

MATERNITY CARE AND MIDWIFERY STAFFING
15 NOVEMBER 2004
CHAIR'S OBSERVATIONS

Speakers:

Mavis Kirkman – Professor of Midwifery, Sheffield University
Lynne Leyshon – Head of Midwifery, Torbay Hospital, Torquay

The session was organised as an education and discussion opportunity to particularly address one of the main reasons that has been given for implementation problems for maternity service reform, i.e. midwife recruitment and retention. I felt that this aim was fully met and it served as a good opportunity for the identification of, and to debate, the issues.

As a result of the presentations and subsequent discussion the key points to consider were as follows:

1. Whilst the MSG had decided to focus upon the needs of the mother, it is clear that the needs of the midwife are very similar. The ways of working that we identified would meet the mothers' needs would also satisfy the needs of the midwives. This would significantly assist in the recruitment and retention of the requisite midwives.
2. There a significant number of midwives currently registered who ay be attracted to return if they were offered the opportunity of new ways of working similar to the Torbay model and meeting the targets of continuity of care set by the MSG.
3. Midwives can be multi-skilled and taught local languages in additional to other professional education.
4. Particularly due to the close proximity of neighbouring services in the BBC, any reforms should be rolled out as simultaneously as possible. In this way proper planning of numbers can be done as there would be minimal cross-boundary movement in order to search for a different service.
5. The climate is ripe for change:
 - a. Perinatal mortality rates are exceptionally high and need to be addressed.
 - b. Patients want and have the right to choice.
 - c. The SHA is promoting its strategy. A key component of this is a healthy start to life.
 - d. The RCM itself has identified the need for change to accommodate and motivate its members.
6. Whole system integration is the preferred method. Resources are not diverted as much as re-organised by acute trusts. In this way all involved in the care pathway are involved together and savings and expenses are budgeted as a whole. In any event it was clear that the term 'pilot' for any of the first tranche of reforms would probably be counterproductive.
7. Cultural barriers maybe assisted by careful choice of words to describe the initiative – it was suggested that "Midwife-led Caseload Teams" maybe a useful way to describe the philosophy.
8. Changes in all aspects of care need to be considered. For example, reduction category X cases can enable fewer beds to be required. Midwife

assessment at home at the outset of labour can ensure that the mother is in hospital for the minimum time, if at all.

9. Midwives to be treated as case managers and enablers rather than gatekeepers.

In summary the information obtained was entirely consistent with our findings and plans to date. Our philosophy of meeting the mum's needs and not the service needs was supported.

Bridget Nisbet
Event Chair