

Getting the midwifery workforce right



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Key messages

- The role of the midwife is clearly described and demarcated. The evidence shows that it is in the interests of women to receive the majority of their care from a small group of midwives they know and trust. Midwifery services should be staffed to enable this to happen.
- The role of the midwife has developed over the years to meet changing population needs and in a changing context of healthcare delivery. The role of the midwife can encompass new tasks but this should always be a) in the interests of women and their babies b) properly resourced c) supported by defined competencies and appropriate education and d) within their scope of practice.
- When a midwife takes on new tasks this does not equate to taking on a specialist or advanced role.
- A midwife may focus her skills on a specific group of women e.g. teenage mothers, women with drug or alcohol problems, safeguarding etc. This does not make her a specialist or advanced midwife. A specialist midwife would be expected to play a more strategic role in service delivery. A specialist midwife would be expected to receive referrals from other midwives or GPs when care was particularly complex. She would also be expected to network amongst other services, have a role in policy influencing and setting for that service and a key role in education.
- Specific local circumstances primarily related to size of service and rural services may exceptionally mean it is appropriate for a midwife to undertake tasks which in another context are usually performed by other professionals e.g. scrubbing in theatre or undertaking ventouse deliveries.
- Support workers play a vital part in maternity teams. They may be employed in clerical, housekeeping or care giving roles. MSWs in particular make an important contribution. There should be a nationally agreed framework with competencies for such roles supported by national training programmes.
- There is no need for a nurse associate role in maternity services.
- Consultant midwives have clearly defined roles, make an enormous difference to the clinical leadership and practice development within units as well as being the catalysts for change and improvement.

Introduction

Maternity services like the rest of the NHS are facing severe financial challenges. The paradox for everyone involved in funding, managing and delivering maternity services is how on the one hand:

"The NHS could and should raise its game on personalised support to parents and their babies, better team working, better use of technology and more joined up maternity services" (Simon Stevens, CEO NHS England)

But on the other hand:

"cuts in staffing and reduction in quality are inevitable if the government's priority is to restore the NHS to financial balance" (Kings' Fund 2016)

In order to try to bring some clarity into debates, policies and decisions about how maternity services should be configured, funded and staffed, the RCM has developed this guidance which explains the role of the midwife, the limits and scope of the role, its relationship with other professionals and care givers and the approaches which are most likely to lead to safe and effective staffing decisions.

Role of the midwife

The role of the midwife is to ensure that women receive the care they need throughout pregnancy, childbirth and the postnatal period. Much of this care will be provided directly by the midwife, whose expertise lies in the care of women and babies during normal birth and pregnancy. Where obstetric or other medical involvement is necessary, the midwife continues to be responsible for providing holistic support, maximising continuity of carer and promoting a positive birth experience for the woman.

The way in which the role of the midwife evolves and develops over time may have significant implications for the overall focus and quality of midwifery care, on the best use of resources and on the midwifery profession itself. That is why the RCM has developed this guidance for midwives, MSWs, other members of the maternity team, midwifery service providers and policy makers.

Definition of the role

The formal definition of a midwife that has been adopted by the International Confederation of Midwives (ICM), the International Federation of Gynaecologists and Obstetricians (FIGO) and the WHO reads as follows:

"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

The activities of a midwife are defined in the European Union *Midwives Directive 80/155/EEC* Article 4 as follows:

"Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

- to provide sound family planning information and advice
- to diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies
- to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk
- to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
- to care for and assist the mother during labour and to monitor the condition of the foetus *in utero* by the appropriate clinical and technical means
- to conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery
- to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus
- to examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation
- to care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant
- to carry out the treatment prescribed by a doctor
- to maintain all necessary records."

For many years the legal definition of a midwife has been accepted by the regulators, the NHS and the profession itself, to encompass the care provided during pregnancy and the postnatal period. Practically this means that for the majority of women midwives make autonomous decisions without reference to a medical practitioner throughout the pregnancy continuum and take full responsibility for their decision making. Where necessary the midwife has a responsibility to refer women to appropriate professionals but to continue to provide care.

