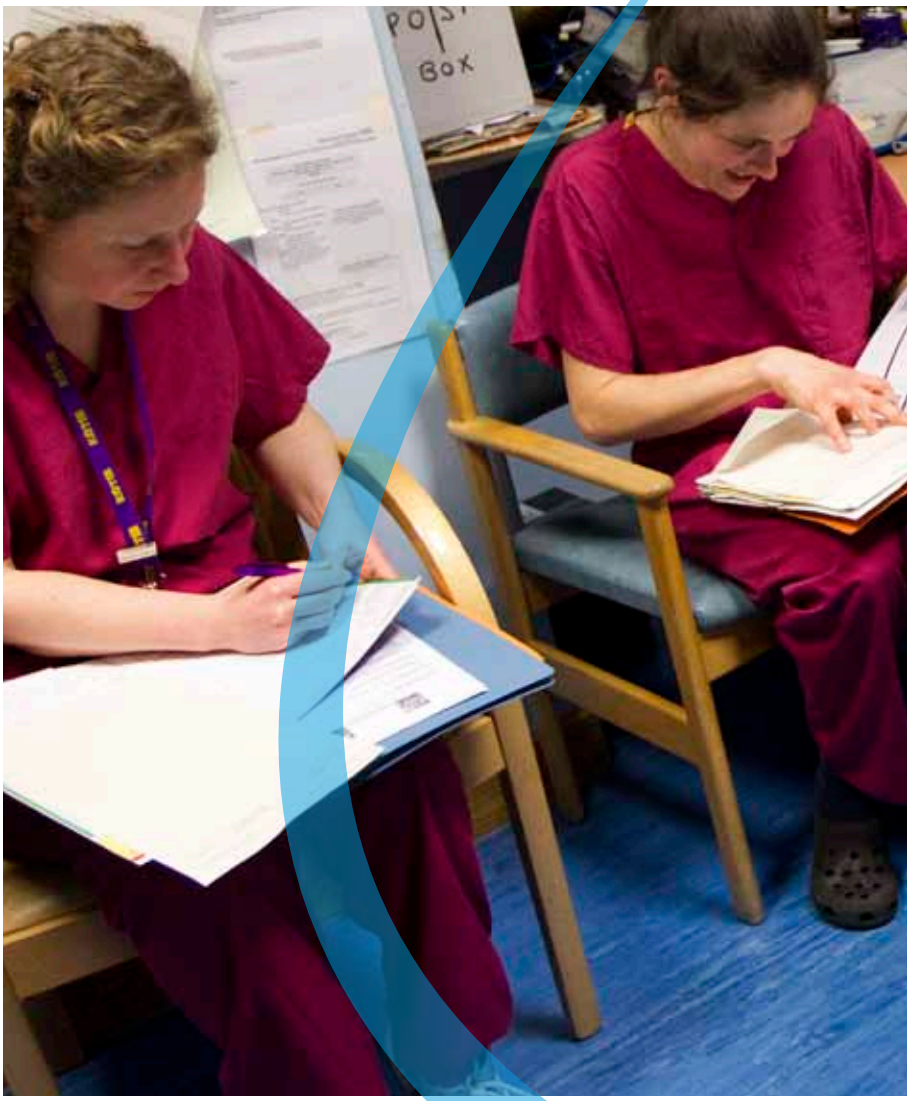
High Quality Midwifery Care

The Royal College of Midwives


Box

High Quality Midwifery Care

Foreword

Delivering high quality maternity care is the responsibility of every midwife. We all need to be activists determined to take both small and big steps to directly or indirectly improve care. This paper is written primarily for midwives and particularly for members of the RCM.

It is particularly pertinent for midwives employed within the NHS but may have resonance for midwives working in other situations. It will also be of interest to RCM members who work in supporting roles to midwives.

