Midwifery 2020 Programme

Core Role of the Midwife Workstream
Final Report

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## Contents

1. **Moving into a Changing World**  
   - Demographic and Lifestyle Changes  
   - Organisation of the NHS  
2. **The Current Reality**  
3. **What is the Future Direction?**  
   - Women’s Expectation of a Midwife  
   - Fathers  
   - All Women need a midwife  
   - Organisation of Care  
   - Support Staff  
4. **How Are We Going to Get There?**  
   - Who is Responsible for Providing Maternity Care  
   - Lead Professional  
   - Coordinator of Care  
   - Expanding the Role of the Midwife  
   - Delegation and Skill Mix  
   - Skill Mix  
   - Ratios  
   - Protecting the Public by Promoting Best Practice  
   - Education  
   - Attitudes Values and Beliefs  
5. **Models of Maternity Care**  
   - Background  
   - Underpinning Philosophies of Maternity Care  
   - Organisation and Delivery of Care  
   - Specific Models of Maternity Care  
   - Guiding Principles  
   - Conclusion  
6. **Recommendations**  
   - Core Role  
   - Delegation and Skill Mix  
   - Models of Care  
7. **References**  
8. **Bibliography & Additional Reading**  
9. **Glossary of Terms**  
10. **Membership of Group**  
11. **Appendix 1: Social Enterprise: policy context and relevance to midwifery**
Midwifery 2020: The Core Role of the Midwife

This work stream covers all aspects of care, including models of care, service delivery, elements of skill mix and social enterprise, led by Wales, supported by Northern Ireland.

1. MOVING INTO A CHANGING WORLD

The view that a midwife is the expert in normal pregnancy is not new but the context within which midwifery is practised has changed over the years. The majority of women in the UK today will go to hospital to give birth. Consequently, the majority of midwives now work in a hospital environment.

Since the early sixties the context for birth has moved from a private social home location to a setting in hospital. With the gradual move to hospital birth midwives have had to develop new skills. Now more recent government policy (Department of Health 2007, Welsh Assembly Government 2005, Scottish Executive 2001), is shifting the focus to community based delivery of maternity care, there are opportunities for midwives to strengthen their skills in organising and leading local services for women and families.

The Prime Minister's Commission

Since the commencement of this work, the Prime Minister's Commission on the Future of Nursing and Midwifery (Department of Health 2010), has been published. While recognising its status as an England-only document, the group is pleased to note that it strongly endorses many of the recommendations related to the core role of the midwife.

Demographic and lifestyle changes

Demographic changes and life choices present increasing challenges to midwives practising throughout the UK, whether employed within maternity services or self employed. In recent years, in the UK, there has been an increase in the number of pregnant women who are living in poverty, who do not speak English as a first language and who need support in accessing services. Midwives are caring for increasing numbers of women with complex physical and social needs such as young
teenagers and women who are misusing drugs and alcohol.

Health inequalities persist and have an effect on women and babies. In relation to maternal mortality, we know that women living in families where both partners are unemployed are up to 7 times more likely to die than women from the more advantaged groups (Lewis 2007) and babies born in the most deprived areas are up to six times more likely to die in infancy (Department of Health 2007a).

An independent inquiry into the safety of maternity services commented that:

- numbers of births have risen since 2002 and are projected to increase;
- there are more older mothers, with higher rates of complication;
- there is more fertility treatment, leading to a higher rate of multiple births;
- there are more obese women, who are less fit for pregnancy;
- there are more women who survive serious childhood illness and go on to have children, and who need extra care in pregnancy and childbirth;
- there are rising rates of intervention in labour, in particular in rates of caesarean section;
- there is increasing social and ethnic diversity, sometimes leading to communication difficulties and other social and clinical challenges in maternity care. a

**Organisation of the NHS**

The reconfiguration of the NHS across the UK has resulted in larger tertiary maternity units, housing a complexity of specialised services. Alongside this, an increase in the number of midwife led units has unintentionally polarised the provision of services into ‘high risk’ and ‘low risk’ environments.

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a) Kings Fund 2005 Independent enquiry into the safety of maternity services in England; whilst this was carried out in England the findings were thought to be relevant across the UK.
In ensuring the effective use of the skills of professional staff, maternity services have been exploring the potential for non-midwifery tasks to be undertaken by maternity support workers.

2. WHAT IS THE CURRENT REALITY?

Over 700,000 women will give birth each year in the UK and it is likely that all of them will have had the majority of their care from a midwife. In women’s homes, birth centres and hospitals, midwives coordinate a woman’s journey through pregnancy, providing the continuity to ensure that she experiences safe, compassionate care in an appropriate environment.

There is international agreement on the definition of the midwife (FIGO 2005) which clearly states the necessary qualifications for midwifery practice, the types of care that can be given by midwives and the locations where midwives can practice:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant.

This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.
A midwife may practise in any setting including the home, community, hospitals, clinics, or health units.

This global definition needs no expanding, and in terms of clinical practice, it is clear and appropriate. It describes the core role and it is this that Midwifery 2020 would seek to focus upon, to maintain and to strengthen. However, we believe that we need to emphasise the philosophy of midwifery care:

‘the essence of being a midwife is the assistance of a woman around the time of childbirth* in a way that recognises that the physical, emotional and spiritual aspects of pregnancy and birth are equally important. The midwife provides competent and safe physical care without sacrificing these other aspects’ (Page L, McCandlish R 2006).

3. WHAT IS THE FUTURE DIRECTION?

Women’s expectations of a midwife
A midwife’s focus should be to enable all women and their families to have a positive and safe experience of pregnancy, birth and early parenting. Recent research into women’s experiences of maternity care (Commission for Healthcare Audit and Inspection 2007), suggest that the strongest indicators of a positive experience relate to communication, support, involving women in their care and being treated with respect, dignity and kindness. It is therefore vital that a component part of the selection of student midwives focuses on interpersonal skills as equally important as academic qualifications and that midwifery education seeks to enhance the emotional intelligence of midwives.

Fathers
Fathers are playing an ever increasing role in childbirth within the family. The perinatal period has long been recognised as the ‘golden opportunity moment’ for intervention with fathers (Cowan 1998), and they are particularly open at this time to information, support and advice (Lupton 1997). Midwives appreciate that a father’s involvement
*Childbirth, in this context, refers to pregnancy, birth and the postnatal period, and support have a significant impact on both the mother and the baby (Lewis 1986), and that.

- a father’s smoking, drinking and drug use is the greatest influence on the mother’s smoking, drinking and drug use;
- a father’s attitude to breastfeeding has a significant impact on the mother’s choice of how to feed her baby;
- a good relationship with the baby’s father, and supportive behaviour by him, is a protective factor for postnatal depression in the mother.

Midwives recognise that when fathers are included and seen as part of the solution rather than part of the problem, then better outcomes can be delivered. Throughout this document the term ‘family’ has been used to include fathers, partners and grandparents or any significant family member who supports a woman through pregnancy, birth and new parenthood.

**All women need a midwife**

Over the years, in the context of the UK, midwives have been practising in a risk averse model of care, adapting their practice to care for women in increasingly technical environments. They have sought to maintain their skills in being the lead professional for healthy women with straightforward pregnancies and have developed new skills in caring for women with complex medical and obstetric conditions.

