Delivering next generations

The psycho-social, economic and political impact of COVID-19 on women and the future midwifery workforce

The COVID-19 pandemic presents many challenges for political leaders and healthcare systems. There is strong evidence to suggest that during crisis, women are most affected. Experts in the field of midwifery and human rights are concerned at how women and families have been treated from the beginning of the pandemic. As new guidelines emerge on COVID-19 that reinforce women's choices during pregnancy and childbirth, women continue to be frightened to go to hospitals and be alone during labour.

In the UK, the impact of years of austerity and gaps in the healthcare workforce are more visible than ever. Limited resources in the maternity services have forced some to close and governmental agencies to develop strategies to rapidly increase the workforce. Midwives are advocates of women's rights. If midwives, including those aspiring to become one, are not protected now, who will protect women and do their jobs in the future?

Midwifery workforce before, during and after COVID-19

There is no doubt that the novel coronavirus pandemic has come with many challenges worldwide. In the UK, an already weakened healthcare system has been exposed. The impact caused by years of underfunding services and unmet promises from political discourses on the social and healthcare structures is now more visible than ever. In 2019, the government published the 'NHS Long term plan' (2019b) to guide how the NHS in England would develop for the next decade. It was encouraging to see that maternity care was placed front and centre in the plan. The plan maintains the commitment to the maternity transformation programme ([MTP], 2015) and the key pledges: continuity of carer for most women by March 2021 and a reduction by 50% of the rates of stillbirth and neonatal and maternal deaths by 2025. However, some experts criticised the absence of a comprehensive workforce implementation plan as a major flaw. This makes it hard to judge how realistic some of the commitments are when there is no indication of how these will be supported by strategic workforce planning (Walton, 2019).

In March 2015, Simon Stevens, chief executive of NHS England, announced a major review of maternity services following the publication of the 'Five year forward view' in 2014 (NHS, 2014). Baroness Julia Cumberlege was asked to independently lead the review, working with a panel of experts and representative bodies. The scope of the review was to assess current maternity care provision and consider service development to meet the changing needs and demands of women and families. The resulting report, 'Better births: improving outcomes of maternity services in England – a five year forward view for maternity care', was published in February 2016 (Better births, 2016).

Subsequent work, including development of the 'Maternity workforce strategy' was conducted through the MTP board. This has brought together Health Education England (HEE) with NHS England, the Department of Health and Social Care, NHS Improvement, Public Health England, the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and other organisations. This strategy aims to reduce maternity services' pressures and grow the current workforce in order to continue to meet the needs of mothers and babies in the future. To secure the supply of staff, they proposed to increase pre-registration midwifery education places by 25% from 2019 (HEE, 2019).

Midwives play a crucial role in coordinating and navigating maternity care. They are the lead health professionals in maternity services and contact for women. They advocate for women's rights and support them to make informed choices throughout pregnancy, childbirth and the immediate postnatal period. Consistency on the midwife and clinical team that provide care enables effective coordination as well building positive relationships between women and the service providers. Research studies have linked continuity to improved health outcomes for mother and baby, as well as greater satisfaction with care (Sandall et al, 2016). It is therefore vital that maternity services have the right numbers of people in the right place with the right competencies and expertise to achieve this.

Estimated midwifery numbers

Data collected by HEE from NHS providers in March 2016 indicated a total demand for approximate 24 353 midwifery posts (in terms of whole time equivalent [WTE]) to meet population demand in England. This figure suggests a broad ratio of one midwife for every 27 births. When the number of midwives not on active assignment is also considered (ie because of a vacancy or long-term leave), there are about 9.3% of posts where a permanent midwife is not available to work in the NHS. To close this gap and deliver flexibility to cover staff who are not on active assignments, HEE suggests that the country would need between

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1 050–2 386 WTE midwives more than are currently projected to be available to the NHS in 2021 (HEE, 2019). In line with the secretary of state's 2018 announcement, HEE proposes to expand midwifery training placement numbers by 25% over four years (Department of Health 2019), with the first 650 places starting in from 2019 and up to 1 000 places for a period of three years thereafter (HEE 2019).