The paper sets out the RCM's ideals in relation to four key areas so that you know what the RCM stands for. It gives you the evidence underpinning our stance. It identifies the challenges faced in achieving our ideals and finally suggests actions that the RCM thinks need to be taken if we are to overcome these challenges.

Not all these actions can be taken by individuals and not all actions will be equally important in different workplaces. Some will only be achieved through influencing and questioning others. We hope that members will use this document in their branches and networks, decide what they want to see change and seek RCM input into local discussions as to what can be done to achieve that change.

Introduction

The Royal College of Midwives defines and champions high quality midwifery, and is a major driver of high quality maternity services. Our values and standards are strongly reflected in policy and practice throughout the UK, and are influential overseas. Our 42,700 members continue to lead, deliver and influence maternity services.

Our awareness of the significant current changes in maternity services, and their influence on midwifery and midwives, prompted this paper. The impact of major health service reforms, financial constraints and demands for greater efficiency, whilst at the same time improving quality safety and women's experience, is felt in every maternity unit. So we all need to be clear about our vision of midwifery, and what needs to happen to achieve it.

The good news is that although midwifery policy and practice vary between the four UK countries, services and individual midwives, there is a UK-wide, indeed global consensus on many important maternity care issues (see opposite page).

The status of midwifery in the UK is the envy of many countries. We deliver generally excellent services, but there is more to do to achieve safe, high quality, individualised care for every woman, every time. Diversity is welcome, but unacceptable variation in standards and outcomes is not.

Our challenge is to determine how best we can provide high quality care now and in the future. What service models and structures should we use, what should our workforce look like, how will midwives be trained and developed, and how can our workplaces create cultures where high quality is achieved?

What follows is a discussion of our values, quality and safety, followed by a summary of four key themes: service delivery, workforce, education and professional development, and workplace culture. Under each theme we set out our ideal, some key evidence, the challenges and actions to take.

If every midwife takes action - working in co-operation with colleagues in maternity services and education - we can together deliver even better maternity care, and face the future with confidence and optimism.

Midwifery at the heart of maternity services

The UK's NHS midwifery-based maternity service usually achieves good outcomes. The midwife is central to high quality maternity care, and the principle that 'all women need a midwife and some need a doctor too' is widely accepted.

The internationally agreed definition (1) recognises the midwife as a responsible and accountable professional who works in partnership with women to:

- **give the necessary support, care and advice during pregnancy, labour and the postpartum period;**
- **conduct births on the midwife's own responsibility;**
- **provide care for the newborn and the infant, including preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures.**

UK legislation from the 1902 Midwives Act onwards protects the public, promotes high quality care through standards for practice and education, and enshrines the profession's purpose and identity.

There has been broad consensus on how to achieve high quality maternity services since the landmark 1993 *Changing Childbirth* report (2). All four UK countries have policies that aim to promote woman-centred care, continuity of care, greater choice of place and type of birth, reduce unnecessary interventions, reduce inequalities and improve safety. Recent policy on early years also underlines the importance of high quality maternity services (3).

Around 26,500 whole-time equivalent midwives work in the NHS. In England 1700 additional midwives have been employed since the general election in 2010, and numbers are stable in the other countries. Midwifery student places have been explicitly protected in England. As a respected professional association, the RCM is always consulted, never ignored, and our policies endorsed by key organisations.

Values, quality and safety

A healthy mother and a healthy baby and family integrity must be the focus of high quality maternity services. High quality care should be safe, effective, woman-centred, timely and equitable. It should also be evidence-based and delivered as close as possible to the communities where women live or work. It should continue to be free and accessible to everyone at the point of need.

High quality care encompasses midwifery-led care for normal pregnancy, birth and the postnatal period. All women need midwifery care at every stage. The midwife helps women make decisions based on their clinical need, values and preferences, on the research evidence and on the context of care. In both the short term and the long term, pregnancy and early years have a decisive impact on the health and well-being of mothers, children and families (page 8). The midwife thus has a vital part to play not only in helping to ensure the health of mother and baby, but in their future health and well-being and that of society as a whole.