Looking to the maternity service of 2020, it is likely that there will be a continuing increase in the number of women with complex medical and obstetric conditions. The skills to engage with women in encouraging healthy lifestyles and the ability to work across the health and social care services will be essential in order to support vulnerable women and families through childbirth and early parenthood. Midwives will want to continue to care for all women, whether or not they have straightforward pregnancies.

**Organisation of care**

It is clear from recent research that midwives want to promote the social model of maternity care where women are the centre of the experience rather than a model that focuses on the running of the organisation (Hunter 2004). As larger maternity units
become the norm, midwives may spend an increasing amount of time ‘meeting the needs of the organisation’ rather than meeting the needs of women (Hunter 2005). In this context, risk averse policies and procedures may not always be women centred. This has an effect on staff morale and is a serious challenge to the recruitment and retention of midwives whose primary reason for wanting to be a midwife is to care for women (Lavender 2004).

As well as complexity of obstetric and medical conditions, the role of social support has increased. New immigrants and those who do not speak English are just two examples of women who may need increased support, advice and information about accessing maternity services.

Although most UK Government policy over the last 15 years has promoted the concept of the midwife as first point of contact for women accessing maternity services (Department of Health 2007b, Welsh Assembly Government 2002, Scottish Executive 2001), the organisational structures to support this are not in place. In most areas of the UK there is not a widely known established system to enable women to access a midwife without first going to a GP.

Support Staff
As the complexity of health and social care has increased so have some aspects of care that are not necessarily those of a midwife. Administrative work has grown exponentially: answering telephones, admitting visitors and general data entry have become everyday tasks of a midwife that could be delegated to administrative staff. Whilst midwives are carrying out these tasks, their clinical skills are not being used to best effect and this is one of the reasons that midwives give for being dissatisfied in their work (Ball et al 2002).

4. HOW ARE WE GOING TO GET THERE?

Who is responsible for providing maternity care?
In the context of maternity care, all women need a midwife and some will need a doctor, too. Some women will also want or need support from others such as social
services. The voluntary sector too has an important role to play in providing services such as antenatal classes, breast feeding advice and postnatal social support.

We believe that there are two key roles that are important to describe if we are to achieve our goals; one is that of lead professional and the other is that of coordinator of care.

**Lead professional**
The role of lead professional is to plan, provide, and review a woman’s care, with her input and agreement, from the initial antenatal assessment through to the postnatal period. In most circumstances, a midwife would take the role of lead professional for all healthy women with straightforward pregnancies and evidence suggests that, for low-risk women, midwife-led care reduces admission to hospital and results in significantly less intervention during birth (Hatem et al 2008). An obstetrician would be the lead professional for women with complications of their pregnancy.

**Coordinator of care**
For almost all pregnant women, the midwife is the conduit for care throughout pregnancy, labour and the postnatal period. Whilst the midwife is expert in the normal, she also provides a pivotal role in coordinating the journey through pregnancy for all women. Whilst the lead professional may change during a pregnancy, the coordinator of care stays the same, providing the continuity that women want.

(The circumstances in which the midwife would not coordinate care would be exceptional, i.e. if a woman requested to be seen solely by an obstetrician or GP).

Her role as coordinator is to ensure that women are referred to health, voluntary and social services when appropriate and that holistic care is provided to optimise every woman’s birth experience regardless of risk factor. The role needs to be articulated clearly and the distinction between lead professional and coordinator of care made explicit to all those involved in a woman’s care.

What is of paramount importance is that women and health professionals are clear about who is taking on this role and what it entails.
Both the role of lead professional and coordinator of care require a multiagency approach, working across health, voluntary and social care boundaries with an understanding of how collaboration can maximise the opportunity for women to have a positive experience and a safe outcome, regardless of whether the pregnancy and birth are straightforward. It provides every woman with appropriate care planning that is unique to her and reduces her chances of receiving conflicting advice.

**Expanding the role of the midwife**

The way in which care is provided evolves over time, depending on many factors i.e. demographic and social change. Over recent years midwives have been expanding their role beyond what has traditionally been seen as the core role. Whether this is appropriate has been much debated by the profession and whilst nursing has embraced specialist and advanced practice roles, some midwives feel that to do so would dilute the emphasis on their fundamental reason for being a midwife.

However, it is inevitable and necessary for the development of the profession that many midwives will want to deepen their knowledge and continue to develop their skills. The challenge for the profession is to encourage and enable midwives to grow in knowledge and skills whilst keeping to the aims of Midwifery 2020, as previously stated:

- to promote a maternity service where the midwife is known and trusted in her community, is recognised as the expert in normal pregnancy, birth and postnatal care, is skilled in the recognition of pathology, can manage this circumstance where appropriate and can recognise and refer women to obstetricians and other specialists/agencies in a timely and collegiate manner when this becomes necessary.

- to re-focus midwifery care on maximising the possibility of normal pregnancy, childbirth and postnatal well-being within a context of birth as a life event where the physical, spiritual and emotional aspects are
equally important, safety is paramount and women feel a sense of privacy and dignity.

To move the debate forward, it is useful to consider the distinction between the term Advanced and Specialist Practice and whether they are appropriate terms to be used in the context of midwifery practice.

Advanced Practice describes a level of expertise and the ‘possession of advanced knowledge and skills not exclusively in the clinical domain but also encompassing individuals working in research, education and managerial/senior leadership roles’ (Welsh Assembly Government 2009). It should not be seen as synonymous with extending the role of midwives. It is not about a narrow focus on acquiring specific skills but rather it is concerned with developing a depth of knowledge and expertise that enables those with advanced practice skills to be role models and future leaders of the profession in clinical, managerial, strategic and academic arenas.

Acknowledging the need to develop Advanced Practice provides a career framework that enables midwives to gain the necessary experience to advance their careers clinically, managerially or in research and academia.

The value of Specialist Practice in midwifery is less clear. Whilst the focus of a midwife is not generally on one specific sphere of midwifery, in some circumstances it may be necessary for midwives to gain more skills and experience in a specific area. It is important that this is not considered as the ‘norm’ but the role maybe developed locally depending on the needs of women and the setting in which care is given. For example, some midwives may need to develop additional skills when working in rural and remote areas, i.e. dating scans, ventouse extraction or, in areas of high prevalence, it may be beneficial for a midwife to develop specific skills in supporting and working with young teenage mothers and families.

The possibility of regulation for these roles may have benefits and needs further exploration. In acknowledging the need for flexible adaptation to new challenges, post registration education is essential and must be available to all midwives, based on local need.
Delegation and skill mix

Midwives understand that, if they are to reaffirm their core role, some aspects of care that they have taken on over the years, now need to be delegated. It is essential for the maintenance of quality care and job satisfaction that midwives are freed from some of the administrative and housekeeping tasks that have sometimes removed them from providing the high levels of care that give them pride in their profession. Whilst delivery of care is the role of the midwife, there is a valuable place in the team for Maternity Support Workers (MSWs), nurses and others with specific skills. For example, Operating Department Assistants and nurses are already providing theatre skills and care to women immediately post caesarean section.

Introduction of the maternity support worker role has been unregulated across the UK, resulting in inconsistent education, training and role clarity. While some parts of the UK have taken a national approach to the development of such roles, with nationally defined curricula and role definition, other areas have seen inappropriate use of support staff in lieu of midwifery posts.

