

Midwifery 2020 UK Policy Review Report
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Introduction

This review was commissioned to inform the work of the Midwifery 2020 UK programme. Key health, education and early years policies published since the 1990s for the UK, Scotland, England, N. Ireland, Wales, and Europe that have had and/or will have an impact on midwifery were sourced and reviewed. Policy affecting: maternity services, workforce planning, education and career pathways and development, practice and outcome measurement was included.

Firstly a broad overview of the key policy commitments across the four countries of the UK and beyond is presented. Then the five Midwifery 2020 UK workstreams: the core and developing role of the midwife; workforce and workload; education and career progression; measuring quality; and public health are used as section headings to present the in-depth review. Finally issues arising from the review likely to impact on the implementation of policy into practice are highlighted.

Key universal policy commitments

The 1997 Labour Party election manifesto pledged to introduce a devolved form of government for Wales, Scotland and Northern Ireland. In 1998 this was realised with the creation of an elected parliament in Scotland, an elected Assembly in Wales and an elected Assembly in Northern Ireland. Prior to devolution differences in health policy across the four countries were minimal. Powers were transferred to the Scottish Parliament and Welsh Assembly Government on July 1st 1999 and to the Northern Ireland Assembly on the 2nd December 1999.

Devolution provided the freedom and opportunity for the four countries of the UK to pursue and develop their own particular health policy and distinct differences are emerging between the health services. Differences are particularly marked in relation to how the health service is organised and managed. The suspension of the Northern Ireland Assembly from 2002–2007 and the focus on massive structural reorganisation appear to have had an impact on the relative speed of development of health policy in Northern Ireland compared to the other three countries during the post devolution period.

At the beginning of 2010, although many of the broad aims for health services across the four countries of the UK are similar e.g. streamlining the acute sector, providing more care closer to home and/or in community settings and making more preventative interventions, these aims are being pursued in different ways. The key overarching country and organisational differences are presented in table 1 below.

Table 1

	England	Wales	Scotland	N. Ireland
Population	50 million	3million	5million	1.7 million
Commissioner/Provider split	Yes	Abolished 2009	Abolished 2004	Yes
Money following the patient/payment by results	Yes	No	No	No
Integration of health and social services	No	No	No	Yes
Integration of acute and community care	Some vertical integration emerging but mainly separate	Yes	Yes	Yes
Tiers of service planning and performance management	Regional tier of Strategic Health Authorities	Direct contact between Local Health Boards and Department of Health	Direct contact between Local Health Boards and Department of Health	Direct contact between HSC Board and DHSSPSNI
Particular remote and rural initiatives	No	Yes	Yes	No
Workforce planning and development	Regional	National	National	National

Although the number and nature of policies impacting on midwifery and maternity services vary across the four countries of the UK there is a common commitment to:

- providing safe services
- woman/family-centred care
- 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
- increasing continuity of carer across the maternity care pathway
- establishing midwives as the first contact professional in maternity services and ‘navigating’ a woman’s journey through pregnancy
- a health promotion and public health role for midwives
- ensuring better access to community-based and midwife-led services
- encouraging normal birth and reducing unnecessary interventions
- increasing breast feeding rates

Policies from each country illustrating these commitments are presented in table 2 below.

Table 2

Policy Commitment	England	Wales	Scotland	N. Ireland
Choice	<p>Maternity and Early Years – Making a Good Start to Family Life (DCSF, DH 2010)</p> <p>High Quality Care for All, NHS next stage review final report (DH, 2008)</p> <p>Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)</p> <p>Making it Better: For Mother and Baby. Clinical case for change (DH, 2007)</p> <p>First Class Delivery – Improving Maternity Services in England and Wales (NAO, 1997)</p>	<p>Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)</p> <p>All Wales Clinical Pathway for Normal Labour (NHS Wales, 2005)</p> <p>First Class Delivery – Improving Maternity Services in England and Wales (NAO, 1997)</p>	<p>Keeping Childbirth Natural and Dynamic Programme (SG, 2008)</p> <p>Clinical Standards March 2005 Maternity Services (NHS QIS, 2005)</p>	<p>A Northern Ireland Strategy for Nursing and Midwifery 2010 – 2015 (DHSSPS, 2010)</p> <p>Developing Better Services: Modernising Hospital and Reforming Structures. (DHSSPS, 2002)</p>

Policy Commitment	England	Wales	Scotland	N. Ireland
More midwife-led care	<p>Towards better births. A review of Maternity Services in England (HCC, 2008)</p> <p>Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)</p> <p>Making it Better: For Mother and Baby. Clinical case for change (DH, 2007)</p>	<p>All Wales Clinical Pathway for Normal Labour (NHS Wales, 2005)</p>	<p>Clinical Standards March 2005 Maternity Services (NHS QIS, 2005)</p> <p>Implementing a Framework for Maternity Services in Scotland: The Overview Report of the Expert Group on Acute Maternity Services (SE, 2002)</p> <p>A Framework for maternity services in Scotland (SE, 2001)</p>	<p>Developing Better Services: Modernising Hospital and Reforming Structures. (DHSSPS, 2002)</p>
Continuity of carer	<p>Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)</p> <p>First Class Delivery – Improving Maternity Services in England and Wales (NAO, 1997)</p>	<p>First Class Delivery – Improving Maternity Services in England and Wales (NAO, 1997)</p>	<p>Keeping Childbirth Natural and Dynamic Programme (SG, 2008)</p>	

Policy Commitment	England	Wales	Scotland	N. Ireland
Midwives as first contact	<p>Framing the Nursing and Midwifery Contribution: driving up the quality of care (DH, 2008)</p> <p>Making it Better: For Mother and Baby. Clinical case for change (DH, 2007)</p> <p>Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)</p>	<p>Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)</p>	<p>Better health. Better care. Action Plan (SG, 2007)</p>	<p>Development Framework final project report (NIPEC, 2006)</p>

