scottish survey report 2022

Royal College of Midwives

Foreword

As the professional association and trade union for midwives and maternity support workers, representing our members and giving them a voice is at the heart of what the Royal College of Midwives (RCM) does. This report marks a significant milestone in the RCM's history, as it is based on the first survey conducted in Scotland at national and health board level.

Why is this important? It matters because, while the root causes of the challenges facing maternity services may be the same across the United Kingdom, the structures and governmental responsibilities are not. In this report, we hear the voices and the experience of members in Scotland – with four out of 10 RCM members in Scotland responding to the survey.

While the quantitative part of the survey provides a sense of how maternity staff are feeling, it is in the qualitative element that a true picture of maternity services in Scotland can be found. Of the 871 midwives who took the time to respond to the survey questions, 574 – two-thirds of those who responded - added a narrative response. This has been sobering reading. The key themes that emerged were the key ingredients of safe care: workforce, workload, education and development, quality of care, wellbeing and workplace cultures and leadership.

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We acknowledge that this survey was undertaken against the backdrop of the pandemic. It is evident from the number and detail of responses that the boards where COVID-19 had the greatest impact experienced the greatest challenges. This is no surprise. However the views expressed shine a light on chronic issues facing maternity services in Scotland, not just those caused by the pandemic. In many cases COVID-19 is exacerbating existing challenges and there is no quick fix to some of these.

What is clear is the passion and professionalism that midwives feel about midwifery and about the quality of care that they want to give. As an essential service they have continued to give, but the edges are frayed and midwives are concerned about themselves, their colleagues and the women and famillies in their care.

This survey not only serves as a baseline, somewhere from which we can move forward and can benchmark that progress, but also a route map for high quality, safe maternity care in Scotland that supports those working within it and meets the needs of women and families.

Jaki Lambert

Director, RCM Scotland

Introduction

Maternity care impacts on the current and future health of the population in Scotland. As a universal service, midwives are key to addressing inequalities and improving outcomes in both the short and long term[1]. The profession needs to be seen and valued.

The guiding principles of the Safe Staffing programme[2], the Scottish Patient Safety programme; Essentials of Safe Care[3] and the outcomes from numerous reviews[4] tell us that reduced maternity workforce capacity and excessive workload have a detrimental effect on safety[5].

Midwives are telling us that this is the case.

The results of this survey need to inform how Scotland progresses with recovery, growing and transforming[6] safe, effective, person centred maternity care that 'ensures the wellbeing of staff[7]'.

This survey gives the clear evidence of the impact of COVID-19 on the midwifery profession in Scotland and the acute distress felt by dedicated professionals who cannot give the quality of care that they want to give to women and families. Many have reached the tipping point[8] described in a recent study into the implication of the pandemic on the future of maternity services design and delivery in England.

However it is clear that the pandemic served to magnify pre-existing concerns relating to the maternity workforce and safety in its widest sense.

This is more than the impact of COVID-19 on the workforce, this is a workforce that does not feel that their profession is valued and with little prospect of educational or career development opportunities.

Moving forward midwives (and the wider maternity team) need to know that there will be enough of them to provide care with a workload that enables them to give the high quality care that achieves positive outcomes.

The 2020 Maternity workforce and education review[9] was commissioned to ensure Scotland has the right number of midwives in the right place with the right skills to support a sustainable midwifery service.

One of the most important finding of this review was that the current shortfall in midwives would only be met if all students are retained, the outflow of retiring midwives is addressed and there are opportunities to bring midwives into the profession. This survey indicates that it is unlikely that this aspiration of 'breaking even' by 2023 will be realised, in fact there is a risk that the 2025 worst case described will also not be realised.

There is still outstanding work to understand the caseload size for women with complex care needs and for providing services to remote and rural Scotland. This work will further inform the projected numbers of midwives required for Scotland and has yet to be undertaken. The boards with the highest responses are also those impacted most by inequalities but where conversely the caseload size is highest.

