Royal College of Midwives - Written evidence (PRT0051)

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents most midwives and maternity support workers (MSWs) in the United Kingdom. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives and MSWs. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

Midwives are the closest clinical leads providing prevention guidance, surveillance and support to women and birthing people during pregnancy and birth. It is for this reason that the RCM believe it is well placed to respond to the House of Lords Preterm Birth Committee's call for evidence.

The RCM is aware of the strong association between ethnic and socioeconomic inequalities and preterm birth[1] and therefore welcome the focus of this inquiry to improve care for groups most at risk. Multiple contributory factors have been identified in relation to preterm birth and given its complexities, the exact causes are often not fully understood.

This response will focus on two key areas where evidence shows clear differences in outcomes; midwifery continuity of care and smoking. It will briefly outline workforce issues and student midwife education, and conclude with a number of policy recommendations.

Midwifery continuity of care

The evidence supports continuity of midwifery care in reducing the likelihood of baby loss and preterm birth.

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[1] Preterm labour and birth (nice.org.uk)

Research evidence from a Cochrane review has demonstrated that continuity of midwifery care can reduce the incidence of preterm birth and baby loss, and recommends this model of care for women at high risk of preterm birth[2]. To confer the most benefit, this should be continuity from a named midwife within a small midwifery team, to provide care throughout the antenatal, intrapartum and postnatal continuum. This should be complemented by oversight and coordination from a multidisciplinary team, specialising in the prevention of preterm birth in a clinic for subsequent pregnancies.

A study conducted in a deprived, diverse inner city London population has shown that preterm births were reduced by approximately half for women allocated to a continuity of midwifery care model, compared to traditional care[3]. Preterm births are higher, in absolute numbers, in racialised minority women, and this cohort had a marked trend reduction in births under 34 weeks (7.2% - 1.8%) compared with white women (2.0% - 1.2%) when receiving caseload midwifery care.

In working towards safer care, the NHS set a goal to implement midwifery continuity of carer for all women in England. However, despite the evidence of improved outcomes associated with this model of care, implementation has since been paused due to the enormity of the pressures with the workforce and achieving safe staffing levels. Currently, individual providers must establish which of their own population groups will benefit most from receiving continuity of midwife care and prioritise meeting needs appropriately, within the constraints of local workforce planning.

The Royal College of Midwives has repeatedly called for sufficient resources to be secured, for maternity services to implement safe and

[2] Ways to help pregnant women avoid preterm birth | Cochrane

[3] Can birth outcome inequality be reduced using targeted caseload midwifery in a deprived diverse inner city population? A retrospective cohort study, London, UK e049991.full-2.pdf

effective continuity of carer pathways for all women accessing maternity services in the UK.

Smoking in Pregnancy

Smoking during pregnancy is a leading yet preventable cause of adverse prenatal and birth outcomes, with known detrimental health implications during childhood[4]. Midwives are perfectly placed to help women who smoke to quit, with all the health benefits that has for women and newborns.

The Saving Babies Lives Version 3 Care Bundle (SBLCBv3) has prioritised reducing smoking in pregnancy[i]. This is because of the strong evidence that reducing smoking in pregnancy reduces the likelihood of miscarriage, premature birth, stillbirth, low birthweight and Sudden Infant Death Syndrome (SIDS)[5].

Smoking is a modifiable risk if women and birthing people are provided with appropriate support. Trusts are advised to offer treatment from an in-house trained tobacco dependence adviser, however, the RCM is concerned that not every Trust is following this guidance. It is aware that variable arrangements currently exist for delivering services; some sit 'in house' with Trusts, some are provided by local authorities, others are out-sourced to an external provider.

In maternity services, responsibility for smoking cessation work is often held by a public health specialist midwife, alongside wider responsibilities which may include weight management or vaccination, for example. Where smoking support is an adjunct to other work, it has been reported that attrition rates amongst women are higher. Also, in areas where stop smoking support is not provided in-house, referrals can be difficult to track, data unreliable and outcomes may not be learned.

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[4] Smoking Cessation Support for Pregnant Women Provided by English Stop Smoking Services and National Health Service Trusts: A Survey (ash.org.uk)
[5] NHS England » Saving babies' lives: version 3

Greater Manchester is a good example of guidance implementation, where a stop smoking adviser lead is based in every trust. Data shows twice as many women stop smoking in this region, compared with the national average. Smoking at time of delivery (SATOD) rates in Greater Manchester have reduced by over a third, from 12.6% (2017-18) to 9.4% (2022-23) and this is despite the challenges of Covid pandemic.

The sustainability of services is raised as a concern, with funding streams that lurch from one year to the next, with uncertainty building in between. Staff will often leave a specialist role, due to the job insecurity, losing knowledge and skills from the organisation.

