

Quality maternal and newborn care: Implications for the UK of *The Lancet* Series on Midwifery



THE ROYAL
COLLEGE OF
MIDWIVES



Royal College of
Obstetricians &
Gynaecologists

Report of a one-day colloquium hosted by
the Royal College of Midwives and the Royal
College of Obstetricians and Gynaecologists, UK
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SUMMARY

The series on midwifery published by *The Lancet* in 2014 is the most critical, wide-reaching and high-profile examination of global midwifery to date. Its main focus is the importance of midwives to maternal and newborn health in low-income countries, but its recommendations are applicable in other settings. This is an opportune moment to feed them into the thinking of the UK government, the reviews of maternity services in England and Scotland, and the Nursing and Midwifery Council review of midwifery education standards.

The Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) therefore held a one-day colloquium to review the findings and their relevance to the UK. Held in London on October 23, 2015, it brought together over 70 participants from all disciplines in the maternity care team, service users, educators, managers, researchers, regulators, nongovernmental organizations, women's advocates and other experts.

Expert speakers gave brief inputs, interspersed with two sessions of group work addressing four themes:

- Is the current education of UK midwives, maternity support workers, obstetricians, paediatricians and general practitioners fit for the challenges of the current and future maternity environments?
- How can a system-wide joint approach to risk assessment, escalation and referral be achieved?
- What do women want and how can they be at the centre of care planning?
- How can the full scope of the role of the midwife be better understood and utilized across the woman's life course to improve health and maximize wellbeing?

The final plenary sessions identified an emerging, wide-ranging agenda of possible future actions and directions of travel. The colloquium ended with three brief, inspirational inputs from a midwife, an obstetrician and a women's advocate, modelling in practice the commitment to teamwork, equality, lack of hierarchy and shared governance that was a major theme of the day.

The main outcomes of the day were a greater shared sense of direction for UK maternity services, and further thinking on the value of the midwifery contribution to the multidisciplinary maternity care team. The actions agreed to take these ideas forward included a pledge from the RCM to look more closely at continuity of carer; to urge a review of midwifery education; to scale up the involvement of women with the college; and to work closely with the RCOG on toolkits and support units for creating positive learning cultures and improving interprofessional education.

1. Introduction

The spur for this colloquium was *The Lancet Series on Midwifery*, the most critical, wide-reaching, and high-profile examination of global midwifery to date (*The Lancet* 2014). Supported by the Bill & Melinda Gates Foundation and the Norwegian aid agency NORAD, the series comprises four papers (two more will follow), commentaries and an editorial (Renfrew et al 2014, Homer et al 2014, van Lerberghe et al 2014, ten Hoop Bender et al 2014).

The series was immediately received positively and debated widely, not only by the international midwifery community but also across the maternal and newborn care, sexual and reproductive health, public health, and human rights communities. The findings and recommendations are supported by all relevant global agencies, and Sweden's Ministry for Foreign Affairs is leading an international initiative to spread knowledge about the benefits of midwives and evidence-based midwifery (<http://midwives4all.org>).

Although the importance of midwives to maternal and newborn health in low-income countries is the series' main focus, its recommendations are applicable in other settings including the UK. It is an opportune moment to feed them into the thinking of the UK government, the reviews of maternity services in England and Scotland, and the Nursing and Midwifery Council (NMC) review of midwifery education standards.

The Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) therefore held a one-day colloquium to review the findings and recommendations and their relevance to the UK, explore what could be learned from low and middle-income countries - including achieving maximum health gain with limited resources - and determine the next steps.

Held at the RCOG headquarters in London on October 23, 2015, the colloquium brought together over 70 participants including all disciplines in the maternity care team, service users, educators, managers, researchers, regulators, nongovernmental organizations, women's advocates and other experts.

The expected outcomes were:

- To develop a shared sense of direction for UK maternity services that will inform the thinking of the UK government, the current reviews of maternity services in England and Scotland, and the NMC review of midwifery education standards.
- To shape thinking on the value of the midwifery contribution to the multidisciplinary maternity care team.
- To agree further actions to take these ideas forward.

The day was structured as a series of brief inputs from expert speakers, interspersed with two sessions of group work addressing four key themes devised by the hosts. All participants were allocated in advance to one of eight groups comprising a mix of people with different skills and experience. Each group had a facilitator and rapporteur, who gave brief reports of the proposed action points to the plenary session. The colloquium ended with an open session to identify an emerging agenda of possible future actions and directions of travel.

Participants agreed to abide by the Chatham House Rule: 'Participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.'

Thanks are due to everyone who contributed to the colloquium and this report, including Gill Adgie, Gabrielle Bourke, Alan Cameron, Soo Downe, Elizabeth Duff, Mandie George, Breedagh Hughes, Angela Hulbert, Louise Hulton, Gail Johnson, Joy Kemp, Carmel Lloyd, Michelle Lyne, Mary Renfrew, Jane Salvage, Jane Sandall, Rachel Scanlan, Eleanor Shaw, Louise Silvertson, Gillian Smith, Barbara Thorpe-Tracey, Suzanne Tyler, James Walker and Cathy Warwick.

2. Setting the scene

Professor Lesley Page, RCM President, opened the colloquium with a welcome on behalf of the RCM. During her four years as RCM President she has visited many maternity services both in the UK and overseas, and notes the potential for the further development of midwifery. The Lancet Series on Midwifery is an important stimulus, and timely in the British Isles in view of the maternity service reviews in England, Scotland and the Republic of Ireland.

The global context: *Louise Silverton, Director for Midwifery, RCM*

Midwives can prevent about two thirds of deaths among women and newborns, and the returns on investments in midwives are the best buy in primary health care (UNFPA, ICM, WHO 2014). *The Lancet Series on Midwifery* of landmark studies shows that development and investment in midwives, their work environment, education, regulation, and management can and does improve the quality of reproductive, maternal and newborn health (MCH) in all countries.

Ms Silverton described how, at its launch, she was struck by the relevance of the series for countries like the UK. Given the recent publicity on how the UK countries rank against similar developed nations, there is clearly more to be done. The colloquium was devised as an opportunity to discuss what the UK should consider taking up from the series to improve outcomes for mothers and babies.

The global policy context contains threats and opportunities. The eight United Nations Millennium Development Goals (MDGs) provided time-bound and

quantified targets for addressing extreme poverty in its many dimensions while promoting gender equality, education, and environmental sustainability (The Millennium Project 2014). Goal 4, *Reduce child mortality*, and Goal 5, *Improve maternal health*, set various targets that stimulated some progress on maternal mortality, but there is much more to do to address perinatal mortality rates and infant mortality.

These goals have been superseded by a new set of UN global goals and a post-2015 development agenda, adopted at the UN Sustainable Development Summit, New York, 25-27 September 2015 (Box 1). Goal 3, *Ensure healthy lives and promote well-being for all at all ages*, has targets including the unfinished health MDGs, emerging global health priorities, universal health coverage and broader determinants of health. Mother and child health is also linked to many other goals, particularly Goal 5 on reducing gender inequality, and there is a focus throughout on sexual and reproductive health. In addition, health statistics are key metrics of progress towards sustainable development.

There is growing global awareness of the importance of midwifery, not only in these global goals, but also in the Midwives4All initiative and recent WHO reports and policy statements (WHO 2014). There are already many enabling factors and useful tools, including the International Confederation of Midwives documents on competencies, education and regulation.

The UK policy context provides important opportunities to scale up and strengthen maternity services and the midwifery contribution, but there are also threats: the National Audit Office (2013) reported that England's maternity services were underfunded, although financial stringency could provide a spur to do things differently. Proposed changes to midwifery regulation have major implications for the profession, and it will be important to retain the supportive elements of midwifery supervision. The challenge, she concluded, is whether we have the political will to act.

Box 1: Transforming our world: the 2030 Agenda for Sustainable Development

'This agenda is a plan of action for people, planet and prosperity. It also seeks to strengthen universal peace in larger freedom. We recognize that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development. All countries and all stakeholders, acting in collaborative partnership, will implement this plan. We are resolved to free the human race from the tyranny of poverty and want and to heal and secure our planet. We are determined to take the bold and transformative steps that are urgently needed to shift the world onto a sustainable and resilient path.

'The 17 Sustainable Development Goals and 169 targets demonstrate the scale and ambition of this new universal agenda. They seek to build on the Millennium Development Goals and complete what these did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: the economic, social and environmental.

'The goals and targets will stimulate action over the next 15 years in areas of critical importance for humanity and the planet.'

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Relevant targets:

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Goal 5. Achieve gender equality and empower all women and girls

Relevant targets:

5.1 End all forms of discrimination against all women and girls everywhere.

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

5.6 Ensure universal access to sexual and reproductive health and reproductive rights.

<https://sustainabledevelopment.un.org/post2015/transformingourworld>

An obstetric viewpoint: *Alan Cameron, Vice President, Clinical Quality, RCOG, and consultant obstetrician, Glasgow*

Professor Cameron welcomed participants on behalf of the RCOG, which was happy to be co-hosting the colloquium.

He endorsed The Lancet Series on Midwifery Series on Midwifery assertion that 'midwifery is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries.' Scaling up quality midwifery accelerates the momentum for reaching global and national maternal and child health goals. Application in practice of the evidence presented in the Lancet series could avert 80% of maternal and newborn deaths, including stillbirths.