Thinking about midwifery in 2016

The role of the midwife as primary carer for women and infants experiencing normal pregnancy and birth has remained essentially unchanged for many years. The value of this role lies in midwives' extensive knowledge, expertise and their ability to detect and act appropriately on a wide range of clinical and other indicators in pregnancy, labour and the postnatal period.

Midwifery is very much relationship-focused rather than providing task or intervention based care. It has its biggest impact on outcomes where midwives are able to provide consistent care over the continuum of antenatal, intrapartum and postnatal care. The intention of delivering continuity of carer i.e. of each pregnant woman seeing as few different health care staff as possible, is central to policy for maternity services across the UK. This is not because midwives are territorial about their role but because they play a distinct role in caring for women and because of the wealth of evidence that shows continuity of care provided by a midwife is linked to the best clinical outcomes for women. Any discussion about the maternity workforce therefore needs to start from a clear understanding that the shared primary objective must be to have sufficient staff with sufficient skills/competence/expertise, to minimise the number of different contacts a woman will be required to have during her pregnancy, birth and early postnatal period.

The RCM affirms the ICM/FIGO/WHO definition of the role of the midwife and the definition contained in the European Union Midwives' Directive. However, whilst the role of the midwife and her scope of practice are established in statute, there is considerable pressure due to current policy initiatives and the changing context of service delivery for flexibility in the focus and emphasis of that role. The current emphasis on developing a 'flexible' NHS workforce, are exacerbating these challenges.



Accordingly, the RCM recognises that:

- local and national policy, strategy, population and staffing needs all legitimately shape the focus and emphasis of a midwife's daily work;
- the provision of safe, effective and high quality care requires a reasonable degree of flexibility on the part of staff groups and careful consideration of an appropriate skill mix for different maternity settings;
- midwives should acknowledge that even when they are the sole care giver, if women are to get safe care they must work within multi-disciplinary teams; and
- midwives are able to access opportunities to develop and enhance their skills and interests.

This means that any work to review the skill mix in maternity must be focused on ensuring that women still receive care that is holistic as opposed to task orientated. Other staff can and should normally be employed in support roles if this leads to greater efficiency, and appropriately educated staff may undertake delegated roles again if this does not undermine the basic principle of women receiving the bulk of their care from an appropriately qualified professional they know and trust.

In order to achieve this it is important to sustain a clear definition of the role of the midwife, in order to ensure consistency in standards of care and the continued advancement of a defined midwifery body of knowledge.

The RCM welcomes any development of the midwife's role which enhances these skills and expertise, or which makes midwifery care more accessible and responsive to women's needs. In the context of ensuring that women are able to exercise choice about the care they receive it is critically important to ensure that there are midwives in the workforce who are competent to:

- work in different settings and to address particular needs which impact on maternal and infant wellbeing (for example domestic violence, substance misuse, homelessness); and
- work in new ways and partnerships to meet the range of women's needs to, for example, promote seamless care or reduce unnecessary delays or barriers such as distances in accessing care and to learn new skills.

Midwives have, however, proved adaptable in responding to changes in the context of their role, and in the settings and systems within which midwifery care is provided. In recent years midwives have become used to and grown in confidence in sharing some elements of care to maximise their productivity.

Midwives already take the lead in making decisions with women about the nature of their care and planning as well as providing 'hands-on' care, as well as co-ordinating care with other specialist colleagues.

