

# The gathering storm: England's midwifery workforce challenges



Promoting · Supporting · Influencing

[www.rcm.org.uk](http://www.rcm.org.uk)

# The gathering storm: England's midwifery workforce challenges

Foreword: Professor Cathy Warwick CBE, Chief Executive, Royal College of Midwives	4
Executive summary	5
Workforce demands up	6
Births up	6
Complexity up	6
Increased demand from policy changes	7
Workforce supply challenges	9
The never-ending shortage?	9
Money wasted on sticking plaster agency staff	9
The vicious cycle caused by the national midwifery shortage	10
The ageing midwifery profession	10
Impact of lack of flexible working opportunities	11
Student midwife numbers dip	11
Constrained budgets hit services	12
Why midwives leave	13
Waving goodbye to our EU midwives?	13
Maternity support workers: easing some of the pressure	14
What can be done?	16
Increase the workforce	16
Retaining the midwives we have	16
Using the staff we have better	17
Fair pay for midwives	17
Evidence based clinical innovations	18



# Foreword

**Maternity services, like the rest of the NHS, are facing many challenges – including severe financial constraints, increasing demands and expectations and continuing staff shortages. Added to these challenges there are further uncertainties arising from, among other things, changes to the funding of healthcare education and the vote to leave the European Union. This gathering storm is threatening the safety, quality and sustainability of maternity services in England.**

It does not have to be this way. The RCM believes that urgent action is needed to increase the number of midwives and maternity support workers (MSWs) entering the workforce and retain the experience and expertise of those already in the service.

The RCM has developed this paper to facilitate a better understanding of the factors that are influencing the demands on maternity services and the supply of midwives and MSWs, and to advocate for a set of practical solutions to address these challenges. These solutions are essential and need to be implemented quickly if we are to improve maternity care for women, and give their babies the best possible start.



*Professor Cathy Warwick CBE  
Chief Executive, Royal College of Midwives*

## Executive summary

**The demands bearing down on midwifery are growing. Births in England are on the up, and 100,000 higher in 2015 than they were in 2001. Complexity is up too, with the women using maternity care typically older than previously and around a fifth are now obese.**

These factors are made worse by some of the challenges facing the midwifery profession. Around 3,500 full-time midwives short, the pressure created by the lack of staff actually forces even more staff to leave because of the intolerable pressure caused by the shortage. With the workforce growing at a snail's pace, money is wasted on short-term agency staff instead of on fixing the problem of not having enough permanent midwifery staff.

The profession is ageing rapidly, with over 1,000 NHS midwives in England now in their sixties; one in three is now over the age of 50. An inability and unwillingness to offer flexible working opportunities to midwives juggling family commitments leads to even more leaving the profession.

Student numbers are dipping just as full tuition fees are introduced and bursaries are abolished. Early signs point to a drop of almost a quarter in applications for nursing and midwifery courses at our universities. All at a time when a huge question mark hangs over the future of more than 1,300 EU midwives who work in the NHS in England.

NHS trusts in England should conduct robust assessments of their midwifery staffing needs, and implement the findings. That will show that overall we need more midwives. To achieve this, we should gradually increase the number of training places, as promised by the Government when they introduced fees for midwifery courses.

We need to work harder at retaining the midwives we already have and using them more efficiently and productively. Finally, our survey findings show that perhaps the single most effective intervention in keeping midwives who might leave is to offer them fair pay for the work they do.

# Workforce demands up

The demands on NHS maternity services in England are rising. Here we set out some of those pressures.

## Births up

At the last count, the number of births in England was on the rise. In 2015, there were 664,399 babies born<sup>1</sup>. That was up on the previous year, and over 100,000 higher than in 2001<sup>2</sup>. Figures for hospital births in the 12 months to 31<sup>st</sup> March 2016 were also up, by almost 11,500 on the preceding year<sup>3</sup>.

More babies being born obviously means more demand on our maternity services, and a greater need for midwives.

## Complexity up

A good illustration of the increase in the complexity of the workload of midwives is the age profile of the women using maternity care<sup>4</sup>. Between 2010 and 2015, the number of babies born to women in every age band under 30 fell, whilst it rose for women in every age band above 30 – not only in England as a whole but also in every region of England too.

Older women using maternity services will, on average, require more support and more midwifery time. More births to women in the older age bands does therefore inevitably place greater demand on our maternity services. And this means more midwives are needed.

In terms of smoking prevalence, of women attending antenatal booking appointments in England in September 2016 and whose smoking status was recorded, 12% smoked<sup>5</sup>.

