

Facilitating Women's Choices

- Can NHS and Independent Midwives work together?



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In response to requests for advice from some maternity services, the RCM is issuing this guidance. We respect that Directors and Heads of Midwifery will continue to make decisions about their staffing and making relationships with others based on their own local circumstances and using their own professional judgement.

There have always been a small number of women who choose not to use NHS maternity services, because their needs and preferences are for types of care they believe are not available. Examples include women who desire wholly consultant led care and high amenity provision who choose private hospitals, as well as women who want the guarantee of continuity of carer from someone who shares their philosophy of care. Some of these women access the services of independent midwifery group practices others contract directly with independent midwives (IMs) working on a self-employed basis. For all of these women, there is no reason why they cannot change their mind at any point and enter the NHS system and indeed some will transfer, particularly if their pregnancies or births become very high risk or very complicated and require complex medical support and intervention.

Since 2014 it has been unlawful for any UK health professional to practice without 'adequate insurances' and the responsibility for determining 'adequacy' has been the responsibility of each professional. All IMs must, to maintain their registration assure the NMC that they have adequate insurance.

In 2017 the NMC issued a statement to a number of self-employed independent midwives confirming that after review, it believed the insurance arrangements they had made were 'inadequate'. This had the effect of preventing some IMs from providing all or some elements of midwifery care. (Those IMs who are members of the Royal College of Nursing may have indemnity insurance covering antenatal and postnatal care only). This decision was unsuccessfully challenged by the IMs in the courts, leaving some finding themselves in the position of being unable to provide intrapartum care to women they have

already booked or feeling inhibited from taking on further clients for the continuum of care.

In the spirit of promoting woman centred services and with goodwill and compromise on all sides, it should be possible for NHS providers to facilitate these women to have the type of births they want and need. A number of Heads of Midwifery have already demonstrated that it is possible for the NHS to work with Independent Midwives in order to facilitate women's choices.

The RCM is aware of two workable options and this guide is an attempt to share best practice.

The first is that Independent Midwives continue to contract with women for the provision of antenatal and postnatal care only, in the full understanding that birth itself will be supported by an NHS provider. To ensure continuity of care it is important for good communications between the IM, the NHS provider and the woman.

The second is that NHS providers give IMs either a bank or honorary contract, thus allowing them to become temporary workers of a particular NHS organisation and therefore benefit from NHS indemnity. This allows women to have continuity of carer from their chosen midwife who will have adequate insurance to attend the birth.

In addition to arrangements between individual IMs and individual maternity services, there is emerging within England an increasing willingness amongst commissioners to engage private midwifery providers to deliver NHS services in collaboration with a local maternity service. Guidance covering the contractual arrangements for this was produced by NHS England (London) in August 2017 and was circulated to Local Maternity Systems.

Scenario One: IMs Providing Ante & Postnatal care in collaboration with NHS Trust that provides intrapartum care.

This is essentially a new 'shared care' arrangement with women contracting directly with the IM of their choice for antenatal and postnatal care only, whilst also booking with a local NHS provider for intrapartum care.

To make this work the starting principle has to be one of mutual trust and respect on all sides. Without this it is unlikely that this arrangement will work. Women need to have faith that whilst they may enter 'the NHS system' their choices, preferences and needs will continue to be accommodated; HOMS need assurance that IMs they work with are competent safe practitioners who will work collaboratively with the policies and guidelines of the unit and IMs need to believe that NHS organisations will facilitate them to continue giving care in a way that is comfortable and supportive.

It makes sense for early three-way conversations to be held between the woman, the IM and the team who are likely to be involved in her birth to ensure there is consistency of information, monitoring and effective communication particularly at the transition from antenatal to intrapartum care and then into the postnatal period. This is essentially a more sophisticated approach to personal care planning. Women who book with an IM for antenatal and postnatal care only, should be encouraged to book early with the local maternity provider, to have early discussions about place of birth and choices for approach to birth. This will ensure they are already known to the service when they go into labour.

IMs providing antenatal and postnatal care only to women need to be very clear at the outset about the limitations of their own role and the support and facilitation they are able to give.

IMs and local maternity services should have clear discussions about the role, if any, the IM can play during birth, including whether she becomes a birth companion. This requires an undertaking not to have any role or active part within the delivery itself, that being clearly the responsibility of the NHS midwives, but to remain with-woman as birth supporter.

