restructure of bands 1–3 to deliver the living wage.

Furthermore, we would like to see a return to UK-wide pay structures for the NHS; this would involve re-setting bands 4–9 of the NHS pay structures to the current Scotland rates. Following re-setting of the NHS pay structure to the Scotland rates for bands 4–9 and the living wage restructure for bands 1–3 there should be an annual pay award determined for the NHS. The RCM believes that the NHSPRB needs to end the public sector pay restraint and should reward an appropriate pay award to ensure that NHS organisations are able to recruit and retain staff in the NHS. We believe that RPI is the most appropriate measure for the cost of living and therefore an award of 1.9% based on the July rate of RPI should be applied to the re-set pay structure to determine salaries for 2017/18.

Section Two – Staffing, Morale and Motivation

The evidence is this submission comes from a variety of official sources. We have also conducted research to inform the NHSPRB about the situation in maternity services; our annual survey of Heads of Midwifery (HOMs) which asks HOMs information about their service for April 2015 – April 2016. The 2016 HOMs survey had a response rate of 53%. The second survey we have conducted is about the reasons midwives give for leaving the NHS. We asked midwives who left the service in the last 24 months or who are intending to leave the service in the next 24 months their reasons for leaving and had 2,719 responses to our survey. We also undertook a FOI request of NHS organisations’ spending on agency, bank and overtime for midwives in 2015. We also present findings from a survey we conducted for our health, safety and wellbeing campaign ‘Caring for You’ about the working conditions that midwives, maternity support workers and student midwives are currently working in.

The evidence we present shows that there is currently a shortage of nearly 3,500 midwives in the UK. This is caused by the rising birth rate and increased complexity of health needs. The RCM has grave concerns that the planned removal of the bursary and introduction of tuition fees for student midwives and if the nearly 1,200 midwives from other EU countries are not given the right to remain we will see an upsurge in the shortage of midwives in the coming months and years. Additionally, the evidence we present shows that maternity units are struggling to meet the demands of the service, with HOMs frequently redeploying staff to other areas; using bank and agency staff; withdrawing services and closing the unit. Fundamentally, organisations are relying on the goodwill of midwives and maternity support workers to staff the units and this is leading to high levels of stress and burn out and is causing midwives to leave midwifery. The most common reasons that midwives give for leaving is staffing levels and workload. Maternity services are in a catch-22 situation with many midwives leaving midwifery because of understaffing which further exacerbates staffing levels. However, 80% of the midwives who are intending to leave midwifery in the next two years said that increased pay would encourage them to stay in midwifery.

The RCM believes that maternity units are facing unprecedented challenge. Maternity units are overworked and understaffed and this has resulted in low levels of staff engagement. Improving staff engagement can not only improve organisations’ financial performance through savings on litigation costs and sickness absence costs but it also improves patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

We believe that fundamentally, midwives and MSWs need to feel valued again and this needs to be reflected in their pay. The RCM would like to see the NHSPRB make an unfettered recommendation on pay and our view is that the pay award for 2017/18 should be a resetting of the pay structure to the Scotland rates; a restructure of bands 1–3 to deliver the living wage; and an uplift for staff based on RPI inflation (1.9% as of July 2016).

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.

The chart below shows the number of births in England compared to the number of WTE midwives from 2001 to 2015. While the graph below does show that the numbers of midwives has increased since 2001 there is a current shortage of nearly 3,500 midwives in England.
Our 2016 HOMs survey found that:

- 38.6% of HOMs said their funded establishment is not adequate for their organisation; this is compared to 29.6% of HOMs in 2015.

- 93.2% of HOMs said their unit is dealing with more complex cases than last year which is compared to 91.3% in 2015.

- 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 complexity has an impact upon the workload and the amount of interaction and care required. Often the women have social factors that require considerable midwifery input to keep both the woman and her baby safe."

Head of Midwifery, England

"No extra time built in to deal with these cases thus impacting on the workload."

Head of Midwifery, England

"It increases workload for midwives, obstetricians and ultra-sonographers and no extra time is given. Newly qualified midwives don’t always understand the implications of co-morbidities."

Head of Midwifery, England

"The level of complexity affects all parts of the maternity pathway which means there is pressure in every part of the service."