Policy Commitment	England	Wales	Scotland	N. Ireland
Public health and health promotion especially smoking cessation	<p>Choosing health: Improving public health and overcoming inequalities (DH, 2010)</p> <p>Healthy Child Programme Pregnancy and the first five years of life (DH, DCSF, 2009)</p> <p>Review of the Health Inequalities Infant Mortality PSA Target (DH, 2007)</p> <p>Choosing health: making healthy choices easier (DH, 2004)</p> <p>Getting the right start: National Service Framework for Children. Standard for Hospital Services (DH, 2003)</p> <p>Tackling health inequalities: 2002 cross cutting review (DH, 2002)</p>	<p>Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)</p>	<p>Better Health, Better Care: Action Plan (SG, 2007)</p>	<p>Healthy Futures 2010 – 2015. The Contribution of Health Visitors and School Nurses in Northern Ireland (DHSSPS, 2010)</p>

Policy Commitment	England	Wales	Scotland	N. Ireland
Access to community and midwife-led services	Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)	A community nursing strategy for Wales. Consultation Document (WAG, 2009)	Implementing a Framework for Maternity Services in Scotland: The Overview Report of the Expert Group on Acute Maternity Services (SE, 2002)	A Healthier Future (DHSSPS, 2004) Delivering Choice: Report of the Northern Ireland Maternity Unit Study Group (DHSS, 1994)
Encouraging normal birth	Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007) Delivering Quality and Value Focus on: Caesarean Section (NHS Institute, 2006)	Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)	Pathways for Maternity Care (NHS QIS, 2009) Keeping Childbirth Natural and Dynamic Programme (SG, 2008)	Developing Better Services: Modernising Hospital and Reforming Structures (DHSSPS, 2002)

Policy Commitment	England	Wales	Scotland	N. Ireland
Increasing breast feeding rates	<p>Modernising Maternity Care A Commissioning Toolkit for England (2nd edition) (Maternity Care Working Party, 2006)</p> <p>Choosing health: making healthy choices easier (DH, 2004)</p> <p>Good practice and innovation in breastfeeding (DH, 2004)</p>	<p>Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)</p>	<p>Better Health, Better Care: Action Plan (SG, 2007)</p>	<p>Healthy Futures 2010 – 2015. The Contribution of Health Visitors and School Nurses in Northern Ireland (DHSSPS, 2010)</p>
Safe services	<p>High Quality Care for All, NHS next stage review final (DH, 2008)</p> <p>Maternity Matters. Choice, access and continuity of care in a safe service (DH, 2007)</p> <p>Building a safer NHS for patients : implementing 'An organisation with a memory' (DH, 2001)</p>	<p>Welsh National Service Framework for Children, Young People and Maternity Services (WAG, 2005)</p>	<p>Implementing a Framework for Maternity Services in Scotland: The Overview Report of the Expert Group on Acute Maternity Services (SE, 2002)</p>	<p>Healthy Futures 2010 – 2015. The Contribution of Health Visitors and School Nurses in Northern Ireland (DHSSPS, 2010)</p> <p>A Healthier Future (DHSSPS, 2004)</p>

Core and developing role of the midwife

Midwifery is regulated by the Nursing and Midwifery Council (NMC). All midwives practising in the UK must be registered with the NMC and the NMC sets the standards for practice, education and statutory supervision of midwives. The 2004 Midwives Rules and Standards are currently being reviewed to ensure that they reflect contemporary practice (Nursing and Midwifery Council 2004). The midwifery profession expects its practitioners to be: knowledgeable and highly skilled advocates for the women in their care; accountable for the quality of the care they give and the services they manage; able to measure and articulate the quality of their care; and confident at exercising a high degree of influence within organisations and across networks that provide maternity services (Department of Health 2008c).

The role of the midwife has been described as spanning preconception to postnatal care (Department of Health & Department for Education and Skills 2001; Scottish Government 2008c). Midwifery care is considered to be at the centre of maternity services and there are commitments in policy documents across the UK that women should be able to access midwives directly rather than having to go through their GP (Department for Children, Schools and Families & Department of Health 2009; Department of Health & Department for Education and Skills 2001; Northern Ireland Practice and Education Council for Nursing and Midwifery 2006; Scottish Government 2007; Scottish Government 2008c; Welsh Assembly Government 2005). A guiding principle in the policy literature for contemporary maternity services is that *"all women will need a midwife and some need doctors too"* (Department of Health 2007).

Role development is a key feature of the both the government and professional policy literature. The core midwifery role is expanding in response to service need and technological developments. For example, what were once seen as extended role skills e.g. cannulation are now viewed as part of core practice and included in the pre-registration curriculum.

The career frameworks in all four countries identify a range of levels of practice and the need to develop new and existing career pathways (Department of Health 2008b; Northern Ireland Practice and Education Council for Nursing and Midwifery 2006; Scottish Executive 2006a; Welsh Assembly Government 2008). New midwifery roles (specialist, advanced and consultant) are developing across the four countries of the UK although the approach, type, scale and speed of change does vary between countries. For example Scotland has 12 consultant midwives (Scottish Government 2008a) whereas there were no consultant midwives reported to be working in Northern Ireland in 2006 (Department of Health, Social Services and Public Safety 2006). Role development is reported in core areas of midwifery practice such as breastfeeding support, in midwives taking on extra skills and/or running new services such as preconception counselling and screening, amniocentesis, ultrasound scanning, ventouse deliveries, arranging for epidurals, oxytocin administration and

the management of hyperemesis (Department of Health, Social Services and Public Safety 2006). Some midwives are also specialising in particular client groups such as teenage mothers and women with particular needs eg those who substance abuse.

