New Vision for Maternity Care

ASSOCIATION OF RADICAL MIDWIVES

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hard copies £5 including p&p
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Preface

The *New Vision for Maternity Care* is a vision that takes us immediately right into the heart of midwifery, seeing the importance of the midwife mother relationship, as well as the purpose of this relationship which is central to maternity care - "caring for the mother and providing a safe space in which she can develop confidence in her own ability to give birth and mother her baby". Giving mothers confidence in birth and mothering is crucial to modern maternity care, fundamental to our work, the work of all who provide maternity care, but that requires midwifery rooted in the community, built on relationship with women.

The first *Vision* by the Association of Radical Midwives (ARM) published in 1986 at the first wave of the 'new' midwifery, was seen as radical at the time. Together with other leaders in midwifery and maternity, including the Royal College of Midwives (RCM), ARM has been instrumental in creating fundamental shifts in policy, awareness, and in many places change in practice. National policy in the UK has, since 1993, espoused a commitment to woman centred care which has a strong evidence base. The midwifery profession has made a major contribution to this. Midwifery led care and different models of care, including continuity of care, have been developed and evaluated. Different commissioning arrangements have been developed. Midwives are now generally educated in three year university level programmes and places in midwifery programmes are so popular that acceptance is very difficult. Midwives and the midwifery profession have a great deal to be proud of.

But fundamental transformation in maternity care was never going to be easy, actual changes in practice are patchy, and access to truly woman centred care and genuine choice of care and place of care is not uniformly available. Many midwives are frustrated not to be able to use all of their skills and give of their best. Perversely, despite years of government policy that upholds the importance of autonomous midwifery, midwifery led care and continuity of care, despite strong evidence of the effectiveness and safety of midwifery led care, services are being centralized and organised in ways that makes the more personal midwifery the *New Vision* describes more difficult. Moreover, what had not been anticipated at the time of ARM's first *Vision* and the early work of RCM and others in transforming maternity was the rise in birth rate, the extreme increase in complexity, and the dramatic changes in the NHS that are apparent now. These changes require resource investment but resource investment will not in itself be enough. As the *New Vision* sets out, cultural as well as organisational change will be required, particularly in the wake of the Francis enquiry which has sent out shock waves and will in itself require deep seated change across the NHS.

Whilst our organisations will, at times, advocate different prescriptions for change, the principles set out in this *New Vision* are ones that the RCM supports.

The *New Vision for Maternity Care* will be of importance to all of us as we set out to improve the start of life for babies and their families, not only midwives and all those providing care, but also policy makers, leaders, managers, and commissioners. All will find in it a way to more life affirming, more humane, more effective and cost effective maternity services.

Professor Lesley Page
President of the Royal College of Midwives

New Vision for Maternity Care

Association of Radical Midwives

Summary

The Association of Radical Midwives (ARM) sees the mother-midwife relationship as central to maternity care: the midwife caring for the mother and providing a safe space in which she can develop confidence in her own ability to give birth and mother her baby. To achieve this, the midwife-mother relationship must develop throughout pregnancy, labour and postnatally. Such continuity of care enhances the experience of mothers and midwives, enabling the mother to look back upon her birth as an empowering start to parenting and future family life. Such relationships nurture the autonomy of the mother and the midwife's commitment to her client and thereby increase her job satisfaction, reducing wastage from the profession. The NHS must foster a spirit of co-operation amongst health professions, promoting a climate of trust and mutual support.

The present maternity services are funded and organised using a top-down approach centred on the consultant-led obstetric unit. The culture of maternity services at present is one of hierarchy, blame and fear. The impact of this on services is entirely negative.

ARM's *Vision* is that services would be funded and organised from the bottom up around individual women and their families and within the communities in which they live. Birth at home or in a local birth centre should be the preferred option for all low-risk women. Community maternity care needs separate funding to promote, enable and support normal birth where possible. This is a more efficient, less costly, friendlier and safer way to provide maternity care.

Instead of being the default place of birth, the consultant-led obstetric unit would become the place to care for women at higher risk of complications and a place for transfer in labour for emergency care. Even when transferred to hospital care in pregnancy or after the birth, high-risk women still need continuity of care from a known midwife. The midwife would accompany her client in labour and, where possible, continue to support and keep her well informed – a friendly known face in an unfamiliar environment.