Our vision is derived from shared values, experiences and evidence. It resonates with the NHS Constitution in England (4) and similar principles enshrined in legislation and policy in Scotland, Wales and Northern Ireland. The core values of the NHS include respect; compassion; commitment to quality of care; and working together for patients.

The quality and effectiveness of midwifery-led care is highlighted in robust evidence from the UK and overseas (5). Major studies help to shape maternity policy, for example on the advantages of midwifery-led settings (6) and midwifery-led continuity of care (7).

Evidence-based standards, guidelines and consensus statements for maternity care form the basis of midwifery practice, produced by authorities like the National Institute for Health and Clinical Excellence (8, 9 and 10), the Royal College of Obstetricians and Gynaecologists (11) and of course the RCM.

Midwives usually deliver safe services that contribute to the UK's improving maternal and neonatal mortality rates. Most women are satisfied with their care and outcomes are good. There are many examples of excellent practice. However we could do even better. Not all women are truly at the centre of their care, some are denied their choices, and some want more and better

interaction with midwives (12). The RCM's own Pressure Points Campaign highlights that there are significant problems in the provision of high quality postnatal care.
https://www.rcm.org.uk/content/pressure-points

Improvement is important because when care doesn't go well there are high human and financial costs. Problems usually result from a combination of failures in a health system, rather than the isolated actions or omissions of a single professional. The underlying causes may be related to limited choice being available in reality and lack of women's involvement in decision-making; unnecessary medical interventions; staff shortages and poor training; lack of capacity; poor skill mix; and organisational structures and cultures that do not support best practice (13).

Whilst more research is needed to develop our understanding of care that delivers the best outcomes, the existing evidence is strong. However the implications of existing evidence, and the guidelines and standards based on it, are not always known or heeded, particularly as they relate to normal birth.

Statements enshrined in maternity policy do not always translate into practice. For example choice of provider, choice of location and choice of type of maternity care are advocated but what choice for women means in reality is different across and within countries, regions and localities (14).

By law every woman has the right to refuse medical treatment and must give informed consent for treatment, except in a small number of cases where women lack mental capacity. All the options must be fully discussed with every woman, her choices must be respected, and her human rights always upheld.

Maternity teams, starting from a holistic perspective that encompasses emotional, psychological and social as well as physical needs, should reach explicit agreement on how they can empower women to make their own personal choices about how they plan their pregnancy, birth and postnatal care. It takes time to realise the benefits of a new midwifery-led unit, or to improve long-term outcomes for children. It is important to invest for the longer term, and invest to save.

These complex, interacting issues inform the four key themes of this paper. If you wish to explore the evidence further you can check the references, and the wealth of information on the RCM website.

The long-term impact of pregnancy and early years

Pregnancy and early life lay the foundations for our individual health, well-being, cognitive development and emotional security - not just in childhood but also in adult life (15). What happens to children before they are born and in their early years profoundly affects their future health and wellbeing.

The evidence is well documented on what is important in maternity care and the opportunities for improving health and wellbeing, for example in the Marmot Review (16). We know that the health of mothers is critical to the development of their children both before and after birth. Their nutritional status before and during pregnancy, their mental health and their lifestyle choices are all important.

Interventions to improve a child's health and life chances are needed from the very beginning of life. These include emotional support, and support for physiological processes. Biological events occurring during fetal and antenatal life predispose a child to a greater risk of subsequent physical and mental health problems. Adverse ante- and postnatal experiences may have a profound effect on the course of health and development over a lifetime. Babies with growth restriction, for example, have an increased lifetime risk for cardiovascular disease, diabetes, and learning difficulties. Breastfed babies are less likely to have infections or become obese and develop type 2 diabetes and other illnesses when they are older. A secure attachment between mother and baby will provide a good foundation for physical health, emotional security and relationships in later life.

Service delivery

Which service models provide the best quality care? We highlight public health, midwifery-led continuity of care and midwifery led settings.

