Staffing

Concerns around staffing in midwifery are not new and have been well publicised. The additional scrutiny of maternity services following high-profile investigations including Shrewsbury and Telford Hospital and East Kent Hospitals has compounded this, with staff feeling pressured to go the extra mile.

In our 2022/23 State of Care report, we looked at the impact of pressures on staff on both the maternity workforce and people using services. We highlighted that while people using services appreciated that maternity staff were often doing their best despite being very busy, people often felt they were not a priority and did not get the help they needed.

Throughout our national maternity inspection programme, we have seen staff going above and beyond to provide compassionate care for women and their families under difficult circumstances. Despite this, we continued to find that many women were not receiving safe care because of the pressures on staff. Staff also told us that this meant they were not always able to provide the care they wanted to deliver.

Staffing levels

As the demand for maternity services continues to increase, the staffing levels need to keep pace with the changes to keep women and babies safe. Staffing levels depend on the acuity of individuals and the numbers of women needing care. During the programme, services used Birthrate Plus, a midwifery-specific national tool for calculating staffing levels and recommended numbers of midwives.

Delays in improving levels of staff affects the ability to provide safe, effective care. Pressures on staff, who told us they did not always feel respected or supported, meant that care was sometimes task-focused rather than patient-focused.

To keep people safe and ensure that people receive consistently safe, good quality care, we expect services to ensure there are appropriate staffing levels and skill mix. Through our inspection programme, we found variation in this area. Some services had good oversight of staffing levels. Managers in these services reviewed and adjusted staffing levels and skill mix in line with NHS best practice, with services often having enough staff with the right qualifications, skills, and experience to keep women safe.

We found that many services had a clear escalation policy to manage staff shortages and reduced bed capacity. This gave managers an awareness and oversight of staffing needs in each service area, so they could provide appropriate cover as necessary. Where managers identified the need for additional staff, members of staff could be moved between service areas, they could access on-call staff or community midwives could be recalled. However, this could affect women's choices, for example, they may need to suspend homebirth services. At one service, it was incredibly concerning to see how redeploying staff left one midwife caring for 13 mothers and babies on the postnatal ward. Following this inspection, we issued a Warning Notice, requiring the trust to make significant improvements.

Staff who were redeployed told us they were often moved to unfamiliar areas, which they felt affected their ability to care for women and their babies. We also heard that there was not always a sense of teamwork between units, which could make redeployment difficult for staff.

We found care was not always person-centred or dignified because of a lack of staff. For example, we heard from women who felt maternity staff were overstretched and overworked:

> "It was very obvious at times the staff were under pressure to manage all the patients on the labour ward. I noticed staff being pulled from the postnatal ward to work in other areas…. I felt sorry for them. I've heard from friends who have experienced the same as me. Not enough staff but everyone trying hard."

> "The triage midwife also spent a lot of time out of the room, looking for someone to hand over to, but everyone was in theatres. This meant it was just me and my partner left alone in the room, for long stretches during the birth. The triage midwife came back into the room for the final stage of the birth, but the labour midwife missed it entirely, due to being in theatres with other women. I totally understand that there were other women who needed her more than me, but for me, it felt out of control and unsafe."

A few services that struggled to maintain safe staffing levels indicated staffing shortages as a primary risk on the risk register. As highlighted in the section on leadership and culture, board-level oversight of key issues such as staffing is vital in enabling leaders to make effective decisions and drive real improvement for women. The importance of board-level oversight was also highlighted in the final report of the Ockenden review, which found that a lack of understanding by the board of issues and concerns resulted in neither effective change nor the development of accountable implementation.

Not having enough staff affected the quality of care they were able to provide and put women at risk. For example, at one service we heard how it was a normal occurrence for induction of labours to be delayed due to staffing issues. In some services, we found women having to wait for long periods for transfer to a labour ward once the induction process had started, and in some cases, there was a lack of effective monitoring during periods of delay. Trusts should be making sure women and their babies are observed closely and that regular assessments are carried out to identify and prioritise those at greatest risk. Where we have found concerns about delayed treatment – including induction of labour – we were clear with trusts that effective oversight of the issue is vital and that all action possible must be taken to mitigate any risk and keep people using the service safe.

Staff acting beyond the scope of their clinical practice

The complexity of maternity care has increased in recent years, with higher numbers of women needing higher levels of care, including high dependency care. As highlighted by the Royal College of Midwives, this demands more of the maternity workforce. Services need staff with the skills and expertise to look after people at each part of the pathway – from antenatal to triage, labour, and postnatally. At every stage, staff play a critical role in ensuring the safety of both mothers and babies, identifying early warning signs and making sure people understand what is happening to them. We know that the number of women with complex medical histories is increasing, which increases risk. In the UK, 1 in 5 pregnant women have multiple pre-existing long-term conditions. Studies have shown that maternal multiple long-term conditions are associated with adverse outcomes. Modern day maternity services have not always kept up with this change.