'The adaptation of the staffing-level tool for the maternity workforce (the maternity workload tool) needs to be prioritised and accelerated to ensure it is appropriate for use with continuity of care models to inform safe staffing levels. Further work on the tool is needed to support NHS boards to establish safe and effective staffing levels for core and continuity teams.'(NES 2021 p4)

1. Vance et al (2014) Midwifery (https://www.thelancet.com/series/midwifery)
2. Health and Care (Staffing) (Scotland) Act 2019 (legislation.gov.uk)
3. Essentials of safe care | Scottish Patient Safety Programme (SPSP) | ihub - Essentials of Safe Care
4. Essentials of safe care | Scottish Patient Safety Programme (SPSP) | ihub - Essentials of Safe Care
5. Vance et al (2014) Midwifery (https://www.thelancet.com/series/midwifery)
6. Health and social care: national workforce strategy - gov.scot (www.gov.scot)
7. Health and Care (Staffing) (Scotland) Act 2019 (legislation.gov.uk)
8. "There's only so much you can be pushed": a commentary on the magnification of the maternity staffing crisis by the 2020/21 COVID-19 pandemic (authorea.com)
9. The midwifery workforce and education review for scotland

The current workload planning tool, named within the safe staffing legislation, is no longer fit for purpose and was recognised to not meet the needs of current maternity care provision. The rebuild has not taken place. There is therefore currently no maternity tool fit for purpose in Scotland.

> **Service transformation from traditional to continuity of care models should be prioritised to accelerate achievement of the anticipated benefits of the key Scottish policy on maternity care and services, The Best Start: a five year forward plan for maternity and neonatal care in Scotland (referred to in this report as Best Start), which include reduced intervention rates and associated workforce demand, and enhanced job satisfaction for midwives. Effective change management strategies need to be employed to avoid attrition during the transition (NES 2021 p4)**

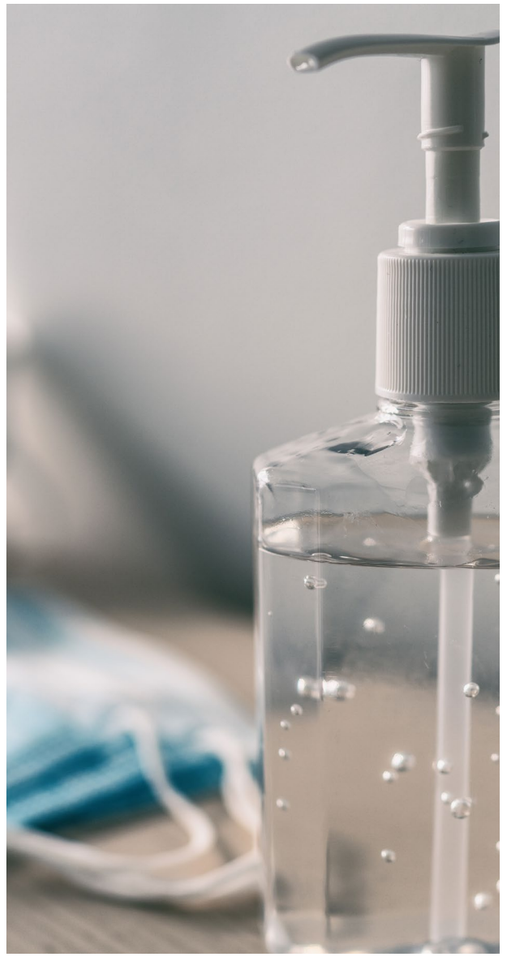
This transformation is important in realising the outcomes the evidence shows will result. However this can only be realised with sufficient investment in people, change processes and leadership development.

Education is more than the minimum requirement, the recent literature review commissioned by the Chief Nursing Officer's Directorate (CNOD) clearly evidenced that levels of practice beyond registration impact on the level of clinical care, evidence based practice and job satisfaction. Currently not only is there no time but no career structure to support this development.

The survey and narrative responses clearly show that many midwives are not able to access the minimum educational requirements to meet the core mandatory training during work time. This is only to meet core mandatory training which is the minimum needed. However this does not begin to address the continuing development needs of the profession and the skills required within the new future midwife standards (NMC 2019)[10].

The need for time to learn and to invest in the wellbeing of midwives was a key finding of the recently published inquiry into perinatal mental health. The lack of consultant midwife clinical leadership

10. NMCstandards-of-proficiency-for-midwives.pdf (nmc.org.uk)



roles to take forward necessary change in boards is not helping.

Clinical supervision was introduced in 2018, following the removal of statutory supervision, with the aim of meeting the goals agreed by the four countries to embed a restorative model that uses a coaching methodology to encourage reflection. This has not been embedded and as there is no dedicated time or resource for this role it was absent in most boards during the pandemic when most needed. The consultant midwfe would be well placed to support this moving forward.

