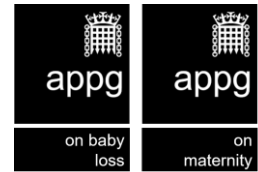


Safe Staffing: The impact of staffing shortages in maternity and neonatal care

Report of the Baby Loss and Maternity
All Party Parliamentary Groups



Foreword

This report stands as part of the joint campaign by the All-Party Parliamentary Groups on Baby Loss and Maternity to push for urgent action on the maternity staffing crisis.

That there is a shortage of maternity staff in England is well documented and widely accepted, including by Government. The Health and Social Care Select Committee and the Ockenden Review have both recommended that the Government takes urgent action to increase the maternity workforce to deliver high-quality, safe and personalised maternity care. What is less well understood is the impact that shortages can have on the quality and safety of maternal and neonatal care, on the experiences of women and families and on the wellbeing and development of staff.

That is what our call for evidence has set out to explore, and we also wanted to tap into the views of respondents on what can be done to effectively tackle shortages. We are extremely grateful to the parents, members of staff and organisations that took the time and trouble to respond to our survey. Their testimony paints a bleak picture of services that are understaffed, overstretched and letting down women and families.

While the overall picture presented by our evidence is extremely concerning, we do take heart from the commitment that staff respondents have to provide women with the very best care (and their obvious frustration when it is not possible for them to achieve this) and from the appreciation that women and families have for the efforts that staff make, particularly when they are working under such challenging circumstances.

There is also cause for optimism from the practical and reasonable suggestions that respondents have made for improving staff recruitment and retention. While there is no escaping the fact that maternity and neonatal services require substantial and sustained investment, a view echoed by most respondents, many of the measures advocated by respondents could be implemented quickly and with little additional expense. We urge the Government and NHS policymakers to give thoughtful consideration to these proposals.

We would like to thank our APPG secretariats for their work in collating, analysing and producing this important and timely report.

Jeremy Hunt

Co-chair, Baby Loss APPG

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Cherilyn Mackrory

Co-chair, Baby Loss APPG

A handwritten signature in blue ink that reads 'Cherilyn Mackrory'.

Jill Mortimer

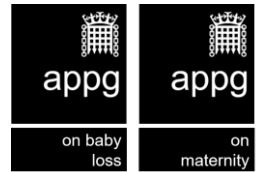
Chair, Maternity APPG

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Introduction

x.i Following the publication of the Ockenden Review into the failings in maternity care at Shrewsbury and Telford Hospital NHS Trust, and with more reports to follow on other struggling maternity services and poor Care Quality Commission ratings for many services with none outstanding, there is an urgent need to get to the heart of understanding and tackling the present staffing crisis.

x.ii The existence of long-running and significant staffing shortages in maternity services have been highlighted in recent reports, such as the Ockenden Review and the Commons Health and Social Care Committee inquiry into the safety of maternity services in England.

x.iii What has been less well understood is the impact that these shortages are having on outcomes of care, on the experience of women and families and on the wellbeing and morale of maternity services staff. Crucially, what can be done in the short term and beyond, to improve recruitment and retention rates, so that women and families get the quality and safety of care that they deserve and staff feel valued and able to give their best?

x.iv These questions are central to the call for evidence into maternity staff that the Baby Loss and Maternity All Party Parliamentary Groups (APPGs) have come together to launch.

Methodology

x.v The call for evidence was open for six weeks, from Wednesday 22 June to Wednesday 3 August. Responses were submitted via an online survey using the website Survey Monkey.

x.vi 14 questions were asked in total. No questions were mandatory, and respondents were free to answer as many or as few as they chose. A copy of the questions can be found at the end of this report.

x.vii Overall, the call for evidence received 102 responses.

x.viii To produce the report, responses were analysed within each individual questions, and a thematic/categorising method was used to produce the final analysis.

x.ix Within each chapter the evidence is grouped by respondent. Staff, representing the majority of respondents, are considered first, followed by service users and then organisations. For some questions there were no responses from service users; their section is correspondingly omitted from those chapters.

1.To what extent are maternity services affected by staffing shortages?

Introduction

1.1 There is a severe shortage of staff in our maternity services. The staff we have are working flat out and doing their best to deliver care, but they are stretched to the limit and it is leaving them

burnt out. Additionally, despite their best efforts, the quality and even the safety of care is not good enough. Staff know that, and those using the service know it too.

1.2 We are seeing midwife-led units and homebirth services close in order to pool staff in obstetric units. We are seeing women's choices curtailed, and antenatal and postnatal services squeezed. Even these steps leave staff overstretched. For many, crisis mode is now the norm.

1.3 All this results in a service where quality has been lost, and perhaps safety too. Staff report working in constant fear of something going wrong, made all the more likely by exhausted staff operating at their limits.

Evidence from staff

1.4 Staff responses were clear in the answer to this question: staffing shortages are severe, pervasive, and having a profound impact on maternity services.

"Sometimes I come onto my shifts and instead of 13 midwives there are seven or eight! It is no wonder that things go wrong when every midwife is doing two peoples' jobs."
(Obstetrician)

1.5 Respondents reported significant problems in the standard of care the NHS can offer service users under the staff shortages.

"... difficulty maintaining the full midwifery shift staffing, and difficulties with medical rota gaps. Impacts all aspects of maternity care." (Obstetrician)

1.6 Notably, staff are not just concerned about the quality of care being provided. Instead, they wrote openly about how the shortage of staff is compromising the fundamental safety of care. Phrases like "stretched to the absolute limit", "burnt out", "dangerous", and "cut to the bare bones" crop up throughout staff testimonies.

"Maternity services are already broken and dangerous due to staff shortages. Many people try to compare health services to the airline industry yet a plane doesn't take off when there is not enough crew, the plane hasn't had its safety checks or been fuelled." (Obstetrician)

1.7 Commonplace are references to midwife-led units and homebirth services being closed so that staff can be pulled into obstetric units, including community midwives – meaning a loss of choice as well as the reduction of postnatal care and visits to an afterthought.

1.8 The impact directly on NHS staff was an important theme of responses. They spoke extensively about stress, exhaustion, burnout, and morale that is at absolute rock bottom. They pointed to this leading to staff on sick leave and others leaving the NHS because they cannot carry on working under such conditions.

"Staff are burnt out, and undervalued. Staff are retiring and not returning as they would once have done, and others who are nowhere near retirement age are looking for ways out of midwifery too. We don't get paid enough to carry the level of responsibility and pressure which we shoulder on a daily basis, and quite frankly we feel utterly undervalued." (Midwife)

1.9 Staff also expressed concern about the impact on their mental health and that of their colleagues of such relentless intensity. The responses made for hard reading.

"Staff cannot practise care in a safe manner and this causes anxiety and possible mental health issues. We cannot carry on like this." (Midwife)

1.10 Alarming, palpable in staff submissions was a widespread and growing sense of fear of mistakes, incidents or other failures in care due to the chronic levels of understaffing.

"FEAR. Staff are frightened to work in an understaffed under-resourced unit, for fear of mistakes or incidents occurring due to the high activity and understaffing. Fear of investigations as a consequence and fear for their mental health and wellbeing as a result. Fear of the impact this has on their family life, fear that it will make them ill. I cannot emphasise FEAR enough, it is sometimes enough to make people go off sick." (Midwife)

1.11 One obstetrician remarked that recent reports on improving the safety of maternity care will not have an impact if staffing is not fixed.

"... no report with all its recommendations will make much difference unless staffing levels are drastically improved." (Obstetrician)

1.12 The cancellation or postponement of training and continuing professional development also featured in responses. This is a concern as we need staff to be continuously improving their skills. There is every sign in the staff responses that we have a workforce in permanent crisis mode.

"Training repeatedly cancelled to cover staffing, annual leave declined and staff exhausted not wanting to cover extra shifts." (Midwife)

1.13 There were also references from staff to the impact of shortages on the all-important relationship between staff and women. This is seen from both sides through the responses from women as well as from staff.

"Service users are angry ... then take it out on staff. Who then feel burnt out. Tired. And yelled at." (Midwife)

1.14 In terms of the factors behind the shortages, the consensus seems to be a long-term failure to invest.

"Too few junior doctors trained in this country for years. Too few midwives trained. Loss of midwifery bursary making midwifery training less enticing. Real terms pay cuts for all NHS staff. Massive student debts making training in medicine less enticing." (Obstetrician)

1.15 There is a sense too that the problem feeds off itself. The total lack of slack in the system leaves it unable to cope when issues or problems arise.

"Insufficient staffing capacity so no slack within the system. This has the effect of meaning there are unexpected staffing shortages at short notice and also increases workload pressures for the remaining staff." (Obstetrician)

Evidence from service users

1.16 Responses from service users mirrored the accounts of staff, painting a picture of an overwhelmed service where staffing shortages directly impact the quality of care.

"I think it's very clear that staffing levels are too low. From waiting hours for painkillers and other medications to not being offered drinks between meals. There seems to be a lack of support and time for anything other than the bare basics." (Service user)

1.17 The impact on quality of care was evident, with service users describing service closures, rushed and overworked staff and failures in patient care.

"Patient care is failing, staff overworked and people are making mistakes." (Service user)

"Closure of midwife-led units for the delivery of babies (can only currently give birth at the consultant-led unit as all others are not in use for delivery), staff cannot inform patients of what is going on... I have been told I can have my baby at one unit but have been told by a different midwife that there is no chance of that happening as the unit hasn't opened yet!" (Service user)

1.18 Again, as with staff responses, the submissions from service users describe not just poor quality of care, but also at times compromised safety too, e.g. "people are making mistakes." In some cases, women's experience of the care they received was very poor.

"Staff are burnt out, rude and missing red flags leading to dangerous practice. Staff are directly traumatising women." (Service user)

Evidence from organisations

1.19 The picture painted by both staff and service user submissions – of staff knowing they are unable to give the standard of care they want to give, and women reporting what that was like for them – is encapsulated by a comment from Mumsnet:

"We hear on Mumsnet forums every day of women at every stage of the pregnancy and birth journey being affected by overworked professionals working in understaffed units and of midwives at the end of their tether struggling to provide care because there are just not enough of them." (Mumsnet)

1.20 NCT submitted evidence which drew on a survey of 1,254 respondents who had given birth in the 12 months from August 2021 to July 2022. This found that a majority (51 per cent) of those who had completed the survey had experienced at least one NICE-identified 'red flag event' and around one in three experienced delays in seeing a midwife, being given pain relief, getting a prescription or being referred.

1.21 The NCT survey also found however that most indicated that they felt that they had been treated as an individual and listened to. Over 90 per cent said this was true of their anaesthetist, although it was lower for sonographers and midwives (76 per cent) as well as obstetricians (73 per cent). Having to repeat oneself to different professionals was also reported in the NCT survey, often risking critical information being missed.

1.22 More broadly, organisations remarked upon similar problems and issues reported by staff. This included the difficult working conditions faced by maternity staff.

"We know that staffing shortages can contribute to a negative workplace environment where people experience excessive workloads, intense pressures and long shifts." (Nursing and Midwifery Council)

1.23 The NMC cited its survey of those leaving the register of UK nurses and midwives as evidence of the spiralling impact of shortages.

"In our survey, people who had worked in midwifery were more likely than nurses and nursing associates to cite too much pressure as a reason for leaving... People on our register who worked in midwifery were more likely to cite this [staffing levels] as a reason [for leaving the register] than across other areas." (Nursing and Midwifery Council)

1.24 Organisations described restrictions on and cuts to services, including loss of the option of birth in a midwife-led unit and homebirths. This has obvious implications for care, including a reduction in choice for women, the loss of personalised or individualised care, and specifically the impact on rollout of the Continuity of Carer policy (and to the vulnerable women set to benefit).

1.25 They also cited impacts such as reduced time to speak to parents and advise them when something has gone wrong, or simply to prepare them for parenthood, and, in general, just less time for compassion to be shown, when needed.

1.26 Organisations echoed staff in pointing to a lack of resources behind the staffing shortage.

"Chiefly, there has been insufficient resource and investment to grow the maternity workforce. While the recent national funding announcements for maternity services are important, we see them as a first step. NHS Providers calculated the costs required to fund the extra workforce needed to successfully implement the recommendations outlined in the interim Ockenden report. We found that a minimum of £250 million in recurrent annual funding would be needed, and if shortfalls in neonatal nurses, maternity support workers and anaesthetists were to be included, the total annual extra recurrent funding required could be as high as £400m." (NHS Providers)

1.27 It is important to remember too that staffing shortages in NHS maternity services are not restricted to midwives and obstetricians. Separately, organisations made a point of mentioning not just midwives, obstetricians and pathologists, but also neonatologists, sonographers, anaesthetists, and others. They also pointed to problems not just in England but also in Scotland, Wales and Northern Ireland.