Good maternity services are based on values including respect, the importance of communication, community knowledge and understanding, and care tailored to a woman's circumstances and needs. The philosophy should be to optimize the normal biological, psychological,

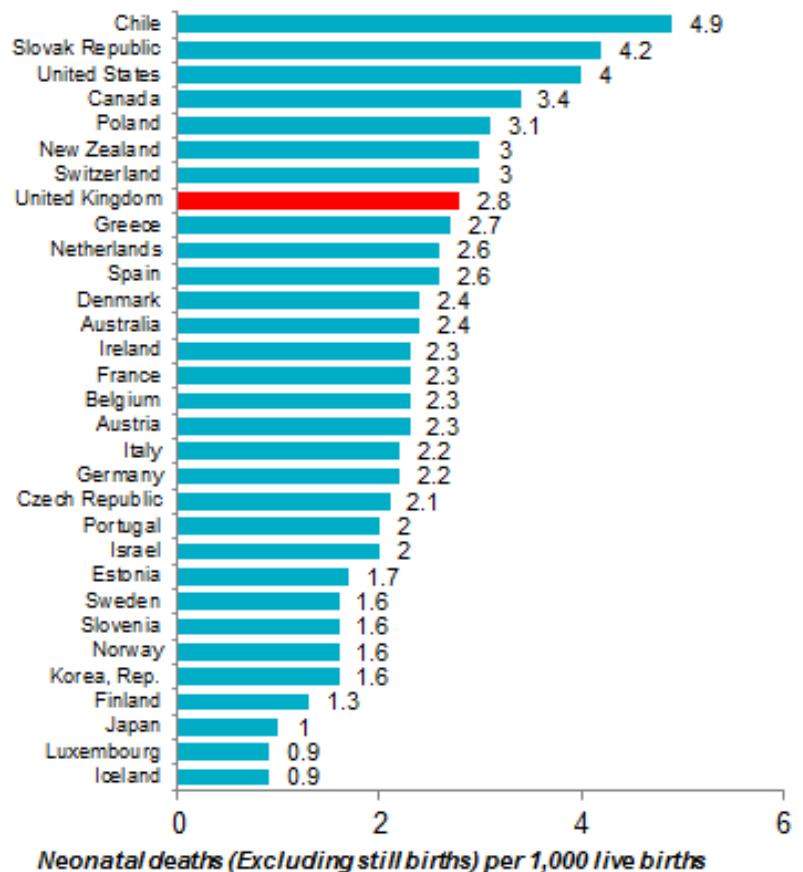
social and cultural processes of childbirth, and reduce interventions to a minimum.

The series calls for a system-level shift from fragmented services for women and newborn infants to interdisciplinary and integrated skilled care and teamwork. Multidisciplinary collaboration and effective teamwork among the various contributors to maternal and child health are needed at the local, district, regional and international levels.

It contains important messages and implications for the UK. Our neonatal mortality rate is one of the highest among OECD high-income countries, and higher mortality rates for early neonatal, late neonatal and post-neonatal periods compared to France, Germany and Sweden. Such comparisons may be misleading because international neonatal mortality rates do not include stillbirths (included in the NHS Outcomes Framework indicator), and there are differences in how countries register non-surviving premature infants and define fetal deaths, but there is no room for complacency (Figure 1).

Figure 1: Neonatal deaths in OECD high income countries per 1,000 live births in 2013

Sources: WHO and World Bank



While UK neonatal mortality and stillbirth rates have decreased overall in recent years, notable geographical variation remains, with no obvious pattern (Figure 2). The rates are highest in women under 20; women over 40; and women living in poverty. Perinatal mortality surveillance for 2013 shows 4722 perinatal deaths (3286 stillbirths and 1436 neonatal deaths) of babies born at 24 weeks gestational age or greater (Manktelow et al 2015). The perinatal mortality rate was 6.0 per 1000 total births, comprising 4.2 stillbirths per 1000 total births and 1.8 neonatal deaths per 1000 live births.

The RCOG's provisional analysis of UK Hospital Episode Statistics for 2013-14 again highlights unexplained variation across a wide range of indicators. The UK recent time series for method of onset of labour shows a fall in the proportion of spontaneous onset, and increases in caesarean and medical induction rates. The crude ratio of

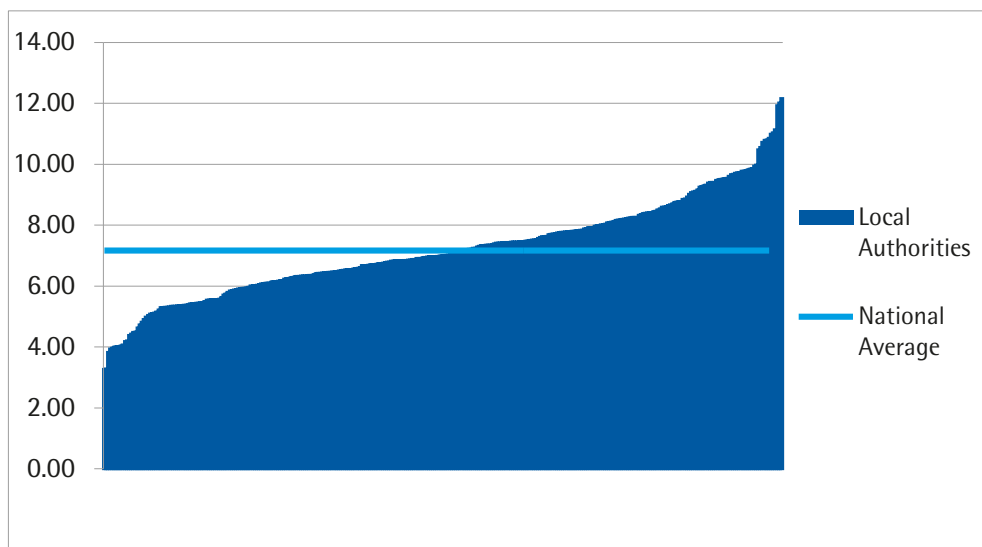
elective to emergency caesareans shows large variation between NHS trusts in 2013-4, from 0.42 to 1.12.

Accounting for a number of clinical risk factors and patient characteristics, there is:

- 3.4-fold variation in the proportion of induced labours resulting in emergency caesarean section in multiparous women;
- 3.9-fold variation in the proportion of deliveries involving instruments for multiparous women;
- 3.8-fold variation in the percentage of pre-labour caesarean sections for primiparous women;
- many statistical outliers across the range of indicators;
- 13.1-fold variation in rates of unplanned neonatal readmissions within 28 days of birth among singleton, term, normal-birth-weight infants.

Figure 2: Trust level variation in neonatal mortality and still birth rates per 1000 births (three year aggregate 2011-2013)

Source: HSCIC Indicator Portal NHS Outcomes Framework Indicator



These trends represent heavy financial as well as human costs. The NHS Litigation Authority says maternity claims represent the second highest number of claims against the NHS, totalling 20% of all claims and 49% of the total value of all claims, at £3.1 billion. Less than 0.1% of births lead to claims, but their value is high as birth injury can result in lifelong disability. Most claims relate

to issues with management of labour, caesarean sections or cases of cerebral palsy. Only 21% of claims relating to cardiotocography involved high-risk pregnancies; 60% related to out of hours incidents, while 69% were for babies born with neurological problems. Issues concerning CTG interpretation also featured in claims relating to the management of labour, caesarean section and cerebral palsy.

The Lancet series findings and recommendations underline the importance of education throughout the life course, endorsed by the RCOG, and pre-pregnancy and pregnancy identification of maternal risks and needs in community settings. Joint working by all professionals at clinics for women at high risk, joint working around areas of litigation, and joint training are vital. We should also work towards better data collection to develop powerful outcome data that will inform the rising medicalization of childbirth. The series represents important opportunities for UK, and should act as a catalyst to influence the national reviews of maternity care.

The Lancet series and its relevance to the UK: *Mary Renfrew, Director, Mother and Infant Research Unit, University of Dundee, and principal investigator of The Lancet Series on Midwifery*

Professor Renfrew examined why the series was needed, what it has achieved so far, and what it might mean in the UK context. The core challenge it addressed was the lack of high quality care for childbearing women, babies and families, which manifests in different ways in different settings.

Preventable mortality of women, babies and stillbirths remains at unacceptable levels in low-income countries. In all countries, many women and children suffer acute and chronic morbidity after birth. Inequalities in the provision of good quality care mean that those already most vulnerable are likely to receive the worst care, with an impact on mortality as well as health and well-being. Some important outcomes are seldom measured. Over-medicalization results in escalating rates of unnecessary interventions with harmful sequelae and unsustainable use of resources. Attention is often focussed on specific technical solutions rather than the whole picture of the skilled and compassionate care needed by all women and all babies. A lack of respectful care is commonly reported. As a result, the rights of women and children to life and to health are severely compromised.

The international community is seeking solutions and identifying approaches to inform global policy developments. Many organizations and people working in maternal and newborn health care have direct experience of the important contribution of midwifery – but as midwifery is implemented inconsistently in many countries, many others do not, and some are not convinced that midwifery can add value to existing services. Even where midwives are educated to international standards, their scope of practice is often limited or they practise in situations where over-medicalized care is the norm and midwifery is undervalued. There has been a dearth of evidence on midwives and their impact in low-income settings, and a clear and urgent need to examine the evidence for the midwifery contribution to high quality care.

This was the context in which the series was planned. A radical approach was needed to understand the challenges and to analyse existing evidence. Around 35 authors from diverse backgrounds and more than 20 countries across five continents worked on it for three years, with the involvement of global agencies and critical readers. It also drew on a diverse evidence base.

A human rights-based approach to the needs of all women, babies and families lies at the heart of the series. It therefore focuses on the needs of childbearing women, babies and families across the continuum of care, rather than individual interventions, the needs of the health system, or only care at birth. This approach resulted in two new developments. The first was a definition of midwifery *from the perspective of what women and babies need*. This is not a definition of a midwife, but a definition of the skilled and compassionate care that all women and all babies need in pregnancy, during labour and birth, and after birth, regardless of where or who they are. Midwifery thus defined may in principle be provided by whoever is caring for women and children, but the analyses went on to demonstrate that the best and most cost-effective way to provide this care is through educated, trained, licensed and regulated midwives, integrated into the health system and working in partnership with other professionals.