1 *Births by mothers' usual area of residence in the UK*, Office for National Statistics: <https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk/2015/areaofusualresidencetables.xls>

2 *State of Maternity Services Report 2016*, Royal College of Midwives: <https://www.rcm.org.uk/download-state-of-maternity-services-report-2016>

3 *Hospital Maternity Activity*, NHS Digital: <http://content.digital.nhs.uk/article/2021/Website-Search?productid=23494&fq=NHS+Maternity+Statistics+-+England&sort=Relevance&size=10&page=1&area=both#top>

4 *State of Maternity Services Report 2016*, Royal College of Midwives: <https://www.rcm.org.uk/download-state-of-maternity-services-report-2016>

5 *Maternity Services Monthly Statistics, England – September 2016, Experimental statistics*, NHS Digital: <http://www.content.digital.nhs.uk/catalogue/PUB23255>

And where height and weight measurements were taken at the booking appointment, 20% were obese.

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

An increase in births combined with increased complexity can ratchet up the pressure felt by our maternity services. And this is a process we are seeing emerge right now.

## Increased demand from policy changes

Changes to clinical practice are having an impact on the service, with additional pressure on midwifery time.

There is, rightly, an increasing focus in recent times on reducing the prevalence of stillbirths, perinatal deaths and the number of babies who are not premature who require care in a neonatal unit. We welcome the drive to improve care in this way.

One result of the policies to deliver on these goals is, however, an increase in the number of inductions and more women coming forward to report concerns about foetal movement. These changes place extra demands on our maternity services. To be clear, this is not a complaint about these developments at all, simply an observation about their impact.

There is also pressure on the service from welcome policies to promote choice of place of birth, more personalised care and care from a known and trusted midwife. In the long term, this should save money as a result of better outcomes and greater maternal satisfaction. In the short term however there is likely to be some additional cost, for example by providing more sites where women can access services (to make good on the promise of choice) and also having more midwives so that women are more likely to get continuity of carer.





## Workforce supply challenges

**There are a number of big challenges facing the midwifery profession. These compound the problems created by the rising demands being placed on them.**

### The never-ending shortage?

The NHS in England has been short of midwives for years, perhaps for a generation or more. It is our calculation that the NHS in England is short of the equivalent of around 3,500 full-time midwives<sup>6</sup>.

We are currently looking at the growing complexity of the midwife's workload, and this may result in the shortage figure being revised upwards at some point in the near future, to take account of some of the additional pressures identified above.

Some progress in recruiting more midwives has been made in recent years. Between May 2010 and October 2016 the number of full-time equivalent (FTE) midwives working in the NHS in England rose by 2,143<sup>7</sup>. But the rate of increase has slowed massively over that time. In the 12 months to October 2016, for example, the number of midwives rose by 171 – that is less than one extra midwife per maternity unit. The growth in the size of the midwifery workforce has clearly stalled.

### Money wasted on sticking-plaster agency staff

Because the NHS does not employ enough midwives, many trusts are constantly having to pay for agency staff to cover the shortfall. Through use of the Freedom of Information Act, the RCM has uncovered almost £25 million spent on agency midwives in 2015.

Additionally, the NHS spent £4.5m on midwives' overtime, and over £43m on bank midwives. In total, the NHS in England spent over £72 million on these sticking plaster solutions in 2015<sup>8</sup>.

6 *State of Maternity Services Report 2016*, Royal College of Midwives: <https://www.rcm.org.uk/download-state-of-maternity-services-report-2016>

7 *NHS Workforce Statistics - October 2016*, Provisional statistics, NHS Digital: <http://content.digital.nhs.uk/searchcatalogue?productid=24139&topics=1%2fWorkforce%2fStaff+numbers&sort=Relevance&size=10&page=1#top>

8 *NHS midwife agency spend could solve midwife shortage says RCM in new report*, Royal College of Midwives: <https://www.rcm.org.uk/news-views-and-analysis/news/nhs-midwife-agency-spend-could-solve-midwife-shortage-says-rcm-in-new>

Using the Government's figure for the average paybill cost for a FTE midwife in 2015/16, this £72m figure would be enough on its own to pay for over 1,500 full-time midwives. And given that a midwife with 10 years' experience will earn an average of £18.02 per hour, but agency staff cost the NHS £41.25 per hour, the health service would get a lot more midwifery time if it spent that £72m on permanent staff.

## The vicious cycle caused by the national midwifery shortage

Almost half of RCM members surveyed in March 2016 reported feeling stressed either every day or most days. The most common reasons for stress were the size of their workload, the impact of the shortage of staff, and simply not having enough time with women to provide the care they want to provide.

