

# MIDWIFERY 2020

# Delivering expectations



**DH INFORMATION READER BOX**

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# Foreword

## From the Chief Nursing Officers of England, Northern Ireland, Scotland and Wales

Midwives and the care they provide to women, babies and families are of the utmost importance to society. Across the United Kingdom midwives are key professionals in ensuring that women have a safe and emotionally satisfying experience during their pregnancy, childbirth and postnatal period.

The coming decade will present new challenges and opportunities for midwives to develop further their role as practitioners, partners and leaders in delivering and shaping maternity services. We commissioned *Midwifery 2020* to develop a vision of midwifery so that midwives across the UK can fulfil women's health and social needs and expectations. Our aim was to consolidate the achievements that midwifery has made and to identify changes needed to the ways midwives work, their role, responsibilities, and the education, training and professional development needed to achieve these outcomes.

The principal objectives of *Midwifery 2020* have been to:

- Review the current and developing role of midwives in the UK within the context of evolving healthcare provision, tackling inequalities, improved outcomes, and user expectations and experiences
- Gather and use available evidence to set the appropriate direction for midwifery services across each of the UK countries
- Use national and international evidence, taking account of factors which will influence the landscape, to scope and describe current and potential models of midwifery service provision
- Scope current midwifery education and consider its fitness for purpose
- Identify current and future career pathways for midwives
- Maximise the potential for midwives to develop capacity and capability in developing and delivering research-based practice
- Scope the role, capabilities and career pathway for maternity support workers/maternity care assistants in supporting midwives, midwifery practice and maternity care
- Consider opportunities and ways of supporting and retaining midwives in practice.

*Midwifery 2020* has been a unique UK-wide collaborative programme with the full and active involvement of the four UK Chief Nursing Officers in England, Northern Ireland, Scotland and Wales and carried out in partnership with the Royal Colleges, the Nursing and Midwifery Council (NMC), and with diverse partners and stakeholders in maternity

care, professional bodies, higher education, user organisations, employers and commissioners of service and education across all four countries.

The work of *Midwifery 2020* has been set firmly within the reality of the political, legal, economic, social and technological changes facing the UK.

There are undoubtedly challenges in developing a vision and way forward for midwifery care across the four countries of the UK because of the different ways in which services are organised and the policies that impact on midwifery and maternity services.

There are, however, many similarities and the key messages that are central to *Midwifery 2020* provide, we believe, a robust and far-reaching vision of the future for midwifery against which all four countries can benchmark their midwifery planning and provision to identify priorities for each country.

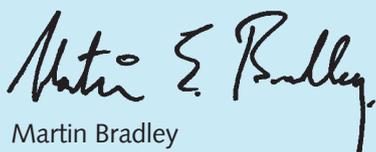
We charge all those involved in delivering expectations for midwifery and maternity services to actively review our key messages and to transform their services for the women, babies and families who are our prime concern.



Rosemary Kennedy, CBE (Chair, *Midwifery 2020*)  
Chief Nursing Officer  
Welsh Assembly Government  
Llywodraeth Cynulliad Cymru



Dame Christine Beasley, DBE  
Chief Nursing Officer  
Department of Health  
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Martin Bradley  
Chief Nursing Officer  
Department of Health, Social Services and Public Safety  
Northern Ireland



Ros Moore  
Chief Nursing Officer  
The Scottish Government  
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# Introduction

*Midwifery 2020* has set out to develop an informed vision (opposite) of the contribution midwives will make to achieving quality, cost-effective maternity services for women, babies and families across the United Kingdom. Midwives, managers, members of the maternity team, educationalists, commissioners and service users considered the future direction for midwifery and this report brings together the outcomes of their deliberations. It is supported by five in-depth workstream reports that are available on the *Midwifery 2020* website at [www.midwifery2020.org](http://www.midwifery2020.org)

We have set out below our key messages resulting from the work of the *Midwifery 2020* programme which underpin the vision of how midwives can lead and deliver care in a changing environment. They reinforce and restate the core values of the profession, celebrate the achievements made in the past, and show how midwives can continue to strengthen their unique contribution as key professionals who ensure that women, their partners and their babies have safe and life enhancing experiences.

The key messages are addressed to all those with an involvement in midwifery and maternity services. How you use the report and its key messages will depend on your role and we urge you to consider what you can do to ensure that midwives can maximise their contribution to delivering quality services for women, babies and families.

## Our vision of Midwifery in 2020

Midwives will continue to be members of a highly skilled workforce with the scope to provide world-class maternity care from the provision of direct care through to Board level contributions.

Midwives will be the lead professional for all healthy women with straightforward pregnancies. For women with complex pregnancies they will work as the key coordinator of care within the multidisciplinary team, liaising closely with obstetricians, general practitioners, health visitors/public health practitioners and maternity support workers/maternity care assistants.

Midwives will deliver innovative evidence-based, cost-effective, quality care across integrated health and social care contexts. They will have the capacity to initiate and to respond to change.

Midwives will embrace a greater public health role. Individual midwives and the midwifery workforce will expect support from those who plan and commission maternity services to enable them to meet the challenges of reducing inequalities and improving maternal and family health.

Holistic models of care will be delivered by a graduate professional who makes autonomous decisions when appropriate, consults where necessary and manages a woman's health and social needs. A woman will have a trusting relationship with a midwife, or small team of midwives, who coordinate her care and provide continuity of care throughout pregnancy and the postnatal period.

Midwives will continue to provide the majority of care to pregnant women and therefore will maintain and develop their competence and will be champions of care in the hospital and community.

Responding to women's experiences of care will drive quality improvement and this will result in an increased focus on social models of care with women and families' needs at the very heart of midwifery and maternity care.

There will be an increased focus on measuring the quality of healthcare across the whole maternity pathway. The best indicators of quality will reflect: person centredness, safety, effectiveness, efficiency, equity and timeliness.

Midwifery education will be rooted in normality whilst preparing midwives to care for all women including those with complex medical, obstetric and social needs. It will prepare and develop midwives to be skilled and safe, empathic and trustworthy with increased emphasis on the principles of autonomy and accountability within multidisciplinary and multi-agency teams.

All midwives will recognise that their learning continues after graduation. They will have access to relevant, timely continuing professional education and will have sufficient time to take part in this education.

Midwives will be part of a culture in which they are respected, aspire to, and are prepared for, strategic roles in service delivery at Board level, for example Director of Nursing and Midwifery, Director of Maternity Services, or Director of Public Health.

Midwifery will be seen as a positive career choice with a range of rewarding career pathways. Careers advisors will promote midwifery and be aware of the full range of career opportunities available to midwives, including those in research. Clinical academic careers for midwives will be promoted to enable the midwifery profession to better engage in the collaborative research agenda.

# Key messages

## Meeting women's needs

- Women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing. Quality maternity services should be defined by the ability to do both. [p22]
- Midwives should have a visible place in a community setting where women can choose to access them as the first point of contact. [p22]
- There are two key roles for midwives that are important if we are to achieve our vision: one is that midwives are the **lead professional** for women with no complications, and the other is as the **coordinator of care** for all women. [p23]
- Each woman and her partner need a midwife they know and trust to coordinate their physical and emotional care through pregnancy and until the end of the postnatal period. [p23]

## The midwifery workforce

- An analysis should be undertaken of the impact of an increasing trend towards part-time working among midwives including the impact on continuity of care, mentoring students, future recruitment, predicted absence and time required for continuing professional development. [p25]
- Each country of the UK should undertake workforce modelling projections, assuming different birth rates, working practices and retirement patterns, to ensure that robust midwifery workforce planning is in place. This modelling should be carried out at country level where policy can influence the required changes, and also needs to take account of local demographics and needs. [p25]

## Developing the midwife's role in public health and reducing inequalities

- Midwives' unique contribution to public health is that they work with women and their partners and families throughout pregnancy, birth and the postnatal period to provide safe, holistic care. For optimum effect, midwifery needs to be firmly rooted in the community where women and their partners live their lives. Midwives should have a good knowledge of the health and social care needs of the local community; be well networked into the local health and social care system; and be proactive in identifying women at risk, and engaging with the woman, her family and other services as appropriate. [p26]

- Seamless maternity services which work effectively between community and hospital settings should continue to be developed. These will support families to achieve improvements in early childcare and development and will facilitate access to parenting programmes and good quality early years' education. [p26]
- Midwives should use their advocacy role for influencing and improving the health and wellbeing of women, children and families. This will include making the economic case for committing resources so that the midwife can deliver public health messages in the antenatal and postnatal periods, and ensuring that there is a midwifery contribution at policy, strategic, political and international level. [p26]

### Measuring the contribution midwives make

- The success of maternity services should be measured in terms of actual and perceived safety, effectiveness of care and the experience of the woman and her partner. Midwifery-specific indicators should be used to monitor quality at an individual midwife level, at team level and at service management level. [p28]
- The definition of quality should be further enhanced to take account of all six dimensions of quality: person-centredness, safety, effectiveness, efficiency, equity, and timeliness, together with women's experience and satisfaction with care. Equity should be included in a measure of quality to ensure that safety, effectiveness and the experience of women and their partners do not vary as a result of factors such as age, ethnicity, area of residence or socio-economic status. [p29]
- The views and experiences of women and their partners are an important part of measuring quality. Effective tools for collecting information about their experiences of care should be developed and widely used. [p30]

### Supporting midwives

- Qualified maternity support workers/maternity care assistants should be employed within a nationally agreed framework, which defines their role, responsibilities and arrangements for delegation and supervision and makes it clear their role is to support and not replace the midwife. [p31]
- NHS providers should ensure that appropriate support systems are in place so that the skilled midwifery workforce can carry out essential clinical duties, this means ensuring appropriate 24-hour administrative, domestic and operating theatre support as such duties are not an effective use of midwifery time. [p32]

### Developing a contemporary image of midwifery

- A national campaign should be undertaken focusing on the nature and importance of midwives and midwifery practice which could inform the general public and potentially inspire the current workforce, as well as continue to attract high-calibre candidates into the profession. [p33]

