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North West Consultant Midwife Capacity Development

“Leading for the future...”

May 2010



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Executive summary

Introduction

Since its launch in 1999 the role of Consultant Midwife has evolved. The role has made a significant contribution to improving the health outcomes for women, transforming midwifery practice and providing greater choices, access and quality afforded by maternity services.

With no national mandate to guide capacity building for these roles there has been significant variation in the rate of growth in the numbers around the UK. The need for these senior posts has been determined at local level, and their creation has therefore been decided based largely on an organisation's ability to afford them.

The recommendations outlined within *Safer Childbirth* (2007) provides the only guidance for the midwifery profession and suggests that maternity providers should aim for the appointment of one Consultant Midwife for every 900 births undertaken. In the North West there are currently 11 Consultant Midwives, four of whom are temporarily occupying Head of Midwifery positions. If the recommendations are to be embraced, this would equate to a total of 98 Consultant Midwives for the North West to meet a ratio of one per 900 births (at the 2012 birth rate). This is unlikely to be achievable since the talent pool of Consultant Midwives is still too small. Aiming for one Consultant Midwife per birth environment (not provider) would be a more realistic target for the North West and would require an additional 27 Consultant Midwives.

This project was instigated as the region had experienced difficulties recruiting Consultant Midwives. Indications were that this was owing to a lack of midwives with the necessary expertise and experience. It was suggested that formal training opportunities are a requirement to promote readiness for these roles.

This report sets out the context and findings of the NHS North West funded project that was to explore the role of Consultant Midwives, the benefits the role offers to the care of women and babies, the barriers to role development and

successful recruitment into Consultant Midwife posts, outlining solutions which would improve the region's capacity, enabling compliance with the recommendations set out in *Safer Childbirth*.

It sets out its findings on the role and responsibilities of Consultant Midwives working within the North West; their expectations and those of the maternity providers, whilst identifying barriers which hinder progress in building capacity, and presents a number of recommendations to overcome these barriers.

Project Scope

The project set out to:

- understand the current capacity and utilisation of Midwifery Consultants
- clarify the barriers to role development
- test the region's current position against the national direction.

Which it would deliver by:

- ensuring consultation with relevant stakeholder and professional groups set out in Appendix 10
- reviewing the current evidence available from both literature and the North West Non Medical Consultant Panel approval process
- undertaking qualitative and quantitative research in the form of focus groups, structured interviews and questionnaires.

Methodological approach

Two methods were employed to collect information from the expert group of stakeholders during this project: structured interviews with Heads of Midwifery and Consultant Midwives; and focus groups of midwifery matrons, advanced practitioners, specialist practitioners and shift-coordinators. While both methods have inherent challenges associated with them, they were selected on their overall merits. Information was then analysed using thematic content analysis.

Key findings

- The last 10 years have seen little evaluation of the Consultant Midwife role. Those who participated in this project felt that this would be an ideal starting point in terms of promoting the region's understanding of the role and its added value. At present there is a stipulation that 50% of a Consultant Midwife's time should be spent in the clinical environment. This percentage of clinical input is rare today, and remains a contentious issue when discussing the role. There is a need to clarify what shape this clinical requirement should take and also what is now a more realistic percentage to adopt.
- There needs to be national guidance which outlines the optimum number of Consultant Midwives required by the profession to ensure sufficient clinical leadership within organisations is achieved.
- There needs to be more Consultant Midwife posts created and based in primary care settings to meet the increasing need for clinical leaders to support midwives in providing care in multiple care settings.
- The existing Continuing Professional Development (CPD) provision in the North West needs to be reviewed to make it more accessible, equitable and suitable to meet the needs of the midwifery workforce, to prepare them for these senior roles.
- The current appraisals process does not consistently facilitate career progression within midwifery and it was suggested that this was an area that necessitated further examination. The creation of a Midwifery Career Pathway was also deemed necessary, to both facilitate and expedite career progression to these roles.
- Finally, the region's non medical consultant application process was seen by those interviewed as posing a potential barrier to further development of these roles owing to its perceived complexity. It was suggested that further guidance be provided by members of the strategic health authority (SHA) to those organisations embarking upon the application process approval panel to reduce this risk.

Recommendations

This report concludes with an outline of the main recommendations for consideration by the key stakeholders and sets out areas to be implemented over the following three years.

Organisational adaptation

1. Maternity providers address organisational resource issues through benchmarking, sharing examples of best practice and publishing cases that demonstrate how the Consultant Midwife has implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery.
2. The SHA Non Medical Consultant Panel develops a group through which Consultant Midwives can meet to identify ways in which the quality and service improvement agenda can be implemented regionally in light of the current economic climate.
3. The SHA organises an annual regional event which enables Consultant Midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users and increasing wider understanding of the role.

Education and development

4. The CPD review ensures that the following skills, essential to consultant role development, are able to be obtained from contracted provision:
 - teaching
 - negotiation
 - influencing
 - leadership
 - strategic networking.
5. The SHA continues to drive inter-professional learning by opening up programmes, traditionally aimed at other health professionals, to midwives.

6. Education providers maximise learning opportunities through application of creative techniques such as e-learning, distance and work based learning packages.
7. Education providers embed and signpost core Clinical Leadership skills within pre-registration and post qualifying learning programmes.
8. The SHA, maternity providers and service commissioners embed education governance within their core work programme ensuring programmes that are clinically credible are developed with robust quality assurance mechanisms.
9. Directors of Human Resources (HR), in partnership with the SHA, undertake a review of the effectiveness of midwifery appraisal and its impact on career progression.
10. The SHA, through its CPD review, drives forward equitable access to CPD opportunities, testing existing systems through feedback from midwives.
11. The Leadership Academy reviews the number of midwives accessing their clinical leadership programmes and enables talent management for midwives through improved marketing.
12. Department of Health, Midwifery 2020 steering group and the SHA develop and promote a Midwifery Career Pathway.
13. The Non Medical Consultant Panel enhance its engagement with the midwifery profession to maximise approval rates by:
 - increasing membership to include current Midwifery Consultants
 - promoting the partnering of applicant organisations during the application process
14. The North West Non Medical Consultant Panel undertakes regular review of compliance with approval submissions surrounding the clinical component of a Midwifery Consultant's role.
15. The SHA, in partnership with the service commissioners, progresses with a programme that sees the optimum number of Consultant Midwives outlined delivered by 2010, ensuring sufficient clinical leadership within organisations, and safer birth standards, are achieved.
16. Maternity providers enhance the interface between Primary Care and maternity services by ensuring the Midwifery Consultant role has its key public health functions clearly articulated and focused on.
17. In addition to the development of more Midwifery Consultants, that a greater proportion of roles are embedded within primary care..

Conclusion

This report has indicated that there are challenges and barriers which need to be addressed in the North West if an increase in both capacity and capability in the Consultant Midwife role is to be both successful and achievable. By exploring these areas with the expert groups, the region has obtained valuable information regarding the measures which are now necessary for further consideration. This information should therefore form the basis on which future work on this subject is built and provide continuing evidence of the workforce development needs of the maternity workforce.

Safer Childbirth (2007) recommends the recruitment of at least one Consultant Midwife per 900 births in order to provide adequate clinical leadership. For the North West this would equate to 98. There are currently seven with the region.

Introduction

BETTER CARE

BETTER HEALTH

BETTER LIFE

The role of Consultant Midwife has continuously evolved since its launch in 1999, making a significant contribution to improving the health outcomes of women, transforming midwifery practice and providing greater choices, access and quality from maternity services.

Early government pledges in the NHS Plan that there would be 1,000 nurse consultants within the NHS by 2004 have been achieved, with 1,020 posts recorded on the Electronic Staff Record by February 2010. However, there has been little national guidance over the years to suggest the optimum number of Midwifery Consultants to ensure sufficient clinical leadership within organisations, despite the significant benefits these roles offer.

Prior to *Safer Childbirth*, there was nothing available to focus attention and guide capacity building for these roles, resulting in significant variation in the rate and degree of growth in the numbers around the UK. Rather, the need for these senior clinical posts has been determined at local level, and their creation based largely on an organisation's ability to afford them.

The recommendations outlined in *Safer Childbirth* suggest that maternity providers should aim to appoint one Consultant Midwife for every 900 births undertaken. In the North West there are currently 11 Consultant Midwives, four of whom are temporarily occupying Head of Midwifery positions. If the recommendations are to be embraced, this would require a total of 98 Consultant Midwife positions. This is recognised as an ambitious figure but with such a significant regional variation it was essential that NHS North West made increasing capacity for these roles a priority.

This report sets out to explore the role of Consultant Midwives in the North West, the benefit the role offers to the care of mothers and babies, the barriers to role development and successful recruitment into Consultant Midwife posts, outlining solutions which would improve the region's capacity enabling compliance with the recommendations set out in *Safer Childbirth*.

It sets out its findings on the roles and responsibilities of Consultant Midwives working within the North West, their expectations and those of the maternity providers whilst identifying barriers which hinder progress in building capacity and presents a number of recommendations to overcome these barriers.

Background and context

Background

Consultant Midwife posts were first introduced in 2000 following the implementation of *Health Service Circular 1999/217*. The purpose of these posts was to provide better outcomes for patients through improved service and care quality and by the establishment of consultant practitioner positions which would strengthen nursing and midwifery leadership, improve career opportunities and assist in the retention of experienced clinicians. It was widely recognised that the traditional career pathway for midwives took them away from hands-on care into management or midwifery education.

National drivers

The NHS Review (2007), supported by the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Royal College of Nursing recognised that clinical leadership and the recognition and promotion of talent is key to developing NHS services for the future. This was reinforced by the recent *King's Fund independent inquiry into safety of maternity services (2008)* which highlighted that absent or poor leadership had significant impact upon safety – a view further enhanced by the findings of the *Centre for Maternal and Child Enquiries Report (2009)*.

Furthermore, the *National Service Framework and Maternity Matters* require that childbearing women are able to choose from a number of high quality, evidence-based maternity services in order to access the care that they feel best meets their own needs. To support this, the Royal Colleges produced *Safer Childbirth (2007) Minimum Standards for the Organisation and Delivery of Care in Labour* which made a specific recommendation that NHS maternity services should have the following:

- at least one Consultant Midwife (though preferably one per 900 births) in order to provide clinical leadership
- increased involvement of Consultant Obstetricians on the labour ward. Consultant Obstetricians are now required to provide 40 hours of cover a week to labour ward

Going forward, the *MARMOT Review (2010)* and the *Midwifery 2020 Programme* recognise that strengthening this clinical leadership is vital if maternity services are to meet the changing needs of families.

Regional drivers

The region's vision for the NHS, as outlined in *Healthier Horizons for the North West (2008)*, states its commitment to the development of clinical leaders with strategic capability which is enhanced by the 140 non medical consultant posts developed since 1999, 8% of which have been in midwifery.

Clinical context

The King's Fund independent inquiry (*Safe Births: Everybody's business*) and the Healthcare Commission's review of maternity services (*Towards Better Births, 2008*), identified common areas for improvement in maternity services. These included leadership, staffing and training, and communication.

Specifically, the King's Fund inquiry found that North West maternity units lacked adequate clinical leadership, which raised concerns around both the quality and safety of maternity care in the region. It suggested that this gap could be bridged by the role of Consultant Midwife as the primary remit of their role is to provide clinical leadership. It was recommended that this be deemed a priority for future investment by the North West's maternity services.

Currently there are 67 consultant midwives in the UK, with over 95% being employed in maternity services provided in England. There are currently 11 Consultant Midwives in the North West although four of these are now in acting positions as Heads of Midwifery.

As stated, 98 consultant midwives would be required to meet the ratio of one per 900 births (at the 2012 birth rate), which is unlikely to be achievable since the talent pool of Consultant Midwives is still too small. Aiming for one Consultant Midwife per birth environment (not provider) would be a more realistic target for the North West and would require an additional 27 Consultant Midwives. It is recognised, however, that in light of the current fiscal challenge; the

increasing birth rate and static workforce profile means any increase in capacity will also need to deliver significant productivity gains, requiring creative and visionary clinical leaders who can facilitate the necessary changes. The Consultant Midwife is ideally placed to progress this.

Of the 660,000 deliveries conducted per annum, at least 60% of all births have a midwife as the most senior professional in attendance (maternity statistics for 2008/09) yet it is Consultant Obstetrician posts that have been increasing steadily over the last few years to 1,400 in the UK. However, growth in Consultant Midwives has not been at a comparable rate. If it is accepted that senior clinical presence improves clinical outcomes on labour wards, then senior presence within midwifery-led birth centres must surely be as important. This would certainly support the case for increasing the number of Consultant Midwives, especially in the light of the government's pledge to provide all pregnant women with a choice of birth location and also to provide support for its campaign to promote normal births.

Midwifery had different historical beginnings to nursing with a completely different legislative process culminating in *The Midwives Act (1902)* which promoted a division of labour between midwives and medical men that increasingly discriminated between assistance and intervention in the process of labour.

The drive within the profession is to re-evaluate and revalue their contribution to promoting normal birth. A Consultant Midwife is perfectly placed to champion this cause, especially since the boundaries between what is considered to be a normal or abnormal pregnancy and childbirth are constantly being reviewed and redefined. For the significant majority of midwives, their role solely as practitioners of normal birth is continually being tested as they are required to adopt increasingly medicalised practices in response to organisational and societal changes. To counter this medicalisation, it is important that clinical areas encourage midwives to provide high level clinical leadership that looks beyond current constraints, seeking creative solutions to institutional problems. It is argued that the

Consultant Midwife remains best placed to achieve this.

Maternal and foetal deaths in the UK have thankfully declined over the years. As a result, society now expects a pregnancy and birth to result in a live mother and baby. Sadly, when this is not the case, society feels compelled to apportion blame. There is a common belief that expectations within society have increased and this has been suggested as a probable reason for the apparent growth in complaints and litigation. Indeed, it is felt that when expectations are not met, the ensuing dissatisfaction frequently leads to legal action being taken against NHS organisations. This has led to women being granted procedures which are not clinically indicated owing to the fear of litigation by maternity care providers.

The forces which fuel expectations are difficult to define precisely, although the publication of the *Patient's Charter (1999)* and *NHS Constitution – Securing the NHS Today for Generations to Come (2009)* combined with increasing public access to information technology has done much to inform society of the standards of care it can expect from its care providers.

Since 1995, the advent of greater choice, increased media coverage of celebrity births and perceived convenience of Caesarean section births as compared to normal vaginal births has seen a steady increase in the proportion of Caesarean section (CS) births in England. In 1989/90, CS accounted for 12% of births. In 2005/6 that rate had doubled to 24% and in 2008/9 the rate was found to have risen to 24.6%.

Yet if we consider, from a quality and productivity perspective, that the average cost of delivery by CS has been estimated at £1,701, while vaginal delivery has been shown to cost an average of £749 it can be seen that a 1% rise in the CS rate is estimated to cost the NHS an additional £5 million per year (Audit Commission, 2002). Furthermore, statistics show that women who undergo spontaneous vaginal birth spend an average of one day in hospital after delivery, those who undergo instrumental deliveries spend an average of one to two days in hospital after

delivery, whereas women who elect to have a CS spend an average of three or four days in hospital after delivery (Hospital Episodes Statistics, 2004). Yet perversely it can be argued that these current price variations can act as incentive for continuing the growth trend in CS.

Subsequently, *High Impact Actions for Nursing and Midwifery (2009)* identifies the promotion of normal births as being one of the targets the NHS is committed to improving, yet maternity statistics for 2008/09 show that in England around 60% of women who had their baby in hospital had a normal birth (*HES Online, 2009*).

Although those Consultant Midwives working within the North West with a remit to promote normal births have not been in post long enough to fully evaluate their impact upon the organisation's CS and homebirth rates it is recognised nationally that, through effective clinical leadership, these roles have a positive impact upon these figures. This report looks to test this further.

Workforce context

Whilst there is no specific definition of the role of Consultant Midwife, NHS Wales (2009) describes the non medical consultant practitioner as being:

“... an expert in clinical practice, bringing innovation and influence to clinical leadership as well as a strategic direction in a particular field for the benefit of patients/clients. A consultant practitioner will exercise the highest degree of personal professional autonomy and decision making and will work beyond the level of practice of clinical specialists and others with extended or advanced roles.”