Government investment in services at the start of life and support for the relationships which can enhance birth and parenting would reap ample rewards throughout the life of its citizens (Jacobs, 1992). Mothers will be supported and nurtured as they start to nurture and support their children.

Restructuring services to be mother-friendly and midwife-friendly will ease the current shortage of midwives.

We fully support the ideals of the National Health Service, publicly funded and free at the point of delivery and we are committed to the implementation of this *Vision* within the NHS. We fully concur with, '*no decision about me without me*' (HM Government, 2010) and believe that midwives are the professionals best suited to helping mothers decide what is best for them and their baby.

Introduction

The Association of Radical Midwives was set up in 1976 by midwives, students and mothers who recognised that the profession was in danger of losing both its roots in the community and its central philosophy of being 'with women' in childbirth. In 1986 ARM published *The Vision: proposals for the future of the maternity services in the UK*. Some of the recommendations that seemed very radical then have been achieved, such as "Midwifery training will be primarily be a 3-year direct entry course" (ARM, 1986).

Other recommendations became an established part of policy documents in England, (*Changing Childbirth*, DoH, 1993; *Maternity Matters*, DoH, 2007), particularly around continuity of midwifery care, the central theme of the *Vision*, but the impact on practice was small. It is probably even more true in 2013 than it was in 1986 that there is, 'a growing awareness that all is not well with the present organisation of maternity care'.

Recent documents from Scotland, Wales and Northern Ireland (*A Refreshed Framework for Maternity Care in Scotland*, Scottish Executive 2011; *A Strategic Vision for Maternity Services in Wales*, Welsh Parliament 2011; *A Strategy for Maternity Care in Northern Ireland 2012 – 2018*, Northern Ireland 2012) have highlighted social aspects of maternity care and acknowledged that improving care during pregnancy can play a major part in improving clinical outcomes and reducing health inequalities.

The past few years have seen the growing application of market economics to health care with the constant need for financial savings. The easiest targets for cost cutting are the number of midwives and the number of obstetric and midwife-led units; in England this has reached crisis point but is less of a problem in the devolved countries. We believe these are false economies and that the way to achieve financial savings is to locate far more maternity care in the community, reducing costly intervention and enabling mothers to have a service more suited to their needs. This concurs with the view of the Royal College of Obstetricians and Gynaecologists that, *"Too many babies are born in the traditional 'hospital' setting."* (*High Quality Women's Health Care*, RCOG, 2011).

Challenges of Current Maternity Care

Challenge 1: The need for relationships

1. Mothers need personal care throughout the childbearing year: *'All mothers need a midwife while some need an obstetrician too'* (Shribman, *Maternity Matters*, 2007). Midwifery care is a personal service based on a one-to-one relationship between a midwife and her client, a relationship which has been described variously as a 'professional friend', 'professional servant' and 'mothering the mother' (Walsh, 1999; Cronk, Taylor, in*: The Midwife Mother Relationship*, Kirkham, 2010).
2. In small units women can get to know their midwives well before labour, but in large hospitals, with the present low staffing levels and rapid patient throughput, midwives simply do not have the time to establish quality relationships. Women need midwives with time to encourage them to develop confidence in their body's ability to give birth and to nurture their newborns.
3. In the relatively limited time midwives now spend with their clients, their technical tasks have increased considerably, especially around screening for clinical conditions and social concerns; their clerical duties have similarly proliferated. A task-orientated, tick-box culture has replaced time spent forming trusting relationships with women.
4. The dominant industrial model means that care is increasingly fragmented and midwives see themselves as technicians and note takers (*Why Midwives Leave*, Ball, Curtis and Kirkham, 2002). All midwives working in the NHS feel themselves to be under considerable pressure to get through a mounting body of work, which can undermine their relationship with individual clients and decrease their job satisfaction (Kirkham, Morgan and Davies, 2006; Kirkham and Davies, 2006).
5. The caring, supportive work that midwives see as central to their role is undervalued. There is an increasing tendency to delegate this 'emotional' work to maternity support workers or even to volunteers such as doulas. This distances women from their midwives.