"The current consultant staff is overstretched, demotivated, tired and low on self-esteem as there are increased work and time pressures." (Royal College of Pathologists)

1.28 Organisational responses did not exclusively focus on how staffing in maternity services reduces how care is personalised, choice is available and care is consistently high-quality. They also highlighted the relationship between adequate staffing and ensuring patient safety.

"Child Death Overview Panels recorded inadequate staffing or bed capacity issues in over 40 child deaths during the period between 1st April 2019 and 31st March 2021." (National Child Mortality Database)

"Given our specialist role we want to draw particular attention to the impact of the potential for more errors being made in maternity care, due to the shortage of midwives and the pressure on existing staff, that might lead to the death of a baby, and the impact of this on parents and future pregnancies." (Association of Child Psychotherapists)

1.29 Part of the solution to this situation is the training and recruitment of new midwives. However, the universities that submitted evidence highlighted several ways in which student midwives were not able to receive the clinical experience they needed to advance successfully towards their chosen profession. When midwives responsible for supporting student midwives do not have the staffing capacity they need to deliver care for women, they may not be able to prioritise the clinical placements of the student midwives coming into their units.

"... staff shortages have a profound impact on the student midwife learning experience, which includes achieving competence and confidence in clinical practice... reduced learning opportunities result in students having to extend their programme, delaying their entry into the NHS workforce." (University of Bournemouth)

1.30 These concerns were shared by midwifery academics who contributed, who also highlighted the financial pressures on student midwives and staffing issues among midwifery lecturers.

"Retention of student midwives – financial pressures (including loss of bursaries), student confidence levels, problems with recruitment and retention of lecturers, challenges with clinical placements, mentorship support and the culture in that clinical setting all have an impact on students and the quality of their learning and contribute to attrition." (UK Network of Professors in Midwifery and Maternal and Infant Health)

1.31 Organisations also noted that the intense pressure on staff was leading to some leaving their professions, because they could not continue to work under poor conditions which were not improving.

1.32 Finally, organisations wanted to point to the financial cost of the current setup. They pointed, for example, to the extra cost of funnelling all women into consultant-led units, when trusts are forced to close midwife-led units and homebirth services. There is also the additional financial cost and inconvenience to women when they are compelled to travel to more distant units when some more local units had services suspended, or where a homebirth was not available.

Summary

1.33 The responses to the survey made it clear that staffing shortages are significant and having a profound impact on maternity services, staff and care in the NHS.

1.34 Consistently understaffed units are struggling to maintain high quality standards of care, and respondents were concerned that the fundamental safety of care is being threatened. Service users described failures in care that are damaging their trust in and relationship with maternity

professionals, while staff expressed their fears that mistakes will be made under the current conditions.

1.35 Quality and safety of maternity care are further threatened by the cancellation and postponement of training and development, while the impact of understaffing on student education has worrying long-term implications for NHS maternity services.

1.36 Overall, the working conditions faced by maternity staff are increasingly difficult and are affecting their morale, wellbeing and health. Here, the staffing crisis is self-perpetuating, as problems caused by deep, longstanding shortages that have been tolerated by the system for years are driving yet more staff away.

2. What impact are staffing shortages having on antenatal care?

Introduction

2.1 Antenatal (AN) classes are an important opportunity for women to learn about having a healthy pregnancy, and how to prepare for the birth of their baby. They are used by health professionals to share information and resources about pregnancy and birth, as well as to find out further information about the woman's health and lifestyle that could be essential during her care.

2.2 This chapter will explore the impact of staff shortages on the availability of antenatal classes as well as their effectiveness in being an opportunity for women to learn and for health professionals to share wellbeing resources and services.

Evidence from staff

2.3 Many respondents reported that AN classes have ceased in their area, as staff shortages make it impossible to run even basic levels of service and teaching. Where services are still going, many were described as unreliable, with appointments frequently cancelled, sometimes at very short notice.

2.4 Midwives reported that, when appointments do take place, staff shortages and the ensuing pressures on staff time mean they are rushed.

“We used to have an hour to see women for their antenatal appointments, give information and assess the health of them and their baby. Now it’s 20 minutes, sometimes 15. You are aware of the list of women to see and end up rushing appointments or you’ll run behind.”
(Midwife)

2.5 Staff raised concerns that these time pressures are affecting the standard of care they are able to offer. They are left with little time to carry out even basic checks, leaving them unable to provide additional care, discuss concerns with service users or offer wellbeing support and services. Respondents emphasised the inevitable impact this is having on the safety of care, as shortages and associated time pressures increase the chances of vital information being missed.

“On the AN ward short staffing means often the bare minimum is done to keep patients safe as there is no time for additional care. Things are often missed due to the chaotic nature of the ward and frequent movement of staff during the shift.” (Midwife)

2.6 Obstetricians also reported that AN clinics are significantly oversubscribed and often cancelled due to medical staff shortages, and raised similar concerns to midwives that the pressures on the service would lead to clinical information being missed.

“High risk antenatal clinics are frequently highly overbooked which reduces the overall experiences for patients due to longer waiting times, over-running clinics etc. It also increases the risks of missing important clinical information and not providing the level of care required due to inability for senior medical staff to provide oversight.” (Obstetrician)

2.7 Respondents raised concerns that service users, aware that staff are rushed, stressed and overworked, are choosing to inform themselves about their care rather than ‘bother’ staff with concerns or questions. Professionals felt that service users are left feeling unprepared for birth, while problems risk going unaddressed.

“Midwives do not have time to give quality informed care so they are left to inform themselves, which often means women do not feel prepared or informed for birth or the PN period.” (Midwife)

2.8 Clinicians also stressed that safety of care is being compromised by the inability of staff to deliver AN services beyond fundamental, basic care.

“Forget mental health support, smoking cessation or addiction issues – no time to ask or offer support beyond the basic check-up. Women are experiencing terribly unsafe and unsupportive care and babies will die because of it.” (Midwife)

Evidence from service users

2.9 Several service users reported alarming experiences of poor AN care due to staff shortages, with the health system unable to provide safe, bespoke care to reflect their individual needs.

“I had a prior medical issue and wished for a c-section due to risks. My care was so poor that I was listed as 'Consultant-led' care at my booking appointment then I had to fight for a mode of delivery talk at every midwife meeting until I was 34 weeks pregnant - TO EVEN DISCUSS. I struggle with an anxiety disorder and this made zero difference to my lack of care. My local midwives made 5 or 6 referrals. It took me raising a complaint at the hospital to get an appointment. Then I didn't even see a consultant. I was booked in for a section a week after my due date accidentally and had to chase that to get it fixed myself. I don't believe I was risk assessed correctly at any point. How can a consultant-led pathway have you never even see a consultant? Unsafe. I was told this was down to organisational errors and the hospital prioritising screening appointments.” (Service user)

2.10 Overall, service users were disillusioned with the level of AN care they are receiving, and raising concerns that staff shortages are impacting their safety.

“Care is completely unsafe. I now believe I will die during my second pregnancy in an NHS hospital because I will not be believed or cared for enough to save my life.” (Service user)

Evidence from organisations

2.11 Submissions from organisations made it clear that staffing shortages mean AN care in the NHS is operating at an inadequate and often unsafe level. A survey conducted by the National Childbirth Trust (NCT) suggests that one in five AN service users “sometimes, rarely or never” had sufficient time to ask questions or discuss concerns with their midwife antenatally or receive sufficient information or support to make informed decisions about their care.

2.12 Organisations highlighted that AN appointments are an important opportunity for health professionals to find out information about a woman’s physical and mental health that will be important in the delivery of her care.

“In addition to physical care, midwives need to ask about mental health, domestic violence and complex social factors and follow up on responses. If staff are overstretched this part of care can be reduced, potentially contributing to poor outcomes or maternal death.”
(University of Southampton)

2.13 The Lullaby Trust set out how antenatal appointments are an opportunity to speak to parents about safe sleeping habits, and also to speak to those who have experienced baby loss about what they have experienced, to offer them additional support and access to Care of Next Infant (CONI) programme, as well as to ensure further care is delivered.

2.14 Organisations emphasised the long-term impact of inadequate AN care on service users and their safety, as a lack of suitable support can have implications for their health.

“Women who are not sufficiently supported can later develop severe mental health challenges, including PTSD, anxiety and depression. It is important that this is prevented by having access to safe maternity services.” (Time Norfolk)

2.15 Submissions also pointed to the impact of staffing shortages on continuity of carer, and the subsequent impacts on quality and safety of care.

“Combined with the evidence that many professionals did not have time to read notes or complete sufficient handover, continuity of care even in its broader sense is not being achieved in many hospitals.” (National Childbirth Trust)

“Many of the benefits of continuity of carer are evident in the antenatal period, with a reduction in preterm birth and stillbirth. If rollout of continuity is halted due to staffing pressures, then some of these benefits may not be realised.” (University of Southampton)

Summary

2.16 It is clear that healthcare professionals, women and stakeholder organisations all feel strongly that staff shortages are hampering AN services and having a significant impact on the care that a woman receives, during her pregnancy, at birth, and in her health outcomes afterwards.

2.17 AN class closures and cancellations are common, while time pressures on remaining AN care means appointments are shorter and increasingly rushed, leaving midwives unable to provide more than basic care.

2.18 Organisations raised particular concerns about the inability of service users to ask questions or discuss concerns, as well as the increased likelihood of health professionals missing key information when assessing patients.

2.19 These concerns are reflected in the accounts from service users, who reported difficulties in access to antenatal care as well as concerns about quality and safety of care being provided.

2.20 Universities and health organisations point to a serious concern that midwives of the future are not being given the opportunities to learn about excellent antenatal care and are qualifying with lower competencies and experience than they should. This is creating a potential crisis for maternity services in the future.

3. What impact are staffing shortages having on labour and birth?

Introduction

3.1 Despite the fact that staff are often pulled into labour wards from other parts of maternity services, labour and birth is still an area suffering from a lack of staff.

3.2 Midwife-led units are frequently closed to pull midwives into the obstetric units, reducing choice and causing disruption. Those receiving care reported at times a sense of fear and abandonment, with staff also reporting how they felt terrible about the standard of care they are able to provide.

3.3 There is a palpable sense throughout submissions of a service that everyone knows is on its knees. Quality care seems to be some way off; the challenge is whether staff are even able to provide routinely safe care.

Evidence from staff

3.4 Staff members reported a range of ways in which shortages are impacting labour and birth, such as the pulling of midwives from midwife-led units to staff obstetric units. This leads to those units and services shutting their doors, meaning less choice and control for service users.

“Women not having their preferred choice of birth because there are no staff to offer homebirth, birth centres being closed as staff moved to cover absence on labour ward or PN ward.” (MSW)

3.5 As well as reducing choice and control for service users, the closure of midwife-led units was reported to have an impact on the quality of care provided, as service users receive care less suited to their specific needs.

“A lot of standalone or alongside birth units are currently closed due to lack of staff, which forces women with uncomplicated pregnancies to give birth in obstetric units, which the evidence shows leads to unnecessary interventions, adverse outcomes, trauma and long-term mental health problems for mothers.” (Midwife)

3.6 More broadly, respondents raised concerns that staffing shortages are forcing maternity services to return to a ‘conveyor belt’ style of labour and birth care.

“With the increase in induction of labour we are back to the conveyor belt system of the 1960s. Individualised care is gone. Staff are tired and are switching off.” (Midwife)

3.7 Clinicians also reported that service users increasingly face delays in or cancellations of booked-in procedures.

“Increased disruption for patients due to having to cancel elective procedures at short notice more having to cancel non-obstetric services to provide staffing for core services. Highly stressful environment for existing staff.” (Obstetrician)

3.8 Alarming, nearly all submissions emphasised the impact of these changes on the quality and safety of care offered in labour and birth units. The following comment, from an obstetrician, captures the 360-degree nature of the impacts that flow from shortages.

“It is TOP of our risk register. Staff are leaving because of exhaustion, because of rota gaps. Education is poor because of need to prioritise care. No time for meal breaks. Less time to TALK to patients. The birth centre is nominally open but in reality it is usually closed because it is easier for midwives to look after TWO women on labour ward. Sometimes no one-to-one care (which is actually the standard). Delays in getting women to theatre.” (Obstetrician)

3.9 One area highlighted repeatedly in staff submissions was how frequently staff are forced to work beyond their scope of practice, and the danger this presents to the people in their care.

“I am a newly qualified midwife and whilst working on the delivery suite staff shortages meant that I had to work in high-risk, high-stress settings. I had a workload that was too much for a less experienced midwife.” (Midwife)

3.10 Feeding into the level of risk is the extent of exhaustion being experienced by staff. The staff left working in overstretched units are being pushed to their limits, often unable to take breaks or provide quality care to service users. As respondents emphasised, these levels of exhaustion and burnout among staff represent a real and urgent threat to patient safety. Exhausted people make mistakes, and they are exhausted because in NHS maternity services operating in crisis mode is the norm.