### Educating midwives

- Pre-registration curricula should be designed to prepare the midwives of the future to work in a range of settings and build professional capacity. These programmes of education and training will focus on developing interpersonal skills, enabling the graduate to fulfil the lead practitioner role, to be the first point of contact for women, to promote and enhance the management of normal births, and to coordinate and provide care in high-risk and complex pregnancies and along the whole of the maternity pathway. [p34]
- Broader entry criteria to midwifery courses can be promoted by more flexible arrangements for the Accreditation of Prior (and Experiential) Learning (AP(E)L). [p35]
- There should be a sufficient critical mass of midwifery educationalists with the capacity to deliver the curricula and provide support for students in practice settings across large geographical areas. [p35]

### Developing midwives

- Continuing professional development (CPD) opportunities, which are academically robust and professionally relevant, should be available to all midwives based on local need. Support should be available to allow midwives access to educational opportunities that are linked demonstrably to enhancing the quality of midwifery care while also contributing to the personal development plan of the midwives concerned. [p37]
- A widely agreed professional system of 'passports' for qualified midwives would provide valid and reliable evidence of the CPD they have successfully completed and avoid duplication particularly when moving to other health boards/trusts. While employers have a crucial role, it is also important to recognise the responsibility of individual practitioners in relation to their own CPD and systems such as e-portfolios could be a means of effectively supporting them. [p37]

## Maximising midwives' influence

- Closer partnership working between higher education institutions and service providers, including joint appointments and secondments, should be strengthened. This will facilitate a flexible career structure and promote a culture where the integration of theory and practice across both pre- and post-registration education programmes is strengthened. Opportunities should be promoted which maximise the potential for midwives to develop capacity and capability in developing research and delivering research-based practice which has been shown to improve care and outcomes for women, babies and families. [p40]
- Clinical academic and research career opportunities for midwives, with the associated employment flexibility, are key to the way forward and should be promoted. [p40]
- Heads of Midwifery should as a key component of their role, provide strategic leadership to achieve an appropriate focus on both professional midwifery matters and maternity service delivery, reporting directly to board level, or via the Director of Nursing or Director of Public Health, on such matters. [p40]
- Innovative and pragmatic solutions for lecturing staff based in higher education institutions should be developed so they can maintain their clinical credibility in midwifery practice. [p41]
- A more flexible career framework should be developed to support midwives in practice and in research and education, enabling experienced midwives to combine both specialist and advanced contributions to practice with the core role of the midwife. [p41]





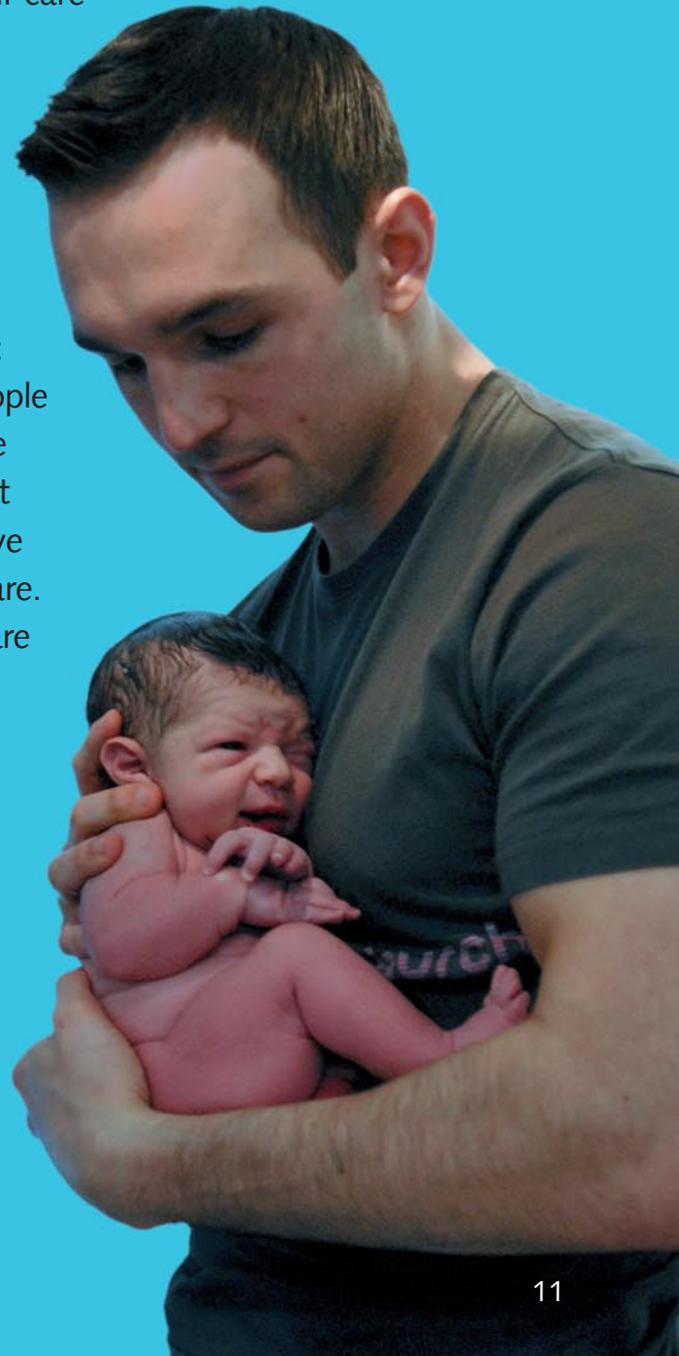
# Midwifery 2020: delivering expectations for the future

Midwives play a central role in ensuring that women have a safe and life-enhancing experience during their maternity care and that their babies and families have the best possible start in life.

Approximately 900,000 women give birth each year in the UK and it is likely that they will receive the majority of their care from a midwife. In women's homes, birth centres and hospitals, midwives coordinate the woman's journey through pregnancy, providing the continuity to ensure that she experiences safe, compassionate care in an appropriate environment.

Midwives are autonomous professionals whose unique and specialist contribution affects the whole population: each of us at the time of birth, the great majority of people who become parents and the half of these who become mothers. Women and their families expect a service that provides clear communication and explanations, effective teamwork, a safe care environment and continuity of care. The midwife's role is to ensure that these expectations are understood and met.

Midwives, in partnership with other members of the multidisciplinary team – for example, obstetricians, general practitioners, health visitors/public health practitioners and maternity support workers/maternity care assistants – face the challenge of meeting the health and social care needs of a rapidly changing population. The midwifery contribution is central to achieving quality care and a more equitable and healthy society.



Much has been achieved in the development of contemporary maternity care, particularly since the publication of *Changing Childbirth*<sup>2</sup> in 1993. Midwives have risen to the challenge of providing woman-centred care; they work autonomously, taking responsibility for a woman's care during pregnancy; and work as key members of the maternity services team. Across the UK there is now a common commitment to:

- Providing physically and emotionally safe services which are woman and family centred
- Establishing midwives as the first professional contact in maternity services who then coordinate a woman's journey through pregnancy
- Offering pregnant women more choice about how to access maternity services
- Offering more choice for location of antenatal, birth and postnatal care
- Developing more midwife-led care and access to community-based services
- Increasing continuity of carer across the maternity care pathway
- Defining a health promotion and public health role for midwives to contribute to the reduction of inequalities
- Encouraging normal birth and reducing unnecessary interventions
- Hearing and responding to the voices of women and families about their experiences of and satisfaction with care<sup>3</sup>.

A feature of *Midwifery 2020* has been active involvement and consultation with a broad range of partners and stakeholders. Their commitment to the views expressed in this report means that the profession can move forward with confidence.

## Definition of the midwife

'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. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

A midwife may practise in any setting including the home, community, hospitals, clinics, or health units.<sup>1</sup>

## Who this report is for

**This report is for everyone with an interest in midwifery and maternity services:**

- **The midwives who provide services for women, and student midwives: the midwives of the future**
- **Those who use and interface with midwifery and maternity services in particular mothers, fathers, partners and families**
- **Those who work with midwives as part of the maternity services team: for example, obstetricians, general practitioners, health visitors/public health practitioners, maternity support workers/maternity care assistants**
- **Those who commission and provide maternity services at local, regional and national levels: workforce planners, heads of midwifery, consultant midwives, local supervising authorities, and chief executive officers**
- **Those who educate midwives and student midwives: higher education institutions, lead midwives for education**
- **Those engaging in research that impacts on maternity services**
- **Government leads, regulatory, professional and advisory bodies.**

# Working towards *Midwifery 2020*

# 2

A United Kingdom Programme Board was set up to lead *Midwifery 2020* and to report directly to the UK Chief Nursing Officers. Membership included major external partners and stakeholders selected for their knowledge, skills and expertise. The members of the Programme Board are listed in Appendix 1.

The UK Programme Board identified five key workstreams each of which were led by one of the four countries and which are outlined on Page 14 (Box 1). A full list of members of each of the workstreams and national steering groups is given at Appendix 2 and we acknowledge the tremendous commitment shown by members and chairs.

Underpinning the work of the workstreams were the principles of user involvement, professional education, leadership, and the provision of safe, emotionally satisfying, effective and evidence-based maternity care to meet user needs. The unique contribution made to midwifery by the statutory supervision of midwives was acknowledged and informed the workstreams' debates.



Box 1

## Midwifery 2020 Five key workstreams

### The core role of the midwife

All aspects of care, including models of care, service delivery, elements of skill mix and social enterprise.

*Wales, in partnership with Northern Ireland, led this work.*

### Workforce and workload

Demographics, education commissioning, attrition and workforce planning.

*Scotland led this work.*

### Education and career progression

Clinical and academic careers, mobility and flexibility, newly qualified midwives, levels of practice, research, midwife managers and teachers, image of midwifery as a career choice.

*England led this work.*

### Measuring quality

Metrics work, clinical quality and outcome indicators and valuing midwifery care.

*England led this work.*

### Public health

The public health role of the midwife taking account of inequalities, parenting education, early years work and multi-agency working.

*Northern Ireland, in partnership with Scotland, led this work.*

A variety of literature reviews, data collection and analysis were commissioned by the workstreams depending on the focus of their work and other reviews were commissioned centrally. Each workstream made use of local, national and international evidence where appropriate to take account of factors which influence the future landscape of service provision.