Head of Midwifery, England
The European Union and Brexit

Like the TUC and many other trade unions, the RCM campaigned to remain in the EU. While the outcome was not what we had hoped, we do respect the democratic outcome of the vote. We are now looking to the future and what this means for RCM members. The EU has played a central role in protecting working people from exploitation, combating discrimination and promoting good employment practices such as equal pay; maternity rights; health and safety protections; equalities protections; rights for agency workers; the working time directive; information and consultation and TUPE protections. The government must commit to keep these rights. We believe that watering down or dismantling this legislation would be a backward step for living standards.

We also need to protect existing workers who come from other EU countries. The RCM has joined a newly formed organisation called the Cavendish Coalition calling for EU workers in the NHS to be granted the right to remain. According to NHS Digital, there are currently 1,192 full time equivalent midwives who are from EU countries and do not currently know if they will be allowed to stay in post-Brexit Britain. Over half of those midwives are in London, where the shortage of midwives is most acute. The RCM is very concerned about that if they were not allowed to stay in the UK the shortage of midwives would increase by over a third to nearly 5,000 midwives.

Changes to the student bursary

The Government is planning to change funding for student midwives by removing the bursary and replacing it with a student loan and introducing tuition fees from September 2017. We believe that the prospect of accumulating significant debt will deter many aspiring students from studying midwifery, particularly as for many student midwives midwifery is their second degree. We conducted a survey of current student midwives and asked them if the proposed system of finance had been in place when they started would they still have studied midwifery and 63.7% said they would not have applied to study midwifery.

If students are deterred from studying midwifery this will add to the increasing shortage of midwives. We believe that the Government should re-think its plans to abolish the bursary for midwifery students and not introduce tuition fees as both of these actions will have consequences for the numbers of new students training to be midwives.

Service delivery

Given the shortage of 3,500 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 temporary staffing, e.g. bank and agency midwives. The HOMs reported that:

- 18.8% of HOMs said their budget had decreased in the last year, compared to 14.6% in 2015.
- 13.6% of HOMs reported that they had to decrease services in the last year, compared to 11.0% in 2015.
- The most common services that HOMs reported having to reduce were parent classes; bereavement support; and breast feeding support.
• 38.6% of HOMs said their unit had to close for a temporary period at some point in the last year because they couldn’t cope with the demand. In total, units closed 281 times. The average was 8.3 times. Eight units closed on ten or more occasions with one unit closing 50 times during the year.

• 81.2% of HOMs said they had to redeploy staff to cover essential services either very or fairly often compared to 75.9% of HOMs in 2015.

• HOMs were asked which areas staff were redeployed to and from, overwhelmingly HOMs reported that staff were redeployed from the antenatal service, community and the postnatal service to the labour and deliver suite.

• 73.9% of HOMs answered that on call community staff have to be called in to cover the labour and delivery suite compared to 64.6% in 2015. 46.2% of HOMs said this restricted the home birth service compared to 35.8% in 2015.

• 62.1% 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).

• 55.2% 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:

“We are currently experiencing shortages with midwives and this has a negative impact on staff taking breaks and leaving work on time. We are actively managing this with movement of staff to maintain a safe service”.
Head of Midwifery, Scotland

“The twelve hour shifts do not enable staff breaks. Where there was a crossover of staff when seven-and-a-half hour shifts were worked, this no longer occurs. Staff can be in theatre etc. at the end of their shift which means they cannot safely transfer their woman to another midwife. I truly believe that these shift patterns are dangerous to staff health, women’s safety and morale”.
Head of Midwifery, Scotland

“Relatively easy for staff to get breaks during the day shifts, however more difficult to achieve on a night shift during periods of increased activity. Community staff frequently report that they regularly work over their contracted hours due to the length of appointment times”.
Head of Midwifery, England

“Clinical staff frequently miss breaks and are late off duty. This has almost become an accepted situation. A more junior workforce increases the problem”.
Head of Midwifery, England

“It is difficult to cover breaks when all staff work twelve-and-a-half hour shifts and require a one hour break. They can more often have a physical break in order to have something to eat but to have a proper “psychological break” where they can fully switch off for 30–60 minutes is more difficult. This is impacted on by the twelve hour shifts, the focus on 1:1 care in labour and the reliance on temporary staffing to cover sickness, maternity leave and vacancies although this has improved in this unit”.
Head of Midwifery, England

“There are days when acuity and capacity is high and therefore I would say it is difficult to ensure all the staff get breaks. They are brilliant at providing good will for the benefit of the women on such occasions. This is clearly not ideal but there is very limited flexibility to call bank staff in at
Evidence to the NHS Pay Review Body

short notice...The staff group that tend to suffer will be the senior midwives as they ensure the juniors get breaks”.
Head of Midwifery, England

Unsocial hours payments and seven days services

The RCM is concerned by the on-going dispute over the junior doctors’ contract. We were pleased by the sensible and fair recommendations in the NHSPRB’s 2015 report into seven day services in the NHS and were pleased that the NHSPRB recognised that unsocial hours payments are necessary for the existing running of seven day services such as maternity services. Midwives have always worked 24 hours a day, seven days a week and 365 days a year to provide high quality, safe services to women and their families.