Public health

Our ideal:

Midwives are crucial members of the public health workforce, well placed to help every child make the best start in life (17). Their health promotion and disease prevention work improves maternity outcomes and long-term health gains by addressing individual and social health determinants, such as breast-feeding, smoking and drinking, and their social and behavioural origins.

Evidence:

For many pregnant women the midwife is the only contact with the NHS. Midwifery involvement in public health helps to improve health, reduce inequalities and save money (18 and 19). Midwives help to improve people's socioeconomic conditions (20). A public health approach includes a commitment to the promotion of positive parenting and an acknowledgement of the importance of the mother's emotional well being.

Challenges:

Midwives know how to make public health interventions, and many public health initiatives require their input, yet their potential and actual contribution is often overlooked, in both policy development and local implementation as well as in terms of resourcing. A more strategic approach is needed to involving them in individual and population based public health initiatives, as part of their core responsibilities and as public health specialists.
Making every contact count is a challenge and is enhanced if visits are long enough and if a woman sees the same midwife for the majority of her visits.

Action:

Midwives should take action to ensure that:

- **each woman has early, direct access to a midwife who can help her make health-promoting changes in behaviour;**
- **every contact with women and her partner counts, and that midwives have the training, resources and time to ensure this is the case;**
- **midwives have access to specialist help for referral of women identified as being in need of help;**
- **midwives are in a position to be a woman's advocate in a complex system. They should be coordinating care and be able to be 'with woman' not 'with organisation' helping her navigate the system;**
- **other agencies involved in health promotion understand the role of the midwife.**

Continuity of care/carer

Our ideal:

There should be midwifery-led continuity of care and carer throughout the pathway of pregnancy, birth and the postnatal period, in both community and hospital settings. One midwife, or a small group of midwives, should care for each woman using their jointly created care plan to ensure continuity.

Evidence:

Women appreciate continuity of carer and particularly want one-to-one care in labour. Outcomes are better when they receive care throughout from the same midwife or a small group of midwives (6), including outcomes for women with complex needs. Continuity can be achieved by the midwife holding caseloads and working with partner midwives, or by small midwifery teams caring for a designated group of women. A recent randomised controlled trial from Australia builds on earlier findings that caseload midwifery is safe and cost-effective for women of any risk (21). There is also evidence that midwives who wish to work in this way find it extremely satisfying, and it increases the agency of both women and midwives (22).

Challenges:

Resource constraints, service configurations and the needs of the workforce are barriers to continuity. The midwifery workforce is almost entirely female and has a growing proportion of part-time staff. Services traditionally use shift patterns that fragment care.

Action:

Midwives should take action to ensure that:

- **every opportunity is taken to achieve continuity of carer along the maternity pathway;**
- **patterns of employment are flexible allowing family-friendly shift patterns, sustainable on-call systems, work practices, terms and conditions and allowing midwives to adopt different patterns of working at different stages of their career;**
- **staffing levels are appropriate across the entire maternity pathway otherwise labour ward care is always prioritised at the expense of antenatal and postnatal care.**

Midwifery-led care and settings

Our ideal:

The care of healthy women should be midwifery-led, normally in midwifery settings. Midwifery led care should also be available for low risk women in obstetric settings. The care of women with more complex needs should be provided by midwives in collaboration with specialist services including obstetrics and will often be provided in obstetric settings. Every woman with a low-risk pregnancy should start her labour with a midwife at home or in a midwife-led unit, unless she chooses an alternative after full discussion of risks and benefits.

Evidence:

Midwifery-led settings are a cost-effective alternative to the prevailing model of obstetric-led settings (23). Compared with obstetric-led settings, when low risk women choose midwifery-led settings it improves many maternal outcomes including satisfaction, and reduces the number of

procedures in labour (5). Midwifery-led units achieve quality outcomes (5). Women at low risk experience high intervention rates in services organised to deliver risk-based care (5). Women at low risk choosing to have their first baby in midwifery led units have a significant risk of transfer to an obstetric led unit but still have better outcomes than if they choose to give birth in an obstetric unit (5). The same women choosing to have their baby at home have an increased risk in their baby experiencing a poor outcome (5).

