Defining the midwifery landscape: from vision to reality

17 March 2011, Edinburgh

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It should be emphasised that the* Defining the Midwifery Landscape *event was attended by an invited audience of professionals from practice, management, education and research areas united by a common interest in, and concern about, the future of midwifery in Scotland. The views expressed were therefore those of the participants and may not represent views held more widely in the midwifery community in Scotland.

It must also be emphasised that the points of view expressed at the events, many of which are reported here, were made in a spirit of free and unhindered expression of opinion and belong to the participants. The ideas and views expressed by participants and summarised in this report do not necessarily reflect the views of NHS Education for Scotland, who sponsored the event, or the Scottish Government.

It is not possible to present in the report all the diverse views and ideas expressed at the event, and an element of selection and analysis has been adopted in its preparation.

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1. Background to the event

Midwifery 2020: Delivering Expectations[1] was published in September 2010. Commissioned by the four UK chief nursing officers, *Midwifery 2020* sets out a blueprint for maximising the contribution of midwives to services in the UK over the next decade. It focuses on midwives' core role, their education and development, their contribution to quality, their public health potential, and the workload and workforce implications of putting it all together.

In Scotland, the *Refreshed Framework for Maternity Care in Scotland*[2] was published in February 2011. Building 2001's national *Framework for Maternity Services in Scotland,*[3] the refreshed framework brings together wider policy around areas such as early years and health inequality and maternity policy initiatives such as the Keeping Childbirth Natural and Dynamic[4] programme.

It is crucial that in addition to reflecting and supporting wider health and social care policy in Scotland, such as the *Healthcare Quality Strategy for NHSScotland*,[5] midwives also explore the implications and actions required of them from *Midwifery 2020* and the refreshed framework.

To support this process, NES hosted an event in February 2010, which preceded the launch of *Midwifery 2020.* Participants were facilitated to engage in group conversations – some of which were difficult and challenging – around the future direction of the profession in Scotland. A report of this event, *Towards 2020: exploring the future for midwifery in Scotland − the start of the journey*, was published in March 2010.

A second NES-hosted event was held on 17 March 2011, after the launch of *Midwifery 2020* and the refreshed framework, to enable participants to consider aspects of implementation. The overall aim of the second event was to support participants to begin the process of developing implementation plans highlighting midwifery contributions to putting these policies into practice. The focus was on three specific topics that reflect key workstreams emerging from the profession:

- leadership
- public health and health inequalities
- education[6] and research.

This second event, *Defining the Midwifery Landscape*, offered an opportunity for midwives to share reflections and experiences with colleagues from across the

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[1] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119261
[2] www.scotland.gov.uk/Publications/2011/02/11122123/0
[3] www.sehd.scot.nhs.uk/publications/ffmsshow/ffms-00.htm
[4] www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/naturalchildbirth
[5] www.scotland.gov.uk/Publications/2010/05/10102307/0
[6] This did not include consideration of pre-registration midwifery education, which is currently being progressed through work by the Nursing and Midwifery Council.

spectrum of midwifery in Scotland and further afield, covering practice, management, education and research interests.

The event focused on the challenges, and the opportunities, inherent in turning a vision into reality. It was about defining what midwives want to achieve for the women and families in their care, supported in particular by the *Refreshed Framework for Maternity Care in Scotland* and *Midwifery 2020*, but also by a range of other policy and practice initiatives, such as the Keeping Childbirth Natural and Dynamic programme, the Scottish Women-held Maternity Record,[7] the Getting it Right for Every Child[8] programme and the *Healthcare Quality Strategy for NHSScotland*, which underpins a focus on providing safe, effective, person-centred care.

This report briefly summarises key issues raised in presentations delivered on the day by subject experts, related discussions among participants and suggested priorities for action at national and local level that emerged through group work. The closing chapter offers a comment from the event organisers on how some of the ideas and themes that emerged from the day may be taken forward.

Policy landscape

The *Refreshed Framework for Maternity Care in Scotland* very much reflects the wider policy landscape in Scotland, including principles from the early years strategy, the Getting it Right for Every Child programme, the *Healthcare Quality Strategy for NHSScotland* and work around inequalities and social inclusion.

The context of modern midwifery in Scotland is one in which there is a rising birthrate among higher-risk women at a time when midwifery is working hard to optimise "normality". Maternal health is seen as being crucial to child health and future development, but challenges to maternal health are presented within health inequality and social exclusion contexts and through the rise in long-term conditions within the population. In service terms, redesign is a constant companion that presents challenges and opportunities for midwives to offer direct access to women, perform robust holistic assessments and provide person-centred, safe, effective and timely interventions.