We were encouraged to see that a number of services, while recognising that midwives provide specialist care, also opted to provide training in high dependency care, which aligns to the midwifery proficiency standards. This enabled women who needed more intensive levels of observation (for example, those who had a postpartum haemorrhage) to stay close to their baby while being treated on the maternity unit.

There are currently no national training requirements for midwives in providing high dependency maternity care, which is defined by RCOG as "an intermediate level of care for pregnant or recently pregnant women where a higher level of observation, monitoring and interventions can be provided than on a ward but not requiring high dependency care/organ support." This is unlike general nursing, where there are competency packages and recognised training packages to ensure staff are appropriately trained to provide this level of care. While some trusts have intensive care outreach services that can care for women when they have babies, these generally provide advice rather than physical care.

Issues with staffing levels were leading to staff having to perform tasks or cover for roles that are outside of their training and not in line with national guidance. Although services were successful in developing innovative solutions to redeploy staff, in others this put women at risk. For example, we were concerned to see instances of unregistered staff acting as Surgical First Assistant (SFA)or scrub nurses, without proven competency.

We would expect everyone performing the SFA role to have completed training in line with national guidelines. We questioned if this practice was replicated in other NHS inpatient services, but were told it was unique to maternity. This is concerning, given procedures such as a caesarean section require the same level of skill and competence as any other surgery.

We identified staffing issues across the workforce, and problems were not limited to midwifery staffing. Where there were low numbers of staff, one trust used Foundation Year 1 (FY1) doctors interchangeably with more experienced FY2 doctors. It is important that services recognise that the FY1 training year is designed to enable medical graduates to begin to take supervised responsibility for patient care. They are not interchangeable with FY2 doctors who have developed more independence.

There were also some services who diversified their workforce by recruiting registered nurses to carry out tasks which fall outside of the protected function of the midwife role which makes it a criminal offence (other than in an emergency or during training) for any person other than a registered midwife or registered medical practitioner to attend to a woman in childbirth. Service leaders need to be assured that these registered nurses are not working outside their scope of practice, and how service delivery and outcomes are monitored in practice.

Training and development

The Health and Social Care Act states that "staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities."

While we saw evidence of good practice, we were concerned that staffing pressures meant midwives and junior doctors sometimes missed out on mandatory training and other learning and development opportunities because of the intensity and inflexibility of their rota. For example, staff discussed not receiving training to use the triage system.

In a number of services we found compliance levels for mandatory training were below the trusts' targets. Not completing mandatory training can negatively affect the safety of women and babies.

In one service, only 39% of staff had completed the Perinatal Institute's growth assessment protocol training, and 51% of all staff groups had completed the fundal height measurement training. This was against the trust target of 90%. The training supports staff in correctly identifying if babies are the expected size against gestational age. At the trust, we saw a number of incidents that demonstrated missed opportunities to identify babies who were small for gestational age.

Worryingly, we saw varying levels of completion rates of maternal and newborn life support training for midwifery staff, with low rates of completion in immediate life support (53%) and newborn life support (56%). This meant service leaders could not be assured all staff were suitably trained to respond to life-saving emergency situations, putting women and babies in their care at an unacceptable risk. In addition, we found a number of examples when staff were unable to describe the process of a birthing pool evacuation in an emergency or locate the necessary equipment.

Some junior doctors told us the intensity of their rota provided them with little or no learning and development opportunities as caring for women took priority. We also found the current workforce challenges meant supervision meetings and annual appraisal meetings were often postponed due to clinical work taking priority.

Junior medical staff told us that the inflexibility of their rota meant they were not always provided with protected or paid time for teaching, including mandatory training, and they felt expected to complete relevant training in their own time.

Staff wellbeing

As reported in our 2022/23 State of Care report, high demand and more pressure on services is continuing to affect the health and wellbeing of staff across all areas we inspect. In 2022/23, we continued to see high sickness rates for staff, with a high proportion of staff saying they felt sick as a result of work-related stress.

Throughout the maternity inspection programme, staff absence caused by sickness and other reasons such as maternity leave, has been a key barrier preventing services from reaching full staffing capacity. While many factors can contribute to high rates of staff sickness and absence, we identified some themes including stress, COVID-19-related absence, and short and long-term sickness.

Low staffing numbers because of high sickness rates can put additional pressure on staff who are able to work, contributing to low morale, exhaustion, and increasing the risk of burnout. Many members of staff told us that a lack of breaks and meal breaks was common, especially during night shifts. Some staff told us they felt unable to stop for a break due to safety concerns from staffing levels. We also heard about staff working late and/or working additional unpaid hours to support the safety of women. This is supported by a recent survey by the Royal College of Midwives, which showed that midwives and maternity support workers are working 100,000 unpaid hours a week to support maternity services. In addition, 87% of respondents did not feel their workplace had safe staffing levels.