This intervention is expected to increase capacity. However, further challenges that need to be explored include completion of the training and the retention in employment of already qualified staff. A survey conducted by the RCM in 2016 found that the reasons that made midwives more likely to leave their jobs were lack of staffing, size of workload and not having enough time to provide care (RCM, 2017). The recommended actions from HEE to retain experienced and skilled staff require new approaches to flexible working as well as addressing issues that affect staff well-being and welfare. Local maternity systems need to work closely with their midwifery workforce to ensure employment and working conditions reflect the new ways of working to deliver continuity of carer (HEE, 2019).

It seems clear that England is short of midwives and the situation has openly been acknowledged by the government. In 2018, the RCM estimated, based on the number of births and the number of staff in post, that the country's NHS was short of the equivalent of 3 500 full-time midwives (RCM, 2018). Although the government's commitment to train an additional 3 000 midwives was welcomed, little attention was paid to ensure enough midwifery lecturers and clinical placements to mirror this steep change in training numbers, the impact of the abolition of bursaries and the introduction of university fees. Furthermore, the challenges posed by Brexit on the workforce should not be overlooked.

In March 2018, there were 1 701 midwives who had trained elsewhere in the European Economic Area and who had registered with the Nursing and Midwifery Council (NMC) to practise in the UK. The number coming to the UK has collapsed since the referendum in 2016, standing at just 33 in the 12 months to the end of March 2018. The number leaving has increased, with 234 leaving in the same period (RCM, 2018).

COVID-19 and the context of those numbers

Healthcare providers and governmental agencies have focused their efforts to consolidate contingency plans in order to increase service capacity, current workforce and reduce pressure on health facilities. The attempts to rapidly increase the numbers in the workforce have shed light on the shortages of midwifery staff.

In response to the ongoing COVID-19 pandemic, the NMC (2020b) has published a joint statement on expanding the midwifery workforce during the COVID-19 outbreak. The actions set in the document support the establishment of a COVID-19 temporary emergency register and invite those midwives who have left within the last three years to opt in, encourage those midwives who are currently on the register but not working clinically to consider clinical practice during the pandemic and change the nature of the programme for undergraduate midwifery students so that they can opt to undertake their final six months of their programme as a clinical placement.

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The NMC (2020a) has developed and published a set of emergency standards for nursing and midwifery education to provide approved education institutions (AEIs) and practice learning partners with the flexibility to enable students within their final six months to complete their training within clinical placements, while ensuring all learning outcomes are met. In addition, the standards include reference to second-year students and how they could also contribute to the needs of the workforce. The document states that second-year students may spend no more than 80% of their hours in clinical placements and 20% of their hours in theoretical learning. The document supports AEIs to be able to adapt their programmes in a way that supports students and offers flexibility for the workforce.

The document also acknowledges that 'during the state of emergency and the pressures on the health and care workforce, supernumerary status of students may not be possible', and states that 'to ensure students still get the support and supervision they need to learn, protected learning time must be provided' (NMC, 2020a). Challenges might arise when NHS Trusts interpret guidance from different perspectives and their ability to recognise students' additional experiences (positive and negative) and specific support needs (Hunter et al, 2020). How this support will be achieved in overstretched services where midwifery staffing is already low and under pressure is difficult to know.

Midwives continue to meet unprecedented circumstances for which they might not feel well-prepared. Same applies to student midwives, preparing them to work in emergency situations while reducing their risk of infection and meeting the needs of women and maternity services is a challenge.

Lessons learned from the Ebola outbreak highlighted how practice had been affected by the emotional burden midwives felt fearing to get infected and their sense of duty to step into risky situations. Motivation and support available impacted the ability of the midwives to cope in challenging circumstances (Erland and Dahl, 2017). However, similarities have been reported in a recent survey from the UK on nursing and midwifery staff: 'Initial findings show that individuals do not feel adequately prepared for the pandemic and are concerned about the risk to themselves and their families' (ICON, 2020).