Currently there are a number of developments that have the potential to impact on the role and scope of practice of midwives. These include:

- National policy drivers to enhance the role of the midwife, such as Better Births the report of the national maternity review in England, the Strategic Vision for Maternity Services in Wales, the Strategy for Maternity Care in Northern Ireland and the forthcoming review of maternity services in Scotland.
- An increasing focus on the public health role of the midwife and the opportunity to deliver broader public health interventions as part of maternity care which expands the components of routine midwifery care¹.
- Strategies for role development across different staff groups, from senior consultants, to midwives, nurses and allied health professionals through to support workers. These anticipate a more flexible approach to professional roles and skill mix, a more developed contribution to prevention, public health and family wellbeing services as well as an increased presence within integrated services, multi-disciplinary teams and cross-sectoral partnerships.
- Changes to junior doctors' roles and responsibilities and to their working hours.
- The continued development of the role of Maternity Support Workers (MSWs).
- Opportunities for midwives to develop clinical skills, such as ultrasonography and the examination of the newborn.
- Changes in the birthrate and in the demographic profile of childbearing women, such as decreases in teenage pregnancies, increases in births to women aged 40 and older and the growing proportion of pregnant women who have pre-existing medical or social conditions. These have implications for rates of caesarean sections and other interventions, which can significantly alter the content of midwifery work.
- Midwifery and other staffing shortages.
- All of the above happening in a broader context of an NHS experiencing extreme financial challenge where safety, productivity, financial balance, choice for women and staff health and wellbeing all have to be addressed.

¹ The RCM's public health model *Stepping up to Public Health* is of particular relevance in this context <https://www.rcm.org.uk/new-resources-available-for-stepping-up-to-public-health>

These developments will require different responses, ranging from simple adaptations and changing emphasis within the role as normally practised, to incorporating new or additional skills into the role e.g. examination of the newborn, to the development of specialist roles focusing on particular issues e.g. mental health, and finally to developing leadership roles e.g. consultant midwives.

The RCM welcomes the fact that midwives are developing areas of interest and specialist skills, and affirms that this is an important part of providing a service response to the increasingly diverse needs of all communities within the population. It will be most effective where midwives sustain their competency and confidence in core midwifery practice. It is important that specialist skills are not automatically conflated with 'higher' skills; and that professional development, grading and other rewards and opportunities do not assume that specialisation equals expertise of a higher value than core midwifery. A midwife who simply concentrates her midwifery expertise on a particular segment of the population is no different from a midwife who has a general caseload. However if a midwife not only focuses her skills on a specific group of women e.g. women with mental health problems but also provides a focus of referral from other midwives, has a role in developing policies and guidelines for this group, educates other midwives etc. she may fit a category of practice which may be described as 'advanced' and may be rewarded differently. The role of the specialist perinatal mental health midwife, for which the RCM has developed specific competencies, would come into this category.

The RCM accepts that the boundary between midwifery skills and medical skills is not inflexible, and that some midwives may develop particular skills in order to sustain continuity of carer, allow more women to benefit from midwifery care at home or in midwifery units or otherwise to improve the care available to women and their babies. Good examples of this are perineal repair, cannulation, examination of the newborn and undertaking the six-week postnatal examination. However this is about adapting the midwife's role to accommodate women's requirements; it is not about advancing skills.

The RCM does not however endorse the extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of, or access to, midwifery expertise. Whilst the RCM accepts that NHS organisations wish to maximise the flexibility of their workforce, it is not acceptable to permanently alter midwifery roles to compensate for staffing shortages or changes in doctors' roles (for example, by routinely requiring midwives to assist in caesarean sections).

We do not believe that this kind of response solves the fundamental problem of medical shortages but merely moves the problem onto another profession². Equally, while the RCM appreciates that many midwives may wish to acquire obstetric skills, this needs to be balanced with the value of sustaining the midwifery model of care.

Guiding criteria for the development of midwives' roles should be considered across the whole service area, and should include:

- The impact on core midwifery care and associated standards (for example, the ability to provide one-to-one care in labour).
- The availability of funds to adequately resource associated training, professional development, monitoring and audit.
- Acceptability to midwives and to women.