We asked HOMs what impact a change to unsocial hours would have and they said:

“Considerable impact as staff often rely on additional unsocial hours payment to support their home/life commitments. Reduction in such payments would create resistance in staff covering a seven day service”.
Head of Midwifery, England

“I feel there will initially be a massive impact with a number of staff, in particular the younger staff reviewing their career choice. A reduction in unsocial payment is essentially a cut in salary and a number of staff will not be willing to work weekends and nights for less money”.
Head of Midwifery, England

We maintain our position that services cannot be extended elsewhere in the NHS by undermining hard working midwives and maternity support workers. We were pleased by the recognition in the NHSPRB’s report that the main barrier to providing extended services is because of staffing levels.

Spending on agency, overtime and bank midwives

In November 2015, following instructions from the Department of Health, NHS Improvement introduced a mandatory cap on the hourly rates paid for agency staff and an annual ceiling for agency spending for each trust. The cap had a staggered introduction, with nursing and midwifery staff affected first and other professions added later and the rate of the hourly cap was reduced over time. Significantly, NHS Improvement allows organisations to break the cap on ‘exceptional safety grounds’. Our research shows that the cap has made little difference so far and organisations are far too reliant on temporary midwives to staff their units safely.

In January 2016 the RCM sent a FOI request to all the NHS trusts in England that have maternity units to ask them how much they have spent on agency and bank staff and overtime for midwives in every month in 2015. The FOI also asked about the numbers of hours of staff time this equated to. This report follows on from the RCM’s report on agency spending in maternity units between 2012–2014 which was published in February 2015. 123 trusts responded to the FOI giving a response rate of 91.1%

The FOI found that NHS organisations spent £72,698,200 on agency, overtime and bank midwives in 2015. £72,698,200 is enough money to pay for 2,063 full time, experienced midwives (paid at the top of band 6 at £35,255 a year) or 3,318 full time, newly qualified midwives (starting salary is £21,909 per year). There were 23 organisations in total that spent more than £1 million on agency, bank and overtime.
The FOI also found that the average spend on agency staff was £41.25 per hour (significantly the highest average monthly spend was in December 2015 when spending peaked at £50.58 per hour. This was after the government introduced a pay cap for agency staff in the NHS); on bank staff was £25.63 per hour; and overtime was £23.06 per hour. This is compared to £18.02 per hour for a band six midwife or £11.21 for a newly qualified midwife. Using the figures for the average hourly spend for agency, bank and overtime to calculate the number of full time midwives this equates to and it would be the equivalent of around 1,400 full time midwives. This is substantially lower than the number of midwives that could be employed permanently with the same sum of money.

The results of our FOI make it clear that the majority of NHS organisations are reliant on temporary midwives (agency, bank or overtime) as a means of staffing their maternity unit and they are paying substantially more for temporary staff per hour than if they employed permanent staff. The amount of money that NHS organisations have spent on agency, bank and overtime in 2015 could pay to hire enough permanent midwives to nearly cover the shortage. When the increased value per hour is taken into consideration, hiring permanent midwives rather than relying on temporary staff would be a substantial improvement in staffing levels as it would result in more hours worked or the same amount of money.

**Vacancies, recruitment, retention and why midwives leave**

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

- 79.5% of HOMs have vacancies in their unit.
- 57.7% of the vacancies were for band six-nine midwives compared to 50.9% in 2015.
- 39.1% of HOMs said they had problems recruiting to specific posts and 11.5% said they had problems recruiting to all posts.
- 22.7% of HOMs said they have problems with retention in specific posts and 5.7% of HOMs said they have problems with retention in all areas.

HOMs spoke about the challenge of vacancies, recruitment and retention particularly in posts for experienced midwives. HOMs said:

“The biggest challenge is recruiting experienced qualified midwives”.