We cannot afford to be complacent. Maternity services in Scotland are excellent and have continued to provide high standards of care despite the challenges faced but relying on goodwill is not an option. This is a profession at breaking point and attempting to implement mass organisational change without the right support, staffing and leadership with job descriptions that reflect the roles and responsibilities required is a fool's errand.

We can – and must – do better for women and families and the midwives in Scotland.

Recommendations

1. Ensure time and support for maternity services to recover, this requires a sustained commitment to ensuring we have enough midwives to provide care with visible profession specific data separate from nursing data.

2. Ensure there are clear mechanisms for maternity leadership to be heard at board level with consistent structures of Director of Midwifery and heads of Midwifery across Scotland.

3. Fund consultant midwives' posts in every board with the remit for safety, clinical supervision and innovation.

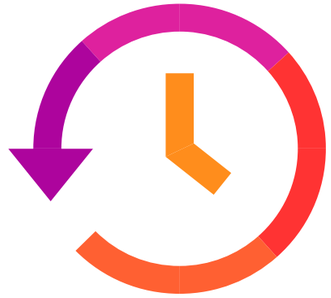
4. Ensure restorative clinical supervision has time built in.

5. Prioritise implementation of the recommendations from the workforce and education review paper with funding for implementing the career development framework with appropriate educational resource for advancing practice.

6. Develop the preceptorship programme for midwives to support the retention of early career midwives.

7. Expedite implementation of the safe staffing legislation with clear timescales including the agreed rebuild of the midwifery workload tool.

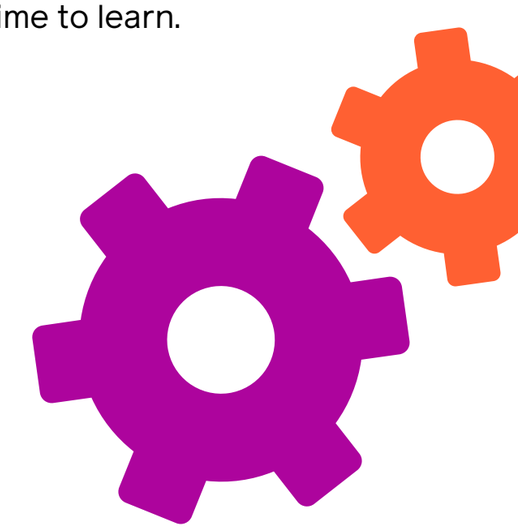
8. Support employer commitment for improving cultures through commitment to Caring for You initiative and standing up for high standards.



9. Review the predicted absence allowance for midwives to accommodate time to learn.

10. Review the caseload size for women with complex care needs and for remote and rural service provision.

11. Invest in educational support in workplace with a clear career structure.



Workforce

Throughout the pandemic, maternity services across Scotland remained open, supporting thousands of women and families through pregnancy, labour, birth and the postnatal period in an uncertain world. Midwives had to adapt rapidly to changing requirements. Staff shortages due to COVID-19 – whether through illness or isolation – were prevalent, putting additional stress on already stretched services. This has undoubtedly taken its toll on a workforce that was already experiencing low morale pre-2020. While many midwives described their love of being a midwife, current conditions are making them consider leaving.

"The pressure is now outweighing my love for the job and the women. I am now dragging myself into work, dreading my shifts and feeling that I cannot go on."

A staggering half of all respondents said they felt there is rarely safe staffing in their workplace/unit. Only six per cent of staff reported that there was always safe staffing in their area. Levels of staffing were consistently described as unsafe and dangerous, with members raising concerns for the welfare of the women using such overstretched services.

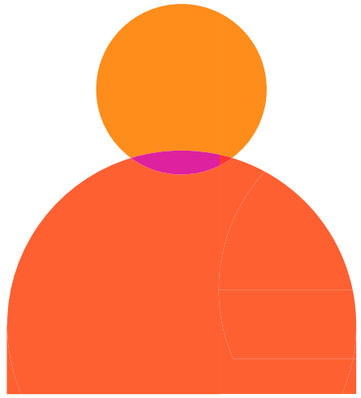
"I cannot remember the last time we had safe staffing within our unit. On a daily basis we are struggling to provide a decent standard of care to our women and their families."

Staffing concerns contributed to over 50% of the narrative responses, with understaffing described as regular and even constant. Some midwives described every shift they work being short-staffed.