In August 2016, in order to understand more about why midwives leave, the RCM surveyed those who had left midwifery in the preceding two years or who were intending to leave in the next two years (the "leavers' survey")<sup>9</sup>. This found that exactly the same three issues were the reasons that made midwives more likely to leave: lack of staffing, size of workload and not having enough time to provide care.

If therefore we can address these issues, we can turn a vicious cycle into a virtuous one. Recruiting more midwives would reduce stress and thereby cut the number of people leaving the service.

## The ageing midwifery profession

Midwifery is an ageing profession<sup>10</sup>. Since 2010, the number of midwives aged under 50 has fallen, whilst the number in their fifties or sixties has risen. In July 2016, one third (32.5%) of all the midwives in England's NHS were in their fifties or sixties. Over 1,000 were in their sixties.

In terms of specific numbers, the total number of NHS midwives in England aged under 50 fell by 27. The number aged 50 or above rose by 1,560. In other words, the entire growth of the midwifery workforce since 2010 has been amongst the oldest midwives, closest to their retirement date. This situation makes the need for more new midwives even more urgent. We will need to replace the older, typically more experienced midwives with new midwives in good time, so that their replacements are able to build up their level of experience before their older colleagues leave the profession.

9 *Why midwives leave – revisited*, Royal College of Midwives: <https://www.rcm.org.uk/sites/default/files/Why%20Midwives%20Leave%20Revisited%20-%20October%202016.pdf>

10 Ministerial answer from health minister Philip Dunne MP to the Rt Hon Andrew Smith MP, answered 8<sup>th</sup> November 2016: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-11-02/51597/>

## Impact of lack of flexible working opportunities

Many midwives are juggling multiple commitments: not only work, but raising a family whilst perhaps also caring for elderly parents. To make this work they need their employer to be flexible in how they roster staff.

But the NHS struggles to offer this. Our latest survey of heads of midwifery (HOMs)<sup>11</sup>, for the 12 months to the end of April 2016, shows that:

- Four in five HOMs (81%) find accommodating requests to reduce the number of night shifts difficult or very difficult
- Four in five HOMs (82%) find accommodating requests to reduce the number of weekend shifts difficult or very difficult
- Nine in 10 HOMs (89%) find accommodating requests to fix shifts (so, no rotation of shifts) difficult or very difficult.

Indeed, a lack of access to flexible working was frequently cited in our leavers' survey last summer as a reason for leaving midwifery.

The RCM believes that as 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 the retention of midwives within the NHS.

## Student midwife numbers dip

It is good that the number of places commissioned on midwifery courses each year rose from just over 2,500 in the 2011/12 academic year to just over 2,600 in the current 2016/17 academic year<sup>12</sup>.

11 *Budget Cuts, Service Cuts, Staffing Shortages – Maternity Services in 2016*, Royal College of Midwives: <https://www.rcm.org.uk/news-views-and-analysis/news/budget-cuts-service-cuts-staffing-shortages-maternity-services-in-2016>

12 Ministerial answer from health minister Philip Dunne MP to Sharon Hodgson MP, answered 2<sup>nd</sup> November 2016: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-10-25/50241/>

It was also positive that the total number of student midwives in training – not just the number of places commissioned for new student midwives – also rose, by over 1,000 in just four years. There were 5,644 midwifery students in 2010/11, but 6,662 in 2014/15<sup>13</sup>.

It is a concern however that in the most recent year for which we have figures (2015/16), this number suddenly fell by 5%, down to 6,350. We are not sure of the reasons behind this fall, given that places for new student midwives have been maintained. We fear it may suggest a growing attrition problem amongst those in training.

A further concern we have is the effect of the changes to student midwife finance. From autumn 2017, all bursaries paid to student midwives to help them make ends meet will end. Additionally, they will go from paying no tuition fees to paying full, £9,000 per year tuition fees. At a stroke, training to become a midwife will become a very expensive decision. Applications for nursing degrees have fallen sharply since the Government withdrew their funding via bursaries and forced students to pay for their courses with loans.

Reports in the press in February 2017 suggested that applications for nursing, midwifery and allied health courses were down almost a quarter (23%) compared to the same stage a year earlier<sup>14</sup>.

## Constrained budgets hit services

The information we are getting from the frontline of care paints a pretty grim picture. Our latest HOMs survey shows that:

- Almost a fifth (19%) of HOMs report that their budget had been cut
- Around one in seven (14%) of HOMs report cutting services, with specialist bereavement support being amongst those most frequently cut
- Two in every five (39%) of HOMs said they had to close units temporarily.