Head of Midwifery, England
Evidence to the NHS Pay Review Body

“Significant and longstanding problems recruiting to experienced band six community midwifery posts”.
Head of Midwifery, England

“Recruiting to band six midwife posts has proved the greatest challenge, we are able to develop our band five midwives to achieve band six, however recruitment of experienced band six midwives remains an issue for this area”.
Head of Midwifery, England

During August 2016 the RCM conducted a survey to investigate why midwives leave midwifery. We asked midwives to complete the survey if they had left midwifery in the last two years or are intending to leave in the next two years. There were 2,719 responses in total.

By far, the greatest reasons that midwives gave for wanting to leave midwifery were because of staffing, workload and not having enough time to spend giving women and their families high quality care. This shows that maternity services are in a catch-22 situation, if more midwives are retained, staffing levels will improve, which will in turn cause fewer midwives to leave. Additionally, if staffing levels improve, midwives will have more time to spend with women, improving the quality of care they are able to give and thus their job satisfaction which again will cause fewer midwives to leave. 80% of the midwives who are intending to leave midwifery in the next two years said that increased pay would encourage them to stay in midwifery.

Midwives made comments about the low pay levels, particularly in relation to the responsibilities of a midwife and the level of workload. Midwives said:

“Midwives are some of the most motivated and highly trained of any workforce and yet they are consistently treated in a derogatory manner by their employer. The level of pay is in no way consistent with the role and responsibility they hold and does not reflect the expertise they have”.
Midwife, England, left midwifery 18–24 months ago

“I have been disappointed in the support to progress in my career and all enthusiasm has been eroded over the past 13 years working as a midwife in the NHS; on top of that my salary has actually decreased; it simply is not worth the effort and stress and resulting debt trying to make a living in London working for the NHS”.
Midwife, England, intending to leave midwifery in the next 6–12 months

“All the band sevens had to reapply for their jobs, with vastly reduced number of posts available. I was reduced to a band six so left as soon as my protected pay stopped. I was expected to carry on doing the same job, despite my pay being reduced”.
Midwife, England, left midwifery 12–18 months ago

“I am currently working as a specialist bereavement midwife overseeing over eight hundred staff members. I am a band six despite the responsibilities and pressures of role. I have been offered little to no additional training or support – money cited as major factor”.
Midwife, England, intending to leave midwifery in the next 18–24 months

“I left midwifery to go on a ski season to have some fun and get away from the pressures of the modern day NHS. I adore midwifery but it is a shame that many people that I met on my season earn more than I do doing a job that doesn’t require three years training and caring for people’s lives. For example, a secretary I met can earn up to £35,000 in their first year of work”.
Midwife, England, left midwifery 6–12 months ago

“Too much pressure for the pay I receive. I can earn more money elsewhere with less stress, where I do not have to work nights and weekends, where I can take my breaks and have holidays that suit...
me, when I want them instead of when the service can release me. The job is simply overwhelming and pay and conditions do not adequately compensate for the level of responsibility”.
Midwives, England, intending to leave midwifery in the next 12–18 months

“We definitely need more midwives but the pay needs to improve. We used to be on par with the police, teachers etc. now we lag far behind.”
Midwife, England, left midwifery 18–24 months ago

“I am leaving midwifery due to the unsociable hours I work, the responsibilities I have, and stress that I am under, which is not appreciated, recognised or reflected in the salary of a midwife. I am unable to provide the quality of care I would like due to workload and staffing levels... I can work in a different profession, earn the same pay without all the stress, responsibility and health related issues”.
Midwife, England, intending to leave midwifery in the next 6 months

“I felt my experience and skills were undervalued. I had to reapply for a substantive post I had been in for eighteen months after already having two interviews for post. It makes me sad to have left after twenty-five years”.
Midwife, Wales, left midwifery in the last 6 months

“I feel very burnt out and dissatisfied with the level of workload and responsibility that I have in my role. We are short staffed and this puts an extra strain on work life. I have a vision of how to improve my team (I am a team leader in the community) but there is never enough time or resources to progress with this. I work ten-twelve hour days, five days a week but my contracted hours are 37.5. I can’t work like this until 68–70 years old. I have to balance a clinical and management role and I have had no training for this. My pay works out that other members of the team earn more than me even though they are a band below me because I don’t get any weekend pay. How is that right or fair?”
Midwife, Scotland, intending to leave midwifery in the next 12–18 months

“I have young children and financially it was not viable to go back to work. I am lucky I did have the choice to leave, unlike many of my colleagues who struggle with childcare and shifts for absolutely minimal money remaining at the end of the month”.
Midwife, England, left midwifery 6–12 months ago