The UK Programme Board also contributed their vision of society in 2020 in terms of political, economic, social and technological changes and challenges, see Appendix 3.

## Reviews commissioned by Midwifery 2020

Masterson, A. (2010) *Midwifery 2020: UK Policy Review Report*. [http://www.midwifery2020.org/documents/2020/policy\\_review.pdf](http://www.midwifery2020.org/documents/2020/policy_review.pdf)

McNeill, J., Lynn, F. and Alderdice, F. (2010) *Systematic Review of Reviews: The public health role of the midwife*. Belfast: School of Nursing and Midwifery, Queen's University. [http://www.midwifery2020.org/documents/2020/Public\\_Health\\_Lit\\_Review.pdf](http://www.midwifery2020.org/documents/2020/Public_Health_Lit_Review.pdf)

Masterson, A. (2010) *The Core Role of the Midwife: A literature review*. [http://www.midwifery2020.org/documents/2020/Core\\_Role\\_Lit\\_review.pdf](http://www.midwifery2020.org/documents/2020/Core_Role_Lit_review.pdf)

# The context of *Midwifery 2020*

# 3

There have been radical changes in the social, economic and cultural context of midwifery and maternity services in the past years and these will continue to influence the work of midwives in the future. In this section we bring together some of the influential trends that need to be taken into account when considering the future direction of midwifery.

Photograph: Leah Photography



## 3.1 Health and social context

Health is largely determined by our social, economic, physical and cultural environment. Although, as we move further into the 21st century, we can see improvements for many people, inequalities in health and health outcomes still persist. The differences in life chances are dramatic and there is a direct correlation between low socio-economic status and poor health outcomes<sup>4</sup>.

Health inequalities affect both women and babies. We know that women living in families where both partners are unemployed are up to seven times more likely to die than women from the more advantaged groups<sup>5</sup>, while babies born in the most deprived areas are up to six times more likely to die in infancy<sup>6</sup>.

An independent inquiry into the safety of maternity services in England in 2005<sup>7</sup> emphasised some of the changes that are taking place:

- Numbers of births per year have risen since 2002 and are projected to increase
- There are more older mothers, with higher rates of complication
- There is 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.

In response to such changes we need a multifaceted, multi-agency approach based on strengthening individuals, families and communities, while at the same time improving the infrastructure and access to services. Midwives and midwifery services have a particular part to play in this. We could go a long way to achieving improvements in health and social outcomes by giving more people, particularly women and children, better life chances<sup>8</sup>. Midwives play a vital role as core professionals in the multidisciplinary maternity team, working with a range of colleagues including obstetricians, GPs, health visitors/public health practitioners and maternity support workers/maternity care assistants.

The quality of care that women, babies and families receive during pregnancy, birth and the early weeks after birth influences the life chances of babies<sup>9</sup> particularly for women with complex needs who have increased risk factors.

In recent years a number of factors have had a significant impact on the capacity of maternity services and midwives to deliver quality care. Many more women and families are recognised as having complex physical and social needs including women and families living in poverty; migrant women who do not speak English as a first language; teenage mothers; women who are misusing drugs and alcohol; women who are obese and those who have long-term conditions such as diabetes. In addition the average age of first birth is now 29.4 years compared with 28.4 years in 1999<sup>10</sup> and increased use of fertility treatment has meant a higher rate of multiple births. These demographic and lifestyle challenges place additional demands on the provision of maternity care.

Parents and children need a framework for care which provides continuity from pre-pregnancy, through pregnancy and childbirth, to the early years of life. A comprehensive approach to early life is needed which builds on existing programmes to ensure our children get the best start in life<sup>8</sup>. Midwives have a key role in ensuring that their contribution integrates with the roles of other professionals and agencies working in collaboration with maternity services.

Early childhood development has a profound influence on subsequent life chances and health through skills development, education and occupational opportunities<sup>11</sup>. Early childhood experiences also directly impact on the subsequent risks of obesity, malnutrition, mental health problems, heart disease, and criminality. So investment in early years provision and support offers the potential to reduce health inequalities within a generation. The importance of parenting education not only relates to pregnancy but also the postnatal period and the establishment of bonding, holistic infant development and parental lifestyle choices that set down important foundations for healthy living.

Midwives work with fathers and partners as they play an increasing role during pregnancy. Their involvement and support have a significant impact on both the mother and on the baby's social, emotional and intellectual development<sup>12,13</sup>. The perinatal period is a 'golden opportunity'<sup>14</sup> for midwives to offer fathers information, support and advice<sup>15</sup>.

## 3.2 Economic context

Public sector funding will be tightly controlled in the next few years in response to the global economic crisis<sup>16</sup>. However, the NHS will continue to have a key role to play in improving the health of the population at a time when there may be higher rates of unemployment and increased health inequalities in disadvantaged areas, and where ill health is seen as a consequence of high rates of unemployment.

There may be challenges in meeting increasing demand driven partly by population growth and change, and partly by ever-increasing expectations of the quality of the service. However, it will be crucial to deliver quality outcomes through improved productivity.

## 3.3 The workforce

Providing quality midwifery care depends on the availability of a workforce of practising, skilled midwives who can lead and contribute to the care of women as part of the multidisciplinary team. Workforce planning is multi-faceted and is influenced by variables which impact on the complexity and intensity of care delivery. These include a woman's choice, risk status, model of care and geography, the projected birth rate, midwives working and retirement patterns and student numbers.

## 3.4 Context of midwifery practice

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. From the early 1960s the most usual place to give birth moved from being a woman's home to hospital settings and the majority of women now give birth in hospital. In recent years larger tertiary maternity units have been developed, housing a range of specialised services, and there has also been an increase in the number of midwife-led units.

Most midwives work in a hospital environment and have maintained their skills as the lead professional for healthy women with straightforward pregnancies while developing new skills in caring for women with complex medical and obstetric conditions. Twenty-first century government policy<sup>17,18,19</sup> is shifting the focus to community-based delivery of maternity care, and there are opportunities for midwives to strengthen their skills in organising and leading local services for women and families.

## 3.5 Midwives as part of the multidisciplinary team

Quality maternity care for women and families depends on the effective contribution of each member of the multidisciplinary team. Midwives are key players as coordinators of care, working alongside other members of the multidisciplinary team. While general practitioners have ongoing responsibility for a woman's general medical care, evidence shows that pregnant women benefit from accessing

maternity services as early as possible and policy direction in all four countries is to have the midwife as the first point of contact<sup>3</sup>.

Midwives work closely with obstetric and GP colleagues to deliver maternity care for women, and increasingly with maternity support workers/maternity care assistants, health visitors/public health practitioners, social care colleagues and specialist workers to respond to the complex health and social needs of some women and their families.

Crucial to the success of such partnership working is timely and effective communication. Poor communication and ineffective team working have been found to be underlying causes of substandard care, in particular a failure to share important information between professionals including GPs, the maternity team and social services<sup>5</sup>. Good communication is fundamental to multidisciplinary working and it is imperative that each member of the team takes personal professional accountability for ensuring clear and effective communication.

## 3.6 Changes in midwifery education

Professional midwifery education programmes require substantial academic, clinical and professional input from skilled educationalists and it is essential to protect and assure the quality of the student learning experience. There are challenges facing the midwifery education workforce, in particular the age profile of the workforce which means that a substantial proportion are due to retire in the coming years, and the need for midwifery lecturers to remain clinically credible. Consequently there will be a need to consider whether the higher education institutions (HEIs) currently delivering midwifery programmes can be rationalised, balancing the need for local provision with the potential for some amalgamation to achieve a greater critical mass of midwifery educationalists and greater economies of scale.

There are opportunities to develop wider access for students and to consider the contribution that information technology can make to effective and flexible education delivery through the innovative use of a variety of teaching methods. The role of lecturers is likely to change and they will need support to develop the skills and expertise to work with new and advancing technology such as the appropriate use of social networking and the use of innovative communications.

Changes in society mean that the profile of the midwifery student body has changed and will continue to change as the profession attracts mature entrants, single parents and students with families of their own. Recruitment and retention strategies need to continue to reflect the characteristics of contemporary recruits to midwifery.

## 3.7 Careers in midwifery

Over recent years opportunities for midwives to develop their careers and move between or combine practice and education have become more limited. The reasons are multifactorial but include:

- Separation of education from practice with the move into HEIs
- Reduction in opportunities for practice-based midwives to undertake secondments as lecturer-practitioners in HEIs
- A flattened career structure in practice and education
- Disparities in pay and reward between practice and education
- Lack of pension portability between practice and education.

Midwifery roles and career progression should reflect the changing needs of health and maternity care and should also reflect the needs of a highly skilled workforce.

## 3.8 Summary

Midwives and maternity services face considerable challenges but also unparalleled opportunities in providing and maintaining high quality midwifery services. The importance of high quality maternity services to the health and wellbeing of the population is increasingly recognised by women and their families, by policy makers and by clinical staff. Understanding and meeting rising expectations is a key component of quality. Maternity service providers and midwives will therefore want to consider how to adapt the way they work and organise themselves to deliver, flexibly, the highest quality of care.

# 4

## Enabling midwives to make the difference

What can we build on and what should be developed so that the midwifery profession can fulfil its mission to meet women and families' needs in 2020?

In this section we examine how midwives can continue to meet women's changing needs; how to make sure we are developing a midwifery workforce for the future; the public health role of the midwife; the importance of measuring the contribution of midwifery care; the support that midwives need to deliver quality care; and conclude with an examination of the image of midwifery, and the education and career pathways that are necessary for midwives to achieve this vision for the future.



## 4.1 Meeting women's needs

### Key message

Women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing. Quality maternity services should be defined by the ability to do both.

A midwife's focus is to enable all women and their families to have a positive and safe experience of pregnancy, birth and early parenting. A social model of maternity care where women, rather than the organisation, are at the centre is a key feature of midwifery-led care<sup>20</sup>. Women value care that is personalised and coordinated by a midwife they know and trust and should be offered a choice of place of birth taking account of individual needs, risks and circumstances. One-to-one support in established labour results in better outcomes for women and this is a key role of the midwife.

