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Professor Jacqueline Dunkley-Bent, OBE
Chief Midwifery Officer
NHS England

Dear Jacqui,

The pressures on our maternity services are thankfully now receiving the attention they deserve both from Trust Boards and from senior health officials. You will know that the RCM has been articulating for over a decade, that the continuing shortage of staff and under investment in maternity services would eventually begin to impact on the care midwives deliver; I think we can all agree we are now at that point. I am grateful for the work you and your team have done to amplify our voice that the safety of services requires concerted action.

The recent data from NHS Digital showing that midwifery numbers are down by 300 only confirms what we have been warning of. Around the country we are now seeing a range of short/medium term measures being introduced to try and alleviate this pressure. Some of these make sense and will certainly help, others though are causing us great concern because they potentially undermine the quality of care given to women. The RCM seeks always to work with individual Trusts and with the NHS where steps are being taken to address issues around staffing, leadership and resourcing and we certainly understand the need for swift and unprecedented action. There are, however, steps we cannot support and there are actions which we believe actually undermine the safety of services and further depress the morale amongst staff. We will continue to be vocal in both our support and our concerns.

By setting them out here, I hope that your team will not just understand where we are coming from, but also will be able to use your influence to ensure that measures taken in the short term are effective but also do not undermine the future of the service or the profession.

Measures taken to alleviate pressure on maternity services that the RCM is supporting

1. **Ensuring all newly qualified midwives are employed.** We understand that some Trusts deliberately overfill to vacancies, with newly qualified midwives, in the expectation that over the course of the year natural turn-over will bring funded establishment back inline. On the other hand, we know of Trusts whose HR policy is to only fill existing funded vacancies. We believe it is crucial at this time to make every effort to offer every newly qualified midwife a substantive full-time contract.

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2. **Facilitating the introduction of newly qualified midwives into the workplace.** We support work being undertaken by the NMC to prioritise and speed-up their administrative processes to ensure newly qualified midwives receive their PIN quickly to ensure they can begin work.
3. **Supporting effective preceptorship.** This long-standing approach to bringing newly qualified midwives into the workforce and transitioning them to autonomous practitioners is proven to reduce attrition. We have long complained that some Trusts have delayed this period, not because of midwives' competence but because it delays the transition from band 5 to band 6 and therefore saves money. There is no reason that a good, well-resourced preceptorship programme should take longer than 12 months. Investment in supporting newly qualified midwives at this stage will improve the skill mix in services and alleviate pressure on colleagues. We welcome the recent announcement of £50k for each unit to support preceptorship and hope that this will speedily find its way into maternity budgets.
4. **Flexible working.** We are delighted that NHS Employers and NHS Staff Side have developed new guidance across the NHS to promote flexible working. Maternity should be the champion for this, with more than 90% of staff being female and more than 50% being part time. Flexible working terms and conditions including for those who wish to retire, and return can give midwives choice and control over where they work and their preferred hours. Bank/agency midwives might be more prepared to join the employed workforce if they could secure working patterns that suit their needs. The current situation of substantive contracts being linked to a minimum number of hours would appear to be counterproductive in the current climate.
5. **Utilising MSWs to the full extent of their capabilities.** NHSE and HEE have done tremendous work over recent years to formalise the framework for Maternity Support Workers with clarity about role, remit, training, and development. It is now imperative that services ensure they are utilising this guidance to enable all MSWs to work to their full remit and competence and are paid appropriately.
6. **Postponement or temporary suspension of Midwifery Continuity of Care schemes.** We are aware of several Trusts that have now formally paused the roll out of organisational change, others are focussing on antenatal and postnatal continuity, leaving the flexibility for some community midwives to come into hospital. This relieves pressure on services and maintains focus on safe staffing levels. This does of course need to be accompanied by risk assessments to mitigate the impact on women already on continuity pathways.
7. **Moratorium on recruitment of senior midwives to national and regional NHS roles.** We suggest that NHSE/I and other ALBs consider an immediate pause on recruitment of senior midwives into national roles or even 'loan' these midwives back into service. We recognise that midwifery leadership is particularly pressurised with a high number of vacancies in

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senior management positions. Midwifery leadership in Trusts has itself been reduced over recent years and now is the time for a substantive investment in growing senior teams. If there are more senior midwives in services, they will be able to take a clinical role helping with morale and supporting staff. At this unprecedented time, we believe that the strengthening of national and regional midwifery teams is depleting the pool of experienced midwives in Trusts where they are currently most needed.

- 8. Pay and Conditions.** The scope already exists to use recruitment and retention premia within the parameters of Agenda for Change to target posts and areas with shortages. This requires Trust Boards to prioritise maternity expenditure. It is becoming increasingly a challenge to recruit into Band 8 posts, particularly with the loss of on-call payments and reduced bank rates for this group. Flex in the system to financially reward and incentivise managers and leaders is now essential. Until measures taken to attract bank/agency midwives into substantive employment have succeeded, it will be necessary in many units to relax and grow the spend on agency staff.

Measures taken to reduce pressures that the RCM cannot support

- 1. Redeploying and employing nurses in midwifery roles.** Nurses and MSWs can make a substantial and important contribution to safe maternity services if they are confident and competent. Under the supervision of a midwife and for defined and limited periods neonatal nurses for example can be used in transitional care, adult nurses in high dependency/recovery settings and gynae nurses in early pregnancy settings. Greater use of nursery nurses and MSWs on postnatal wards not only frees up midwifery time but also enhances infant care, and breastfeeding support. However, the RCM cannot support the general redeployment of nurses into midwifery in unfamiliar areas and unfamiliar work. This is unlikely to be safe and may in fact result in additional pressure for the midwifery workforce. We are particularly concerned at the impact of using agency nurses to cover shortages in midwifery staffing.
- 2. Employing nurse (and other professional) managers/leaders to cover senior midwifery vacancies.** Midwifery must have a strong credible voice both with Trust Boards and with the workforce. Only a registered midwife can effectively lead and manage maternity services and the RCM will oppose any proposals to bring nurses lacking appropriate experience and expertise and without a midwifery qualification into senior roles within services.
- 3. Fast-tracking students into practice.** We are concerned that one of the results of the staffing shortages caused by the pandemic is that a proportion of third year students remain some way from completing their necessary practice hours. We believe it is short-sighted and potentially unsafe to reduce the length of the midwifery programme or the requirements for theory and practice hours required to consolidate learning. Given the upheaval and



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disruption to their training, these students are likely to require additional not less support on qualification.

4. **Withdrawing specialist roles/services.** Over recent years maternity services have expanded and specialised to give skilled targeted support and care to women at particular risk. This matches the increase in complex and vulnerable pregnancies. This is not the time to withdraw support or pause specialist services such as perinatal mental health support or to redeploy midwives who have expertise in caring for women living with significant vulnerabilities such as substance misuse, domestic violence, or homelessness. We believe it will prove a false economy to withdraw these services.
5. **Removal of the super-numerary labour ward coordinator.** In times of great pressure, it is more important than ever that services retain an experienced midwife able to have oversight of all activity on a labour ward and to provide expertise and support for clinical staff, particularly those newly qualified. We will oppose any proposals to remove the supernumerary labour ward coordinator or redeploy this role as part of the core staffing.

We believe it is important that our members know what local proposals RCM supports and in what circumstances we are likely to raise concerns or challenge and so we will be sharing this letter with both our DoM/HoM members and with our activists.

But I would like to reiterate that the RCM seeks at all times to work constructively at local, regional and national level to support sound decision making in order to keep maternity services safe and we will continue to work with Trusts, LMSs and with NHSE/I to ensure this happens.

Yours sincerely,

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