Service needs will vary in different localities and with different populations, and the rationale for developing particular roles, or substituting roles traditionally undertaken by midwives with other professionals, will vary accordingly. For example, it is probably more efficient and effective for the average sized consultant unit to use professionals other than midwives, such as scrub nurses, to assist in theatre. However in a very small obstetric unit it may still be more efficient and effective to use midwifery staff. Equally in an HDU a nurse may be better suited to provide general high dependency nursing care, working alongside a midwife who provides the midwifery care. Whereas, a rural midwifery unit may decide that training midwives in ventouse extraction would make a very real difference to the service's ability to provide accessible, seamless care. In all cases, the rationale for role development should be demonstrable (in terms of improved maternal and infant health outcomes) and not merely in terms of convenience or professional preference.

Midwifery numbers

The RCM continues to maintain that England is 3500 midwives short based on the broad requirements of Birthrate Plus. Even in Scotland, Wales and Northern Ireland, where there are broadly enough midwives to meet demand, large numbers of skilled and experienced midwives are due to retire in the next 5 to 10 years. The impact of the shortages in England is demonstrated by Heads of Midwifery who report routinely reducing services, and temporarily closing services as well as reducing access to midwives' training and development opportunities. We have evidenced this in our State of Maternity Services Report³. The impact is also shown in the amount of unpaid additional hours midwives are routinely working, their failure to take required breaks and the stress they are under. In terms of the impact on women, the RCM is fully supportive of the vision for maternity services set out in the *Better Births* and we completely concur that this vision is not achievable without adequate staff and without the time and resources to develop, educate and lead these midwives. This is consistent with our assessment for maternity services across the UK.

The RCM continues to support Birthrate Plus as a robust and credible workforce planning tool for midwives⁴. It has a long track record in enabling managers to measure the work and time involved in providing high quality maternity services and translating this into staffing numbers. It has now been endorsed by NICE as a workforce planning tool that can assist with implementing the recommendations in the NICE guideline for safe midwifery staffing⁵.

We are aware that BR+ requires updating so as to reflect current midwifery practice, such as the huge workload associated with safeguarding and child protection, the increased role of midwives in providing public health and the evidence of the Birthplace study in relation to the safety of midwifery-led care. We are keen to work with BR+ on a reissue of the methodology to ensure that it continues to be relevant and helpful.

We welcomed the publication of the NICE safe midwifery staffing guidelines and are currently completing assisting guidance for Heads of Midwifery to ensure they are equipped to use it. Last year we issued an FOI request to gauge the extent to which NHS trusts are using the guidelines. At that point 42 per cent of trusts had still not used the guidelines to formally review midwifery staffing, although half of these did have plans to do so.

³ RCM (2015) State of Maternity Services Report 2015 <https://www.rcm.org.uk/briefings-and-reports>

⁴ The RCM is however aware that Scotland has developed its own tool based on the Association of UK University Hospitals (AUKUH) nursing care tool.

⁵ <https://www.nice.org.uk/guidance/ng4/resources>

² This begs many questions around accountability and governance if midwives take on more roles outside their scope of practice.

Encouragingly, 33 per cent of trusts had used the guidelines and had identified a shortage of midwives, with 28 per cent reporting that their boards now had an agreed plan to increase staffing levels.

We hope to see future guidance reinforcing the requirement to use the guidelines.

The RCM is pleased that student midwife commissions have increased slightly in recent years (at a time when student nurse commissions have generally reduced) and to some extent this has contributed to a reduction in the midwifery shortage. However, from our own membership database we can see that the demographics of the profession are changing and that there will be large numbers of skilled and experienced clinicians and leaders retiring within the next five years. We are not convinced that the numbers entering the profession will continue to balance those predicted to leave and we are concerned that there will be a shortage of clinical and managerial leaders.