While it was acknowledged by many that COVID-19 had caused workforce pressures, respondents were keen to emphasise that the issue was longstanding and only exacerbated by the pandemic. The impact of COVID was palpable in testimonies. As well as the additional impact on staffing, it was evident that the pandemic has increased the workload of maternity staff and negatively affected the mental health of frontline NHS workers.

There are persistent concerns over introducing new models of care without the right staffing levels in place was a key area of concern.

Some respondents said they only stayed in the job as they felt they did not have an alternative, were not qualified to do anything else or they were the main breadwinner. The vast majority - 75% - said they have considered leaving their current post due to staffing levels, dissatisfaction with the quality of care they were able to provide, and dissatisfaction with the level of support from their line manager.



Only six per cent of staff reported that there was always safe staffing in their area

While the pandemic may have delayed the retirement plans of some respondents, who preferred to stay on to support colleagues and services users, concerns were raised by respondents that the departure of so many senior members of the maternity team was having a negative impact on the skill mix in their unit. It is also clear that the impact has hastened the decisions of others to leave the profession. According to the survey, a staggering three-quarters of respondents said they were considering leaving the profession.

Worryingly, experienced midwives did not feel that they had the capacity to provide the support that was required, including through the preceptorship year for newly qualified midwives in their transition to developing competency and moving to band 6.

A number of respondents said that there was a lack of development opportunities on offer in maternity with limited career progression.

Some respondents felt unable to grow their skillset in their current role.

Low morale is not something unique to those who have been in the profession for some time. Newly qualified midwives were also reporting a desire to leave the profession. Many expressed regrets about their decision to enter midwifery, and cited concerns about the impact staying in the job would have on their mental and physical health.

> **"I was so excited to start my new career but I have already thought about leaving."**

The number of newly qualified midwives in post is the highest for over 10 years, something which the RCM has welcomed and actively encouraged. However, an ongoing rise in these numbers – and retention of those already trained - is essential to ensure workforce levels are maintained.

As an essential service maternity staff were not expected to be redeployed to other specialties or areas outside maternity. However, tasks that were not usually undertaken by midwives were being assigned to maternity staff to lessen the load elsewhere in hospitals and healthcare facilities. In addition, maternity services were challenged with covering within and between both individual unit, wards and the balance of care between hospital and community on both a service planning and as part of daily escalation. This was difficult for everyone to both manage, lead and provide care. This impacted on the strain felt by midwives being moved to a different area, often during a shift.

Similarly, around a third of respondents had been moved to another unit during a shift in the last 18 months, with more than one in 10 of those having been moved two or three times a week. Many respondents emphasised that being moved to another area is a stressful experience, particularly for those with little recent experience in the new unit, while even the threat of being redeployed was a source of anxiety for staff.

> **"After working many years in a low-risk unit I was suddenly forced [into] working in a high-risk unit... I was terrified that I was going to lose my registration as I worked in a very different environment than what I was used to."**

For some, moving to areas of midwifery where they were less comfortable and/or less experienced was causing them to fear for their registration. Of particular concern for some members was a lack of accommodation for supernumerary training when moving to unfamiliar areas of practice.

Three-quarters of respondents said they were considering leaving the profession

Workload

After staffing, the concern raised by most respondents was the increased workload being experienced in maternity services. Members described an overwhelmed workforce struggling to manage a seemingly endless workload.

"More times than I can probably remember I have had to support colleagues who were so stressed they were in floods of tears ... struggling to cope with an enormous workload"