The Royal College of Midwives (2006) advise that the introduction of MSWs ‘should be within a clear framework which defines their role, responsibilities and arrangements for supervision… to ensure that MSWs …complement the skills of the midwife without compromising the quality and safety of care.’

Therefore in 2020, there should be UK agreement on the core role, the education programmes and the introduction of maternity support workers within maternity services to ensure that the aspects of care which may be delegated by a midwife are done so appropriately and to an appropriately trained individual.

We also recommend that the UK governments move to regulate MSWs to ensure the safety of patients and the public.

In accordance with Midwives Rules and Standards (Nursing and Midwifery Council 2004), midwifery care or advice can only be provided by a practising midwife. It is for the midwife to decide whether delegation of tasks is appropriate and she remains
accountable for the appropriateness of the delegation. It may be useful to distinguish three areas of work:

a) essential midwifery – not to be delegated
b) non-midwifery, e.g. administration - delegated
c) aspects of care which could be carried out by a midwife but which may be delegated to an appropriately trained MSW.

In respect of the delegation, a distinction needs to be made on the basis of the knowledge and understanding required to interpret the consequences of the care given. If care can be given without the need for clinical interpretation, it may be suitable for delegation, i.e. transferring information from a paper record to a computerised system, providing refreshments to a mother and her partner, or stocking and cleaning of equipment. On the other hand, whilst applying a fetal monitor may seem a simple task, it requires the professional knowledge and skills of abdominal palpation, auscultation and interpretation to interpret results.

If aspects of care are delegated, it is vital that this does not disrupt the provision of holistic care through task allocation to several MSWs and there is also a danger of reducing the quality of care by breaking down the activities of a midwife into tasks.

The midwife must ensure that the person who does the work has been appropriately trained, is competent and able to understand and accurately report back to the midwife. The midwife must then provide adequate supervision and support to ensure that care is provided to the required standard. To re-iterate the overarching principle, the rationale for delegation must be for the benefit of women and families and not a response to reducing costs.

**Skill mix**

Existing maternity services policy across the UK recommends that women and families have care provided by the right person, in the right place, at the right time, dependent on their needs. This direction of travel supports the philosophy of skill mix in future maternity services, therefore all four UK countries are discussing the use of a range of support workers in both hospital and community settings. There is

However, it is also vital to have agreement on the ratios of support workers versus registered midwives to ensure that the quality and safety of maternity services are maintained and improved.

When seeking to establish the appropriate skill mix, the focus must be on the needs of women and families and not on the needs of the organisation. To this end, Maternity Services must regularly develop, update and administer workforce plans, using nationally agreed midwifery specific tools such as Birth Rate Plus. Such workforce plans must include the skill mix of midwives and support staff required to provide high-quality care to women and their families which meets UK best practice standards.

**Ratios**

Essential midwifery care, provided by a midwife, must be calculated based on current evidence. For 2010 this would mean using existing UK recommendations such as Safer Child Birth, (Royal College of Obstetricians and Gynaecologists 2007), which recommends, as a minimum, an intrapartum standard of one whole time equivalent midwifer per 28 births and one-to-one care from a midwife for all women in established labour.

The Kings Fund review of English maternity services (2007) identified the impact on maternity services of a shortage of midwives compounded by the diversion from essential clinical duties due to administrative overload. By 2020, maternity services should have appropriate support systems in place to avoid this misuse of valuable and skilled resource. Employment of administrative and clerical staff to carry out non-midwifery work will be essential, bearing in mind that maternity services are provided over a 24-hour period, with a need for 24-hour support.

Other roles must also be considered for the future sustainability of maternity services and to ensure that women have the appropriate care by an appropriately trained professional. One example of this is outlined in the joint college statement around the staffing of obstetric theatres (CODP 2007). Towards 2020, there should be a move
away from skilled midwives acting as ‘scrub nurse’ within theatres, with organisations ensuring that they comply with the recommended training and staffing requirements. The employment of an appropriate perioperative workforce, including, for example, nurses or operating department assistants, will be required to ensure that the midwife’s role in caring for the woman’s holistic needs is implemented.

Birthrate Plus (Ball & Washbrook 1996) is clear that ward and clinic staffing levels for midwives are based upon the premise that they are supported by MSW’s and clerical staff and these staff needs are assessed on a shift by shift basis.

To ensure that women and their families have the appropriate support it is important to use all available evidence when considering midwife to MSW ratios. Evidence from extensive application of Birthrate Plus across the UK indicates that for:

Antenatal and Intrapartum care: There can be no substitute for care by a midwife but units should ensure that midwives are well supported by clerical and MSW staff.

Postnatal care: A maximum of 20% of time might be provided by MSWs in providing hospital postnatal care and this must be determined locally. However, a maximum of 25% of midwife time could be provided by MSWs who would work under the direction of the midwife in charge of each woman’s care, in a community setting.

**Protecting the public by promoting best practice**

Midwives are supported in providing safe, family focused maternity services through a supervisory framework. Statutory supervision of midwives protects the public by promoting best practice, preventing poor practice and intervening in unacceptable practice and aims to support and develop midwives in the provision of safe, quality care for women. Supervisors of midwives are key in promoting the core role of the midwife and in ensuring that service delivery models are safe, family-centred and evidence-based. Midwifery 2020 supports the pivotal role that supervision plays and
would want assurance that the ratio of supervisors to midwives meets the Nursing and Midwifery Council’s ratios currently accepted as evidence of best practice.

Education
The education and training of midwives is dealt with in detail by a separate workstream. However, some themes emerge that require re-emphasising.

Midwifery must remain a graduate profession, as identified by the Prime Minister’s Commission, with increased emphasis placed on the development of communication skills and the Nursing and Midwifery Council’s essential skills clusters for pre registration midwifery education (2009).

Midwifery education must be rooted in normality whilst preparing midwives to care for women of all risks, with the aim of educating future midwives to be skilled and safe, empathetic and be able to act appropriately in an emergency. All newly qualified midwives will be expected to be proficient in examination of the newborn, prescribing, suturing and intravenous cannulation and this will require changes to the pre registration curriculum.

The principles of autonomy and accountability within multi-professional and multi-agency teams needs increased emphasis within the midwifery curriculum.

Attitudes, values and beliefs
Lastly, but of overarching importance is the need to reassert the codes of behaviour, attitudes and values necessary to practice as a midwife and to ensure that these are upheld through midwifery education programmes and through role models in every area of midwifery practice. This is re-iterated by the Prime Minister’s Commission which states that ‘midwives must declare their commitment to society and service users in a pledge to tackle unacceptable variations in standards and deliver high-quality care’.

In A Vision for Midwifery Education, the Association of Radical Midwives (2006) stated that they wished to see midwifery attracting applicants with a vocational commitment to mothers, babies and families. Whilst ‘vocation’ could be seen as a religious calling,
in this context it is used to describe a type of work that demands special commitment, in terms of its contribution to society, and therefore a set of values and attitudes that are required by those who practice as midwives.

The NMC (2008) clarifies what this means, in The Code – standards of conduct, performance and ethics for nurses and midwives by stating that:

‘the people in your care must be able to trust you with their health and well-being’ and to justify that trust, you must ‘make the care of people your first concern, treating them as individuals and respecting their dignity’.

The Code also emphasises the need to use this respectful relationship of trust in working with colleagues cooperatively, in sharing skills and supporting team work.