Solution: Maternity services should be organised in a way that enables and encourages women to have a midwife they can get to know and trust to support them antenatally, for the birth and in the postnatal period, which is particularly important for establishing and maintaining breastfeeding.

Challenge 2: Centralisation

1. The most pressing concern at present is the merging of obstetric units, which takes care further away from the community and results in super-sized units where midwives often find it harder to deliver woman-centred care. In 1973 there were 527 maternity units in England (*Birth Counts,* Macfarlane *et al,* 2000), by 2007 the number had halved to 262 (Birthplace in England Collaborative Group, 2011) and more have closed over the last five years. Mergers and closures reduce choice for women; larger units are almost certainly more costly, lead to increased medicalisation, user-dissatisfaction and midwife discontent (Bones, 2005; Walsh, 2007). As far as maternity care is concerned, "the fiscal, physiological and social consequences of centralisation are unacceptable" (Bones, 2005 p, 563).
2. These large units are run on an industrial model. Women are rapidly processed through their labour and postnatal stay, where care is task-orientated and fragmented. There is little opportunity for women to develop confidence in their own bodies or to form trusting relationships with staff. Midwives find that they are constantly moved from place to place within the trust to plug the gaps in the service and thereby lose the opportunity to develop relationships with colleagues as well as relationships with women.
3. Gaynor, Laudicella and Propper (2012) examined the impact of mergers on a large set of outcomes including financial performance, productivity, waiting times and clinical quality and found little evidence that mergers achieved gains other than a reduction in activity. The evidence on mergers remains inconclusive and expected benefits from mergers often fail to materialise.
4. The rationale for merging obstetric units is to provide 24-hour consultant cover and to provide a larger client base for neonatal intensive care units which are now deemed to be a requisite part of maternity care (RCOG, 2011). However, the Birthplace study (Birthplace in England Collaborative Group, 2011) found that all low-risk women had more morbidity when they laboured in obstetric units. Babies did equally well in all settings except babies of first time mothers planning a home birth; 45% of these mothers were transferred to hospital in labour where they laboured on average a further 6 hours. The CMACE report (2010) pointed out that: *"both subtle and overt antagonism to homebirth from hospital based staff is likely to increase rather than decrease risk to women and their babies."*

   Solution: ARM believes that because there is no evidence of improved outcomes following mergers, the Government and DoH should halt all plans for centralisation of maternity units. Mothers should have a choice of place of birth in line with the Government recommendations in *Maternity Matters* (2007). Monolithic services drive down standards.

Challenge 3: Birth Centres under Pressure

1. The National Childbirth Trust's report *Location, Location, Location* (2009) reported that only 4.2% of women had the full range of choices of place of birth. Some midwifery units have been retained and some new birth centres have been built in response to research evidence, user-demand, government policy and professional commitment. There are around 90 birth centres open in England at any one time, more than half of them located alongside obstetric units. Provision is patchy with some counties having a number of freestanding birth centres and some having none. The situation is no better in the devolved countries.
2. While many freestanding birth centres currently appear to be thriving (Gutteridge, 2011), their number fluctuates from month to month and year to year as they are opened and closed either temporarily or permanently. Some freestanding birth centres fail to reach their potential owing to a combination of lack of managerial support, medical prejudice, cost cutting, staff shortages and lack of political championing (Deery *et al*, 2010), while others are under constant threat of closure, either for financial reasons – they are seen as an expensive luxury – or because staff are redeployed to obstetric units.

3. When mergers are proposed, some obstetric units are replaced with a midwife-led unit. Fighting to retain the 'full range of services', the media tend to present replacement midwifery units in a negative light, although the evidence shows that women are very satisfied with their care in birth centres and the clinical outcomes are excellent (Birthplace in England Collaborative Group, 2011).
4. It may be no coincidence that the geographical areas which retained midwifery units, for example, Shropshire, Somerset, Torbay and some parts of Wales, have managed to avoid the increased surgical delivery rates seen elsewhere in the UK. It appears that there needs to be a critical mass of midwife-led care in any one area for financial managers to see its value.

Solution: The Government, the DoH and CCGs should make it a priority to ensure provision of birth centres. Birth centres should be recognised as the birth place of choice for low-risk women (unless they choose a home birth) because they are associated with substantially less maternal morbidity without endangering babies and are a cost-effective way of providing safe, family-centred maternity care (Birthplace in England collaborative group, 2011).

