Royal College of Midwives

NHS 10-year health plan consultation response

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The RCM supports the 3 shifts in this consultation, but many plans will need funding attached. Women's health has been historically underfunded, under-resourced and under-researched. The Secretary of State has himself stated Maternity services are the shame of the nation. Right now, NHS maternity services in England are failing too many women and failing the midwives, maternity support workers and other staff who work in them.

The 10-year Health Plan can address this, and to begin to close the gap for current and future generations. Maternity care is for many women the gateway to, and their first major interaction with, the NHS. Maternity care offers a great opportunity to influence positive health choices and to ensure babies are born with the best start in life. As such, investment in maternity care is an investment in the future health of the nation.

Every woman and family accessing maternity services should be able to trust that the care they receive will be safe and of good quality. Sadly, we know that this is not always the case, as evidenced by the CQC's national review of maternity services, published in September 2024, which found that almost half (47%) were required improvement for safety. This is symptomatic of the systemic pressures being exerted on services due to increasingly complex care, staff shortages, high levels of staff burnout and the poor quality of NHS estates for maternity services.

The Royal College of Midwives (RCM) believes that all of these issues are surmountable, and significant progress is achievable by working in partnership between organisations like ours that represent staff, NHS England, local Trusts and policymakers. Listening to staff, to those who can see how to improve outcomes but do not currently have the agency to effect change, is key, and the RCM is a very willing partner to make this happen.

Although health is a devolved matter, listening to and learning from the other home nations is important. The Enabling Safe, Quality Maternity Services report, commissioned by the Northern Ireland Assembly and published in October 2024, should be considered as a blueprint for maternity care with much to be learnt and considered across the UK.

The changes need not all cost money; in fact, we believe that they would save money. Two-fifths of all clinical negligence payments relate to maternity care a large proportion

of the NHS compensation bill[1].- around £1 billion annually. Running our maternity services on the cheap is proving a very costly mistake.

There are several core areas that, if committed to, could bring about significant and lasting positive change in maternity care:

The RCM supports the right staff, in the right place, with the right education and skills.

The RCM supports learning to listen and listening to learn to reduce inequalities.

The RCM wants maternity expertise in prevention and public health recognised and invested in.

The RCM wants to see the right staff, in the right place, with the right education and skills.

The safety of maternity services in England - Health and Social Care Committee - House of Commons report stated that the NHS has too few midwives. Government has committed to the ongoing increase in supply through increased student midwife training places however safe care isn't just about the numbers – it's about ensuring that the right staff are in the right place and that they have the right education and skills to provide the most appropriate care.

The RCM consistently hears from its members that many shifts are understaffed and that when this is the case, priority is given to supporting women in labour. When faced with the risk of care becoming unsafe due to an extreme lack of skilled staff to deliver care in labour, services pulling staff from antenatal and postnatal areas would seem to make sense, but it puts extreme pressure on antenatal and postnatal care. Fewer staff in these area's mean there is not enough expertise to recognise and escalate complications early, including the identification of perinatal mental health concerns. Suicide is the most common cause of death for women in the postnatal period, so having access to good perinatal mental health support early is imperative.

The RCM supports having the right staff in the right place reflects the need for increased specialist support.

There is an increasing number of women presenting with complexity, including significantly raised BMIs, increased age and pre-existing health conditions including diabetes and raised blood pressure Women with these preexisting conditions and black and Asian women in disadvantaged communities require more care, support and intervention, and require an increase in specialisms within midwifery. One stop diabetic clinics with specialist midwives and the wider medical teams have shown how this more collaborative intense provision of care can lead to reducing complications.

[1] 41% of all clinical negligence payments 2022-23, totalling £2.6 billion, relate to maternity (NHS Resolution annual report and accounts 2022/23)

This also has the benefit of advancing midwives' practice and gives midwives more reason to stay in the profession.