“Breaks are missed so staff get tired and impacts on decision making. Staff are frequently interrupted to help another midwife, thus leaving them juggling their workload and not being able to be with their woman all the time.” (Midwife)

3.11 The level of risk was further underlined by the palpable sense of fear in staff submissions, as respondents described the anxiety they have from working in an environment where things could go badly wrong very quickly.

“Practising in fear, exhaustion and constant surveillance. Not safe or joyful. Desperate and anxious.” (Midwife)

3.12 Tragically, there were reports of instances where staffing shortages had caused harm. Several respondents described failures in care that would not have occurred with safe staffing levels.

“The delays in inviting women in for induction of labour have been unprecedented this past year. One lady was delayed and her newborn unfortunately died soon after birth. This may not have happened had we had the capacity to induce her labour sooner.” (Midwife)

Evidence from service users

3.13 The responses from service users illustrate what it is like being on the receiving end of the problems and issues described in staff submissions. In their responses there is a repeated sense of fear and abandonment, with staff largely absent while they go through an experience that at times scares them. At least one service user makes clear that their birth happened during the pandemic, which further impacted her sense of isolation at a traumatic time.

3.14 In the following short comment, this respondent captured the essential problem with staffing levels at present, and just why staff reported being fearful and anxious about working under these conditions.

“There is dangerously low staffing. If emergencies occur, there aren’t enough staff to deal with it.” (Service user)

3.15 The following respondent lists several of the ways in which shortages impact on the quality of care they received.

“Problems are being missed or dismissed as there's not time to listen properly to patients ... parents feeling like they are on a conveyor belt to get baby out as quick as possible once in hospital ... midwives having to move between birthing a stillborn and a live baby at the same time and all the different emotions each parent brings, emotionally extremely difficult for midwives ... lack of staffing leads to it being impossible to have continuity of carer so women and birthing people having to repeat themselves and not able to develop a trusting relationship leading to more trauma postnatally.” (Service user)

Evidence from organisations

3.16 The University of Southampton underlined the relationship between midwifery staffing and more positive outcomes during labour and birth.

“There is considerable research evidence showing the adverse effects that shortages of midwifery staff have on the safety and quality of care. Our research group at the University of Southampton reviewed the scientific literature on the relationship between midwifery staffing and outcomes during labour and birth. We found that organisations with more midwifery staff had better outcomes for both mothers and babies. These included less perineal trauma, less postpartum haemorrhage, less fetal distress, lower need for neonatal resuscitation, and reduced admission to the neonatal unit.” (University of Southampton)

3.17 These findings were echoed by the UK Network of Professors in Midwifery and Maternal and Infant Health, which set out a number of ways in which poor staffing delivers care for women that is poorer than it should be in terms of quality and safety. They further stated that there is a link between proper staffing levels and better outcomes.

3.18 The University of Bournemouth focused on how staff shortages can mean poor clinical placements for student midwives and how this can damage their learning process, with implications when they enter the workplace post-qualification. As in other areas of the service, labour units are so short-staffed that midwives simply do not have the time to give to students and their learning needs.

“Staff shortages and workload pressures are affecting students’ experience of care provision during labour and birth so they are less likely to witness or be engaged in personalised care that could then negatively impacts on their own learning and meeting the required NMC standards future provision of care.” (University of Bournemouth)

3.19 Bliss outlined the impact staffing shortages are having on the drive nationally to have more women with babies set to be born very early to do so in a neonatal intensive care unit (NICU), as the target is not being met with some areas performing more poorly than others.

“Maternity services which are stretched and understaffed can lead to women not being transferred to a hospital with a NICU for birth, resulting in transfer to NICU post-birth instead. Not only is this associated with poorer neonatal outcomes, it also increases the likelihood of separation between babies and their parents if the mother cannot be transferred at the same time.” (Bliss)

3.20 Antenatal Results and Choices detailed the impact of staff shortages on women undergoing termination of pregnancy for fetal abnormality, and their partners. They set out how these people need sensitive, coordinated and individualised care, but are not getting that because staff simply do not have the time.

3.21 Finally, the Royal College of Pathologists highlighted how less analysis of placentas is taking place than should happen, to look at cases where something has gone wrong. Staff shortages mean the placentas are less likely to be sent for analysis, and less capacity to analyse them too, because of shortages of pathologists with relevant skills.

Summary

3.22 It is clear from submissions that in a scenario where there are fewer maternity staff than there should be, many are pulled into labour wards as a matter of priority. Yet, even in labour wards, where staff are pooled to minimise shortages, deep problems exist.

3.23 Staff have reported feeling fear and anxiety about working in a service where the level of risk is higher than it should be. They described an increased risk of mistakes and failures in care as overworked staff face exhaustion and burnout, while some staff reported colleagues forced by circumstance to work beyond their scope of practice. Indeed, some respondents submitted evidence that harm and even death is occurring because of how short-staffed the service is.

3.24 Service users can feel the pressures on the service, with their testimonies communicating a sense of fear and abandonment during labour and birth. They are also experiencing a reduction in choice of care as midwife-led units close, alongside delays and cancellations of booked-in procedures.

3.25 Organisations have set out how the staffing crisis impacts on care provision, with understaffed services linked directly to poorer outcomes.

3.26 Even at this critical stage in the maternity journey, when understaffed, under-resourced maternity services prioritise for scarce staffing resources, we see the impact of those shortages on not just the quality of care but the safety of care too.

4. What impact are staffing shortages having on postnatal care?

Introduction

4.1 Leaving hospital following birth can be an extremely daunting prospect, especially for those that have had a traumatic or difficult experience. Good quality, compassionate, regular continuation of care can have a significantly positive impact. This chapter will look at the effects of staffing levels on care provided to mothers and babies once they have left hospitals.

4.2 We were keen to explore how service users felt about their experience of postnatal (PN) care, including quality and safety, as well as understanding the views of staff working within the service.

Evidence from staff

4.3 Responses to the call for evidence from staff were universally very negative regarding PN care. Many painted a terrible picture of staffing levels and the provision of care within PN settings.

“It is a conveyor belt system” (Community Midwife)

4.4 There were widespread reports of staff being redeployed to cover labour ward shortages, leaving PN wards very short-staffed and the remaining staff overstretched. Respondents reported that care can be ‘minimal’ in these situations: focused on reaching minimum requirements so that women and their babies can be discharged and sent home, to free up space and time on wards.

“Focused on number of beds available rather than quality of care, no time to get to know the women, often understaffed and staff taken to support labour ward when high activity making it even more unsafe.” (Midwife)

4.5 Respondents also reported the opposite problem occurring – staff shortages meaning there are delays in discharge, and women not able to move from the labour ward to the PN ward for specific care. This causes capacity problems within the system.

4.6 There were also reports of situations in some Trusts and hospitals where women are 'raced' into PN care after birth because there are pressures on labour wards, but then are also quickly discharged from hospital altogether because of pressure of PN wards. These decisions are not based on the needs of the woman, but on the threadbare state of the service.

“Women are often rushed to the postnatal ward shortly after birth without sufficient time to bond with their baby and recover from birth.” (Midwife)

“We have seen readmission rates with jaundice double and women do not have the support in or out of hospital to identify when things are not going well.” (Midwife)

4.7 There are clear implications for the safety of both the mother and the baby, especially when considering support for feeding.

“Women are not having a good experience on postnatal wards. They are not getting help with breastfeeding, or even just the basic care they need due to midwives being stretched so much. ... Midwives are now expected to care for 12 women and babies overnight. This is not safe and means women do not get the feeding support they need.” (Midwife)

4.8 Staff felt that PN care is an area of the maternity service that has been a target for cuts and poor staffing levels for years, perhaps even decades. Respondents were clear that they felt PN care has suffered far greater cuts than other parts of maternity care.

“Postnatal has suffered the most in staff shortages. Many of the roles have been devolved to unqualified healthcare workers and their care is now fragmented.” (Midwife)

4.9 It is common for the provision of care and treatment to be left to maternity support workers (MSW) rather than midwives. While many MSWs provide fantastic care and support, they do not have the professional training that midwives have that ensure they would not run the risk of infections or other health conditions in both mothers and babies being missed.

“Midwife support workers are being used as midwife replacements when they don’t have the same level of knowledge or experience about biology or physiology and are assessing wounds, stitches and blood loss all with no extra training.” (Midwifery Team Leader)

4.10 Respondents described general moves to centralised PN clinics, rather than home visiting to check on mothers and babies, which for some parents can mean very long journeys when they are very newly postpartum. In some instances, responses cited women not being invited to clinics and receiving just a phone call.

“In our trust, postnatal visits have been slashed, with women being asked to attend clinics miles away from home three days after having major abdominal surgery because there are not enough staff to visit them at home.” (Midwife)

4.11 There was a strongly expressed concern amongst respondents that the disappearance of home visits is a very real safeguarding risk. There was also an awareness that women would not receive the benefit of strongly individualised and tailored care and advice. This is especially prevalent when it comes to safe sleep messaging, feeding support and the detection of illness and infection, as well as mental health support and referrals.

“There’s not often mental health support or time for midwives to discuss the birth and more and more women are coming home feeling traumatised, with severe birth injuries and excessive blood loss, with the increase in interventions and inductions.” (Midwife)

Evidence from service users

4.12 The service users who submitted responses described feeling abandoned in PN care, with a strong sense that they were on their own and that midwives were simply not available.

“I was wheeled into recovery. I still had blood covered socks on. No one explained anything. No help with breastfeeding. I was repeatedly asked if I had a nice elective because no one read notes. I was told ‘next time I should shave’, for my emergency section. I guess mothers need to be psychic. I held my baby tightly and almost never put her down after my traumatic labour. I woke up to the person opposite me being screeched at to ‘not fall asleep with her baby, as she’d already been told before’. I basically didn’t sleep for three days after birth. On day two, a support worker opened my curtain to announce, ‘There’s breakfast around the corner if you want some.’ I could barely move. I passed on breakfast, as I’m sure many mums did. I don’t even know what would fix this level of care. No one cares about mothers.”
(Service User)

4.13 Respondents told us that care for mothers and babies to ensure that they are thriving is very limited. Service users responded with negative experiences with having to attend PN clinics rather than receiving home visits.

“Being asked to go into hospital a day after discharge rather than a home visit. I had a four-day labour ending in surgical intervention and they wanted me to be up and about and travelling into the hospital as there were staff off sick so they were short to do home visits. I hadn’t really planned to go out for two weeks at least but felt very pressured to do this even though I could barely climb a flight of stairs.” (Service User)

4.14 Respondents also described poor support for feeding and lactation.

“Asked three times to see lactation consultants while in hospital but no one available, I was called a week after discharge. My baby was unable to feed successfully and we left hospital without having established breastfeeding which is what I wanted.” (Service User)

4.15 Mothers also reported feeling rushed, with no one supporting or checking on them, and no time to bond with their baby in a safe, medical setting.

“I left hospital six hours after giving birth to my first child. I left feeling incredibly weary and anxious. No offer was made to stay in hospital for any longer. Had one official appointment from the health visitor at six weeks and haven’t heard from one since! My daughter is now 16 months old.” (Service User)

4.16 Many of the service users had evidently traumatic experiences, whether during their pregnancy, birth, or postnatally.

“Everyone did their best but you could see just how stretched everyone was and running around just doing the basics was enough, no time to ask what you needed or help with baby care etc. even when mums were struggling.” (Service User)

4.17 For some service users, this had had obvious effects on their relationship with and trust of maternity staff.

“There was no postnatal care for me despite days of labour, an emergency caesarean section, and huge blood loss. I was discharged very quickly. Staff are also disillusioned and

possibly sadistic as that may be there only motivations for staying in the profession.” (Service User)

Evidence from organisations

4.18 Organisations' responses mirrored submissions from staff regarding those working on PN wards being repeatedly pulled to cover shortfalls in labour wards. Organisations also told us that this extended to staff from community services as well. This has a clear impact on the quality and availability of PN services.

“Postnatal care is key to safety. However, in hospitals, staff are drawn from postnatal to cover other areas.” (UK Network of Professors in Midwifery & Maternal & Newborn Health)

4.19 Organisations also shared concerns with care being increasingly delivered in clinics rather than home visits, requiring them to travel when newly postpartum. Organisations were aware that some women have no at-home PN care and that care was often provided by MSWs rather than fully qualified midwives. Respondents shared that this trend is evident even though women increasingly have more complex needs.

4.20 There were repeated references to PN care being treated as a “Cinderella service,” with little sign of improvement. Organisations shared research in the call for evidence that showed that good and adequate staffing levels within PN settings to better outcomes; less maternal readmission, better breastfeeding rates, and better reported maternal experience.