Midwifery 2020 is pleased to note that the Prime Minister’s Commission on the future of nursing and midwifery strongly endorses the pivotal role of empathy in the delivery of health care.

With this end in mind, the selection, education, recruitment and ongoing professional development of midwives needs to focus on ensuring that all women receive skilled, competent, empathetic care from a midwife that they can trust. These values of trust and respect will also be demonstrated through the professional relationships that midwives generate with colleagues.

5. MODELS OF MATERNITY CARE

One of the principle objectives of the Core Role of the Midwife workstream is to scope and describe current and potential models of care using regional, national and international evidence and taking into account additional factors of influence.

The well-being and needs of a mother and her child are paramount and should be the primary focus (Nursing and Midwifery Council (NMC) 2004) when considering or reviewing models of maternity care. In terms of continuity of midwifery care the
group agrees with the guiding principle that every pregnant woman requires care from a midwife and some will need a doctor, too. (Department of Health (DH) 2007a). It is therefore fundamentally important that this is the focus of any recommendation on future models of care. Midwives are the experts in normal pregnancy and birth and have the skills to refer to and coordinate between any specialist services that may be required.

The key principles agreed by the group to be incorporated in any recommended model of care are that:

- Women should have a seamless maternity service supported by an integrated model of midwifery care;
- The majority of maternity care is based in the community setting, therefore when planning models of midwifery care there should be equal value given to acute and community based provision;
- Women should have easy access to a midwife as first point of professional contact when pregnant;
- Women should receive the majority of their midwifery care by the same midwife;
- Women should have 24-hour access to advice and support from a midwife when they think they are in labour;
- Women should have one-to-one care by a midwife when in established labour;
- The role of the midwife extends to the postnatal period, the duration of which is determined by the professional judgment of the midwife;
- The needs of women and their families should determine the models and location of care;
- To effectively care for women, midwives should be able to directly refer to other professionals/agencies and receive referrals back;
Women’s care should be embedded in a multi-agency and multi-professional arena.

Background
In many parts of the world midwives are the primary providers of care for childbearing women. However, there are considerable variations in the education and role of the midwife and the organisation and delivery of maternity services (World Health Organisation, 2006). For example, in New Zealand and the Netherlands care is offered by midwives, obstetricians and family doctors, whilst in North America obstetric-led care is the norm.

Underpinning philosophies of maternity care
The way in which maternity care is organised and delivered, and the role that midwifery plays within this, is influenced by the philosophy of care that applies locally. The two leading approaches in current maternity care can be described as ‘medical’ or ‘technological’, and ‘social’ or ‘humanizing’ (often referred to as the ‘midwifery model’ of care). Broadly, the medical/technological approach is characterized by a focus on the identification of ill health and curing, risk-aversion, and use of technical solutions for health problems. It has been argued that this tends towards objectifying and fragmenting individuals by concentrating on specific biological components of the body, rather than considering the whole person, and any possible physical, psycho-social and emotional interactions (Bryar 1995, Rooks 1999, Page 2009). In contrast, the midwifery/social/humanizing approach prioritizes relationships and social interaction. It tends to focus on the maintenance of well-being and the promotion of normality by enhancing the physiological capacity of most women to give birth with minimum or no interventions (Rooks 1999, Sandall et al 2008). This philosophy of care is seen as holistic, because it acknowledges that psycho-social factors, such as the relationship between the woman and her family, and between the woman and her care giver, are essential components of physical and clinical health for the mother and her baby.

All those who have examined the nature of maternity care over the last few decades have observed that the medical/technological model of maternity care has become dominant almost everywhere in the world. In the UK, this occurred in
parallel with the major shift in place of birth from home to hospital which took place in the 1970s. Midwifery practice began to be increasingly influenced by a risk-averse ‘illness’ perspective, and a view that the process of birth needed to be ‘managed’ and improved on by science (McFarland, 1999).

**Organisation and delivery of care**

These two contrasting philosophies underpin the current organisation and delivery of maternity care in the UK. There is growing emphasis on increasing the provision of midwife-led services, which reflect a holistic model of care rather than a technocratic model. We recommend that this trend continues.

In midwife-led services, the midwife is the lead professional and lead carer for the majority of women in normal pregnancy and childbirth. Pregnancy and birth are viewed as normal life events and care is woman-centered. Midwives also work within the context of services where women have, or develop, complex needs. These women can continue to benefit from midwifery care that is aimed at providing holistic support and normalizing the process where possible. The midwife will usually need to refer and interface with other services, agencies, and specialists.

A continuing theme through ‘Changing Childbirth’ (DoH 1993), ‘Delivering Choice’ (DHSSPS 1994), Standard 11 of the National Service Framework (NSF) (Department of Health, 2004b) and more recently ‘Maternity Matters’ (DoH 2007) was that maternity services should offer more choice, continuity and control to women through the different models of care available. The recommendations made in London's Health Strategy, *A Framework for Action* (Darzi 2007) are based on a number of principles, the first of which is that health services should focus on individual needs and choices.

The priority for modern maternity services throughout the UK is to provide choice within a range of safe, high-quality models of care. The reality is, however, that the care and choices women receive during their pregnancy and labour can vary greatly according to the place or model of care they chose to have, or are able to have (Phipps 2009).
Midwife-led services can be based in hospital settings, in standalone or alongside birth centres, or in community settings. Evidence on the relationship between the location of care delivery and birth outcomes is mixed (Hatem et al, 2009). The current Cochrane review of home-like settings indicates that low risk women randomized to birth centres that are geographically close to hospital settings have less intervention than those randomized to the hospital, but the evidence on perinatal mortality is unclear (Hodnett et al 2002). Observational studies from around the world tend to support these findings. In all cases intervention is reduced, but some non-randomised studies suggest reduced perinatal mortality, whilst in others it is increased. There are no randomized trials of outcomes for women and babies in free-standing birth centres, or at home. Non-randomised studies tend to show similar results as those for the alongside birth centers (Walsh & Downe 2004).

The overall percentage of women who are offered the opportunity to give birth at home, and who take this option up, remains low, at around 2.7% in UK in 2007. However, in seven specific local authorities in England and Wales in 2009, this has risen to 10% (Phipps, 2009). This suggests that there is a greater interest in this option than the national data would suggest, and that women may not be being routinely offered this choice. For a healthy woman with a straightforward, low risk pregnancy, there is no evidence that a home birth is less safe than a hospital birth, provided the midwife is experienced and has the backup of a modern hospital system (Cresswell and Stephens 2007). A Joint Statement of support for homebirths for women with uncomplicated pregnancy from the Royal College of Obstetricians and Royal College of Midwives was published in 2007.

The UK Birthplace study that is currently being undertaken will add comprehensive prospective data to this body of evidence.

The Core Role of the Midwife group envisages that, in 2020, although hospital maternity care will remain, there will be greater emphasis on community based provision of maternity services, planned taking into account the needs of the local population.
Specific Models of Maternity Care
The following subsections provide brief information relating to evidence which support the variety of models of maternity care.

Community Midwifery/Home Birth
Community midwifery care is provided for the majority of women during the antenatal and the postnatal periods. The importance of early contact in the antenatal period as highlighted by Shribman (2007) is that ‘it gives more time for informed choices in planning their care and ensures women can take advantage of all support and tests’.

Community midwifery care in the antenatal and postnatal periods is provided at GP surgeries, ‘drop-in’ sessions at shopping or community centres and via Sure Start schemes (DoH, 2007).