Box 2: Re-examining the evidence – a new lens

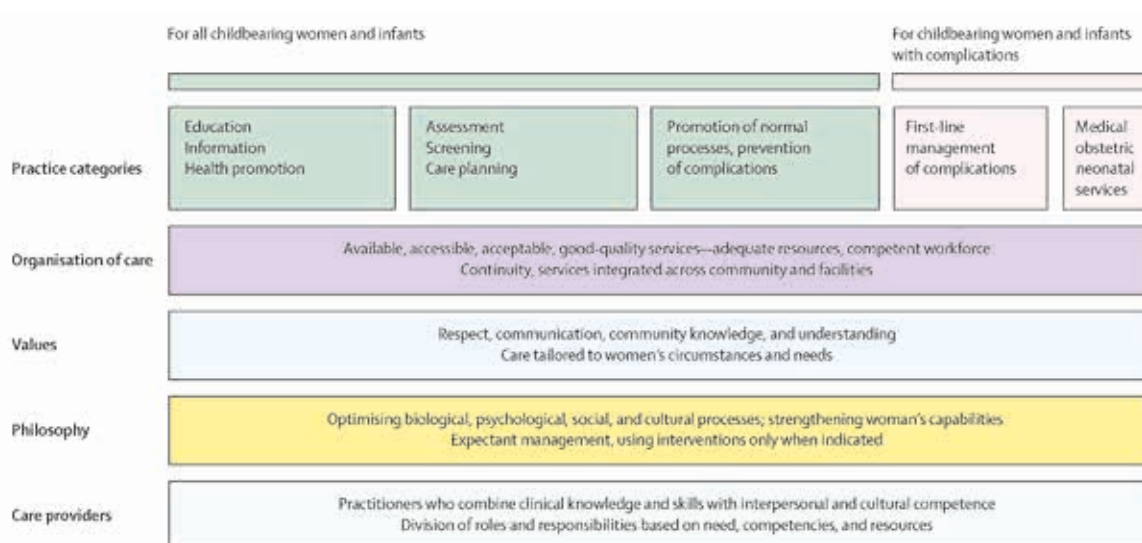
- 'Focus on women and infants, and families.
- Human rights-based – all women and babies regardless of context or circumstances.
- Diverse sources of evidence.
- All relevant outcomes – survival, health, wellbeing.
- Low, middle, high-income countries.
- Long-term view – quality care and services.
- Distinguishing what, how and who.
- Interdisciplinary, cross-sectoral health systems.
- Diverse workforces, integrated services.
- Specific contribution of midwives.
- Evidence-informed consensus.

The series' second new development was the Framework for Quality Maternal and Newborn Care (QMNC) framework, which describes the quality care needed by women and infants in all settings (Figure 3). It was built by re-examining diverse evidence through a new lens that focuses on the needs of the woman, infant and family, rather than the needs of the system or practitioners (Box 2). The analyses separated out *what* is done – usually called practices, interventions, or tasks – from *how* it is done and *who* does it.

This enabled identification of the impact of the organization of care and continuity, for example, separately from specific interventions, and from the provision of respectful care. Rather than focus on a low-risk/high-risk dichotomy, it focuses on the needs of *all* women and babies and also those with complications, recognising that high quality midwifery care is always needed even in situations where other forms of care are needed as well. It was thus able to identify the impact of preventive and supportive care for all as well as the management of complications.

Framework for quality maternal and newborn care (QMNC)

from: Renfrew MJ, McFadden A, Bastos MH et al The Lancet 2014; 384, pp1129–1145 L



The framework allowed analysis of the broad impact of the complex processes inherent in high quality midwifery. Re-analyses of 461 Cochrane reviews of interventions found that at least 56 outcomes could be improved by midwifery. Costs and resource use were also better. Over 60% of effective practices demonstrated the importance of optimizing normal biological, psychological, social, and cultural processes and of strengthening women's own capabilities. Outcomes were also improved by provision of care in regard to wider public health factors such as nutrition and family planning; care for women with problems of domestic violence, mental illness and substance misuse; and the positive offering of information, education, support, and respectful, compassionate care in pregnancy, during labour and birth, and after birth.

The framework also offered a stable context for modelling different scenarios, examining the impact of midwifery implemented to different degrees in low and middle-income settings. These calculations found that over 80% of maternal and newborn mortality and stillbirths could be reduced by the implementation of midwifery (Homer et al 2014). Health system analyses in countries where midwifery was part of a successful strategy to

reduce maternal mortality showed the need to integrate midwifery in the health system in multidisciplinary teams (van Lerberghe et al 2014, ten Hoop Bender et al 2014).

The series tells us that midwifery makes a massive difference: it can make an important contribution to tackling all the challenges the series set out to examine. Midwifery care given by educated, trained, licensed and regulated midwives is essential. This is an important message for all decision-makers. In some countries there are no midwives and little focus on the skilled and compassionate care that makes the difference. In others, even midwives educated to international standards find their practice limited by a lack of professional status, poor remuneration, over-medicalized systems and professional territoriality. This is unacceptable – the costs to women, babies, families, communities and society are too high.

The evidence in the series also calls into question the risk-focused and task-focused analysis of maternal and newborn care. The new analyses demonstrate that *how* care is given is as important as *what* care is given. A focus on minimum levels of care and on treating complications is not enough.

Box 3: Implications of The Lancet series for the UK

Supports policy direction of woman-centred, person-centred services:

- Challenges risk assessment as organizing principle.
- Evidence for the further changes needed to maternal and newborn strategy, policy, practice.
- Integrated team working in which midwives play their full part is key to positive outcomes for women, babies, families, services.
- Key public health contribution – needs different roles and structures.

QMNC framework can inform analysis, planning, education, research:

- Distinguishing between what, how, and who, e.g. response to the Kirkup report on Morecambe Bay; reviews of maternity and newborn services; curriculum planning; and examining mechanisms of action.
- Helps to identify that 13 of 17 Sustainable Development Goals could be improved by midwifery.

Model for analysis and planning of future quality service provision in other fields.

- The analysis of the mechanisms of action – distinguishing between who, how, and what care is provided, and including values and philosophy as core to quality care – could be replicated in other topic areas.

The worldwide recognition of its positive impact puts midwifery into the first line of key interventions that should be available for all women and babies. This includes the UK, where the profession is strong, established and mature, and where the policy focus has long been the needs of women, babies and families. Yet even here there are barriers to the full scope of midwifery care. The series can inform debate about tackling them, strengthen existing strategic directions and challenge existing policy and practice. The distinctions made between *what* is needed, *how* that is provided and *who* provides is a language and an understanding that can be used to frame midwifery, its impact and its characteristics for students, colleagues, policy makers, and the public (Box 3).

The framework can be used to develop standards, education curricula and monitoring systems. It can help to avoid a dichotomy between care for 'low-risk' and 'high-risk' women, as the focus is on skilled and compassionate care for all. It can demonstrate that even when the technical approaches have been put in place, much more is needed to ensure they are used in a way that optimises normal processes of pregnancy, birth, postpartum and the early weeks of life and avoids over-medicalized approaches.

The evidence demonstrates the importance of optimising normal processes and strengthening women's capabilities; a focus on risk management and technical interventions is not enough. At the same time, it demonstrates that care should take place in the context of effective interdisciplinary work, with interventions and technical solutions available when needed. As one example, the framework offers a way to analyse and learn from the tragic events in Morecombe Bay NHS Foundation Trust (the Kirkup report, HM Government 2015). Interdisciplinary conversations, and education, are needed to address problems positively, and the framework gives a foundation for examining what is needed.

The framework may also offer a context for discussions on the changes taking place to midwifery supervision in the UK and on supervision of midwives (NMC 2015), to ensure that the needs of women, babies and families are at the heart of supervision, as well as of care and services.

The impact of midwifery reaches well beyond pregnancy, birth and postpartum. A growing body of evidence demonstrates the importance of the fetus/infant's first 1000 days for brain development and how the emotional world into which they are born impacts on their future health and wellbeing. At the same time, midwifery's positive impact on longer-term and psychosocial outcomes as well as short-term clinical outcomes demonstrates its essential role in care for women who are vulnerable through anxiety and depression, poverty, domestic violence, mental illness or substance use, which can all affect the baby's physiological and behavioural functioning. Midwifery has an essential contribution to make to these discussions, and to strategic planning for promoting the long-term health and development of children.

Professor Renfrew concluded that midwifery is key to quality care for all women, babies and families. The evidence and new analyses presented in the series can inform strategic developments both globally and nationally. It can help to avoid polarized positions and narrow discourses, keep our perspectives and ambitions broad, and strengthen the position of midwifery in our national strategies for women, children and families. As the series affirms, a system-level shift is needed, 'from fragmented maternal and newborn care focussed on identification and treatment of pathology for the minority, to skilled, compassionate care for all. Midwifery is pivotal to this approach.'

(This paper is adapted from: Renfrew M (2015). Midwifery – key to quality care. MIDIRS. June 2015. 25 (2) 141-146)

3. Other expert perspectives

Scaling up UK midwifery: *Jane Sandall, Professor of Social Science and Women's Health, King's College London*

Professor Sandall highlighted the projected effect of scaling up midwifery. Universal coverage resulted in reductions in maternal deaths, stillbirths, and neonatal deaths in the 78 *Lancet* study countries. In countries with a low human development index, a modest increase in midwifery, including family planning, reduced maternal mortality by 27%; a substantial coverage increase halved maternal mortality; and universal coverage reduced maternal mortality by 82%.