Our overall conclusion therefore is that very often the shortage of midwives is not necessarily a supply issue, although the situation does vary across the UK. In England in particular, this is a problem of trust finances constraining the ability of maternity services to employ sufficient midwives, leading to excessive workloads/caseloads, over use of agency staff and failure to properly manage peaks of activity. For women this means that whilst most maternity services meet the standard of 1:1 care in labour, antenatal care is often disjointed and the quality of postnatal care poor, with insufficient specialist midwives to care for women with particular needs and conditions (such as recently highlighted shortages in maternal mental health) and it means that units close or services are withdrawn. For midwives it means a long hours culture, where there is little support for continuing professional development and high anxiety caused by continually feeling unable to give of your best. So the real challenge for the maternity workforce is that there are not enough midwives and the real solution lies in recognising that if the NHS is serious about delivering the care it aspires to, it has to increase the number of midwives it employs.



Maternity skill mix

The NHS currently faces enormous financial challenges, with real growth since 2010 virtually flatlining at 0.1 per cent a year and 67 per cent of English providers finishing 2015/16 in deficit. It is these financial challenges that are driving the policy solutions and practical management actions that have been advanced in recent months. The RCM has successfully challenged individual organisations that have proposed, among other things:

- engaging volunteers to do the work currently undertaken by MSWs;
- employing nurses to care for pregnant women undergoing induction of labour and in-patient antenatal care;
- requiring midwives to routinely undertake ventouse deliveries;
- using midwives to fill in for junior doctor vacancies on tier one rotas.

The RCM wholly supports the concept of the right staff in the right place at the right time doing the right thing. There is much work currently undertaken by midwives that could be better and more appropriately carried out by administrative and clerical staff, by house keeping staff and most obviously through a support role that allows units to flex their skill mix.

We recognise that midwives are not the only carers that contribute to high quality maternity care and indeed that they are not always the most appropriate person – for example midwives should not be routinely cleaning rooms, maintaining patient records or (as per our comments above) assisting in operating theatres.

The legal definition of a midwife means that in practice, midwives can make autonomous decisions without reference to a medical practitioner throughout the pregnancy continuum and take full responsibility for their decision making. This is important in the context of governance around role substitution or delegated decision making. In more recent years midwives have become used to and grown in confidence in sharing some elements of care with non-regulated health colleagues in order to maximise their productivity. Midwives already take the lead in making decisions with women about the nature of their care and planning as well as providing 'hands-on' care. These are not separate or distinct elements of maternity but central to midwifery.

Maternity Support Workers⁶

The MSW role, a non-regulated, non-professional staff member able to provide support to midwives, to take on some routine tasks and work under delegated authority has become increasingly important since its widespread introduction twenty years ago. MSWs make an important contribution to maternity care, and the development of that contribution should be encouraged. The RCM supports the appropriate use of MSWs and have welcomed them into membership. The RCM recommends that support workers should be integrated within the maternity care team, working under the supervision of midwives, and appropriately trained. They should not undertake duties which require midwifery training and registration, be the primary named contact or lead professional, or be used to deputise for midwives. However, given the nature of midwifery care and the midwifery role, particularly the focus on minimising any possibility of unnecessarily fragmenting care, there will always be a limit to the amount of care MSWs can undertake and the total number of MSWs that can be employed.

It is fair to say that for many midwives accepting this role has been a challenge and many initially saw this as role substitution. However, it is also fair to say that in the last 20 years MSWs have proved time and time again their value to the wider maternity team and to women; they provide capacity and skills, they allow for a more flexible deployment of workforce and they allow midwives to spend more time with women who need them most.

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. The RCM is disappointed therefore that recent reviews, particularly the Cavendish Review of the role of support staff and the Carter Review of efficiencies in hospitals, have given insufficient attention to support functions in maternity services. This has either been ignored or it has been assumed that a nursing model is automatically transferable to midwifery.