This is expanded further by the *Career Framework for Health* (see Appendix Five) which acknowledges that a non medical consultant practitioner routinely functions at Level 8 and is described as:

“staff working at a very high level of clinical expertise and/or (having) responsibility for (the) planning of services with the role focusing on four key aspects:

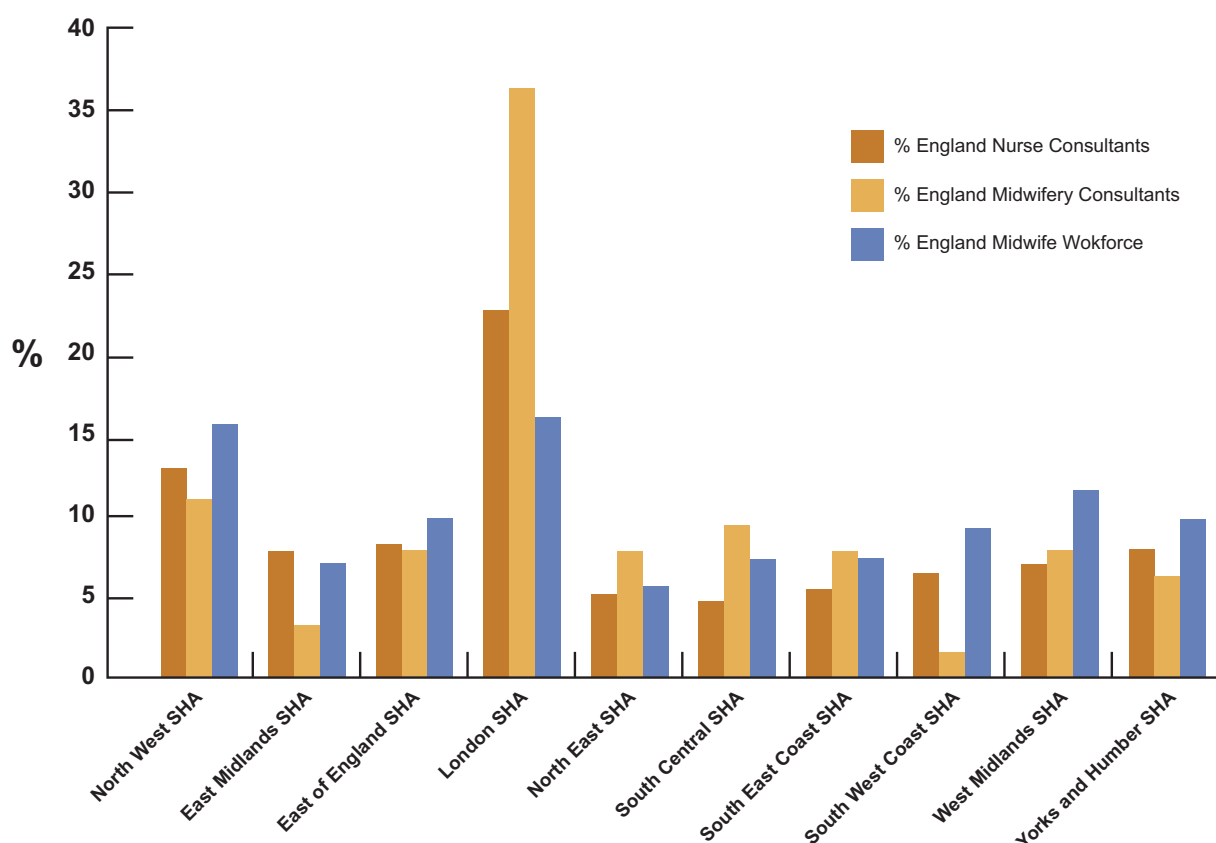
- 1. Provide expert professional advice to clients, carers and colleagues***
- 2. Undertake research in a specialist area***
- 3. Provide education and training to other staff and students***
- 4. Ensure the maintenance of clinical excellence.”***
(National profiles for midwifery, 2006)

It is widely recognised that the title Consultant Midwife should have real and consistent meaning and should therefore only apply to those appointed to approved posts, with midwives who meet the appropriate level of competence. The title should not be conferred solely in recognition of excellence or innovative practice.

In addressing their skill mix, organisations are challenged to consider Consultant Midwives, Advanced Practitioners and the maternity workforce in respect to their service delivery model recognising the added value each role and function provides. The added value of the Consultant Midwife is the ability to provide an effective and dynamic link between clinical practice and service development, supporting new models for delivering client care. Furthermore, maternity care is increasingly being moved into the community setting to meet the recommendations of the *Maternity Matters* report. Subsequently, NHS organisations are encouraged to develop posts across a range of services.

National and regional workforce demographics

Table One: Proportion of England's workforce



Strategic Health Authority

The NHS in the North West employs 16.2% of England's midwifery workforce yet only employs 11.1% of the available Midwifery Consultants, whilst it employs only 15.2% of the English nursing workforce but employs 13.1% of the Nurse Consultants in England. It is important if we are to achieve the aspirations of *Safer Childbirth* that energy be spent on improving this position. It is also apparent from the graph, that the proportion of midwifery consultants is greater than

that of nursing in the London, North East, South Central, South East Coast and the West Midlands SHAs, whilst in the North West this fails to be the case, suggesting that the North West could do more to build capacity in these posts so bringing the numbers in line with the other SHAs. This is further reinforced if we consider that the North West has 13.1% (88,167) of English live births (672,809).

Role and function of the Consultant Midwife

In 2006, the Royal College of Midwives (RCM) commissioned a report (*Articulating the work and impact of the Consultant Midwife role in the UK*) to review the work undertaken by Consultant Midwives. The aim of this report was to develop an evidential case for successfully promoting this role, which was built upon four specific areas:

- expert practice
- professional leadership and consultancy
- education, training and development
- practice and service development, research and evaluation.

By undertaking a 'scoping exercise' among Consultant Midwives, it was hoped to distill from their achievements and experience a compelling and credible evidential argument for the continuance and promotion of this role as a vital rung in the leadership ladder.

The focus of the Consultant Midwife's role will usually fall within specific areas of responsibility. These areas, or remits, are as follows:

- public health
- normal childbirth
- midwifery-led services
- intrapartum care
- practice development.

By looking at the four key areas which define the role of the Consultant Midwife, the RCM report found that they incorporated the activities identified in Table Two (a). NHS North West then tested these views during its' interviews with Consultant Midwives and was able to find significant congruence. This therefore suggests that national evidence is equally as applicable within the North West service delivery context.

Table Two (a): RCM report summary of Consultant Midwife activities

<p>Professional leadership and consultancy</p> <ul style="list-style-type: none"> • Provide advice on policy and guidelines concerning pregnancy, childbirth and associated complexities locally, nationally and internationally. • Contribute to publications, interviews, and peer-reviewed journals; presents to media, local and national audiences to promote best practice and matters affecting public health. • Advise and provide clinical support for midwives in complex cases. • Lead partnerships with other agencies, internally and externally, and informs commissioning arrangements. • Secure local authority or private funding for projects or services, and also often undertake the role of SPOC (Single Point of Contact) for child-protection issues. • Lead multi-agency and cross boundary approach. • Promote the role of midwife. • Improvement in – and development of – maternity services. • Develop care pathways and lead on the development and implementation of a variety of action plans reviewing maternity services in partnership with Head of Midwifery. • Ensure local and national policy is disseminated and implemented. • Provide a visible clinical leadership presence. • Secure external funding for research essential to the development of practice. 	<p>Expert practice</p> <ul style="list-style-type: none"> • Spend 50% of the time in the clinical environment. • Develop guidelines governing practice. • Advocate for women at ward rounds - contribute to the care-plans of the women, challenging any decisions. • Undertake case load management of women who may need additional support. • Instigate the referral for vulnerable groups to partner agencies thus ensuring continuity of service. • Provide expert clinical advice. • Lead the care to the socially excluded and vulnerable. • Develop Birth Centres. • Instigate multi-disciplinary discussions with regard to a variety of issues affecting women, thus pushing back boundaries. • Champion the promotion of normal childbirth. • Act as an agent for change. • Network at strategic level and implement national and regional policies. • Contribute to strategic steering groups. • Form partnership with local authorities to establish Children's Centres and ensure that midwives have a presence there. • Participate in NICE Clinical Guideline Development Group.
<p>Practice and service development, research and evaluation</p> <ul style="list-style-type: none"> • Lead the audit process regarding topics such as midwifery-led care. • Benchmark good practice. • Undertake primary research. • Contribute to research and strategy groups. • Members of university research and development departments. 	<p>Education, training and development</p> <ul style="list-style-type: none"> • Participate in and lead on multi-disciplinary education and training. • Programmes on areas such as public health and Children's Centres. • A member of the curriculum planning group. • Organise and facilitate mandatory training days on topics including ALSO skills drills and neo-natal life support. • Joint appointments between Higher Education Institutions and Trusts.

Table Two (b): North West findings

<p>Professional leadership and consultancy</p> <ul style="list-style-type: none"> • Leads the strategic development of midwifery. • Promotes effective communication among professional groups. • Provides expert advice and opinion to a variety of disciplines. • Acts as a mentor and role model. • Acts as a resource both internally and externally. • Implements innovative practices within the organisation. • Acts as a change agent for services and practice. • Works collaboratively. • Influences strategic panels/forums and Trust boards. • Influences staff culture and attitudes. 	<p>Expert practitioner</p> <ul style="list-style-type: none"> • Provides expert knowledge to inform midwifery practice. • Makes key decisions where precedents do not exist. • Has direct involvement in clinical practice. • Attends at homebirths and complex cases, VBAC clinics. • Creates evidence-based clinical guidelines and policy formation. • Is an advocate for women. • Acts as an advisor regarding best midwifery practice. • Makes critical judgements to meet the expectations and demand on service. • Undertakes workshops and focus groups to generate views. • Leads on the midwifery governance strategy. • Participates in benchmarking groups. • Disseminates evidence-based practice within the organisation.
<p>Practice and service development, research, audit and evaluation</p> <ul style="list-style-type: none"> • Critically appraises and applies research findings. • Creates evidence-based guidelines. • Participates in research committees/forums. • Disseminates new evidence and research findings. • Creates a culture of research awareness. • Implements audit of practice and services. • Participates in primary research. 	<p>Education, training and development</p> <ul style="list-style-type: none"> • Leads on the development and monitoring of practices. • Provides a named link for Higher Education Institutions. • Undertakes lecturing. • Develops multi-disciplinary education and training programmes. • Incorporates national recommendations into local practice. • Facilitates skills drills and implements action plans. • Advises on student curriculum. • Member of the Board of Studies.

Clearly, across a complex service model significant consideration needs to be given to the skill mix of the workforce and the added value that the Consultant Midwife offers. To enable this, a clearer understanding of the role and function of other practitioners is required. These can be summarised as:

Specialist practitioner

- Specialist for own area of work.
- Assesses women, plans, implements care and supervises other staff.
- Acts as a source of advice and expertise within own speciality. Leads changes in clinical practice and contributes to service development through ensuring all clinical practice is evidence and research-based.

(National profiles for midwifery, 2006)

Specialist practice requires in-depth knowledge and experience within a specific area, often clinical, that enhances the practice and responsibilities of the role. Specialisation can occur within the midwife's required standard of practice or it can denote advanced learning at a level of practice in a specialism that is more advanced than the competencies associated with initial registration. The level at which this practice is then undertaken will vary and can be described as horizontal development.

Advanced (higher level) practitioners

- Provides specialist care for a specific group.
- Advises other midwives in related matters.
- Shares specialist knowledge.

(National profiles for midwifery, 2006)

Advanced practitioners have been defined as proficient health care professionals who provide a high level of expert evidence-based practice and clinical expertise in a specialist area. They are experienced practitioners with decision-making autonomy, responsibility and accountability and they contribute to the leadership, education, development and supervision of others. The advanced practitioner works collaboratively with others or independently to meet the needs of the patients and their families. They assist with the education and development of other staff, and

assist with the development of clinical services and advanced practice (*Salford University, 2004; NHS Wales, 2009*).

Modern Matron

- Manages and provides leadership for ward managers and specialist midwives and other staff.
- Ensures client/carer involvement in development of services and standards of cleanliness.
- Provides specialist education and training to other staff.

For many, the primary focus of a matron appears to be around ensuring a safe and clean clinical environments exist.

“The role of the matron should focus on providing a clean environment for care, ensuring best practice in infection control, improving clinical care standards, and treating patients with dignity and respect.”

(Professor Christine Beasley, Chief Nursing Officer, 2007)

When considering these different roles it can be seen that the level and depth of leadership, clinical expertise and research input required appears to be what differentiates them from each other.

Furthermore, when accounting for the variation in level descriptors within the knowledge and skills framework (KSF), the importance of the appropriate skill mix is further reinforced (see Table Three). One that sees the role of the Consultant Midwife as a key.

Table Three: KSF Descriptors

KSF descriptors - level of practice

Consultant practitioners level 4
 Matrons level 3-4
 Advanced practitioners level 3
 Specialist practitioners level 3

The added value of the Consultant Midwife role

As described, many enhanced roles in midwifery exist. However, owing to the multi-environmental nature of midwifery care, a high standard of clinical leadership is required to reduce the current expenditure on acute services. The facility to provide for normal births, shorter in-patient stays and an increased Primary Care Trust (PCT) requirement for additional community-based services may be most effectively organised by a Consultant Midwife.

A suggested role profile for the Consultant Midwife as lead for normal childbirth may be gleaned by reviewing the requirements in *Safer Childbirth*, which promotes the view that there should be one Consultant Midwife/900 births and one/birth environment. This will lead services towards – and encourage the midwifery workforce to develop the abilities to sustain – the integral philosophy informing *Making it Better* (Department of Health 2007), which advocates:

- safer care
- improving access and outcomes
- more choice
- promoting normality
- home like birth environment
- local ante and postnatal services closer to home.

Clinicians should be taking the lead in developing future NHS services, in keeping with Lord Darzi's recommendations. It is vital that an experienced midwife, imbued with leadership and clinical skills which are on a par with her Consultant Obstetric and Neonatal colleagues, helps to drive maternity services towards the full implementation of the North West core pathway for birth.

The benefits of employing a Consultant Midwife may be seen in a variety of ways which are readily measurable.

- The role results in improvements in the workplace, both culturally and clinically (evidence-based guidance).
- Less intervention in costly areas (a reduction, perhaps, in epidurals in the drive towards achieving normality in birth). Additionally, by reducing the length of a postnatal stay can reduce a unit's square footage of space thus impacting positively on Trust overhead costs. This is particularly important where there is a Level 3 Neonatal Intensive Care Unit (NICU), since postnatal blockages lead to bed blocked labour wards and the subsequent inability to accept patients for an available neonatal cot loses the Trust in the region of £2,000 per NICU cot per day.
- Consultant Midwives provide organisations with practitioners who are able to bring both operational and strategic perspectives to the role, thus facilitating developments within the service which are focused on the client.
- The speciality will be championed and promoted by high-impact leaders who are clinically and strategically aware, thus reflecting well on the organisations that employ them.
- Consultant Midwives act as role models in the clinical environment, highly visible and able to empower midwives to employ techniques revealing safeguarding issues.
- The role will align with an organisation's Risk Management Strategy assisting the Trust to achieve a higher Clinical Negligence Scheme for Trusts (CNST) level and reduce compensatory payments.
- The role provides leaders who are clinically expert and equipped to deliver a higher quality of healthcare to women and their families.
- The role will increase the status of midwifery as a profession and encourage Trusts to improve care in a variety of ways by facilitating the normal birth initiative.

- The role provides scope to work across professional and organisational boundaries. The role maximises the potential for clinically focused research, educational opportunities and provides a multi-dimensional perspective at operational and strategic level to facilitate service development.
- The role provides an alternative to a purely management function enabling continued involvement in the clinical area, this facilitates retention of experienced staff in the clinical area, promoting best practice for women, by staff across the service.

A simple mnemonic helps in summarising these benefits.

Creates a positive image for the profession

Leading and improving services

Instrumental in interpreting and implementing Government policies.

Multi-faceted

Better outcomes for women achieved

Influencing strategic policies and the midwifery vision for the future.

Necessary in providing clinical leadership and a career pathway for midwives

Generating user involvement and **G**etting it right for the public

Additionally the following mnemonic can be used to describe the skill set needed.

Committed, credible and confident

Optimistic and organised

Negotiator

Supportive, sincere and sales person

Understanding

Loyal

Tenacious

Analytical, astute and approachable

Nurturing

Tactical

Motivational

Influential and inspirational

Decisive and driven

Wise

Innovative

Facilitator and flexible

Emotionally intelligent

As we have seen the Consultant Midwife's role encompasses greater leadership and research responsibilities than the other roles outlined. This is important for commissioners and providers to understand when considering the service delivery model and supporting workforce. Some examples of these benefits are outlined in the following case studies.

Table Four: Consultant Midwife case studies

Case studies illustrating the added value of the Consultant Midwife role.

Consultant Midwives - making a difference

Debbie Garrod is a Consultant Midwife who works in Stockport NHS Foundation Trust. She has held this position since 2002 and has a remit for public health. During her time in post Debbie has provided professional leadership on all public health issues within maternity services, and also taken the lead on a range of initiatives designed to promote normal childbirth.

This strategic role has enabled Debbie to make a difference to more parents and also to be in a position to articulate and demonstrate the role of the midwife as public health practitioner and 'change agent' in a broader arena.

She is currently responsible for the following:

1. Working with Local Authority colleagues in Children's Centres and the re-location of maternity services in the Centres. This includes postnatal drop-in sessions.
2. The development and implementation of a service user strategy which will lead later this year to the re-forming of the Maternity Services Liaison Committee (MSLC). The Service User Forum Group 'Talkback!' now meets every six weeks and the feedback and suggestions from the parents who take part are brought straight into the service
3. Following the Trust's selection as an 'early adopter' for the NHS Institute for Innovation and Improvement Toolkit for promoting normal births, she has been actively involved in leading the development of the Vaginal Birth After Caesarean (VBAC) service. The Trust is now focusing on promoting normality in the first pregnancy and birth and have just started a one-day (mandatory) public health study day which includes a session on this topic for all midwives.

The role has enabled Debbie to continue to practise clinically as well as to develop services, provide teaching and training and carry out research and audits. Supporting midwives to develop their own practice and to improve services for women has been the key.

Contact details

Email debbie.garrod@stockport.nhs.uk

Consultant Midwives - making a difference

Nicola Parry is a Consultant Midwife who works in Blackpool Fylde and Wyre NHS Foundation Trust. She has held this position since 2009 and has a remit for normal childbirth. During her time in post Nicola has focused on developing services which promote the normal birth agenda and increase the choices pregnant women and their families receive.

Nicola's role as Consultant Midwife has enabled her to have tough discussions with midwifery and medical colleagues in order to ensure practice is based on evidence as opposed to merely tradition or routine. By asking questions, challenging practices, and providing a visible leadership presence, the culture within the organisation has undergone a positive change.