Workload and workforce planning

Surveying RCM members earlier this year, we found that midwifery staff in England worked a total of 118,000 unpaid overtime hours per week. It is no wonder staff frequently report feeling exhausted, stressed and burnt out. Unsurprisingly, morale and motivation are at rock bottom and highly skilled midwives and MSWs need to see their work valued with fair pay and recognition of the societal benefits of safe, high quality maternity services for the next 10 years and beyond

The RCM recommend retaining skilled, experienced midwives within the NHS is a priority.

There is a lot of focus on training more new midwives, and that is very welcome. But it is just as important - if not more so - to retain existing staff. Far better to keep an existing skilled, mid-career midwife in NHS employment than to spend three years to train a new midwife. It is only if we keep experienced staff in post that the new midwives, we are training help us grow the workforce, rather than simply replace those we are losing out the other side. Too often those running services have deployed long, inflexible shifts with little autonomy for staff to choose what works for them. The result has been stress and burnout, with many opting to leave NHS employment to protect their health and wellbeing as well as prioritising their family and home life. However, some Trusts have embraced new ways of working to offer staff greater flexibility and control over their working hours. There is evidence of improved retention rates and morale where such initiatives are in place.

Where such schemes are not available, some staff opt to work for the Trust 'Bank' which allows them to pick and choose their shifts flexibly. However, Bank rates should be negotiated between NHS trade unions and NHS employers, to ensure bank workers get paid and treated fairly.

The next generation in midwifery

Every maternity service is a teaching environment, with midwifery students undertaking clinical placements within them. To develop the next generation of midwives to be the experienced staff of tomorrow, it's imperative that they are able to be supported by the current generation. However, the RCM is aware that, due to staff shortages and intense workloads, students are not always given the level of support they need.

The RCM would ask that the clinical placement programme be reviewed to ensure it is working for students trusts and universities. The NET's survey for 2024 may give a wider indication of this need.

The increases in student places at university are welcome, in terms of growing the workforce, but we know that universities are struggling to support the additional numbers, both in terms of class sizes and facilities to teach them. As set out above, hospitals do not always have enough existing experienced staff in a position to provide them with a good quality clinical placement. Services also do not have the funded

establishment to employ them once they qualify as current staffing establishments do not always reflect the number of midwives required based on the complexity and acuity of women.

This is a particularly bitter blow when those students have accrued significant debt, both through tuition fees and maintenance costs. As set out in our recent State of UK Midwifery Student Finance report, increasing numbers of midwifery students are 'second career' or mature students. Because of the way in which maintenance loans and grants are made, those with families lose access to existing benefits and support for childcare costs.

The RCM is calling for the forgiveness of student debt after three years post-qualification working in the NHS.

Registered Midwife Degree Apprenticeships (RMDAs) are a proven NHS success story, supporting MSWs to qualify as midwives. Attrition rates are significantly lower than for other undergraduate midwifery courses and retention of those staff within 'home' Trusts is strong. However, there are impediments to RMDAs being rolled out more widely, because Trusts supporting an MSW to study as an apprentice are currently unable to access funds to support the salary gap created by the cost to replace the MSW. We believe money has been earmarked to fix this. This must be communicated to Trusts and the funding provided.

Learning to listen and listening to learn

The experience of working in and accessing NHS maternity care should be a positive one. However, recent reports have demonstrated that this is not always the case. Staff often cite poor behaviours and toxic cultures within the workplace, both between different parts of the multidisciplinary maternity team or between midwives themselves

Collectively, we must address these behaviours and support staff to create more cohesive, supportive workplaces.

The RCM asks that the process for speaking up in the NHS be strengthened ensure staff feel safe to speak up with their concerns and experiences be heard and learnt from.

Importantly we need to work to eliminate racism and other forms of discrimination listening to both staff and women and families. These create toxic workplaces, which drive staff out of the service.

The RCM wants all staff to be enabled and empowered to raise concerns about prejudiced behaviour in the workplace.