“In our recent research using national routine data we found that NHS Trusts with higher numbers of midwives per 100 births had more women reporting positive experiences while on postnatal wards. Women were more likely to report that they were discharged without delay, that they were always helped in a reasonable time and were given the information and explanations that they needed” (University of Southampton)

4.21 Cuts to staffing have left little to no time for midwives or health visitors to give parents advice, such as on safer sleeping, mental healthcare or breastfeeding. Respondents told us that many women discontinue breastfeeding because of a lack of support and guidance.

4.22 PN care is also critical when reviewing new mothers' progress, because most maternal deaths occur postnatally, with links to maternal mental health and postpartum depression.

4.23 Organisations were very aware of the implication of low staffing and limited care for students' learning. Student midwives are not seeing adequate care modelled because staff training them cannot provide the quality of care that incoming midwives should be learning. This has a knock-on effect on their future delivery.

4.24 A survey conducted by the National Childbirth Trust (NCT) found that the difficulty in being able to see or speak to a healthcare professional was felt most acutely at the PN stage. Barely over half (56 per cent) reported being able to see a midwife in a timely manner always or most of the time, and 42 per cent said the same for an obstetrician. Additionally, in answering the NCT survey respondents referred to PN wards as “carnage”, “hell” and “total chaos”. PN care was consistently rated lower than other aspects of maternity care, by NCT respondents.

4.25 The Royal College of Pathologists also shared concerns regarding PN care support in investigations of stillbirths by coroners. PN care provides appropriate support to parents and families in these situations, but can also provide advice and insight to those conducting the work.

Summary

4.26 Our call for evidence findings show that staffing level issues within maternity settings are clearly impacting the personalised, sensitive, supportive nature of PN care. In many examples, mothers and families feel as though they are being abandoned and services are operating by providing minimal care.

4.27 There are clear safety concerns due to inappropriately-qualified staff having to fill in positions, or staff being redeployed to other, stretched wards leaving PN services running at a reduced service. This is also putting additional pressure on PN clinics, which are leaving mothers feeling pressured into travelling long distances for care when newly postpartum.

4.28 Important follow-up postnatal services, such as lactation, home visiting and mental health support, are currently being de-prioritised so that staff can deliver core services.

4.29 Service users feel abandoned and left without support, finding it difficult to see or speak to healthcare professionals both on postnatal wards and for follow-up, at-home care. Their responses describe negative experiences of postnatal care, some of which are distinctly traumatic.

5. What impact are staffing shortages having on neonatal care?

Introduction

5.1 Every year, over 90,000 babies are cared for in neonatal units in the UK because they have either been born prematurely or unwell. We were keen for this report to capture the experiences of those working within neonatal units as well as those that have been service users with their baby.

5.2 This chapter will discuss the effects of limited staffing on the current provision of neonatal care, including quality, safety and accessibility of care given.

Evidence from staff

5.3 Overall, respondents painted a picture of a burnt out, stretched thin, desperate situation in neonatal care at the moment. They felt that a lack of staff and limited care options were showing direct correlations to fetal distress, medical interventions during labour and neonatal admissions.

“There are no nurses as well. Consultant neonatologists are doing nursing shifts.” (Midwife)

5.4 The extent of understaffing was regularly described as dangerous, and respondents reported staff feeling compelled to work additional hours in order to deliver sufficient, good care.

“Our level 3 unit is dangerously understaffed with skilled neonatal nurses. Consultants regularly work 24 hour shifts without break. They are exhausted.” (Consultant Obstetrician)

5.5 Staff also reported a threat to safety of care in the skill mix of staff, with reports of specialised staffing positions in neonatal wards being recruited to with staff that have inadequate medical training or expertise.

“Positions being filled by nursery nurses and maternity nurses without suitable training to detect deviations from the norm and the physiology behind certain complications.” (Midwife)

5.6 Limited staffing was also said to impact on breastfeeding support in neonatal settings, with staff reporting that mothers were not being given appropriate breastfeeding support and guidance. Many described increases in rates of babies being readmitted after leaving the neonatal units due to dehydration and losing weight, which respondents felt would not happen if mothers and families were provided with appropriate feeding support whilst they were still in the NICU wards.

5.7 As well as feeding concerns, respondents reported increases in readmissions with jaundice. They often felt that a lack of staff on units meant that routine observations were not going ahead as they should, and early signs of issues or infections were not being picked up.

“Less breastfeeding [support], missed jaundice, especially for families from Black, Asian, minority ethnic background” (Midwife)

5.8 Responding neonatal nurses raised concerns that parents were having to watch their babies more closely to pick up on health concerns and issues themselves, as there just are not enough staff for regular rounds and observations.

“Patients [are] feeling they have to watch over their children in incubators as not enough staff monitoring subtle changes that can lead to disability or death. Patients having to report changes to nurses e.g. SATs dropping or skin colour changes, need to move tube as causing skin damage” (Midwife)

5.9 It was also reported that all of these issues are having a disproportionate impact on babies and mothers that were from Black, Asian and Minority Ethnic backgrounds.

Evidence from service users

5.10 Service users painted a picture of a neonatal service struggling to provide adequate care in the face of extensive staff shortages. Parents describe NICU units as so oversubscribed and full that they are having to shut, meaning that babies’ care was having to be downgraded to admit them to different wards. In other cases, babies are being moved to unfamiliar hospitals far from home. This is also reported as happening to mothers, so they are separated from their baby in NICU by many miles.

“Excellent care but ended up spending time in 5 different neonatal units around the country as my local ones didn’t have space.” (Service user, quoted by NCT)

5.11 We also heard from one respondent whose son was moved for specialised care that was unavailable at their local hospital, with the journey then contributing to his death.

“In London lots of different hospitals have different specialisms and babies have to be transported between the two, which increases risk hugely. Our baby was cooled for this, and it impacted on his health, and contributed to his death.” (Service user)

Evidence from organisations

5.12 There was a unanimous feeling from organisations that increases in mortality rates within neonatal units are linked to decreases in the required one-to-one nursing for babies receiving the most intensive level of care. This is prevalent under current neonatal and maternity staffing levels.

5.13 It was very clear that organisations were conscious that rates of neonatal admission and neonatal resuscitation are directly linked to a care setting’s inability to provide safe and adequate care in other areas of the service during pregnancy and birth.

“The ability to provide continuity of carer [in maternity] would reduce preterm birth by 24%.” (Bournemouth University)

5.14 Due to staffing levels, neonatal resuscitation is not always being led by appropriately skilled personnel – which is incredibly dangerous - and there are often delays in neonatal team attendances when simultaneous or complex deliveries occur. Organisations also reported tier 1 neonatal medical staff covering both paediatrics and neonatal units overnight, which is unacceptable.

5.15 There were a number of responses which laid out the impact of neonatal staffing levels on safety and care that was able to be given. Neonatal units have far less overall staff than other units, so staffing issues will disproportionately impact their care.

“There are far fewer medical staff working on neonatal units compared to nurses, so even small gaps on a medical rota can have a big impact on babies’ care, and how effectively the unit is operating.” (Bliss)

5.16 Limitations on the amount of time given to skin-to-skin were reported, which research shows to improve outcomes for neonates, as well as dedicated time for breastfeeding support to ensure babies are feeding well.

“Midwives lack time to learn new skills, such as kangaroo skin-to-skin care for babies, which improves newborn survival, prevents morbidity and promotes bonding between mother and baby.” (Bournemouth University)

5.17 Respondents were also very aware of staffing impacts on neonatal wraparound care. There were reported difficulties in accessing specialised treatment and testing, such as urgent CT scans, out of hours echocardiogram services, psychotherapy, and staffing with expert knowledge to administer pain management and onward care planning. These all have an impact on babies outcomes and future development.

“Limited availability of echocardiogram service out of hours leading to poor cardiac monitoring in high-risk babies. Difficulty in accessing urgent CT brain scan and having it reported in a timely fashion due to ongoing significant gaps in neuroradiology support” (National Child Maternity Database)

5.18 We also heard about the impact of staffing levels on providing wraparound care when neonates go home, such as continuing with breastfeeding support and speech therapists. One respondent told us about the critical need to ensure home visiting staff can pass on safe sleep messaging, to help prevent SUDI and SIDS. This is not always possible with current staffing levels.

“Safer sleep is particularly important for babies that are born premature or at low birth weight as they are at increased risk of Sudden Infant Death Syndrome – it is essential that staff are able to pass on safer sleep messages to families on neonatal wards.” (The Lullaby Trust)

Summary

5.19 Staff and organisations that responded to the call for evidence were clear that impacts to their service due to staffing bore a very real threat to neonatal care and babies’ lives.

5.20 Wraparound services are essential in ensuring neonatal babies can thrive when leaving the unit and both staff and organisations told us that these services are in danger of not providing adequate information and care with current staffing levels. Staff described feeling compelled to work extra hours to keep services running, while raising concerns about the skills mix in neonatal units,

5.21 Breastfeeding support, critical care services and home visiting have all been reported as running at reduced functions, with many responses telling us about increases in incidences of readmissions directly linked to these services being reduced.

5.22 Submissions from service users reflected this, as their responses described being at the other side of reduced staffing and limited care, and having seen the impact on their babies’ care.

6. What impact are staffing shortages having on bereavement care?

Introduction

6.1 This chapter will look at the impact of staffing shortages on bereavement care when a baby dies. Nothing can remove the pain or grief bereaved parents feel, but high quality bereavement care can have a very positive influence on how parents experience their loss with a lasting impact over many years.

6.2 We wanted to explore the impact staffing shortages are having on the quality and safety of bereavement care, on women and families’ experiences, and on individual staff.

Evidence from staff

6.3 The vast majority of responses from staff paint a picture of staff too stretched to offer high quality bereavement care, with respondents reporting the dilemma of having to choose between offering bereavement care or going to assist a woman in labour with a living baby.

“Bereavement midwives are pulling in to doing generic work due to staff shortages. Patients who are experiencing baby loss are therefore not able to access support.” (Maternity staff)

6.4 Demand is outstripping supply, with bereaved families left in the hands of staff inexperienced in bereavement care, sometimes without one-to-one care during labour, or even being left alone.

“Women are being cared for by those with limited experience of bereavement.” (Midwife)

6.5 Many respondents also reported that limited numbers of bereavement midwives in their service - often only one - meant that they ended up having to work in the evening, come in on days off and receive phone calls from work while at home.

“I am the sole bereavement midwife in the Trust. I have had to work clinically at times which has impacted on my care. I often work late in order to ensure that calls to parents are made.”
(Bereavement Midwife)

6.6 The result of such pressures is that mistakes are made and bereaved families are not referred on for support such as psychological support, as midwives do not have the time to make the referrals. There is also no access to debriefing in a timely manner for staff.

“Not enough hours allocated to the role, means mistakes can be made or important actions missed which can impact on the care for the women and families.” (Midwife)

6.7 The staffing shortages were also described as limiting the ability of maternity services to provide one-to-one care during labour and birth, which included bereavement care.

“In labour and birth care should be 1-2-1 and this should equally apply to bereaved families. Staff should not be pulled from the bereft families to deal with a live delivery or a high-risk patient who requires constant care. All too often this is the reality of the workplace.”
(Midwife)

6.8 Respondents also noted that as well as shortages in maternity, staff shortages in pathology mean that families are having to wait over four months for post-mortem results. This will undoubtedly have a detrimental impact on bereaved families' wellbeing.

6.9 There were a handful of responses saying that bereavement care was operating well in their trust, but this represents a small minority.

6.10 Many individual staff who responded clearly wanted to be able to do more for bereaved families but recognise that without more resources this will not be possible.

Evidence from service users

6.11 There were only a handful of responses from bereaved families. Although one bereaved parent praised the bereavement care they received (but put this down to support from charities rather than the NHS), others stated a lack of care with no follow-up after leaving the hospital.

“It's appalling. No follow up at all not even a call. Absolutely shocking and poor. Made a horrible experience worse by lack of care.” (Bereaved Parent)

6.12 The voices of bereaved families also came through in the evidence shared by some organisations in their submissions.

“Bereaved parents have told us that they went without support because the only bereavement midwife working in a large NHS Trust was on holiday and no cover was provided.” (Antenatal Results and Choices)

Evidence from organisations

6.13 Organisations reported that bereavement care is not being given enough priority. They emphasised the consensus view that bereavement care is vitally important both for parents at the time of their baby’s death, and for their long-term wellbeing and that of any future children. Despite this, under the current staffing pressures, bereavement care was described as neglected.

“Lack of midwives has placed perinatal bereavement care low down in the priority list.” (UK Network of Professors in Midwifery & Maternal & Newborn Health)

6.14 Concerns were also raised by organisations about the number of bereavement specialists. Respondents reported limited availability of support from bereavement specialists for bereaved parents following the death of a baby. The National Child Mortality Database notes that Child Death Overview Panel reports consistently identify inadequacy of bereavement services for families. A recent survey by Sands showed that 9 per cent of trusts in England have no bereavement specialists, with an average of less than one for each maternity unit across the country and only two hours of working time to dedicate to each death.