In the 12 months since her appointment:

- the Caesarean section rate is down by 4-6%
- the creation of normal birth rooms has reduced the length of stay for women and heightened the quality of the birth experience with a resultant implication of lower costs shouldered by the Trust
- there are fewer women opting for pharmacological relief in labour and more women requesting water births
- the home birth rate has increased by 3% and is led by an enthusiastic team of midwives
- Nicola has also introduced a process for reviewing critical incidents which have occurred on the unit, adopting a multi-disciplinary, lessons-learned approach.

This strategic role has enabled Nicola to make a difference to more parents and also to be in a position to articulate and demonstrate the role of the midwife as a 'change agent' in a broader arena.

Contact details

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Telephone 01253 655647

Consultant Midwives - making a difference

Faye MacRory is a Consultant Midwife who works in Central Manchester University Hospitals NHS Foundation Trust. She has held this position since 2001 and has a remit for public health. During her time in post, Faye has focused on developing services which reduce health inequalities and promote choice for all women, especially those involved with substance misuse.

Faye created the UK's first Specialist Midwifery Service (Manchester Specialist Midwifery Service – MSMS) in April 2001. It specialises in providing a service to women and their families where:

1. drug/alcohol use and mental health is problematic
2. support and co-ordinated care is provided to HIV positive women identified through the antenatal HIV screening programme
3. a wide range of training is provided to maternity and other services which include domestic abuse, brief interventions in alcohol and antenatal HIV testing. This involves collaboration across a wide range of both statutory and voluntary health and social care agencies in addressing the complex issues associated with mental health, domestic abuse/violence, sexual abuse, prostitution and HIV
4. MSMS is an innovative and dynamic service that has achieved national and international recognition. It has an extremely good reputation among partner agencies and stakeholders, and was described by a number of representatives and clients as providing an 'invaluable' service.

5. MSMS provides accessible, responsive, client-centred and holistic support to some of the most vulnerable women in Manchester. The service was popular with clients who appreciated the additional support and empathetic way it was delivered. MSMS uses creative and practical approaches to engage and support clients who are both hard to reach and hard to help. The service plays an important role in helping to co-ordinate and share information from different agencies supporting these vulnerable women during the pregnancy continuum.

In July 2003 Faye was named Outstanding Achiever of the Year in the Health and Social Care Awards at the Department of Health. Additionally in July 2004, the Service was awarded a Certificate of Commendation at the House of Commons by the All Party Parliamentary Group on Maternity for its innovative practice in maternity services. Faye was also a finalist in both the Nursing Times Awards and the Greater Manchester NHS Awards in 2005. In 2006 Faye completed a Master's degree in Collaborative Health Care which focused upon the partnership between the NHS and prison healthcare. Faye has also had a number of articles and chapters published. Demand for the service has grown considerably and Faye is approached and recognised internationally as an expert in this field due to her pioneering work. The role of Consultant Midwife has enabled Faye to influence the care women across the world now receive.

Contact details

Email faye.macrory@cmft.nhs.uk

Consultant Midwives - making a difference

Anita Fleming is a Consultant Midwife who works in East Lancashire Hospitals NHS Trust. She has held this acting position since 2008 and has a remit for public health. During her time in post Anita has focused on continuing the work undertaken by her predecessor by developing services which reduce health inequalities in the area.

Anita's greatest achievement has been the creation of a social needs assessment tool (SNAT) as a result of the high infant mortality rate in the area. Anita discovered that the right questions were not being asked to ascertain the woman's risk of infant mortality during the booking visit and it was apparent that a more effective infant risk assessment was required. The SNAT is going to be implemented at the booking visit, information is updated at the 28-week antenatal clinic visit and again postnatally. It involves working in collaboration with GPs, health visitors, the police, social services, councillors and other members of the multidisciplinary team in order to improve communication across boundaries.

Anita's leadership role as Consultant Midwife has enabled her to have a positive impact upon the services provided to all women and their families but especially amongst vulnerable groups. Through strategic and collaborative networking she has been able to act as an agent for real change.

Contact details

Email anita.fleming@elht.nhs.uk

Consultant Midwives - making a difference

Eileen Stringer is a Consultant Midwife who works in Pennine Acute Hospitals NHS Trust and has held this position since 2001. She has a remit for public health.

The aim of the post was to achieve a coherent high quality service that reflected and took into account the wider health and social needs of women and their families. The intended outcome was to integrate community midwifery particularly into a social model of care that was firmly embedded into the wider community framework and had a high profile with women and families. Partnership working was a key objective.

The process was largely financed by external funding over the last seven years from a number of sources including the Department of Health, the Neighbourhood Renewal Fund, New Deal for Communities, the Teenage Pregnancy Grant, Sure Start, Local Authority and Primary Care Trust. The Acute Trust has also committed to funding key posts and has mainstreamed some of the posts that were originally externally funded. Much of the funding has been steadily reducing over the last few years and the changes continue to be integrated into the main workforce. Within the next two years there will be very little external funding.

Through her role as Consultant Midwife and her ability to work strategically, Eileen has changed the community midwifery service into a group based model which is the same across all four communities. Each group has a leader who is responsible for implementing the model of care within her area. The model of care is explicit as to the standard of care we need to achieve. The model is supported by policies.

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The full case studies are found in Appendix One

2010 North West non medical consultant profile

The North West currently employs **16.2%** or 4,155 of the total number of midwives working within the NHS in England (NHS North West LSA Database); and of this number, only **0.28%** are Consultant Midwives. In comparison, the number of nurses within the region totals 44,275.72 and with a significantly greater proportion being consultants (**0.32 %**). It can be seen that nursing has fared better than midwifery and the allied health care sector when it comes to the investment in non medical consultant roles, due to the specific focus applied through the national policy agenda. This is reflected in the number of applications submitted to the Non Medical Consultant Panel (see table five), further compounded by a limited success rate in approval (50%).

Table Five: Comparative statistics for the growth in Consultant Midwife numbers in the last five years compared with nursing and allied health care.

Discipline	Application approved by SHA approval panel	Successful appointment
Nursing	30	30
Allied Health Professionals	12	12
Midwifery	8	4

Of the three groups highlighted in the table above, the midwifery profession appears to have significantly less growth in its Midwifery Consultant workforce than the other groups. There are a number of potential reasons for this:

- difficulty with Consultant Midwife applications and/or approval process
- a lack of understanding and value of the Consultant Midwife role
- a lack of midwives with adequate skills/expertise required for the Consultant Midwife role
- a lack of appropriate preparation in terms of CPD opportunities for midwives
- other workforce issues are given greater priority for investment within midwifery services.

Within the North West, both nursing and allied health care professions appear to be investing in these non medical consultant posts more than any other group. There is therefore potential for further exploration to identify why these disciplines have chosen to increase their clinical leadership roles within their workforce and why midwifery has not, especially in view of the national and regional drivers which exist for midwifery.

The North West births ratio is **1:28** which is line with national average (1:2, March 2008). The 2009 figures are not yet available. The London ratio of midwives to births is **1:30** (December 2008). From these figures, it would appear that both the North West and London regions' Trusts (London to a slightly lesser degree) are choosing to invest their workforce budgets in the creation of other midwifery roles rather than investing in building the capacity of Consultant Midwives posts. This choice to increase midwife numbers by maternity service providers may be an attempt to achieve the 1-1 care in labour as recommended by the Royal Colleges in 2007 and CMACE (formerly the Confidential Enquiry into Maternal and Child Health – CEMACH) reports in order to improve safety and quality of care in labour. However, recent reviews of safety within maternity units have also emphasised as a priority for maternity services within the North West to increase investment in clinical leadership roles. Table Six separates the number of North West non medical consultants into their specific disciplines.

Table Six: Number of non medical consultant practitioners per discipline in the North West.

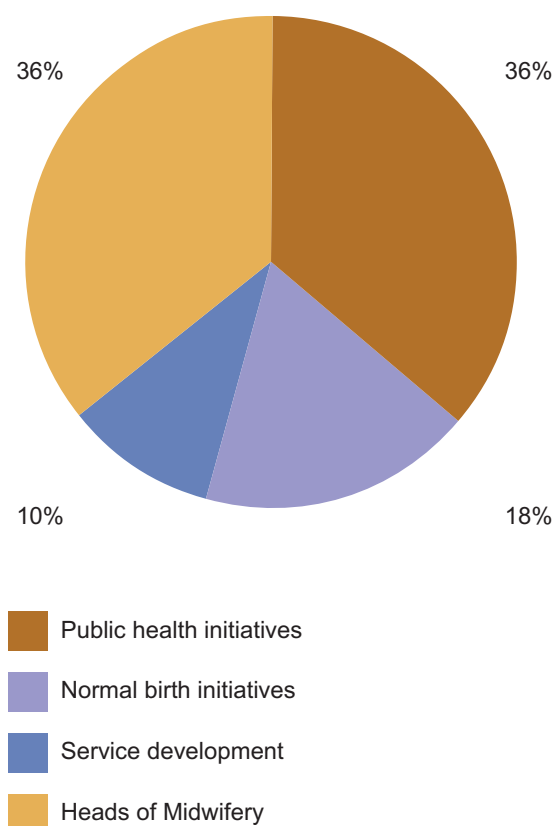
Physiotherapy	9
Paramedic	1
Nurse	86
Midwifery	11 (4 of whom are operating in other midwifery roles)
Occupational Health	1
Pharmacy	7
Radiography	3
Occupational Therapy	1
Podiatry	1
Dietician	1
Health Visiting	1
Mental Health	17

Within the North West, there are currently 11 Consultant Midwives. Three have taken on temporary roles as Heads of Midwifery and a further one is working in neonatology. Of the remaining seven Consultant Midwives, six are employed within secondary care, and one within primary care. All seven consultant midwives have a remit which focuses on one of the following:

- normal birth initiative – this includes reducing caesarean section rates, increasing normal and home birth rates and implementing the Maternity Matters agenda
- public health initiative – this includes reducing health inequalities, addressing areas such as teenage pregnancy, smoking in pregnancy, substance misuse, mental health needs, and domestic violence
- practice development and midwifery-led care – this includes developing midwifery-led services and increasing birthplace choices within localities, while addressing multidisciplinary training and practice development requirements.

The graph (Table Seven) below outlines the distribution of the Consultant Midwives across the region in terms of the current remit. It would appear that 36% of Consultant Midwives in the North West have a remit in public health, which is in response to the health inequalities that exist within the region. An equal percentage (36%) of those previously employed as Consultant Midwives have subsequently moved into other roles, such as Heads of Midwifery. Although there is a drive to move maternity services into a variety of settings, the role of the Consultant Midwife seems to be employed within secondary (88%) rather than primary care settings (12%).

Table Seven: North West Consultant Midwife remits



Focus of existing North West Midwife Consultants

Consultant Midwives in the North West have generally been recruited to those geographical areas with the highest levels of

social deprivation and poor health outcomes, although there are still areas with the same demographics and outcomes within the region that have yet to appoint to these roles. Social deprivation has been found to be a significant factor in adding to a person's chances of having poor health outcomes.

Table Seven demonstrates how the Consultant Midwife's role is increasingly focused on addressing public health issues (54%) with the prevention of risk as a fundamental component of this role. However, it is generally felt within the profession that many midwives are not trained or equipped to deal with families who have such complex and varied social challenges now presented to them. The Consultant Midwife's role is therefore vital in bridging this gap, by providing the clinical leadership, support and guidance midwives require in such cases, while ensuring that the women accessing maternity services within the region are given the best possible care.

Approval process

As identified in Table Five earlier, the approval rate of Consultant Midwives is low (50%) and may present a barrier to building capacity. To understand this consideration needs to be given to the North West approach. The North West Non Medical Consultant Approval Panel was established in 2000 in line with the principles outlined in the HSC 217/1999. The approval process is undertaken at regional level and panel members comprised representatives from nursing, midwifery, pharmacy and allied healthcare professionals (AHP) backgrounds as well as workforce modernisation and commissioning teams.

The key purpose of the panel has been to provide advice and expertise on new consultant positions and applications by providing the quality assurance required for such influential positions. Another function has been to guarantee the maintenance of a register of non-medical consultant posts for the region and to co-ordinate communication and developments on the non-medical consultant posts including benchmarking and trends.

This robust approval system undoubtedly achieves its function of ensuring posts are scrutinised for quality. However, feedback received during the process of undertaking this project would suggest that for the interviewees challenges exist in accessing this process.

These are that it is:

- time consuming
- too detailed
- overly complex
- a deterrent to application submissions
- not focused sufficiently on service requirements, i.e. how particular services wish to develop, based on their local population needs.

Supporting capacity building to the Consultant Midwife role in the North West

If, as identified, the North West requires an increased number of Midwife Consultants then we need to consider the ability of the system to respond. This includes:

- current workforce capacity/talent pool
- succession planning.

Increasing the talent pool of midwives who could successfully take up a Consultant Midwife post is particularly important in the North West for the following reasons:

- a significant percentage of Consultant Midwives currently in posts are over 50 years old
- the public health agenda and the obligation to decrease health inequality are issues which are particularly acute within the North West region. The greatest outcomes in maternity care have been made where consultant midwives are in post, some of whom have won awards
- the shape of many maternity services in the region is being remodeled and it is believed that it will impact positively by increasing the number of settings for intra-partum care for healthy women and rationalisation of sites for specialist maternity care. With the birth rate rising across the whole of the North West region, there will be an increase in demands upon services which will need to be governed by strong clinical leadership in the person of a Consultant Midwife. It is believed that there will be a requirement for a further 27 posts.

- although a number of Consultant Midwife positions have been advertised within the region, there has been a marked inability to recruit owing to a reported lack of skills/expertise within the senior midwifery workforce.

If we are to develop the talent pool required, greater utilisation of the existing talent management schemes offered by organisations such as the Leadership Academy must be realised especially when considering the existing workforce demographics which show a very flat structure (Table Eight) and the age profile of the existing midwifery workforce (Table Nine). It is recognised that at least 40% of the North West's Consultant Midwives will have retired within the next 10 -15 years.

If we consider those who may opt to retire at 55 under the current NHS pension scheme then at least 70% of the North West's Consultant Midwives may well have retired within 10 years. (There are no detailed figures on Consultant Midwifery turnover due to the small number of current appointees.) If we are to see the changes of the magnitude suggested by *Safer Childbirth* then good succession planning and talent management is of paramount importance.

Table Eight: Midwifery talent pool within the North West (excludes **number?** Bank/Agency midwives)

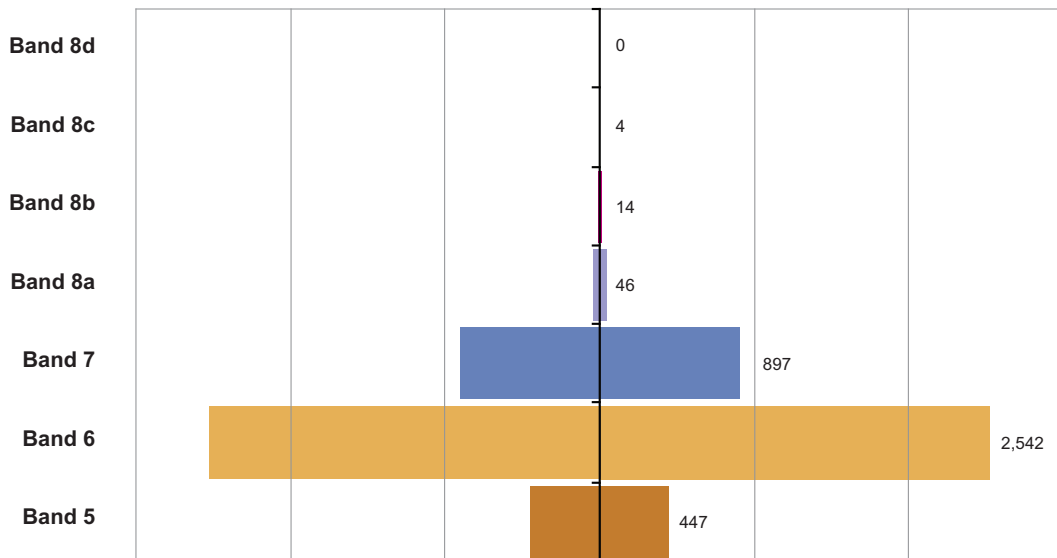
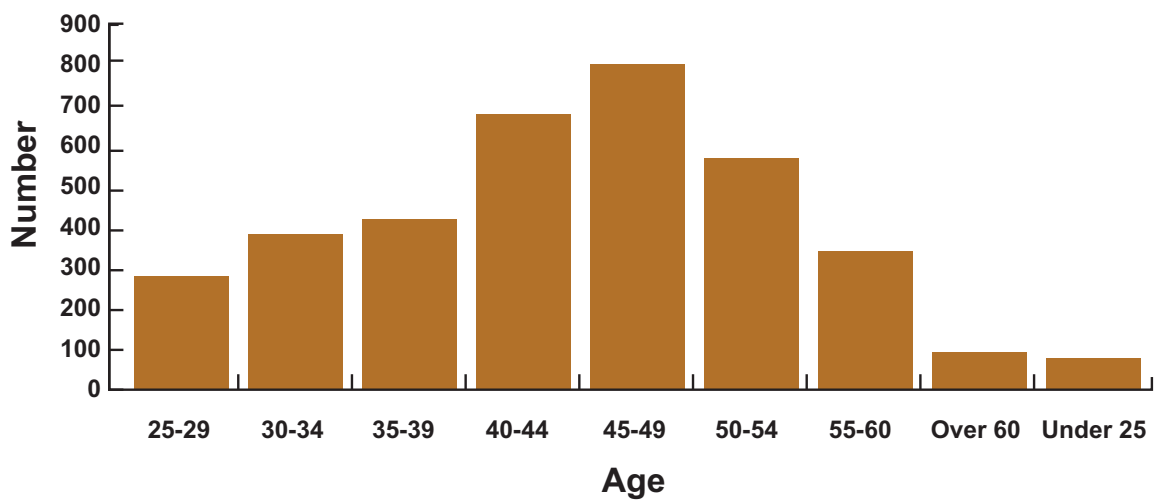


Table Nine: North West Midwifery workforce



At least **40%** of the North West's Consultant Midwives will have retired within the next 10 -15 years. If we consider those who may opt to retire at 55 under the current NHS pension scheme then at least **70%** of the North West's Consultant Midwives are likely to have retired within the next 10 years. There are no detailed figures on Consultant Midwifery turnover due to the small number of current appointees.