13 Ministerial answers from health ministers Ben Gummer MP and Philip Dunne MP to Craig Whittaker MP and the Rt Hon Norman Lamb MP, answered on 10<sup>th</sup> December 2015 and 28<sup>th</sup> October 2016: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2015-12-03/18698/> and <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-10-25/50052/>

14 e.g. *Students turn backs on nursing degrees in wake of Government decision to axe NHS bursaries*, official figures suggest, the Daily Telegraph: <http://www.telegraph.co.uk/education/2017/02/02/students-turn-backs-nursing-degrees-wake-government-decision/>

## Why midwives leave

Of the 2,719 who responded to our leavers' survey, the survey found that the most common reasons for leaving were dissatisfaction with the quality of care they were able to give because of lack of time, as well as staffing levels and workload. Midwives were asked what factors might encourage them to stay or return to midwifery. The most popular factors were appropriate staffing levels; a change in workload; more support from management; a change in working conditions; a change in workplace culture; and increased pay.

This reveals a catch-22 situation where midwives leave because there are an insufficient number of midwives, which in turn leads to even more pressure on those who remain. Clearly, the solution is to reduce and then eliminate the shortage altogether.

## Waving goodbye to our EU midwives?

In September 2016 there were 1,355 midwives (headcount) working in the NHS in England who came from elsewhere in the European Union<sup>15</sup>. Right now, we (but, more importantly, they) do not know for sure if they will be legally entitled to remain in this country after the UK formally leaves the European Union. Indeed, the Secretary of State for International Trade, the Rt Hon Dr Liam Fox MP, has talked about EU nationals with lives here in the UK as useful bargaining chips in the Brexit negotiations ahead<sup>16</sup>.

It is not enough to guarantee the rights of EU midwives already here, the UK Government should go further and declare that the door will remain open to EU nationals, with the appropriate professional qualifications, to continue to come to the UK post-Brexit to work in our healthcare system.

Between September 2015 and September 2016, just over 250 new EU midwives started working in the NHS and just over 200 EU midwives left employment in the NHS<sup>17</sup>. If the door had been closed to new EU midwives coming during this period, we would lost around 450 midwives (200 would have left and 250 would not have been able to come to the UK), instead of gaining a net of around 50.

<sup>15</sup> *EU staff by staff group, September 2015 to September 2016*, NHS Digital: [http://content.digital.nhs.uk/media/23302/EU-staff-by-staff-group-September-2015-to-September-2016/xls/EU\\_staff\\_by\\_staff\\_group\\_\\_September\\_2015\\_to\\_September\\_2016.xlsx](http://content.digital.nhs.uk/media/23302/EU-staff-by-staff-group-September-2015-to-September-2016/xls/EU_staff_by_staff_group__September_2015_to_September_2016.xlsx)

<sup>16</sup> EU nationals in UK 'one of our main cards' in Brexit deal - Liam Fox, Sky News: <http://news.sky.com/story/eu-nationals-in-uk-one-of-our-main-cards-in-brexit-deal-liam-fox-10605533>

<sup>17</sup> *NHS Leavers Nationality 2012-16 and NHS Joiners Nationality 2012-16* files, accessible at <http://content.digital.nhs.uk/article/4163/2016-Supplementary-information-files>

## Maternity support workers: easing some of the pressure

MSWs are now an integral part of the maternity team, and working alongside midwives they can make a valuable contribution to delivering care. In particular they can add real value to the health promotion and prevention work needed to ensure the NHS is sustainable in the long term.

MSWs cannot replace midwives, but if used appropriately they can free up midwifery time. With appropriate training and support they can do many things, such as providing information and guidance on staying healthy during pregnancy (e.g. smoking cessation and healthy eating advice), supporting midwives as a second person at homebirths, giving breastfeeding advice and undertaking postnatal home visits. Given the nature of how MSWs have developed, we believe that it eliminates the need to create a midwifery associate role.

We remain concerned however that in some cases MSWs are not being used appropriately, particularly in England, with no agreed job description, set of competencies, training or appropriate remuneration linked to job evaluation. Without this not only are individual MSWs denied career opportunities but there is a danger that they will be asked to take on elements of care that should only be delivered by a midwife. Examples of this include taking detailed antenatal histories, undertaking foetal heart rate monitoring during labour, or undertaking newborn examinations. To address this, we believe MSWs should be regulated professionals.