However, if larger maternity units become the norm, midwives may spend an increasing amount of time 'meeting the needs of the organisation' rather than the needs of women<sup>21</sup>. Over the years some maternity practice in the UK has become increasingly risk averse, as midwives have adapted their practice to care for women in increasingly technical environments. While using technology for women with complex medical and obstetric conditions can be appropriate, for many women indiscriminate use of technology may increase their chance of unnecessary interventions.

In addition to the effect this may have on the woman, this could damage staff morale and is a serious challenge to recruitment and retention of midwives whose primary professional motivation is to care for women<sup>22</sup>.

Looking to the maternity service of 2020, it is likely that the number of women with complex medical and obstetric conditions will continue to rise. As midwives will continue to coordinate care for all women, whether or not they have straightforward pregnancies, it will be essential for them to develop the skills to engage with women in encouraging healthy lifestyles, and also working across health and social care services to support vulnerable women and families through childbirth and early parenthood.

In the context of maternity care, all women need a midwife; some also need an obstetrician, while some will also want or need support from others such as health visitors, GPs and social services<sup>17</sup>. The voluntary sector also has an important role to play in providing services such as antenatal classes, breastfeeding advice and postnatal social support.

Most recent UK Government policy has promoted the midwife as first point of contact for women accessing maternity services<sup>17,23,24</sup>. In this system once the woman has confirmed her pregnancy, she will self refer or be directed to a midwife who, where possible, will be the first point of professional contact. The aim is to facilitate early risk assessment and booking with maternity services before 12 weeks gestation. However, the organisational structures are not universally in place to support this and in many areas there is not yet a system that enables women to choose to access a midwife without first going to a

### Key message

Midwives should have a visible place in a community setting where women can choose to access them as the first point of contact.

GP. Where the system exists the midwife undertakes an initial risk assessment, streaming the women appropriately to a care package tailored to her individual need. Although midwives take the lead, it is key that they can communicate effectively with the GP and other members of the maternity team about the medical and social history of the women in their care.

There are two key roles for midwives that are important if we are to achieve our vision: one is that midwives are the **lead professional** for women with no complications, and the other is as the **coordinator of care** for all women. The definition of these roles is set out below.

### Lead professional

The role of lead professional is to plan, provide, and review a woman's care, with her input and agreement, from initial antenatal assessment through to the end of the postnatal period. In most circumstances, a midwife would take the role of lead professional for all healthy women with straightforward pregnancies. For low-risk women, midwife-led care reduces admission to hospital and results in significantly less intervention during birth<sup>25,26</sup>.

### Coordinator of care

For almost all pregnant women, the midwife coordinates her care throughout pregnancy, labour and the postnatal period. The midwife is expert in the normal, but also provides a pivotal role in coordinating the journey through pregnancy for all women, ensuring they are referred to health, voluntary and social services when appropriate and that holistic care is provided to optimise each woman's birth experience regardless of risk factor. Whilst the lead professional may change during a pregnancy, for example to the obstetrician when necessary, the coordinator of care remains the same, providing the continuity that women want.

The distinction between lead professional and coordinator of care should be made explicit to women and health professionals. Both these roles require a multidisciplinary and multi-agency approach.

Collaboration across health, voluntary and social care boundaries can maximise the opportunity for women to have a positive experience and a safe outcome, regardless of whether the pregnancy and birth is straightforward. It provides every woman with appropriate care planning that is unique to her and reduces her chances of receiving conflicting advice.

### Statutory supervision: protecting the public by promoting best practice

Midwives are supported in providing safe, family-focused maternity services through a supervisory framework<sup>27</sup>. Statutory supervision of

#### Key message

There are two key roles for midwives that are important if we are to achieve our vision: one is that midwives are the **lead professional** for women with no complications, and the other is as the **coordinator of care** for all women.

#### Key message

Each woman and her partner need a midwife they know and trust to coordinate their physical and emotional care through pregnancy and until the end of the postnatal period.

midwives protect the public by promoting best practice, preventing poor practice and intervening in unacceptable practice. It 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.

### **Models of maternity care**

Quality midwifery care needs to be underpinned by models of care that take as their focus the wellbeing of women, babies and families. A key concept is that every woman requires care from a midwife and some will also need care from a doctor or other members of the team<sup>17</sup>. Midwives offer care within the context of multidisciplinary maternity teams and quality maternity teams will have as a principle the continuity of midwifery care. Outlined below are the key principles of all models of care which maximise continuity of midwifery care.

#### **Key principles for all models of midwifery 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 equal value should be given to acute and community based provision
- Women should have easy access to a midwife as the 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 1:1 midwifery care 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 together with the woman
- 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 and agencies and receive referrals back
- Women's care should be embedded in a multi-agency and multiprofessional arena

[Core role of the midwife report:

[http://www.midwifery2020.org/documents/2020/Core\\_Role.pdf](http://www.midwifery2020.org/documents/2020/Core_Role.pdf)]

## 4.2 The midwifery workforce

It is important to take into account the characteristics of the midwifery workforce when planning for future maternity services to meet women's needs. We therefore established some of the key facts about the workforce, see Box 2. [Workforce and workload report: [http://www.midwifery2020.org/documents/2020/Workforce\\_Workload.pdf](http://www.midwifery2020.org/documents/2020/Workforce_Workload.pdf)]

### Box 2

#### Midwifery workforce: key facts (2008 data)

- The number of midwifery staff in post at 30 September 2008 was 29,875 (23,828.4 wte)<sup>28</sup>
- The majority of the workforce is female and most are working part-time
- There are 4,056 midwives currently registered with the NMC who had not notified their intention to practise
- The midwifery workforce across the UK is ageing with 40%-45% of the midwifery workforce reaching the current retirement age in the next ten years
- More than two thirds of midwives are over 40 years and a quarter are over 50 years, with Northern Ireland having the highest proportion of midwives over 50 years
- The average age of a midwife is 42-43 years
- Across the UK the overall percentage of midwives working part-time is 57% with Scotland and Northern Ireland having 62% and 66% respectively
- Midwife-to-birth ratio or per capita is not directly comparable across the UK owing to differences such as service provision, geography etc.
- 96% of midwives work in the NHS

### Key message

An analysis should be undertaken of the impact of an increasing trend towards part-time working among midwives including the impact on continuity of care, mentoring students, future recruitment, predicted absence and time required for continuing professional development.

### Key message

Each country of the UK should undertake workforce modelling projections, assuming different birth rates, working practices and retirement ages, to ensure that robust midwifery workforce planning is in place. This modelling should be carried out at country level where policy can influence the required changes, and also needs to take account of local demographics and needs.

Estimates of the projected birthrate have, in the past, underestimated growth with a consequent impact on the workload for maternity care and midwives. Such variation should be taken into account in workforce planning projections and consideration of alternative scenarios.

There has been a move from full-time to part-time working among midwives in all countries which has a marked impact on all aspects of workforce planning. For example, in Scotland from 1998 to 2009, whole time staff have decreased from 49% in 1998 to 38% in 2009. [Workforce and Workstream report: [http://www.midwifery2020.org/documents/2020/Workforce\\_Workload.pdf](http://www.midwifery2020.org/documents/2020/Workforce_Workload.pdf)]

At present, more midwives are currently working part-time hours and this trend has increased year on year for the last ten years.

Projections should, for example, take account of the proportion of staff expected to retire and this factor needs to be taken together with the rate at which the workforce is being replaced.

# 4.3

## Developing the midwife's role in public health and addressing health inequalities

### Key message

Midwives' unique contribution to public health is that they work with women throughout pregnancy, birth and the postnatal period to provide safe, holistic care. For optimum effect, midwifery needs to be firmly rooted in the community where women and their partners live their lives. Midwives should have a good knowledge of the health and social care needs of the local community; be well networked into the local health and social care system; and be proactive in identifying women at risk, and engaging with the woman, her family and other services as appropriate.

### Key message

Seamless maternity services which work effectively between community and hospital settings should continue to be developed. These will support families to achieve improvements in early childcare and development and will facilitate access to parenting programmes, and good quality early years education.

### Key message

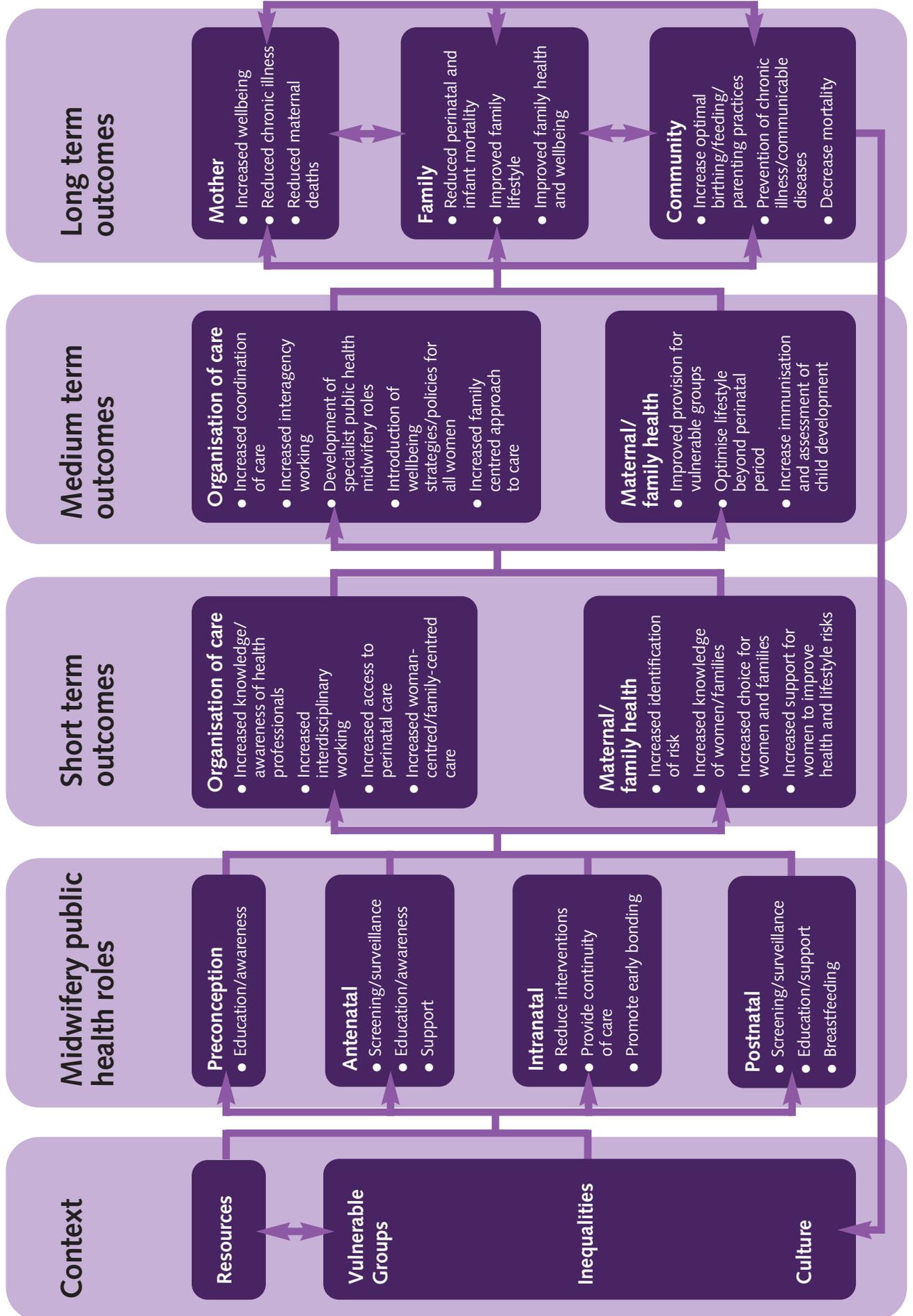
Midwives should use their advocacy role for influencing and improving the health and wellbeing of women, children and families. This will include making the economic case for committing resources so that the midwife can deliver public health messages in the antenatal and postnatal period, and ensuring that there is a midwifery contribution at policy, strategic, political and international level.

