# Response to

# The Lord Darzi Review of Health and Care/IPPR

# March 2018

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

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**The Royal College of Midwives' response to The Lord Darzi Review of Health and Care/IPPR**

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

The RCM welcomes the opportunity to respond to this consultation and our views are set out below.

***Summary***

1. The RCM continues to support, for 2030 and beyond, a comprehensive health and care system which is, as now, free at the point of need, paid for out of general taxation. We support in principle the merging of health and care systems, but it is essential that all sectors of care remain adequately funded. We support the expansion of 'sin taxes' which encourage behaviour change that pay long-term dividends alongside the creation of new income streams.

2. A modern maternity service should be flexible and adaptive. New technologies, new challenges and new populations will all demand the provision of maternity services that are open to learning and open to change. The National Maternity Review has laid out radical policy ambitions for maternity which will help in our sustainability challenge. As midwives refocus their role in relation to women's expectations and policy drivers there will be an inevitable shift in professional boundaries and practices (not to mention locations of care) but it is essential that as this takes place the body of knowledge that defines midwifery and the activities of the midwife are retained and enhanced. Quality maternal and newborn care has a lasting impact on mothers' and infants' physical and psychosocial health and wellbeing, on their need to pay for ongoing health care costs, and on the ability of their families to escape poverty. It also has an economic impact on communities and countries and boosts efforts to tackle intergenerational inequalities in health[1].

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[1] Mary J Renfrew et.al, *Midwifery: an executive summary for the Lancet's Series*, Jun 2014

***Funding requirements and options***

3. Since 1951, NHS spending in England has increased on average by 3.7% per year in real terms[2]. Between 2009/10 and 2020/21 however, planned expenditure on the NHS in England will rise by an average annual rate of just 0.9%[3].

1. The resource situation has particular implications for any plans to merge health and social care. There is a strong case for such a merger but the challenge to make it work is not just structural but also relate to funding. Any merger should not be attempted until we face up to that reality and have found the money.

2. Whilst many would argue that more needs to be spent on providing NHS care, the unmet demands for social care are arguably far greater. Whilst spending on the NHS in England has at least kept pace with inflation, spending on social care has not[4]. However, if health and social care were to be merged and paid for out of the same pot, it seems inevitable that social care spending would rise at the expense of healthcare. This could have a damaging effect on services such as maternity care.

3. The question is how the taxes to pay for health and care are raised. The story of the "dementia tax" in last year's UK general election illustrates just how hard it is for politicians to identify sources of money for meeting the funding demands of long-term care. The RCM believes that one way forward would be to support taxes that simultaneously raise revenue and change behaviour. This helps to reduce demand for treatment (by improving public health) whilst raising money to pay for the care that is needed. In 2016/17, tobacco duties raised £8.9bn and alcohol duties over £11bn[5]; we would like to see these kinds of duties expanded, e.g. a tax on saturated fat in food.

4. Funding is a big challenge in a time of continuing fiscal restraint and if health and care are to work closer together, as they should. The RCM believes that this nettle must be grasped, and one way to do that is to seek policy solutions – such as sin taxes – that move public behaviour in a positive direction whilst raising money to deal with the effects of unhealthy public behaviour.

***The workforce – key to improving quality***

5. Fundamental to quality of services is capacity, so we urge the Review to take a serious look at the NHS workforce as it is *the* key to improving quality. For maternity services we are fortunate that there is a workforce planning tool (Birthrate Plus) which is based on the needs of women and babies and which is robust, credible, supported by the RCM and widely used in NHS maternity units across England. It has a long track record in enabling managers to measure the work and time involved in providing high quality maternity services and translating this into staffing numbers. It has now been endorsed by NICE as a workforce planning tool that can assist with

[2] The Health Foundation, *Health and care funding in a nutshell*
[3] The King's Fund, *The NHS budget and how it has changed*, Jan 2016
[4] The Health Foundation, ibid.
[5] HM Revenue & Customs, *HMRC Tax Receipts and National Insurance Contributions for the UK*, March 2018

implementing the recommendations in the NICE guideline for safe midwifery staffing[6].

6. The RCM has used the Birthrate Plus methodology to assess the adequacy of the size of the midwifery workforce; our current assessment is that midwifery services in England are around 3,500 full time equivalent midwives short of what would be needed to ensure that every woman could receive 1:1 midwifery care in labour, as clinically recommended[7]. The impact of these shortages is demonstrated by our annual surveys of Heads of Midwifery, the findings of which routinely highlight a reduction in services, temporarily suspensions of services as well as a reduction in access to midwives' training and development opportunities.

7. A major driver of demand for midwives is obviously the number of babies being born, with births in England up 100,000 on the number from around the turn of the century. The effect of this high number of births is compounded by the growing complexity of many births. For example, births to older women have risen significantly since 2001: down for women under 20 and those in their early twenties, but up for all older age groups (including 10,000 more births to women in their forties)[8]. The most recent figures, for October 2017, also reveal that 11 per cent of women whose smoking status was recorded at the time of their booking appointment were smokers and 21 per cent for whom their BMI was calculated were obese at the same time[9], adding to complexity. We must drive improvements in public health to reduce the demands placed on the service by complexity.