Partnership working needs to be a strong emphasis in the 10 year plan. Following a recommendation from 2022's Ockenden Review, the Progress in Partnership Maternity and Neonatal Working Group (PiP) chaired by the RCM and RCOG was created which brings together professional bodies, frontline staff and women, with a clear focus on improving maternity and neonatal safety – and it is delivering.

The RCM recommends partnership working, such as PiP, is a blueprint that should be replicated across more areas of NHS care, uniting everyone around delivering better healthcare.

Inequalities, prevention and public health

Maternity care offers a great opportunity to influence positive health choices and to ensure babies are born with the best start in life. As the most trusted healthcare professional for women during pregnancy, midwives can have a positive influence on the health of the whole family, including around smoking, healthier lifestyles and parenting skills. Appointment scheduling does not always support this and therefore a review of OPD appointment lengths may improve this.

The RCM recognises too that there is much-needed work required to address the significant inequalities of outcome and experience for black, Asian, disabled and neurodiverse women, and those from disadvantaged backgrounds and would want to see changes to inequalities feature heavily in the plan.

Inequalities

There are still significant inequalities of outcome for those from black, Asian or disadvantaged backgrounds. Well-trained, specialist staff make a substantial impact on narrowing the gap. Midwives can support an increased focus on prevention to support people to stay healthy and independent for longer and influence positive outcomes for life.

Prevention is a key area for improvement and should tackle health inequalities. Maternity care has some of the starkest outcomes where those inequalities can be seen. For example, in the latest UK-wide figures, published in October 2024, black women are three times more likely to die during pregnancy or shortly after than white women, and Asian women almost twice as likely to die.
Change in understanding and preventing inequalities needs to star early in education. The RCM's decolonising the midwifery curriculum toolkit and position statement on decolonising midwifery practice will help ensure midwives are taught and practise in a way that reflects the diversity of the communities they serve. Evidence shows that the lack of literature, education and training on the assessment of women of colour impacts the health disparities that black and Asian women experience, for example by not illustrating how some symptoms can present differently on the skin of a black woman compared to the skin of a white woman. Training and education must include information about how diagnosis can vary between women of different ethnicities.

The RCM also supports the call by the NHS Race & Health Observatory to create an open access library of images of black, Asian and ethnic minority newborns to support decolonisation.

The RCM believes policymakers should also ensure translation services are properly funded and ringfenced so that women for whom English is not their first language can provide accurate information to maternity staff and receive back the information and reassurance they need.

The RCM believes maternity services must understand and help address the social determinants of pregnancy outcomes, intervening to offer care according to need.

The MBRRACE report reveals that women living in the most deprived areas are more than twice as likely to die during the perinatal period than women who live in the least deprived areas this needs wider support from all Government departments.

Ensuring women receive the most appropriate care is paramount.

The RCM is supporting the rollout of a standardised Maternity Disadvantage Assessment Tool, the first of its kind, which can be used during routine midwifery appointments to enable midwives to identify social risk factors more consistently. Centralised support by NHS England for this rollout will help maternity services meet the needs of all women and families in an equitable way.

Migrant women are at higher risk of experiencing poor outcomes. A body of evidence shows that lack of entitlement to NHS care due to migration status is a significant factor in this, acting as a deterrent against accessing maternity services. Fear of unaffordable bills is leading women to delay accessing care or to simply avoid care altogether.

Women with disabilities, not only physical but including neurodiversity have expressed dissatisfaction with maternity care provision. Surveys have shown that often reasonable adjustments or accommodations had not been made for them. When reasonable adjustments are not in place, independence and dignity can be undermined. There is evidence that women have felt they were treated less favourably because of their disability, and their rights poorly respected.

The RCM recommends that services should be able to accommodate reasonable adjustments in pathways, including, where necessary, longer appointments. Policies and guidance should be produced jointly with women, including when services are being designed and periodic reviews of unit layout should consider how to improve provision for women with disabilities.

Maternity services need to be able to support women who are in the criminal justice system.