Challenge 4: Fear-driven Medicalised Childbirth

1. Much medical intervention is blamed on fear of litigation and, indeed, CNST requires trusts to produce protocols and guidelines in order to minimise payments to NHSLA central funds. Midwives are bound by their terms of employment to follow these protocols. However, such constraints on practice conflict with the midwife's role in supporting women to achieve normal birth. Their *Code* (NMC, 2008) says "You must make a referral to another practitioner when it is in the best interests of someone in your care" which is interpreted as referral to an obstetrician only if pregnancy or labour is deviating from normal.
2. With care prescribed by protocol, many studies have shown that women feel they are on a conveyor-belt (*Towards Better Births*, Healthcare Commission, 2008). The dominant industrial model means that care is highly and increasingly fragmented and midwives are seen and may see themselves as technicians (de Vries and Barroso, 1997). Studies have shown that women feel that midwives are engaged in 'checking not listening' (Edwards, 2005).
3. Tolerance of difference has decreased and midwives can be reluctant to acknowledge and follow women's birth plans for fear of them wanting something that does not fit the protocol. Midwives who do endeavour to meet the needs of individuals may be seen as deviant (CMACE, 2010; Flaxman, 2011); some have really suffered (AIMS, 2011). This is one manifestation of the present fear of birth which is seen amongst both the general population and professionals (Robinson, 2003). This is particularly sad as birth has never been safer.

Solution: The midwifery model sees the work of birth as done by the woman herself. It recognises that her body will work optimally if she receives individualised care, tailored to her specific needs, in a supportive environment. Every woman is different, every labour is different; labouring women cannot be fitted into 'one size fits all' protocols.

When mothers have confidence and trust in their midwives, based on a personal relationship, they can usually achieve their high expectations of birth. We need to work at developing a culture that shares and builds on women's anticipation of a happy and safe pregnancy and birth instead of fuelling their fears. A personal relationship with a midwife can also mitigate their distress when outcomes are not so happy.

Challenge 5: Too few midwives, too little time

1. The woman in early labour now comes into hospital and meets, not her own known and trusted midwife, but a triage system originally designed to prioritise care on the battlefield. Despite her

expressed need to be in hospital, evidenced by presenting herself for care, she may be sent home again, undermining her confidence (Cheyne, 2012). In busy hospitals with a finite number of beds, women are processed through the system with maximum efficiency and discharged to the care of a community midwifery service cut to the bone.

2. The irony is that the Birthplace study (Birthplace in England collaborative group, 2011) showed that women take up to 40% longer to deliver their babies in obstetric units than they do in midwife-led units or at home (obstetric units 9.01 hours, alongside midwifery units 7.92 hours; free-standing midwifery units 7.49 hours; home 6.6 hours. Birthplace Study, Final report part 5).

Solution: The maternity services must be restructured to provide safe, woman-friendly care and enable the majority of midwives to practise the full range of midwifery care according to the International Confederation of Midwives' definition of a midwife:

ICM Definition of a 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 child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

(International Confederation of Midwives, 2011)

Challenge 6: Recruitment and retention

1. Midwives are leaving the profession because they do not wish to practise as obstetric technicians (Ball, Curtis and Kirkham, 2002) and lack the time to give woman-centred midwifery care. Many others work only part-time because midwifery has become a constantly stressful and exhausting occupation. Midwives are losing their professional status as they have less and less control over how, when and where they work.

2. We know that midwifery care can have a very positive impact upon mothers' childbearing experience and on long-term and short-term clinical outcomes (Hatem *et al*, 2008). During labour, we know that the continuous presence of a supportive companion can help mothers and improve outcomes (Hodnett et al, 2007). We also know that continuity of care from a known midwife throughout the childbearing year can improve clinical outcomes (McLachlan, 2012) and family relationships (McCourt and Stevens, 2009).

Solution: In the context of a rising birth rate and a shortage of midwives, we have produced this document to show how midwives could be encouraged to return to the profession and practise in a way that will improve maternity care and reduce the pressure on NHS beds. The maternity services could be organised to much better effect to make full use of midwives' skills and take the pressure off acute trusts which see and organise maternity as an emergency service.