Midwifery-led Care
Options for midwifery-led models of care include those situated as stand-alone models in the local community or along side the acute hospital setting. These units have the potential to deliver safe, quality care for women and babies promoting a philosophy of normal and natural childbirth if strategically organised ((DoH, 2007; Gould, 2009). These models of care require strong midwifery stakeholders’ voices to be heard at policy and planning groups nationally. Midwifery led units on a hospital site are currently operational in the four countries; however, the patterns of care provided may vary to reflect local need. A Cochrane review (2009) involving 12,276 women where midwife-led were compared with other models of care and examined aspects of continuity, normality and safety. Overall, the review demonstrated that midwife-managed care for a healthy woman is safe and confers added benefits for women. Specific findings supported the research hypothesis, in that midwife-managed care resulted in similar or reduced rates of intervention; similar clinical outcomes and complication rates; enhanced satisfaction with care; improved continuity of carer; and was cost effective throughout antenatal, intrapartum and postnatal care (Sandall et al, 2009). Work such as this led the way for further developing midwifery services across the United Kingdom and Republic...
of Ireland and a significant shift has been achieved, particularly around the development of ‘alongside’ and ‘stand-alone’ midwife managed birth units.

**Team Midwifery and Caseload Midwifery**
These models of midwifery care are currently practiced throughout the United Kingdom. In some cases, small teams of six or more community-based midwives aim to provide antenatal, intrapartum and postnatal care for women, supported by core staff on the maternity ward, delivery suite and antenatal clinics. This model is based on evidence from trials showing clear advantages for women who receive care from a team of midwives. Alternatively, Williams et al (2009) demonstrated that in Australia the caseload model where a maximum of two midwives may provide full care throughout pregnancy, labour and the postnatal period to a small group of women. This was reported to be associated with high levels of maternal satisfaction and that supportive relationships with midwives in a caseload scheme are highly valued by women. However, although team and caseload models have demonstrated many benefits to women, its effects on midwives are less advantageous and to this many midwives feel that the aims of such models are unachievable in midwifery practice (Andrews 2006).

**Obstetric-led care**
For those women who are classified as being in high risk groups, consultant-led model is the safest option and therefore must be provided in a modern maternity system to promote safety for both mother and child in high risk groups. Although the lead professional is the obstetrician, throughout the woman’s pregnancy, coordination and continuity of care is provided by midwives and a range of other professionals which may include anaesthetists and paediatricians.

**General Practitioner (GP)-led care**
Internationally, the involvement of General Practitioners (GPs) in maternity care is significantly reduced, similar rationale being cited as: interference with lifestyle and interruption of office routine; fear of litigation and costs of malpractice insurance; insufficient training and numbers of cases to retain competency.
In Canada, the USA, and to a lesser extent in Australia and New Zealand, GPs still providing intrapartum care are GP-obstetricians rather than maternity care providers. They provide low-risk as well as high-risk obstetric care, especially in rural areas with few specialist obstetricians. In Europe, GPs do not provide high-risk obstetrical care, emphasising their function as generalists and competing with midwives for a central role in maternity care for women with an uncomplicated pregnancy (Wiegers 2003). A literature survey revealed that GPs in United Kingdom had high levels of involvement in some aspects of maternity care: confirmation of pregnancy (90%), postnatal visiting (76%), the six week postnatal check (95%). There were low levels of involvement in intrapartum care (7% had attended a birth in the last year); and extremely variable levels of involvement in routine antenatal care (0 to 15+ visits). The future promotion of this model of maternity care would require greater partnership and collaboration with midwives, preferably in shared care programs, however, the advice from NICE (2008) emphasises that GPs should refer all pregnant women to maternity services as soon as possible.

**Non-NHS midwifery care**

For women choosing to have maternity care outside what is provided by the NHS, a range of care should be made available. Independent midwives are registered midwives who have chosen to work alongside the NHS in a self-employed capacity. Independent midwives fully support the principles of the NHS and are currently working to ensure that all women have access to the full range of services available. The role of the independent midwife encompasses the care of women and babies during pregnancy, birth and the early weeks of motherhood. Women who access independent midwives are also entitled to NHS care when they need it. Non-NHS care should also be available from obstetricians for those women who wish to access it. Some midwives are now exploring the development of a social enterprise model of care. A summary of the current health policy context in the UK relating to this, and a highlight of the key issues can be found in Appendix 1.

**Multidisciplinary care**

A number of multi-professional team approaches to the management of complex pregnancy are emerging in the maternity care literature. There has also been an
increase in the number of maternity units with midwives with a special interest in supporting women with complex pregnancy, but appraisal of the role of the midwife within the multi-professional team in the provision of care for women with complex pregnancy is essential. Reports of multi-professional approaches to management of other subgroups of women with complex pregnancy highlight the importance of communication, with midwives acting as a link between disciplines, and how midwives play a key listening role with women and encourage women to look forward to ordinary aspects of pregnancy and parenthood in the midst of a complex pregnancy and birth.

Guiding principles

Currently there are a variety of models of maternity care available and others that could be enhanced. The focus when planning or reviewing these models of maternity care is that safety, choice and continuity of care are the guiding principles. The commonality throughout all the models is the contribution and role of the midwife. The guiding principles for any models of care are that:

Women should have a seamless maternity service supported by an integrated model of midwifery care

There are significant benefits to having an integrated, multi-professional maternity team who work across acute and primary care settings to deliver care. Multi-professional teams have a long history of working in partnership in order to effectively serve the needs of women and families, ensuring minimal duplication of professional resources, mutual respect for individual team roles and maintaining confidence between the professions.

An integrated midwifery service is the backbone of the maternity team, enabling the majority of care for healthy women, alongside shared care for high-risk women, to be delivered within their locality during pregnancy and in the home post birth. Through working in an integrated model, midwives are able to directly refer women and babies for a range of maternity and associated services across acute and primary care sectors. This minimises risk for women and families, through
facilitating earliest possible intervention for those presenting with medical, obstetric or social complications.

The integrated midwifery model also facilitates the provision of homebirth for all women and families, through midwives working in partnership with obstetric and pediatric colleagues and having seamless access to maternity units in the acute setting.

**The majority of maternity care is based in the community setting, therefore when planning models of midwifery care there should be equal value given to acute and community based provision**

Resources should be deployed to follow the woman’s chosen pathway of care.

**Women should have early and easy access to a midwife as first point of professional contact when pregnant**

Women should know how and where to access a midwife. Ideally this contact should occur by 10 weeks’ gestation and should involve discussion of pregnancy screening tests and key public health messages.

**Women should receive the majority of their midwifery care from the same midwife**

Continuity of carer and care has been a key policy principle since the early 1990s. Research evidence demonstrates that women value continuity of carer in the antenatal and postnatal period (Waldenstrom & Turnbull 1998, Homer et al 2000, Page 2009). It is recommended that a midwife is allocated as the coordinator of care for the woman’s antenatal care. Where possible, this midwife should plan and provide the majority of the woman’s antenatal care with support from the wider team as required. Ideally the midwife providing care should continue the woman’s postnatal care in the community.

**Women should have easy access to advice and support from a midwife when they think they are in labour**

Women should be made aware of how to contact a midwife for advice and support
Women should have one-to-one care by a midwife when in established labour
Continuity of care should always be provided by a competent, skilled and empathetic midwife who should only care for one woman in established labour. The plan for care in labour and ethos of care for the woman should not be changed if there is a change of midwife, unless the needs of the woman require it to be so.