“The realities of the job are not what I trained for and the working conditions and workload are completely unreasonable... Why would I stay when I can have a better salary and work-life balance elsewhere, as well as not having to constantly deal with high levels of risk and stress? If the Government want well trained and educated people to choose to stay in this profession, they need to drastically improve our terms, conditions and working conditions – we’re degree professionals now, so we have higher expectations and more career options”.
Midwife, England, intending to leave midwifery in the next 6 months

“An issue where I work is the very high cost of living/rental in this area. We do not qualify for inner/outer London living allowance, even though this area has the highest discrepancy between income/living costs in the UK. As a result, young people do not stay around long after qualification, meaning a high turnover of staff. Retention rates are dreadful. I’m sure this will get worse as the cost of studying for a midwifery degree starts to rocket in September 2017. The lack of any long term vision to address these issues is heartbreaking”.
Midwife, England, intending to leave midwifery in the next 18–24 months

“A higher salary that allows me at least to live on my own; better working hours; being able to get a break every day; higher staffing levels; less bullying and harassment; less discrimination; and better teamwork”.
Midwife, England, left midwifery 6–12 months ago
“With over a decade of experience and significant skills in safeguarding, management and other areas, my skills simply aren’t recognised or valued in the NHS. There is little progression available and affording to live in London with a family is simply not covered, even with a band seven salary. The difference between salaries of doctors and midwives is truly shameful.”
Midwife, England, left midwifery 12–18 months ago

“I absolutely love the work I have done since qualifying yet to watch new midwives constantly upset and unable to fulfill the expectations placed upon them I could not recommend this level of stress to anyone – and the pay is not worth it.”
Midwife, England, intending to leave midwifery in the next 12–18 months

As discussed in the previous section, the RCM believes the NHSPRB needs to make an unfettered recommendation for pay to start to relieve the very real recruitment and retention pressures that there are in the NHS. As our HOMs survey and leavers survey show there is a growing shortage of midwives and the ongoing pay restraint in the NHS is causing increased recruitment and retention difficulties. In addition to an unfettered increase to pay we would like the NHSPRB’s view on how organisations could make best use of local or regional RRP to tackle staffing shortages for midwives.

Fundamentally, we believe that pay in the NHS is too low and this is adding to already large recruitment and retention problems in maternity units. It is particularly telling that Oxleas NHS Foundation Trust and East and North Hertfordshire NHS Trust, have launched ‘incentive’ schemes to recruit newly qualified nurses (in Oxleas) and newly qualified nurses and midwives (in East and North Hertfordshire) which involve offering an additional sum of money in to new recruits in exchange for opting out of the NHS Pension Scheme. The RCM, along with the other NHS trade unions, are fundamentally opposed to this. We believe that this is an attempt to undermine the NHS Pension Scheme and we are very concerned about the long term financial impact this could have on RCM members who are not paying into the NHS Pension Scheme. In particular, we have made the case that targeting midwives and nurses will increase the gender pensions gap further as both groups are predominantly female employees.

However, it is clear that both organisations have identified that the starting salary is too low to recruit midwives and nurses. We believe that if trusts are struggling to recruit midwives and nurses they should offer to pay a local RRP, it is not acceptable to pay a sum of money in exchange for being a member of the NHS Pension Scheme.

**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 seven years HOMs surveys:

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<tbody>
<tr>
<td>Band 2 MSWs</td>
<td>15.0%</td>
<td>14.3%</td>
<td>12.7%</td>
<td>13.6%</td>
<td>13.1%</td>
<td>12.9%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Band 3 MSWs</td>
<td>4.3%</td>
<td>4.9%</td>
<td>5.6%</td>
<td>5.6%</td>
<td>6.5%</td>
<td>6.5%</td>
<td>6.8%</td>
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<tr>
<td>Band 4 MSWs</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>0.9%</td>
<td>1.1%</td>
<td>1.2%</td>
<td>1.3%</td>
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<tr>
<td>Band 5 Midwives</td>
<td>6.4%</td>
<td>7.9%</td>
<td>5.7%</td>
<td>7.1%</td>
<td>7.0%</td>
<td>7.8%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Band 6 Midwives</td>
<td>53.0%</td>
<td>52.1%</td>
<td>55.9%</td>
<td>54.5%</td>
<td>54.8%</td>
<td>55.9%</td>
<td>54.3%</td>
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<tr>
<td>Band 7 Midwives</td>
<td>18.3%</td>
<td>17.3%</td>
<td>16.3%</td>
<td>16.0%</td>
<td>14.5%</td>
<td>13.8%</td>
<td>13.7%</td>
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<tr>
<td>Band 8 and 9 Midwives</td>
<td>2.2%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>2.3%</td>
<td>2.9%</td>
<td>2.0%</td>
<td>2.2%</td>
</tr>
</tbody>
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The most significant result is the steady decline in the proportion of band seven posts from 18.3% in 2010 to 13.7% in 2016.