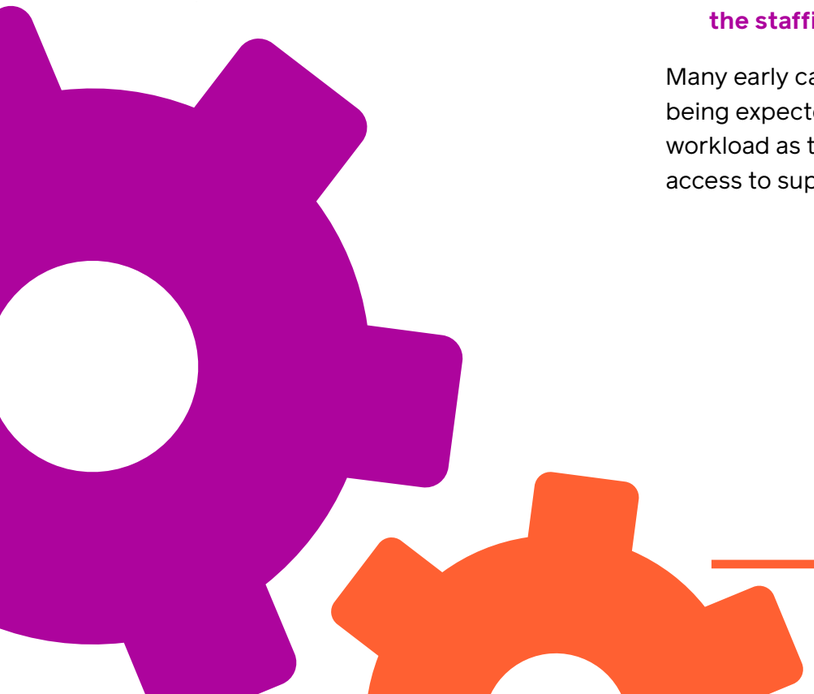
Support for midwives can come in many forms – from ensuring the right staffing levels to giving them the time they need to train and learn together. What is fundamental to this, though, is the need to value midwives for what they do. It is clear from the survey responses that while the role has developed with greater and greater expectations of what can be delivered, this is not reflected in the grading relative to other professionals. As a result, midwives feel undervalued.

"We are expected to carry our own caseloads and take sole responsibility for women in our care. We teach students, teach new mums and families, we independently look after labouring women and deliver babies. For some reason a midwife is not highly valued."

The impact of the increasing complexity of care for both women and babies was cited by many respondents. Growing numbers of women present with additional and complex care needs both from pre-existing medical conditions, social complexity and new complications arising during pregnancy. This has been compounded in some boards by higher rates of induction and elective and emergency caesarean section that accelerated during the pandemic which have added to the workload of midwives.

"Midwifery has changed with the acuity of women increasing with more complex needs and medical conditions. This isn't factored into the staffing levels."

Many early career midwives were routinely being expected to manage the same workload as their colleagues without access to supervision.



Education and development

A learning environment with access to education and development opportunities in midwifery and in the multidisciplinary team is essential for safe care.

The absolute minimum continuous professional development requirement is to meet the core mandatory training for maternity staff in Scotland. The impact of workforce and workload pressures on access to education and development was notable. Ongoing education and development is vital in the provision of safe maternity care – and is fundamental to registration. Despite this, more than 40% of respondents said they were unable to access this during working hours. Of these, eight out of 10 had been asked to complete the training in their own time.

"Mandatory safety training cancelled due to short staffing making a dangerous situation even less safe."

As well as training being completed at home, there were several reports of mandatory training days being cancelled.

As set out in the section on workforce, the departure from the service of experienced midwives is having a negative impact on the training and development of those new to the profession. This has led to some early career midwives being expected to practice beyond their competency. Of the 12% of respondents who had been qualified for less than two years, 51% said they had been left in charge during that period.

Many senior midwives felt they were unable to give their junior colleagues the support, mentorship and attention they needed. They expressed concerns about the impact this would have on the confidence and skills of newly qualified midwives.

"Highly experienced staff are being replaced by newly qualified midwives, some still awaiting registration. This places an additional pressure on experienced staff and is very unfair and dangerous to newly qualified midwives."

Some members of staff referenced an emerging trend, necessitated by chronic understaffing, of relatively junior midwives training their newly qualified colleagues. One midwife described this as 'the blind leading the blind' and expressed significant concerns about the future of midwifery if so many members of the profession were unable to access adequate educational and training opportunities.

Education and development is more than the core mandatory training however. A number of respondents said that there was a lack of development and career progression opportunities on offer in midwifery of career progression.

Quality of care

As well as the impact on the health and morale of midwives, workload was reported to be affecting the ability of members to provide good quality care to patients.

While the survey did not ask RCM members about the quality of maternity care, it is striking that 20% of those who responded included narrative responses on the issue. Many expressed their concern and their distress at not being able to provide the level of care that they wanted to give or that women want to receive.

Significantly, many expressed the worry that the care being offered was no longer safe, and anxieties over potential adverse outcomes and loss of registrations were widespread.

Many respondents reported rising incidents and adverse outcomes in care, attributing it directly to the overstretched services and pressures on overworked midwives. Concerns with the quality of care being given was cited by 65% of those thinking of quitting.