The RCM is clear: prison will never be a safe place to be pregnant. Pregnant women in prison are reportedly seven times more likely to suffer a stillbirth and more than twice as likely to have a premature birth. Women in prison must have equivalent maternity care to that of women on the outside, yet they are almost twice as likely to miss obstetric appointments. Delays to treatment and the lack of care that has been shown, following a number of tragic incidents, constitute a gross violation of women's rights and reform needs influence from the NHS.

Prevention and public health

Smoking is strongly associated with socioeconomic status, with women experiencing deprivation six times more likely to smoke than those that are not.

Smoking in pregnancy is directly linked with preterm birth, stillbirth, sudden infant death and many long-term health conditions. Smoking also damages a mother's health and is associated with maternal risks in pregnancy, such as placental abruption and eclampsia.

The RCM asks that, while acknowledging the number of women who smoke during pregnancy is slowly reducing, continued NHS commitment to specialist stop smoking

services must continue, including sustainable funding and having services embedded within all maternity services. The RCM supports innovative measures, such as financial incentive schemes, which assist women to quit.

Additionally, NHS staff who smoke are more likely to have sickness absence, which can significantly impact on delivery of care and workforce planning.

The RCM welcomes the plan by NHS England to extend smokefree zones on hospital grounds, both as a benefit to staff and those accessing services. In addition, we would like to see the stepping up of initiatives to help NHS staff to stop smoking, including allowing staff to participate during their working day

Breastfeeding provides an opportunity to address health inequalities, but women need proper support to start and sustain breastfeeding, conferring significant health benefits for both mother and baby. Maternity services should be sufficiently resourced and staffed to enable antenatal and postnatal care provision to support women to make informed choices on infant feeding.

With a predominantly female workforce, and due to the nature of their work, maternity services should be a positive place for pregnant and breastfeeding staff. However, surveys of our members show that facilities are often inappropriate – such as toilets for breastfeeding or expressing – or non-existent.

The RCM would like to see a strengthening of ACAS guidance on breastfeeding in the workplace and enforcing compliance with health and safety law and the Equality Act 2010.

In recent years, food insecurity has more than doubled in the UK. Studies have shown that women experiencing food insecurity are up to four times more likely to have poor mental health. It is also associated with an increased risk of obesity, developing diabetes during pregnancy and with dental problems. Healthy Start is an existing scheme that supports qualifying pregnant women and young families to eat well and get the vitamins they need for healthy development.

The RCM recommends the Healthy Start scheme is reviewed, specifically in relation to eligibility criteria, barriers to claiming and voucher value. It should be increased in line with inflation and be benchmarked with other benefits in future.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Historically, some elements of maternity care have been provided in the community. However, access to care has reduced dramatically with the removal of midwives from many GP surgeries and the closure of community-based health care. Because antenatal appointments are often complex, they are now more likely to take place in centralised facilities and the significant reduction of community-based models has also led to this. Currently, this means hospital-based maternity services, but could, in future and with the right levels of investment, include an expansion of community-based women's health hubs and support the models of care required.

Women's health hubs

The RCM asks that in order for women's health hubs to be developed, there needs to be long-term sustainable funding for the national roll-out of hubs. Part of the investment needs to be focused on training and development of the healthcare professionals working in hubs, so that they have the necessary skills to deliver high-quality care and ensure the long-term sustainability of hubs.

Hubs should be supported to provide end to end care in some core aspects of women's health, particularly in those core aspects of women's health where there have been long-standing barriers to access. These include contraception (including postnatal contraception), menopause care, medical and conservative management of menstrual health and gynaecological conditions, pre-conception and fertility health support and pelvic floor care. The reestablishment of shared information between GP's and midwives would improve care, women's feedback is that they have to tell their story more than once so data sharing would prevent this and improve risk assessments.

Consideration should be given, once hubs are able to deliver against the core elements of women's health, as to whether additional services could be integrated into the women's health hub model. This could include a greater focus on prevention or co-location of antenatal and postnatal health services such as midwifery-led antenatal clinics, maternal mental health and breastfeeding support, with the primary focus of moving services closer to where women live and work. There will need to be appropriate system oversight, to ensure the right level of coordination and collaboration across women's health hubs, family hubs, maternal mental health networks and other local and regional services and networks.