Midwifery role development also occurs in response to non-maternity or midwifery specific policy. For example in England the Diabetes National Service Framework which highlights the importance of close monitoring and specialist care throughout pregnancy and childbirth for women with pre-existing diabetes and those who develop gestational diabetes (Department of Health 2001). In response many services have established specialist midwifery roles in diabetes. Women are also vulnerable to developing mood disorder during pregnancy and in the postnatal period. Mental disorder is a significant cause of maternal mortality. Perinatal mental illness is a significant, and potentially preventable, cause of maternal mortality. Mental health policy too therefore is having an impact on midwifery services, roles and practice (Department of Health 2010b;HM Government 2009a;Oates 2000). Women have twice the risk of experiencing domestic violence whilst they are pregnant. Consequently, policy in relation to domestic violence has resulted in an expectation that all midwives should ask women about domestic violence (Department of Health 2005;HM Government 2010b) and several organisations have set up specialist and consultant midwives with particular interest and expertise in this area.

Structural changes in the organisation and delivery of health services in general are also having an impact on the shape and location of maternity services and therefore on midwifery roles and practice. For example, in England, Transforming Community Services is also being used successfully as a mechanism for enabling the transformation of maternity services and in particular promoting community maternity services (Department of Health 2009i).

Pay modernisation initiatives, particularly Agenda for Change (Department of Health 2004a) and the associated Knowledge and Skills Framework (KSF) (Department of Health 2004b), have been promoted as providing the foundation for describing and redesigning future roles in midwifery (Scottish Executive 2006a). Front line care, the report of the Prime Minister's Commission for the future of nursing and midwifery in England has recommended that regulation of Advanced Midwifery practice be considered (Prime Minister's Commission 2010).

Leadership is receiving increasing attention in the policy and professional literature (Department of Health 2009b; Department of Health 2009c; Department of Health, Social Services and Public Safety 2010a; Scottish Executive 2006a; Scottish Government 2008a; Scottish Government 2009). Government commitments include improving the overall quality of leadership in general, developing strong clinical leadership in particular (NSR Implementation Team 2009) and building leadership capacity in the service as a whole (Welsh Assembly Government 2006; Welsh Assembly Government 2005).

Heads of Midwifery (HoMs) are recognised as providing strategic and organisational leadership and investment in HoMs, and their ongoing development, is advocated as a means of contributing to improved services and staff development (Department of Health 2007; Department of Health 2008c; Prime Minister's Commission 2010). The HoM role has the potential to increase midwives' influence on boards and in the commissioning process (Department of Health 2009a). Consultant midwives are also promoted as having an important clinical leadership role (Department of Health 2007).

The types of leadership likely to be required by leaders are also articulated in some of the policy documents. For example the Scottish Government highlights the importance of leaders being able to lead across partnerships and networks (Scottish Government 2009).

Workforce and workload

The success of the NHS in all four countries depends on an appropriately skilled workforce. As identified in table 1 above there is a difference between England (regional) and the other three countries (national) in the arrangements for workforce planning. In England Primary Care Trusts (PCTs) and acute trusts are expected to ensure that there is an appropriately skilled maternity and neonatal workforce who receive regular continuing professional development; and that there are sufficient staff, working flexibly across hospital and community settings, to provide high-quality maternity and neonatal care (Department of Health 2009a; Department of Health, Unite the Union, & Community Practitioners' and Health Visitors' Association 2009). In addition to provide the national perspective, the Department of Health England has recently established a Nursing and Midwifery Professional Advisory Body. Its role will be to provide professional oversight, assurance and expertise to the Chief Nursing Officer's Next Stage Review Nursing and Midwifery Advisory Board and the High Quality Workforce Board. It will inform decisions at a national level concerning workforce planning, development and education for the nursing and midwifery professions and associated support staff to encourage transformational developments in service provision and delivery.

Policy both directed at the health sector and that directed at the workforce and labour market in general in all four countries encourages a move towards increasing flexibility and diversity within the workforce (NHS Wales 2008). In England, ten years ago 'The NHS Plan' acknowledged that the biggest constraint facing the NHS was the shortage of human resources and contained a raft of proposals for new service developments based on a reconfigured workforce (Department of Health 2000). Successive policy documents have suggested that the skill mix be examined and new roles be developed (HM Government 2009b; NHS Employers and Care Services Improvement Partnership 2006; NHS National Workforce Projects 2009).

Innovative partnership working with the wider maternity workforce and new 'kinds' of health professionals will also be required. For example across the UK with health visitors in relation to public health and safeguarding as envisaged in 'Action on Health Visiting' (Unite, CPHVA, & Department of Health 2009a). Similarly, with Family Nurse Partnership (FNP) nurses in England and Scotland to implement the FNP programme. This programme is based on a model of intensive, nurse-led home visiting for vulnerable, first time, young parents which involves FNP nurses visiting parents from early pregnancy until the child is two years old. The aim of the visits is to build a close, supportive relationship with the whole family and guide mothers to adopt healthier lifestyles, improve their parenting skills, and become self-sufficient (Department for Children, Schools and Families 2009a; Department for Children, Schools and Families & Department of Health 2009; Scottish Government 2010b). In addition the use of nurses and or maternity support workers for example in theatre and recovery post caesarean section is increasingly advocated (NHS Employers and Care Services Improvement Partnership 2006; NHS Institute 2006).

Alongside these particular initiatives related to the maternity workforce, significant investment is also being made in initiatives designed to increase flexibility in recruitment and training of NHS staff in general which in turn are having an impact on the maternity workforce. Such developments have been encouraged and supported by a variety of broader policy commitments. These include The Leitch Report (HM Treasury 2006) which emphasised that:

"Without the continuous learning and development of health care staff, especially those in the lowest pay and career grades and those most frequently excluded from learning and qualification, the plans for service transformation are at risk."

In order to meet future policy and service requirements career pathways will need to encompass the currently registered and non-registered workforce. Key reports have suggested that as yet insufficient use is being made of support workers (Healthcare Commission 2008; NHS National Workforce Projects 2009). The National Audit Office has said that Agenda for Change should be used to design new and more effective ways of working across the health workforce and that using the KSF is key to this (National Audit Office 2009).