Succession planning for the role

At present, the general view within the profession is that succession planning within midwifery per se could be improved and needs to be aligned to commitments made in the Health Act 2009 (NHS Constitution) and be aligned to the national Career Framework identified in Appendix Six. Modernising and developing an organisation's workforce depends on robust workforce planning processes linked to education and training provision and on-going development of their existing workforce. Employers should address the short and long term needs for successors by investing in the development of its staff to ensure that it has a ready stream of capable individuals. Succession planning and succession management are crucial processes and should be an integral part of an organisation's Human Resource strategy. In addition to ensuring successors, the succession planning process allows an organisation to review its talent pool.

Further analysis of Table Eight suggests that members of these groups would require development in the following areas should they aspire to a Midwifery Consultant post.

- **Band 8a** (Ready or almost ready). This group offers the smallest numbers but would generally be the quickest group to develop to Consultant Midwife roles. These midwives would probably require selection by a portfolio of evidence, panel approval and/or CPD module top-up.

- **Band 7** (Ready, almost ready or not ready). This group consists of midwives who would potentially require the greatest variation in terms of their development. For those who possess a Masters degree, a portfolio of evidence and panel for selection may be sufficient. For others, CPD top-up modules and work-based learning opportunities may suffice. However, there will be midwives within this group who do not possess a Masters degree and would require significant development.
- **Band 6** (Not ready). These midwives account for the largest group within the midwifery workforce. It would be reasonable to suggest that most of this group would not possess a Masters Degree and would therefore need to undertake a bespoke programme similar to the band 5 midwives.
- **Band 5** (Not ready). This group of midwives is relatively small in number and would require the greatest amount of professional/career development. Most would probably need to undertake a bespoke Consultant Midwife Development Masters degree programme, similar to that in the South Central SHA. However, this may be difficult to implement at present as the Nursing Midwifery Council (NMC) requires that focus is on preceptorship of band 5 competencies and not additional educational courses.

NHS Education for Scotland has undertaken considerable work to address the issue of succession planning to the non medical consultant role within their region. An example of their work into succession planning involved the planned retirement of an existing non medical consultant post holder. To enable a clear understanding of the role, three potential candidates were provided with formal part-time shadowing experience for three months. Following this all were offered an opportunity to apply for the post, which resulted in the successful recruitment of one of the candidates. This was an example of how productive the effective use of existing resources can be and result in quality outcomes.

Methodology

BETTER CARE

BETTER HEALTH

BETTER LIFE

Methodology

In addition to the literature review and context setting described earlier, it was important to test the information with North West stakeholders. Two methods were employed to collect the experience and views from the expert group of stakeholders during this project: structured interviews with Heads of Midwifery and Consultant Midwives and focus groups of midwifery matrons, advanced practitioners, specialist practitioners and shift-co-ordinators. While both methods have inherent challenges associated with them, they were selected on their overall merits. Copies of all the questions can be found in Appendices Two, Three and Four.

The questions asked during the focus group sessions targeted four key areas and included:

- background, context and career progression
- roles and responsibility
- current CPD opportunities
- succession planning.

The questions asked during the structured interviews related to:

- local factors and appointment process
- better outcomes for women
- purpose and responsibility
- governance
- funding
- post alignment with Higher Education Institutions (HEIs)
- barriers to capacity building.

Sample selection

A sample of senior midwives from the three North West zones participated in three focus group sessions. These sessions lasted for approximately two hours and the groups comprised midwifery matrons, advanced midwifery practitioners, specialist practitioners and midwifery shift coordinators. The structured interviews undertaken lasted approximately two hours and focused on the Heads of Midwifery and Consultant Midwives who work together in three of the regions maternity units participated, along with three Heads of Midwifery from units without Consultant Midwives. In addition to these groups one maternity services commissioner also agreed to be interviewed. All those interviewed worked within one of the following:

- one District General Hospital
- one Foundation Trust (FT)
- one District General Hospital which was applying for FT status.

Purposive sample selection was undertaken to increase the probability of the findings being representative of the region's maternity providers.

Analysis

Information collected was analysed using thematic content analysis and common themes were identified.

Findings and implications

Structured interviews of Heads of Midwifery and Consultant Midwives

As described the expert reference group consisted of:

Consultant Midwives (33% male, 67% female) Heads of Midwifery (100% female) with all the participants being of white British origin. It is recognised that this is not reflective of the broader midwifery workforce.

Their views on the role and the direction of travel were explored enabling a series of recommendations to be created.

Background and context of existing postholders

While at present it is recommended that midwives have a minimum of five years post-qualification experience before applying for Consultant Midwife posts, a significant number of the group stated that they would prefer a minimum of between seven and 10 years, five years of which had been spent in a leadership capacity. However, it was also recognised that it was the experience to which the individual had been exposed which should recommend them for consideration of advancement into a consultant post, rather than their length of service alone determining suitability. The implication of this finding is that unless the issue of what constitutes the optimum career length of candidates applying for these posts is clarified and agreed, then there will be scope for subjectivity within employing organisations.

Recommendation

- The SHA organise an annual regional event which enables consultant midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users and increasing wider understanding of the role.

In terms of Consultant Midwives' prior experience, all those interviewed believed it was essential that aspiring Consultant Midwives should possess a

broad range of clinical experience which would equip them with the necessary range of skills and expertise. Such experience would cover all areas of midwifery care and it was felt that this was more likely to be achieved if individuals had worked for a number of organisations rather than gaining all their clinical experience in one setting.

It was felt that this variety should take the form of both primary and secondary care settings, especially in the light of the drive to move maternity care into an assortment of settings to improve client choice and access to maternity care. The group saw this as an exciting opportunity to create consultant posts which are embedded in primary care settings in the future, keeping the needs of the woman and her family at the centre of the services organisations provide.

Recent experience within antenatal, intrapartum, postnatal, community and both primary and secondary care settings were deemed vital in providing this broad knowledge base required for the role. Within this experience, the group saw an opportunity for senior midwives to undertake service improvement projects which would enable additional skills to be obtained such as project management skills, problem solving, negotiation, and innovative practices. However, releasing senior midwives from their usual duties was a source of concern for many of the group, especially in the current economic climate. Secondment opportunities were viewed by both groups as a viable option in assisting midwives to achieve the skills required for the consultant role. It was also acknowledged that there were challenges with regard to the recruitment to these posts and it was believed that this was owing to a perceived lack of senior midwives who possessed the required skills for the role of Consultant Midwife.

This would have implications for the existing provision of midwifery CPD in terms of its suitability to prepare midwives for these roles. However it would improve client choice and access to maternity care by supplying effective clinical leaders where they are needed to support midwives and influence care pathways.

Recommendations

- The CPD review ensures that the following skills, essential to Consultant Role Development, are able to be obtained from contracted provision: teaching, negotiating, influencing, leadership, and strategic networking.
- The SHA continues to drive inter-professional learning by opening up programmes traditionally aimed at other health professionals to midwives.
- In addition to the development of more Midwifery Consultants, that a greater proportion of roles are embedded within primary care.

When discussing which aspect of the role the Consultant Midwives felt had been the most difficult to achieve in an operational role, the majority felt that it was in the gaining of strategic awareness and input. This was considered to be a fundamental aspect of the consultant's role and it was felt that shadowing opportunities within organisations should be encouraged and made easier to access in order to assist aspiring consultants to achieve this experience and to bridge this developmental need.

“Having the title consultant gives permission to attend meetings, where high level decisions are being made – meetings that I wouldn't have access to otherwise, which means I am able to raise midwifery issues and influence executive decisions.”

(North West Midwife Consultant)

It was appreciated by most interviewed that investment into the senior midwifery workforce would have to be made if Consultant Midwife capacity within the region were to be built over the coming years. However, where that investment was to come from remained a matter for further debate. The implication of this finding is that unless more guidance regarding the number of posts that should be created within a region is provided, it may not demonstrate the value placed on these roles.

Recommendation

- The SHA, in partnership with service commissioners, progresses with a programme that sees the optimum number of Consultant Midwives outlined delivered by 2012 ensuring sufficient clinical leadership within organisations is achieved and safer birth standards achieved.

Current CPD opportunities for senior midwives

It was felt by those participating in the focus groups that the current CPD provision did not meet the needs of senior midwives in terms of preparing them for the role of consultant. Many were of the opinion that the most difficult aspect or skill to acquire was the attainment of strategic insight and experience. Most of the Consultant Midwives had knowledge of the RCM leadership course, but there was mixed opinion regarding its value in preparing them for the role, since most of the those interviewed had attended it once in post, rather than prior to their appointment. It was felt that regional funding for, and provision of, leadership courses would be useful, since it would standardise the preparation necessary for the role and could even impact positively on recruitment rates. The implication of this finding is that a review of the current provision of CPD in the region is needed to establish whether it is adequately creating aspiring Consultant Midwives who are fit for purpose/practice.

Recommendation

- The SHA, maternity providers and service commissioners embed education governance within their core work programme ensuring programmes that are clinically credible are developed with robust quality assurance mechanisms.

Responsibilities of Consultant Midwives in the North West

Many of the senior midwives were not even aware that there was a leadership programme provided by the RCM, or that the region's Leadership Academy existed, let alone that it was in fact available to them. The implication of this finding is that the North West Leadership Academy may need to target the midwifery profession, so that aspiring Consultant Midwives have greater understanding of the courses the Academy provides and also obtain greater access to leadership courses in the future.

Recommendation

- The Leadership Academy reviews the number of midwives accessing their Clinical Leadership Programmes and enables talent management for midwives through improved marketing.

Further issues arose with regard to the accessibility of current CPD provision. It was felt that, since midwives often had to undertake CPD either by funding it themselves and/or attending in their own time, it presented an obstacle which was, in many cases, insurmountable. The reasons offered were many and varied; but among the most compelling were considerations with regard to childcare and other family commitments. These considerations were further bolstered by the fact that courses were often hosted in distant locations (e.g. London) and this raised the not insignificant matter of finding the funds not only for travel but also (in some cases) overnight accommodation. The implication of this finding is that unless the alleged barriers which exist in accessing CPD are not addressed the CPD opportunities which would help to prepare midwives for the Consultant Midwife roles will not achieve their objectives.

Recommendation

- Education providers maximise learning opportunities through application of distance and e-learning packages.

Negative workforce issues such as inadequate staffing levels, inappropriate skill mix and increasing workload were identified by all focus

group members as being a genuine barrier to their professional development. These issues were frequently cited as reasons why senior midwives were unable to fulfill commitments to attend either internal mandatory – or external – training. They were frequently told they were unable to attend because of unexpected sickness and/or workload. Access to CPD was also perceived by a significant number of participants to be inequitable and it was suggested that a more robust monitoring system be implemented within organisations to overcome this potential obstacle to career progression.

It was largely felt that opportunities to access CPD had become more difficult in recent years and it was believed that this would only get harder over time if it is not addressed. The reason why this was believed to be the case was largely attributed to a perceived lack of funding and value placed upon professional development, especially in the current climate when organisations are being required to make huge financial savings. The implication of this finding is that the North West region's ability to increase capacity to these roles will be unsuccessful unless there is consistent organisational value attributed to and access to CPD.

Recommendation

- The SHA, through its CPD Review drives forward equitable access to CPD opportunities testing existing systems through feedback from midwives.

The provision of a formal process of training/development was raised and all of those interviewed believed this would be useful as the current ad hoc process for gaining preparation for the consultant role was not deemed to be effective owing to the poor recruitment rates. Whilst the model adopted by the South Central SHA was considered to be of an extremely high standard it was also recognised that this was targeting a different group than the one needed in the North West. It was suggested that the implementation of a top-up portfolio system, application and panel selection would be a useful way forward in preparing and recruiting staff in the region.

Academic level

While each group felt that a Masters degree lent credibility to the role, it was also felt that a less rigid approach to the application process should be considered. In order to recognise those individuals who had demonstrated a level of academic commitment and practical expertise in their current role, but who did not possess a formal Masters degree qualification, it was suggested that applications be (on occasion) considered on individual merit and that those midwives who did not possess a Masters degree but were deserving of consideration by their clear development and achievement should not be routinely excluded from applying for these posts. The group felt that the APEL (Accreditation of Prior Experiential Learning) system of recognition for prior experience and attainment should be explored as a way forward, along with a portfolio approach to career progression. The implication of this finding is that unless some flexibility regarding the application process for these posts is introduced, there will be suitable individuals excluded from applying.

The majority of Consultant Midwives interviewed had obtained a Masters degree prior to being appointed; and one was appointed subject to agreeing to undertake and successfully complete a Masters degree. All felt a Masters Degree was the desired minimum academic standard required to secure academic credibility. However, they also felt that it would have more cachet if the academic bar had the potential to be raised to allow Consultant Midwives to undertake a doctorate when in post. This, of course, would necessitate the allocation of protected learning periods, as is the case with their medical counterparts. However, it was recognised that in the current economic climate it would be difficult to secure this time. One option could be for each post holder to prepare a business case which supports this aspect of their professional development.

When discussing the value of specific Masters programmes, it was suggested that a Masters degree in midwifery alone was possibly of limited value. While it undoubtedly enabled individuals to acquire the skills to allow them to analyse and synthesise data at a certain academic level, it would not necessarily prepare them for the role as much as other subjects. Those Consultant

Midwives who possessed Masters degrees in subjects such as transforming health care and health care research and leadership felt that those programmes had been extremely useful in providing them with those skills which have been invaluable in their current posts.

The implication of this finding is that midwives may not be selecting the most appropriate Masters degree in terms of its ability to prepare them for Consultant Midwife roles. It is important therefore that all stakeholders are engaged with education providers in developing programmes that are both clinically credible and of sufficient value to develop the cohort of future consultants.

Recommendation

- The SHA maternity providers and service commissioners embed education governance within their core work programme ensuring programmes that are clinically credible are developed with robust quality assurance mechanisms.

While a qualification in teaching and education was not deemed to be an essential requirement for the post, most of the participants felt that the skills required for the delivery of lectures, for example presentation skills and a high standard of verbal and written communication, would be extremely beneficial. They also stated that in addition to this, influencing, persuasion and negotiating skills and strategic experience were necessary for the role.

Recommendation

- The CPD Review ensures that the following skills, essential to consultant role development, are able to be obtained from contracted provision:
 - teaching, negotiating, influencing, leadership, strategic networking.

The implication of this finding is that unless midwives are able to acquire specific skills, they will not be adequately prepared for Consultant Midwife roles.

It was recognised that, by 2012, nursing and midwifery training would be changing to a graduate programme. It was therefore felt that it may be an option for future consultants to be

supported in attaining a doctorate qualification while in post; but the group felt that midwives should not be expected to have more than a Masters degree in order to be initially considered for these posts.

In terms of the banding for this role, 8b/8c were considered to be most appropriate. A third of those interviewed felt that the post should be banded lower than the Head of Midwifery since it was felt that the consultant's role was separate from managerial issues and did not involve the overall accountability for the provision of maternity services that the Head of Midwifery's role has. However, more than half of those questioned believed that the role was different but equal to the Head of Midwifery in that it provided clinical leadership, whereas the Head of Midwifery supplies the managerial role for the service. It was generally believed that the scope of the role determined the banding allocated to it.

From its inception, the non medical consultant role has been defined as providing clinical leadership, not managerial support or functions.

Within the focus groups, the adoption of managerial responsibilities by Consultant Midwives was viewed as having an equal measure of advantages and disadvantages. It was believed that historically organisations had interpreted the role and its responsibilities to meet the service requirements and as such there had been some perceived obligation on the part of the post holder to fill any managerial gaps. This, it was felt, served to blur the boundaries of the role and led to confusion among colleagues which produced an unfortunate dilution of the role. As one participant reflected as she recounted a recent conversation she had had with another midwife and an obstetrician:

“...Well, if they aren't managers and they aren't providing clinical leadership ... what are they doing?”

All the Heads of Midwifery and Consultant Midwives agreed that their roles had developed since their initial appointment, encompassing other responsibilities such as management and governance. This was viewed by a minority of

Consultant Midwives as being an inevitable consequence of the role. However there was a degree of acceptance that, in the absence of a Head of Midwifery, the consultant was often the most senior midwifery presence within a maternity unit and as such had a duty to bridge the gaps and to maintain a safe service. Other Consultant Midwives were passionate in their refusal to adopt managerial responsibilities for which they had no formal training and which were never intended to be part of their leadership role. They stated that this had the potential to dilute the impact of the consultant role by clouding and confusing the overall purpose of the post.

The implication of this finding is that whilst some Consultant Midwives are undertaking managerial responsibilities, then the perception of the Consultant Midwife as a clinical leader is open to confusion.

Approval panel application process

Half of those interviewed felt that the regional application process for securing these Consultant Midwife roles had the potential to act as a barrier to future growth. They stated that they had felt both overwhelmed by the amount of information required on the application forms, unsure what information was required, and were almost deterred from completing the process as a result.