Midwives have a vital role to play in improving health and social wellbeing for all women and reducing health inequalities. Vulnerable groups include immigrant families, traveller families and young parents, and there is good evidence of poorer obstetric outcomes for socio-economically disadvantaged women and babies which may have effects throughout the whole of life. There is a negative lifelong impact of poor early bonding and attachment and feeding practice which impacts on our society in terms of increased levels of violence and obesity. Increasing rates of intervention, particularly caesarean section, have an impact on women's expectations and experience of childbirth and family relationships. [Public Health report: [http://www.midwifery2020.org/documents/2020/Public\\_Health.pdf](http://www.midwifery2020.org/documents/2020/Public_Health.pdf)]

Disadvantage may start before birth and accumulates throughout life and so action to reduce inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. For this reason giving every child the best start in life is of the highest priority<sup>8</sup>.

Midwives are well placed to help every child make the best possible start in life and so can improve the public health of the community through their vital work with women and their families. Each midwife has the opportunity to influence the woman and subsequent life chances for her child from pre-conception to the postnatal period.

Midwives have a major role to play in public health as they work with women and their families during pregnancy and into the first weeks of family life. They provide screening, education and awareness for women, their partners and families coordinating care and contributing to improved family health and wellbeing. The diagram opposite shows the short, medium and long-term outcomes that midwives can achieve by maximising their contribution from a public health perspective<sup>29</sup>.



## 4.4

### Measuring the contribution midwives make

#### Key message

The success of maternity services should be measured in terms of actual and perceived safety, effectiveness of care and the experience of the woman and her partner. Midwifery-specific indicators should be used to monitor quality at an individual midwife level, at team/group level and at service management level.

Systematic measurement of the quality of midwifery care is vital to drive improvements and each of the four countries has taken steps to address this challenge. [Measuring Quality report: Appendix 1 List of existing sources of maternity indicators:

[http://www.midwifery2020.org/documents/2020/Measuring\\_Quality.pdf](http://www.midwifery2020.org/documents/2020/Measuring_Quality.pdf)] Although demonstrating the quality of midwifery care is increasingly important for maternity service providers, responsibility for quality rests with individual midwives as well as with those responsible for planning and managing care.

For individual midwives the provision of quality care and quality improvement should be supported by:

- Appropriate education, training and continuing professional development
- Use of evidence-based guidelines to improve practice
- Use of reflective practice
- The system of statutory supervision of midwives
- Feedback of information collected about the care women receive from each midwife.

Midwifery practice which has been evidenced as being safe, effective and valued by women can be used to develop meaningful quality measurements. Examples of these include:

- Early access to a midwife with booking within 12 completed weeks of pregnancy [Measuring Quality Appendix 3]
- Continuity of midwife-led care
- Choice of having a home birth [Measuring Quality Appendix 5]
- Choice of giving birth in a birth centre [Measuring Quality Appendix 5]
- 1:1 midwifery care in established labour [Measuring Quality Appendix 5]
- Reducing perineal trauma [Measuring Quality Appendix 4]
- Uninterrupted skin-to-skin contact between mother and baby immediately following the birth [Measuring Quality Appendix 2].

[Measuring Quality report:

[http://www.midwifery2020.org/documents/2020/Measuring\\_Quality.pdf](http://www.midwifery2020.org/documents/2020/Measuring_Quality.pdf)]

Consideration could be given to the use of 'intelligent targets', which are in use in Wales, that measure both performance targets and the processes by which they are achieved<sup>30</sup>. Measuring normal birth rates is an example where 'intelligent targets' could be introduced<sup>31</sup>.

It is argued that today's healthcare system functions at lower levels than it can and should, and six aims for improvements to address key dimensions have been proposed<sup>32</sup> (see Box 3 below). Quality indicators for midwifery should take these into account.

### Box 3

#### Aims for improvement in today's healthcare system

**Safe:** avoiding injuries to patients from the care that is intended to help them

**Effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit

**Patient-centred:** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

**Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care

**Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy

**Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status<sup>32</sup>.

The best indicators of quality for midwifery are those which reflect these six dimensions and the extent to which they are provided or achieved.

An increasing number of women and families have complex physical and social needs and equitable care should be available to all women. The importance of care for pregnant women with socially complex factors has been recognised by the National Institute for Health and Clinical Excellence (NICE) who are currently developing guidelines aimed at optimising care and improving outcomes for these women<sup>33</sup>. It will be important to use information about the midwifery care provided to women with complex factors to further improve the quality of care.

In theory, improvements in information technology should make the task of collecting data about midwifery services easier but in practice this can place undue administrative demands on midwives, often without noticeable benefits. Future developments in measuring quality outcomes must not increase this burden and should be directed towards using the results to improve practice and reward the provision of quality midwifery care.

Data routinely collected in local maternity data systems may also be a source of useful information. For example, analysing not just the duration of antenatal clinic consultations but the content may give an indication of the quality of the interaction between a midwife and a pregnant woman.

### Key message

The definition of quality should be further enhanced to take account of all six dimensions of quality: person-centredness, safety, effectiveness, efficiency, equity, and timeliness, together with women's experience and satisfaction with care. Equity should be included in a measure of quality to ensure that safety, effectiveness and the experience of women and their partners do not vary as a result of factors such as age, ethnicity, area of residence or socio-economic status.

The experiences of people who use health services are as important as measures of clinical effectiveness. Although many outcomes are already measured by existing datasets, it is more difficult to measure the care that women actually receive. In the past women's views of care have been largely collected by satisfaction surveys but these do not provide information which is helpful for quality improvement. This has been recognised in the development of new maternity datasets. [Measuring Quality report: [http://www.midwifery2020.org/documents/2020/Measuring\\_Quality.pdf](http://www.midwifery2020.org/documents/2020/Measuring_Quality.pdf)]

### Key message

**The views and experiences of women and their partners are an important part of measuring quality. Effective tools for collecting information about their experiences of care should be developed and widely used.**

Understanding and improving a woman's experience of midwifery care is increasingly important and an integral component of the quality of maternity care. Women also have a view on both the safety and effectiveness of their care. They view care as unsafe not only when there is a lack of staff, poor monitoring and inadequate information, but when they are left alone and worried, or when they do not know who is looking after them, or are not receiving the full attention of their midwife<sup>34</sup>.

In England, patient reported outcome measures (PROMs)<sup>35,36</sup> are already being used and this approach could be developed for maternity settings. These are typically short, self-completed questionnaires, which measure a respondent's health status or health related quality of life at a single point in time. The strongest indicators of a positive experience are related to interaction with staff<sup>37</sup> and include communication, explanations and support, and being treated with respect, dignity and kindness. Measures of experience will become more widely used as they are easier to interpret and provide results that are more practical.

## 4.5 Supporting midwives

Midwives are responsible for the delivery of care but there is also a valuable place in the maternity team for maternity support workers/maternity care assistants (MSW/MCA). As these roles develop to complement and support midwives in providing a quality service to women, we need a greater understanding of how the future of this workforce will evolve. In February 2010 the Royal College of Midwives published guidance in an updated position statement about maternity support workers/maternity care assistants and the valuable role they play within the maternity care team<sup>38</sup>.

The introduction of the MSW/MCA role has been unregulated, and there has been a lack of clarity and consistency regarding title, task and training, accountability and governance which leaves women, managers and midwives with uncertainty around the scope of practice and competence<sup>39</sup>. Some countries of the UK have taken a national approach, with nationally defined curricula and role definition.

A national agreement on the core role, the education programme and the introduction of MSWs/MCAs within maternity services would ensure that aspects of care are delegated by a midwife to an appropriately trained individual. The midwife should provide adequate supervision and support to ensure that safe care is provided to the required standard. Delegation must always be for the benefit of women and families and where aspects of care are delegated this must not disrupt the provision of holistic care or reduce the quality of care.

The justification for having particular numbers of support workers to registered midwives should be to ensure that the quality and safety of maternity services are maintained and improved. The focus should be on the needs of women and families and not on the needs of the organisation and to achieve this maternity services must develop, update and administer workforce plans, using agreed midwifery-specific tools. These plans should include the skill mix of midwives and support staff required to provide the quality care that meets best practice standards.