Midwifery Support Workers (MSWs) can be trained to different levels of competence; greater use of them, if appropriately trained and supervised, has the potential to reshape the workforce across the whole maternity care pathway and particularly in postnatal care (Healthcare Commission 2008). Strategic approaches to MSW development are underway at a national level in Scotland, Wales and Northern Ireland and at a more local level in England (NHS Employers and Care Services Improvement Partnership 2006) although within a national initiative. For example in Wales a flexible and transferable curriculum has been designed to be recognised nationally and provide a standardised and coherent approach to educational provision for

MSWs (National Leadership and Innovation Agency for Health & Royal College of Midwives 2009). Similarly in Scotland a defined role for the maternity care assistant (MCA) has been identified and a competency framework designed. NHS Education Scotland identified five areas of core competencies and training needs for inclusion in training programmes for maternity care assistant: pregnancy, childbirth and the postnatal period; education; clinical skills; baby care and personal skills and competencies (NHS Education for Scotland 2006). In Northern Ireland a national training programme and job description for a band 3 Maternity Support Worker has been developed and training is due to start in 2010. This was developed by the Northern Ireland Practice Education Council in response to the value for money audit carried out in 2006 (Northern Ireland Practice and Education Council for Nursing and Midwifery 2010).

Workforce planning and development requires both strategic cross-profession, whole labour market approaches (House of Commons Health Committee 2007) and cognisance of the diverse local labour market challenges and realities within and between countries. For example the midwifery profession although ageing in all UK countries is doing so at different rates in each country (Department of Health, Social Services and Public Safety 2006; NHS Employers and Care Services Improvement Partnership 2006). The Department of Health England has emphasised its commitment to ensuring that workforce planning in the NHS is locally led and rooted in service improvement (HM Government 2009b). The Workforce Review Team has stated that workforce planning should flow explicitly from agreed service strategy and that the future workforce should be characterised by offering *"the right people, with the right skills, in the right places, at the right time"* (The Workforce Review Team 2009). For example, it has been suggested that changes to the care pathway eg that the numbers of antenatal visits for women with uncomplicated pregnancies should be reduced (House of Commons Health Committee 2003) and if this were adopted in practice it would have a knock on impact on the workforce required.

Education and career progression

All midwives working in the UK must be registered with the NMC and must have completed successfully an approved midwifery programme of education. Midwives are also expected to undertake continuing professional and personal development throughout their career, including developing new knowledge and skills. Supervision of midwives is a statutory responsibility which provides support and guidance to every midwife practising in the UK (Nursing and Midwifery Council 2010). The NMC standards for pre-registration midwifery education are informed by the international definition of a midwife and the requirements of the European Union Directive Recognition of Professional Qualifications 2005/36/EC Article 40 (Nursing and Midwifery Council 2009b). All pre-registration programmes have been at degree level since 2008. New career pathways are emerging and being piloted in various parts of the UK eg clinical academic careers and fellowships (Scottish Government 2008a).

All four countries are increasingly promoting a stronger link between investment in education and service transformation. For example in England ‘High Quality Care for All’ (Department of Health 2008a) highlights the importance of improving the quality of NHS education and training in delivering quality improvements for patient care in England. It also notes the importance of

“Strengthened arrangements to ensure staff has consistent and equitable opportunities to update and develop their skills” and the importance of the provision of a range of training and development opportunities for staff of all grades and from all areas.”

In England, the recently published ‘NHS 2010–2015: from good to great. preventative, people-centred, productive’ (Department of Health 2009d) and the operating framework for the NHS in England 2010/11 (Department of Health 2009h) highlight the need for employers to:

- review their training plans and align them to support the delivery of local clinical visions and new ways of working;
- review and where possible reduce the number of postgraduate medical specialty training posts, consistent with long-term requirements;
- review and where possible reduce the number of pre-registration commissions consistent with long-term requirements;
- ensure sufficient investment to support the redeployment of staff into new ways of working, especially those moving to new roles and settings; and
- check the workforce is appropriately regulated to ensure patient safety.

Such ideas were set out in Standard C11 of Standards for Better Health (Department of Health 2006). This established an expectation that health care organisations ensure that staff concerned with all aspects of the provision of health care are appropriately recruited, trained and qualified for the work they undertake; participate in mandatory training programmes; and participate in further professional and occupational development commensurate with their work throughout their working lives. This expectation has been reiterated and developed further by the Care Quality Commission in its ‘Essential standards of quality and safety’ (Care Quality Commission 2009a). This operationalises the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and emphasises that:

- the learning and development needs of staff be identified based on the needs of people who use services and the skills needed from staff to ensure that the service meets essential standards of quality and safety;
- staff have a learning and development plan in place from the point of induction;
- staff should to receive appropriate training, professional development, supervision and appraisal and be able to obtain further qualifications appropriate to the work they perform;

- the staff learning and development programme needs to take account of the working patterns of staff;
- a record be kept of those attending the learning and development activities that staff attend; and
- risk is managed through effective procedures for learning and development.

Finally in England the NHS Constitution (Department of Health 2009g;The State of Readiness Group 2009) pledges *“to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed”*. Key policy changes including the European Working Time Directive (HM Government 1998) and Modernising Medical Careers (Department of Health 2003) will radically change the way in which junior doctors work and are trained in the future and will have a wider impact on the planning of the non-medical workforce including midwifery and education commissioning (NHS West Midlands 2007).

A similarly service-linked approach is evident in Northern Ireland's Development Framework (Northern Ireland Practice and Education Council for Nursing and Midwifery 2006). This framework has been explicitly developed to meet Northern Ireland's future health and care needs including an increased emphasis on public health; midwife-led services; and midwives being the first point of contact in maternity services. This service-linked approach is also reinforced in the new nursing and midwifery strategy for Northern Ireland which is currently being consulted on (Department of Health, Social Services and Public Safety 2010a).