The needs of women and their families should determine the models and location of care
NHS providers should plan and design models of maternity care which meet the needs of their individualized women within the local population.

To effectively care for women, midwives should be able to directly refer to other professionals/ agencies and receive referrals back
NHS providers should have systems in place to ensure women can move easily between different models of care as required dependant on their need.

Women's care should be embedded in a multiagency and multi-professional arena
NHS providers should have a collaborative working relationship with all other agencies based on mutual trust and respect to ensure that women and families receive optimum support. They should also ensure clear understanding of roles and facilitate effective communication between professionals and other agencies.

Conclusion
This paper is a broad outline of key principles that formulate models of midwifery care. In revision of care in maternity services it is recommended that all future midwifery models should be designed to meet the key principles outlined in this paper taking into account the needs of women and practitioners and their views on what constitutes a safe and satisfying birth experience.
6. RECOMMENDATIONS

Most of the following recommendations have been stated in other policy documents over the last 15 years. They are not new. Urgent work is required to analyse why these have not been implemented across the UK, in order to enhance understanding of factors which may prevent or promote implementation. We therefore recommend that a four country study be commissioned to explore these issues. These recommendations have to be read in this context. Models of care will need to be put in place to enable midwives to meet the recommendations and this will require multi-professional and inter-professional collaboration and a willingness to provide midwives with facilities.

Core Role

- Midwives will coordinate care for all women;
- The distinction between coordinator of care and lead professional needs to be made;
- A career framework will be developed that enables midwives to gain the necessary experience to advance their careers clinically, managerially or in research and academia;
- Special interest roles should only be developed in order to support the promotion of normality, safety and continuity of care. These should be considered locally depending on the needs of women and the setting in which care is given;
- Post registration education is essential and must be available to all midwives, based on local need;
- The selection of student midwives will focus on their interpersonal skills as much as their academic qualifications;
- Midwifery education must be rooted in normality whilst preparing midwives to care for women of all risks, with the aim of training future midwives to be skilled and safe, empathetic and trustworthy and be able to act appropriately in an emergency with increased emphasis on the principles of autonomy and accountability within multi-professional and multi-agency teams;
• The curriculum must be extended to ensure that all newly qualified midwives are proficient in examination of the newborn, prescribing, suturing and intravenous cannulation.

Delegation and Skill Mix
• UK governments move to regulate MSWs to ensure the safety of patients and the public;
• NHS providers must ensure that appropriate support systems are in place to enable the skilled midwifery workforce to undertake essential clinical duties with particular emphasis on 24-hour administrative, clerical support and operating theatre staff;
• The introduction of MSWs should be within a UK-agreed framework which defines their role, responsibilities and arrangements for supervision;
• All aspects of care which may be delegated by a midwife are done so to an appropriately trained individual who is accountable to a midwife;
• Maternity Services must regularly develop, update and administer workforce plans, using nationally-agreed, midwifery-specific tools such as Birthrate Plus and recognise Safer Child Birth recommendations of 28 births per midwife or and one-to-one care for all women in established labour, from a midwife;
• The ratio of supervisors to midwives meets the Nursing and Midwifery Council’s recommendations, currently accepted as evidence of best practice.

Models of Care
The following key principles must be incorporated into all models of care:
• Women should have a seamless maternity service supported by an integrated model of midwifery care;
• The majority of maternity care is based in the community setting, therefore when planning models of midwifery care there should be equal value given to acute and community based provision;
• Women should have easy access to a midwife as first point of professional contact when pregnant;
Women should receive the majority of their midwifery care by
the same midwife;

Women should have 24-hour access to advice and support from a midwife
when they think they are in labour;

Women should have one-to-one care by a midwife when in established
labour;

The role of the midwife extends to the postnatal period, the duration of which
is determined by the professional judgment of the midwife.

The needs of women and their families should determine the models and
location of care;

To effectively care for women, midwives should be able to directly refer to
other professionals/agencies and receive referrals back;

Women’s care should be embedded in a multi-agency and multi-professional
arena.
7. REFERENCES


8. BIBLIOGRAPHY AND ADDITIONAL READING


9. GLOSSARY OF TERMS:

Acute Trust  An NHS body in England that provides secondary care or hospital based healthcare services from one or more hospitals

Antenatal care  Professional care provided to a woman and her partner to support them and their baby through the pathway of pregnancy and to help achieve the best possible health, psychological and social outcomes for the mother, baby and family

Birth centres  A facility (free standing or within a maternity hospital) managed and run by midwives which provides a comfortable home-like environment for women and partners who anticipate a straightforward birth. As with home births, all midwifery services must be provided within the safety net of a functioning local network providing prompt emergency transfer when required

Birthrate Plus®  Birthrate Plus is a framework for workforce planning and strategic decision making in maternity services. To determine the case mix for this model, clinical scores are allocated retrospectively to mothers and babies depending on the normality of the process and outcome of the labour. There are five categories of clinical score used in Birthrate Plus

Clinical Negligence Scheme for Trusts  The scheme that manages all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995. All NHS Trusts (including Foundation Trusts) and Primary Care Trusts (PCTs) in England currently belong to the scheme. http://www.nhsla.com/Claims/Schemes/CNST

In Scotland - NHS Quality Improvement Scotland. Will be known as Health Improvement Scotland in 2011.

Commissioning  The process local authorities and PCTs undertake to make sure that services funded by them meet the needs of the clients and patients.

England – Strategic Health Authorities / PCTs
Scotland – Health Boards
Wales - Healthcare Inspectorate Wales

Coordinator of care  A health professional, normally a midwife, who is responsible for ensuring that women and their families have access to services and care from a range of health
professionals, social care and voluntary services, when relevant

**Heads of Midwifery**  
The organisational and strategic leader for local maternity care provision and midwifery focused services. May also be known as Director of Midwifery Services

**Home birth**  
Usually a planned event where the woman gives birth at home, with care provided by a midwife. Should complications arise, all NHS home birth services are provided within a functioning, swiftly responsive, and well understood local network of emergency services and transfer arrangements

**Intrapartum**  
Pertaining to the period of labour and birth

**Lead professional**  
The health professional responsible for planning, providing and reviewing a woman’s care, with her input and agreement, from the initial antenatal assessment through to the postnatal period. In most circumstances, a midwife would take the role of lead professional for all healthy women with straightforward pregnancies and an obstetrician would be lead professional for women with complications of their pregnancy

**Midwifery**  
The profession which leads on normal pregnancy and birth and provides expert care to all mothers and babies irrespective of complexity during pregnancy, childbirth and the postnatal period within a family centred environment

**Midwife-led care**  
Care where the midwife is the lead professional. Midwife led care is suitable for women assessed to be low risk. Also referred to as Midwife led practice

**National Institute for Health and Clinical Excellence (NICE)**  
A special health authority producing guidance for the NHS and patients on medicines, medical equipment and clinical procedures

**Next Stage Review**  
*NHS Next Stage Review: A High Quality Workforce*, published by DH June 2008 and sets out how the findings of Darzi: *A High Quality Workforce* (June 2008) the future of the NHS workforce will be taken forward

**NMC**  
Nursing and Midwifery Council

**One-to-one care in labour**  
The undivided care a woman and her partner receive from a midwife once her labour is established. This will
require that the midwife is not caring for any other woman in established labour to ensure that women do not feel alone and anxious

Pathway
A course usually followed

Postnatal care
Professional care provided to meet the needs of women and their babies up to 6-8 weeks after birth, in the context of their families

Postpartum
The period immediately after birth

Primary Care Trust (PCT)
An NHS primary care trust (PCT) is a type of NHS trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care

Public Health
‘the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals’ (C.E.A. Winslow, 1920)

Public Service Agreement (PSA)
Sets out what organisations agree to deliver in return for funding. PSAs set out the key improvements that the public can expect from Government expenditure. They are three year agreements, negotiated between the Department and HM Treasury during the Spending Review process. Each PSA sets out the department’s high level aim, priority objectives and key outcome-based performance targets

Royal College of Gynaecologists (RCOG)
The professional organisation for obstetricians and gynecologists. The RCOG encourages the study and advancement of the science and practice of obstetrics and gynaecology.