“In addition to for caring for bereaved families, the majority of bereavement specialists also have many other responsibilities including directly training other staff in bereavement care, or organising it, completing paperwork, gathering feedback, assessing quality of bereavement care in their trust, implementing improvement plans and complying with national guidance on reporting baby deaths and the care mothers and babies received.” (Sands)

6.15 Staffing shortages mean that bereavement specialists are pulled away from this role. Echoing the responses from individual staff, many organisations reported that staffing shortages across maternity services mean that bereavement specialists are often called away from this role to cover rota gaps and work clinically in other parts of the service.

In giving oral evidence to the APPGs, the Bereavement Midwives Forum highlighted that staffing shortages were leading to bereavement midwives being pulled in to cover regular shifts, to a reduction in training and to untrained staff having to deal with complicated bereavement situations.

6.16 Organisations also emphasised staffing shortages are preventing maternity services from providing timely and compassionate bereavement care which in turn has longer term impacts for families. The UK Network of Professors in midwifery and maternal and newborn health noted that routine assessments for conditions such as post-traumatic stress disorder do not happen because there are not enough staff to carry them out. Errors here can lead to long term impacts on parents and families affecting future pregnancies and the ability to parent future babies.

“No screening is done of bereaved parents to pick up who is most at risk. Parents are often prescribed antidepressants inappropriately instead of being referred for support.” (The Lullaby Trust)

6.17 It was also reported that the lack of staff means that time to understand the experiences of women from different ethnic groups is not available.

“The recent APPG inquiry into the maternity experiences of Muslim women found that miscarriage care did not follow NICE guidelines. Care was insensitive with little empathy shown. Women were not provided with psychological support and information for early pregnancy loss bereavement care, which when provided should also include culturally / faith sensitive options”. (UK Network of Professors in Midwifery & Maternal & Newborn Health)

Summary

6.18 Good bereavement care following pregnancy loss or the death of a baby is important for the wellbeing of parents at the time and in the future. Poor care can have long-term negative impacts on parents, siblings and experience in future pregnancies.

6.19 The call for evidence found that in too many maternity services, there are not currently enough staff to ensure good quality bereavement care, with bereavement specialists regularly called away from this role to cover staffing shortages in other parts of the service. This leaves bereaved families in the hands of inexperienced staff and specialists working over their hours to support families.

6.20 Stretched staff also means that there is no time to assess and refer families on for other support they may benefit from such as psychological support, or to understand and properly support the needs of families from diverse backgrounds.

7. What impact are staffing shortages having on learning from incidents?

Introduction

7.1 More than 4,500 babies die before, during or shortly after birth every year in the UK. When each tragedy occurs, a hospital review is undertaken to understand why the baby died and whether the care mother and baby received throughout pregnancy, labour, birth and after birth (if the baby lived for a period) was appropriate. A review aims to investigate whether anything could have been done differently to prevent the baby from dying. A proportion of deaths may be referred to an external investigation body, such as the Healthcare Safety Investigation Branch (HSIB), but the vast majority of baby deaths will only be reviewed by the hospital itself.

7.2 It is important that the hospitals have the correct infrastructure in place to properly conduct these reviews, and implement the learnings that come from them to prevent further deaths. This chapter will explore the responses from staff, service users and organisations about the impact of staff shortages on reviews and the ability of hospitals and staff to learn from an incident and prevent it from happening again.

Evidence from staff

7.3 In the responses to the inquiry, staff working in maternity units seemed to conclude that while everybody was doing their best, staff shortages were limiting the ability of staff to learn from incidents and were a serious barrier to the health system ensuring that serious incidents were not repeated.

“We are doing our very best, but in this current climate providing entirely safe midwifery care is almost impossible so further mistakes- and deaths- will occur without change” (Midwife)

7.4 The challenges with learning from incidents begin as soon as the incident has happened with several respondents pointing to the fact that staff shortages are causing a delay in incident reporting as staff simply do not have enough time, or they are forced to do this at home in their free time.

“There is limited work being done on incidents and learning from it. Incidents are delayed on reporting them as midwives are too busy in shifts to write the report. Often they need to do this at home to have time, in their own time.” (Midwife)

7.5 In cases when learning is in place, however, this delay still occurs, with staff struggling to pass on the learnings in a timely manner due to intense pressure on their time.

“Patient Safety Midwife and Risk Midwife don't have enough time to keep up with incident reporting therefore often a delay in disseminating learning.” (Midwife and Bereavement Lead; Midwife)

7.6 Pressures on time also means that when learnings are passed on, staff are struggling to engage with them, and crucially to learn how to prevent a repeated incident.

“You can only learn from an incident if you have the time to debrief, feedback and implement change in a timely fashion. Staff are at the pit front and don't even get time for lunch/breaks let alone spend time going over the latest incident. Emails are sent out for staff to read outside of the workplace.” (Midwife)

7.7 Many respondents blamed the inability of staff to learn from incidents on the challenges of staff having to cover gaps in rotas.

“Risk and education teams often pulled to work clinically to cover staff shortages so some training has been cancelled and reports are delayed. There is no protection for educators and newly qualified midwives are not properly supported.” (Midwife)

7.8 Obstetricians in particular pointed out the challenges that the Governance team face.

“The governance team are overstretched. Audit is suffering as acute risk management takes priority. Endless Governance requirements take skilled midwives away from acute care.” (Obstetrician)

7.9 Staff reported that the staff shortages are not only causing delays in reporting, discussing and learning from incidents when they happen, but are also preventing staff from doing basic training.

“Staff do not have the time to learn from incidents, literally, every day they come to work it is a matter of survival, managers are unable to allocate time for personal development. Study days cancelled regularly... every day it is a fight.” (Midwife)

7.10 A number of staff reported a toxic blame culture and bullying management structure when a serious incident has happened, which is hampering the ability of the staff to learn, and to want to learn. The implications of this could be that staff become fearful of reporting incidents if they feel that they will be personally blamed, rather than there being an acknowledgement of the challenges that staff are under due to staff shortages.

“Huge effects. Additional stress of staff shortages and under extra scrutiny from Ockenden report have led management to accuse rather than support and learn following serious incidents.” (Midwife)

7.11 There were a few positive contributions from staff who highlighted that the Datix reporting system was working well.

“Datix reporting seems to have increased as staff are keen to learn. Anything to improve care and the work place!” (Midwife)

7.12 However there were high levels of scepticism from a number of respondents about how effective the systems and processes used to learn from serious incidents are, with some they are simply a tick box exercise that was taking up more of their time away from providing care to their patients.

“It's a tick box incident. Most are attributed to human factors yet these factors are not addressed because we do not have the staff numbers to address them. There becomes a sense of inevitability about the incidents as almost every shift we are creating the very conditions that cause them.” (Midwife)

7.13 There was an awareness that staff shortages are having an impact on the ability of midwives to deliver care, and this appears to be creating distrust between colleagues on the quality of the patient's notes.

“Staff feel stressed about impact of staff shortages and on edge about making a mistake or missing care particularly in community as often short staffed or missing documentation of the care they have given on ward so if care reviewed they worry about it as not true record of events” (Fetal monitoring lead and coordinator)

7.14 There was a feeling of inevitability across the responses that serious incidents will continue to occur due to the impact of staff shortages on the ability to learn from incidents. The challenges that staff and the system face because of this were well summarised by both a midwife and an obstetrician in their responses.

“There is no time to learn from an incident before another one, and when there is an incident, it mostly leads to more tick boxes on paperwork, which takes the midwife away from the woman, which leads to her not getting a feeling for what is happening, which leads

to an incident. Reduced staffing means there is no time for team meetings to discuss learning or to look at new ways of working that might reduce incidents.” (Midwife)

“To perform quality investigations takes time and training for staff. Due to staff shortages those staff are then required to work on something else (for example on Labour Ward). This means they do not have the time or training to adequately investigate and learn from incidents. In simple terms, more incidents occur due to staff shortages, then those incidents can’t be investigated or learnt from as the staff meant to be doing it are covering rota gaps.” (Obstetrician)

Evidence from service users

7.15 Women responding to the inquiry seemed to be doubtful of the ability and willingness of staff and hospitals to learn from serious incidents.

“They aren't learning a thing.” (Service user)

7.16 Several respondents shared their own experiences of poor learning systems following a serious incident and what they describe as ‘cover ups’, as well as the challenges of being involved in a ‘learning from incidents process’.

“They don't want to learn. I have been through the learning from incidents process. They only try to cover up faults. If they don't accept that poor staffing and no space on labour wards etc is affecting things then they will continue to have poor care.” (Service user)

7.17 Service users are clearly aware of staff shortages in hospitals and the impact that this is having on their care. They are sympathetic with health professionals, however recognise that change needs to happen, and much more urgently than is currently taking place to enforce change.

“Had ventouse and forceps delivery as son in distress which should have been a csection, twice had unstable lie but second time induced anyway even though may have been in wrong position, too busy, too overworked and undervalued to be able to reflect and learn” (Service user)

Evidence from organisations

7.18 The submissions to the inquiry from organisations focused on several different aspects of the learning from incidents process, highlighting best practice and warning about how to avoid failing to learn from an incident. Some responses focused on the importance of a midwife’s basic knowledge, others looked at organisational problems during the review of a baby’s death, and several highlighted the importance of having the service user at the centre of a review to improve learning.

7.19 The Nursing and Midwifery Council highlighted the importance of a Midwife’s basic knowledge in their response by discussing their Midwifery Standards. The Standards say that midwives must understand the relationship between safe staffing levels, effective team working, appropriate skill mix and the safety and quality of care. However they do point out that while the Standards are meant to “set the foundations for midwives’ education by establishing what we expect a new midwife to know, understand and be capable of doing, at the start of their career” they also make the point that services must also have the resources for these standards to be met.

7.20 Sands highlighted in their submission that research shows that engaging parents in the review of their baby's death improves the focus and therefore quality of the review process. They referenced a 2021 Sands report, which recommended that there must be ring-fenced funding to secure staff time to support parents throughout the review and to release staff to participate in hospital reviews and in training, meaning that more staff will be needed to cover the gaps.

"There is no doubt... that timely, parent-centred, clear and sensitive parent engagement, as outlined by the PMRT and Sands, takes more time and resource for Trusts and Health Boards, where historically few parents were properly engaged at all in the review of their baby's death. Meaningful engagement for all families will require funding and staff training and will need to be monitored to ensure it genuinely is reaching all parents, equally." (Sands)

7.21 Sands also spoke about the unequal distribution of perinatal pathologists across the UK, with some areas, such as Northern Ireland, having none while areas such as the North East of England have very few, and about there being a concentration in London and the North West.

"Responses to our recent audit of bereavement care suggest over half of all parents who are waiting for their baby's post-mortem results wait over 12 weeks, 85% wait over 2 months with just 15% of parents getting the results back within the 8 week national standard." (Sands)

7.22 Time Norfolk also spoke about the importance of the voice of the service user, and shone a light on a process that is working well.

"Service user voice is important to ensure quality of maternity services. Maternal Voice Partnerships at hospitals is creating a safe platform for feedback. It is vital that this feedback is responded to with action points and communicated to senior midwifery teams and the Government." (Time Norfolk)

7.23 The UK Network of Professors in Midwifery and Maternal and Newborn Health gave an example of what can be learnt from best practice in other health organisations when it comes to conducting an inquiry and learning from an incident.

"Lessons from safety in other healthcare environments demonstrate that a positive, strengths-based approach to promoting health and well-being is needed. Learning from what goes right, as well as from what goes wrong, is critical. The focus of recent inquiries on examining what went wrong has identified problems but has not identified characteristics of successful organisations." (The UK Network of Professors in Midwifery and Maternal and Newborn Health)

7.24 They outline the impacts of this approach on staff, including creating a culture of blame, staff sickness and increasing the likelihood of errors in the future. They also highlight that the focus of inquiries on midwives has damaged morale and created a loss of attractiveness to the profession for new recruits.

7.25 Professor Christine McCourt from City, University of London also focuses her submission to the inquiry on the wider system failures involved with reviews and the way that they are conducted.

“Lack of sufficient staff leads to cuts in all types of learning including audit, attendance at audit meetings, training and so on. It's important to be clear though that other factors are key here, such as structural and compensation arrangements which encourage services to be defensive, plus a tendency to blame individual professionals rather than look at structural and organisation problems in the services.” (Professor Christine McCourt from City, University of London)

Summary

7.26 Submissions to the inquiry from staff, service users and organisations highlight the varying problems with staff shortages at every stage of the process of learning from an incident. The problems at each stage also create a much bigger system wide challenge, with the system seeming to be reactive, rather than proactive in its response to learning, and then even that is limited.