There are also important country specific challenges. For example, in Scotland there is very low density of population in the Highlands and Islands (only 8 people per sq km compared to Glasgow with 3,540 people per sq km) and most of the remote populations are in Island communities. This causes difficulty for midwives in remote and rural areas to access robust supported learning programmes, and their need for rotation to bigger centres for skills update has been highlighted (Scottish Government 2010a).

A link between education and safe practice is frequently made (Lewis & Drife 2004;Welsh Assembly Government 2008) and there has been a huge expansion in the amount of mandatory training midwives are expected to undertake. Many non-maternity specific policies have education implications too particularly with regard to mandatory training. For example there are particular requirements regarding access to and funding for training related to safeguarding (Care Quality Commission 2009b;Care Quality Commission 2009c;Department for Children, Schools and Families 2009b;Department of Health 2003;Gilbert 2008;Independent Safeguarding Authority 2010;The Lord Laming 2009).

All midwives also have a major role in teaching and mentoring student midwives and an expected role in teaching and mentoring junior doctors and medical students

(Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, & Royal College of Anaesthetists 2007).

Along with all the healthcare regulators, the Nursing and Midwifery Council (NMC) is exploring revalidation in response to the government White Paper on regulation, 'Trust Assurance and Safety: the Regulation of Healthcare Professionals in the 21st Century' (Nursing and Midwifery Council 2009a).

Measuring quality

Explicit references to and expectations about quality are currently more prevalent in the English and Scottish policy documents. For example the Care Quality Commission has set 'Essential standards for quality and safety' (Care Quality Commission 2009a) and the Scottish Government has recently re-launched its quality strategy (Scottish Government 2010c) which focuses particularly on patients expectations of a quality service which are reported to be: caring and compassionate treatment, clear communication and explanation, effective collaboration with the clinician, clean and safe care environment and continuity of care.

'High quality care for all: NHS Next Stage Review final report' (Department of Health 2008a) set out a vision for an NHS that is clinically effective, personal and safe for all, and which:

- helps people stay healthy
- has quality at its heart, gets the basics right every time, and gives the public information about the standard of quality achieved
- works in partnership with its staff enabling them to lead and manage the organisations in which they work
- integrates health and social care
- works within a constitution setting out rights and responsibilities.

Quality in this context spans: patient safety; patient experience and effectiveness of care. From April 2010 in England PCTs and Trusts will be required to produce annual Quality Accounts and report publicly on their quality performance (Department of Health 2009e). Accurate, timely, meaningful and comparable measures or metrics of quality related to midwifery will therefore be required. Midwives from point of care to board will need to be able to measure, interpret and act such data.

Quality related to midwifery in particular is tends to be conceptualised as providing choice, access and continuity of care in a safe service (Department of Health 2009a). For example specific guidance from the NHS Institute in England and NHS Quality Improvement Scotland emphasises the importance of all women being able to access a midwife directly, the midwife being the lead healthcare professional throughout for normal pregnancies, if risks are identified that midwives have the skills and knowledge to optimise the potential for normal care, and there are clear guidelines for the management of women who experience variations from the norm

in order to avoid inappropriate interventions (NHS Institute 2006; NHS Quality Improvement Scotland 2009).

The most recent report from the Local Supervising Authorities highlights the areas of practice that need further improvement including assessment of the foetal condition, foetal heart interpretation in labour, record keeping, communication skills, drug errors, assessment of the maternal condition and appropriate referral to more experienced personnel (Nursing and Midwifery Council 2010).

The need for investment in the development of robust metrics to measure the quality of maternity services is increasingly being noted (Department for Children, Schools and Families & Department of Health 2009; Healthcare Commission 2008; Healthcare Inspectorate Wales 2007).

Public health

Progress on health inequalities over the last 10 years has been summed up as: 'much achieved; more to do' (Department of Health 2009f; Scottish Government 2008b). In relation to England the Audit Commission has noted that it is hard to know how much has been spent on tackling the causes of ill-health and on reducing health inequalities, or what the impact has been. Despite some progress complex problems such as teenage pregnancy have proved challenging, and inequalities in the health of people from certain areas and social backgrounds has not only resisted improvement, but has even increased in some cases (Audit Commission 2010a). Better collection and recording of socio-economic data is thought to be important in improving performance (House of Commons Health Committee 2010).

Maternity care is presented as having a key role in reducing inequalities in health. Evidence suggests that an individual's risk of developing ill-health is related in part to the circumstances of the previous generation and that intervening before and during pregnancy and early in life improves health (Billingham & Shribman 2009; Department of Health 2002; Marmot 2010; Scottish Government 2008b; Unite, CPHVA, & Department of Health 2009b). For example the English White Paper 'Choosing health: Improving public health and overcoming inequalities' sets out how good quality maternity care can make a substantial contribution to improving:

- the immediate health and well-being of women and babies, and overcoming the substantial inequalities in their mortality and morbidity;
- the long-term health of the population, because of the links between some birth outcomes (e.g. low birth weight) and life-long morbidity, and the positive association between breastfeeding and a reduction in obesity, high blood pressure, coronary heart disease, diabetes and some maternal cancers; improving the health of women by providing an opportunity for health professionals to engage with those who might otherwise be reluctant to

access health services, and to support them in making healthier lifestyle choices (for example around smoking, diet or substance misuse) thereby helping to meet the national targets for improving the health of the population (Department of Health 2010a).

As a consequence there has been an increasing interest in the public health role of midwives. In 2001 in England the government signalled its intention to develop the public health contribution of, midwives. Since then valuable health promoting role of midwives in all settings and services has been regularly emphasised (Department of Health 2007; Department of Health, Social Services and Public Safety 2010b; HM Government 2004) and there has been a growing commitment to a public health role in all four countries (Department of Health 2010a; Department of Health, Social Services and Public Safety 2002; Scottish Executive 2006b; Welsh Assembly Government 2004).