Basic Principles

- **Care should promote the health and well being of the woman and her baby.**
- **The mother is the central person in the process of care.**
- **The relationship between mother and midwife is fundamental to good midwifery care (Kirkham, 2010).**
- **All childbearing women should have access to their own personal midwife throughout the childbearing period.**
- **All women should exercise fully informed choice in childbirth including the right to decline treatment. Choices would include type of care and carer, the place and manner of birth (which includes home birth, now enshrined in European law (Ternovszky v. Hungary 2010)).**
- **Midwives have a duty to help women choose the best type of care for them but should avoid coercion into compliance with professionally favoured choices.**
- **The majority of care should be based in the community (RCOG, 2011),**
- **Midwives are the professionals best equipped to support normal birth; ways of working that ensure that their skills are fully used should be developed.**
- **Women have the right to give birth in a calm and peaceful environment whatever the birth setting; women's privacy should be respected.**
- **Service providers should be accountable to women and their families.**

The New Vision

- In 10 years time, around 60% of midwives will work in community based group practices of 2-6 midwives (WTE). Groups of midwives will work from a variety of places depending on local need. These could include Children's Centres, Health Centres, Birth Centres, GPs' surgeries, Community Centres or easily accessible stand-alone premises. Group Practice midwives will be responsible for the care of most women. They will also be involved to varying degrees with the care of women who need obstetric involvement in their care. The acute sector will no longer be responsible for community midwife provision and will provide a midwifery service only for women who also need obstetric oversight.

- Community Midwifery Trusts will co-ordinate arrangements for accessing obstetric care for women who need it or want it. They will ensure the provision of birth centres and community maternity rooms in alongside midwifery units and in obstetric units. They will work closely with LSA Midwifery Officers to ensure that midwifery care is safe and effective.

- Around 40% of midwives will be hospital based, and organised in teams. These teams, working with a consultant obstetrician, will be responsible for the antenatal, intrapartum and postnatal care of women who present with complications at booking or who develop them during pregnancy and whose care is transferred to the hospital team. A higher ratio of midwives to mothers will be needed to provide the more intensive care required. Hospital teams caring for high risk women will have a team member, a link midwife, working mainly in the community, to provide community care pre- and post-natally. They will also liase with the community based Midwifery Group Practices in the woman's area.

- Midwives will be the recognised point of entry into care for all pregnant women. Their services will be publicised widely and information will be available for women to choose the team or group practice that they prefer. The midwife's role is that of the expert in matters relating to pregnancy, childbirth, breastfeeding and early motherhood. The midwife is the educator in this field, encouraging women to define and fulfil their own needs, a care-giver at a time when women may be at their most vulnerable, a sympathetic and trusted friend.

- Group practices will encourage antenatal discussion groups, postnatal support groups, breastfeeding groups and so on, as well as conducting education for birth and parenthood classes. Women booked for obstetric care will be encouraged to attend these groups to build friendships with other local mums-to-be to widen their network of social support after the birth. The aim will be to help all women take an active part in their pregnancies, birth and parenting. Pregnancy tests will be available free of charge at the group practices and at hospital. Midwives will be seen as the main professionals to consult in all matters relating to childbirth.

Group Midwifery Practices

- Some self-managing Midwifery Group Practices will be set up under approved AQP schemes in social enterprises, co-operatives or private companies (as are GPs' surgeries) and will be registered with and inspected by the Care Quality Commission. Other Midwifery Group Practices could be set up directly under the Community Midwifery Trust or under the auspices of a GP practice. Midwifery Group Practices will have access to the indemnity insurance of CNST and will pay a capitation fee according to the number of women they book. The new system will have the flexibility to allow for variations of local needs around the country and the preferences of women and midwives.
- Midwifery Group Practices will be composed of midwives with varying lengths of experience and other workers, such as maternity care assistants and doulas. Practices will require administrative support for such tasks as: keeping records so that outcome statistics can be

produced; communication with other agencies such as referrals; stock management; taking minutes; and keeping accounts.