Similar data are lacking for high-income countries, but the Morecambe Bay inquiry highlighted wide variations in standards, echoing findings from data on 657,000 women who gave birth in the UK in 2010-11:

- unacceptable variation in mortality and morbidity of mothers and babies;
- variation in rates of harm and near miss;
- unacceptable variation in unnecessary interventions and necessary interventions;
- unacceptable variation in experience of care;
- inequalities in care process and outcomes;
- care and compassion seen as less important, yet integral to system failures;
- lack of respect for some women;
- longer-term and psychosocial outcomes overlooked.

In addition, recent surveys suggest that women are not always listened to. The evidence shows that they want midwife-led continuity of carer, which is associated with several benefits for mothers and babies, and no adverse effects compared with models of medical-led care and shared care. Satisfaction levels are higher and there is

a trend towards the cost-saving effect. In the Cochrane review, levels of continuity (measured by the percentage of women who were attended during birth by a known carer) varied from 63% - 98%, compared to 0.3% - 21% in other models. The current baseline is:

- the proportion of women who saw the named midwife/back up midwife every time during pregnancy (34%);
- the proportion of women who saw the named midwife/back up midwife every time during the postnatal period (27%);
- the proportion of women who were attended during birth by a known midwife (25%).

The WHO vision of the quality of care for pregnant women and newborns, alongside *The Lancet* series recommendations, provides a helpful lens for benchmarking UK services (WHO 2014). It says services should be safe - delivering health care which minimizes risks and harm to service users; effective - providing services based on scientific knowledge and evidence-based guidelines; timely - reducing delays in providing/receiving care; efficient - delivering care in a manner which maximizes resource use and avoids wastage; equitable - delivering care that does not vary in quality because of characteristics such as gender, race, ethnicity, geographical location or socioeconomic status; and people-centred - providing care that takes account of the preferences and aspirations of service users and their cultures.

The UK itself has also produced visions and guidelines. The NHS Mandate aims to improve inequalities faced during pregnancy and maternity, and to improve the experience of women and families during pregnancy and in early years. The 'implementation challenge' is to scale up a range of initiatives including the RCM Better Birth Initiative, the NHS England Personalized Maternity Care Project, and NHS England strategic networks for maternity care.

The challenges of creating sustainable continuity models of midwifery work for midwives include the need to change midwives' working patterns; concerns about burnout; concerns about cost; organizational disruption; and effective change management. The issues to be resolved include whether they should be community or

hospital based; available to all women; the optimum size of the team and caseload; self-rostering of on-call; management support; boundaries and time off; relationships in the maternity care team; and working hours. Amid these many areas for improvement, Professor Sandall emphasised the need for myth-busting – highlighting the evidence of what worked, what worked less well and what was achievable.

Opportunities for strengthening UK health systems: *Louise Hulton, Technical Director, Options Consultancy*

Dr Hulton was involved in *The Lancet* series as a reviewer of the paper that looks at countries with high maternal mortality (van Leberghe et al 2014). It documented the experience of low-income and middle-income countries that deployed midwives as one of the core constituents of their strategy to improve maternal and newborn health. It examined the constellation of various diverse interventions for strengthening health systems in Burkina Faso, Cambodia, Indonesia and Morocco from 1980 to the present, among which scaling up the pre-service education of midwives was one element.

These efforts were characterized by expansion of the network of health facilities, increased uptake of facility birthing, scaling up the production of midwives, and reduction of financial barriers. The paper found that in these countries, attention to improving the quality of care was a late development. Medicalization and respectful woman-centred care received little or no attention, and concerns about the quality of care and effective coverage appeared late in the process. The quality maternal and newborn health framework is far from being translated into professional practice in many countries, and awareness of the various dimensions of quality is only just dawning among managers of maternal and newborn health programmes.

These findings have wider policy implications. They suggest that a strategy for improving maternal and newborn health depends on the design and investment in the overall network. Managing quality means addressing some blind spots:

- policy-makers are only just beginning to take the quality dimension of respectful women-centred care to heart;

- medicalization of maternity services has led to an epidemic of caesarean sections;
- other aspects of medicalization and iatrogenesis are poorly documented.

Political support was absent in the early days of reform, partly compensated by international donor support. Later, during the 2000s, investment in midwives gained political traction: politicians endorsed it publicly and actively as the maternal health agenda gained visibility, and increased access to midwives proved effective and popular. Political support gives impetus to current efforts; failure to provide adequate maternal care is becoming a political liability as civil society become more critical and vocal, the expectations of an increasingly well informed public are rising, and the credibility and legitimacy of health authorities depends on their will and ability to respond to these expectations.

WHO, as already mentioned by Professor Sandall, envisages a world where 'every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period'. It defines quality of care as 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred.'

This vision aligns with two complementary global action agendas conceptualized by WHO and partners in 2013–2014, at a critical time when the global community also agreed a new UN *Global Strategy for Women's and Children's Health (2016–2030)*, and is entering the new Sustainable Development Goal era. The strategic objectives for ending preventable maternal and newborn mortality and stillbirths are as follows:

- engage in data-driven country analysis to effectively address all causes of death, morbidities, disability and foster country leadership;
- strengthen and invest in care during pregnancy, labour, birth and the first day and week of life, ensuring full integration of maternal and newborn care;
- focus on improving quality of care;
- strengthen health systems – health work force, commodities, innovation;
- reach every women and every newborn and address inequities in the context of a human rights approach;

- harness the power of parents, families and communities and engage with civil society;
- count every woman, newborn and stillbirth: strengthen measurement capacity and improve data quality to drive improvement and accountability.

What are the 'takeaways' for the UK? Quality of care is the way forward, but should this be driven mainly through the lens of risk? What are the expectations of the public and civil society groups, and how effectively are they engaged? How is medicalization being addressed? And what is the role of midwifery in all these issues?

In a final challenge to influence political priorities, Dr Hulton said the words 'midwives' and 'midwifery' did not appear in the Conservative Party manifesto. It made no specific pledge to invest in midwifery services, although there was commitment to increasing funding of mental health services and ensuring women had access to mental health support during and after pregnancy, while strengthening the health visiting programme for new mothers.

The Labour Party manifesto committed to investing in 3,000 more midwives, and a pre-publication blogpost pledged 'guaranteed personalised one to one care from a midwife!'

Implications for UK policy to enable improvement of maternal and newborn health through midwifery: Soo Downe, Professor in Midwifery Studies, University of Central Lancashire

'Midwifery' means all of us, Professor Downe began, and quoted from the from *The Lancet* series (Renfrew et al 2014): 'Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimizing normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.'

Highlighting UK-relevant recommendations, she gave examples of how the QMNC framework already described by Professor Renfrew could act as a policy driver (Box 4). It may help to bridge the policy-practice gap, and minimize the distance between 'ivory towers' and 'real life'. On the high ground, manageable problems lend themselves to solution through the application of research method and theory, but in the 'swampy lowland' of practice, 'messy confusing problems defy technical solution' but are 'the problems of greatest human concern' (Schon 1983).

Box 4: Examples of policy as a driver for implementing QMNC

QMNC domain	Policy
Practice	Education/health promotion/Supporting women's capacity for physiological birth while recognizing/minimizing/treating complications
Care organization	AAAQ/equity/continuity (care/r)/well trained, educated, and supported staff
Values	Care and compassion, respect, personalized
Philosophy	Maximizing physiological processes, promoting and developing women's capacity/service user and family engagement, minimizing routine unnecessary interventions
Providers	Appropriate skill mix/care provider(s), clinical skills and care and compassion (the 6 Cs)

Related to the UK statistics for 2013-14 previously cited, the latest RCM survey highlights what we are not doing: physiological pregnancy and birth (RCM 2015). A cross-sectional prevalence survey (prospective or retrospective) of hospital births in seven units over five continuous weeks spanning a six-month period in 2014 examined induction, augmentation of labour, artificial rupture of membranes, epidural anaesthesia, episiotomy, CTG, use of a catheter, fetal blood sampling, antibiotics during labour and other local interventions or procedures. In 3063 births, only 17% - 27% of women underwent none of these interventions.

Through relationship-based (midwifery) care, prematurity, fetal death, instrumental birth, caesarean sections, costs and possibly longer-term chronic disease could be reduced, and physiological birth, breastfeeding and well-being improved. Seven trials from low and middle income countries (119,428 births) offered relevant learning by showing what could be achieved by 'just getting women talking': 37% lower maternal mortality, 23% lower neonatal mortality and 9% fewer stillbirths.

When at least 30% of local women took part, the intervention could save an estimated 283,000 newborn infants and 41,100 mothers a year in the rural areas of 74 countries in the Countdown global multidisciplinary, multi-institutional collaboration.

Contradictory drivers may have unintended consequences, including shifting care for women and babies, and resources, to the right of the QMNC framework. They include:

- Rapid spread of population screening for risk of stillbirth;
- seeking expensive technical solutions for preterm birth;
- time spent on recording and paper/computer work (reduce bureaucracy/increase monitoring/protect trusts and staff);
- routine induction to prevent caesarean section (reduce CS/increase physiological birth);
- widespread use of antibiotics in neonates (fear of sepsis/risk of resistance);
- overuse of CTG (fear of litigation/too much medicine campaign).

As Einstein said, 'insanity is doing the same thing, over and over again, but expecting different results'. These risks and benefits can be balanced, even in our current systems. These systems will work for healthy women and newborns and those with complications if they have enough skilled and caring staff; the right resources at the right place, used for (only) those that need them; are seamless; and have time for trusting respectful relationships. All stakeholders, including government, service commissioners, professional institutions, professionals, women's groups and the media, should recognise the risks as well as the benefits of the current system, and consciously set out to learn from where it goes well. Additional opportunities not mentioned by other speakers included the NHS Five year forward plan (ref) and Vanguard sites.