> **"I often come away from shift feeling like I have been unable to provide the care women and families deserve. I feel that patient safety is being impacted by the lack of staff on shift."**

Concerns were also raised about the quality of care able to be provided to women with more complex needs. This has an impact on the equity of care, something which governments across the UK have expressed their intention to address. Language barriers were the most commonly referenced issue of equity of care, with several midwives expressing the concern that a 20-minute appointment was insufficient to communicate effectively with patients when translation services were required. Many members also expressed concerns relating to deteriorating patient relationships.

> **"I love being a midwife. I hate the care I am giving."**

While the lack of IT resources impacts on the ability to carry out administrative tasks effectively, RCM members also expressed concern at the impact on the quality of care. This was particularly acute in the monitoring and assessing of women's and babies' health and wellbeing. Midwives are having to share equipment, potentially delaying care as the midwife waits for access to the equipment.

> **"Postnatal wards expected to take antenatal patients but not enough equipment to facilitate fetal monitoring"**

"I love being a midwife. I hate the care I am giving."

Wellbeing and morale

The pandemic has exposed a fragility in maternity services that has been present for a long time. Where it has had the greatest impact, though, is around morale and mental health among midwives. Stress and exhaustion were reported as widespread among midwives, with nearly nine out of 10 respondents having experienced work-related stress. Many respondents reported crying at work before, during and after shifts, while others said they often saw their colleagues in tears at work.

Around one in 12 respondents specifically referenced problems with their mental health or the mental health of their colleagues. Many reported taking sick leave as a result of stress, anxiety and other mental health difficulties attributed to their work. Some respondents said they were leaving the profession to protect their mental health.

"The pressure in the hospital is immense. I line manage exhausted and broken midwives and support staff. We try but fail to provide safe compassionate care. I have never seen it so bad in my 19 years in the job."

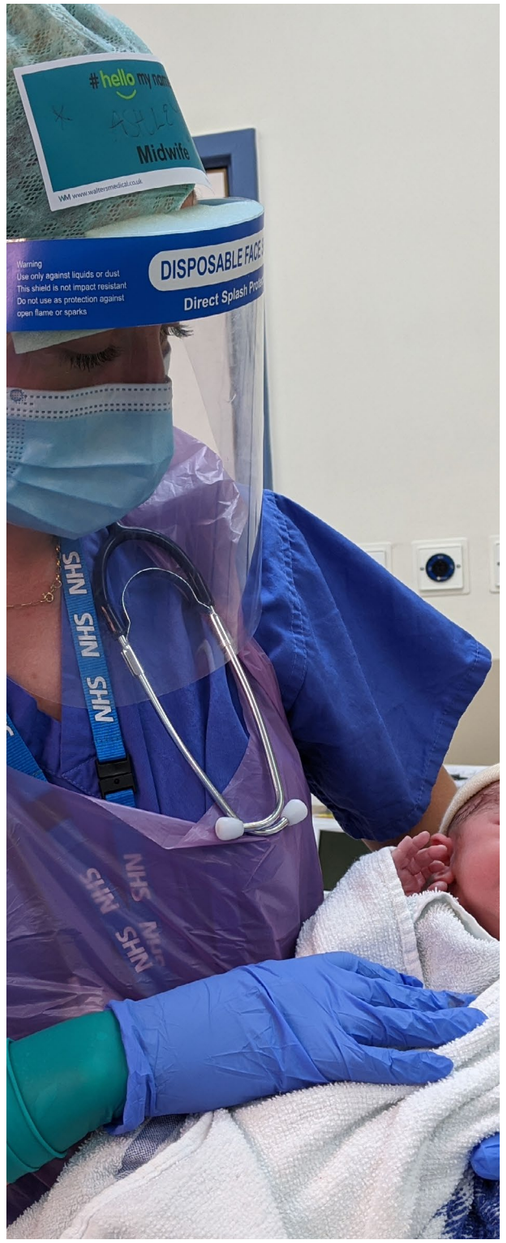
Others described going on medication or other treatment. Some reported having developed anxiety, depression and other mental health issues as a direct result of their work as midwives. Those with pre-existing mental health conditions found they were exacerbated by their working conditions. In addition, one in 10 spoke of the impact their working conditions on their personal lives. Some reported experiencing issues in their relationships, while others felt their jobs were preventing them from spending time with their children.

"I have nothing left to give my own children and family at the end of the day. I am at breaking point."

While maternity staff are often there for the happiest period in a family's life, they also have to deal with poor outcomes. This is undoubtedly devastating for the family, but it also takes its toll on maternity staff. Workload and staffing pressures meant that staff were not being given the time, space and support needed to address their trauma.