7.27 Staff responses described staffing shortages as causing delays in incident reporting, difficulties in passing on lessons and an inability to access even basic training. If staff struggle to find availability to even report an incident, as well as to attend learning sessions or read learning resources, then incidents will continue to happen.

7.28 Respondents highlighted how this could then create a toxic work culture, with staff feeling demoralised about how the system is run and how they are treated when incidents occur, which could lead to even more staff leaving the profession.

8. What impact are staffing shortages having on the morale and wellbeing of maternity staff?

Introduction

8.1 The previous chapter examined how staffing shortages impacted on the quality and safety of maternity services and on outcomes for women and babies, as well as their overall experience of maternity care.

8.2 We also wanted to know how staffing shortages are impacting on midwives, obstetricians, Midwifery Support Workers (MSWs) and other members of the maternity team. In particular, how is it affecting morale and wellbeing, opportunities for training and development and strategies for recruiting and retaining staff?

8.3 The following three chapters look at the impact of staffing shortages on NHS maternity staff.

Evidence from staff

8.4 There was near unanimity among staff respondents that shortages were having a significant and negative impact on their morale and wellbeing. Consistently, staff reported feeling tired, exhausted, burnt out, demoralised and physically and mentally unwell. Significantly, experienced clinicians report never having seen morale so low.



“Midwives are exhausted, overworked, stressed and the sickness rate has increased as they are burnt out. Midwives are crying on shifts, having panic attacks before coming in, it’s creating a mental health crisis.” (Midwife)

8.5 Across the country, staff are working at a pace and level of intensity that is not sustainable and are being given unrealistic workloads. Working through the Covid-19 pandemic, when care could not be deferred or cancelled, has exacerbated feelings of burnout and exhaustion.

8.6 The number of staff that are leaving is placing additional pressure on those that remain. This is affecting all levels of the service, from students interrupting their studies, to newly qualified midwives leaving within two years of qualifying, to experienced midwives who retire earlier than planned because they are unable to sustain such challenging pressures.

“Staff are exhausted, burnt out, disillusioned, struggling coming to work, mental health issues are on the rise, long-term sickness, morale and it is having an effect with an exodus of quality, qualified staff. Not enough students are being funded to train and once qualified they seem to get lost in the ‘system’ or lack of.” (Midwife)

8.7 Of those staff that have not left, an increasing number are reporting sick, due to the stresses of the job and the toll these are taking on their physical and mental health and wellbeing.

8.8 Many staff are frustrated that staffing shortages have compromised the quality and standard of care that they are able to provide to women and families. In some cases, this is leading to feelings of resentment about their job and staff becoming disengaged from the women they are caring for.

“We know we’re not providing the gold standard midwifery care that we are taught in university and the evidence supports. We try our best, we break ourselves, we lose sleep and cry with parents and colleagues when it all goes wrong. It’s no way to care for people.” (Midwife)

8.9 Respondents describe feeling anxious and fearful about going into understaffed and unsupportive workplaces. Worryingly, some staff are fearful of making errors that could have serious consequences for the wellbeing of the women and babies they care for.

“We are broken! I question why I come to work when I know that I will not be able to do a good job as there are daily staff shortages. I know the women I am looking after will receive substandard care, my own job and regulation is on the line as I am cutting corners and all the while getting paid less each year to do it! If you come to hospital for something is this the type of doctor you want looking after you? I wouldn’t but that’s the reality.” (Obstetrician)

8.10 While services have introduced wellbeing initiatives and policies, the sense among respondents was that these are often seen as cosmetic, especially in the face of staff crying on shifts, being unable to take breaks, and generally feeling undervalued and unsupported.

“It’s dire, there is talk of caring, staff wellbeing etc. It’s lip service. When it comes to the nitty gritty, the ‘caring for you’ is gone. I’ve recently been denied a day off to move house.” (Midwife)

Evidence from service users

8.11 While there were only a few women who answered this question, those that did respond were conscious of the impact that working in busy and understaffed units were having on midwives' physical and mental health and on their morale.

8.12 Women can see how exhausted many midwives were, how they were missing breaks and how demoralising this was – although while some women perceived the professionalism of midwives who didn't let their feelings show, other women felt that midwives were not shy in making their feelings known.

8.13 Alarming, some women were concerned that midwives were so busy that they didn't have time to pay proper attention to the women in their care, with the implication that this could compromise safety and lead to adverse outcomes.

“Staff aren't doing well. The culture in the hospital is terrible, but it comes from the top. I do not feel that midwives will stay under poor management, who are keen to blame them. Everyone on the unit saw me there and not one person helped or even spoke to me like an adult because they weren't invested enough in me as a patient. They didn't have time. They were too busy on their other tasks to pay real attention and it's dangerous. I even had someone in the midwives office huff and slam a door when I couldn't be silent for a contraction.” (Service user)

Evidence from organisations

8.14 Responding organisations report that staffing shortages have led to significant morale problems affecting all professionals working across maternity care. A number of organisations, such as Mumsnet, Bliss and the NMC, have surveyed staff and the feedback they receive tallies with the responses from staff to this call for evidence.

8.15 Consistent among organisational responses were reports that morale and wellbeing are at the lowest point that many staff can recall.

“Midwives are leaving because they simply can't cope anymore. The demands are unrealistic. It's now normal to work a 13-hour shift with no break. No food, no drink and not even time to go to the toilet.” (Midwife quoted in Mumsnet discussion forum)

8.16 Understaffing and unmanageable workloads are the main drivers of negative staff morale and wellbeing. Poor mental health is becoming a major issue, with staff reporting feeling rundown, anxious, compassion fatigue, flashbacks and intrusive thoughts.

“Existing staff are having to plug the gap by working through fatigue and stress, where they are unable to seek advice from colleagues, as well as unable to build relationships with fellow staff and patients, thereby making clinical errors, sickness and burnout more likely. The detrimental impact on individuals is clear as we have heard about exhausted senior NHS staff crying with frustration and anger, as well as reports of staff reduced to tears from being stretched too thin.” (NHS Providers)

8.17 Organisations noted a notable decline in the number of staff who look forward to going to work, as feeling overworked, long shifts and a sense of being undervalued are all contributing to negative working environments.

8.18 Organisations also spoke of less experienced staff feeling unprepared and lacking in confidence, with little opportunity to debrief or support their own wellbeing.

“Bereavement care can be challenging for professionals at the best of times. They may feel unprepared and daunted and need support to boost their confidence and skills, enabling them to provide excellent care for families whilst also looking after their own wellbeing. This can be very hard to achieve when services are understaffed, and staff are under extreme pressure with no opportunity to debrief with colleagues and to support their own emotional and psychological wellbeing.” (Sands)

8.19 Responses also stressed increases in fatigue and stress among staff having to plug gaps in shifts and rotas, leading to disengagement from colleagues and women, and increasing the risk of clinical errors and potential harm for women and babies.

“They said that they had left the register because of poor staffing management and overall staff shortages. Many noted that they felt the ratio of nursing and midwifery professionals to patients and people using services are borderline unsafe, both in terms of higher chance of malpractice, and unreachable workload expectations for the professional. Such pressures were noted by 58 respondents on our register (2.5 percent) to be damaging to mental and physical health.” (NMC)

Summary

8.20 With understaffed and overstretched services - exacerbated by the challenge of keeping services going through the Covid-19 pandemic - and with so many colleagues leaving, it is little wonder that staffing shortages are having such a profound and negative impact on maternity services staff. While this is not a new issue for maternity services, there is a sense that staff morale and wellbeing are now at their lowest point.

8.21 The effect on staff is manifested in feeling physically and mentally exhausted, stressed, burnt out and demoralised. This is affecting professionals of all levels of experiences, from recently qualified to those nearing retirement, and is prompting many to leave maternity services.

8.22 There is widespread frustration that staffing shortages are compromising the quality of care that staff are able to give women, as well as anxiety about making mistakes that could have serious consequences for women and babies.

8.23 Where wellbeing initiatives and policies exist, they can be seen as cosmetic and inadequate. Mental health problems are widely reported among staff.

9. What impact are staffing shortages having on the training and development of maternity staff?

Evidence from staff

9.1 Responses from staff describe a myriad of ways in which staffing shortages are impacting the training and development of maternity staff. They include the delay, suspension or cancellation of training courses – often at short notice, and lower take-up of training opportunities and attendance at courses.

9.2 There were also widespread reports of staff having to miss training or being pulled back to cover shortages in clinical areas. This includes instructors and practice development staff as well as course participants. This is often because Trusts/Boards are not backfilling the posts or protecting the time of staff doing training.

9.3 Staff respondents also emphasised the frequent curtailment of opportunities for continuous practice development (CPD), with focus predominantly on mandatory training. However, even mandatory training is getting cancelled and is increasingly being conducted online.

9.4 It was widely reported that staff are increasingly required to undertake training in their own time and using their own funds to do so. The time pressures on maternity staff were also described as leaving them with insufficient capacity to mentor students or undertake preceptorship for newly qualified midwives.

9.5 As responses highlighted, there are worrying implications of reduced training and development on the quality and safety of maternity services. Most immediately, the concern that maternity staff are not gaining new skills, improving their knowledge or using the latest evidence. Where practice development teams are having to cover staff shortages, they are unable to support staff in their knowledge and skills development.

“Training is constantly being cancelled as staff are pulled to cover any gaps in service. The cumulative effect will be that large numbers of staff remain in the red for their training. That is not safe as our workplace policies and protocols are in a state of constant flux and people may well be using outdated information.” (Obstetrician)

9.6 Responses also reported that staffing shortages are causing a failure on the part of individual staff, teams and services to comply with training requirements, workplace policies and practice guidance and protocols. This increases the likelihood of staff using outdated techniques, procedures and information.

“Training is constantly being cancelled as staff are pulled to cover any gaps in service. The cumulative effect will be that large numbers of staff remain in the red for their training. That is not safe as our workplace policies and protocols are in a state of constant flux and people may well be using outdated information.” (Midwife)

9.7 Staff emphasised having insufficient capacity to provide adequate mentoring or preceptorship programmes for students and newly qualified staff. This can skew the experience of students on placement and deny them exposure to different types and settings of care.

9.8 There were also concerns about the safety of shifting mandatory training to exclusively online/e-learning.

“There is limited training and developing sessions now as even the instructors are pulled onto the wards to help. Mandatory training is all online and you can just skip through the videos to pass. It’s extremely unsafe.” (Midwife)

9.9 It should be noted that some respondents reported positive developments, including increased Health Education England (HEE) investment in midwifery-specific training programmes and better access to online training.

Evidence from organisations

9.10 A number of the responses from organisations reflected their position as either a Higher Education Institute (HEI) provider of pre- and post-registration programmes or a charity providing maternity-related training courses.

9.11 Among their observations on the impact of staffing shortages on learning and development was the trend of staff being unable to take time away from work for training or being required to fund training themselves and attend in their own time. There were also reports of an increase in the number of staff dropping out of training courses provided by charities.

“We are seeing an impact on our own courses even because midwives are not being allowed by service managers to reduce their own hours unpaid to take up a professional development course, they are willing to pay for personally. If this continues, it will also lead to course closures as courses can’t be sustained financially with low uptake.” (City University London)

9.12 Responses reported that Trusts/Boards are making bereavement training available to only a minority of healthcare professionals in contact with families experiencing pregnancy loss or the death of a baby.

“In most trusts and boards, bereavement care training is offered once a year and only for one hour, which is too short to cover the breadth and depth needed to equip healthcare professionals with the skills, knowledge and confidence they need to provide excellent care for families, whilst also looking after their own wellbeing.” (Sands)

9.13 Organisations described staffing shortages leaving little or no capacity to enable staff to refresh, update or respond to new evidence, with associated limited opportunities to learn from incidents and multi-professional working.

9.14 Widespread was the concern that staffing shortages are compromising the quality of mentoring of students and the ability to provide safe placements, as well as the time available to support newly qualified midwives and junior doctors.

“Staffing shortages impact on mentoring and ability to provide safe placements for student midwives. Shortages also limit time available to support newly qualified staff. Newly Qualified Midwives (NQM) and junior doctors are particularly vulnerable to stress as clinical demands limit time with preceptors.” (UK Network of Professors in Midwifery & Maternal & Newborn Health)

9.15 Organisations highlighted implications for the quality and safety of care, including the lack of opportunities for CPD for staff, and their consequent inability to share new evidence. They emphasised that this is feeding a theory-knowledge gap for students. This can exacerbate their fears of making errors, and increase feelings of stress, ultimately resulting in more students and newly qualified staff leaving.

“Where qualified staff have no capacity for continuous professional development, they have limited ability to share new evidence with students, which results in a theory-knowledge gap between what students learn in university about new evidence and what they witness in placement. This can increase student fear of making errors and harming women and their babies, as well as exacerbating stress and increasing the numbers of students and newly qualified staff leaving the profession.” (University of Bournemouth)

9.16 Where staff are denied time and financial support for training and development, they leave, thereby exacerbating the staffing shortages that have limited their learning opportunities.