In this scenario the IM will continue to charge a fee for her services to the woman, but by booking with the provider unit the Trust will be able to claim the NHS tariff for intrapartum care. This ensures all parties are paid for the care they provide.

Scenario Two: IMs provide total care to their clients through a contractual arrangement with the NHS.

This scenario is not very much different to the first, except that by reaching a local arrangement the IM is able to provide intrapartum care by temporarily becoming an NHS employee or equivalent. Thus women still contract with their IM for the care they will provide and also to book with a local provider unit.

With an NHS provider offering a bank or honorary contract¹ to an IM, they temporarily become in legal terms an employee of that NHS organisation. (Some NHS organisations prefer bank contracts where the IM is paid standard bank rates for hours worked; some prefer an honorary contract where no payment is made).

Where this has worked well IMs join the Trust bank and in addition to being able to attend the births of their own clients they may be available to support the trust in other times of staffing challenge. This is a real win-win situation.

The HOMs that have reached agreement with IMs have followed the following steps:

Step 1: Interview the IM.

HOMs and their management colleagues always interview midwives they are going to employ; taking on an independent midwife to work on a bank or honorary contract is no different. The same criteria and standards should be applied in determining suitability, essentially addressing the question: would I want this midwife working for me?

Step 2: Ensure the IM is clinically up to date.

Any new starter needs to demonstrate proof of completion of mandatory training and relevant skills and drills. Whilst some NHS organisations might accept proof from another, most will probably require, for governance sake, IMs to complete their own local mandatory updates etc.

Step 3: Confirm that the IM has appropriate and adequate insurance to cover any antenatal/postnatal care they will be providing.

Step 4: Complete standard Governance Checks.

Ensuring good governance entails seeking disclosure from the IM of any current or past investigations that have been undertaken in respect of professional practice, either through the supervisory processes that existed up until April 2017 or through the NMC. In addition it will be useful to document acceptance by the IM that she would normally follow Trust/national guidelines and protocols and a commitment to raise with the midwifery management team any requests by women for care outside of those guidelines. Finally IMs should agree to document any labour care provided using the records system of their hosting Trust.

Step 5: Agree the terms of the contract.

IMs offered a bank contract will be paid by the NHS the standard bank rates for the hours worked, they should therefore confirm that they will not receive any payment from women for the care they provide as part of the bank contract, i.e. the intrapartum element. Trusts/Boards will have their own policies for issuing honorary contracts and setting out terms that meet the requirements of NHS Resolution. IMs offered an honorary contract will be subject to the same level of pre-employment checks as a substantive employee in line with the NHS recruitment and selection policies and employment check standards.

The honorary contract will include reference to key Trust/Board documents including confidentiality, health and safety and standards of behaviour. IMs offered an honorary contract are unpaid by the Trust/Board and therefore able to continue receiving payment direct from the woman.

¹ An honorary contract is a mechanism by which an NHS trust/board may engage from time to time the services of persons, who are not paid employees, to carry out regular or ad-hoc work on behalf of the Trust. The issuing of an honorary contract is governed by Trust/board policies and confers NHS indemnity on the individual concerned.

Step 6: Agree the parameters of care.

Having interviewed the IM, midwife managers will have a good sense of the scope of their confidence and competence to provide care should a woman's risk status rise or her birth become more complicated or her choices change. The IM and HOM should agree in advance whether the scope of the bank contract covers home births, midwife-led unit births and obstetric-led unit births. If it doesn't then a clear transfer plan clarifying the on-going role and involvement of the IM needs to be determined.

We recommend that all of the above be confirmed and documented in writing.

Step 7: Confirm all arrangements with women.

For the women concerned it is important that they are booked with the NHS provider in order that they are known to the service when they go into labour and that they are comfortable with the arrangements that have been made. Each individual woman's care plan will be documented by her IM who will ensure that her hosting NHS trust is aware of women she has booked and the care she is providing.

Other things to consider:

- Ensure the existing NHS workforce of midwives and obstetricians is aware of these arrangements and why they are being made. Focus on supporting women's choices but listen to the concerns and anxieties of the team.
- Be clear, particularly in relation to homebirths about the expectations on the existing NHS midwifery staff, are community midwives competent and confident to support homebirths?
- Be clear about how these arrangements will work for women seeking homebirths out of your area, can you facilitate this?



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