Professor Downe ended with a reminder of the contemporary relevance of the Hippocratic oath, which begins: *First, do no harm.*

4. Stakeholder views on four key issues

Two sessions of group work during the colloquium enabled all participants to reflect together on the series and the speakers' inputs. They address four key themes devised by the hosts, using four prompt questions for each theme (Box 5).

Box 5: Themes discussed in group work sessions

Theme 1: Is the current education of UK midwives, maternity support workers, obstetricians, paediatricians and general practitioners fit for the challenges of the current and future maternity environments?

Theme 2: How can a system-wide joint approach to risk assessment, escalation and referral be achieved?

Theme 3: What do women want and how can they be at the centre of care planning?

Theme 4: How can the full scope of the role of the midwife be better understood and utilized across the woman's life course to improve health and maximize wellbeing?

What follows is a summary of the key points made during these wide-ranging discussions, and of the action points identified to help shape an emerging agenda and the next steps.

Theme 1

Is the current education of UK midwives, maternity support workers, obstetricians, paediatricians and general practitioners fit for the challenges of the current and future maternity environments?

Question 1: *Is the current training of professionals who provide maternity care of appropriate quality and length?*

The outputs from midwifery and obstetric training are very different and more attention should be paid to education for social models of care. Medics value research and leadership, but this is less salient in midwifery education. The standards for midwifery education are the same across the UK but education delivery is variable. Student midwives feel they are taught ideals that they do not see in practice.

We always argue that programmes are not long enough for midwives; the goal posts keep changing, with more and more added to the curriculum but nothing taken away. Perhaps some midwives could have a fourth year of training for research, with a career pathway into research. Length is perhaps less important than achievement of competency. How do we know – is training and education sufficiently well evaluated?

Newly qualified doctors may be unlikely to attend women on their own, whereas midwives are more likely to be thrown in the deep end, and often look after women with complex care needs on day one after qualification as the provision of preceptorship varies hugely. There needs to be clarity on what the newly qualified midwife is expected to be able to do. Myth-busting is needed regarding skills and knowledge, and skills coming into midwifery.

Some doctors say direct entry midwives are less skilled than midwives who are qualified nurses, but many direct entry midwives are highly qualified with pre-existing bachelor/masters/PhD and have significant life skills.

Learning has to be lifelong and does not stop following qualification. There are problems with midwives' post-registration education and training. Unlike doctors, they have no career framework, and no protected time for education and training. Do consultant midwives still have a role to play in the system? The NHS does not care for its workforce; people are used as workhorses, which leads to poor quality care.

There are tensions between professionals, and current education models do not enable sufficient integration between professionals. Professionals need to be respectful of each other and have collaborative relationships, with clear pathways of care and clear handover. We need to understand each other's training, and develop awareness and appreciation for everyone's roles and philosophies. The current training approach is fundamentally flawed - we learn separately, yet need to work closely together in collaboration. It is too late to wait until people have become entrenched in their own roles. In view of the differences between midwifery and medical regulation, closer working between the NMC and GMC may be needed.

Joint training/education is needed on interprofessional working, so all professionals can become aware of the limits of their competence and of good conduct. Examples of good practice include use of different models of interprofessional education, and interprofessional workshops during training allowing identification of role overlap, and who is best placed at the time to provide care - the focus must be on mothers and babies.

The GP role in maternity care is not currently fit for practice/purpose and needs to be clarified. Input from GPs varies across the UK, with GPs becoming less skilled and reluctant to offer obstetric care - does this matter? They should perhaps be more involved in the postnatal period. GP input is possibly more important in remote and rural areas, with more evidence of GPs being involved in, for example, Scotland.

There are inequalities around medicalization. Education and training content is reflected in the involvement of students with a particular clientele. Over-medicalization is often linked with level of experience; more junior doctors may be more likely to intervene, and the presence of the consultant on the labour ward 24 hours a day may be influential. Midwives need to understand the balance between normality and complexity. The level of support post-registration varies between doctors and midwives.

Question 2: *Do trainees gain sufficient hands-on experience and theoretical underpinning to support women in all settings with varied needs?*

The Lancet series quality framework should be used as the core rationale underpinning training of both midwives and doctors, including interprofessional learning. Currently their education is separate until professionals meet on the labour ward. Midwives have insufficient experience to meet the framework requirements. There is no distinction in midwifery training between normal and complex care, although in reality some midwives develop a specialist area of expertise or interest, and work in different ways from medics.

The midwifery curriculum of 50:50 hands-on/theoretical includes education on normal and complex childbirth, but experience varies, often dependent on service provision rather than responding to students' choices and needs. Multidisciplinary education and training is helpful, using simulation. 'Human factors' are important - recognizing each other's roles in dealing with emergency situations and complex care. Experience of home birth is variable for midwives and almost non-existent for doctors, which skews views of 'normality'. Doctors' training is heavily based in physiology, with almost no social and cultural learning.

Question 3: *How can we develop more effective interprofessional learning to meet the needs of parents and babies?*

Moving from fragmentation to integration needs to be a political priority. We should look at potential models of good practice outside maternity care, including Schwarz

rounds, human factors, safety briefings and ward rounds, and map locations where interprofessional education works. Maternity Services Liaison Committees could be utilised. E-learning and video-based learning is valuable, and the profile of useful resources like the RCOG/RCM undermining behaviours toolkit should be raised. Midwifery revalidation could provide more opportunity for midwives and doctors to work more closely together, with feedback and reflection.

Leadership and the culture between professionals is the key. We should all sometimes walk in each other's shoes; for example, doctors should sit with women and discuss whether they should deliver in a midwifery-led unit, and midwives should discuss why they should deliver in an obstetric unit. Midwives and doctors do not advocate for each other, and we should stop undermining each other.

Question 4: *How well is the education workforce equipped to meet the needs of students in the current context, in both university and practice settings?*

The 'elephant in the room' here is the different status of midwives and doctors. There are also difficulties with midwives being managed by nurses, and the reduced status of heads of midwifery is weakening leadership.

The GMC requirements for supervision of doctors are changing, becoming more formal and requiring training. The requirements are also variable for midwives, including mentorship issues around parity and equity of assessment. The overall quality of supervision and mentorship varies; there is no protected time for midwifery clinicians to provide supervision in practice.

Actions proposed

- Focus on methods and opportunities for initial and continuing joint education and training which are reflective of 'real' life situations.
- Ensure parity of training provision for obstetricians and midwives, including structured programmes and objectives with protected time.
- Review and act on evidence about quality and length of training.

- Consider a move to four-year midwifery training, and build lifelong education into the structure, as in medical education, with formal preceptorship.
- Value research and leadership training in midwifery education.
- Address the variations in theoretical/hands-on training to respond to women's needs rather than service provision.
- Use the quality framework as the core rationale underpinning training of both doctors and midwives, and create a culture of learning with the framework at its heart.
- Enable medical academics to continue to practise, and lead clinical practice.
- Address the inequalities of status between different professionals in the maternity care team.

Theme 2

How can a system-wide joint approach to risk assessment, escalation and referral be achieved?

Question 1: *What behaviours and tools are needed to achieve equity and respect for each profession's contribution in a woman-centred system of care?*

We discussed the prevalence of bullying, with reference to the RCOG/RCM joint activity on undermining behaviours. When two elephants fight they do not realise the damage they cause; if each elephant represents a profession involved in the care of women and babies, we need to respect each other so that women are not trampled.

Role modelling is important, including how midwives are taught and regarded by senior colleagues. There is concern about midwives feeling demoralised - how to care for women day after day, the realities of the job and the profession. Some think there is an unrealistic view of the midwifery profession and how it is perceived, in relation to negative media images of the NHS generally and also poor quality maternity care at Morecambe Bay.

There is not enough time to train midwifery students so they can be confident, and insufficient ongoing practice support to keep their enthusiasm alive. In one example of good practice among mentors, minimal hierarchy encouraged more open dialogue between all staff. Direct feedback from support workers to consultant neonatologists was valued and respected. Better communication between staff of all disciplines led to more shared training and an enhanced service to women and babies.

Bullying in neonatal services was not felt to be so common, perhaps because of support within the team as a whole – collective decisions about behaviour; doing simulations together; all staff on first-name terms. It takes a lot of work to flatten the hierarchy and there has to be willingness to work in this way. One neonatal directorate was transformed by having a manager who can manage, is competent and not a bully, with a low-key style of leading that allows the team to do their jobs properly.

The definition of midwifery is important and potentially very useful. People don't understand others' jobs: one welcome pack for all new staff started with of the definition of midwifery, and highlighted that many members of the multiprofessional team 'do midwifery', not only midwives.

Our society is not woman-centred and suffers from gender-based violence, and gender inequality that is structural and system based, so it is no surprise that tools for behaviour change are needed; sexism appears to be insidious; power and control are not equal; gender matters! Women's and children's services are perceived to be low in the pecking order of medical specialties.

In Cardiff, midwifery students are helping to teach medical students about normal birth, acknowledging that midwives have expert knowledge on normality that is important to share. Medics could be allocated to senior midwives to experience normality.

There are deep concerns on the abolition of statutory supervision of midwives. Important reflection activities may be lost, affecting the broader maternity culture. The RCM's hard work to retain some of the good things about supervision is commended.

Good leadership is vital, but many coordinators and managers are concerned above all with how to avoid and minimize risk – it is all about fear, with little praise on labour wards. Some teams are developing debriefing sessions at the end of each shift to foster staff resilience.

Values, objectivity and feedback were thought to be key to successful units.

Much of what is discussed has been around for years, but outcomes have not improved. The evidence exists but is not implemented.