In Scotland 'Nursing for Health: A review of the contribution of nurses, midwives and health visitors to improving the public's health in Scotland' (Scottish Executive 2006b) describes measures to re-establish nursing and midwifery's expertise in the vital areas of improving health and public health, including:

- positioning nursing and midwifery in the mainstream of health improvement developing nursing and midwifery's contribution to public health as full and legitimate partners in the health improvement process
- adopting public health approaches in nursing and midwifery work working in multi-disciplinary, multi-agency partnerships.

Across the UK particular policy commitments have been made in relation to midwifery and its contribution to smoking cessation, obesity and increasing breast feeding rates and duration (Billingham & Shribman 2009; Department of Health 2002; Department of Health 2004b; Department of Health 2010a; Department of Health, Social Services and Public Safety 2010b; Health Inequalities Unit, DH 2007; Lewis & Drife 2004; Marmot 2010; Maternity Care Working Party 2006; Scottish Government 2007; Office of the First Minister and Deputy First Minister 2006).

Increasing the involvement of fathers in maternity care is a growing area of policy interest (HM Government 2010a). Better engagement of fathers is thought to have significant benefits for children's social, emotional and intellectual development and wellbeing yet role that fathers play has often been overlooked, particularly during pregnancy and the early years (Audit Commission 2010b). For example in England 'Healthy lives, brighter futures' and 'Maternity and early years – making a good start to family life' it is noted that many maternity services are implementing new ways of engaging fathers in antenatal support and parenting groups. In addition, the Government has recently updated best practice guidance to state that maternity units should have overnight facilities for partners of women in labour provided within or near the unit, and that mothers and fathers should expect to be involved in the planning process for any new maternity facilities (Department for Children,

Schools and Families & Department of Health 2009) and specific interventions with fathers are proposed in the 'Healthy Child Programme Pregnancy and the first five years of life' (Billingham & Shribman 2009). A focus on fathers is evident too in 'Healthy Futures 2010 – 2015. The Contribution of Health Visitors and School Nurses in Northern Ireland' (Department of Health, Social Services and Public Safety 2010b).

Implementation

The House of Commons Health Committee (House of Commons Health Committee 2003) noted that the 'Changing Childbirth' report of the House of Commons Expert Maternity Panel in 1993 recommended many of the elements still being pursued as policy commitments such as more midwife-led care, and greater choice over place of delivery and the professional providing care and therefore the difficulties in implementation. Bosanquet and colleagues highlighted challenge of making such choices meaningful in anything other than urban areas and the potential destabilising effect to the whole system if women were truly to begin to exercise such choices (Bosanquet et al. 2005).

Over the next five years at least the NHS in all four countries will be moving from a position of growth to one of consolidation (Department of Health 2009d; Flory 2009). This will require fundamental changes in the way that services are delivered and innovation to improve productivity and quality outcomes. In practice this will require attention to reduce inappropriate clinical variation eg different caesarean and intervention rates and supporting the development of evidence based and cost effective care. It is also likely to necessitate pathway re-design and more local maternity services. There will be significant pressures to improve productivity by developing new ways of working, creating new assistant and advanced practice roles and increasing the flexibility and adaptability of the midwifery workforce in general.

Some changes may be more straightforward to implement in particular parts of the UK because of the organisation of health services. For example maternity services are believed to be most effective at meeting women's needs and tackling inequalities where health and social care are integrated and so arguably the structural context in Wales and Scotland may therefore be more conducive.

Making change actually happen will require leadership (Department of Health 2009b). Good leaders are required at every level and successful healthcare organisations create and foster conditions for talent spotting and leadership development (Department of Health 2009c). Indeed in Scotland midwives at all levels and in all settings are exhorted to take personal responsibility for contributing to the policy agenda (Scottish Executive 2006a).

Taking a 'whole systems' approach to planning will also be essential so that the midwifery workforce in particular is looked at in the context of the wider health workforce and with cognisance of local labour market factors.

Conclusions

The policy review suggested the following areas were likely to be particularly important to consider in Midwifery 2020 UK:

- changes in birth rates and maternal health needs e.g. associated with smoking, obesity, age
- an increasing interest in and focus on the nature of the midwifery role and interventions with fathers
- increasingly informed service users
- greater focus on cost
- developments in technology e.g. increases in scanning etc
- commissioners' strategic intentions for maternity services
- good/best practice directives and changing user perspectives and expectations
- remote and rural populations
- demographic and labour market changes
- the overall size and shape of the midwifery workforce
- changes in the education and postgraduate training of other health professionals including medicine
- ensuring European Working Time Directive compliance
- numbers and roles of Advanced Midwifery Practitioners
- likely increase in numbers of staff in MSW roles (Agenda for Change bands 1–4) including Assistant Practitioners
- education (both pre and post-registration) which is high quality, patient-safe, and value for money and delivered in innovative ways
- development of clinical leaders
- workforce productivity especially removal of unnecessary variation and duplication within the system
- quality and outcomes.

References

- Audit Commission 2010b, *Giving children a healthy start*, Audit Commission, London.
- Audit Commission 2010a, *Healthy balance A review of public health performance and spending*, Audit Commission, London.
- Billingham, K. & Shribman, S. 2009, *Healthy Child Programme Pregnancy and the first five years of life*, Department of Health, London.
- Bosanquet, N., Ferry, J., Lees, C., & Thornton, J. 2005, *Maternity services in the NHS, Reform*, London.
- Care Quality Commission 2009a, *Guidance about compliance. Essential standards of quality and safety*, Care Quality Commission, London.
- Care Quality Commission 2009b, *Review of the involvement and action taken by health bodies in relation to the case of Baby P*, Care Quality Commission, London.
- Care Quality Commission 2009c, *Safeguarding children. A review of arrangements in the NHS for safeguarding children*, Care Quality Commission, London.
- Department for Children, Schools and Families 2009a, *Family Nurse Partnership Programme*.
- Department for Children, Schools and Families 2009b, *The Protection of Children in England: action plan. The Government's response to Lord Laming*, TSO, London, Cm 7589.
- Department for Children, Schools and Families & Department of Health 2009, *Healthy lives, brighter futures. The strategy for children and young people's health*, Department for Children, Schools and Families, Department of Health, London.
- Department of Health 2000, *The NHS Plan. A plan for investment, a plan for reform*. Cm 4818.
- Department of Health 2001, *National Service Framework for Diabetes*, Department of Health, London.
- Department of Health 2002, *Tackling health inequalities: 2002 cross cutting review*, Department of Health, London.
- Department of Health 2003, *Getting the right start: National Service Framework for Children. Standard for Hospital Services*, Department of Health, London.
- Department of Health 2003, *Modernising medical careers: the response of the four UK Health Ministers to the consultation on "Unfinished business – proposals for reform of the senior house officer grade*. Department of Health, London
- Department of Health 2004a *Agenda for change final agreement*. Department of Health, London