Midwives can also be freed from some of the administrative and housekeeping tasks that can prevent them from providing the high levels of care that give them pride in their profession. The King's Fund review of England's maternity services<sup>34</sup> identified the impact of a shortage of midwives compounded by their administrative overload. Maternity services should have appropriate support systems in place to avoid this misuse of a valuable and skilled resource. Administrative staff will be essential, bearing in mind that maternity services are provided over a 24-hour period, with a need for 24-hour support.

### Key message

**Qualified maternity support workers/maternity care assistants should be employed within a nationally agreed framework which defines their role, responsibilities and arrangements for delegation and supervision and makes it clear their role is to support and not replace the midwife.**

## Key message

**NHS providers should ensure that appropriate support systems are in place so that the skilled midwifery workforce can carry out essential clinical duties, this means ensuring appropriate 24-hour administrative, domestic and operating theatre support, as such duties are not an effective use of midwifery time.**

Other roles should also be considered for the future sustainability of maternity services and to ensure women receive appropriate care from an appropriately trained professional. One example of this is outlined in the joint statement around the staffing of obstetric theatres<sup>40</sup>. Towards 2020, there should be a move away from skilled midwives acting as 'scrub nurses' within theatres. An appropriate perioperative workforce including, for example, nurses or operating department assistants, will be necessary to ensure that the midwife's role focuses on caring for the woman's holistic needs.

## 4.6 Developing a contemporary image of midwifery

The image of midwives and midwifery creates expectations among women, families and the wider community, potential recruits to the profession, midwives themselves and other health and social care professionals and workers. There are both positive portrayals in which midwives are seen as caring and compassionate, and negative representations, particularly on the Internet.

This is important because at worst poor self-image among midwives can result in low self-value and uncaring behaviour. Although the general public are often warm and positive about midwives individually, they can be perceived as having little autonomy, authority, or control and playing a subservient role to doctors.

Midwives need to reclaim the core values of their profession and promote these with professional pride to lift the overall public perceptions of midwifery. Existing positive images should be retained, promoted and used to raise the profile of midwives through positive campaigning.

The title 'midwife' is protected by law, this should be highlighted and projected widely to positively promote the lead role that midwives can and do have.

The benefits of midwife-led care during pregnancy should be emphasised. There is good evidence supporting the benefits of midwife-led care when compared to medical-led care including both a significant reduction in fetal loss before 24 weeks and antenatal hospitalisation, lower costs, shorter hospital stay for mothers and neonates and better experience for all women<sup>25,26</sup>. Other benefits include better maternal outcomes, less intervention in labour such as fetal monitoring, fewer instrumental deliveries, episiotomies and lower use of analgesia and anaesthesia. There is also evidence of higher breastfeeding initiation.

### Key message

A national campaign should be undertaken focusing on the nature and importance of midwives and midwifery practice which could inform the general public and potentially inspire the current workforce, as well as attract high-calibre candidates into the profession.

We need to reposition the midwifery profession, clearly projecting positive and innovative images that can ensure that midwifery is perceived as a positive career choice with a range of rewarding career pathways. Promoting midwifery as a positive career choice will inspire potential midwives of the future and encourage existing midwives to see their profession from a fresh new perspective, and enhance the perception of women who use their services.

Marketing is an important tool in communicating this message to the public, including using the many media channels available, such as television, national press, radio, the Internet, and cinema.

# 4.7

## Educating midwives

Midwifery education should be rooted in normality whilst preparing midwives to care for all women, regardless of their medical or social complexity. This would aim to continue to educate future midwives to be skilled and safe, empathic and trustworthy with increased emphasis on the principles of autonomy and accountability within multidisciplinary and multi-agency teams and to be able to act appropriately in an emergency. Pre-registration education programmes must continue to meet the requirements of the Nursing and Midwifery Council (NMC) to enable new midwives to practise safely, meet the needs of women and to receive a degree level academic award.

### Key message

**Pre-registration curricula should be designed to prepare the midwives of the future to work in a range of settings and build professional capacity. These graduate programmes of education should focus on interpersonal skills, to enable the prospective midwife to fulfil the lead practitioner role, to be the first point of contact for women, to promote and enhance the management of normal births, and to coordinate and provide care in high-risk and complex pregnancies and along the whole of the maternity pathway.**

The strongest indicators of a woman's positive experience relate to communication, support, involving women in their care, and being treated with respect, dignity and kindness<sup>41</sup>. It is therefore vital that interpersonal skills are given equal priority with academic qualifications in selecting student midwives and that midwifery education enhances the emotional intelligence of midwives emphasising the development of skills and knowledge to sustain authentic, empathetic behaviours and compassionate caring.

To meet future expectations and to reposition pre-registration programmes within a European context, programmes will need to enable new midwives to fulfil the core role of the midwife, and to combine 'normality' with the 'reality' of the future. This places particular emphasis on:

- Confidence to undertake the lead role of the midwife, act as the first point of contact for women and make an effective contribution to the multidisciplinary team
- Skills required for the promotion and maintenance of 'normality'
- Safe administration of medicines within contemporary prescribing frameworks at the point of registration
- Examination of the newborn
- Technological understanding and skills for information, communication and practice
- Skills such as cannulation and suturing to augment emergency obstetric skills
- Delegation skills to ensure that maternity support workers/maternity care assistants and others make an effective contribution.

The following knowledge and skills also need to be appropriately strengthened within pre-registration programmes:

- promoting and supporting breastfeeding
- supporting women and their families during the postnatal period
- supporting women and their partners in the transition to parenthood
- developing public health and wellbeing

- making a midwifery contribution when women have complex needs
- developing cultural competence.

The majority of midwifery education programmes are three-year programmes, although a small number of pre-registration shortened programmes also exist. Annual decisions made about the numbers of funded student places are based on workforce projections for qualified midwifery staff.

To ensure appropriate admission onto NMC approved shortened pre-registration programmes, robust consideration of individual applicants' previous theoretical learning and clinical experience should be undertaken. This will ensure that candidates on the adult nursing register may be admitted appropriately and incorrect assumptions about previous experience and/or theoretical knowledge can be avoided.

In the future pre-registration midwifery programmes should be encouraged to embrace a wider entry gate with a key focus on the robust mapping of individuals' accredited prior and experiential learning (AP(E)L) to inform access to education. Such a change to entry requirements would require collaboration with EU colleagues. It is envisaged that for instance, individuals who are registered on branches of nursing in addition to the adult branch of the NMC register, and maternity support workers/maternity care assistants who have undertaken a foundation degree, are worthy of consideration. Others working in related fields such as public health, physiotherapy and health science graduates may also be potential future candidates. In addition, initiatives that promote part-time routes on pre-registration programmes should be explored.

The preliminary findings of a recent survey of Lead Midwives for Education (LMEs) undertaken as part of a study investigating the impact of midwife teachers on pre-registration midwifery programme outcomes (the MINT project), identified 55 programme providers in the UK<sup>42</sup>. Respondents revealed a wide range of student midwives, from 16 – 249, per provider, with full-time equivalent midwifery teachers (lecturers) ranging from 2.8 to 22. It would appear from these data that not all HEIs have sufficient educationalists to be able to sustain resourcing programmes to the required academic level, maintain practice credibility, and engage in personal and professional development and in research.

Consideration should be given to the use of blended learning, especially e-learning coupled with small group learning on practice sites so that students, especially mature entrants with dependants, do not have to travel long distances to a university.

Practice placement providers need to ensure that senior student midwives, during the final six months of their programme of studies, are given the necessary learning opportunities, support and supervision to be able to take on the full scope of practice as a midwife at the point of registration.

### Key message

**Broader entry criteria to midwifery courses can be promoted by more flexible arrangements for the Accreditation of Prior (and Experiential) Learning (AP(E)L).**

### Key message

**There should be a sufficient critical mass of midwifery educationalists to resource the curricula and provide support for students in practice settings across large geographical areas.**

## 4.8 Developing midwives

### Preceptorship

The transition from student midwife to practising midwife can be challenging and daunting and preceptorship is a means of providing structured, focused support and guidance to newly qualified midwives. Preceptorship needs to be clearly defined, constructed and monitored if it is to successfully address the needs of new midwives and assist them on the journey of lifelong learning. *Flying Start*, which was developed in Scotland, is one example of a structured preceptorship programme and was used along with the framework in Wales to develop the *Preceptorship Framework for England for newly registered nurses, midwives and allied health professionals*<sup>43</sup>.

The framework is not intended to be a substitute for any form of performance management, including regulatory body processes. Preceptorship may be complemented by a range of other processes and systems such as statutory supervision of midwives, induction, coaching, mentorship, mandatory training and flexible distance or e-learning packages for newly qualified practitioners.

### Post-registration programmes

Post-registration programmes of education should enable midwives to contribute to and promote 'normality' in complex care scenarios. The complexity of maternity care will, in certain circumstances, require some midwives to develop and maintain competence in specific aspects of care, according to local needs. These could include long-term medical conditions such as hypertension, heart disease and diabetes, perinatal mental health, older mothers, assisted conception, and health inequalities.

There is an increasing range of demanding roles which require high levels of additional responsibility such as:

- Delivery suite lead / coordinator
- Birth centre lead
- Primary care / team lead
- Governance roles including risk management and clinical audit
- Education / practice development
- Service improvement / quality enhancement.

Post-registration programmes of education are needed to enable midwives to develop leadership, management and cultural competencies that support innovation and create positive practice environments.

## Continuing professional development

CPD opportunities should be academically robust and professionally relevant. Midwives should be supported in accessing opportunities that are linked to enhancing the quality of care while also contributing to their own personal development plans. A widely agreed professional system of 'passports' for qualified midwives would be valuable to provide valid and reliable evidence of the CPD they have successfully completed and to avoid duplication particularly when moving to other health boards/trusts. While employers have a crucial role, it is also important to recognise the responsibility of individual practitioners in relation to their own CPD and the use of systems such as e-portfolios could be a means of effectively supporting them.