The implication of this finding is that unless more guidance and input from individuals on the approval panel is given in assisting organisations during the application process then the time the process will take will be longer owing to the number of amendments required.

Recommendation

- The Non Medical Consultant Panel enhances its engagement with the midwifery profession to maximise approval rates by:
 - increasing membership to include current midwifery consultants
 - promoting the partnering of applicant organisations during the application process.

Better outcomes for women

It was agreed by all that the Consultant Midwife’s role provided huge benefits, allowing them to exert influence upon the care of clients with specific and complex needs. It was felt that the Consultant Midwife’s clinical expertise was invaluable when it came to helping guide and support staff and also increase the choices provided to women. One clear advantage lay in the fact that they were able to impact positively on women’s pregnancies and birth experiences by promoting greater choice. It was also believed that the Consultant Midwife’s clinical expertise was invaluable in helping to guide and support staff through changes in practice, to change organisational cultures and also to develop services in line with national and local policy. As described by one participant:

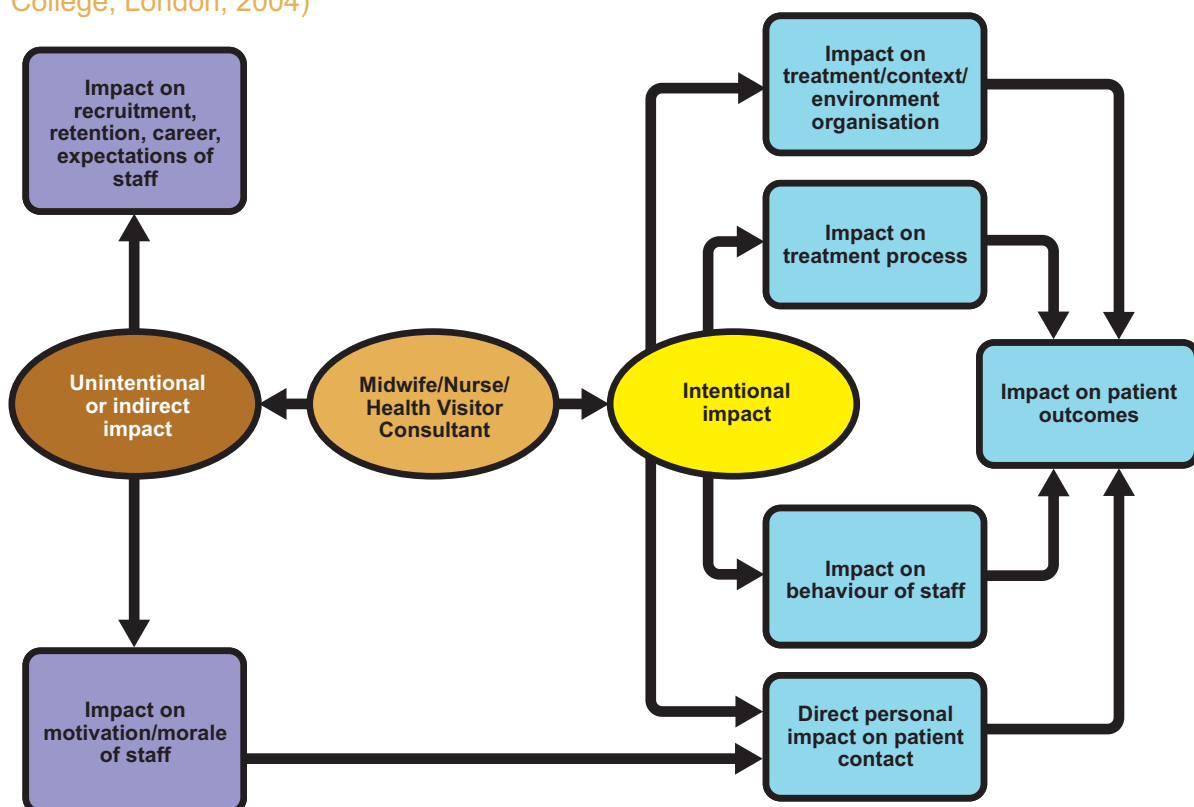
“A midwife influences the care one woman receives, a Consultant Midwife influences the care all women receive.”

Irrespective of the remit held, all the Consultant Midwives interviewed had responsibility for the following areas, generally viewed as the most important aspects of their roles as consultant practitioners:

- supporting and guiding all staff and clients
- leading on training programmes
- forming evidence based policies and guidelines
- leading on service development projects in conjunction with the Head of Midwifery
- working collaboratively
- networking and applying innovative solutions to complex challenges.

It was this focus on service development and the creation of a strategic vision, in addition to the leadership, education, research and expert practice of the role, which contributed to its added value and benefits for women and their families. This positive impact was also seen by Guest (2004) who examined the impact of non medical consultants in London (See Table 10) .

Table 10: A model of the impact of non medical consultants on patient care. (King’s College, London, 2004)



Many Consultant Midwives stated that the role had enabled them to initiate and lead on the initiatives such as the maternity service user involvement strategy group, the development of birth centres and the introduction of midwives working in Children's Centres, all of which were centred on their local community's needs. It was believed by those involved that more community based services improve access to maternity care for women and their families but require considerable clinical leadership which, because of the multi-setting nature of midwifery care, a Consultant Midwife is best placed to provide.

“Our Consultant Midwife has driven many services forward and people don't always see that she was the person behind them once they're in place ...”
(North West Midwifery Matron)

It was also felt that through the training, education the Consultant Midwives facilitates, the culture and attitudes within an organisation are influenced positively. This results in evidence based guidance, less intervention, greater satisfaction and morbidity, facilitates client-focused service developments and greater choice.

“... The facts and figures matter– they might not change – but the quality of care and the whole birth experience of those women will have.”
(North West Head of Midwifery)

Evaluation of the role

By its very nature, the role of the Consultant Midwife means it is locally-determined and invariably multi-faceted. While this was viewed positively by those participating in the group work, since it enabled and promoted the consultant's creativity and innovation, it was deemed to harbour the potential to make it more difficult for midwives to understand what steps were needed in order to prepare and attain the required skills.

The groups also suggested that the role should provide a visible leadership presence, but many were concerned that this had not always been the case. Their comments reflected a perceived lack of consistency regarding the execution of the role and its responsibilities within organisations. This

observation was seen as preventing a “one size fits all” approach to the role, but it was also deemed as fundamentally contributing to the apparent confusion surrounding the role and its value.

All those interviewed agreed that there had been insufficient evaluation of the Consultant Midwife's role since it was introduced over 10 years ago. This had contributed to a lack of understanding of the added value of these posts. It was suggested that a qualitative research study could be implemented which would seek to garner feedback from patients and staff. This feedback would demonstrate the added quality of the care these women received – and midwives were able to give and could form an essential part of a role evaluation. It was recommended that cases are published in which Consultant Midwives have implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery, thereby sharing examples of good practice. The implication of this finding is that unless an evaluation of the Consultant Midwife role is made, there will continue to be a lack of understanding of the added value of these posts and little incentive for organisations to increase their capacity.

Recommendation

- The SHA organises an annual regional event which enables Consultant Midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users increasing wider system understanding of the role.

All of the participants felt that a clearly defined and attainable career pathway to the role of Consultant Midwife was required in the form of a flow chart to facilitate any increase in capacity building for the role within the region. They also believed that greater understanding of the role was required by stakeholders so that organisations would be able to see the added value not only in the role itself but also in the need to support staff in developing towards it. While confusion currently surrounds the role, it was generally viewed by all those involved as being a positive step forward and of definite value and benefit to the profession.

“Adopting the role of Consultant Midwife into the profession demonstrates where we want the profession to go and also provides more career progression opportunities...”

(North West Midwife)

Both groups felt that a clear career pathway would be helpful in informing and guiding midwives along the most effective route to the role. They stated they had managed to prepare themselves for their current roles using informed guesswork to determine what skills would be useful to acquire if they were to be promoted successfully. This however, was not felt to be the most effective way of achieving the desired outcome and a more efficient route was requested. It was also believed that a career framework or pathway would enable managers and supervisors of midwives to advise aspiring consultants more effectively, thereby reducing the time taken to achieve readiness for the role. A number of those interviewed recommended a review to include the identification of existing obstacles faced by midwives when attempting to progress in their careers. The implication of this finding is that unless a clear career pathway is developed to these roles then the time midwives take to achieve readiness for the role may be prolonged.

Recommendation

- Department of Health, Midwifery 2020 steering group and the SHA develop and promote a midwifery career pathway.

Purpose

Although local and national guidance identifies the four key aspects of a consultant role, those interviewed suggested that the emphasis given to each aspect of the role varied from organisation to organisation, post to post and often from day to day, depending upon where the priorities were at any given time.

It was generally considered by both groups that the role of the Consultant Midwife was essentially about supporting the whole service, pioneering change, influencing practice agendas, acting and influencing at a strategic level and was free from operational issues.

Roles and responsibility

There appeared to be some confusion among a number of the participants as to what the role and responsibilities of a Consultant Midwife involved. Some members admitted to being unaware as they had come from organisations which had not created these posts. Other participants believed that they were currently practicing at a consultant level because they had adopted additional advanced practice responsibilities. All those interviewed suggested that greater marketing of the role was needed to promote understanding amongst both the other Heads of Midwifery and the Directors of Nursing in the region. Those interviewed had strong views regarding what they expected from the role. They felt that if a midwife were to have the title “consultant”, which in itself was a contentious issue amongst them, then they had to display extraordinary abilities, both clinically and personally. The implication of this finding is that unless the role and responsibilities of the Consultant Midwife is clarified to stakeholders, then confusion surrounding its value and the sustainability of it will continue.

Recommendation

- The SHA organises an annual regional event which enables Consultant Midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users and increasing wider understanding of the role.

The introduction of non medical consultants in 1999 - 2000 was an attempt by the government to keep senior clinicians within the clinical environment. However there has been much discussion and dispute about whether this is actually happening in reality. Some midwives have stated that, once in consultant roles, those individuals are indeed removed from the clinical area, either by choice or by necessity.

While the majority of midwives involved in the focus groups understood that 50% of the Consultant Midwife’s role involved clinical contact, none of those involved felt that this was happening enough, if at all. Opinions of how that clinical contact was to be delivered were not unnaturally varied. In organisations where

Consultant Midwives were not employed, it was generally felt that clinical contact should take the form of a face-to-face exchange in which the Consultant Midwife worked alongside other midwives in order to influence practice as it was happening. It was also felt that this would provide an ideal opportunity to influence an organisation's workforce culture, practice, standards and opinion of the role. It was believed that by increasing a Consultant Midwife's clinical input within an organisation, it would therefore promote clinical credibility encouraging acceptance of the role by medical and midwifery staff.

“...I mean, when you mention the word ‘consultant’, people immediately think of someone who is at the top of their clinical game, and when the wheels start to come off that’s the person you want to come and help you. If that person hasn’t been near a clinical situation for 18 months or whatever, are they necessarily the best person ...?”
(Advanced Midwifery Practitioner)

Among those midwives who had worked in organisations which employed Consultant Midwives, the role was viewed as being rather more remote, like an engine driving changes in maternity care on a regional, national and international level, instead of as a pair of experienced hands assisting in an operational capacity. Although this group of midwives appreciated the benefits offered by the role when direct care was provided by a Consultant Midwife, they also felt that direct clinical care could and should be given by more junior staff, albeit under the guidance of Consultant Midwives when complex cases made their inclusion necessary. The implication of this is finding is that if a Consultant Midwife's clinical input differs from the application submitted to the Non Medical Consultant Approval Panel then there is the potential for difficulty in achieving acceptance of the role.

Recommendation

- The North West Non Medical Consultant Panel undertakes regular review of the compliance with approval submissions surrounding the clinical component of a Midwifery Consultant role.

The research and leadership components of the role were considered by the group to be what differentiated it from other roles and levels of practice, for example, matron and advanced practitioner. They believed it was the weighting given to these specific components of the role that had the potential to form the basis of a career pathway and provide the foundation for further midwifery development to these roles in the future. The groups also felt that an understanding of research methodology and the skills required to implement primary research were crucial if midwifery practice and services were to be both evidence-based and quality-driven.

The groups believed that the role of the Consultant Midwife was fundamentally centred on its clinical leadership component. All participants hoped that the role would provide midwifery influence at an executive decision making level, enabling clinical issues to be addressed and considered when planning future service provision. As one of the group said:

“The voice of the Consultant Midwife is heard at board level, which means it bridges the strategic and operational gap.”

Bridging the strategic gap was viewed as a specific and essential function of the Consultant Midwife. It was believed that the role provided opportunities to champion the midwifery agenda at a national and international level and this was recognised as being vital if a midwifery voice were to be heard at this (decision making) level.

Expectations of the role

It was generally felt that individuals applying for the role of consultant should have previously worked at a minimum of band 7 and have had between two and five years in a significant leadership role such as matron or clinical area manager. It was also suggested that these roles should have exposed these individuals to service and personal development experiences. The majority of those interviewed recommended that the clinical and leadership aspects of the role should continue to provide the main focus for these posts, as strong and effective leadership is what is required - especially to deliver on the QIPP (Quality, Innovation, Productivity and Prevention) agenda.

It was suggested that a key reason behind the region experiencing difficulties in recruiting to these posts was largely owing to the unrealistic expectations placed on candidates. An example of this was that too many job descriptions fielded requirements which were too stringent and held little in the way of flexibility. This no doubt served to dissuade many suitable candidates from applying. In response to this, the participants suggested that the region facilitate workshops with key stakeholders to review and agree the essential criteria for these roles.

All of those interviewed recognised that there had been particular challenges faced by Consultant Midwives nationally since their introduction, not least in their relationships with Heads of Midwifery. Both groups felt strongly that the successful outcome from consultant roles was linked to the positive relationship between the two midwifery leaders. Most agreed that the leadership element to the role can and is often provided by the Head of Midwifery; however, it was also highlighted that this role had changed dramatically in recent years and would necessitate them spreading themselves too thinly which prompted concerns from the group that this could result in an erosion of standards and quality.

It was also felt that more awareness of the Consultant Midwife's role would help to build a greater appreciation of how the two roles are interlinked and can complement each other to achieve even better quality of service, care and outcomes for women and their families.

It was suggested that the views held by some Heads of Midwifery regarding the Consultant Midwife's role are often influenced by their past experiences of the role. If this has been a negative experience, then there will be little inclination for them to invest in the role for their organisations in the future. The implication of this finding is that unless there is a collective promotion of the role by organisations currently employing Consultant Midwives, then the added value the role will be overlooked.

Recommendation

- Maternity providers address organisational resource issues through benchmarking, sharing examples of best practice and publishing cases that demonstrate how the consultant midwife has implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery.

It was viewed not only as being important that the Head of Midwifery was seen as a supportive figure to the Consultant Midwife, but also that the infrastructure existed within an organisation to support the role before someone was brought into that post. To achieve this, the group believed a job description should be defined and agreed and that within the hierarchy of the organisation people could then see where the Consultant Midwife fitted into the organisation and what was expected of them. While the Non Medical Consultant Approval Panel provides a quality assurance function to address such matters, it was felt by the group that once in post this was not always the reality.

Recommendation

- The North West Non Medical Consultant Panel undertake regular review of the compliance with approval submissions surrounding the clinical component of a Midwifery Consultant role.

It became clear that the direct relationship between the Head of Midwifery and the Consultant Midwifery was a key factor in determining the acceptance of the role and the effectiveness in achieving the productivity gains required of the system of the role.

Skill mix

While those organisations without Consultant Midwives have chosen to develop individuals to focus separately on the four key areas of the Consultant Midwife role, it could be argued that this may not provide the most cost effective way of meeting service needs. Even utilising this approach to service delivery, it could be argued that the level and depth of leadership and research input and overall service improvement experience will be less than that of a Consultant Midwife.

As described earlier the benefits that a Consultant Midwife can offer through progressing less costly interventions can make significant savings to the NHS, whereas the current flat hierarchy described, although providing greater headcount, will in the longer term be not only more costly but significantly less productive.

The implication of this finding is that the traditional organisational infrastructure reduces the potential for capacity building to the Consultant Midwife role within the North West.

Recommendation

- The SHA, in partnership with service commissioners, progresses with a programme that sees the optimum number of Consultant Midwives outlined delivered by 2012 ensuring sufficient clinical leadership within organisations is achieved and safer birth standards achieved.

Governance

A new initiative which links to the Safer Birth Programme has recently been launched throughout England and involves 12 sites including two in the North West. The overall purpose is to help maternity units throughout the country create systematic approaches and systems which ensure they consistently deliver the safest possible care during labour to mothers and their babies. These 12 sites will subsequently form a network which will share their learning with other maternity units throughout the country. The initiative focuses on the four key challenges facing our maternity services highlighted in the King's Fund report. These areas include communication, staffing, training and leadership and Consultant Midwives are ideally placed to have a positive impact upon this.

It was felt by both groups, however, that the role of the Consultant Midwife was best aligned with the safety agenda for maternity care, but the level of input into an organisation's governance strategy appeared to differ from post to post. All the Consultant Midwives interviewed had varying degrees of input into areas such as guidelines and policy development, in-service training, Risk Management Forums and Clinical Negligence Scheme for Trusts (CNST) standards. Concern was raised that there is sometimes a temptation to be involved in everything to which the Consultant Midwife is asked to contribute, but this was thought to lead to individuals becoming less effective in the role.

Funding

All those interviewed stated the current economic climate made it increasingly difficult to justify investing in these roles. However, the Consultant Midwives seemed to be very practiced at finding and generating money for the organisations in which they worked.