“A lack of time for training and development is a key reason people told us they leave our register. Midwives’ time is stretched like never before, and consequently time to learn and to reflect gets squeezed. Midwives need protected learning time, and funding, so they can keep their skills and knowledge up to date and provide the best and safest care for women and families.” (NMC)

9.17 It was also reported that some training providers will no longer be able to provide certain courses, or may go out of business altogether, if they can no longer depend on bookings from healthcare professionals.

“We are seeing an impact on our own courses even because midwives are not being allowed by service managers to reduce their own hours unpaid to take up a professional development course, they are willing to pay for personally. If this continues, it will also lead to course closures as courses can’t be sustained financially with low uptake.” (City University London)

Summary

9.18 The evidence from respondents suggests that, due to staffing shortages, opportunities for continuing professional development (CPD) are severely limited while mandatory training courses are often cancelled or restricted to online learning.

9.19 The disappearance of CPD opportunities, combined with limited and sporadic mandatory training, is resulting in staff missing out on the breadth and depth of knowledge and practice to equip them with the learning, skills and confidence to give women and families the safest and best quality care.

9.20 In recent years, Governments across the UK have increased funding for midwifery and obstetric trainees, and there is no shortage of interest in a career in midwifery or obstetrics, with most degree programmes heavily oversubscribed. But recruitment takes time, staff are leaving at a faster rate than their replacements can be recruited, and those that remain are having to work under increasingly challenging conditions – thereby increasing the likelihood that yet more staff will leave.

10. What impact are staffing shortages having on the recruitment and retention of maternity staff?

Evidence from staff

10.1 It is evident from the majority of staff respondents that retention is recruitment hugely pressing issue. Staff are leaving the service at an unprecedented rate, and far faster than services are able to recruit to vacant posts. A vicious cycle is taking hold, with the increase in staff leaving making conditions that much harder for their remaining colleagues.

“More and more midwives are leaving. It’s a vicious cycle as more leave, the day-to-day workload gets worse for the remaining staff, who then eventually leave.” (Midwife)

10.2 Crucially, recruitment takes time and services are finding it increasingly difficult to fill all vacancies as there is a diminishing pool of midwives to recruit from.

10.3 A concern for many staff is the increasing proportion of posts being filled by newly qualified midwives (NQM) which is skewing skill-mix towards relatively inexperienced staff, again emphasising the importance of retention.

“We are constantly out to recruitment, new resignations come in monthly. Recruitment takes a long time; we never manage to fill all the vacancies as the midwives just aren’t out there. Our biggest recruitment is for newly qualified midwives and that is going to ruin the skill-mix.” (Midwife)

10.4 Overworked staff are struggling to support students and NQMs. As a consequence, students struggle to gain the requisite experience to qualify and are often denied the chance to work in midwife-led settings, because birth centres and home births are suspended, often due to staff shortages.

10.5 Since the ending of the bursary and introduction of course fees, there has been a reduction in the number of mature students applying for pre-registration programmes, and a proportionate increase in younger students with a greater inclination to leave, either before or not long after qualifying.

“More midwives are leaving the profession than ever before, students and newly qualified midwives either never start or leave within the first few months. Since the bursary stopped and student midwives have to pay the entire course fee, we no longer see older students who really desire to be midwives, we have much younger girls who then go on to do something else.” (Midwife)

10.6 It is notable that services are failing to retain all midwives, regardless of experience or banding. Students and NQMs can feel overwhelmed or stressed, particularly if they are not getting appropriate support from overworked colleagues. Accordingly, they are increasingly likely to leave within a year of qualifying.

“13/13 of our locally trained midwives are leaving. We have been neglected for so long that we are really struggling. Psychological support for midwives would be helpful, especially when they are involved in a serious incident.” (Obstetrician)

10.7 On the other side, there are myriad reasons why more experienced maternity staff are leaving, but among the most common causes are stress and burnout, frustration at being unable to provide optimal care to women, working in unsupportive (and sometimes toxic) working environments, working hours and conditions that are not conducive to a healthy work-life balance and levels of pay that are not commensurate with the additional work and responsibility that increasingly falls on their shoulders.

“Staff come to work knowing that they will be doing more than one person’s job, every day! They don’t get breaks. They make mistakes. They are exhausted. This means staff leave or cut down hours, making the situation worse.” (Obstetrician)

“Staff have a choice and can leave knowing they will get another job. Why work in a busy tertiary unit for the same pay as a local low risk unit with less travel and cheaper housing?” (Midwife)

10.8 It was widely reported that older staff are choosing to retire early rather than continue with the pressure of working long and often unsocial hours in poorly staffed, unsafe and demoralised services.

“My trust does nothing! Never asks staff who are about to retire and use their expertise and experience in a way to keep them on to support new staff. People just leave and no-one questions it. No exit interviews to see how we can improve.” (Midwife)

10.9 Within maternity services, there are also problems in retaining maternity support workers (MSWs) with some suggestions that MSWs are not always treated with the same respect as is accorded their professional colleagues, and that this is a cause of discontent.

“We have been told we are all replaceable. No-one wants to work in an area where they are not being treated with respect.” (MSW)

Evidence from organisations

10.10 A number of the responses from organisations echoed the concerns expressed by staff about the impact of shortages on recruitment and retention. It was emphasised that stress caused by rising workload and staff shortages is leading to high numbers of midwives leaving roles, particularly among students, NQMs and midwives approaching retirement age. This instability in staffing is compounding problems for existing staff.

There is a vicious cycle building. The more midwives that leave, the harder it is to provide good quality care for those who remain, the more moral distress they experience, the more

they are off sick, and the more likely they are to provide poor quality care and/or to leave.
(UK Network of Professors in Midwifery & Maternal & Newborn Health)

10.11 Concerns were raised that Trusts/Boards are relying on staff goodwill to address shortages in a way that is not sustainable and which will lead to higher rates of attrition and difficulties with recruitment over time.

“Trusts increasingly relying on the goodwill of staff to address shortages is not a sustainable solution and will likely lead to higher rates of attrition and difficulties in recruitment over time. To recruit and retain staff, it is imperative that roles in maternity services are appealing, which includes sufficient pay, flexibility, job satisfaction and access to CPD.” (NHS Providers)

10.12 Organisations also referenced the impact of staffing shortages on the quality of care midwives can offer, their ability to keep their knowledge and skills up-to-date and the pressure they feel under, all of which contribute to significant issues with retention and recruitment.

10.13 Responses also stressed problems of wider shortages in the multi-disciplinary team working in maternal and neonatal services, including child and adolescent psychotherapists and underinvestment in psychological and psychotherapeutic staffing.

10.14 It was clear that Higher Education Institutions (HEIs) are also affected by shortages of lecturers, supervisors and assessors, all of which impacts on the quality of education provided, the retention of students in training and the numbers qualifying. Many lecturers are due for retirement and without some form of financial incentive for midwives to work in academia, it is only likely that more will leave due to workload pressures.

“Succession planning is vital as we approach a period where many midwifery lecturers are due for retirement. This will require increased investment to incentivise midwives to consider academia as a career move including financial reward, opportunities for CPD in teaching, research and professional practice. Without this recruitment, more midwifery lecturers will leave due to workload pressure either through early retirement or complete change of career.” (University of Bournemouth)

Summary

10.15 NHS employers have implemented some welcome initiatives to increase recruitment and expand entry routes into maternity services. However, until Trusts/Boards improve the retention of maternity staff, the impact of these recruitment initiatives will be limited, as the exodus of staff will continue, because they don't feel valued, or because they can get better hours and conditions working elsewhere, or because they are simply exhausted and fed up.

10.16 Crucially, staffing shortages are a self-perpetuating issue. Overworked, exhausted and burnt out staff are leaving maternity services, increasing the staffing shortages and making working conditions increasingly difficult for those who remain.

11. What measures are necessary to address staffing shortages in the short term?

Introduction

11.1 The purpose of this call for evidence has been two-fold: to understand how staffing shortages impact on the quality of services, on women’s experience of care and on staff morale, wellbeing and development; and to consider what measures, both in the short and medium to long-term term, could be introduced to tackle staffing shortages.

11.2 Previous chapters have addressed the first point; in the following chapters, we turn our attention to respondents’ recommendations for actions to improve recruitment and retention. In thinking about this, we were particularly interested in practical and innovative ideas that respondents had, in addition to calls for a substantial increase in funding for maternity services and staffing budgets.

Evidence from staff

11.3 The first measure suggested by staff respondents was better terms and conditions, with improved pay being the overwhelmingly predominant response. Some respondents also suggested better financial incentives for working bank shifts. Other proposals included increasing mileage rates, restoring free car parking and introducing a bonus payment in recognition of staff working through the Covid-19 crisis.

“We feel forgotten about, no thanks for working incredibly hard through the pandemic and always, just blamed when things out of our control go wrong. We want to be paid fairly, we all consistently work through breaks and overtime without pay. It’s no wonder people leave and work in other jobs that are better paid.” (Midwife)

11.4 Responding obstetric colleagues would like to see equitable locum pay rates and better remuneration for extra shifts and on-call working.

“Drastic action to look at overall services to ensure safety of mothers and babies through their pregnancy and birth journey. Better remuneration for extra shifts and on-calls to recognise those covering gaps.” (Obstetrician)

11.5 Respondents also stressed the need for action to increase the supply of staff in maternity services, including expanding the number of short courses for nurses wanting to convert to midwifery, recruiting more overseas staff, more opportunities for MSWs, incentives for retired midwives to return to mentor NQMs and students, and deployment of nurses working in maternity. Other suggestions included giving visas back to EU staff and focusing on recruiting them and greater use of agency staff.

“Reintroduction of funded training with bursary and more places for registered nurses to undertake short training courses to midwifery qualification. Improving recruitment processes to include overseas midwives. Increasing opportunities for support staff MSWs and nurses working within maternity services.” (Midwife)

11.6 Another solution proposed by respondents was the implementation of measures to support education and training, ranging from scrapping fees for students and restoring the bursary, to backfilling posts to enable staff to attend training, to ringfencing funding for education and preceptorship support. There was also general support for measures that will aid staff development and career progression, including mentoring and support for NQMs.

11.7 Staff also stressed the urgent need for a greater focus on the health, wellbeing and welfare of maternity staff. Among the measures in this category, the most popular was facilitating more flexible working arrangements, so that staff could work in the areas that they were skilled in and work the hours that fitted with the work/life balance they wanted to achieve. Other proposals included ensuring staff took breaks (and reimbursing them if they hadn't been able to take a break). But responses were also aimed at improving workplace cultures and behaviours, including more action to tackle bullying and generally valuing staff and treating them with respect (a point made in particular by MSWs).

“Look after the staff you have. Appreciate their commitment and hard work. Understand they are affected by what they see at work and may need support. Stop blaming individuals for system failures. Understand bad outcomes are inevitable when you’re pushing staff to the limit in a high-risk specialty.” (Obstetric student)

11.8 Finally, staff proposed changes to service delivery and models of care. Above all else, respondents want continuity of carer programmes to be suspended immediately or focused on antenatal and postnatal continuity, which would enable an increase in staffing of core services.

“Let’s be honest as a workforce and let the women know what service they can currently expect – stop raising expectations to prevent disappointment. Change continuity of care model to continuity of antenatal and postnatal care. Women need an experienced birth midwife and if they are high risk you can’t expect a COC midwife to know all the policies for antenatal, intrapartum and postnatal care, and be proficient at them all clinically.” (Midwife)

Evidence from organisations

11.9 Only about half the organisations that submitted evidence responded to this question. Of those that did, the majority emphasised that retention of existing staff had to be the priority.

11.10 Measures suggested included improving the morale and wellbeing of existing staff, tackling unacceptable behaviours, supporting CPD and providing supportive interventions.

“RCOG’s 2022 workforce report advocated for mentorship and learning opportunities to be included through team job planning, exist interviews to understand further the reasons doctors’ leave, and reducing attrition by improving opportunities for flexible working.” (RCOG)

11.11 Organisations also stressed the importance of supporting NQMs and MSWs with mentorship and career progression opportunities (and more generally embedding career progression in roles).

11.12 Another proposed measure was increasing workplace flexibility through, for example, incentives for long-serving staff and those at the end of their careers to provide support to NQMs. Flexibility should also be about trying to match staff to the areas in which they most wish to practice.