What concerned midwives about the MSW role and continues to be the concern of the RCM is the wide variation in role, in training and development and in the pay and conditions of this group of colleagues. In England there is now a wide range of MSW job descriptions, titles and roles from

⁶ The term 'Maternity Support Worker' is used to describe any unregistered employee who works specifically for a maternity service and who provides support to a maternity team and to women and their families. There are however other titles used in different parts of the UK for these employees, such as Maternity Care Assistants and Maternity Care Support Workers. This paper uses Maternity Support Workers and MSWs as generic terms to cover all such posts.

cleaning rooms after delivery, processing paperwork, data input, delivering health promotion messages, providing practical parenting assistance (such as bathing) through to breastfeeding support, undertaking routine diagnostic tests and attending home births with midwives. There is however no standard job description, no portability of qualifications and experience and no consistent link of role to Agenda for Change (AfC) grades. Nor is there any clear route for career progression. RCM surveys suggest that the number of MSWs employed is variable and may be based on short-term cost considerations and that some are performing tasks beyond their competence. Attempts to introduce greater consistency in England have been strongly resisted; this does not compare well with the situation in Scotland, Wales and Northern Ireland where all have to some extent successfully introduced standard job descriptions, competency frameworks and training programmes. In Scotland, for example, there is a Competency Framework for Healthcare Support Workers which provides a set of core skills and competences to help deliver person-centred care.

It is unacceptable that employers are able to create job roles and training packages that have no transferability to other situations. While some employers undoubtedly do develop their support worker workforce and employ them appropriately, this is far from universal and is unlikely to improve significantly until there are nationally agreed roles, job descriptions and pay banding.

MSW members of the RCM continually say that all they want is role clarity, respect and recognition for the role and care they provide and to be treated fairly. The RCM has already undertaken considerable work to scope out the parameters of the MSW role and to set out a clear framework for their roles and responsibilities, learning and development standards and pay banding and job evaluation. We are currently updating this and we will continue to press for a national approach to MSW training, competency and role definition and locally the RCM is influencing and negotiating to try and get these adopted in trusts.

Apprenticeships

The RCM is aware that there is much discussion across the NHS about the use of apprenticeships as one way that organisations can grow their own local workforce and that allows people to gain skills and experience in order to progress their careers. However the current framework for midwifery education effectively precludes apprenticeships from being a helpful development within midwifery. Not only are all candidates for midwifery education required to have completed 12 years of secondary education, but there is no accreditation for prior learning in midwifery. So MSWs or others who have achieved a foundation health degree still need to undertake a

full midwifery education programme. The European Union only completed its revision of the regulations relating to midwifery education in the past 12 months and there appears to be no appetite to amend these requirements.

The RCM certainly supports a career framework and investment in the development of MSWs. Some, but by no means all, do wish to proceed into a career in midwifery and those who meet the entry requirements have successfully applied to midwifery education programmes. We are currently planning some work with Lead Midwife Educators in Universities (LMEs) to gauge the academic experience of MSWs who have embarked on midwifery degree courses. Moreover there remains scope to ensure that MSWs are developed, especially those starting at NVQ/AfC band 2 progressing through to NVQ/AfC band 4. Skills for Health are currently working on the MSW level 3 Apprenticeship pathway and we believe it is important for everyone to see how this impacts on workforce planning and meeting service need.

Nursing (Midwifery) Associates

Recent developments in nursing, such as proposals for a Nurse Associate role raise questions about the extent to which workforce challenges facing general nursing are the same as the workforce challenges facing midwifery and whether solutions that work for general nursing are easily transferable to and appropriate for midwifery.

The recent HEE consultation on a new proposed nurse associate role specifically excluded midwifery. However, the RCM has tried to conceptualise how such a role might be translated into midwifery and whether on balance it would be helpful. Our conclusion was that it would not. The new role being envisaged by HEE seemed to us to exactly match what already exists: a role that supports, assists and complements the care given by registered professionals, that works within defined principles of practice and is supported by a competency framework. This is exactly what the RCM has been calling for, for MSWs. Equally, clear standards and a clear job title, a flexible and portable skill set and appropriate career progression is long overdue for developing the MSW workforce.

Rather than create a new role we would propose that NHS energy and commitment is given instead to properly developing and supporting the MSW workforce. This would not only increase their productivity and contribution but would also demonstrate a real commitment to developing this element of the NHS workforce.