PROMPT is a good multidisciplinary teaching model, effective in Bristol where it started, but with more diverse outcomes elsewhere. It seems to work better where the multidisciplinary team is effective, especially between acute and community.

Team ward rounds help to improve the culture but do not always include midwives. Multidisciplinary ward and handover rounds should include the midwifery handover ward round.

Culture is critical. Attitudes become ingrained in training and practice is then very hard to change. Positive behaviours are established in positive cultures and allow practices such as freedom to challenge. Midwives should have the freedom to call consultants if they see the need, not wait for someone above to do or authorize. Undermining behaviours need to be challenged.

Consultants should be present in the unit – when on call for the labour ward, they should be on the labour ward. Consultant midwives should provide clinical leadership, but they are often making strategic input to areas such as culture and guidelines rather than working with midwives on the shop floor, whereas medical consultants continue to be involved in clinical practice.

GPs are generally too busy to do maternity care, and may also avoid it because they are deskilled. GPs in training are no longer required to do obstetrics, though this may change. Communication and relationships between community and acute trusts is poor. GPs cannot access acute IT systems for results etc, and the tariff has an impact. There are models of how GPs can work in CCGs

and with midwives, but funding is focused on long-term care and preventing emergencies.

Midwives see the concept of autonomy as standing alone, but it should mean that practitioners have responsibility and independence, with the ability to make decisions rather than continuously refer back. Any initiatives should have multidisciplinary team involvement. Strong teams need strong rules to clarify expectations.

Geography within services can create real barriers, such as units being in different buildings or on different floors.

Professionals lack understanding of each other's roles and involvement. Women lack understanding of professionals' roles and responsibilities, as highlighted at Morecombe Bay.

Everyone in the team has a role in clinical governance. Guidelines need consensus so that the team acts as one.

Consultant obstetricians and anaesthetists have clear job descriptions, but not consultant midwives. The co-ordinating midwife (labour ward) may well be involved, but not the consultant midwife.

Making care more woman-centred requires more midwives, and good junior doctor contracts. Morale is poor, and practitioners feel they are fire-fighting. Agency midwives and locum doctors are treated as pairs of hands. More resources are needed to make strong teams. Robust data is needed to clarify whether more midwives equals better outcomes.

Question 2: *What is required to achieve a shared approach to maternal and fetal assessment?*

We should have a shared approach to the care we are giving to the woman carrying the baby; woman and fetus are inseparable and the fetus is seen through the woman. This approach should include public health and pre-pregnancy issues. Key public health messages like smoking and obesity need to be addressed, with a strong feeling that a change of approach is necessary.

Perhaps this should be a societal approach. Where is the woman being seen - in the community or at the hospital? We should meet women where they are, but what does that mean for the structure of maternity services? There should be networks of experts; a joint vision; signposting; and good referral pathways. The woman and the professionals should know whom to call.

In a shared approach, the midwife is the key in primary care; if she were based in a community hub, continuity of midwifery carer could be firmly rooted in the community, and midwifery would be seen as a community service. However, there is lack of access to community services in deprived areas, especially for women with mental health problems - the midwife as lead coordinator is even more important for vulnerable women.

These networks exist in some health centres, and connections with local organizations such as citizens' advice bureaux should be strengthened. Building relationships is key, enabling information-sharing based on a trusting partnership between midwife and woman.

More midwives are needed, and a shared governance framework and consensus; 80% of women will fit the model if the guidelines are correct.

We need shared education and understanding of key indicators. Better communication with GPs could help, as they often already know the women with difficulties and understand the context.

Most care takes place in the community and the multidisciplinary team does not exist there. Co-locating services can help, such as midwives using health centres for bookings. In remote and community settings, technology such as telemedicine and Skype can help to communicate more directly.

Develop a model where community teams of midwifery services have a named obstetric consultant to refer to in the acute trust. Community-based hubs can then escalate upwards as required. Community teams should not work in isolation.

Remote workers should be rotated through integrated units, challenging cultures where midwives not known in the unit are isolated or not respected by those who normally work there or are known to each other. Integration and shared learning should help. Develop an upstream model such as stopping unwanted pregnancies and looking after women better before they become pregnant. Pre-conception care and planning. Consider models such as coils inserted routinely at LSCS and long-acting reversible contraception.

Communications to GPs after birth contain much irrelevant information and therefore lack impact. Better integrated IT systems would improve this. GPs want key information rather irrelevant paper. Ask other professionals what information they need.

Question 3: *How can we enable two-way traffic between low-risk and complex care pathways? How can continuity be maintained?*

The midwife should be the coordinator of care for all women. Yet continuity of carer is disrupted if the woman transfers to the acute sector. The primary/secondary care divide is vast; too much power is based and held in the hospital. The community midwife may be able to give continuity of care even if her woman becomes an inpatient, but this approach is not enabled by service providers. Equally, hospital midwives should visit women at home. Midwives need to flow seamlessly between the two settings in order to maintain the midwifery specialty that is central to providing excellent personalized care.

Midwives often cannot access GP records, a barrier to providing care, especially from an information-sharing and safeguarding perspective. Women must consent to their information being shared in order to protect their rights.

Language is important: labelling women with a risk status is not helpful. Terminology that creates barriers should be dropped.

All women need a midwife; only some need an obstetrician (e.g. midwife-led or obstetric-led care). Break down barriers between midwives and obstetricians.

Women need someone to take responsibility for their care. Care needs to be seamless and woman-centred, not systems-led.

The system must change: the woman should be at the centre, and the team around her.

Community care should be strengthened. Develop a sense of trust with the community women have come from that when they return good care will continue. If a referral is made, midwives should keep track and continue to be involved in the woman's care.

The risk of litigation is an issue – the 'just in case' approach is expensive and has become an industry. We should manage risk. The significant risk should be identified, and the woman only referred for that risk.

Continuing education should provide time for reflection, review and communication.

Some think NICE guidelines constrain care, while others feel it is acceptable to deviate as long as there is consensus. Is it about territory? We need to review guidelines and evaluate whether what we are doing is necessary.

The blame culture is different for doctors and midwives. An example: giving the wrong drug, with no ill effects on the patient; the doctor will be taken aside and the lessons discussed, but the midwife will be suspended, investigated, possibly disciplined and referred to the NMC.

The large size of some maternity units is a challenge to personalized care. The context of the unit plays a part.

Question 4: *How can initial and ongoing education prepare members of the maternity team for reflective practice and effective team working?*

Learning together as a team is important, avoiding attributing blame, and learning from events, but this currently seems to be very hard to do although tools exist. Understanding the different roles in the maternity setting is crucial to better teamwork.

More multidisciplinary working and interprofessional education could be achieved in various ways:

- Clinical events reviews of cases from the previous day before, with the right people round the table and commitment achieved when there is a positive culture and professional conversation.
- Interprofessional reflection, for example in an action learning set.
- Shared handovers: identify the risks for the next 12 hours, build in five minutes of education, update around the board and then move around the rooms.
- Hot debriefs: immediate debrief after an event; complete a form on why an event has occurred; the request can be made by any team member.

Build a no-blame culture, with more education on how to create a positive one. Good leadership, with stable management teams, and a head of midwifery and clinical director who have a shared vision.

Actions proposed

- Maternity continuity of carer is essential. The midwife must be the constant, central to the continuum of pregnancy. The desired shared approach will comprise relationships rooted in the community, and midwives leading continuity as the main coordinators of care, with an additional signposting role. Integrated functional networks are key to success. The network of experts should be based in the community rather than the hospital, with better communication between all.
- Resources: more midwives, finance and time.
- Culture: behaviours and understanding of roles. Over-riding ethos of equal but different. Redefine autonomy. Shared governance between all team members. Teach and do reflective practice as a team.
- Shared learning, with integrated modules in student training to establish better understanding and regard for roles. Midwives should take the lead in medical training lead to show normality: the first week of training should be given by midwives using a range of methods, then exposing them to normal birth. Packages of multidisciplinary training.
- Change the terminology and break down barriers.

Theme 3

What do women want and how can they be at the centre of care planning?

Question 1: *How can we ensure quality in a resource-constrained health service?*

Strategies are needed both for good care and to reduce costs. While continuity of carer may help to reduce costs, it is safer to see it as cost-neutral. Empowering women may reduce their need for further intense care, and helps reduce resources. Fragmented care systems, seeing a different professional every visit, are not safe – poor care is expensive care.

One way to deliver quality in a resource-constrained service is only doing things for which there is evidence, and not doing things that are not needed. However, some of the things that matter are hard to measure and evidence is scant – can we rely on the evidence alone? Complementary to this, we need effective data sharing and harvesting from existing records, to avoid women having to give the same data again and again.

Resources are not just money: the effectiveness of the workforce has to be maximised. Multidisciplinary teams are the best use of resources. Staff are expensive so we must make sure they are only doing what they need and are trained to do. The working conditions of midwives affect the birthing experience of women. Student midwives soon become disillusioned, but if we nurture the midwife, we nurture the women.

The reduction of resource in the postnatal period has been dramatic over the last 30 years. Health visiting is trying to reinvent what we had 30 years ago. Obstetricians and midwives are not the only people who contribute to maternity care. New research suggests that midwives are switching to health visiting because the midwifery care they give does not match their expectations, especially postnatally.

Skill mix should be deployed in its fullest sense, with the woman at the centre. We cannot focus solely on the special relationship between women and midwives, but

must support wider structures. A good metric to consider: the woman I cared for has more friends and is part of a network, better than when I first met her, and is in better health. Peer support, being part of a community and a family, uses people as a resource; peer support and breastfeeding must be part of that team, reliable and predictable for women, not discriminatory or 'lucky' for some. There should be better use of children's centres and the voluntary sector.