Both groups suggested that, because of their lack of managerial input, Consultant Midwives have become adept at employing innovative/creative methods which result in cost savings through effective and efficient care delivery. The quality of services the employing organisation provides attracts women, thereby generating more money. Further suggestions for possible funding solutions were thought to lie in joint appointments and research departments within Trusts. The implication of this finding is that unless Consultant Midwives share their methods to produce cost savings through effective and efficient care delivery, then organisations may continue to view these roles as expensive luxuries reducing the incentive to build capacity.

Recommendation

- Non Medical Consultant Panel develops a group through which consultant midwives can meet to identify ways in which the quality and service improvement agenda can be implemented regionally in light of the current economic climate.

Post alignment with Higher Education Institutions (HEIs)

There was mixed opinion within the groups regarding the potential benefits of Consultant Midwife joint appointments with HEIs. One criticism of this was that consultants frequently found it difficult meeting the competing demands and deadlines of both Trust and HEI. Some of the group members went so far as to state their concern that joint appointments would result in neither job being done particularly well.

Despite the inherent difficulties it was generally viewed as being beneficial since it allowed access to an academic audience and also guaranteed that they were well placed to influence the midwifery culture at an early stage. It was also believed by some that involvement with HEIs provided an opportunity to contribute to curriculum development, and most of the consultants interviewed were active members of the Board of Studies and Research and Development Committees.

Barriers to capacity building

All of those interviewed cited a lack of organisational resources as providing the biggest barrier to capacity building. The group believed that the additional cost to organisations was difficult to justify in the current economic climate.

A lack of understanding around the role, its value and the responsibilities of a Consultant Midwife were also believed to form an obstacle to further capacity building, especially among those organisations that do not currently employ Consultant Midwives.

Concern was raised by those interviewed with regard to the lack of appropriate skill sets among the region's senior midwifery workforce, mainly in terms of strategic experience and leadership expertise. Unless development of these midwives is addressed, the difficulty in recruiting and succession planning for these roles will continue.

The absence of a clear career pathway was frequently mentioned as being an obstacle in supporting and guiding midwives in their career progression. If left unresolved, it was felt that this would slow attempts to build the region's capacity for Consultant Midwives.

It was also acknowledged by those interviewed that inadequate identification and development of staff for the Consultant Midwife role needs to be addressed more robustly and consistently within organisations if the profession is to begin to succession plan for these roles.

Those involved in the interviews believed that too many stringent essential criteria on job descriptions would potentially result in midwifery talent being lost and consequently could create a potential barrier to capacity building and succession planning to these roles. An example of an appropriate job profile is available on NHS Employers (see Appendix Eight)

It was felt very strongly by both groups that a Head of Midwifery's negative experiences of the Consultant Midwife role would undoubtedly create a barrier to increasing capacity within the region, unless opinions could be changed through positive contributions from other Heads of Midwifery.

Finally, it was felt that unless additional support is made available to those organisations that begin the application process, proposals may be delayed unnecessarily or abandoned altogether.

Recommendations

- The Non Medical Consultant Panel enhances its engagement with the midwifery profession to maximise approval rates by:
 - increasing membership to include current Midwifery Consultants
 - promoting the partnering of applicant organisations during the application process.

Succession Planning

All groups expressed some concerns regarding the challenges that had been faced within the region when recruiting senior midwives to these posts. They felt that unless the succession planning and development of senior midwives was made a priority then there would be little chance of increasing the capacity of these roles in the future. They stated that the organisational culture which sometimes exists can result in a lot of senior midwives not being exposed to or have experience of skills in specific areas of leadership.

Recommendation

- Education providers embed and signpost core clinical leadership skills within pre-registration and post qualifying learning programmes.

Appraisals and supervision were both identified as providing the greatest opportunity for recognising midwifery talent; however, concern was expressed that these opportunities were not being exploited to their fullest potential. Many of those participating in the focus groups stated that the appraisal system was merely a “paper exercise” with little apparent value being placed on an individual’s actual career development and progression.

“I don’t think we as a profession are particularly good at nurturing our staff’s potential. I think we are all right at spotting it, but then nothing seems to happen to help that talent progress. Saying that, I also think it’s up to an individual to be self-motivated and proactive in making that happen.”
(North West Head of Midwifery)

The implication of this finding is that unless the aspiring Consultant Midwives are being identified then the opportunities to build capacity in the North West will be reduced.

Recommendation

- Directors of HR, in partnership with the SHA, undertake a review of the effectiveness of midwifery appraisal and its impact on career progression.

Summary of recommendations

BETTER CARE

BETTER HEALTH

BETTER LIFE

Organisational adaptation

1. Maternity providers address organisational resource issues through benchmarking, sharing examples of best practice and publishing cases that demonstrate how the Consultant Midwife has implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery.
2. The Strategic Health Authority (SHA) Non Medical Consultant Panel develops a group through which Consultant Midwives can meet to identify ways in which the quality and service improvement agenda can be implemented regionally in light of the current economic climate.
3. The SHA organises an annual regional event which enables Consultant Midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users and increasing wider understanding of the role.

Education and development

4. The CPD review ensures that the following skills, essential to consultant role development, are able to be obtained from contracted provision:
 - teaching
 - negotiation
 - influencing
 - leadership
 - strategic networking.
5. The SHA continues to drive inter-professional learning by opening up programmes traditionally aimed at other health professionals.
6. Education providers maximise learning opportunities through application of creative techniques such as e-learning, distance and work based learning packages.
7. Education providers embed and signpost core Clinical Leadership skills within pre-registration and post qualifying learning programmes.
8. The SHA, maternity providers and service commissioners embed education governance within their core work programme ensuring programmes that are clinically credible are developed with robust quality assurance mechanisms.

9. Directors of HR, in partnership with the SHA, undertake a review of the effectiveness of midwifery appraisal and its impact on career progression.
10. The SHA, through its CPD Review, drives forward equitable access to CPD opportunities testing existing systems through feedback from midwives.
11. The Leadership Academy review the number of midwives accessing their Clinical Leadership Programmes and enable talent management for midwives through improved marketing.

Workforce planning and development

12. Department of Health, Midwifery 2020 steering group and the SHA develop and promote a midwifery career pathway.
13. The Non Medical Consultant Panel enhances its engagement with the midwifery profession to maximise approval rates by:
 - increasing membership to include current midwifery consultants
 - promoting the partnering of applicant organisations during the application process.
14. The North West Non Medical Consultant Panel undertakes regular review of the compliance with approval submissions surrounding the clinical component of a Midwifery Consultant role.
15. The SHA, in partnership with service commissioners, progress with a programme that sees the optimum number of Consultant Midwives outlined delivered by 2012, ensuring sufficient clinical leadership within organisations is achieved and safer birth standards achieved.
16. Maternity providers enhance the interface between primary care and maternity services by ensuring the Midwifery Consultant role has its key public health functions clearly articulated and focused on.
17. In addition to the development of more Midwifery Consultants, that a greater proportion of roles are embedded within primary care.

Conclusion

This project has focused on the role of the Consultant Midwife in the North West and was undertaken to explore the belief that there needs to be an increase in the capability of experienced midwives to enable their successful recruitment into Consultant Midwife posts, thereby improving the region's capacity to comply with the recommendations outlined in *Safer Childbirth*. It is the result of the combined efforts of many people listed in Appendices Eight and Nine and without whom the recommendations could not have been developed.

It is recognised that the context in which the project has been placed; economic recession, the media's influence over society's perception of the childbirth process, the increasing Caesarean section rate and organisational cultures, all have the potential to impact on the region's ability to build capacity to the Consultant Midwife role but do not detract from the important priority that must be placed on this work programme going forward if *Safer Childbirth* is to be achieved.

The areas chosen for exploration were adopted because they held the potential for revealing the most information about the current capacity and utilisation of Midwifery Consultants, clarifying the barriers to future role development and testing the region's current position against the national direction.

It was this project's intention to clarify the expectations of maternity providers in terms of the Consultant Midwife role, its responsibilities and its added value, compared to other senior midwifery posts. There would appear to have been insufficient evaluation of the role to support its further expansion. However, it is clear from the case studies provided in this report that the Consultant Midwives in the North West have implemented innovative and creative service improvements which have had a positive effect on both the quality of care staff are able to provide and families are able to access. It may therefore be worth the region considering the formation of a Consultant Midwife-led benchmarking group, which shares examples of best practice and publishes cases in which Consultant Midwives have implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery.

From the findings it would also seem that the current CPD provision for the preparation of midwives to these roles has inherent challenges in terms of its accessibility, flexibility and suitability. This is further compounded by the existing appraisal process which is perceived as not always being conducive to promoting an individual's career progression since it fails to balance the individual's need with the demands of service provision and resources. The absence of a clear midwifery pathway also makes career progression difficult for midwives who aspire to these senior roles. Further work is therefore required to consider the impact on the national post-qualification framework and the transferability of skills. The output of this project may develop expectations in the midwifery workforce of a versatile career framework. In delivering the ambition of growth in the number of Consultant Midwives, it is anticipated that an increased demand in post qualification training will be generated. Future CPD opportunities could also focus on the acquisition of skills such as teaching, negotiating, influencing, leadership, strategic networking as these are all considered to be important in preparing midwives for the role of Consultant Midwife .

This report has indicated that there are challenges and barriers which need to be addressed in the North West, if an increase in both capacity and capability to the Consultant Midwife role is to be both successful and achievable. By exploring these areas with the expert groups, the region has obtained valuable information regarding the measures which are now necessary for further consideration. This information should therefore form the basis on which future work in this subject is built and provide continuing evidence of the workforce development needs of the maternity workforce and to this effect and action plan for delivery of the recommendations and appropriate communication strategy have been identified (see Appendix 10). Increasing clinical leadership in the future is vital if maternity services are to meet the changing needs of families and the vision for midwifery is to become a reality. The provision of clinical leadership through Consultant Midwives is an integral part of that vision for the midwifery profession.

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Glossary of terms

Allied health care

Allied health professions are clinical healthcare professions distinct from medicine, dentistry, and nursing. They work in a health care team to make the healthcare system function.

ALSO

Advanced Life Support in Obstetrics. This is a training programme provided by and for professionals working in the area of midwifery, obstetrics or maternity anaesthesia and centres training around dealing with obstetric emergencies.

Antenatal

Antenatal refers to the completion of 24 weeks gestational age until birth.

Caesarean section

Also known as C-Section, is a surgical procedure in which incisions are made through a mother's abdomen and uterus to deliver one or more babies.

Change agent

An individual or thing that causes a process in which something becomes different.

Clinical leadership

Leadership in the clinical environment

Clinical Negligence Scheme for Trusts (CNST)

Clinical Negligence Scheme for Trusts is a scheme of risk pooling providing indemnity cover for NHS bodies in England.

Clinical Governance

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system.

Head of Midwifery

A midwifery manager with overall day to day responsibility for the maternity service.

Home birth

Home birth is a birth that is planned to occur at home.

Intra partum care

Within labour.

Midwifery-led care

Care which is provided to pregnant women, when the most senior professional providing that care is a midwife.

Midwifery-led birth centres

A health care facility that is staffed by midwives who provide the most senior professional presence.

Multi-disciplinary

Of, relating to several disciplines for example midwifery, medicine, social work, health visiting.

Neonatal

Neonatal refers to the first 28 days of life.

Normal (vaginal) birth

Childbirth without medical intervention to aid the birth process.

Payment by results

Payment by results is a means by which organisations are reimbursed for the activity they carry out.

Postnatal

Postnatal is the period beginning immediately after the birth of a child and extending for about six weeks.

Primary Care Trust (PCT)

An NHS primary care trust (PCT) is a type of NHS trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care.

Public health

Public health is the science and the art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society.

Midwifery quality indicators

Evidence-based indicators that support the measurement of quality, safety and reliability of care.

Risk management

The identification, assessment and prioritisation of risks followed by coordinated and economical application of resources to minimise, monitor and control the probability and or impact of unfortunate events.

Skill Drill

The Skill Drill challenge is designed to show or teach the recruits a skill that is needed for a particular clinical situation.

Succession planning

Succession planning is a process for identifying and developing internal personnel with the potential to fill key or critical organisational positions. Succession planning ensures the availability of experienced and capable employees prepared to assume these roles as they become available.

Tariffs

A classified list or scale of charges made in any private or public business.

Workforce planning

Strategic workforce planning is the business process for ensuring that an organisation has suitable access to talent to ensure future success.

Appendices

List of appendices

- Appendix One:** Consultant Midwives case studies
- Appendix Two:** Structured interview questions
- Appendix Three:** Rationale for interview questions
- Appendix Four:** Example of the focus group questions
- Appendix Five:** Career framework for health
- Appendix Six:** Mapping a career
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Appendix One

Case studies

BETTER CARE

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BETTER LIFE

**Debbie Garrod - Consultant Midwife,
Stockport NHS Foundation Trust
Remit for Public Health**

Consultant midwives - making a difference

“Following a background in teaching, training and education and a period of 10 years self-employment, I was fortunate to be selected to start my midwifery training in 1990. I was on one of the seven pilot ‘direct entry’ training programmes and qualified as a Midwife in 1993.

After qualifying, I spent a further year at this Trust and then worked in three other Greater Manchester Trusts in a variety of midwifery roles, focussing on developing services which reduce health inequalities, promote normal birth and choice for all women. I also spent a year on secondment at Manchester University’s Centre for Healthcare Management. I studied for a Masters degree in ‘Management and Leadership in Health and Social Care’ and received my MA in 2001. I have undertaken research into the needs of pregnant women with mental health problems and have had a number of articles and chapters published on this and other issues.

In 2002 I took up my current role as Consultant Midwife in Public Health. In addition to providing professional leadership on all Public Health issues within maternity services, I also take the lead on a range of initiatives designed to promote normality, with a particular focus on developing the Vaginal Birth After Caesarean (VBAC) service.

I work closely with the Local Authority, PCT and 3rd sector organisations; the development of Children’s Centre midwifery services is a key area of responsibility. I represent our organisation on a number of Strategic Partnership Boards including teenage pregnancy and domestic abuse.

I have been an antenatal teacher for the National Childbirth Trust (NCT) since 1982 and I continue to value this work as it offers a different and helpful perspective to my midwifery role. It also dove-tails into my role

and I am currently leading on the Trust’s strategy to involve service users.

Being a consultant midwife enables me to achieve the balance of clinical work, service development, professional leadership, teaching and research that suits my skills. It is an incredibly varied role and allows me to focus on different areas of the service over a period of 18 months to two years and then to re-focus when service developments have been embedded. Over the eight years that I’ve been here the team has evolved and changed but the philosophy of woman-centred care and a welcoming of new ideas have stayed the same.

I am passionate about maternity services and making them the very best they can be for women, their partners and families. I am particularly committed to ensuring that all women have access to the range of choices that should be available to them. I see pregnancy as a ‘window of opportunity’ where midwives can be powerful agents for change, working with women and families to support health and well being and so reduce health inequalities. The implementation of evidence-based care is of critical importance, as is flexibility and the willingness to adapt services in light of current research.

I work closely with a number of ‘Public Health’ midwives, and we have been able to implement some really innovative and effective approaches to care, for example the Contraceptive Care Plan for teenage mothers and the Enhanced Breastfeeding Support Initiative. Both of these have achieved positive outcomes in terms of increasing uptake of contraceptive services and improving breastfeeding maintenance rates. The collaborative working that is key to my role has enabled me to bid for funding for such initiatives from partner agencies.

I am a keen exponent of normality in childbearing and of the central importance of a positive birth experience wherever possible as I

believe that this sets the new family off to the best start. We have completely revised and re-written our programme for preparation for birth and parenting in line with these principles and it continues to evaluate well and to be recognised as setting a 'gold standard' for antenatal education.

I made a conscious decision to move on from a very 'hands on' role when I applied for this job. My motivation was to be in a strategic role where I could make a difference to more parents and also to be in a position to articulate and demonstrate the role of the midwife as public health practitioner and 'change agent' in a broader arena.

Three of my current key areas of responsibility are:

1. Working with Local Authority colleagues in Children's Centres and the re-location of maternity services in the Centres. This includes postnatal drop-in sessions.
2. The development and implementation of our Service User Strategy which will lead later this year to the re-forming of the MSLC. The

Service User Forum Group 'Talkback!' now meets six-weekly and the feedback and suggestions from the parents who take part are brought straight into our service

3. Following our selection as an 'early adopter' for the NHSI Toolkit on promoting normal births I have been actively involved in leading the development of the VBAC service. We are now focussing on promoting normality in the 1st pregnancy and birth and have just started a 1-day (mandatory) Public Health Study Day which includes a session on this topic, for all midwives.

The role is perfect as it enables me to continue to practise clinically as well as to develop services, provide teaching and training and do some research and audit. Supporting midwives to develop their own practice and to improve services for women is a key part of my role and one that I love."

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**Eileen Stringer - Consultant Midwife,
Pennine Acute Hospital NHS Trust
Remit for Public Health**

Consultant Midwives - making a difference

Eileen started her NHS career like so many following a traditional nursing route. Having progressed in her career, she decided to embark upon the short post-registration midwifery training programme. In 2001, Eileen commenced her current role as a consultant midwife with a remit for public health.

The post was commissioned originally as part of the Neighbourhood Renewal Fund (NRF) in Rochdale. The NRF funded a public health consultant midwife to work in Rochdale in order to introduce practice changes in midwifery that would help to address the wider determinants of health. The post was originally funded for one year but was subsequently funded for a second year. The Local Authority part funded the post for a further two year, with the Acute Trust committing to the remaining costs and it went on to fully fund the post from 2007.