Department of Health 2004b *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*. Department of Health, London

Department of Health 2004c, *Choosing health: making healthy choices easier*, Department of Health, London.

Department of Health 2005, *Responding to domestic abuse: a handbook for health professionals*, Department of Health, London.

Department of Health 2006, *Standards for better health*, Department of Health, London.

Department of Health 2007, *Maternity Matters. Choice, access and continuity of care in a safe service*, Department of Health, London.

Department of Health 2008a, *High Quality Care for All, NHS next stage review final report*, Department of Health, London.

Department of Health 2008b, *A High Quality Workforce. NHS Next Stage Review*, Department of Health, London.

Department of Health 2008c, *Framing the Nursing and Midwifery Contribution: driving up the quality of care*, Department of Health, London.

Department of Health 2009a, *Delivering High Quality Midwifery Care: the priorities, opportunities and challenges for midwives*, Department of Health, London.

Department of Health 2009b, *Inspiring leaders: leadership for quality*, Department of Health, London.

Department of Health 2009c, *Inspiring Leadership for Quality: The Approach*, Department of Health, London.

Department of Health 2009d, *NHS 2010–2015: from good to great. preventative, people-centred, productive*, Department of Health, London, Cm 7775.

Department of Health 2009e, *Quality reporting in 2008–09 Annual Reports and Accounts: A consultation for NHS foundation trusts and NHS organisations in East of England*, Department of Health, London.

Department of Health 2009f, *Tackling Health Inequalities: 10 Years On. A review of developments in tackling health inequalities in England over the last 10 years*, Department of Health, London.

Department of Health 2009g, *The NHS Constitution. The NHS belongs to us all.*, Department of Health, London.

Department of Health 2009h, *The operating framework for the NHS in England 2010/11*, Department of Health, London.

Department of Health 2009i, *Transforming community services: enabling new patterns of provision*, Department of Health, London.

Department of Health 2010a, *Choosing health: Improving public health and overcoming inequalities*.

Department of Health 2010b, *Women's Mental Health: Into the Mainstream Strategic Development of Mental Health Care for Women*, Department of Health, London.

Department of Health & Department for Education and Skills 2001, *National Service Framework for children, young people and maternity services*.

Department of Health, Unite the Union, & Community Practitioners' and Health Visitors' Association 2009, *Getting it right for children and families. Maximising the contribution of the health visiting team 'Ambition, Action, Achievement'*, Department of Health, London.

Department of Health, Social Services and Public Safety 2010b, *Healthy Futures 2010 – 2015. The Contribution of Health Visitors and School Nurses in Northern Ireland*, Nursing, Midwifery and Allied Health Professions Directorate, Department of Health, Social Services and Public Safety, Belfast.

Department of Health, Social Services and Public Safety 2006, *Audit of acute maternity services*, PricewaterhouseCoopers LLP, London.

Department of Health, Social Services and Public Safety 2002, *Investing for Health*, DHSSPS, Belfast.

Department of Health, Social Services and Public Safety 2010a, *A Northern Ireland Strategy for Nursing and Midwifery 2010 – 2015*, DHSSPS, Belfast.

Flory, D. 2009, *The Quarter*, Department of Health, London, Quarter 1 2009/10.

Gilbert, C. 2008, *Safeguarding children. The third joint chief inspectors' report on arrangements to safeguard children*, Ofsted, London.

Health Inequalities Unit, DH 2007, *Review of the Health Inequalities Infant Mortality PSA Target*, Department of Health, London.

Healthcare Commission 2008, *Towards better births. A review of Maternity Services in England*, Healthcare Commission, London.

Healthcare Inspectorate Wales 2007, *Maternity Services in Wales – Findings and Themes from the All Wales Review*, Healthcare Inspectorate Wales, Caerphilly.

HM Government 1998, *The working time regulations 1998*. HMSO, London

HM Government 2004, *Choosing health. Making healthy choices easier*, HM Government, London, Cm 6374.

HM Government 2009b, *Working Together – Public Services on your side*, HMSO, London.

HM Government 2010a, *Maternity and Early Years Making a good start to family life*, HM Government, London.

HM Government 2010b, *Together we can end violence against women and girls: a strategy*, HM Government, London.