Royal College of Midwives (RCM)
UK trade union and professional organisation for midwives

Social care
A range of services that support the most vulnerable people in society to carry on in their daily lives

Stakeholders
DH has a wide range of stakeholders that all share an interest in its work, including patients an the public, local
and regional NHS organisations, local authorities and social care providers, charities, and the voluntary and community sector

**Sure Start**
Cross-government programme that helps children and parents through increased availability to childcare and improved health and emotional development for young people

**Trust**
An NHS body that provides secondary care or hospital based healthcare services from one or more hospitals.

**WHO**
World Health Organisation
## 10. MEMBERSHIP OF WORKSTREAM

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<tr>
<th>Name</th>
<th>Title</th>
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<td>Jackie Foster</td>
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This short paper has been developed for the Core role of the midwife workstream group to summarise current health policy context and support in the UK and in the four countries relating to social enterprise in health and social care, and highlight key issues relating to social enterprise and midwifery.

1. **Definition of a Social Enterprise**

A social enterprise (SE) is a business that trades for social or environmental purposes in a variety of industries and sectors. As with a business it is based on the trading of goods and services and it must secure trade and customers. Staff often have a say in how the business is run. The difference between an SE and a business is that profits are used towards addressing its defined social or environmental purpose.

Ethos and purpose, rather than legal or organisational structure, are generally perceived to be the defining characteristics of a social enterprise.¹

The following definition is commonly used:

“A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.”²

2. **Policy contexts**

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UK government policy supports social enterprise to address public policy and enable better health care service delivery, in particular in areas where ‘traditional’ providers may be unable or unwilling to operate.

### Scotland

The key policy document is *Enterprising Third Sector Action Plan, 2008-11*. There are no Scottish Government policy documents that specifically relate to health care and social enterprise.

To date, the Scottish Social Enterprise Coalition (SSEC) has not been involved in any midwifery projects and is not aware of any that have been set up in Scotland. There has been resistance to social enterprises taking on health care in Scotland and services that have been outsourced were being returned ‘in-house’. SSEC’s website is www.scottishsocialenterprise.org.uk.

### Northern Ireland

There is a draft policy document relating to social enterprise generally, *Social Economy Enterprise Strategy 2009-2011*, consultation on which closed in October 2009.

To date, the Northern Irish Social Economy Network (NISEN) has not had any dealings with any midwifery enterprises. NISEN’s website is www.socialeconomynetwork.org.

### Wales

The main Welsh Government policy document is *The aims and objectives for the Social Enterprise Action Plan 2009*.

To date, there are no midwifery social enterprises in Wales. According to Community Enterprise Wales (CEW), provisions made

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3. [http://www.scotland.gov.uk/Topics/People/15300/Actionplan](http://www.scotland.gov.uk/Topics/People/15300/Actionplan)
by the Welsh government in relation to social enterprise generally
had been under utilised, often due to Transfer of Undertakings
(Protection of Employment) Regulations (TUPE)/pensions issues.6
There is no dedicated fund for SE in Wales and European Union
funding has been used by some Welsh social enterprises.

CEW website is www.cewales.org.

**England**

Since 2002 the Department of Health has invested in, and promoted social
enterprise as a mechanism for delivering policy to improve quality and
access to services. Key dates and policy documents are outlined below.

- 2002: the Social Enterprise Strategy set out the government’s aim to
  ‘create a dynamic and sustainable social enterprise sector’ and argued
  that social enterprises would play an important role in new ways of
delivering public services through social inclusion and community
participation.

- 2006: the White Paper ‘*Our health, our care, our say*’ Social
  Enterprise Unit established at the Department of Health to support
development of SEs.

- 2008: the ‘*Operating Framework for the NHS in England*’ set out the
government’s aim of separating Primary Care Trust (PCT) provider and
commissioning functions.

- 2008: the policy report *High Quality Care for All: NHS Next Stage
  Review Final Report* introduced a ‘right to request’ to enable the
setting up of a social enterprise by PCT staff (see section 5).

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6 Social enterprises must provide a pension equal to that provided by the NHS for those transferred out of the NHS, which is cost prohibitive – a problem commonly referred to by the pathfinders.


• 2009: NHS operating framework for the NHS in England\textsuperscript{11} required that PCTs are in a contractual relationship with service providers.

• 2009: Transforming Community Services\textsuperscript{12} programme launched (see section 4).

3. Developing Social Enterprise in England: the Pathfinder Programme

In 2006, the Social Enterprise Unit identified 26 social enterprises to take part in its Pathfinder Programme to lead the way in delivering ‘innovative services’. \textsuperscript{13} One of these, Maternal Link, offered midwifery services. This organisation withdrew from the scheme (see section 9).

A recent review of the programme\textsuperscript{14} found that the ‘gestation’ period for a social enterprise was longer than expected and all had experienced delays in progress due to engagement, finance or support. Sixteen of the original Pathfinder SEs are now running and a further seven have secured contracts with PCTs.

The report described benefits of SEs within health and social care to be:

• Enhanced quality care provision
• Better fit to patient needs
• Value for money
• Innovation
• Wider social dividend
• Expert knowledge in specific areas

It also noted that some SE pathfinders had been unable to compete with commercial providers and the majority had found it very difficult to get started, in part due to the lack of practical and financial support. However,

\textsuperscript{11} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107
\textsuperscript{12} http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/index.htm
\textsuperscript{13} http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4139501
most were optimistic about the future, which was partly due to the renewed interest from NHS commissioners about SEs.

The Department of Health’s response to the evaluation further supported social enterprise, noting that ‘the ethos and values of the social enterprise model are a catalyst for improving choice, equality and access to services and enable services to be delivered in an innovative and efficient manner’.

4. Transforming Community Services

The Transforming Community Services programme in England, launched in January 2009, aims to ‘support the NHS in its drive to improve quality and productivity by encouraging clinicians to innovate to transform services and by promoting healthy lifestyles and focusing on prevention’. This programme reinvigorated the government’s focus on social enterprise and its demand for the separation of PCT commissioning and provider functions.

5. Right to Request: benefit to existing NHS staff in England

High Quality Care for All: NHS Next Stage Review Final Report 6 established that staff working in PCTs should be enabled to make a business case to a PCT board to provide patient care through social enterprise. A ‘right to request’ guide was published which set out the implications and practical advice for staff. A PCT is now obliged to consider all ‘right to request’ cases and give reasons for any decision. If an SE is set up under the right to request, the PCT must offer it uncontested contracts for up to five years to enable it to establish itself. Thereafter, an SE will be able to compete for other contracts with other PCTs.