Eileen's role was originally based in Rochdale which had a small maternity unit of approximately 2000 births in 2003. The Hospital had undergone a merger into the Pennine Acute Trust in 2001 and had become one of four maternity units with a combined birth rate of approximately 9,500 births. The four units were approximately eight to ten miles apart and were all based in the North East sector of Greater Manchester. Each unit was affiliated with at least one PCT and one local Authority. After the second year in post, it became apparent that any work undertaken needed to be translated across the four maternity units and communities and the remit of the role subsequently expanded significantly.

The aim of the post was to achieve a coherent high quality service that reflected and took into account the wider health and social needs of women and their families. The intended

outcome was to integrate community midwifery particularly into a social model of care that was firmly embedded into the wider community framework and had a high profile with women and families. Partnership working was a key objective.

The process was largely financed by external funding over the last seven years from a number of sources including the Department of Health, NRF, New Deal for Communities, the Teenage Pregnancy Grant, Sure Start, Local Authority and PCT. The Acute Trust has also committed to funding key posts and has mainstreamed some of the posts that were originally externally funded. Much of the funding has been steadily reducing over the last few years and we continue to integrate the changes into the main workforce. We envisage that within the next two years there will be very little external funding.

Through her role as Consultant Midwife and her ability to work strategically, Eileen has changed the community midwifery service into a group based model which is the same across all four communities. The model of care is explicit as to the standard of care we need to achieve. The model is supported by policies.

Finally, Eileen's role has also enabled the implementation of changes that address health inequalities and Infant mortality. Without the Consultant Midwife's role within this organisation, Eileen believes that they would have found it difficult as a service to move forward within the context of National policies such as the National Service Framework and Maternity Matters.

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**Faye MacRory- Consultant Midwife,
Central Manchester University Hospitals
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Remit for Public Health**

Consultant Midwives - making a difference

In 1979 Faye qualified as a Registered Nurse in Sheffield and as a Midwife in 1982 in Manchester. Following a period of working in Saudi Arabia she studied full-time for a Degree in Psychology at the University of Manchester and graduated in 1992. On her return to St. Mary's she spent the next few years challenging the judgemental practice she observed towards women with complex lifestyles that included drugs, alcohol and prostitution. Several years of campaigning for change with colleagues in the voluntary sector led to her appointment as Drug Liaison Midwife in 1995 which was the first jointly funded post between drug and maternity services in the UK. In June 1997 Faye received an MBE for Services to Healthcare in Manchester and in 2001 Faye took up her current role as Consultant Midwife in Public Health. In addition to providing professional leadership on all public health issues.

Faye created Manchester's and the Country's first Specialist Midwifery Service (MSMS) in April 2001. It specialises in providing a service to women and their families where:

- Drug/alcohol use and mental health is problematic.
- Supports and co-ordinates the care for HIV positive women identified through the antenatal HIV screening programme.
- Service provision firmly rooted in the sphere of public health and embraces all aspects of a vulnerable, socially excluded life-style.
- The service has a city-wide remit and broad ranging responsibilities that include providing input to three maternity hospitals, four drug service bases, a sexual health project for sex workers (MASH).
- The regional in-patient detoxification unit and HMP Styal.

- A wide range of training is provided to maternity and other services which include domestic abuse, brief interventions in alcohol and antenatal HIV testing. This involves collaboration across a wide range of both statutory and voluntary health and social care agencies in addressing the complex issues associated with mental health, domestic abuse/violence, sexual abuse, prostitution and HIV.
- The team currently consists of five Specialist Midwives, two for drug and alcohol issues, two for HIV/sexual health, and one for Perinatal mental health. Their work crosses the conventional care boundaries usually associated with maternity care and as such ensures an individualised plan of care is provided.
- Manchester Specialist Midwifery Service (MSMS) is an innovative and dynamic service that has achieved international and national recognition. It has an extremely good reputation among partner agencies and stakeholders, and was described by a number of representatives and clients as providing an 'invaluable' service.
- MSMS provides accessible, responsive, client-centred and holistic support to some of the most vulnerable women in Manchester. The service was popular with clients who appreciated the additional support and empathetic way it was delivered. MSMS uses creative and practical approaches to engage and support clients who are both hard-to-reach and hard-to-help. The service plays an important role in helping to co-ordinate and share information from different agencies supporting these vulnerable women during the pregnancy continuum.
- MSMS is an important resource for professionals in Manchester working with pregnant women with drug and alcohol, HIV and mental health issues. Staff in the service

have a considerable range and depth of knowledge in their specialist areas. The service has also made a significant contribution to developing good practice in the areas in which it works and in introducing more consistent practice in Manchester.

- The accessibility and responsiveness of MSMS has resulted in the service being used as a referral point for pregnant women with additional needs that are beyond the remit of the service, but for whom there is no appropriate service available.

In July 2003 Faye was named as Outstanding Achiever of the Year in the Health and Social Care Awards at the Department of Health. Additionally in July 2004, the Service was awarded a Certificate of Commendation at The House of Commons by The All Party Parliamentary Group on Maternity for their innovative practice in maternity services. Faye was also a finalist in both the Nursing Times Awards and the Greater Manchester NHS Awards in 2005. In 2006 Faye completed a

Masters degree in Collaborative Health Care which focused upon the partnership between the NHS and prison healthcare. Faye has also had a number of articles and chapters published on this and other issues. Demand for the service has grown considerably and Faye is approached and recognised internationally as an expert in this field due to her pioneering work. The role of Consultant Midwife has enabled Faye to influence the care women across the world now receive.

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**Nicola Parry Consultant Midwife –
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Remit for Normal Childbirth**

Consultant Midwives - making a difference

Nicola started her NHS career like so many following a traditional nursing route. Having progressed through the ranks, she decided to embark upon the 18-month post-registration midwifery training programme. In 2003, Nicola became a matron, which she feels provided valuable preparation for her current role as a consultant midwife, which she took up in 2009.

The drivers for this role were both national and regional. Documents such as Maternity Matters and the NHS Constitution provided the national focus while local issues such as the need to provide pregnant women with greater choice and quality of care regarding place of birth, reducing the caesarean section and instrumental rates while also raising the profile of midwives within the organisation.

Since her appointment in 2009, Nicola has successfully led the creation of two normal birth rooms, VBAC clinic, normal birth workshops and has provided clinical leadership to support and assist staff who are unfamiliar with attending homebirths and water births. In addition to this, Nicola has also implemented weekly reviews of caesarean sections, often challenging the decision-making and rationale for specific cases.

Nicola's role as consultant midwife has enabled her to have tough discussions with midwifery and medical colleagues in order to ensure practice is based on evidence as opposed to merely tradition or routine. By asking questions, challenging practices, and providing a visible leadership presence the culture within the organisation has undergone a positive change.

In the twelve months since her appointment the:

- Caesarean section rate is down by 4-6%
- the creation of normal birth rooms has reduced the length of stay for women and heightened the quality of the birth experience with a resultant implication of lower costs shouldered by the Trust
- there are less women opting for pharmacological relief in labour and more women requesting water births
- the home birth rate has increased by 3% and is led by an enthusiastic team of midwives
- finally, Nicola has also introduced a process for reviewing critical incidents which have occurred on the unit, adopting a multi-disciplinary lessons-learnt approach.

The ongoing discussions and contact between Nicola and Director of Nursing and Quality and this is useful in ensuring a midwifery voice is heard at Board level. The excellent channels of communication which exist between the Head of Midwifery and Nicola ensure that maternity services have both clinical and managerial leaders resulting in high-impact actions being achieved.

Over the next 12 months, Nicola plans to develop a care pathway for women who have breech presentations at term. She also plans to have regular input into the obstetric joint clinics for women with complicated pregnancies. In doing this, she hopes to support such women to have as normal a birth experience as possible.

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Anita Fleming Acting Consultant Midwife – East Lancashire Hospital NHS Trust Remit for Public Health

Consultant Midwives - making a difference

Anita Fleming, Acting Consultant Midwife, East Lancashire Hospitals NHS Trust, remit: public health, normal birth and CNST project lead.

The drivers for that post initially were linked to the area's high incidence of social deprivation which resulted in high teenage pregnancy rates and high infant mortality rates, which, seven years ago, happened to be the highest in the country. Breastfeeding rates were low and ethnic minority groups and drug-users were prevalent.

Anita worked as a Registered General Nurse for three years prior to commencing her midwifery training in 1989. She qualified as a midwife in 1991 and subsequently accepted a seconded post in 2009 as a consultant midwife in public health within East Lancashire NHS Hospital Trusts.

If the role of consultant midwife had not been introduced within this organisation, the public health agenda would not have been successfully addressed as it has been; it would have taken longer to implement since responsibilities would have been parcelled out to team members and thus been diluted with no one person taking overall responsibility. Other roles would not have enabled the midwifery input which has been achieved and the relationships with PCTs and commissioners would not have been realised.

Anita's greatest achievement has been the creation of a social needs assessment tool (SNAT) and this came as the result of the high infant mortality rate in the area. Anita discovered that the right questions were not being asked to ascertain the woman's risk of infant mortality during the booking visit and it was apparent that a more effective infant risk

assessment was required. The SNAT is implemented at the booking visit, information is updated at the 28-week antenatal clinic visit and again postnatally. It involves working in collaboration with GPs, health visitors and other members of the multidisciplinary team in order to improve communication.

The consultant midwife's role was funded as a joint appointment with UCLAN and East Lancashire Hospitals. Anita is required to undertake one day a week within the university where she participates within REACH (Research, Evaluation and Audit into Child Health). She also teaches student midwives.

Key outcomes & impact

- Quality of service around the public health agenda.
- Inspiring midwives to aspire to consultant midwife role.
- Supporting staff to give more choices to women.
- Greater user involvement through MSLC.
- Working on a bigger scale collaboratively
- Strategic exposure to processes, PCTs and Trust boards.
- Understand commissioning and provider service issues.
- Presenting at national conferences.

Supporting material

- Publications.
- Three book chapters.
- Assessment for infant mortality tool.
- Presentations.

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Appendix Two

Structured interview questions

1. Context and appointment process

- What were the organisational drivers for this post? What was the remit of the post when advertised?
- What do Consultant Midwives bring to the role/organisation that other roles couldn't in order to fulfill the service requirements? (For example, a research fellow, lecturer practitioner, specialist and advanced practitioners).
- Why do we need practitioners who have roles which focus on leadership, research and education?
- What are your expectations in terms of the level of experience, knowledge and skills a Consultant Midwife should have?
- What infrastructure was in place to support this role within the organisation?

2. Impact on client care

- What has been the added value of the role to their organisation?
- How has the inclusion of a Consultant Midwife within your organisation improved patient care and service development?
- What targets were set for the role and how are they evaluated?
- How does the post facilitate the development of staff in order to provide high quality healthcare to women and their families?

3. Purpose and responsibility of the post

- What arrangements are in place to enable the post holder to fulfill the four functions of the role? Was a flexible timetable of activities outlined for the post?
- What are you looking for from the role of Consultant Midwife within your organisation?
- What do you regard as the specific role(s) and responsibilities of a consultant within your organisation?
- Were key stakeholders involved in integrating the post into the organisational and health economy structure?

4. Clinical governance arrangements

- In what way do you believe the role aligns with your organisation's clinical governance strategy?
- Has this post had any impact upon the CNST level and subsequent payments by your Trusts?
- What CPD, supervision and mentoring arrangements were in place to support this role?

5. Funding arrangements

- What determines the banding the post gets within an organisation?
- Where would you expect a Consultant Midwife to be banded and why?
- How could the additional costs of a Consultant Midwife's salary to an organisation be justified in the current economic climate?
- How can we evaluate the role and the proven benefits of these posts to ensure they become easier to measure and value?

6. Alignment with HEI

- Does the post facilitate involvement with HEIs to achieve the research and education aspects of the role?

7. Other

- What do you regard as being the current barriers to the development of more Consultant Midwife posts within the region? And how do you think these barriers could be overcome?
- Why do you believe the region has experienced difficulties in recruiting to the posts?

Appendix Three

Rationale for interview questions

BETTER CARE

The first questions were designed to ascertain the qualifications and background of the participants. They served to provide an overview of where, when and how the interviewees had developed within their career. This was done to determine whether the type of training/qualifications they had gained had equipped them with the skills required to become Consultant Midwives.

The second group of questions was designed to elicit information regarding the organisation's motivation for creating a Consultant Midwife post, what their expectations of the post were and what they had put in place to ensure the role's success. This was done to establish what they saw as being the real benefits of the Consultant Midwife role in terms of what it had brought to their local community and organisation in comparison to other roles. The questions also hoped to establish consistency with regard to what was expected of the role within organisations.

The third group of questions explored the impact of the role in terms of patient care and asked what had been the added value to their organisation. The aim of this question was to identify the real benefits of these roles upon patient outcomes and the achievement of the maternity quality indicators.

The fourth group of questions revolved around how the organisation had ensured the fulfillment of the four key components of the role and how it had interpreted the role/responsibilities. This also gave participants the opportunity to examine practices within their organisation and criticise what they perceived to be in-built faults within the current situation but also to voice opinion on how things could be improved for future posts.

The fifth group of questions aimed to explore the impact of the Consultant Midwife role in relation to service quality and clinical governance. It aimed to establish how the role aligns with their organisation's clinical governance strategy, what the impact was upon the CNST level of that organisation and how important was this role alignment to service providers.

BETTER HEALTH

The sixth group of questions were designed to elicit information regarding the funding arrangements of Consultant Midwife posts. Identifying what determined the banding the post was given within their organisation and how the cost of these senior posts could be justified in the current economic climate. Finally, participants were asked to identify how the Consultant Midwife role was currently being evaluated within their organisation. This was done so the proven benefits of these posts could be more easily measured and valued.

The seventh group of questions aimed to establish what importance was given to research and education, and how the research and education aspects of the role were being achieved. This was done to identify how organisations recognise the additional responsibilities of the consultant role and what was required in order facilitate this.

Finally, the eighth group of questions aimed to ascertain what these stakeholders perceived as being the current barriers to the development of more Consultant Midwife posts within the region, and also explore ways to overcome these barriers. This was done to inform the project outcomes, ensuring they were realistic and achievable.

BETTER LIFE

Appendix Four

Focus group questions

Consultant Midwife role and responsibilities

- Consultant Midwife's role comprises of 50% clinical input. What form should this clinical input take?
- Consultant Midwife's role comprises of a professional leadership and consultancy function, what if any managerial duties should be included?
- What form should the education and research functions of the role take?
- Has the Consultant Midwife's role had an impact on patient care, service development and clinical research?
- What are your views regarding a proposed increase in Consultant Midwife capacity in the region?

CPD

- What CPD opportunities are available to experienced midwives to prepare them for a leadership role?
- What are the barriers to CPD opportunities?
- What developmental opportunities would you like to see available within your organisation?
- How do you believe non recruitment to Consultant Midwife posts could be reduced?
- What do you think predicts the general views about the Consultant Midwife role?

Succession planning

- How do we spot talent within our workforce and what do we do with that knowledge?
- How do we develop our staff so they can apply for leadership roles?
- What areas of your professional development are most difficult for midwives to develop?

Appendix Five

Career framework for health

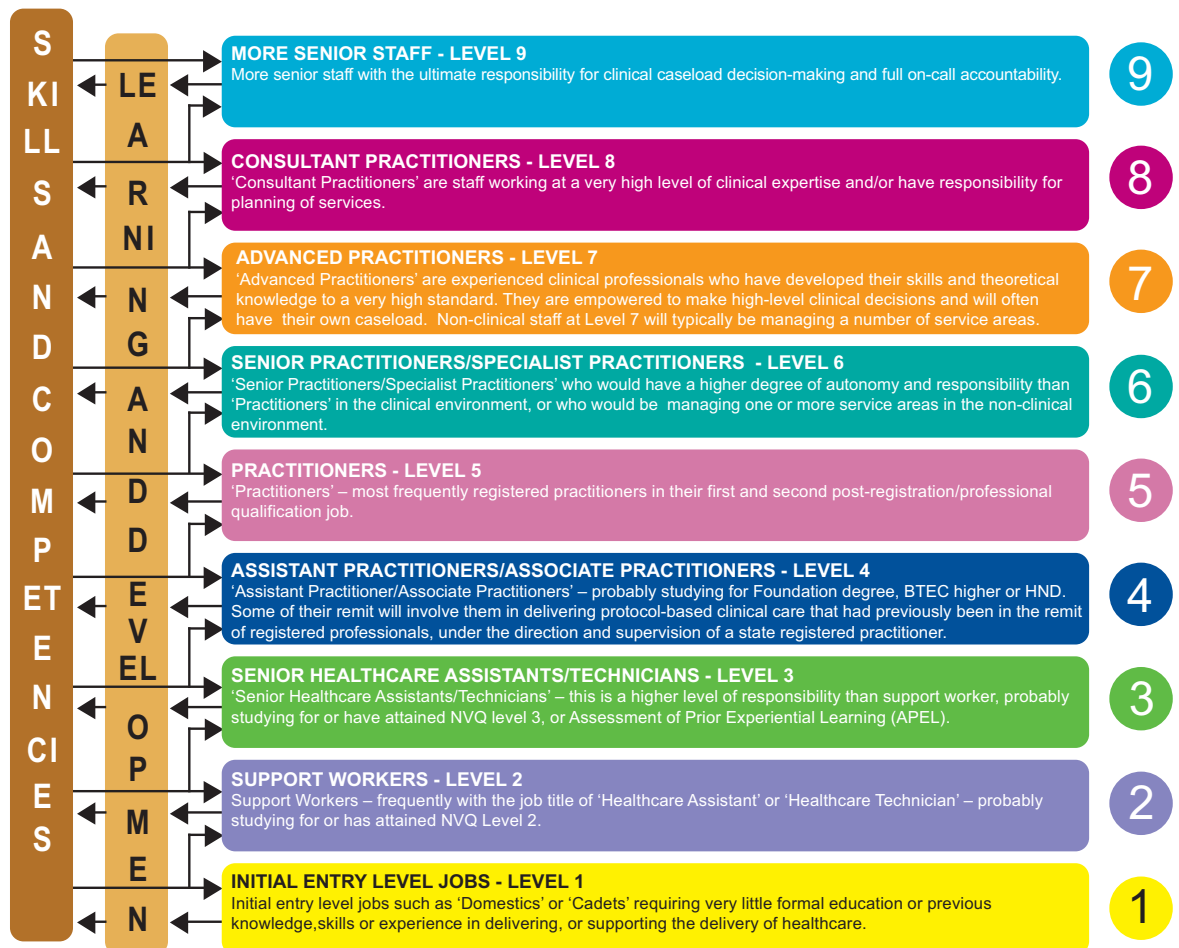
BETTER CARE

BETTER HEALTH

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The career framework for health aims to provide guidance for NHS and partner organisations on the implementation of a flexible career and skills escalator concept, enabling an individual with transferable, competence-based skills to progress in a direction which meets workforce, service and individual need.