Challenges:

Despite the safety and good outcomes associated with midwifery-led care and although the number of alongside midwifery-led units and numbers birthing in them has increased, the home birth rate remains low, intervention rates continue to rise, and the percentage of women birthing in freestanding units has not significantly increased. Women, midwives, obstetricians and managers, as groups and as individuals, have different assumptions and attitudes to risk.

Action:

Midwives should take action to ensure that:

- **women have a full discussion of the evidence to help them make the best choices for themselves;**
- **women do not have to choose their place of birth until late in pregnancy;**
- **the options of birth at home or in a midwifery-led unit are available and the default option for women at low risk;**
- **guidelines about the care of low risk women apply uniformly across maternity services regardless of their choice of place of birth;**
- **midwifery-led care is available in obstetric units for low risk women who choose that option for place of birth;**
- **protocols are in place to support midwifery care for all women with the aim of normalising the care of women who are at high risk.**

Workforce

How many midwives and what mix of staff provide the best quality midwifery care, and how should they be rewarded? This theme highlights workforce planning, skill mix and staff deployment, and pay, terms and conditions.

Workforce planning

Our ideal:

Women should be cared for in the right place and at the right time, by the right people with the right skills and values to deliver high quality care, now and in future. Evidence-based tools should be used for effective workforce planning to determine the number and mix of staff needed in each birthplace.

Evidence:

Effective workforce planning is essential to ensure the future security of the national supply of midwives; determine local staff numbers; and determine daily staffing levels to match workflow (24). There is limited research evidence demonstrating a clear link between maternity staffing, maternity workforce characteristics and birth outcomes but much anecdotal evidence and further work needs to be done in this area (25).

Challenges:

The birth rate, which remains at a historically high level, and the increasing number of midwives retiring in next five years, will exacerbate the current shortfall in midwife supply unless compensatory measures are taken. Poor planning is often attributable to short-term cost considerations. Failure to act on evidence and implement a workforce plan leads to heavy workloads and other challenges that create low morale, stress and ill health. Two thirds of midwives in the 2011 NHS staff survey in England reported having insufficient time to do their work (26).

Action:

Midwives should take action to ensure that:

- **a robust workforce planning tool such as Birthrate Plus (27), is deployed regularly to ensure staffing levels are safe and sufficient;**
- **complaints, patient surveys and staff surveys are being analysed to assess whether women feel they have enough time with midwives (28);**
- **workforce planners are taking account of future changes to the workforce arising from the retirement of midwives;**
- **additional tasks required of midwives are properly costed and funded.**

Skill mix and staff deployment

Our ideal:

The ratio of midwives to other professionals and non-registered staff should enable midwives to direct all care and deliver most of it. Non registered staff can make a very significant contribution to care. When they are part of the maternity team they should be trained, supported and clear about their roles and responsibilities. These roles and responsibilities should be appropriate. Non registered staff cannot substitute for a midwife.

Evidence:

Effective teams are the key to improving outcomes for mothers and babies (29). A high ratio of midwives to support staff allows for flexible and sustainable services, and frees time for midwives to care. Support workers giving care must have appropriate training and supervision (30). Those not involved in clinical work also provide valuable input and enable the best use of midwives' time and skills.

Challenges:

Matching staffing levels, skill mix and staff deployment to the model of care, taking staff health and wellbeing into account, is complex - and even more challenging when resources are restricted. RCM surveys suggest that the number of maternity support workers employed

is variable and may be based on short-term cost considerations, and that some are performing tasks beyond their competence. The wider division of labour and relationships with private sector providers, independent midwives, doulas and volunteers should be kept under review.