Midwives work long, often demanding shifts. Taking their contractual breaks is fundamental to their physical and mental wellbeing. What this survey shows, however, is that nearly every respondent has missed breaks over the last 18 months. Even more worrying is that this is not just the longer meal breaks, but breaks to get a glass of water or even go to the toilet.

Over nine out of 10 respondents worked without breaks in the last 18 months, with more than half (52%) saying this happens two to three times a week. Several midwives had experienced urinary tract and kidney infections as a result of being unable to go to the toilet or getting enough fluids while on shift.



When I say no break, I mean flooding through sanitary products onto my clothing because I cannot take 10 minutes to change my tampon in a 12-hour shift."

Many respondents said that missing breaks had become the 'norm' in their unit and expressed frustration at the response of management to the issue. Some reported having to argue to receive their breaks, while other expressed feelings of guilt when asking to take a break as the service is so overwhelmed.

As well as working through breaks, respondents reported regularly working extra unpaid hours to complete their work and support the overstretched services. Early starts and late finishes, combined with unpaid breaks that were not being taken, meant many members were working significant extra hours without time or pay being given in return.

Many said they had to do these extra hours to finish patient care and administration, while others said they stayed after a shift out of fears for patient care and safety caused by understaffing. Many of those reporting working extra hours specifically referenced documentation as the cause.

"I start work early every single shift, and often work over an hour past the end of my shift... I'm currently accruing around 10 unpaid hours of overtime a week."

Shortages in IT equipment led to concerns about the quality of electronic records, while the increasing volume or administration was commonly cited as a reason for midwives working extra hours, particularly at the end of shifts. Some said they had taken documentation home to complete in their own time. For many members, there was a feeling that the administration required of them was detracting from the care they were able to give.

For some members there were persistent issues with taking annual leave in their workplace. While this has been exacerbated during the pandemic, many respondents cited chronic concerns. Some midwives reported their requests not being approved, despite being placed months in advance. This was of particular concern to several respondents who had school-age children and found themselves unable to take their annual leave during school holidays.

Others described issues with annual leave being cancelled and/or rescheduled, which several linked to the frequency of movement between departments.

Midwifery can be a physically demanding job. Where workloads are increased, so too is the physical toll. Around one in 20 members reported physical health problems that they attributed to the workforce and workload challenges.

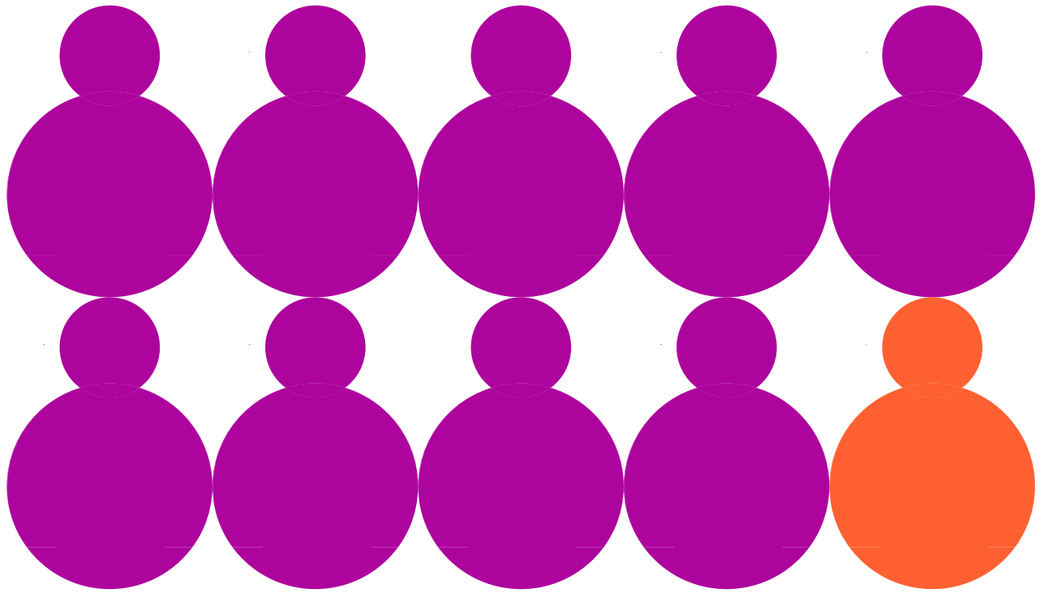
Despite legislative changes around parental and caring leave, the majority of caring responsibilities, whether for children or older parents, still rests with women. Midwifery is a predominantly female profession, but, despite this, there is little or no recognition of the need for flexible working. A number of respondents expressed frustration with the shift pattern they worked and/or the difficulties in achieving flexible working. Several respondents said they had made applications for flexible working that were rejected, while others described applications that had only been successful after the intervention of the RCM.

