The pay & conditions debate: what is the reality of the working environment in midwifery higher education?

Abstract

This series of six articles is inspired by themes arising from the Royal College of Midwives (RCM 2023) State of Midwifery Education report. The series explores the current landscape and challenges in educating the future midwifery workforce, particularly those that relate to the Higher Education (HE) workforce itself. This fourth article in the series looks at what it's really like to work in midwifery education vs as a midwife. The challenges associated with transition, remuneration, workload, casual working and the breadth of the midwifery education role are examined, particularly in comparison to other disciplines within higher education. We explore how educators can be better supported in their training of the future midwifery workforce, whilst assuring their own progression and equal treatment in an increasingly competitive and tightly regulated sector.

Key words

Higher education, pay, conditions, casual working

Introduction

Working in midwifery, can be (as with many health professions), incredibly hard work. Shifts are typically long and/or anti-social, medicalisation and complexity provide ongoing challenges, the threat of litigation looms large and the National Health Service (NHS) (where the majority of UK registered midwives work) has been chronically underfunded and under resourced for the better part of fifteen years (Ham, 2023). These things, alongside an alarming number of serious incidents and investigations over the previous decade, including the recent damning birth trauma inquiry report (APPG Birth Trauma, 2024), have contributed to a much changing perception of the value and meaning of midwifery in modern UK society.

Against this backdrop, it might seem a peculiar focus to consider the working conditions of midwifery academics rather than the midwives that may be struggling in challenging frontline conditions. What we put forward for consideration here is that in a workforce with a high turnover of clinical staff and an established shortage of approximately 2,500 midwives, it is midwifery educators that are nurturing the next generation of staff that will go some way towards a solution to some of the issues. More staff, and properly trained staff, will backfill gaps, improve working conditions and fulfil the goals of the NHS long term workforce plan (2023a). As detailed in the RCM State of Midwifery Education report (2023), a focus on equitable pay and conditions in higher education are paramount to attract talent and this is needed if we are to increase student places and bolster the workforce as the NHS future workforce plan demands.

More importantly, we must create the conditions for midwifery students to receive a quality and safe education and this cannot be reasonably achieved unless the educators themselves are also motivated, nurtured and happy. We take for granted the impact of our midwifery educators at our peril; poorly educated or poorly treated student midwives do not make safe, compassionate midwives (that is, if they complete their education at all). Midwifery educators are the lynchpin in this process. This article discusses the current working conditions of the educators with these points in mind to propose solutions to nurture and support the future profession.

Equal and fair?

The average starting salary for a lecturer in the UK is £34,308 (UCU, 2023). This is less than the £35,392 received at entry step point for Band 6 midwives (NHS Employers, 2023). Whilst we know

many university employers will salary match for new staff, some will not. We also know that many midwives in clinical practice will likely be in receipt of unsocial hours and overtime payments alongside recruitment and retention premia (NHS Employers, 2024a). The NHS Employers' submission to the NHS England Pay Review Body (2024) defines the average additional earnings of midwives at Band 6 as an uplift equating to 22.9% of basic pay. This means that an entry-level full-time Band 6 midwife (perhaps with only one year's clinical experience) would likely be earning in the region of £43,497. This is over £9,000 more than the average salary offered to an entry level lecturer. As the RCM report acknowledges, the more experienced the midwife, the more this disparity would inevitably increase. Universities are also unlikely to salary match those on salaries over the top end of an entry-level lecturer banding unless they have relevant education experience or qualifications. As this unfolds, midwifery education becomes further disconnected from an important pool of talent and expertise and the students lose out on a crucial source of learning. The salary inequity explains why the education workforce is becoming younger and less experienced and that some lecturers are returning to practice to earn a higher salary (RCM, 2023); why would an experienced midwife take a substantial pay cut to work in higher education? Particularly in the middle of a cost-of-living crisis?