- Caseloads should not exceed 28 women per full-time midwife per year. Smaller caseloads may be appropriate in exceptional circumstances such as extremely sparsely populated areas or those with a high proportion of very vulnerable women. The midwives' caseloads should include pregnant women of every level of need and the booked midwife would provide care in whatever place is appropriate for the individual mother. Midwives offering caseload care will need a considerable degree of autonomy and flexibility in managing their work.
- Women may come to them seeking pre-conceptual advice or requesting a pregnancy test. They may come for an introductory chat or for a full booking visit. All women would be given a comprehensive list of group practices in the district as well as the telephone number of the local Supervisor of Midwives with the advice that any problems would be dealt with by her in strict confidence.
- Midwives in Midwifery Group Practices will have direct access to laboratory and other services (e.g. scans) which may be required for women experiencing a normal pregnancy. They will have direct access to consultant obstetricians to request an opinion on any case in doubt, though any decision to transfer the woman to consultant care will be shared between the woman, the consultant and the midwife, as partners in care.
- Midwives in Midwifery Group Practices will attend women giving birth at home, in birth centres and in hospital, according to individual circumstances and choices. Length of postnatal stays in birth centres or hospital will vary depending on the mother's condition and personal preferences. Group Practice midwives will maintain contact with clients in hospital as far as possible. Postnatal care will continue at home until the establishment of satisfactory feeding and while the family adjusts to the new baby.
- Each Midwifery Group Practice will be represented at regular (e.g. monthly) meetings with their peers and a Supervisor of Midwives to discuss any relevant information that could be usefully shared (e.g. research findings, specific case studies). This will be a source of support and communication between practices and an opportunity to identify needs and formulate policies. There will also be great benefits derived from the participation of hospital team midwives in such meetings to ensure that channels of communication are open and midwives have the opportunity to see each other as colleagues.

Hospital Teams

- Continuity of care will also be prioritised for women who are diagnosed as having complications at booking or during their pregnancy and/or who wish their care to be hospital based. Their care will be managed by a small team of midwives working in close co-operation with an obstetric team. The midwives should ensure that women are fully involved in decision-making, including the right to decline suggested treatment.
- The hospital midwives will conduct antenatal, intrapartum and postnatal care, including home visits (unless geographically prohibitive) for all the women they book. The ratio of midwives to women who book with the hospital teams should be higher and the care received of a superior quality to the present stretched resources found in most hospitals.
- There will be sufficient flexibility in the service to allow the care of women with complications to be shared between a group practice and a hospital team if the woman so chooses. It is expected that community group practice midwives will maintain some supportive relationship with women who have been transferred to hospital teams and provide postnatal care.

- Hospital team midwives could choose to organise themselves into fixed rota shifts or variable shifts depending on their individual requirements. Women should have an opportunity to become familiar with the entire team during the course of their care.

- Hospital team midwives will be involved in antenatal and postnatal education. They will facilitate additional discussion and support groups for women with high-risk pregnancies, such as women with diabetes or high BMI, women with a previous premature birth or women expecting more than one baby. They will develop the skills necessary to maximise women's opportunities for normal birth and assist in instrumental and caesarean births as familiar and skilled care givers.

The Role of Doctors

- We recognise that the GP has a long-term commitment to the family and could be the source of much valuable complementary care and support. We support this contribution. Some GPs may wish to host midwifery practices within their own premises.

- The hospital-based consultant obstetrician will be recognised, as now, as being the expert in the complications of pregnancy and birth. The consultant will be supported by a registrar and will share much responsibility for care with a trusted team of midwives. The pregnant woman and her partner should be given sufficient time at appointments for all aspects of care to be discussed so that the most suitable management plan can be agreed upon. Outcomes are likely to improve where advice is understood and tailored to individual needs.

- The consultant and registrar will meet regularly with their team of midwives to discuss relevant research and initiate any changes in care considered useful. The professionals will share responsibility and decision making with the woman, who will retain her legal right to accept or decline treatment offered. Other doctors, medical students and student midwives could participate as learners, if the woman gave her consent.

- The consultant obstetrician will be available to give an opinion on any aspect of a woman's care that gave cause for concern to a Group Practice midwife. Any decision to transfer part or total care to the hospital-based team will involve the woman, her midwife and the consultant. A flexible approach to the sharing of care would be maintained to suit individual circumstances. Midwifery and medical staff will recognise and respect each others' skills and come to decisions with the full participation of the women and their partners.