Currently, the overwhelming majority of midwives are employed by acute trusts rather than PCTs and so the potential benefits of right to request does not apply to them.


The report by the Prime Minister’s Commission on the Future of Nursing and Midwifery in England\(^{17}\) published in March 2010, set out benefits of social enterprise in its findings stating:

‘The proven safety of midwife-led care means there are distinct opportunities for more midwife-led services to be developed and supported across the NHS, especially in non-traditional locations that give easier access to key support such as social services, health visiting and the third sector, the RCM told us. The social enterprise philosophy is ripe for nursing and midwifery leadership. They stimulate engagement and empowerment of staff and service users to devise new, effective ways of delivering services’ (p.84).

It also referred to evidence\(^{18}\) demonstrating the benefits of employee engagement which facilitates ‘transformational nursing and midwifery leadership’ (p.84).

7. **Funding in England**

The Social Enterprise Investment Fund (SEIF) was set up in 2007 and is available to a social enterprise within England. To be eligible for support an SE must meet the following criteria: it must have primarily social objectives, with profits reinvested for that purpose in the business or community, the service must involve an innovative approach to the

\(^{17}\) Prime Minister’s Commission. (2010) *Front Line Care: Report by the Commission on the Future of Nursing and Midwifery in England*, p. 84.

delivery of health and/or social care and make a positive impact on the health and well-being of the client group and be designed through stakeholder, community and staff involvement. Social enterprises that can apply to SEIF include:

- Multi-agency partnerships, particularly voluntary and community groups wishing to use their expertise to provide services across health and social care;
- Existing social enterprises looking to expand into health and social care;
- Groups of professionals, such as nurses or therapists, seeking to form a social enterprise to deliver their services using the right to request.

All social enterprises who apply would be expected to have a not-for-profit status.

8. **Professional Indemnity and insurance cover**

In England a third party (e.g. a social enterprise) engaged by a PCT to provide services under the NHS Act 2006 may benefit from the PCT’s discretionary clinical negligence cover under the NHS Clinical Negligence Scheme for Trusts (CNST)\(^{19}\). The third party must be providing services provided by the PCT immediately prior to engagement of the third party. Primary medical, dental or ophthalmic services cannot be covered by CNST.

Although amendment of the *National Health Service Act 2006* extended access to CNST to non-NHS providers providing NHS-funded care regulations have not yet been made.

The government’s policy on professional indemnity and/or insurance is to ensure that in due course, there will be provision for compulsory cover as a condition of registration included in the legislative framework for each

\(^{19}\) Currently, only NHS organisations can be members of CNST.
health care profession. For those professions that currently do not yet have such provision, such as nurses and midwives, new legislation was proposed in 2009. In response to concerns that this approach was disproportionate, the Secretary of State for Health initiated a review of the policy on indemnity and insurance cover for all health professionals. The review will report findings to Ministers in May 2010.

9. **Midwifery and social enterprise**

In an article in 2007\(^\text{20}\), Sean O’Sullivan of the RCM policy unit suggested that whereas in some NHS services, such as mental health and learning difficulties, there has been a long tradition of involving voluntary and private organisations, this had not been the case for midwifery. However, as social enterprises in primary and community care form part of a more diverse market of health and social care providers, midwives could be well positioned to respond to an emerging market of diverse maternity services providers. He identified how SEs are able to engage with local communities and are, therefore, well suited to working with women from disadvantaged groups who may find it difficult to access statutory services.

He described advantages of social enterprises for midwives as including:

- Increased autonomy about how midwifery care is organised and delivered;
- Increased scope to influence the way services are delivered;
- Greater say in management of midwifery services, giving employees greater organisational control leading to better performance;
- Ability to contribute to the wider objectives of midwifery care, such as public health and tackling health inequalities by virtue of their strong links with the community.

and disadvantages as being:

- High start-up costs (notwithstanding any government funding);

• Challenge of establishing infrastructure support such as human resources, payroll and financial management;
• Directly accountability for incidences of clinical or financial failure;
• Failing enterprise may be vulnerable to takeovers or mergers.

For pregnant women and new mothers, the fragmentation of service providers could make navigation of the system more complicated, particularly for women with complex needs.

10. **Examples of Social Enterprise in Midwifery**

**Independent Midwives UK (IM UK) www.independentmidwives.org.uk**

IM UK was awarded a grant from the social enterprise fund in March 2009 towards the costs of setting up an SE and has made a further request for funding from the fund. In addition, it has sought other funds.

In an article published on the RCN website in December 2009²¹, Brenda Van Der Kooy stated;

‘The Independent Midwives Association, encouraged by the Department of Health, is becoming a social enterprise known as Independent Midwives UK in order to contract the services of its members - self employed independent midwives - to PCTs in England. This will mean that a midwife can carry her own caseload of NHS clients and have indemnity cover through the NHS Litigation Authority.’

There is no commercial indemnity policy or insurance cover variable to a midwife working as a self-employed practitioner for care during labour or birth. Extension of indemnity cover is under review (see section 8); as yet, IMUK social enterprise has not achieved any commission for services.

Birth and Beyond Consultancy

Birth and Beyond Consultancy (BBC) is a social enterprise that describes itself as:

‘a comprehensive, collaborative birth service group….[which] offers a full range of services during the childbearing year that carries through the full circle of life’ It aims to provide a ‘non-traditional childbirth education for expectant parents Birth and Beyond aims to empower women and their partners by opening the mind, body and spirit to the power within’.

BBC was set up originally to provide antenatal education to provide standardized advice to help the woman make decisions and be in control of her pregnancy and labour. It does not provide intrapartum care.

BBC was turned down by the SEIF and received other grant funding from a local business fund. The directors of BBC have not been able to pay themselves a great amount and still have to work full time. However, BBC has recently been commissioned by Hull PCT to deliver classes across the city in children's centres, and is in the process of employing 15 other midwives on a sessional basis with a clear pay structure.


Maternal Link was originally set up as a pathfinder social enterprise project (see section 3) to provide antenatal, postnatal and community midwifery services at home or in birth centres in the Trafford area.

It aimed to design, develop and manage midwifery-led care in the community for home births and at birth centres on behalf of the NHS on a social enterprise franchised basis. Its goal is to develop a national network of birth centres by operating a franchise model with each birth centre having its own financial, legal and regulatory entity.
The organisation is no longer active and did not progress beyond the initial concept and discussions with the Social Enterprise Unit. Informal feedback from the Maternal Link founder was that reasons for failure were lack of practical support and commissioners’ lack of understanding of SE concept.

11. **Nursing**

The Royal College of Nursing (RCN), states that there are an increasing number of nurse-led specialist services taking the form of social enterprises.\(^{22}\) The RCN gives its support to social enterprises that are sustainable, making the point that if new organisations are not sustainable, individuals will have to be cared for by other providers and staff will face uncertainties and need to find new posts.

It believes social enterprises must be committed to meeting public sector equality duties as a deliverer of NHS services, participate in NHS workforce planning systems where appropriate, and include professional development and high standards in employment and health and safety. The RCN is now running training on setting up social enterprise and has produced its own guides to setting up a social enterprise on its website.\(^ {23}\)