> **"The 12 hour shifts are terrible for the health of older staff and the younger staff with families have logistical family problems. The shifts are not "family friendly" for staff with children."**

The need to have some choice or say over shift patterns was key. On call was an issue raised where midwives on call for home births were being called for covering other services after working in the day.

Many stressed that, while they supported continuity of carer in principle, it is not possible with the current levels of staffing and workload. Others referenced the lack of consultation over a significant change to their working practice and emphasised the impact it would have on their personal lives. These changes were of particular concern to those with caring responsibilities, and particularly for single parent families.

Over nine out of 10 respondents worked without breaks in the last 18 months



> **"Without warning or consultation we were told that our model of care would be completely overturned. This has left us feeling more than ever, like we are insignificant and disposable."**

Finally, some midwives reported concerns over expectations of maternity care, reporting that women's expectations around birth are growing, further adding to a midwife's workload and distress at not being able to provide the care that women want.

> **"I feel that public are being given unrealistic expectations of care that we can provide. These expectations lead to complaints and unsatisfied service users."**

Culture and leadership

The RCM has long advocated for strong leadership within maternity services, with Directors of Midwifery having a direct relationship with executive boards supported by operational heads of midwifery. Sadly this is still not the norm, with no consistent model of leadership and management and so there is often a disconnect between what maternity services need and what boards are prepared to support. The current lack of career structures and development opportunities appear to widen the gap between leaders and midwives working clinically. For those in leadership roles, that disconnect can be difficult to manage, with pressure from executives above and teams below. Despite this, there were some very positive narrative responses regarding supportive managers and teams.

However, there was discontent about managers' ability to support clinical care. There was a common feeling that management are 'detached from the realities of work' in maternity care, with many members remarking on the reluctance of senior staff to pitch in, even when services were most understaffed and overstretched.

Many midwives said they felt there was lack of support from senior management, and often a lack of consultation with staff regarding changes. For some members, this lack of support was a factor in their choosing to leave midwifery, with some saying they had no relationship with the professional leadership at their workplace.

"I think we are very unsupported by management. We are not involved in the decisions made about the way we work. We are not heard and we are tired."

For some midwives, it was important that senior staff worked clinically to gain understanding of the challenges facing midwifery units. There appears a lack of appreciation of responsibilities held by senior staff in maternity services. Perhaps it's an indication of the difficulty those in leadership roles find themselves in that while some respondents were grateful to have extra hands available during particularly busy times, this was also seen negatively as the loss of someone to undertake their substantive role in keeping the service safe and supported.

The picture was mixed for line management, varying across Scotland and often even within boards. Some respondents reported that they experienced solidarity and support for those directly above them in the chain of command. Others, however, described issues with workplace culture that they attributed in part to the actions and attitudes of line managers, with many citing this as a reason they were considering leaving their current post.

"Our line manager is incredibly understanding and supportive, however the management above that are nowhere to be seen in such difficult times."

"I think we are very unsupported by management. We are not involved in the decisions made about the way we work. We are not heard and we are tired."

In some health boards workplace culture was raised as a particular problem. Survey responses showed differences in experience between health boards, and also differences within the same board, between different teams and departments.

'Starting in labour ward has been horrible, little support and unhelpful and rude colleagues. I've been coming home crying from most of my shifts and wondering how I'm going to get though it again '

While nearly two-thirds said they had not experienced bullying, nearly one in five had been bullied by a colleague and a similar number had experienced bullying by a line manager.

The continual pulling of staff had contributed to negative cultures due to resentment with staff feeling unappreciated. More than one in 10 respondents have experienced discrimination by a manager and eight per cent by a colleague

"Toxic cultures and behaviours still exist as staff are scared to report the perpetrator for fear of retribution"

Despite this, many members made specific reference to the support they received from their colleagues. For several, relationships with their peers were all that was keeping them going at work.

"The team of midwives I work with are absolutely fantastic and we get each other through each shift but this can't be maintained indefinitely"

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