- Women with existing health conditions such as diabetes and cardiac problems will see the appropriate consultant early in pregnancy. Their midwife will be able to accompany them to that appointment if desired.

Financial considerations

Costs

- We see **No Fault Compensation** as the way forward for families and maternity services. The present problems of CNST-led care are adversely affecting mothers and their babies. All births should be covered by No Fault Compensation. This would not obviate the need for professional indemnity insurance but would make it affordable for all midwives.

- Although, if implemented, our *Vision* would lessen the need for independent midwifery, we think that it would be unhealthy for the NHS to have a monopoly on birth. No fault compensation for births of all UK citizens would enable independent midwives to access affordable professional indemnity insurance.

- There would be an initial need for investment in birth centres. Increasing the number of birth centres would be financed by savings made by reducing the number of beds in obstetric units. Alongside midwifery units should be carved out of existing accommodation in all obstetric units which lack one.
- Recent cuts have released suitable premises around the country which could be rented by Midwifery Group Practices. Suitable commercial health premises are available for £15 per square foot in London, £10 elsewhere. Such costs would be borne by the capitation fee.
- There must be a substantial public relations campaign to inform women and the general public of the safety of midwifery care, in whatever place it is provided.

Benefits

- There would be substantial short-term and long-term savings from the implementation of this *Vision*:
- Caseload midwifery has been shown substantially to reduce caesarean section rates and other high-cost aspects of care (McLachlan *et al*, 2012).
- Increased breastfeeding rates will improve child health, preventing paediatric admissions.
- It is anticipated that improved continuity of care will lead to improvements in mothers' mental health, benefiting themselves as well as their babies and family life.

Funding

- Commissioning and finance of community midwifery group practices must be separated from that of acute services to prevent midwives and funds being diverted from community care to acute care. At the same time community Group Practice midwives will need to be able to come into hospital with their clients in labour or at other times should the need arise.

Payment by Results

- The benchmark of safe and affordable maternity care should be good maternal and infant outcomes and the normal birth rate. Payment by Results should be configured to support preventative care and reward those who achieve the best clinical outcomes with the least intervention.
- Something akin to the GPs' Quality Outcomes Framework could be used for Midwifery Group Practices, with points given for such outcomes as percentages of known midwife at the birth and breastfeeding rates at discharge.
- The biggest challenge is the interface between community and hospital. ARM would not like to return to a system that rewards unnecessary intervention but one which pays fairly for appropriate intervention. Again, it may be useful to look at General Practice and institute a similar system for midwifery practices.

Supervision

- Supervision of midwives has improved considerably in recent years with much smaller supervisory caseloads and with midwives choosing their supervisor. We think that the Supervision of Midwives should be retained and developed. This is particularly important if midwives are no longer to be employed by acute Trusts. We see a role for LSA Midwifery Officers to form learning and support networks for midwives who will be working in a more autonomous way.
- Pregnant women should know who the Supervisor of Midwives is and that they can approach her if they have issues to raise with her.

Change Management

- We recognise that this will be an entirely new way of working for many midwives currently managed from obstetric units and resistance may come from midwives themselves.
- Under the *Vision* there will still be a need for core midwives in obstetric units, so some midwives will be able to carry on working as they do at present. An NCT study of where women want to give birth (2009) found the following proportions: 20% consultant obstetric unit; 40% alongside midwifery unit ; 20% free-standing midwifery unit; 20% home. Thus, it is anticipated that initially only those midwives working in the community and in free-standing birth centres would work in Midwifery Group Practices. The number of midwives working this way would gradually increase over time.
- We believe that it is possible to make a gradual transition to this way of working without upsetting midwives' personal lives.

Benefits for midwives

- We believe that midwives will find that there are as many benefits as drawbacks to caseload midwifery.
- Providing real continuity of care will give midwives greater job satisfaction.
- Group Practice Midwifery will provide a satisfying clinical career path, an alternative to a management career path.
- Midwives working in the community and birth centres will have more control over their working lives, they will organise their on-calls amongst themselves and cover for each other if one of the group has been up all night at a birth.
- Group Practice midwives will not be called into hospital to cover labour ward but instead will bring their 'own' women into hospital for birth if the woman wants a hospital birth.
- Midwives will be on call for their own women only and, having a closer relationship to their midwife, women quickly learn to consider their midwife's needs as well as their own. Women having their own midwife tend not to make unreasonable demands.
- Midwives choosing the responsibility of carrying a caseload will be rewarded financially. We anticipate that midwifery practices will receive a fee of around £2,000 per client (with a yearly increase in line with inflation). Enhanced remuneration would be funded through savings in medical and hospital time (epidurals and surgical deliveries, admission to special care baby units and so on).
- Midwives will carry the size of caseload which suits them according to the stage of their family life and their personal preferences. Midwives with carer's responsibilities will be able to carry a small caseload to maintain their registration. The caseload approach enables them to work round their other responsibilities.