Action:

Midwives should take action to ensure that:

- **staff deployment is based on women's needs not those of the organisation;**
- **staffing patterns enable flexibility for staff with different needs and enhance continuity of care;**
- **the role of support workers is clarified and that in England they are properly trained and supported, using nationally agreed guidelines such as those developed in Wales;**
- **adequate numbers of support staff are employed in non-clinical roles to free midwives to provide more midwifery care.**

Pay, terms and conditions

Our ideal:

Midwives' pay, terms and conditions should acknowledge the challenges of delivering safe, flexible, high quality care in a round-the-clock service and with high levels of continuity. A UK wide pay and conditions system, underpinned by a robust and equality-proofed job evaluation scheme and knowledge and skills framework, is the most transparent and fair approach. Where midwives are working in systems which fall outside of a UK wide system their terms and conditions should reflect that system as closely as possible.

Evidence:

Undermining pay, terms and conditions damages morale and makes it harder to recruit and retain midwives. The experiment with local pay in the NHS in the mid-1990s was widely regarded as an unmitigated failure. Health service managers generally support Agenda for Change, the UK wide pay and terms and conditions system.

Challenge:

Some local employers have attempted to move away from Agenda for Change. The government has attempted to limit the independence of the NHS Pay Review Body by seeking to cap the annual uplift it can award, and also intends to change pay progression terms and conditions. In England and Wales ministers have ignored recommendations of the Pay Review Body and imposed pay cuts. Midwives provide a 24-hour service ideally with high levels of continuity. This requires staff to work irregular and unsocial hours and be on call.

Action:

Midwives should take action to ensure that:

- **measures are taken to improve the terms and conditions that affect midwives' working lives, beginning with fair local implementation of Agenda for Change;**
- **locally, collaborative discussions take place to ensure flexible, family-friendly working conditions.**

Education and professional development

How best can midwives be educated, developed and supported to provide high quality care? This theme looks at initial training, midwifery leadership in education, and the transition to newly qualified midwife.

Pre-registration midwifery education

Our ideal:

Excellence in education, the foundation of high quality midwifery, is the goal of the global and UK rules and standards for midwifery education set by the International Confederation of Midwives (ICM) (31) and the Nursing and Midwifery Council (32 and 33). The NMC guiding principles include safe and effective practice, provision of woman-centred care, respect for individuals and communities, quality and excellence.

Evidence:

The ICM and NMC rules and standards are based on explicit values and evidence, and were developed through consensus of midwives and other experts. Along with research by the NMC and others, they indicate how to achieve the desired outcomes of education, and underline and sustain the contribution of education to the future of midwifery and to high quality care.

Challenges:

More research is needed on education outcomes. There are serious concerns about the capacity and sustainability of the education workforce, arising from its ageing profile (60% are over 50) and reductions in staff to cut costs. Over a quarter of institutions are struggling to fill vacancies

as university salaries have not kept pace with those in the NHS. As student numbers also grow, high quality education experiences are increasingly difficult to provide.

It is also a challenge in areas with populations who are high risk and have associated high rates of intervention to ensure that student midwives have adequate exposure to normality and are prepared to provide midwifery care to women with a wide range of needs and in a variety of settings.

Action:

Midwives should take action to ensure that:

- **the NMC rules and standards are fully implemented;**
- **every higher education institution should maintain acceptable staff: student ratios;**
- **midwifery teachers spend 20% of their time supporting students in practice;**
- **education programmes prepare students to promote and facilitate normal physiological childbirth as well as identify and manage appropriately, complications and complexities;**
- **creative models for practice learning experiences are explored, including those based on caseload experience;**
- **pre-registration midwifery programmes should be included in future allocations of the service increment for teaching (SIFT) and its equivalents;**
- **research on education outcomes should be commissioned to assess the value of different routes to becoming a midwife.**

Midwifery leadership in education

Our ideal:

National and international standards emphasise the importance of midwifery leadership of midwifery education. The midwifery faculty should be self-governing, and led by a midwifery teacher with management experience responsible for developing and leading the midwifery education programme. Midwife teachers should have a good grounding in clinical practice and continue to be actively engaged in practice as a midwife teacher. They should be qualified teachers and have ready access to research funding and opportunities for further study, including at doctorate and post-doctorate level and clinical/academic career pathways developed.