When asked about downbanding staff:

- 6.8% of HOMs had to downband staff during the year.
- 41.11 WTE MSW posts had been downbanded in the last year and 17.03 WTE midwife posts have been downbanded in the last year.
- 41.6% of the MSW posts that were downbanded were in band three and 58.4% were in band 4 and 88% of the midwife posts that were downbanded were in band seven and 12% were in band eight.

The RCM believes that the significant reduction in band seven 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 graph below shows the age profile of midwives in England from 2002–2016. It shows that midwives in England are getting older, with 47.1% aged 45 or older and 14.3% 55 or older. The graph also shows a dip in the numbers of midwives aged between 35–44. We believe that the number of midwives aged 35–44 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.
In the 2016 HOMs survey we asked questions about the ability of HOMs to be able to support flexible work arrangements. They reported that:

- 81.2% of HOMs said they found accommodating requests to reduce the number of night shifts difficult/very difficult.

- 81.8% of HOMs said they found accommodating requests to reduce the number of weekends difficult/very difficult.

- 89.4% 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:

*Marked increase in requests for flexible working has come to a head in the past year that staff now requesting flexible working cannot be accommodated due to sheer numbers and difficulty in ensuring a fair roster for all staff*.

Head of Midwifery, England

*With great difficulty. The applications for flexible working are at an all time high due to the numbers of midwives with young children and the prohibitive prices around child care. With the older staff there are often issues surrounding older parents with increasing dependency. Adopting a balanced and equitable approach is very difficult*.

Head of Midwifery, England

The Family and Childcare Trust’s annual Childcare Costs Survey 2016 found that the costs of sending a child under two to nursery part time (25 hours) is £116.77 per week or £6,072 per year, which is a 1.1% rise since 2015. There are also issues with the opening hours for many child care facilities that make child care difficult for midwives working twelve hour shifts.
In our leavers survey many midwives identified the lack of access to flexible working as a reason for leaving midwifery. Midwives said:

“I retired early due to ill health. There is no equality in the NHS if you are disabled. If you are broken, as I was by over thirty years of midwifery you are thrown on the scrap heap...there is no compassion for the carers”. 
Midwife, England, left midwifery 6–12 months ago

“I have worked at the same hospital for twenty-one years, I love being a midwife and am extremely passionate about helping women to make the transition to parenthood. I worked full time for the first fifteen years of my career, but now have three young children (one of whom has autism) and I would like to work part-time. Unfortunately my employers no longer support midwives who have young children and families. I am devastated”. 
Midwife, England, intending to leave midwifery in the next 6–12 months

“I took retirement when I could as the pressure of work became too much and there was no support in reducing the workload for someone coming up to sixty”. 
Midwife, England, left midwifery 18–24 months ago

“Long shifts on a busy delivery suite is not healthy for either the midwife or the women they are caring for. I feel so disappointed having trained to do the job I had always longed to do but didn’t feel I could give the women in my care 100%, which is what they should receive at all times. I would have been very happy to move into a different area of midwifery working less hours and shorter shifts but this was not possible due to being newly qualified”. 
Midwife, England, left midwifery 18–24 months ago

“Upon returning from maternity leave, my request to reduce my working hours from full time to part time was denied. As my husband works away, I am the sole childcare provider during the week so I would be unable to work the required three twelve-hour shifts a week to cover full time hours (I could have done the necessary part time hours at weekends). In addition, the shift start time of 7.30 and end time of 20.30 is outside of any childcare providers opening hours”. 
Midwife, England, left midwifery 18–24 months ago

“I have two small children under two. When I am due to return to work from maternity leave, I have been told I will need to work on labour ward (I am currently a community midwife) and the shift pattern is not conducive to childcare options available. I would be paying out more in childcare than I earn! My husband also work shifts as a police officer therefore out of hours childcare really hard to find. If I was returning to community midwifery with more regular hours it would have been much easier to manage”. 
Midwife, England, intending to leave midwifery in the next 6–12 months