Education

- Student midwives will continue to be educated to graduate level in Higher Education Institutions to enable multidisciplinary team learning where appropriate and the underpinning of theory with evidence from education and research experts.
- Student midwives will be fully informed, prior to admission onto the course, of the planned change in the provision of maternity care and how this will affect midwives' working lives. It is anticipated that most students would come to midwifery having been first employed as a maternity assistant or doula in a Midwifery Group Practice.
- Selection processes should take cognisance of life experience and personal philosophy of birth.

- A broad range of topics should be taught along with lifelong learning skills and with an emphasis on promoting active birth
- Practical skills can be gained in fully equipped skills simulation labs, utilising clinical experts and assessed for both low and high risk situations
- The education team should have a range of expertise from all maternity areas, and spend a minimum of 20% of time working in clinical practice, carrying a small case load and working as part of a clinical team
- Clinical practice should be no less than 50% of an educational programme and should be supervised by a named mentor and graded against clear clinical proficiencies
- Clinical practice should include opportunities to work within high risk obstetric units, stand-alone midwife-led birth units and with women in their own homes
- Clinical skills should include a minimum of 40 births, and the full range of experiences including caseload, home and water birth, and breech and twin births where possible.
- Pathways should be available for postgraduate study towards specialist clinical, managerial and research roles

Management

- Community group practices will manage their caseloads themselves. They will have the administrative support of a practice manager who will do such things as obtaining tardy laboratory results; keeping records on clients so that statistics can be produced on, for example, birth outcome and breastfeeding rates; administration associated with referrals to other agencies; stock control; taking minutes at meetings; and financial administration.
- Midwives working in hospital teams and as 'core' midwives will continue to be employed by Trusts and Health Boards.
- The present hierarchical structure of midwifery management in hospital needs to be reassessed. One of the main problems is the lack of a career progression that encourages or maintains clinical commitment. Good caring midwives move away from the 'hands-on' situation and may lose touch with what is happening at grass roots level. This estrangement can lead to lack of support for clinical midwives and consequent lack of support by practising midwives for their managers. Essential to this proposed management structure are:
    - Midwifery managers and co-ordinators maintaining some clinical commitment.
    - The involvement of midwives in the appointment of managers and co-ordinators.
    - The status of clinical midwives and midwife managers to be equal.

Maternity Services Liaison Committees

- MSLCs would be retained or re-established to ensure the active involvement of service users, user group representatives and all other interested parties. They will be enhanced to provide an interface between community and acute services.
- There will be a need for greater co-operation and co-ordination between Midwifery Group Practices and maternity units (CMACE report 2011). This is especially important around transferring women from community to hospital care at any time.

Conclusion

This is our *New Vision* for the maternity services of the future. We wish to change the perceptions of the general public about birth and about midwives so that we can practise the profession for which we have been trained. Organisational change and financial and educational input is needed to start this process. Once women know other women who have experienced birth with continuity of care and real autonomy, whether at home or in hospital, this care will be expected. This new standard of care will bring about improved clinical outcomes for mother and baby, substantial savings for the NHS and positive cultural change within maternity services and the wider public. Babies whose mothers have a more confident start to motherhood will have a happier and healthier start to life.

Midwives are unique in their combination of skill, sensitivity and training to be 'with woman' through one of life's landmark experiences which has long-term effects on the individual, the family and society as a whole. We must generate a new respect for both motherhood and midwifery. We owe it to ourselves and to future generations.

Throughout this document the midwife is referred to as 'she'. The term 'mother' or 'woman' should be taken to include her partner and children where appropriate. No offence is implied to male midwives, partners or children.

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