Student midwives are facing unprecedented pressures in both their personal lives and midwifery education. From being withdrawn from clinical practice to adapting to remote learning and opting in or out of an extended clinical

placement, the landscape of midwifery education in the UK has drastically changed. Support needs to be available for student midwives and training in place to prepare them for unprecedented circumstances. Research that identifies student emotional and educational needs is desperately necessary. Leadership is important both clinically and academically in addressing the workforce needs (O'Connell et al, 2020).

In December 2019, the government announced a financial grant of at least £5 000 for student midwives as part of the commitment to increase the numbers by 2025 (Prime Minister's Office, 2020). Efforts to support the workforce and healthcare programmes in times of crisis are welcomed but further economic investment is needed to support individuals and the research and academic curriculum gaps that need to be addressed (Hunter et al, 2020). Without nurses and midwives there would be no healthcare. But meeting these aims will require a re-calibration of education, workforce planning and investment levels to ensure protection to these health workers.

For midwifery, recognition of their full breadth of skills, knowledge and care of the health of women and communities remains a challenge. The 2021 'State of the world's midwifery report' (International Confederation of Midwives [ICM] and United Nations Population Fund [UNFPA], 2019) should provide a picture of progress on the global call to action issued in 2014 to ensure that midwifery be supported by quality education, regulation and effective human and financial resource management (UNFPA et al, 2014). Crucially, there remains a need to champion midwifery as a profession and ensure that all women can have access to these services (Lancet, 2020).

COVID-19, pregnant women and families

The COVID-19 global pandemic has had an impact on the maternity services but also on those using them. At a time when pregnant women and their families might be experiencing fear and anxiety of the uncertainty, personalised and safe midwifery care could play a key role. The majority of women are healthy and are currently experiencing a life event that may bring extra clinical, emotional and social needs. Unfortunately, lack of preparedness and resources of the healthcare system, together with scarce evidence of what could work, has left many women and families without the recommended care and short of options of where to give birth.

Experts in the field of midwifery care and human rights all across the globe have been alarmed at how women, babies and families have been treated from the beginning of the pandemic. Concerns have been raised following the cascades of stories reported in the media of the traumatic experiences women are going through during pregnancy and childbirth. Women's voices have been ignored and midwives expertise has been overlooked.

As new guidelines and evidence emerges on COVID-19 that reinforce the importance of choice of birth place and birth partner, encourage skin-to-skin and early breastfeeding establishment, very different stories continue to occur all across the world. A survey to heads of midwifery and midwifery directors in the UK, conducted by the RCM at the end of March 2020, found that services that were struggling with staff shortages even before the outbreak have seen their vacancy posts now doubled. This means that about one in five staff posts are currently unstaffed.

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In addition, over a fifth (22%) of the survey respondents reported that local midwife-led maternity units had been closed, with more than a third (36%) of areas also either stopping (32%) or restricting (4%) home births. In 11 cases, the midwife-led unit had been closed to provide facilities to assess or care for coronavirus patients. The RCM stated:

> ***'What this survey shows is that coronavirus is exposing the gaps that already exist in maternity services. The shortage of midwives has doubled since the start of the outbreak, a situation which is only likely to worsen as the pandemic spreads further.'***

This situation has not only increased health inequalities across the UK but also created unjustified fear and stress amongst service users, potentially having detrimental effects on women and babies. Birthrights, a human rights charity, called on the government for the protection of UK women in childbirth during the national emergency. The organisation warned that 'the withdrawal of home birth and birth centre services could be unlawful and lead health trusts to be responsible for significant risk to life if women choose to give birth without medical assistance' (Birthrights, 2020).

Despite national and international guidelines supporting women's choices of birth place, safe midwifery care and birth partner support during labour (National Institute for Health and Care Excellence [NICE], 2017; ICM, 2020; WHO 2020), some units across the UK had been forced to centralise maternity services, refuse care to those choosing to birth at home and stop birth partners during labour. These prospects prompt some women to express their concerns and fears of hospital births (potentially increasing their chances of acquiring the infection and birthing alone), and claim intentions to free birth.