Smoking cessation midwives are a perfect example of the benefits that care continuity can offer. Midwifery-led continuity of care, where it is properly resourced, has been shown to improve outcomes for socially disadvantaged women[6]. Smoking is a stigmatised activity, associated with social deprivation and women need to build trusting relationships with their midwives. This enables them to access appropriate support, in the form of very brief advice (VBA), carbon monoxide (CO) monitoring and wrap around services.

Due to feelings of guilt and shame, we know that some women are reluctant to attend stop smoking advice clinics. They need appointments to take place in their own home, for privacy and confidentiality. Band 3 and 4 advisors, who are not midwives, but are also responsible for delivering essential care and support with smoking cessation, are unable to dispense nicotine replacement products in premises other than those NHS or approved settings. This puts a barrier in the way of seamless and effective care.

Specialist midwives' time is not protected and often they are pulled in to support a unit that is struggling with staffing numbers. This leads to midwives running clinics all day, where they are providing care to women

[6] Ways to help pregnant women avoid preterm birth | Cochrane

and support with smoking cessation, then being called in to cover staff shortfalls overnight. This is having an impact on the quality and safety of maternity services and on staff retention.

Tasks associated with smoking support, such as the provision of VBA and CO monitoring are low down on the list of priorities when services are under pressure. Time is very limited at antenatal appointments to provide VBA and support with stopping smoking, together with the required screening for CO.

Workforce and Student Midwives

We have a long-standing workforce crisis in maternity services, which is taking time to resolve. Although the birthrate in England and Wales is falling[7], maternity care is becoming ever more complex[8]. Although the number of midwives is now slowly rising, this improvement in staffing follows several years of it being quite static. The latest estimate (based on a recognised formula, calculated by Birthrate Plus) shows a shortage of 2,500 midwives in the NHS in England, although this figure will be updated in the summer, when birth statistics are published. The RCM is advising on measures that will improve both recruitment and retention of midwives[9].

The number of midwifery students across the UK has increased significantly over the last decade, which the RCM welcomes[10]. However, there are worrying signs that the pipeline of future midwives is also suffering from retention issues. A growing tide of students leave midwifery courses before they graduate. In 2021/22, around 15% failed to complete their degree, with reasons given that include ill health, caring responsibilities and financial hardship.

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[7] Births in England and Wales - Office for National Statistics (ons.gov.uk)
[8] RCM Position Statement: Safer Staffing rcm_position-statement_safer_staffing.pdf
[9] rcm_-how-to-fix-guide_-28-feb-2024.pdf
[10] rcm-state-of-midwifery-education-2023.pdf

New midwifery apprenticeships, primarily for maternity support workers (MSWs) already working in the NHS, are proving to be a real success, enabling those from a broader range of backgrounds to qualify. The RCM supports the UK Government's plans for 5% of new midwives to enter the profession in England through apprenticeships by 2028.

All midwifery students are required to undertake a short placement in the neonatal unit during their pre-registration education course. The length of time is no longer stipulated – in reality, this is often only a week or two weeks. Although students are likely to see or care for newborn infants who are preterm during this time, this is not a requirement and not stipulated in the NMC standards[11] or EU Directive.

Post-registration midwives may choose to work in a neonatal unit and may then be required to undertake additional training. However, there is no longer a standardised programme of education for neonatal practitioners (this ceased in 2004 when the NMC became the regulatory body). Each Trust will stipulate the training that their neonatal practitioners are required to do – some practitioners, including midwives, will have no additional training and will learn 'on the job'.

Recommendations

- Dedicated funding should be ringfenced to ensure adequate staffing and resource allocation, sufficient to provide workforce numbers to allow roll out of continuity of midwife models of care, starting with those most at risk of preterm birth.
- Trusts should be supported to assess population groups who would most benefit from receiving continuity of carer throughout the perinatal period.

[11] NMC Standards for Midwives https://www.nmc.org.uk/standards/standards-for-midwives/standards-for-pre-registration-midwifery-programmes/

- Trusts should be encouraged to promote working patterns and practices that support the work life balance of staff.
- Streamlined and sustainable stop smoking services need to be firmly embedded within all maternity services.
- Dedicated stop smoking leads should offer women and birthing people sufficiently resourced support in every Trust.
- Specialist midwives should have protected time for their roles and not be used to cover staffing shortages.
- The restrictions around dispensing of nicotine replacement products is an obstacle that should be removed, with clearance from the MHRA.
- There needs to be a clear and standardised proficiency within the midwifery education standards, to ensure students have the appropriate knowledge, skills and experience in relation to preterm birth.

27 March 2024

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[i] Saving Babies Lives Version 3 A care bundle for reducing perinatal mortality PRN00614-Saving-babies-lives-version-three-a-care-bundle-for-reducing-perinatal-mortality.pdf (england.nhs.uk)