Effective planning and delivery of these programmes requires partnership between service users, commissioners, HEIs and service providers so that appropriate courses are provided and desired outcomes are achieved. [Education and Careers report: <http://www.midwifery2020.org/documents/2020/Education.pdf>]

### Key message

**Continuing professional development (CPD) opportunities, which are academically robust and professionally relevant, should be available to all midwives based on local need. Support should be available to allow midwives access to educational opportunities that are linked demonstrably to enhancing the quality of midwifery care while also contributing to the personal development plan of the midwives concerned.**

### Key message

**A widely agreed professional system of 'passports' for qualified midwives would provide valid and reliable evidence of the CPD they have successfully completed and avoid duplication particularly when moving to other health boards/trusts. While employers have a crucial role, it is also important to recognise the responsibility of individual practitioners in relation to their own CPD and systems such as e-portfolios could be a means of effectively supporting them.**

## 4.9 Maximising midwives' influence

In order to maximise the influence midwives have when contributing to improving outcomes and experiences for women, babies and families, it is essential that we develop career pathways which enhance lifelong learning and build capacity and leadership.

Whilst opportunities currently exist for midwives to pursue practice, management and academic careers, there is a lack of a clear career structure. To move forward, guidance should be provided for the development of a career framework to encompass existing and new midwifery roles. This framework should reflect the needs of a highly skilled workforce that has the scope to provide world-class maternity care by 2020 and beyond, from the provision of direct care for women and their families through to strategic and board level contributions.

Future role development should have a direct impact on women's experiences and should enhance the quality of maternity services. The drivers for role development emerge from the constantly changing context of care design and delivery and from public expectations, including a greater emphasis on normality and an enhanced contribution to the care of the newborn including the first examination of the newborn.

### Expanding the role of the midwife

By engaging in lifelong learning, midwives will continue to develop and update their practice, to think innovatively as leaders and to contribute to system design and service delivery. All midwives are autonomous practitioners and in addition to their core role, some midwives will progress to roles which require specialist knowledge and skills, and possibly to advanced practice roles where midwifery education, practice and research are integrated effectively.

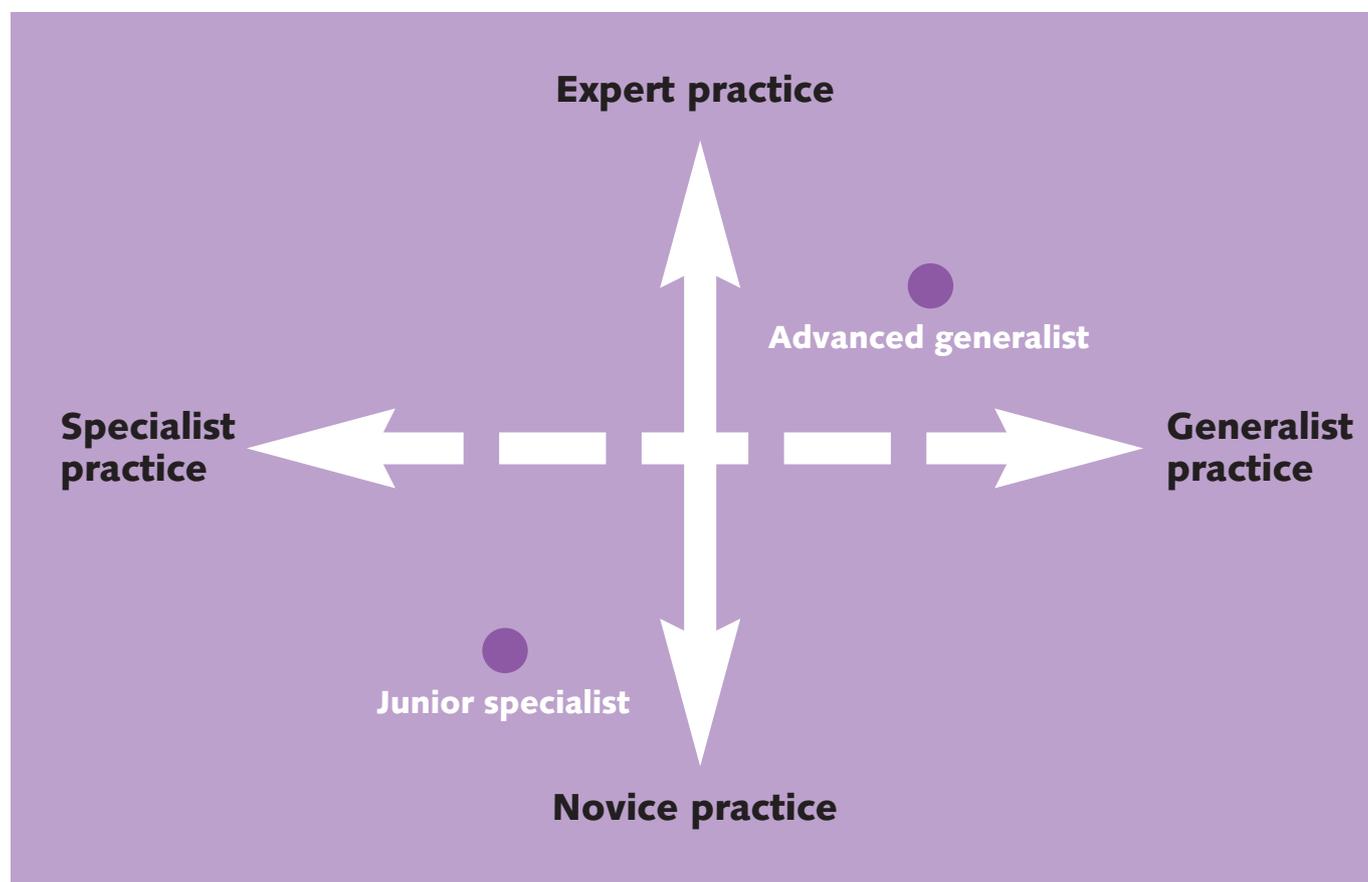
### Specialist and advanced practice

There are important distinctions between 'specialist' and 'advanced' midwifery roles (Figure 1).

**Specialist midwifery practice** will normally be particular to a specific context, be it a client group, a skill set or an organisational concept. For example, some midwives may work in areas which require them, for some or part of their role, to develop specialist knowledge or skill sets such as a midwife with a specialist focus on teenage pregnancy. Such roles are likely to be underpinned by additional education and development appropriate to the role. It is possible for 'specialist' practice to be demonstrated at a number of different levels.

**Figure 1**

The relationship between 'specialist' and 'advanced level' practice



Advanced practice<sup>44</sup> is, however, benchmarked by a particular level of practice and some midwives may progress in their careers to take on advanced level roles. These roles are characterised by high levels of clinical skill, competence and autonomous decision making when discharging the responsibilities of that role and, in common with other roles at this level, will normally be underpinned by masters level education, robust supervision and competence assessment.

Such roles may be developed, where appropriate in response to the needs of women, across both generalist and specialist areas of midwifery practice. Thus, some midwives who specialise may be advanced practitioners; however, not all advanced practitioners will be specialists. This recognises that the developmental pathway towards advanced level practice may be different for individual practitioners, with some following an 'advanced specialist' route through focus on high-level skills and decision making within a particular client group or clinical context, while others will develop a portfolio that reflects high-level assessment, decision making and autonomous practice across a greater breadth of practice (advanced generalist).

Importantly, for both specialist practice and advanced level practice to support strong governance, role consistency and the safe and effective

## Key message

Closer partnership working between higher education institutions and service providers, including joint appointments and secondments, should be strengthened. This will facilitate a flexible career structure and promote a culture where the integration of theory and practice across both pre- and post-registration education programmes is strengthened. Opportunities should be promoted which maximise the potential for midwives to develop capacity and capability in developing and delivering research-based practice which has been shown to improve care and outcomes for women, babies and families.

## Key message

Clinical academic and research career opportunities for midwives with the associated employment flexibility are key to the way forward and should be promoted.

## Key message

Heads of Midwifery should as a key component of their role, provide strategic leadership to achieve an appropriate focus on both professional midwifery matters and maternity service delivery, reporting directly to board level, or via the Director of Nursing or Director of Public Health, on such matters.

care of women and children, these roles should be subject to clear role expectations, good employment practice and appropriate educational underpinning. Post-holders in these roles remain accountable, as registered midwives, for their competence across their wider scope of practice. Midwives in such roles would maintain a clinical portfolio which identifies their progress along the career continuum, demonstrates their on-going competence and maintains their clinical credibility within the profession.

For **midwives pursuing a clinical academic career**, education and training opportunities organised at four sequential levels have been recommended together with best use being made of UK Clinical Research Networks<sup>45</sup> and clinical research facilities. Session-based contracts of employment could enable midwives to combine midwifery practice with research or educational roles and achieve greater flexibility. Clinical academic roles will be an important feature of the future career structure for midwives. An appropriately resourced robust system of mentoring and peer support should also be developed.

Clinical academic career pathways between the NHS and higher education have a key role to play in ensuring that the link between education provision, research and practice is reinforced and strengthened. These roles are emerging based on the recommendations of the United Kingdom Clinical Research Collaboration (UKCRC) Subcommittee for Nurses in Clinical Research (Workforce)<sup>46</sup>. These recommendations have the potential to increase both the research capacity and capability of midwives and are set within the more general context of modernisation within the NHS and the need to create flexible career opportunities for healthcare staff.

**Midwives undertaking leadership and management roles**, whether in practice, education or research, should be supported by appropriate preparation programmes. There is also the potential to build professional capacities for more strategic level midwifery roles, such as Head of Midwifery, Director of Nursing and Midwifery, Director of Public Health, Dean of Health School/Faculty, or a strategic role in commissioning. These roles would give midwives the opportunity to contribute fully in determining the quality of care, to workforce planning, and commissioning services. It is acknowledged that senior strategic roles may make it difficult to maintain NMC registration, and this needs to be explored further by employers and the NMC.

The **consultant midwife** role is a strategic one with the potential to provide leadership and influence a range of areas including the promotion of normal childbirth, the midwifery contribution to research and evidence-based practice through to audit. Whilst the detail of the role is determined locally, the consultant midwife works closely with other members of the maternity team, acting as a role model for midwives. In addition, the consultant midwife plays a significant part in

facilitating change and developing a positive practice culture in which the quality of care is of a consistently high standard, woman centred, based on best available evidence and results in effective outcomes for women, babies and families.