Evidence:

There is international expert consensus on the importance of midwifery leadership in education (34). Independent collaborative research across England, Wales and Scotland underlined the fundamental importance of midwifery educators to the quality of midwifery and the future of the profession (35). It concluded that the teaching team needs sufficient staff with academic, practice and education expertise to facilitate and teach the vast majority of the curriculum and its application.

Challenges:

Some higher education institutions do not value midwifery lecturers or facilitate their leadership (35). Career opportunities are limited, and some feel they must leave midwifery to progress. It is difficult to get funding and time for research. Many struggle to combine midwifery practice with university requirements, and few posts combine teaching, research and practice. Pay and/or conditions are worse for lecturers than their NHS counterparts at Agenda for Change bands 7 or 8, and than other academic staff.

Action:

Midwives should take action to ensure that:

- **every midwifery faculty is self-governing and responsible for developing and leading the midwifery education programme;**
- **every midwifery faculty has a teaching team which includes those who are expert teachers of midwifery practice as well as experts in academic research (35);**
- **the head of the programme is an educator with midwifery, teaching and management experience;**
- **work is undertaken to review and overcome the barriers to a career in midwifery education, including access to clinical-academic career paths and research funding.**

From student to midwife

Our ideal:

Rules, standards, regulations and enforcement have a place in the pursuit of quality, but as the Berwick report notes, 'they pale in potential compared to the power of pervasive and constant learning' (36). Employers, universities, regulatory bodies and royal colleges recognise, fund, promote and support midwives' continuing professional development. Every newly qualified midwife should be helped in the transition to confident practitioner, on the continuum from novice to expert (37).

Evidence:

Certain factors encourage best performance from newly qualified midwives. Those who adapt best graduate from universities that provide sufficient and appropriate skills sessions, balance normality teaching with complexity, and provide good midwife teacher support in practice learning experiences; gain employment soon after qualifying; and work in units with good support and a well organised preceptorship period (35).

Challenges:

Recent reports express concerns about new midwives' readiness for work. Explanations include failures in pre-registration programmes; delay in obtaining employment; inadequacies in preceptorship schemes; and unrealistic expectations (35). The key role of clinical mentor (32) and preceptor is threatened in services with midwife shortages.

Action:

Midwives should take action to ensure that:

- **there is support for midwives' continuing professional development, including the availability of mentors and preceptors;**
- **all newly qualified midwives undergo a preceptorship programme and have the option of posts with enough hours to consolidate their experience;**
- **in an organisation with high turnover there are additional midwives funded in order to ensure high quality preceptorship programmes;**
- **senior students and newly qualified midwives with an interest in midwifery research should be offered the opportunity to contribute and to embark on training for a clinical academic career.**

Workplace culture

How can our workplaces create cultures where high quality is achieved? We need to listen to women, put their interests first and treat them with respect, protect and promote staff health and wellbeing and ensure the development of a learning environment, good governance and strong midwifery leadership.

Listening to women

Our ideal:

Every woman should always be heard and heeded, and involved in decisions about her care. Women should be fully involved in the design, delivery and evaluation of maternity services, using a coherent and focused approach with tested tools to create simple, sustainable solutions.

Evidence:

Starting with women, listening to their needs, and co-designing the experience to meet those needs creates an environment where they feel supported and safe. Useful guidance, projects and resources are available across the UK (9). For example, the evidence-based *NHS Patient Experience Framework* guides the measurement of women's experiences (38).

Challenges:

The first principle that all midwives should 'be with the woman' is sometimes forgotten in the pressure of daily work. Many units fail to find effective ways of helping women and staff routinely to share their ideas on improving women's experiences, and to introduce changes.