Comparing midwifery with nursing or other allied health professions further highlights this disparity. Professionals in areas such as nursing can often spend many years at agenda for change Band 5 (Stoye and Warner, 2024). For those on Band 5, Band 6 is typically only achieved through specialism, further study, or an increase in responsibilities (often managerial or supervisory in nature) and so is achieved later on in careers. For those on band 5, an entry level lecturer salary is more likely to constitute an income uplift (or at least income parity) and appeal to a greater range of experience levels. Midwives are somewhat unique, in that achievement of Band 6 is expected on completion of preceptorship (which for full time staff usually takes about a year (NHS England, 2023b)). This higher banding for midwives is based on assessment of the responsibilities of the role by the NHS Job Evaluation scheme (2024b); midwives are seen to operate with greater autonomy earlier in their careers. Put bluntly, an entry level lecturer salary may have incredibly limited appeal to any band 6 midwife beyond their very early career years. While this substantial disparity between salaries in clinical practice and education exists, the status quo is unlikely to shift in terms of attracting experienced midwives into the education workforce (or indeed in retaining them) and universities should consider how they are ensuring competitive salary offers for the talent they wish to both attract and keep.

Temporary, fixed-term and/or zero-hours contracts are also endemic within HE and this has featured in episodes of industrial action in recent years. The University and College Union (UCU) state that higher education is the 2nd highest user of casual labour with one third of all academics employed on fixed-term contracts and 41% on hourly-paid contracts (UCU, 2021). The degree to which this affects midwifery educators is unclear though likely significant; we already know that more women than men are represented in the casual workforce in HE (ibid) and as we know, the midwifery education workforce is predominantly female. Casual working may be beneficial for those juggling family or caring responsibilities however it is an established barrier to career advancement and does not contribute to equitable working conditions. Casual workers have more limited access to support, mentoring, progression and promotion than those on permanent contracts and report financial difficulties, mental health issues, insecurity and an inability to plan for the future (UCU, 2019). Universities might consider how they support female educators who are balancing family/caring responsibilities; this may positively influence a move away from casual working and thus support better working conditions.

Motivations & Expectations

Bearing in mind the apparent lack of financial motivation and/or job security offered by a career in midwifery education, an examination of the motivations of those midwives who *do* make the transition into education is missing from the literature and sorely needed. If not for financial reward, then why are midwives taking a pay cut to work in education? A 2012 mixed-methods survey of 146 new nursing, midwifery and allied health lecturers noted that great satisfaction can be gleaned by nurturing new professionals and that the autonomy and flexibility of the education workplace is positively received (Smith and Boyd, 2012). Conversely, however, new lecturers reported heavy workloads, a 're-learning' of organisational processes and language, learning how to be an educator, struggles finding time for research and maintaining clinical credibility (Smith and Boyd, 2012). This paper is over 12 years old however, and the data suggests conditions are probably worse, as we explore later in this article, and the study does not directly address motivations for entry.

There is naturally a concern that midwives may be entering education as they are disillusioned with the working conditions in clinical practice of which we know stress, burnout, poor staffing and heavy workloads are all factors (Cull et al., 2020). We also know that shift work is hard physical labour and working these over a 24-hour, 365-day rota harder still. This is exacerbated if staff have caring responsibilities and childcare to negotiate, and we know that will be the case for the majority female midwifery workforce as it is for women working across the UK (CPP, 2022; NMC, 2024). It is not difficult then to imagine that midwives may enter higher education roles believing the working conditions might be 'better' in all these respects though again, the literature does not exist to confirm this.

Anecdotally, colleagues have affirmed to us that they had made assumptions regarding the easier conditions in HE, but that the transition constituted somewhat of a rude awakening. Education roles are not immediately 'life or death' so do not carry the attendant anxieties or stressors, nor the physical burden of long shift work, but they can nonetheless become all consuming. There is no handing over after a shift and the responsibilities of pastoral support for personal students can be overwhelming. Students are present for up to three years (longer if they intercalate or extend their course). Students may also ask for support at all hours and as they are (at least on direct entry programmes) paying customers, they rightfully demand a response in a timely manner and engagement when they see fit. This can mean working over and above contracted hours, or at the least flexibly, to meet expectations. The lecturers surveyed in the Smith and Boyd (2012) study highlighted this when discussing the time needed to prepare teaching or get to grips with marking and this is likely to have worsened due to increasing student numbers against stagnant educator recruitment (RCM, 2023). These expectations are indeed different to clinical practice, as are the impacts, but they are not necessarily 'less' challenging. This can be a surprise to some.