“When I went on maternity leave, I was in a seconded role. I was made to interview for the post when my daughter was three months old. I did not get the job, and I suspected it was because I would have another baby and wanted to only work four days (as I was before going on maternity leave). When I resigned, my manager informed me that ‘when I’ve had my next baby, I can concentrate on my career’ – confirming my previous thoughts”. 
Midwife, England, left midwifery in the last 6 months

“Mothers returning from maternity leave are not supported as they should be by the NHS. For the short time period that flexibility is needed compared to a working lifetime, I feel it would be beneficial to allow flexibility to keep a valuable workforce engaged and motivated. Instead we are made to feel inferior if we choose our children over our career”. 
Midwife, England, left in the last 6 months
“If a more common sense approach to staffing were taken. There are a vast number of midwives in exactly the same position, all trying to juggle young families. If only we were allowed to work fewer hours, we’d all stay and staffing would be better.”
Midwife, England, left midwifery 18–24 months ago

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:

- 60.2% of HOMs said that moral and motivation in their organisation was ‘ok’ or ‘poor’. Only 1.1% of HOMs rated morale and motivation as very good.
- 47.7% of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from other staff members.
- 37.5% of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from service users.
- 33.0% of HOMs said there were complaints of bullying, harassment, verbal and physical abuse from other friends/family users.

HOMs said:

“One individual on the labour suite however staff unwilling to submit evidence hence anecdotal, so managers trying different approaches. More verbal abuse from women and their families and friends than ever before.”
Head of Midwifery, England

“Staff feel there are being asked to do more and more due to increasing complexity of women and the financial constraints that are facing partner agencies. There is also increasing bureaucracy which means more paperwork and less time for providing clinical care. Staff are also concerned about the implications of the National Maternity Review, in particular how they will maintain a work-life balance if ‘caseloading’ is brought in.”
Head of Midwifery, England

“Constant denigration of the NHS and in particular midwifery in the media is having an effect on maternity services nationwide. Coupled with the increase in demand for evidence and data and the ever present demand for meeting efficiency savings morale and motivation across all levels of staff is taking a battering.”
Head of Midwifery, England
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:

- 16.3% of HOMs disagreed/strongly disagreed with the statement ‘maternity is a priority in my organisation’.
- 17.6% of HOMs disagreed/strongly disagreed with the statement ‘I am able to influence the Board in my organisation’.
- 18.3% of HOMs disagree/strongly disagreed with the statement ‘I feel valued as a Head of Midwifery’.
- 23.3% of HOMs disagreed/strongly disagreed with the statement ‘I have enough support from the Board in my organisation’.
- 36.0% of HOMs disagreed/strongly disagreed with the statement ‘I am able to do my job to a standard I am personally happy with’; and
- 69.8% 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 HOMs, are feeling pressurised and that is affecting their morale and motivation and their ability to give high quality, safe care.

**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 generally².

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.

In June 2016 the RCM launched our health, safety and wellbeing campaign called ‘Caring for You’. The campaign asks for NHS organisations to sign up to our Caring for You Charter that asks HOMs to work in partnership with RCM health and safety representatives to sign up to five commitments to improve midwives’ MSWs’ and student midwives’ health, safety and wellbeing at work.

In March 2016 the RCM conducted a survey of our members about their health, safety and wellbeing at work. The survey had 1,361 responses. It was clear from the results of the survey that the increased pressure and demands are having a significant effect on the health, safety and
wellbeing of midwives and maternity support workers. RCM members are reporting that they are feeling stressed, burned out and unable to give high quality care to women and their families. While there is a high level of camaraderie in maternity units there are also many reports of bullying and undermining behaviours. Some of the key findings of the survey are:

- Only 21% of RCM members said they take their entitled breaks most or all of the time.
- 17% of members work 5 hours or more every week unpaid.
- 48% of members said they felt stress every day or most days. The most common reasons for stress were workload; staff shortages and not enough time to do their job.
- 57% of members agreed with the statement ‘I have to neglect some tasks because there is so much to do.’
- 56% of members agreed with the statement ‘I feel overwhelmed by how much work I have to do.’
- 50% of members agreed with the statement ‘I am worried about making a mistake at work because I am exhausted.’
- 18% of members agreed with the statement ‘I often cry at work because of the pressure I am under.’