Action:

Midwives should take action to ensure that:

- **every midwife is able to put each individual woman at the centre of care, has the time to listen to them and share information;**
- **their organisation is upholding the NHS Constitution for England and its UK equivalents;**

- **the *no decision about me without me* philosophy is being practised;**
- **robust, meaningful mechanisms are established to involve women and local communities in service planning, delivery, decision-making and evaluation.**

Staff health and wellbeing

Our ideal:

Midwives must be healthy, well and at work. Promoting their health and wellbeing contributes directly to high quality care. Its constitution says the NHS must 'provide support and opportunities for staff to maintain their health, well-being and safety' **(4)**, embedded in the workplace culture, and its importance consistently demonstrated by staff and managers **(39)**.

Evidence:

Unhealthy, stressed staff pay a high personal price and are costly to their employer, to the NHS, to women and families and to society. Intensive staff engagement and better patient outcomes are strongly linked with less absenteeism, better performance and financial efficiency **(40)**.

Challenges:

NHS staff surveys repeatedly highlight bullying, stress, tiredness, and workplace cultures that are not midwife-friendly **(41)**. Many employers have not fully implemented the Boorman report's recommendations on staff health and wellbeing **(40)**. Managers must create a climate in which staff are genuinely valued, and work together on improving health and wellbeing.

Action:

Midwives should take action to ensure that:

- **the Boorman recommendations are implemented in full (39);**
- **staff feel safe, supported, respected and valued (36);**
- **that there is investment in training and development;**
- **there is action in place to tackle discrimination and harassment; to improve diversity; to eliminate bullying; to reduce workplace accidents; to provide better occupational health services;**
- **annual staff surveys are conducted and acted upon (42);**

Governance and leadership

Our ideal:

Good governance and strong leadership enable high quality care by developing positive workplace cultures that respect the human rights of both staff and service users. Staff must be able to raise concerns. Statutory supervision of midwives has a critical part to play in governance. Managers, clinicians, supervisors of midwives and representatives together create environments where 'everyone comes to work every day knowing they will be treated with respect, supported to do their work and expand their skills, and be appreciated for what they do' (36).

Evidence:

The drivers of high quality care include workplace cultures that facilitate good teamwork, innovation, time to care and staff raising concerns (12). The more positive the staff experience, the better the outcomes for the employer (43). Effective governance requires boards to pay as much attention to quality of care as to management of finances (44).

Challenges:

Many maternity services need stronger clinical governance, more effective leadership and statutory supervision of midwives must be supported and developed. Not all heads of midwifery are well supported or are in the right place (level) in the organisational structure and some cannot contribute effectively. NHS leadership training is not sufficiently widely available or effective, and better succession planning is needed. The flat managerial structure of midwifery limits conventional leadership development opportunities. Supervision of midwives needs to be proactive, responsive and supportive of midwives and women **(33)**.

Action:

Midwives must take action to ensure that:

- **senior midwives are supported to execute their responsibilities for quality and safety (12);**
- **the voice of midwifery is heard and heeded at board level;**
- **the head of midwifery has free access to the Board and chief executive;**
- **staff and service users are engaged in monitoring and improving quality;**
- **midwives' talent and potential is systematically identified and developed through supportive effective statutory supervision of midwives and effective leadership training, as the Francis report recommends (45).**

Conclusion

This briefing addresses a major challenge to all midwives: how best can we provide high quality care now and in future? It looks at what service models we should use, what our workforce should look like, how midwives should be trained and developed, and how our workplaces can create high quality cultures.

With the right values, the right education and the right leadership, midwives can turn round outdated service models and practices. While most UK maternity care is safe and good quality, it could get even better. Changing times demand new solutions. We need a strong public health approach, community-based care for all, continuity of care instead of fragmentation, and respect for the central contribution of midwifery to high quality maternity services. This is what the RCM stands for – do you?

Further information

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