The Transition Period

The transition from midwife to educator of student midwives can also be a demanding journey, and this may impact on the working conditions experienced by early career academics as they establish new identities. Gray, Baker and De Leo (2023) discuss this in their scoping review where they identified ten global papers that considered the experiences of midwives transitioning from clinical midwifery practice to higher education teaching roles. The picture they paint from their retrieved studies is one of a crisis of identity (at least for a time), whereby midwives reported a lack of support, a shift in identity and a fear of losing clinical credibility.

Two personal reflections published by midwives making the transition into HE reported similar themes (Baker, 2019; Foster, 2018). Foster describes the experience of needing to understand and appropriately support students who are struggling financially as well as the burden of pastoral

support (a theme we return to below). She describes being "…overwhelmed by the sheer volume of challenges presented by some of the more vulnerable students whom I was supporting, and I became quite distressed as a few were experiencing particularly serious difficulties". Baker (2019) also describes the elements of student support needed within the role but also the opportunities of earlier career transition which leads to easier identification with, and empathy for, students. These experiences align with the earlier Smith and Boyd (2012) findings and underscore the importance of supporting early career academics as they make the transition from clinician to educator. Mentorship might be an important element of support for this early-career process and has been identified in similar research in nursing, particularly for Global Majority staff (Iheduru-Anderson and Shingles, 2023; Jackson et al., 2015).

The Breadth & Depth of the Education Role

In the last article we touched on the broad and intensive nature of the midwifery education role to highlight that this contributes to inequalities and barriers to progression for the largely female workforce (Chenery-Morris and Divers, 2024). We noted the longer teaching year, less time for research or scholarly activity, the multiple roles midwifery educators embody to cover 'academic assessor' and/or 'link lecturer' roles and the emotional labour of nurturing students who are requiring increasing support (ibid). This has equally not been aided by regulatory change in 2018 (NMC, 2023) when the 'Practice Supervisor' and 'Practice Assessor' roles were introduced and the requirement for students to spend 40% of their time with one 'mentor' was removed. This has led to academics picking up a great deal of the responsibility for supporting, nurturing and guiding students in both practice and university settings. We also previously acknowledged that the need to keep NMC registration current remains when working in education, with 3 yearly revalidation and related CPD still necessary. This is in addition to the 'standard' work of education in preparing teaching materials, teaching, marking and moderation, personal tutoring, outreach, admissions and recruitment. HE is also a competitive industry where advancement is only possible if substantial personal development is evidenced in the form of such things as research, further study, publications, and conference presentations. This is already a large remit before we consider the staff/student teaching time.

The 'staff-student ratio' (or SSR) reflects the number of students each academic may be working with. Typically, this is an indicator of academic quality, used by university league tables to rate courses and not dissimilar to the staff patient ratios used to guide resourcing in clinical practice. A lower ratio is assumed to be better as logic would lead to an assumption that this equates to greater student time and contact. However, whilst midwifery ratios are variable, dependent on the demographics of the women cared for, models of care and community case mix and often are calculated using complex algorithms or software such as Birthrate Plus (Griffiths et al., 2024), HE staff-student ratios are less clearly defined. Unlike some other health disciplines (and the RCM report highlights physiotherapy which has a recommended ratio of 1:15), there is no ideal SSR for midwifery nor direction on this from the regulator. The national average midwifery staff-student ratio for 2022/23 is 1:19 and this has been increasing year on year since 2010 from 1:14 (RCM, 2023). The authors' direct experience also reflects this rise; originally when Sam joined our current University in 2006, there were five midwifery educators (4.6 whole time equivalents) and 14-16 students per cohort. This gave a student staff ratio (SSR) of approximately 1 staff member to 10 students, although the midwifery team also taught part-time post registration courses too. At present the SSR for the direct entry 3-year degree where we work sits around 1:17, though is better for the shortened 2-year programme for qualified at nurses at 1:14. Of course, staff can (and do) work interchangeably across midwifery programmes which makes for an overall SSR of about 1:16.