Furthermore, the effects of the pandemic have affected routine maternity health services with reduction and cancellations of some routine antenatal and postnatal clinics with the deployment of staff away to acute settings (Franka and Ingela, 2020). In addition to the emotional impact these measures have on women, from a socioeconomic perspective, it might incur costs to the most disadvantaged having to travel long, unnecessary distances during reduced public transport services or even not attend for care at all (Hussein, 2020).

The government guidance and service providers approach has been highly criticised by experts on the field of health and women's rights. A call to protect women and families, maternity services and keep as many healthy women and staff as possible outside hospitals was widely documented (Birthrights, 2020; MUNet, 2020; RCM,

2020). Evidence available from the Birthplace study suggests that women without complications have less risk if they give birth outside hospital – at home or in birth centres – and there is no increased risk for babies in the vast majority of cases (Birthplace in England Collaborative Group, 2011).

On 9 April 2020, the RCOG published a guideline informed by the RCM Professorial Advisory Group (Renfrew et al, 2020). The document was developed to support maternity service leads in decision-making about midwife-led birth settings in the evolving coronavirus pandemic.

The positive impact of midwife-led birth settings is well-documented and includes reductions in the need for a range of medical interventions that could lead to longer hospital stays (Birthplace in England Collaborative Group, 2011; NICE, 2017). This is of significant importance to prevent avoidable harm and availability of midwife-led care settings for birth should therefore be continued as far as is possible during the pandemic. There is also considerable evidence to support the safety of home birth for healthy women when facilitated by qualified midwives practising within a supportive network.

A set of principles were developed by the RCM's COVID-19 professorial advisory group, drawing on evidence of essential components of quality care and incorporating the latest information from the World Health Organization and the ICM on COVID-19. Amongst them are:

- Continue to provide evidence-based, equitable, safe, compassionate and respectful care for physical and mental health, wherever and whenever care takes place, by remote access if necessary
- Protect the human rights of women and newborn infants, as far as possible
- Ensure birth companionship
- Protect and support staff, including their mental health needs (RCM,2020; RCOG, 2020).

It was encouraging to see how these guidelines were not only promoting and protecting women and families' well-being and rights but maternity staff too. On the same date, NHS England published a clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic supporting the RCOG statements (NHS England, 2020).

Points to consider

- How deployment of midwifery staff into community settings, rather than acute settings, could safeguard both women and midwives' rights and potentially protect their health during a national emergency?
- How emotional and physical preparedness for health crisis could be integrated in the midwifery curriculum?
- Are midwifery teaching academics prepared for a more global health approach? How do we prepare the trainers?
- How can we influence the political agenda and advocate for women's rights in childbirth and the future of midwives?

Midwifery and maternity services have long been recognised as advocates for women and families' well-being and rights. At a time of national emergency, they should be allowed to and provided with the necessary resources to continue to do so. Even during crisis, women will continue to become pregnant and babies will continue to be born. Sexual and reproductive health services need to be protected on the political agenda, not only to safeguard the service providers but to respect the women that make use of them. This commitment should ensure the protection of midwives with adequate equipment and resources to safeguard their physical and mental health, and facilitate and support women's choices during pregnancy and childbirth.

> ***'Wherever women and babies are, whatever their circumstances or the health system in place, their survival, health, and well-being can be improved by midwifery care' (Sakala and Newburn, 2014).***

Conclusion

In the UK, the impact of years of austerity on the NHS and the gaps in the healthcare workforce are now more visible than ever. Midwifery vacancies have been unfilled for years. The limited resources in the maternity services have forced some to close, leaving some women frightened and potentially given birth alone. Governmental agencies are encouraging those in retirement, those registered as midwives but not practising clinically and second- and third-year students to remain in practice and contribute, even though adequate supervision and protection is not guaranteed, to the workforce.

We are in a global pandemic, however we need to ensure that we do not fail the midwives of the future. They are advocates of women and their rights. If political powers continue to neglect investment on healthcare, personal protective equipment, facilities and psychosocial support for the workforce, I am afraid that we will not only be failing midwives and midwives-to-be but we will be failing women and generations to come. **BJM**

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