While staff told us they had identified and reported these issues to managers and leaders, some said they felt their concerns were dismissed and ignored. It was concerning to hear from staff who felt that their job had become harder and that they were “pushed to the brink” and “emotionally exhausted”.

We expect providers to care about and promote the wellbeing of staff to enable them to provide, safe, effective, person-centred care. Some services were taking action to improve how they support staff, for example by introducing wellbeing coaches, employee support services and guidance on managing stress. However, it was not clear on the impact of these strategies on staff absence and sickness levels.

Workforce planning and recruitment

Recruitment and retention of staff remains a chronic issue for maternity services and presents a major national concern. It is vital that services can recruit to maintain safe staffing levels. Staff then need to be supported to carry out their roles with the appropriate levels of training on an ongoing basis.

Retaining staff is perhaps an even greater challenge. Sustainable improvement in this area requires further investment to support the wellbeing of staff, enable them to provide the level of care they want to deliver, and prevent them from being driven away by current pressures.

The Royal College of Midwives (RCM) has warned that staffing is the most important issue, which is placing unacceptable levels of pressure on staff and compromising the safety and quality of care for women. These issues extend to recruiting students to join the profession and there is work to be done to future-proof the maternity workforce, with data from UCAS showing that midwifery applications for June 2024 were at their lowest for more than 6 years.

Throughout our inspection programme, we have continued to see high numbers of vacancies. In some cases, services lacked enough maternity staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care and treatment.

NHS Resolution's Maternity Incentive Scheme is a financial incentive programme that aims to enhance maternity safety within NHS trusts and encourage them to implement essential safety measures. The scheme has numerous requirements for trusts to ensure effective midwifery workforce planning. However, we found some services had not fulfilled these requirements, for example by not following best practice when calculating the midwifery staffing.

Services identified high staff turnover as being associated with a lack of opportunities to progress to other roles. Although staff were promoted at one service, we still found issues with staffing shortages as the service had not replaced midwives it had promoted.

In an attempt to combat some of these issues, in 2022/23, the government announced that all maternity units would be given additional funds to increase supernumerary capacity and improve support for midwives, with a continued focus on retention and pastoral support activities. The majority of units we visited had a recruitment and retention midwife in post, whose role included:

- providing pastoral support to the workforce
- attracting new staff through proactive succession plans to address shortfalls in staff numbers and skills mix
- working with matrons and midwives to identify where improvements could be made to support staff retention.

Some recruitment and retention midwives collated themes from staff exit interviews to drive improvement. At one service, 18 members of staff who planned to leave had been retained as the recruitment midwife had identified what staff need and ensured the availability of clinical development opportunities.

In contrast to staff shortages, several services were found to have low vacancy rates and limited staff turnover, although no reason was provided as to how the service achieved this.

Reporting red flag events

The National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings' describes a midwifery 'red flag' event as "a warning sign that something may be wrong with midwifery staffing" such as delays in medical reviews and maternity triage difficulties. Nearly all the services we inspected reported maternity red flag staffing incidents in line with these guidelines. However, we saw inconsistencies in how these were recorded, monitored and mitigated. We noted that a few services had no red flag incidents within the reporting timeframe.

In addition, it was not always possible to identify in trusts' board papers whether maternity red flags were presented to the board. This could mean that boards were not fully appraised of the safety concerns women were experiencing.

We saw that maternity red flags were primarily associated with delays in care, with most red flag events identified as delays to induction of labour where one-to-one care was unavailable, or staffing or bed availability that was considered to compromise safe infant delivery for women. Some services aimed to prevent future red flag events through a review of planned admissions, enabling transparent conversations about activities within all units and discussing red flag incidents at safety champion and governance meetings to identify themes and learning.

Medical staffing

Reviews by doctors in triage are often compromised because middle grade rotas are hard to fill. The middle grade cover for triage is often (but not always) from the intrapartum team, who will prioritise intrapartum over triage unless the case is very urgent. Often, these doctors are also covering gynaecology emergencies from the emergency department. There is no dedicated national model of obstetric cover.

All units we inspected had adjusted the level of consultant cover to meet the requirements set out in the Ockenden Review recommendation to have 2 ward rounds in a 24-hour period. However, as we highlighted in our interim blog, we are concerned that the cover model is often fragile, and the rotas rely on every consultant being available and establishing a culture of escalation for support. While funding was provided following the Ockenden report, it was not enough to meet the demand from trusts.

We recommend NHS England:

- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.