“The age profile of our register suggests high rates of retirement are likely to remain the case for some time. To mitigate the impact of this, key considerations could be around increasing workplace flexibility for people at the end of their careers and enabling longer serving members of the team to provide support to newly-qualified nurses and midwives. Culture is another vital factor and the importance of valuing staff and supporting them in continued professional development.” (NMC)

11.13 Responding organisations also proposed regular, methodical and rigorous workforce planning. The RCOG’s response said they are currently developing a tool which will allow the benchmarking of obstetric medical staffing nationally and allow policymakers to determine what safe staffing looks like in maternity services.

“...managers regularly reviewing and adjusting staffing levels and skill mix. Keeping staffing levels and skills under review is a good way to address and prevent staffing shortages in the short term.” (CQC)

11.14 Another short-term measure to combat staffing shortages was the need to get commitment from finance departments to proactively hire staff in order to pre-empt vacancies.

11.15 Respondents also suggested measures to improve recruitment, including training grants for midwifery degrees and encouraging programmes to support nurses interested in midwifery. This extended to members of the wider team, including perinatal pathology.

To increase trainee uptake by delivering the paediatric and perinatal pathology curriculum online, to address postcode lottery in training posts. Trainees are put off because they see my colleagues under huge amounts of work, stressed. (Royal College of Pathologists)

11.16 There was however concern that without more concerted action at a national level, then the measures that local services are putting in place to improve morale and cultures will only have a limited impact at best.

Trusts continue to work to improve the wellbeing and retention of staff, but they are concerned for their workforce, and many have found that some of the wellbeing-focused approaches within their control lose effectiveness over time as they can only go so far in absence of national action to tackle root causes. (NHS Providers)

12. What measures are necessary to address staffing shortages in the medium to long term?

Evidence from staff

12.1 The staff responses to this question were broadly similar to the ideas for short-term measures to tackle shortages. This suggests that while respondents support urgent action to tackle shortages now, they also want sustainable action and not just quick fixes.

12.2 Pay again featured prominently among responses, but in the context of the medium to long-term, a number of respondents argued for not just an immediate increase, but action on pay that seeks to restore the cumulative loss to earnings over the last decade.

“The recent pay NHS pay award is frankly an insult – it needs to be reviewed urgently and a full-scale pay restoration to bring pay back into line with the cost of living and inflation.”
(Midwife)

12.3 There were also lots of ideas for investing in education and ongoing career progression. Some of these suggestions, such as restoration of the bursary or protected time for training and better support for NQMs, had also been advanced as short-term solutions. But there were also some new proposals, such as developing apprenticeship schemes for midwifery and the concept of paying students when they are on placement. There was also more support for investing in clinical leadership than had appeared in the responses around short-term solutions.

“Get into schools and promote profession, better pay, see benefits as career, stop forcing people to retire and not return due to pension restrictions, offer apprenticeship for midwifery and the conversion from nurse to midwifery.” (Midwife)

12.4 There was again broad support for previously mentioned actions to improve the supply of staff, including expanding the number of short courses for nurses wanting to convert to midwifery and recruiting more overseas staff (with one respondent suggesting that there should be one national intake of overseas midwives, who could then be allocated to local trusts). Other suggestions included developing new roles, such as midwifery associates and physician assistants.

12.5 While there had been a lot of support for short-term measures to address staff health and wellbeing, there was if anything even more emphasis in the responses to this question. Time and again, respondents argued for more to be done to listen to and engage with staff, to value them, to facilitate flexible working, to give them better conditions in which to work (including more capital investment), to increase investment in wellbeing services and counselling support and to tackle bullying and other unacceptable behaviours.

“Improved psychological support to prevent burnout and depression, more choice over career progression, stop the loss of midwives imposed by punitive measures if they cannot provide continuity of carer. Better working times for the working mothers (and fathers).”
(Obstetrician)

12.6 With regards to service design and delivery, responses on short-term and medium-term measures were broadly similar, with most focus on suspending or reforming continuity of carer. There was however greater emphasis on the importance of workforce planning, underpinned by increased investment in services.

“In the longer term, decent workforce planning is essential. This always feels like it is completed on a whim with barely sufficient people starting training which, after people leave training for various reasons, means too few people complete training (and as more people leave training, the problem becomes compounded because the quality of training

deteriorates as people have to increasingly become involved in more service provision, so even more people leave).” (Obstetrician)

Evidence from organisations

12.7 There were only a handful of responses from organisations that went into any detail about possible medium to long term solutions. However, a number specifically recommended the implementation of a fully funded, multi-year spending increase for maternity services in England, underpinned by a national workforce plan, in line with the previous recommendations of the Commons Health and Social Care Committee and the Ockenden Review.

“The NHS needs a fully costed and funded multi-year national workforce plan to properly assess, recruit, and retain the extra staff that are needed to deliver services sustainably. The long-term ambition must be to detail how safe levels of health and social care staff will be trained, recruited and retained in the coming years, with the levels of funding necessary to enable this change. Additionally, this plan must be focused on numbers needed in the workforce, not only to address existing gaps, but to build flexibility and resilience into the system.” (NHS Providers)

12.8 With regards to workforce planning, respondents wanted to see the inclusion of specialist staff and those in the wider workforce, including, for example, allied health professionals and neonatal nursing staff.

“Nothing can remove parents’ pain and grief following pregnancy loss or the death of a baby, but high-quality care from professionals can have a huge impact on their wellbeing and for the rest of their lives. While we welcome the ambition within the recent Women’s Health Strategy to ensure that all maternity services have a bereavement midwife, more must be done to make this a reality, and to ensure that services have the number of bereavement specialists they need to fully implement the National Bereavement Care Pathway, based on their local circumstances.” (Sands)

12.9 Another proposal made by organisations was for more support for learning and development, from the restoration of the bursary, to more mentoring and support for NQMs, to access to CPD and more multidisciplinary training and development and a greater focus on career development.

12.10 Responses also suggested measures to improve flexible working opportunities, strengthening clinical leadership and also embedding into practice the NMC’s Standards of Proficiency for Midwives.

12.11 There were also proposals to maximise the role of MSWs to increase capacity amongst more senior staff or those with specialist expertise.

12.12 Finally, organisations stressed the importance of developing good leadership and a supportive open culture.

“High-quality leadership encourages staff to raise concerns, managers’ risks proactively and uses every opportunity as a chance to learn and improve. Good leadership and a supportive open culture will help services attract and retain the staff they need to deliver safe care. As

our inspections show, there also needs to be sufficient investment to ensure adequate staffing levels, with the right training to enable delivery of high quality, safe and personalised maternity care.” (CQC)

Summary

12.13 There is a broad consensus, across staff and organisation responses, on what needs to be done to tackle shortages, in both the short and the medium to long-term. In particular:

- Increased investment in maternity services, in line with the recommendations of the Commons Health and Social Care Committee and the Ockenden Review for a multi-year, fully funded settlement. Respondents linked this to the implementation of more robust workforce planning measures, in order to better assess how many staff are needed to provide safe maternity services.
- A focus on improving the health and wellbeing of maternity staff, through more flexible working opportunities, a culture that values and respects staff and action to tackle unacceptable behaviours.
- Better support for students and newly qualified staff, including more investment in mentoring, preceptorship, CPD and career progression.
- Measures to increase entry routes into maternity roles, including enabling expanding programmes for nurses wanting to convert to midwifery, more development opportunities for MSWs and incentives for newly retired staff to mentor students and newly qualified staff.

12.14 Perhaps not surprisingly, staff respondents placed greater emphasis on improving pay and conditions, both as an immediate step and, longer-term, as a redress to the cumulative loss of earnings over the last decade.

13. Conclusion and recommendations

Conclusion

13.1 The evidence that we have collected in this report, paints a bleak picture of maternity and neonatal services that are understaffed, overstretched and letting down women, families and maternity staff, alike.

13.2 The collective testimony of women, healthcare professionals and stakeholder organisations highlight the negative impact that staffing shortages are having on quality and safety across the entire maternity pathway:

- During pregnancy, staff struggle to provide women with all the information that they need and this is creating uncertainties for some women about exactly how safe their care will be.
- On labour wards, staff are forced by an absence of senior and experienced colleagues to work beyond their scope of practice, creating unacceptably high levels of risk.

- In the days after birth, many mothers and families report feeling abandoned as staff are redeployed to assist core services and follow-up postnatal services are de-prioritised.
- Bereaved families are affected by staffing shortages because stretched staff have little time to support families, understand what their needs are or refer them to services such as psychological support.
- In neonatal care, staff are working at breaking point to provide minimum levels of appropriate care, and readmissions are increasing as a direct consequence of the reduced functioning of services such as breastfeeding support, critical care, and home visiting.

13.3 The extensive and wide-ranging impact of staffing shortages are also taking their toll on exhausted and demoralised staff, frustrated at the environment that is not always enabling them to provide care of the safest and highest quality and fearful about making mistakes that could have serious consequences for women and babies. Staff are caught in a vicious circle, as the more staff that leave, the greater the pressure is on those that remain, which in turn increases the likelihood that even more staff will choose to reduce their hours or leave the service altogether.

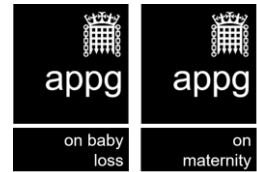
13.4 This makes it even more important that staff can develop their knowledge and skills, and undertake regular training alongside their multi-professional teams in safety policies and procedures. Unfortunately, evidence from respondents suggests that staffing shortages are severely limiting opportunities for professional development and making it harder to provide even mandatory, safety training.

13.5 While NHS employers are implementing some welcome initiatives to increase staff recruitment, there needs to be far greater focus on retention, on stemming the flow of staff who are leaving maternity services because they do not feel valued, or because they can get better hours and conditions working elsewhere or because they are simply exhausted and fed-up.

Recommendations

13.6 Having considered the evidence and particularly the ideas that staff, women and stakeholder organisations have proposed for tackling staffing shortages, the Baby Loss and Maternity APPGs recommend implementation of the following actions:

1. The following measures, recommended by the Commons Health and Social Care Committee and/or the Ockenden Review, should be implemented as a matter of urgency:
 - a. A multi-year, fully funded settlement for maternity and neonatal services.
 - b. The ringfencing of a proportion of the funding settlement for the training and development of maternity and neonatal staff. This should be sufficient to cover the back-filling of posts.
 - c. The establishment of and adherence to nationally agreed minimum staffing levels for maternity and neonatal staff.
2. Workforce planning for maternity and neonatal services must be firmly based on the needs of women, babies and families, in order to ensure that:



- a. Both core services, and key additional support services – such as breastfeeding support, home visiting and mental health services - are safely staffed.
- b. Maternity and neonatal staff are, as far as is possible, not redeployed or asked to cover different services.
- c. Staff have time to provide to provide both standard elements of care, such as observations, as well as more personalised elements, such as having the time to provide women and family with sufficient information to enable them to make informed decisions about their care.
- d. There is sufficient staffing across maternity and neonatal service pathways, to prevent unnecessary complications and reduce readmissions to hospital for mothers and babies
- e. There are enough staff to be able provide high quality bereavement care.
- f. There is time and space to learn from incidents and to implement changes.

3. The Department of Health, NHS England, and Health Education England (HEE) in partnership with the Royal Colleges should develop a national strategy for improving the retention of maternity and neonatal staff, to cover, among other things:

- a. Increased opportunities for flexible working for staff at all levels, and all stages of their careers.
- b. Continuing Professional Development and other training opportunities.
- c. Access to psychological and therapeutic support services.
- d. Action to tackle bullying, harassment, racism and other unacceptable behaviours in the workplace.
- e. Leadership development and support, and career progression.

4. Trusts/Boards should provide maternity and neonatal services with dedicated funding to ensure that all students are mentored and newly qualified staff undergo a period of preceptorship.

5. HEE to review and, if necessary, increase commissions for maternity and neonatal trainees beyond 2022/23. Within this there should be increased funding for midwifery apprenticeship programmes on the same basis as is currently available for nursing apprenticeship programmes. Consideration should also be given to expanding the number of places on shortened programmes for nurses wishing to retrain as midwives.

Appendix A: Survey questions

To what extent are maternity services affected by staffing shortages?

What are the principal factors that are causing staffing shortages?

What impact are staffing shortages having on the quality and/or safety of antenatal care?

What impact are staffing shortages having on the quality and/or safety of labour and birth?

What impact are staffing shortages having on the quality and/or safety of postnatal care?

What impact are staffing shortages having on the quality and/or safety of neonatal care?

What impact are staffing shortages having on the quality and/or safety of bereavement care?

What impact are staffing shortages having on the quality and/or safety of learning from incidents?

What impact are staffing shortages having on women and families experience of antenatal care?

What impact are staffing shortages having on the morale and wellbeing of maternity staff?

What impact are staffing shortages having on the training and development of maternity staff?

What impact are staffing shortages having on the recruitment and retention of maternity staff?

What measures are necessary to address staffing shortages in the short term?

What measures are necessary to address staffing shortages in the medium to long term?

Tell us anything else that you haven't been able to submit in the boxes above