Career framework for the NHS



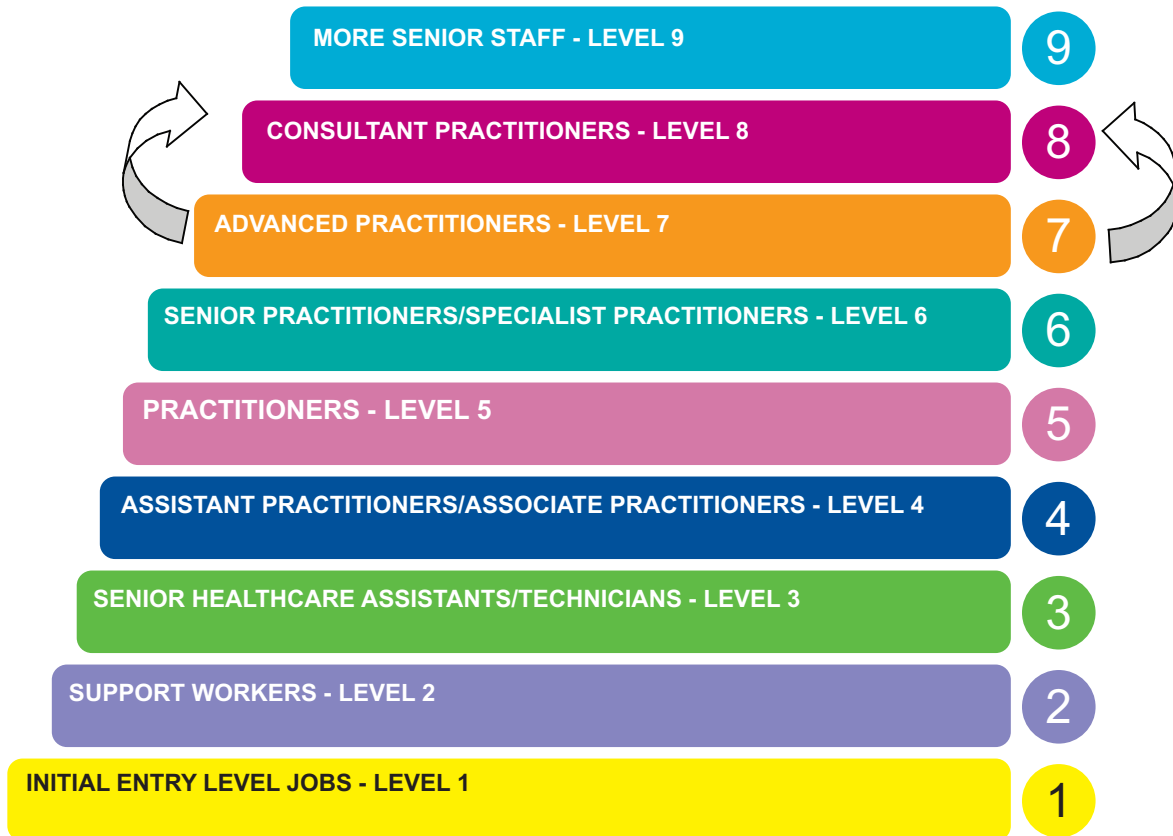
Career framework for health

- Enables skills escalation.
- Aids the development of new roles that meet patient needs.
- Aids the development of competence-based workforce planning.
- Enables individual career planning.
- Acts as a tool for recruitment and retention.
- Facilitates transferability.

Appendix Six

Mapping a career

Mapping a career



Appendix Seven

Table of recommendation and actions

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Recommendation	Action	Responsibility	Time
Organisational adaptation			
1. Maternity providers address organisational resource issues through benchmarking, sharing examples of best practice and publishing cases that demonstrate how the Consultant Midwife has implemented innovative/creative methods resulting in cost savings through effective and efficient care delivery.	Conduct interviews with Consultant Midwives by utilising e-win best practice template. Publish case studies on e-win website.	SHA Workforce Strategy Team	June – December 2010
2. The Strategic Health Authority (SHA) Non Medical Consultant Panel develop a group through which consultant midwives can meet to identify ways in which the quality and service improvement agenda can be implemented regionally in light of the current economic climate.	Incorporate the quality and service improvement agenda into the Consultant midwife forum meetings.	Regional Midwifery lead and Local Supervisory Authority Officer for the North West	June 2010 – June 2011
3. The SHA organises an annual regional event which enables consultant midwives in the North West to demonstrate to stakeholders the added value of their roles promoting benefits to users and increasing wider understanding of the role.	Arrange a regional conference, targeting all midwives, supervisors and managers in the region.	Regional midwifery lead	June 2010 – June 2011

Recommendation	Action	Responsibility	Time
Education and development			
<p>4. The CPD Review ensures that the following skills, essential to consultant role development, are able to be obtained from contracted provision:</p> <ul style="list-style-type: none"> • teaching • negotiating • influencing • leadership • strategic networking. 	Incorporate this recommendation into the work being undertaken by the CPD team.	SHA CPD lead/team.	June 2010 – June 2012
<p>5. The SHA continues to drive inter-professional learning by opening up programmes traditionally aimed at other health professionals to midwives.</p>	Learning and Development Leads in NHS Organisations to liaise with education providers to facilitate multi-professional access to all PQF modules and more specifically increase access for midwives.	The SHA and education providers.	June 2010 – June 2013
<p>6. Education providers maximise learning opportunities through application of creative techniques such as e-learning/distance and work based learning packages.</p>	SHA Commissioners to liaise with education providers to ensure a range of teaching and learning methods are utilised increasing flexibility in education delivery.	Education providers.	June 2010 - June 2013
<p>7. Education providers embed and signpost core clinical leadership skills within pre-registration and post qualifying learning programmes.</p>	SHA to map provision, education providers to flag where the relevant clinical leadership is within programmes.	SHA CPD lead/team.	June 2100 - June 2012

Recommendation	Action	Responsibility	Time
8. The SHA, maternity providers and service commissioners embed education governance within their core work programme ensuring programmes that are clinically credible are developed with robust quality assurance mechanisms.	Incorporate this recommendation into the work being undertaken by the CPD team.	SHA CPD Team/Trust LDA leads.	June 2010 - June 2012
9. Directors of HR, in partnership with the SHA, undertake a review of the effectiveness of midwifery appraisal and its impact on career progression.	Link World Class HR to the quality and service improvement agenda and include in HR forum meetings.	Directors of HR and SHA.	June 2010 – June 2012
10. The SHA, through its CPD review, drives forward equitable access to CPD opportunities testing existing systems through feedback from midwives.	Incorporate this recommendation into the work being undertaken by the CPD team.	SHA CPD lead/team.	June 2010 – June 2011
11. The Leadership Academy reviews the number of midwives accessing their Clinical Leadership Programmes and enable talent management for midwives through improved marketing.	Leadership Academy to audit the specific disciplines accessing their clinical leadership programmes.	Members of the Leadership Academy.	June 2010 – June 2011
Workforce planning and development			
12. Department of Health, Midwifery 2020 steering group and the SHA develop and promote a midwifery career pathway.	Commission a project lead to undertake this work.	Department of Health, Midwifery 2020 steering group and the SHA.	June - December 2010

Recommendation	Action	Responsibility	Time
<p>13. The Non Medical Consultant Panel enhances its engagement with the midwifery profession to maximise approval rates by:</p> <ul style="list-style-type: none"> • Increasing membership to include current midwifery consultants • promoting the partnering of applicant organisations during the application process. 	The Non Medical Consultant Panel assigns a particular individual to lead each application.	Non Medical Consultant Panel members.	June - December 2010
<p>14. The North West Non Medical Consultant Panel undertakes regular review of the compliance with approval submissions surrounding the clinical component of a Midwifery Consultant role.</p>	The Non Medical Consultant Panel undertakes annual reviews/audit of post compliance.	North West Non-Medical Consultant Panel members.	June 2010
<p>15. The SHA in partnership with service commissioners progress with a programme that sees the optimum number of Consultant Midwives outlined delivered by 2012 ensuring sufficient clinical leadership within organisations is achieved and safer birth standards achieved.</p>	The SHA in partnership with PCT commissioners undertake a review which incorporate this recommendation into the work being proposed.	The SHA in partnership with PCT commissioners.	June 2010 - June 2012
<p>16. Maternity providers enhance the interface between primary care and maternity services by ensuring the Midwifery Consultant role has its key public health functions clearly articulated and focused on.</p>	The SHA in partnership with service providers incorporate this recommendation into their future midwifery workforce plans.	The SHA in partnership with PCT commissioners.	June 2010 - June 2012

Appendix Eight

Consultant Midwife Capacity Development Project Steering Group

BETTER CARE

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BETTER LIFE

Author

Lesley Edwards;
Project Lead: May 2010

Consultant Midwife Capacity Development Project Steering Group

Chris Jeffries

Associate Director for Commissioning and
Professional Education

Joe McArdle

Assistant Director of Commissioning and
Education

Mike Burgess

Assistant Director for Workforce Planning

Mary Bell

Assistant Director of Maternity and Early Years

Sue Louth

North West AHP Workforce Lead

Lucy Brown

Workforce Modernisation

Lesley Edwards

Project Lead

Appendix Nine

Professional groups and membership

Consultant Midwife Capacity Development Critical Reference Group

Jenny Furlong

Post Qualification Harmonisation Manager

Marian Drezak

LSA Regional Officer

DR Mike Farrell

Skills for Health

Mervi Jokinen

RCM

Support and Advisory Network

Gaye Jackson

CPD Lead

Kim Leigh

Learning and Development Lead

Victoria MacMillan

QA Lead

Kevin Moynes

Director of HR

Donna Sidonio

Workforce Strategy

Consultant Midwife Capacity Development Expert Groups

Heads of Midwifery

Consultant Midwives

Midwifery Matrons

Advanced Midwifery Practitioners

Specialist Midwifery Practitioners

Midwives

Appendix 10

Communication and Dissemination Strategy

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	Stakeholder	Communication Strategy	Responsibility	Timescale
Internal SHA Stakeholders				
1.	Children and Young People Directorate	Report available on Workforce Education Portal	Assistant Director for Children and Young people	June / July 2010
2.	Leadership Academy		Nick Fowler-Johnson	June / July 2010
3.	Quality and Performance Directorate		Assistant Director for Quality	June / July 2010
4.	Workforce and Education Directorate		Associate Director for Commissioning and Professional Education	June / July 2010
External Stakeholders				
5.	Service Users	Presentation to the MSLC	Assistant Director for Children and Young People	June - December 2010
6.	Consultant Midwives	Discuss at the Consultant Midwife Forum meeting hard copy available and electronic link to report on SHA website. Regional event	Assistant Director for Children and Young People	June – December 2010
7.	Senior Midwifery Managers	Electronic link to report on SHA website. Regional event and circulation of a flyer	Assistant Director for Children and Young People	June – December 2010
8.	Heads of Midwifery	Discuss at the Head of midwifery forum meeting. Hard copy available and electronic link to report on SHA website. Regional event	Assistant Director for Children and Young People	June – December 2010
9.	Royal College of Midwives	Hard copy available and electronic link to report on SHA website	Assistant Director for Children and Young People, Royal College of Midwives	June - September 2010

	Stakeholder	Communication Strategy	Responsibility	Timescale
10.	Non Medical Consultants Approval Panel	Discuss at the Non Medical Consultants Approval Panel meeting. Provide a hard copy and electronic link to report on SHA website.	Assistant Director for Children and Young People. Assistant Director of Education Commissioning	June - September 2010
11.	Maternity Matters Steering Group	Presentation to the Steering Group	CMCD Project Lead	June 2010
12.	Department of Health	Formal discussion and web link	Assistant Director of Education Commissioning	June - September 2010
13.	Directors of Nursing	Presentation at Directors of Nursing Forum and website link	Assistant Director of Education Commissioning	June - September 2010
14.	NHS Careers Team	Links with NHS Employers	HR Team	June - December 2010
15.	Birth Pathway Group	Share report	Assistant Director for Children and Young People	June - September 2010
16.	Midwives from public and independent sectors	Electronic link to report on SHA website. Regional event and circulation of flyer	Local Supervising Authority Regional Representative	June - September 2010
17.	Local Supervising Authority	Presentation to supervisor of midwives regional meeting and display the final report on the LSA website	Local Supervising Authority Regional representative and CMCD Project Lead	January and June 2010
18.	Higher Education Institutions	Information flyer and report, executive summary	Associate Director for Commissioning and Professional Education	June - September 2010
19.	Deaneries	Executive Summary Report	Associate Director for Commissioning and Professional Education	June - September 2010
20.	Medical Workforce	Executive Summary and Deanery STEC	Ruth Hussey Medical Director and Post Graduate Deaneries	June - December 2010
21.	FT and HR Service Planners	Full Report	Assistant Director for Workforce Strategy	June - December 2010

	Stakeholder	Communication Strategy	Responsibility	Timescale
22.	NHS South Central	Full Report	Suzanne Cunningham	June - September 2010
23.	King's Fund	Full Report	Anna Dickson	June - September 2010
24.	Department of Health Policy Team	Full Report	Jane Verity	June 2010
25.	National Workforce Planners	Executive Summary Report	Assistant Director of Workforce Strategy	June - September 2010
26.	PCT Contract leads	Executive Summary Report	Mary to send details	June - September 2010
27.	Midwifery 2020	Full Report	Assistant Director of Education Commissioning	June - December 2010
28.	National Childbirth Trust	Full Report	Belinda Phipps	June - September 2010

Appendix 11

Consultant Midwife job description

Job Title: Consultant Midwife

Job Statement: Provides a consultant service that promotes professional midwifery practice. Provides leadership on evidence-based changes to practice.

Factor	Relevant job Information	Job Evaluation Level
Communication and Relationship skills	Communicates highly complex information, requires sensitivity, tact and negotiating skills/presenting complex information. Communicates complex midwifery information requiring persuasive skills, tact and sensitivity; presenting complex information to university students.	5 (a), (b)
Knowledge, training and experience	Highly developed specialist knowledge. Professional/clinical knowledge acquired through degree in midwifery, masters degree seven years at senior level, plus continuing professional development (CPD).	7
Analytical and judgemental skills	Highly complex situations that require analysis and comparison of a range of options. Judgements on a variety of highly complex clinical problems.	5
Planning and organisational skills	Broad range of complex activities, some ongoing, requires formulation and adjustment of plans ore strategies. Strategic planning regarding maternity for directorate develops plans to implement changes to all areas of midwifery/university strategic review and development of education.	4
Physical skills	Highly developed physical skills, accuracy important/precision, hand/eye coordination. Examining patients. Assisting at birth/suturing.	4
Responsibility for patient/client care	Develops specialised programmes of care/provides highly specialised advice. Caseload covers women with special needs; provision of programmes of care and advice.	6 (a), (c)
Responsibility for policy/service development	Proposes policy that impacts beyond own area/policy implementation and service development for a service. Develops and proposes changes to midwifery services beyond own area/for a service.	3/4
Responsibility for financial and physical resources	Personal duty of care/regularly handles cash/stock control/authorised signatory for small cash/financial payments. Personal use of equipment, small items of equipment/stock.	1/2 (a), (d)
Responsibility for human resources	Teaching/delivery of core training. Runs post and undergraduate training.	3 (c)

Factor	Relevant job Information	Job Evaluation Level
Responsibility for information resources	Records personally general clinical observations. Processes own work/time records.	1
Responsibility for research and development	Coordinating and implementing research and development programmes, securing funding. Advising on Directorate and Trust research and development; obtaining funding for primary research; leading strategy on audits.	4/5
Freedom to act	Guided by organisational and broad occupational policies, some interpretation required. Works within codes of practice and professional guidelines, needs to interpret and establish what needs to be done.	5
Physical effort	Occasional moderate weights for several short periods per shift. Assists women in labour, occasional short bursts of lifting equipment and pushing patients on trolleys.	2 (d)
Mental effort	Frequent concentration, unpredictable work. Concentration when writing, researching and in meetings; unpredictable work.	3 (a)
Emotional effort	Occasional/frequent distressing or emotional circumstances. Conveying unwelcome news to staff/patients occasionally/frequently.	2/3 (a)
Working Conditions	Occasional exposure to highly unpleasant working conditions. Exposure during labour to body fluids, foul linen.	3 (b)
JE Score/Band	JE Score 594-632	Band 8b/8c