Women presume those caring for them are competent; they need to know who is caring for them, what their role is and what they will do. They want to be cared for by someone who is nice, kind and helpful; consistency, compassion; being listened to and supported; continuity and knowing the person with them; and a service environment is safe, clean and well presented. But we should never assume we know what an individual woman wants - we should ask her.

Why don't all those who provide midwifery care provide it with respect? We need systems to support those providing care. Personalized care will only happen with a relationship and that needs continuity of carer. Collaboration is vital; women do not expect there to be professional boundaries. The midwife must be able to assist the wrap-around in care by attending specialist clinics with the woman for continuity.

Continuity means not just the same face, but also the care package - is that what women are after, care or carer? Women need different things at different times of the journey. Faces do matter, but women say they want the presence of a midwife, and to feel they are known by the people looking after them; the authentic, compassionate presence of a person listening, valuing and 'being with'. Women also want education and knowledge - they can't take it all in - and need it when they want it. Technology might help for those in deprived areas, or where language is an issue.

The team members must have shared information and commonality of approach, but at present it can be ad hoc: strict guidelines and protocols are needed for the multidisciplinary team. Continuity enables better coordination of care by all team members.

All NHS maternity services should aim for continuity for some groups of women, starting with women with medically or socially complex pregnancies, and scaling up from that; or women who want a home birth and need continuity to have their wishes fulfilled. This also matches resources to demand and reduces referrals, which should reduce interventions and costs.

NICE guidelines and the NMC Code may help to identify the qualities of the ideal six-strong midwife team, without being too prescriptive. In the Dutch Buurtzorg model, colleagues are not just like-minded, but communicate and respect and work together. If midwives introduce themselves using the team name, it helps make the team cohesive. Myth-busting is needed: midwives can do the small teams in hospitals, and do not have to be on call: the workforce can cope with this, arrange effective shift patterns etc.

Question 2: *Given the challenges of achieving sustainable change in NHS maternity services, what are the levers and drivers for service change and planning to be responsive to women's needs and views?*

What is possible and what is the offer? Every woman wants the best care she can get; for some this means having all the tests going. Women don't know how to access and navigate the system. In Scotland the midwife is the first point of contact.

Midwives need to be visible in the community, and the community must know who they are and what they do. We are too hospital-focused - the hub must not be the hospital - and commissioners need to understand this. There should be meaningful services closer to home, including GPs, midwifery hubs, health visitors and children's centres. The midwifery unit should be seen as the default option for many women; this care, and the reduced admissions to labour wards, should be incentivized. Women think hospital and interventions are safer, so we need to promote a social, not medical, model of service through community groups, education in schools, and assessing women at home before they are admitted in labour.

Some drivers are the national reviews in England and Scotland; use of evidence to inform providers and commissioners; a fiscal climate where we can no longer afford to keep doing what we're doing – fiscal challenge breeds creative thinking; and workforce planning – all professional groups face workforce challenges.

The problems caused by poor population health put massive strain on the NHS. The public health challenge is to work to improve the health of all women who access services. Maternity services are a key public health service – should consultant midwives work in public health rather than acute trusts? Commissioners and government need to commission and resource accordingly.

Another lever is to strengthen commissioning, especially in England. Clinical commissioning groups usually cover relatively small populations; how big should they be, and do they understand public health? Is commissioning at the right level? Commissioning is fragmented; we need strategic commissioning tailored to a population. The tariff has a massive negative influence on care, and potentially drives provision down – could it drive it up? It encourages intervention and seeing women as medically complex, and does not acknowledge social complexity. Hospitals find the tariff too difficult to measure. Tariff and commissioning should have a long-term public health focus.

Use of all these levers must be coordinated. We want to end fragmentation in services, but also end fragmentation in delivery and change. The question is the extent of centralised action needed, as opposed to the very strong localized agenda since the passing of the Health and Social Care Act.

Question 3: *How can women be heard and heeded to influence the planning and provision of UK maternity services?*

Is it even possible to say what women want? There are commonalities among women's views: respect, trust, autonomy. We should not plan services around the voices of the loudest groups, and encourage women who are uncertain and isolated into the system. We should learn how to recognize the effectiveness of interventions at a community level, not necessarily from healthcare

professionals, perhaps through local groups, looking at mobilization of women and building social capital. We can get women of all backgrounds together to decide what they want, using women's stories to help them decide what they want.

Where are the voices of women's partners? Many fathers feel overwhelmed and not empowered, but sometimes they see what is going wrong better than others. They ask questions and see things, and could challenge the status quo.

Maternity services liaison committees at their best are excellent because they ensure voices are heard from a wide range of women. They are multidisciplinary and include service users. We need community development and co-production activities to engage and involve women. Some 'walk the patch', with people going on to the wards, talking to women and finding out what happened, good and bad. This is not just about helping individuals, but about making a bigger change to the system or staff more widely.

The professional royal colleges may have a responsibility to listen to women more – and they have the power to make women's voices heard, and jointly advise policy-makers. The RCM and RCOG work together at high level, but less so locally; we have a long way to go.

Cochrane reviews show that face-to-face conversations are clinically important. For truly relationship-based care we should have informal everyday conversations with women in our care, not just reporting after an event using a questionnaire. If you know someone, you can read the signs, understand what she is telling you, predict and prevent problems escalating. As a key part of reducing interventions and promoting health, could this be financially incentivized? Social interaction and relationship-based care should be valued as highly as technology.

The changes in our professions and models of health care, the hospital pressures and systems, and the less frequent presence of student midwives, mean we have less time to chat to women. We didn't have a plan to chat, we just did other stuff and by default we collected data, but we gave away those tasks to other staff. Midwives on 12-

hour shifts become burnt out, and may have little time for meaningful conversation – it has to be made an explicit priority. The whole system needs to change: the woman must have these kinds of relationship with her health visitor, GP and other health care workers.

We need a series of subsystems all doing things differently. They will be monitored for outcomes but that proper comparison must be made: one poor outcome from a midwifery-led unit needs investigating but should not be a game-changer. Meanwhile poor outcomes from obstetrician-led units are not necessarily subjected to the same scrutiny.

Midwifery education is lacking in community development skills. The issue here is the default of maternity services being part of the acute sector and not community health, which would enable much closer collaboration.

Question 4: *How can the care journey be tailored to each individual women's needs and wishes?*

This is simpler than it looks – it isn't about tailoring care for each woman, because there is a lot of general care they want and need, and most people are not that different. Some people are very different, but have similar needs and wants. Women should be offered a menu from which they can choose; is this over and above baseline care or is it a free choice?

The discourse of risk has resulted in 20% of the maternity budget being spent on litigation. Individualized care with women as leading partners should liberate some of these funds. The agreed protocols to assess for, say, venous thromboembolism or pressure ulcers are part of the tick-box culture that undermines individualization and personalization. We need strong professional leadership that trusts professionals to do the right thing. Risk is not binary or about reducing women to simple 'high risk' v low risk, but seeing them in a more rounded way. Women aren't at the centre in the risk-based way of thinking. It is not meant to be a punishment or a bad thing, but about the chance of having a problem, and what can be done to keep women well (screening is risk-reducing). Having a conversation with the woman can help avoid the labelling.

Can we risk getting rid of the pathways if teams are properly constructed? As in *The Lancet* framework, the concept should be that people have social and medical needs at certain times, and we need the staff to tailor the care throughout the journey. Professionals should assess and escalate properly, and use guidelines flexibly. This will require trust: the midwife needs to trust her colleagues that they will pick up if she refers, and that the midwife stays the midwife, but we are not in that position now.

Actions proposed

- Clarify women's assumptions; don't assume we know what they need and want; sense-check with the local community, then act on it.
- Provide appropriate, accessible and high quality services according to what women need and want at community level.
- Build multidisciplinary teams with a shared philosophy, maximizing skills, focusing on continuity of care and carer, and building relationships with women to empower themselves, with due regard to equity and access. This will release resource, and end silos and fragmentation. Maximize the community and voluntary sector and women's own networks, using their largely untapped potential for long-term health and empowerment.
- Use all available levers, especially evidence! Learn from existing examples of good practice.
- Respond to the public health challenge, do better workforce planning, and improve commissioning and the tariff
- Use four levels of engagement; caring conversations – philosophy, a way of 'being with women', that carries on through the life course and involves partners and fathers; maternity services liaison committees and community groups; strategic clinical networks; and professional organizations working together to develop solutions, and liaising at national and local levels.
- Work together with users to move forward on problems that are known and shared – policy-makers like to divide and rule! Politicians should be held to account for the care of women at risk because of socioeconomic circumstances.

- Educate midwives and others to prepare them for the changes, and ensure that they see it in practice.
- A radical system shift is needed that builds communities of women; changes the conversation from risk to relationship; and liberates the multidisciplinary team from a focus on risk assessment to building models that create and sustain relationships.

Theme 4

How can the full scope of the role of the midwife be better understood and utilized across the woman's life course to improve health and maximize wellbeing?

Question 1: *How could the midwife's contribution be strengthened to include newborn care, pre-conception care, contraception and wider women's health matters?*

The heavy burden of risk assessment antenatally takes the midwife away from essential care. The focus on a medical model during pregnancy steals time from normal low-risk information-sharing to support parenting. Decisions are made in the acute hospital setting, taking decision-making away from women and families. The public health approach puts the women back into focus.

How much does the midwife's role address newborn care, preconception, contraception and wider women's health? Some feel these are still part of the role, though eroded, but question how well it is delivered. The average midwife may not have adequate knowledge and skills to address these issues, but could become expert in signposting. Are women getting this care already at the right level, who is delivering it and is it good enough? It is not clear whether the gap has been filled by others; it is generally just a generic approach.