These are relatively high numbers. A brief look at the Guardian university league tables for 2024 shows that only 26.2% of ranked institutions (n=32) had an overall SSR of 18:1 or above (The Guardian, 2024). When narrowing this down to the SSRs of midwifery courses, this figure leaps to 46.2% (24 of 52 ranked courses). This may be, again, in part because of increasing student numbers against static recruitment to education posts (RCM, 2023). It may of course also not paint a complete picture as not all academics teaching on midwifery programmes may be midwives and so, dependent on how the SSR is calculated, the picture may be better or worse than indicated. It does suggest, however, that midwifery educators are more thinly distributed in comparison to other subjects when we already know they are teaching a longer academic year and have a greater number of responsibilities to assure regulatory demands. This does not equate to a necessarily 'easy' job that supports mental health nor one that can always be fulfilled within contracted working hours. We already know that overtime is in general, a problem for the sector, with university staff working two unpaid days of work every week (UCU, 2022). It could be assumed, then, that this too might be higher for those working within midwifery education based on the SSR picture. There is an urgent need to increase recruitment to assure both the working conditions of staff and the quality of the education student midwives are receiving.

Conclusion

Concluding this article and not ending on a sour note presents a challenge. Taking the lead from Gill Walton (Chief Executive of the RCM), who made a plea to celebrate progress and positivity in her keynote at the recent national conference (RCM, 2024), there is of course much in the working conditions of midwifery education to recommend it; staff generally find working with students rewarding and, the limited evidence suggests, enjoy the autonomy and flexibility of the role (Boyd and Smith, 2021; Ebert et al., 2020). However, overall midwifery education pay and working conditions are not in great shape and solutions to problems can only be arrived at if the problem itself is clearly outlined and that is what we have attempted to do here.

Ultimately, we need to encourage experienced AND passionate midwives into HE by way of proper salary matching; the easy way to do this is to raise entry level lecturer wages to mirror the pay of the staff we seek from band 6 and above. We could also (as the RCM report suggests) provide better opportunities for midwives to engage with HE throughout their careers. AHPs have done good work here recently that we can learn from (CODH and NHS, 2023) and there is interesting new work afoot to develop an educator's career framework for nurses and midwives which may more clearly articulate the pathways to entry (Skills for Health, 2024). A better understanding of the motivations of midwives entering HE is also much needed both to further develop these and increase recruitment as well as to ensure we are recruiting the right staff for the role. Finally, some acknowledgement of the increased workload, teaching year, regulatory 'extra' requirements and increased pastoral burden of midwifery education is overdue; this will of course require much needed investment in staff to balance student/staff ratios.

Summary

- Pay disparity between clinical practice and entry level lecturer salary means we are not attracting (or retaining) experienced midwives into education
- This is unique to midwifery as it is one of the few health professions where staff are on a higher banding from relatively early in their career
- There is a need to understand the motivating factors for midwives entering higher education so we can harness this but currently no real research exists

- Challenging working conditions in clinical practice may lead midwives into thinking education roles will achieve better work/life balance but this is often not the case
- Midwifery educators have heavy workloads in comparison to non-regulated higher education programmes and many roles to fulfil
- SSRs are challenging, appear generally worse in midwifery than in most other subjects, indicating the education workforce has not kept up with the increase in student numbers

Things for Student Midwives, Midwives and Midwifery Educators to Consider

1. **Establish relationships.** University staff and practice staff need regular connection to foster relationships, discuss opportunities and begin all-stage career conversations about pathways into education.
2. **Encourage collaboration.** Expertise from practice can be used to inform and improve education. Consider how guest lecturing opportunities can develop staff, improve student/practice links and add contemporary perspectives to student education.
3. **Support transition**. Consider how midwives making the transition into academia can be supported. What support mechanisms are in place to help establish a new identity?
4. **Further research.** A better understanding of the drivers and motivating factors for midwives entering higher education roles is needed to develop and support recruitment.
5. **Sharing workloads**. Leaders in academia could consider how to better support the increased workloads of midwifery academics, such as moving tasks to academic administration or clinical skills colleagues, sharing interviewing with nursing colleagues and setting clear expectations and boundaries with students.

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