**Lead Midwives for Education (LME)** are recognised as providing key strategic and organisational leadership and the LMEs of the future will need to have transformational leadership skills. Their leadership and contribution to the development of innovations in evidence-based education and practice, will continue to be key aspects of the role. There will be a need to promote and facilitate inspirational teaching, learning and research and collaboration with practice-based colleagues in the pursuit of midwifery developments to ensure that services are fit for the twenty-first century. LMEs and Directors/Heads of Midwifery will need to collaborate to facilitate joint appointments and flexible working arrangements for colleagues occupying these key roles. Sabbatical opportunities also need to be considered as a means of developing individuals and ultimately informing service design and delivery.

**Midwifery lecturing staff** who are credible in the practice environment are well positioned to support students, engage in staff development, particularly the provision of post-registration programmes of study, and in practice development and expanding the evidence base for midwifery. It is essential that we develop a career structure that enables midwives in all settings to be adaptable and take on changed roles and responsibilities and to access education and training appropriately.

New roles and career pathways should incorporate **joint appointments** between hospital trusts/boards and educational institutions. Posts should be developed whereby lecturers can rotate into practice, and practice midwives into education and the further development of practice-based professorial roles is encouraged. Career mapping is required to ensure the design of clear career pathways to prepare midwives for these new and emerging roles and for the development of career pathways that include education and practice. Career pathways need to be sufficiently flexible to give midwives the opportunity to pursue sabbatical and other forms of leave and career breaks which have the potential to enrich their contribution upon return.

Midwives need to make best use of technological advances in the provision of care. This will be of particular importance, for example, when supporting women in geographically isolated areas. Midwifery leadership is vital to ensure the appropriate development and use of technologies and health informatics and more midwives with expertise in this field are needed.

### Key message

**Innovative and pragmatic solutions for midwifery lecturing staff based in higher education institutions should be developed so staff can maintain their clinical credibility in midwifery practice.**

### Key message

**A more flexible career framework should be developed to support midwives in practice and in research and education, enabling experienced midwives to combine both specialist and advanced contributions to practice with the core role of the midwife.**



# Delivering expectations

# 5

*Midwifery 2020* sets out a vision of how midwives can respond to the challenges and opportunities of meeting the needs of women, babies and their families in the future.

The key messages in this report provide a framework against which all those with an involvement in maternity services across the UK can benchmark their current services and can plan their own responses which will enable midwives to further develop appropriate quality care and services. We recognise that depending on your role and involvement in maternity services some key messages will be of more relevance to you than others.

The key messages address a wide range of issues and achieving them is likely to mean that changes and developments will be needed to the organisation of midwifery services, education and training for midwives, career structures and opportunities, quality improvement, workforce planning and the role of the midwife in reducing health inequalities.



## Midwives

Midwives are key to achieving the vision of midwifery in 2020. Their commitment to women, babies and their families is clear and their role is vitally important to the future of the maternity services.

We would like midwives to:

- Build on effective communication and teamwork with colleagues in the maternity services team to continuously improve the delivery of quality services for women, babies and their families
- Review and agree their clinical guidelines and indicators of quality
- Promote their profession and contribute to a fresh, positive professional image
- Review and develop their inherent contribution to public health, addressing inequalities and meeting the complex needs of women and their families
- Develop their role as advocates for all women, particularly those with complex needs

## Mothers, fathers, partners, families and consumer groups

Women and their families already work in partnership with midwives and their ongoing contribution to improving services is greatly valued.

We would like them to:

- Review their contribution to improving the quality of services
- Explore how they can contribute to improved outcomes
- Work with professionals to bring about change

## The maternity care team

Midwives work as members of the maternity care team alongside for example, GPs, obstetricians, health visitors/public health practitioners, and maternity support workers/maternity care assistants to provide quality care to women, babies and families.

We would like them to:

- Review how best to ensure seamless maternity and social services through undertaking effective communication among all members of the maternity and social care team to work for the best interests of women, babies and families
- Strengthen teamwork to improve quality maternity services
- Review how the maternity team can work together through the antenatal and postnatal period to ensure each child has the best possible start in life

## Those who commission maternity services

In commissioning maternity services, considerable influence can be brought to bear on the services that are provided. Those who commission services have an opportunity to improve the quality of maternity care and to ensure optimum outcomes for their populations.

We would like them to:

- Be clear about the quality of the services and the standards they expect
- Ensure evidence-based practice underpins the delivery of care
- Support midwives in maximising their contribution to the planning and provision of care by ensuring robust workforce and workload planning based on local demographic information

## Service providers at local, regional, and national levels

Together with midwives, service providers play a vital role in ensuring the quality of their maternity services and in providing services which reflect what women and their families want.

We would like service providers to:

- Review their models of care to ensure that services meet the needs of all women, from the provision of midwife-led care for straightforward pregnancies to that required to support those with complex physical, mental and social needs
- Ensure service provision actively targets and aims to reduce inequalities
- Ensure midwives have the opportunities to keep their knowledge current
- Develop opportunities for midwives to expand their skills to meet women's needs and local priorities, and provide a career structure to reflect midwives' skills
- Review the contribution made by maternity support workers/maternity care assistants and ensure there are adequate domestic, administrative and theatre staff to support midwives
- Systematically collect local data to measure the quality of care, including women's experiences and provide feedback to midwives to improve the quality of care

## Educationalists

Educationalists have a vital role in ensuring that the midwives of the future have the skills and attributes needed to provide quality care to the wide range of women who access maternity services. They also have a key role in making sure opportunities are available to support

qualified midwives as they continue to expand their knowledge base.

We would like educationalists to:

- Ensure pre-registration curricula are fit for purpose to educate the midwives of the future to work in a range of settings and combine normality with the reality of the future
- Explore the possibility of making AP(E)L schemes more flexible
- Provide continuing professional education opportunities that reflect midwives' needs
- Develop education and training opportunities for those midwives aspiring to leadership roles
- Ensure they work in partnership with service providers in promoting the development of joint appointments and secondments

## Researchers

Midwifery practice can only develop and improve if there is a robust base of research to draw upon. It is important that the existing body of research continues to expand and, equally importantly, to be implemented in practice.

We would like researchers to:

- Ensure research-based evidence is readily available to be integrated into practice
- Focus research in areas which can reduce inequalities and lead to improvements in outcomes and care for women
- Disseminate the results of research widely

## Government leads, regulatory bodies and professional bodies

At national level, government leads, regulatory and professional bodies are well placed to influence and facilitate the future direction of midwifery.

We would like them to:

- Provide leadership to all those in the midwifery profession
- Drive forward the further development of midwifery quality indicators
- Explore ways to develop more flexible career frameworks for midwives

If we address these challenges and take advantage of these opportunities, we will have maximised the contribution that midwives make to the health and wellbeing of women, babies and their families across the United Kingdom.

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# Appendices

## Appendix 1

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# Appendix 3

## Midwifery 2020 Analysis of political, economic, social and technological change: a vision for the future

### POLITICAL/LEGAL

Greater emphasis on child protection

EU regulations

EU migration

'Right' to have a child

What form will the NHS take in 2020?

Increased emphasis on women's rights

### ECONOMIC/WORKFORCE

Midwifery – are there enough people coming through?

More interprofessional working

Increasingly ageing workforce

Training and development

Career pathways

Growing polarisation of rich and poor families

### SOCIAL

'Blended' families

Lack of social support for families

Loss of extended families and role models

More 'motherless' mothers

Older mothers

Rising expectations – access to knowledge

Obesity amongst women

Ageing society – where will resources be spent

More women working to support families

Increased emphasis on parenting skills

More mobile population

### TECHNOLOGICAL

Availability of information via www – well informed population

Gene therapy

Reproductive technology – parents with conditions previously prohibitive now having children

IT to communicate with women in remote communities

Increased use of IVR/IUI

### CHALLENGE FOR MIDWIFERY 2020

- Working in partnership with other agencies – better joint working between professions
- Extending work with family
- Demands of working with a mobile and increasingly diverse population
- People who may never have had the opportunity to parent may have access to reproductive technology
- Raises the challenge of how the service will be funded and managed
- Working with women with, potentially, increasing expectations of the service
- 2020 may well involve greater 'partnership' working with women

### CHALLENGE FOR MIDWIFERY 2020

- Declining population and greater opportunities available for young people raises the question of who will provide midwifery care, who will the profession recruit?
- Strong sense that the workforce will still be mainly female in 2020 and mainly part-time
- Extending the type of work now done with Sure Start, social work and social services
- More and better joint working
- What can be done to ensure that a new cohort of leaders is ready in 2020?
- 2020 midwife will need greater clinical skills
- In order to attract people into the profession may need to provide more part-time courses
- Need to recognise that the profession will have to attract older people for whom midwifery will be their second or even third career choice
- Meeting the needs of socially excluded groups, for example, in terms of advice and support

### CHALLENGE FOR MIDWIFERY 2020

- Working with families with children from different relationships
- Who will provide this support?
- How will mothers and fathers learn to be parents?
- Who will provide this input?
- More women without support or advice offered by own mother
- 'Risks' associated with older mothers
- Meeting rising expectations of mothers who are better informed of choices/options open to them. For example, will there be an increasing demand for caesarean sections?
- Looking at the consequences for the health of the mother and her baby
- With an increasingly ageing population and a falling birth rate, will midwifery have to compete for funds?
- More women in work during pregnancy and more women returning to work after giving birth
- Who will provide education for parenting skills and when will this input be given? At school, prior to conception?
- How will the NHS keep track on an increasingly mobile population?

### CHALLENGE FOR MIDWIFERY 2020

- Working with an increasingly well informed client group
- Dealing with service user expectations and difficult decisions
- Increased medical needs of a cohort of mothers – some unknown risks in pregnancy/childbirth
- Use of telemedicine in remote parts of Scotland – need to communicate differently, awareness of need to intervene in very difficult geographies
- Potential increase in multiple births
- Parental demands and associated anxieties
- Training and development needs







MIDWIFERY  
2020

# Delivering expectations

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