Estates

The existing community staffing model for maternity care is well established however existing estates across community and hospital requires investment if progress is to be made to undertake more care outside of the acute setting. There has been significant underinvestment in the estate over decades. Reports by the CQC and the Kirkup Review of East Kent identified this in acute services as well and have cited rooms that are too small to house vital equipment, leading to significant safety concerns, while bays and single rooms are too small to house larger bariatric beds required for many women. While some Trusts work effectively in community settings, improving access to ante- and postnatal care, there is little integration, with women directed to hospital for all appointments, adding to the strain on both them and the estates.

The RCM recommends investment is not diverted away from existing funding commitments that are intended to upgrade maternity services and facilities. Current workforce challenges neglected and outdated estates and measures to address health inequalities continue to be urgent priorities and enablers to transfer of care.

Bringing care closer

Taken together, these solution measures can all contribute to improving the quality and safety of services both in the acute and community settings and to giving babies the best possible start in life. However, the ultimate success of these policies also rests on ensuring that implementation is underpinned by:

- a culture that places women at the centre of their care, listens to their questions and concerns, understands what they want and need and tailors' services accordingly. Giving women the time to discuss and consider the options available to them and empowering them to make their own decisions must be the golden thread that runs through all these policies.
- commensurate levels of funding for modernising estates and facilities, upgrading equipment and, above all, investing in the recruitment, retention and development of the maternity, neonatal and early years workforce.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Better use of technology in maternity care could significantly improve women's experience of services. This is particularly true in terms of a single, universal digital record, which could ensure that women do not have to give multiple accounts of prior potentially traumatic events or information. It would also assist consistency of care and ensure that women's choices are understood and respected.

However, midwives' and MSWs' experience of current digital systems is poor. They report inconsistent use of digital systems across the country with multiple maternity IT systems leading to lack of interoperability across maternity settings. This can lead to a reduction in effective audit to support quality developments in services and lak of transfer of vital details for women.

There is insufficient funding to develop and training to implement new technology effectively. In addition, many community midwives and MSWs have reported issues with lack of quality computer hardware and connectivity across remote and rural areas. Even for those based within hospital settings, simple things, like having access to a working mouse or a printer, can significantly impact the ability to utilise digital options. Therefore, an enabler is getting the basics right first

There is also an opportunity to use digital platforms to address women's concerns, answer questions and, where necessary, triage women's care. This could help improve women's access to and experience of maternity services, while reducing the impact on in-person attendance. This alleviates stress and anxiety for the women and frees up staff time.

The RCM would welcome improvements in access to diagnostic tools in maternity care. Alongside this, though, there is a requirement to improve and grow the training opportunities for sonographers.

An expansion of a standardised specialist digital midwife role could help to unlock many of these challenges, developing a clear career pathway to retain talent and grow future digitalised maternity services. They would act as an advocate for greater digital integration in maternity services and help drive digital transformation and innovation to improve outcomes for mothers and their babies.

This digital transformation could also support improvements to data analysis and disaggregation to review access to care by black, Asian and the most disadvantaged women and determine pathways to improve access for women.

The RCM would want effective data utilisation to inform strategic decisions and maximise the potential use of data driven AI, such as clinical decision support.

It is important to recognise, though, that while digital transformation presents many opportunities, there are also issues of digital poverty, particularly among those from disadvantaged backgrounds, migrant women or women in prison. Extreme care needs to be taken not to exacerbate the inequalities these women already experience.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

As stated previously, maternity services often serve as the front door of the NHS for women, for whom pregnancy may be their first healthcare interaction.

The RCM asks that the plan acknowledge the long-term impact of midwifery intervention in pregnancy on the health and wellbeing of babies through to adulthood something that is acknowledged by the World Health Organisation.