This dynamic and evolving context raises many issues for midwives, including the following.

- How can midwives sustain their core role, focusing on the needs of women during pregnancy, childbirth and the postnatal period, in the midst of the need to meet a wide range of healthcare priorities, agendas and pressures? As has been suggested, it sometimes seems that "everyone wants a piece of the midwife".
- How do services ensure effective and efficient skill mix in the maternity context? Robust debate is required to define not only what other professional groups *can* deliver for pregnant women and their families, but also what they

[7] www.healthcareimprovementscotland.org/programmes/reproductive,_maternal__child/woman_held_maternity_record/scottish_woman_held_maternity.aspx
[8] www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec

should deliver. This raises issues about what aspects of care require a *registered* practitioner, and what aspects require a *trained* practitioner.

- How can research and education be developed to ensure excellent midwifery practice and that all members of the midwifery team are fit for purpose?

The current economic situation presents significant challenges to maternity services, but it also offers important opportunities to encourage innovation and debate on how future services should be shaped.

2. Specific topics – presentations and discussions

Each specific topic was introduced through a 15-minute presentation. Following this, workshops of 75 minutes for each topic were held, during which participants were asked to:

- generally review the workshop topic and related presentation
- define what needs to happen at national and local levels in relation to the workshop topic
- agree priority issues for action at national and local levels.

The following briefly summarises the presentations and workshop discussions in relation to the three specific topics:

- leadership
- public health and health inequalities
- education and research.

Leadership: introduction[9]

Leadership is a two-way process and is not automatically conferred through seniority. Midwives need to be prepared to lead, but they also need to be given the opportunity to have a voice.

Preparation and succession planning are vital to ensure a supply of midwifery leaders for the future. Structures need to be reviewed to ensure that these leaders have direct access to executive nurse directors at NHS board level.

Midwifery leaders have always advocated strongly for women, but they now also have to advocate for their profession. There is a tendency, however, for midwifery leaders to be drawn into wider roles within organisations that restrict their scope for leading maternity services.

Consultant midwives, professors of midwifery, local supervising authority midwifery officers (LSAMOs) and lead midwives in education (LMEs) are vital parts of the midwifery leadership structure. They are not only the leaders of the future, but also the leaders of the present.

Research has shown that successful maternity services are those in which midwifery leadership, medical leadership and health board leadership work together. Where midwifery leadership works alone or is organisationally isolated, progress is rarely evident and is rarely sustained. It is clear, therefore, that midwifery leadership should not be working in isolation.

Midwifery leadership underpins the provision of high-quality, effective and efficient midwifery services and involves:

[9] This summary is based on a presentation given by Gillian Smith, Director, Royal College of Midwives UK Board for Scotland.

- speaking up for midwifery services as a key part of maternity care
- promoting midwifery to service users
- demonstrating the value of midwifery within the wider health and social care service
- protecting the philosophy of midwifery from medical encroachment
- promoting effective team working
- leading through compassion and care, and not by fear
- advocating for midwifery leadership at Scottish Government level.

There are concerns, however, that midwifery leadership influence at NHS board and national levels is reducing, resulting in a sense of disempowerment in taking forward midwifery-specific issues. This raises a number of questions, including the following.

- Does midwifery have the potential to develop leaders?
- Do midwives want to be led?
- Who will protect the midwifery profession?

General discussion in groups

A high percentage of experienced midwives will retire in the next 5−10 years, meaning that the need for succession planning for leadership to start now is urgent. Despite this, questions remain about how midwives can best identify and nurture talent and leadership potential.

A strong midwifery voice is required at strategic level within the Scottish Government to ensure that the midwifery perspective is reflected at the highest levels of leadership. Midwifery leaders at NHS board level should have direct access to executive nurse directors and there should be a midwifery representative on executive boards. Midwifery leaders should take opportunities to articulate the role and value of midwives within these forums and others and should advocate for increases in the numbers of consultant midwives.

Central to attempts to promote midwifery leadership at NHS board level is the need to discard a parochial approach that focuses exclusively on midwifery concerns and fails to engage with the wider policy and healthcare agenda. A narrow cultural focus can stifle midwifery leadership potential. In addition, there are concerns about the difficulties busy midwifery managers in NHS boards face in balancing their professional leadership function against pressing and ongoing operational issues to which they must devote their attention.