8. The main source of recruitment to maternity services in England is via pre-registration midwifery degree programmes. Since 2010, training commissions for student midwives have been maintained at around 2,500 places a year, even in years when commissions have been reduced for other healthcare degree programmes. This has contributed to a modest reduction in the shortage of midwives in England, but without a substantial increase in training places there will continue to be an undersupply of midwives into the next decade and beyond. This is because the overall contribution that pre-registration training makes to the midwifery workforce is diluted by a number of factors, such as retirements due to the ageing midwifery workforce (32 per cent of midwives in October 2017 were in their fifties, sixties or seventies[10]).

9. Fundamentally, shortages are a problem not of supply but of finances constraining the ability of maternity services to employ sufficient midwives, leading to excessive workloads, burnout and stress[11]. It means a 'long hours' culture, where there is little support for continuing professional development and high anxiety caused by continually feeling unable to give of your best. For women it means that antenatal care is often disjointed and the quality of postnatal care poor. A very real challenge with regard to quality of NHS maternity services is therefore that there are not enough midwives.

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[6] NICE. *Safe midwifery staffing for maternity settings*. Feb 2015
[7] RCM. *Midwife shortage soars, as birth rate figure continues to rise steadily in England*, Jul 2016.
[8] RCM. *State of Maternity Services Report*, 2016.
[9] NHS Digital, *Maternity Services Monthly Statistics, England - October 2017, Experimental statistics*, March 2018
[10] Statistics released in answer to a Parliamentary Question from Roger Godsiff MP, March 2018.
[11] RCM, *Caring for you: Survey Results*, May 2016.

10. In terms of aligning skills with future needs, the RCM welcomes any development of the midwife's role which enhances standards of care and which makes care more accessible and responsive to women's needs. This kind of approach can enhance the quality of care by maximising the contribution that midwives can make. It will require having midwives who are competent to work in different settings, work in new ways, learn new skills and address particular needs which impact on maternal and infant wellbeing.

11. However, there is much work currently undertaken by midwives that could be better and more appropriately carried out by administrative and clerical staff, by housekeeping staff and most obviously through a support role that allows units to flex their skill mix. Matching staffing levels, skill mix and staff deployment to the model of care, taking staff health and wellbeing into account, is complex – and even more challenging and essential when resources are restricted. But getting it right means that midwives concentrate their time on delivering quality care rather than functions that could be better carried out by others who are not in a position themselves to deliver clinical care.

12. The RCM does not endorse the extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of, or access to, midwifery expertise. It is not acceptable permanently to alter midwifery roles to compensate for staffing shortages or changes in doctors' roles. Therefore, proposals for advanced practitioner roles are not necessary for maternity care. What maternity services need instead are more consultant midwives, whose focus is improving quality of care. Further, the MSW role has become increasingly important since its widespread introduction 20 years ago and their contribution to maternity care should be further encouraged.

***New models of care***

13. There is a recognition throughout the NHS that models of care have to change, both in the short term through the STP process and the *Five Year Forward View* but also long term, to improve quality and meet the challenges of 21st-century healthcare. In the context of maternity services, the NHS must develop new models of care to improve outcomes for women and babies, tackle socially graded disease, reduce inequalities and set our population on the right path to long-term health and wellbeing .

14. The National Maternity Review in England (*Better Births*)[12] has laid out a vision for maternity services which correctly views a woman's contact with a maternity service as one of the most, if not the most, critical times in her child's life. The RCM fully supports the *Better Births* recommendations and urges this Review to look carefully at the vision it sets out. In particular, the proposals for Local Maternity Systems, in which providers and commissioners collaborate on co-designing services, offers the possibility of driving up quality, and allowing new kinds of providers to enhance women's choice of maternity care. Fostering collaboration will allow those services which run at a 'loss' – but which otherwise provide essential care with exceptional

[12] National Maternity Review. *Better Births, Improving outcomes of maternity services in England, A Five Year Forward View for Maternity*. Feb 2016.

clinical outcomes – to remain sustainable as part of the wider network. Picking up the themes in the *Five Year Forward View*, the *Better Births* call to bring care closer to where women and their families live, via community hubs, will enable women to access elements of their care from multiagency teams working together to offer midwifery, obstetrics and other services, including public health (e.g. smoking cessation, weight reduction).

15. *Better Births* also urges the NHS to develop systems to facilitate continuity of carer, whereby a woman's care from pregnancy through to the postnatal period is provided by midwives working in small teams. Care delivered in this way is more highly rated by women than care that is delivered in a more fragmented fashion by professionals working out of different teams. Having a midwife to know and understand women also facilitates public health messaging. Positive clinical outcomes associated with this model of care include less likelihood of preterm birth, baby loss and episiotomy. Robust economic analysis of continuity of care is limited at this stage, but the hypothesis is that allowing midwives to work more closely with women will lead to more positive maternity outcomes and that this will result in a net benefit to the NHS. This example of a new way of thinking about how best professionals can care for women is precisely the kind of innovation that is needed for sustainable midwifery services and the NHS as a whole.

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