- HM Government 2009a, *New Horizons. A shared vision for mental health*, Department of Health, London.
- HM Treasury 2006, *The Leitch Review of Skills: Prosperity for all in the Global Economy – world class skills. Final Report*, HMSO, Norwich.
- House of Commons Health Committee 2010, *Inequalities in Access to Maternity Services. House of Commons Health Committee, Eighth Report of Session 2002–03*.
- House of Commons Health Committee 2007, *Workforce Planning: Fourth report of session 2006–07, vol 1. HC 171–1*, TSO, London.
- House of Commons Health Committee 2003, *Choice in Maternity Services, House of Commons Health Committee, Ninth Report of Session 2002–03*, House of Commons Health Committee, London.
- Independent Safeguarding Authority 2010, *ISA Referral Guidance*, Independent Safeguarding Authority, London.
- Lewis, G. & Drife, J. 2004, *Why mothers die 2000 – 2002: the sixth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*, RCOG Press, London.
- Marmot, M. 2010, *Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010*, The Marmot Review, London.
- Maternity Care Working Party 2006, *Modernising Maternity Care A Commissioning Toolkit for England (2nd edition)* London.
- National Audit Office 2009, *Agenda for change*.
- National Leadership and Innovation Agency for Health & Royal College of Midwives 2009, *All Wales Maternity Support Worker Curriculum. The national curriculum for the education and development of Maternity Support Workers*, NLIAH, Cardiff.
- NHS Education for Scotland 2006, *Maternity Care Assistants in Scotland. A Competency Framework*, NHS Education for Scotland, Edinburgh.
- NHS Employers and Care Services Improvement Partnership 2006, *Maternity support workers : enhancing the work of the maternity team: national large scale workforce change.*, Department of Health, Leeds.
- NHS Institute 2006, *Delivering Quality and Value Focus on: Caesarean Section*, NHS Institute, Warwick.
- NHS National Workforce Projects 2009, *Maternity Workforce Resource Pack*, NHS National Workforce Projects, Manchester.
- NHS Quality Improvement Scotland 2009, *Pathways for Maternity Care*, NHS QIS, Edinburgh.
- NHS Wales 2008, *A strategy for a flexible and sustainable workforce. Report of the flexible and sustainable task and finish group.*, NHS Wales, Cardiff.

NHS West Midlands 2007, *Multiprofessional education and training commissioning plan 2008–09*, NHS West Midlands, Birmingham.

Northern Ireland Practice and Education Council for Nursing and Midwifery 2006, *Development Framework Final Project Report*, NIPEC, Belfast.

Northern Ireland Practice and Education Council for Nursing and Midwifery.
Development of a regional preparation programme for maternity support workers.
Internet . 2010. NIPEC. 24–3–2010.

Ref Type: Electronic Citation

NSR Implementation Team 2009, *High Quality Care for All. Our journey so far.*,
Department of Health, London.

Nursing and Midwifery Council. Revalidation. Internet . 2009a. 11–3–2009a.

Ref Type: Electronic Citation

Nursing and Midwifery Council 2004, *Midwives Rules and Standards*, Nursing and
Midwifery Council, London.

Nursing and Midwifery Council 2009b, *Standards for preregistration midwifery
education*, Nursing and Midwifery Council, London.

Nursing and Midwifery Council 2010, *Supervision, support and safety: analysis of the
2008–2009 local supervising authorities' annual reports to the Nursing and
Midwifery Council*, NMC, London.

Oates, M. 2000, *Perinatal Maternal Mental Health Services*, Royal College of
Psychiatrists, London.

Office of the First Minister and Deputy First Minister 2006, *Our Children and Young
People – Our Pledge Action Plan 2008–2011*, Office of the First Minister and Deputy
First Minister, Belfast.

Prime Minister's Commission 2010, *Front line care: the future of nursing and
midwifery in England. Report of the Prime Minister's Commission on the future of
Nursing and Midwifery in England 2010*, Prime Minister's Commission, London.

Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, &
Royal College of Anaesthetists 2007, *Safer childbirth: minimum standards for the
organisation and delivery of care in labour*, RCOG Press, London.

Scottish Executive 2006b, *Nursing for health: A review of the contribution of nurses,
midwives and health visitors to improving the public's health in Scotland*, Scottish
Executive, Edinburgh.

Scottish Executive 2006a, *Delivering Care, Enabling Health: Harnessing the Nursing,
Midwifery and Allied Health Professions' Contribution to Implementing Delivering for
Health in Scotland*, Scottish Executive, Edinburgh.

Scottish Government 2008a, *Curam: Nurses, Midwives and Allied Health
Professionals working for Scotland's health*, Scottish Government, Edinburgh.

Scottish Government 2008b, *Equally Well: Report of the Ministerial Task Force on Health Inequalities*, Scottish Government, Edinburgh.

Scottish Government 2007, *Better Health, Better Care: Action Plan*, Scottish Government, Edinburgh.

Scottish Government 2010a, *Delivering for Remote and Rural Healthcare: The Final Report of the Remote and Rural Workstream*, Scottish Government Health Directorates, Edinburgh.

Scottish Government 2010c, *NHS Quality Strategy*.

Scottish Government 2009, *Delivering quality through leadership, the leadership development strategy for NHS Scotland*, Scottish Government, Edinburgh.

Scottish Government 2010b, *New Family Nurse Partnership Programme To Provide A Healthier Start To Scottish Children*, Scottish Government, Edinburgh.

Scottish Government. Keeping Childbirth Natural and Dynamic Programme. Internet . 6-10-2008c. 11-1-2010c.

Ref Type: Electronic Citation

The Lord Laming 2009, *The Protection of Children in England: A Progress Report*, The Stationery Office, London.

The State of Readiness Group 2009, *The NHS Constitution State of Readiness Group*, Department of Health, London.

The Workforce Review Team 2009, *Workforce Review Team Annual Report 2007/8*, NHS Workforce Review Team, Winchester.

Unite, CPHVA, & Department of Health 2009b, *Joint statement Unite/CPHVA and DH for 'Action on Health Visiting Programme*, Unite, CPHVA and Department of Health, London.

Unite, CPHVA, & Department of Health 2009a, *Action on Health Visiting Programme*, Department of Health, London.

Welsh Assembly Government 2004, *Making the connections – delivering better public services for Wales*, WAG, Cardiff.

Welsh Assembly Government 2006, *Designed to work*, WAG, Cardiff.

Welsh Assembly Government 2005, *Welsh National Service Framework for Children, Young People and Maternity Services*, WAG, Cardiff.

Welsh Assembly Government 2008, *Designed to realise our potential. A 'Beliefs and Actions' Statement for Nurses, Midwives and Specialist Community Public Health Nurses in Wales for 2008 and Beyond*, WAG, Cardiff.