Advanced Midwifery Practitioner roles

Advanced/extended roles

At the other end of the spectrum we are aware that the shortages in medical establishments, particularly in staffing junior doctor rotas is leading to discussion of advanced practitioner roles. Again these are being widely discussed in nursing, but we have tested their applicability to maternity and again found them wanting.

Current discussions about the need for an advanced practitioner role in general nursing overlook the existence of this role in midwifery – it is called Consultant Midwife and fulfils the need for an experienced clinical expert with a wider sphere of practice. Consultant Midwives have a clinical, educational, leadership and research role across a wide midwifery setting commonly in promoting normal birth or public health. The balance of these will be determined locally. They make an enormous difference to the clinical leadership and practice development within units as well as being the catalysts for change and improvement, often around specialist roles.

What most maternity services need is not another new Advanced Practitioner role but more Consultant Midwives. Further we can not see how midwives can generally take on medical roles without placing safety at risk. The nature of midwifery is that of consulting and transferring care when appropriate, for example making the decision about when to induce a labour etc. Taking midwives into medical roles, not only depletes the midwifery workforce; we are also concerned that posts and roles are being proposed without any plan for either their sustainability or the forward career progression of individuals.

Conclusion

A modern maternity service should be flexible and adaptive; we cannot fossilize the role of the midwife, nor should we seek to. New technologies, digital healthcare, new challenges and new populations will all demand the provision of maternity services that are open to learning and open to change. Nevertheless, it is equally important that we are not over-hasty in embracing innovation and reform which may reduce continuity, impede holistic care, lower quality standards or deskill midwives.

As midwives re-focus their role in relation to women's expectations and policy drivers there will be an inevitable shift in professional boundaries and practices, but it is essential that as this takes place the body of knowledge that defines midwifery and the activities of the midwife are retained and enhanced.

The RCM urges all midwives to take personal responsibility for ensuring that their own professional development affirms the midwifery philosophy of care and promotes normality and quality of care. Midwives who are facing pressure to alter their role in ways that they feel uncomfortable with are urged to contact the RCM for advice.

Appendix: What the RCM supports and doesn't support

The RCM supports:

- Continuity of carer. There must be sufficient midwives and other maternity staff with sufficient skills, competence and expertise to minimise the number of different contacts a woman will be required to have during her pregnancy, birth and the early postnatal period.
- Any development of the midwife's role which enhances her midwifery skills and expertise or which makes midwifery care more accessible and responsive to women's needs.
- The significant engagement of midwives in strategic planning, education, service development and research where such developments constitute higher or advanced roles e.g. consultant midwives.
- Having midwives in the workforce who are competent to work in different settings, work in new ways, learn new skills and address particular needs which impact on maternal and infant wellbeing.
- Birthrate Plus® as a robust and credible workforce planning tool for midwives⁷.
- The concept of the right staff in the right place at the right time doing the right thing. Midwives are not the only carers that contribute to high quality maternity care and there is much that they currently do that could be better and more appropriately carried out by support workers.
- The appropriate use of MSWs, together with the establishment of an appropriate career framework and investment in the development of MSWs.

⁷ Birthrate Plus® has now been endorsed by NICE.

The RCM does not support:

- Conflating specific expertise with specialist/advanced roles. Professional development, grading and other rewards should not be based on an assumption that a specific focus is equivalent to expertise of a higher value than core midwifery.
- The extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of, or access to, midwifery expertise.
- Permanently altering midwifery roles to compensate for staffing shortages or changes in doctors' roles.
- Extending the proposed nurse associate role to midwifery. Rather than create a new role it would be preferable to properly support and develop the MSW workforce.
- Developing a new Advanced Practitioner role within midwifery. There is no need for such a role when Consultant Midwives are already fulfilling the need for an experienced clinical expert with a wider sphere of practice, whose role can focus on different elements of expert practice, service development, clinical leadership and education and training.



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