# What can be done?

**We need action now to turn this situation around. Here we set out some practical steps that decision makers at every level can take to help do just that.**

## Increase the workforce

The NHS in England is short of around 3,500 full-time midwives. Absolutely fundamental to what we need to do with the NHS midwifery workforce in England is increase it.

Given this, and given the age profile of the profession, it is our assessment that we need to grow the number of midwives we train. The Government has said that the introduction of full tuition fees and the abolition of maintenance grants for student midwives from autumn 2017 will lead to 10,000 new training places<sup>18</sup>. We have never supported this policy, but if it is to happen then we want a substantial number of these new places to be set aside for midwifery.

Work will also have to be undertaken between universities and NHS trusts at the local level to ensure training places are available in areas where clinical placements can be facilitated.

More broadly, we recommend that trusts across England conduct robust midwifery staffing assessments using an approved methodology, e.g. Birthrate Plus<sup>19</sup>, and implement the findings of these assessments in full.

## Retaining the midwives we have

As we found in our leavers' survey, midwives are being driven from the profession by the widespread inability or unwillingness of the NHS to allow midwives to work flexibly. Midwives, especially those in certain age bands, need greater flexibility over how they are rostered, for example, to enable them to juggle work and family commitments.

A service that does not offer them what they need soon finds that they leave, making the England-wide midwifery shortage even worse.

<sup>18</sup> *NHS bursary reform policy paper*, Department of Health: <https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform>

<sup>19</sup> Birthrate Plus: <https://www.birthrateplus.co.uk/>

Providing a full-spectrum maternity service, e.g. choice of birth in an obstetric unit, midwife-led unit and at home, as well as antenatal and postnatal care offered in the community, also allows midwives to work in the setting that suits them best. That is likely to keep them happy and keep them working in the NHS.

## Using the staff we have better

Some of the work that midwives currently undertake would best and more efficiently be undertaken by other staff. This would free up midwifery time to undertake more clinical tasks. Examples of how this could be done include round-the-clock provision of clerical staff in our busiest maternity units, IT systems that minimise the need for the multiple entry of data, increased use of MSWs where appropriate (such as to support a midwife attending a homebirth), and not using midwives in operating theatres.

It is important to note that this part of the solution is only appropriate up to a point. Many clinical settings and many clinical tasks can only be covered by a midwife, and quite rightly so. Additionally, it must be noted that some of this work, e.g. taking midwives out of theatres, is already widely undertaken. Overall, there is scope here to use midwives more efficiently, but it can only go so far.

## Fair pay for midwives

In 2016, the salary of a midwife at the top of band 6 working in the NHS in England was £6,000 less than it would have been if their salary had simply risen at the rate of inflation since 2010<sup>20</sup>. If, as planned, pay restraint continues until 2020, it is forecast that this figure will reach £9,000.

During 2016 the RCM conducted a survey of 2,719 midwives who had left midwifery in the preceding two years or who planned to leave midwifery in the next two years. Of the midwives who intended to leave, four in every five (80%) said that increased pay would encourage them to stay in the profession. This has the potential to be a key intervention to staunch the loss of midwives from the NHS.

20. Evidence to the NHS Pay Review Body, September 2016, Royal College of Midwives: <https://www.rcm.org.uk/sites/default/files/Royal%20College%20of%20Midwives%20Evidence%20to%20the%20NHS%20Pay%20Review%20Body%20-%20September%202016.pdf>

## Evidence based clinical innovations

Making changes to how we deliver maternity services can both improve care and also cut pressure on the workforce and the service. We should be pursuing such changes.

Take, for example, the issue of where women give birth. The more births that take place outside of obstetric units, the fewer the number of interventions that occur and the number of midwives needed reduces. Some women need to give birth in an obstetric unit, but at present far more do so that is necessary, meaning there is scope to encourage more women to give birth in non-obstetric settings.

Increasing continuity of carer should also lead to the more efficient delivery of maternity care. Small changes, such as enabling partners to stay overnight in maternity units, can greatly increase women's satisfaction, whilst reducing pressure on staff.

In some areas, more interventions will help to save babies' lives; induction would be an example of this. Where that is the case, we should consider carefully whether more of these might be carried out in community settings, to reduce pressure on our maternity units. Equally, some of the things we do are unnecessary. Recent work looking at term admissions to neonatal units, for example, shows that a failure to follow NICE guidelines results in an over-diagnosis of hypoglycaemia, unnecessary transfers to neonatal services and more needless pressure on services.

*Royal College of Midwives  
February 2017*



[www.rcm.org.uk](http://www.rcm.org.uk)