There are too few midwives to deliver these functions in addition to current workloads. The midwife with time to spend with women provides additional benefits in picking up wider health issues. What can midwives stop doing that is not necessarily their role, to release them to provide essential midwifery and do what only a midwife can do?

Some of these functions might be delivered better by others. Midwives and maternity support workers could adopt a general approach to preconception care by starting in schools. There is a role for specialist preconception care by experts in, for example, epilepsy and diabetes.

A review of what women want in this area, how and where would help ensure that it is provided by the right person at the right place and time. Women in communities should be informed what is/could/should be available for their health benefits and requirements.

Levers for change could include economic arguments and analysis to demonstrate the cost-effectiveness of midwives undertaking their proper role. Economic analysis of current care is likely to show a value, but introducing specific models of care and then conducting cost-benefit analysis should identify benefits for women and families as well as long-term cost savings. This could be started with vulnerable women, who are likely to demonstrate the greatest health benefits.

Once a designed service meets a population's needs it is likely to be requested by others to become part of a universal service that meets local needs. Savings should be reinvested to develop a universal service, but currently money saved in maternity services does not go back into the service.

Question 2: *In these times of financial restraint, to what extent can we ensure that the contributions of every member of the maternity team are equally valued?*

Politicians must be held to account when they do not keep promises on care and service delivery, and we must ensure they know and appreciate what local care is like.

Multidisciplinary teams that value midwives equally with other members of the team create equal relationships, avoid duplication, and work more effectively together. This involves issues of power and lack of trust. Shared values and mutual respect, joint learning and education, and effective leadership where professionals work collaboratively, could save money.

The move of midwifery education to universities and long clinical days may have reduced the opportunities for shared learning. Workplace culture should support all staff to attend shared learning activities.

Financial constraints are accelerating task shifting to maternity support workers. This can be effective – successful breastfeeding support can be delivered by trained and regulated support workers – but their education must be regulated and roles clearly defined. Practitioners should be released from paperwork by more administrative support.

The system doesn't enable the proper use of every member of the team, and needs radical restructuring.

Question 3: *Do professionals in UK maternity services have the leadership and structures to take the midwifery contribution forward?*

No! We are not preparing leaders of the future, whether nationally or locally, and doing nothing will not develop them. The NHS seems to value management rather than a visionary, strategic approach – leadership is associated with managerial capacity and there are minimal opportunities for career development. It should be seen as integral to everybody's role.

Leadership roles at local level are not seen as attractive. Practitioners are not standing up to the senior roles and some midwives do not want to leave band 6. Almost half of all midwives work part-time, which may affect their willingness to engage and commit. In a predominantly female profession, how can leaders be enabled to undertake a leading role and maintain a work-life balance?

Role modelling is key, and reinforces the importance of being the first follower, with the courage to follow good practice when you see it. We should target people with potential to lead change.

Undermining and undervaluing leadership is harmful. Midwife leaders may not be valued at clinical director

level. Many current leaders have had no training in their role, but are required to speak and present at political and executive levels. The development of new leaders in role is ad hoc, for example consultant midwives, who may be brought in to undertake management roles and are not enabled to develop their position.

Links between practice settings and universities should be stronger. Practitioners who go on to further study are not empowered to bring about change, and often come back into the same job, not valued or supported. There is often a failure to recognize how education can support and bring about change. It is important to nurture inspiring staff, and develop and maintain their interest in the future and their values.

Some maternity units have good leadership – what are they doing that works? We should learn from areas doing it well, and use evidence to construct the arguments. There should be a leadership academy, fellowship schemes and secondments. Some of this work is already in place, but needs to be developed and be more strategic, multifaceted and multilateral, and adopt a consistent approach to what a leadership team should look like and how care and quality is addressed. Revalidation may have a part to play.

Question 4: *What system of regulation would best enable high quality midwifery?*

We need to envision what regulation should look like, and study other models; in some countries it is statutory and led by ministries of health, while in others it is profession-specific and led.

Regulation needs to keep the woman and baby at the centre of care and keep them safe. Would a generic approach to regulation do this? It could enable cross-border working, but the profession benefits from being self-regulating. Midwives need self-regulation and regulation by midwives, including supportive supervision. There should be a stronger midwifery voice in regulation, and more representation at government level.

The situation is complicated by the plethora of government agencies with different priorities – e.g. reduce bureaucracy v. document everything. Regulation should reduce micromanagement, limit documentation to the minimum necessary demonstrated by good quality evidence, and avoid blame.

Actions proposed

- A whole system change is needed to end the division of care into pre-post natal, and focus on the reproductive life cycle and continuity of care. Restructure the system around women, eliminate the perceived hierarchy of roles, and enable the proper and valued contribution of every member of the team.
- The core elements of midwifery should be defined, to include preconception, conception, newborn care and health, and the non-core elements should be dropped. Role definition should shape the framework for regulation of education and training of support workers and others.
- Explore what good leadership looks like and learn from good practice, identifying what is currently working and who is delivering it – recognizing that service delivery is different in different parts of the UK, just as women are different with different needs.
- Perverse incentives related to the tariff that reward interventions and undermine a collaborative ethos should be ended.
- Nurture, educate and invest in young leaders, inviting them to boards to be part of the vision, weaving in education and practice, and educate midwives in first following and conflict management.
- Midwives should regulate and supervise midwives in a system that has the safety of women, babies and families at its heart, supports professional developments, and avoids micromanagement and blame.

5. An emerging agenda

In the closing session of the colloquium, Ms Silverton reflected on the main messages emerging from the day. The first key point was the effective use of resources. Resting and pauses are a natural part of birth and midwifery; it shouldn't be busy all the time. Is there enough money? How do we make better use of what we have?

The woman needs to be at the centre of the journey, but we must avoid duplication and provide care close to home. There must be continuity of carer to guide women along their journey.

The default position is now that women have their care in main centres, but services need to be more community-focused and take care to women, including obstetricians, which reduces the need for expensive infrastructure and saves them time. GPs and health visitors, as part of community teams, should be involved. Women's groups and other community organizations should be involved. The midwife's role should shift to that of a change agent and community facilitator.

How can a social model of care be commissioned, is it understood, and how can it be enhanced?

Teams need to work together, and thus need to share training and continuing professional development so that they have mutual respect and can provide seamless care for women. There are many good models for interprofessional learning, in and beyond maternity services and education. Learning should be continuous through a career and be applied to practice. Medical academics continue in practice and lead it – why not midwives? The status and rewards of midwifery should be higher.

The risk/tick-box culture and care model has many drawbacks, and professional judgement should be more highly valued. Shared learning from adverse events is needed, and less blame.

Relationships are key, between professionals, professionals and women, women and services. Relationship-based care must be valued as much as medical care, so we should build models that develop and sustain relationships. This needs a stable workforce.

Leadership needs to be supported and potential leaders nurtured, starting with leadership education embedded in everyone's training. What can we learn from examples of good leadership, and how to be the first follower when you see good practice?

There are concerns about a generic approach to regulation to ensure the safety of women. There is a lack of trust in midwives; self-regulation is needed. There should be a drive towards reducing bureaucracy, micro-reporting and documentation, she concluded.

The colloquium ended with three brief inputs from a midwife, an obstetrician and a women's advocate, modelling in practice the commitment to teamwork, equality, lack of hierarchy and shared governance that was a major theme of the day.

Cathy Warwick, Chief Executive, RCM, said she was reassured that the conversations reflected the focus of the NHSE maternity review on systems and relationships. Responding to Ms Silverton's earlier challenge about finding the political will to change, she added a challenge to herself and the RCM – 'do we have the will to do things differently?' The rest of the world is catching up with the UK, so the UK should accelerate progress and remain ahead of the game. The UK is fortunate to have midwives working in a midwifery-dependent system, and indeed many obstetricians, 'doing midwifery', as well as women's research. Midwives' big challenges are not to think 'it's

all about us'. We think we are woman-centred, but are we really? Are we really signed up to multidisciplinary teamwork, or do we just pay it lip service? Terminology was key – are our words picturing what we really want? There were many potential actions to consider as the next steps. The RCM should look more closely at continuity of carer, to help midwives be more self-managing. Midwifery education should be reviewed to see what will make a difference. The involvement of women with the RCM should be scaled up. It should also work closely with the RCOG on toolkits and support units for creating positive learning cultures and improving interprofessional education.

James Walker, Professor of Obstetrics and Gynaecology, University of Leeds, underlined the importance of learning from each other, recognizing that we all share the same concerns and are not in competition with each other. Professional education should be shared from an early stage. Instead of talking about problems, we should talk about solutions, involving the full range of professional and lay groups. Joint solution-based approaches to politicians and policy-makers would be much more powerful, especially in view of the tough external pressures. The main message of the day was a sense of common concerns, shared purpose, and mutual respect.

Elizabeth Duff, Senior Policy Adviser, National Childbirth Trust, said maternity services' relationships with women were at greater risk because of socioeconomic circumstances and inequalities. Individual women and women's groups should be heard – and heeded; existing local and national fora can be used to hear their voices. Bringing women together helps to stimulate better outcomes. These groups are well organized and well established in the UK. Every action must include women – sharing information, offering choice, listening, and keeping them in the loop. As in the QMNC framework, empowering women will strengthen their capacities, and enhance their sense of responsibility for themselves, their children and their families.

6. References and resources

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Other resources

Countdown to 2015: maternal, newborn & child survival

<http://www.countdown2015mnch.org/about-countdown>

Midwifery Action

<http://midwiferyaction.org>

<https://www.youtube.com/user/midwiferyaction>

Midwives4All

<http://midwives4all.org>

The Global Goals for Sustainable Development (2015)

<http://www.globalgoals.org>

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