Tackling causes of ill health

Prevention is multifactorial and complex and some of the solutions lie outside maternity services. Women experience a range of health determinants that impact on outcomes. These include access to housing, community safety and exposure to safe air quality.

- Addressing wider societal issues is essential and a considerable challenge and requires wider support and initiatives across Government departments.
- The RCM advocates for more funding and resource allocation to underserved areas, ensuring equitable access to high-quality prenatal and postnatal services.
- Supporting midwives in developing skills to engage with and support women from deprived communities, as well as promoting continuity of care for the most deprived women, could be vital steps.

Supporting perinatal mental health

Strengthening perinatal mental health is part of the solution but access to care in community settings is a blocker. At least one in five women will develop a mental illness during pregnancy or in the first year after having a baby, ranging from anxiety and depression to more severe illness. Black and minority ethnic women, young mothers, those facing domestic abuse, multiple disadvantages or pregnancy and baby loss experience particularly poor outcomes associated with mental ill-health. The human cost of failing to care for women, babies and families affected by mental ill-health is undeniable; there is also a substantial economic and social burden on society, with untreated maternal mental illness estimated to cost the UK as much as £8.1bn for each annual cohort of births in the UK.

Despite perinatal mental illness being the most common health complication during or after pregnancy, women can find it hard to access the right care, due to variations in the availability of services, the lack of specialist midwives or because the nearest perinatal mental health service is far from a woman's home.

Making perinatal mental health support more accessible does not have a single solution. In part, it requires a reduction in the stigma that, despite some improvement, still exists around mental ill-health. It also needs investment in the training of staff to spot and/or signpost to appropriate care, including ensuring that there are well-resourced teams of specialist perinatal mental health midwives and health visitors in every area, delivering services that meet national quality standards and align with the ambitions in NHS England's Long-Term Plan.

Some Trusts have already set up successful outreach programmes, many of which sit outside the hospital site, to support those experiencing perinatal mental ill-health. Sharing of these examples by the Department of Health & Social Care and/or NHS England could encourage others to establish similar projects.

The case for supporting and enhancing women's mental health during pregnancy and after birth could not be clearer. Creating positive change for all women, babies and families impacted by perinatal mental illness will require implementation of the following priorities:

The RCM asks that for additional investment in universal services, with training and education to support midwives and health visitors to skilfully discuss and assess mental health at every routine contact.

- Maintaining funding for services that support women experiencing trauma and baby loss.
- Tackling health inequalities in maternal mental health care, through targets to reduce disparities in maternal deaths, a commitment to a trauma-informed approach to service provision and equipping all staff to address the mental health and social needs of women.
- Improving data collection and transparency, to better demonstrate where progress is being made and identify where gaps in the provision and quality of services remains.

The RCM urges policymakers to ensure that the care all women receive within maternity services are responsive to the needs of each woman. Maternity services must have the necessary resources and capacity to ensure that all women receive fair and equitable treatment from maternity services. This includes ensuring that midwifery education and practice includes information about how diagnosis can vary between women of different ethnicities, reducing the risk of signs being missed or diagnoses being wrong.

Thanks to Government action, pregnant women are exempt from prescription charges, charges for NHS dental care and NHS optical care. It is imperative that women are made more aware of these benefits, as they could help address underlying health issues early. In addition, programmes such as Healthy Start could be expanded and more widely and accessibly promoted to address poor diet and food insecurity.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do, that is in the next year or so:

- Invest in recruitment and retention supporting growth of apprenticeship programmes through salary support funding.
- Review workforce establishments in line with increasing complexity and acuity.
- Continue to work in partnership to reduce the discrimination and poor culture in the NHS.
- Publish and act on the NHS Estates Survey and reinstate staff rooms and private spaces for staff to debrief.

In the middle, that is in the next two to five years:

- Planning education trajectories to meet the increased workforce needs to be identified in the establishment review.

Long term change, that will take more than five years:

- Fit for purpose estates planning that accommodate current service provision and future requirements for moving more care to community.