However, our survey also found that when organisations work with health and safety representatives take positive action on health, safety and wellbeing it makes a difference. It leads to lower stress levels and better health and wellbeing for staff and improved care for women and their families. For example, we found that 53% of members who work in organisations that do not take positive action on health, safety and wellbeing report bullying, harassment and abuse from managers compared to 12% of members who work in organisations that do take positive action on health, safety and wellbeing.

So far, over 25% of NHS organisations have signed up to the RCM’s Caring for You Charter and while we are hopeful that this will make a positive difference to midwives’, maternity support workers’ and student midwives’ working conditions it is clear that staffing issues need to be resolved. As discussed previously, our evidence from our leavers survey shows, 80% of midwives who intend to leave midwifery in the next two years could be persuaded to stay if their pay improves.

2 Employee Engagement and NHS Performance Michael A West and Jeremy Dawson, The Kings Fund 2012

3 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
Conclusion

The RCM has welcomed the opportunity to present evidence to the NHSPRB. The key arguments that we have made are:

- The RCM is increasingly concerned by the way the Government continues to constrain the NHSPRB and we are particularly alarmed that after six years of pay restraint they have announced they will continue with pay restraint until 2020. This fundamentally threatens the independence of the NHSPRB; undermines the integrity of the system; and will cause lasting damage to the morale and motivation of staff, worsening the staffing crisis in the NHS.

- The Government needs to stop considering their pay policy in isolation; they need a total strategy for the whole workforce. The RCM is concerned that the Government’s zeal for cutting pay, terms and conditions for NHS staff will actually result in far higher costs to the NHS in terms of low staff engagement and patient outcomes. Investment in staff is an investment in high quality care.

- The evidence we present shows that there is currently a shortage of nearly 3,500 midwives in the UK. This is caused by the rising birth rate and increased complexity of health needs. The RCM has grave concerns that the planned removal of the bursary and introduction of tuition fees for student midwives and if the nearly 1,200 midwives from other EU countries are not given the right to remain we will see an upsurge in the shortage of midwives in the coming months and years. Additionally, the evidence we present shows that maternity units are struggling to meet the demands of the service, with HOMs frequently redeploying staff to other areas; using bank and agency staff; withdrawing services and closing the unit. Fundamentally, organisations are relying on the goodwill of midwives and maternity support workers to staff the units and this is leading to high levels of stress and burn out and is causing midwives to leave midwifery. The most common reasons that midwives give for leaving is staffing levels and workload. Maternity services are in a catch-22 situation with many midwives leaving midwifery because of understaffing which further exacerbates staffing levels. However, 80% of the midwives who are intending to leave midwifery in the next two years said that increased pay would encourage them to stay in midwifery.

- The RCM believes that maternity units are facing unprecedented challenge. Maternity units are overworked and understaffed and this has resulted in low levels of staff engagement. Improving staff engagement can not only improve organisations’ financial performance through savings on litigation costs and sickness absence costs but it also improves patient outcomes. Midwives and maternity support workers have never been so challenged in their ability to provide high quality and safe care.

RCM recommendations

- We would like the NHSPRB’s view on how organisations could make best use of local or regional recruitment and retention premia (RRP) in Agenda for Change to tackle staffing shortages for midwives.

- 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 it is still their view.

- We welcome the introduction of mandatory gender pay gap reporting in the public sector to help to shed light on the impact of long incremental points in the NHS. We would welcome the NHSPRB’s views on the introduction of gender pay gap reporting in the NHS.

- We do not agree with ‘targeting’ of pay awards as this could result in unintended consequences or cause anomalies in the pay structure.

- We believe that the increase to the national minimum wage is part of Government’s social policy and this should be funded in addition to the increase to the pay bill. The RCM believes that the best way to do this is a restructure of bands 1–3 to deliver the living wage.

- We would like to see a return to UK-wide pay structures for the NHS; this would involve re-setting bands 4–9 of the NHS pay structures to the current Scotland rates.

- Following re-setting of the NHS pay structure to the Scotland rates for bands 4–9 and the living wage restructure for bands 1–3 there should be an annual pay award determined for the NHS. The RCM believes that the NHSPRB needs to break the public sector pay restraint and should recommend an appropriate pay award to ensure that NHS organisations are able to recruit and retain staff in the NHS. We believe that retail prices index (RPI) is the most appropriate measure for cost of living and therefore an award of 1.9% based on the July rate of RPI should be applied to the re-set pay structure to determine salaries for 2017/18.