The point made in the leadership introduction that leadership is not conferred automatically by seniority or rank is an important message that reinforces the need to nurture leadership potential at all levels of the midwifery workforce. It was noted that some midwifery managers have not been able to benefit from leadership development opportunities. It was also noted, with some regret, that few clinical practitioners were among the event participants, as there is a strong need to "distribute" leadership throughout the midwifery ranks.

Midwifery requires "leadership champions" who can set benchmarks for others to follow, promote the value of strong leadership in the profession and act as

professional opinion leaders, stimulating reflection and debate. The consultant midwife role is recognised as being a strength for midwifery leadership in general, but there are concerns that consultant midwives hold no real power at local or national levels. Supervisors of midwives also represent a strength for midwifery leadership, but it is not clear how well supervisors recognise and, consequently, follow through their leadership function.

There is a need to measure where midwifery leadership is at present to establish a baseline against which future progression can be mapped. It is not sufficient for midwives simply to state how they want leadership to develop within the profession: they must first understand where they currently stand.

There is a need to implement national frameworks and standards for leadership to drive midwifery leadership development at all levels, supported by the development of centres of excellence to promote midwifery leadership through education and research. In addition, the theory and practice of leadership should be woven explicitly into pre- and post-registration midwifery education programmes. Universities and NHS boards need to work together to prepare the midwifery workforce to accept and adopt leadership roles and to engage midwives with leadership options within their career planning. Support for leadership development at NHS board level should be provided through protected time for leadership development and the provision of mentorship and support opportunities for leaders.

Organisational cultures should be addressed to facilitate equality of opportunity for all.

National action: top priorities

- The creation of a midwifery appointment at government level.
- Support for the wider implementation of existing leadership standards and frameworks.
- The development of centre of excellences to promote midwifery leadership through education and research.

Local action: top priorities

- Midwifery leaders better utilising direct access to executive nurse directors.
- The development of a supported career framework for midwife leaders.
- Implementation of national leadership standards and frameworks.
- Protected time for leadership development and the provision of mentorship and support opportunities for leaders.
- The head of midwifery in every unit providing professional, in addition to managerial, leadership.

Public health and health inequalities: introduction[10]

According to the World Health Organization, reducing health inequalities is a matter of fairness and social justice. Evidence shows that the more unfair and unequal a society, the more prevalent health inequalities become, while countries that are more equal and that have greater investment in public services have less inequality.

[10] This summary is based on a presentation given by Christine Duncan, Change and Delivery Manager – Maternity Services, Scottish Government.

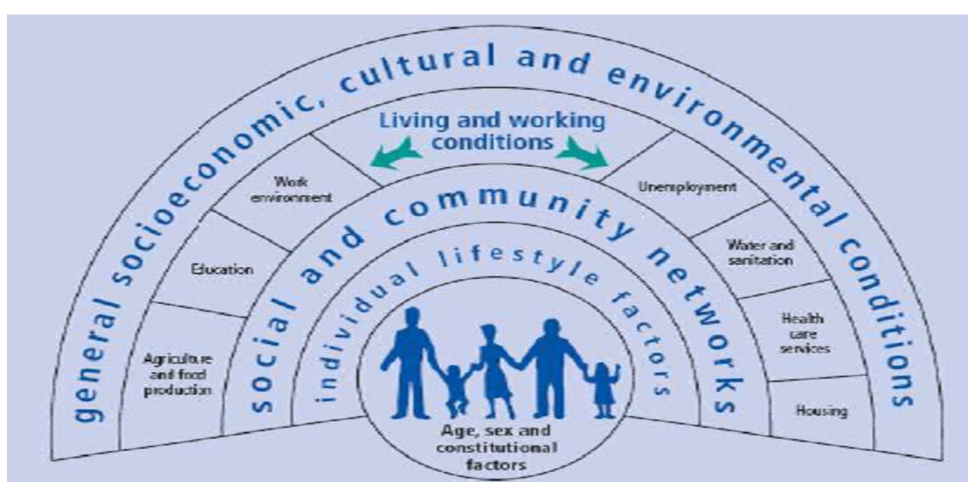
Social inequalities are not just about poverty. Issues such as gender are also crucial to inequalities, and it is important that midwives have a strong understanding of the impact of gender inequalities on women's health. Questions can be asked about how robustly midwives respond to the impact of social inequalities on women's pregnancies, particularly in comparison with responses to physiological events in pregnancy. While systems and processes are in place to deal with physiological problems such as a mother's raised blood pressure, it is unlikely that there will be similarly robust systems and processes to tackle the social inequalities she faces.

There is much debate presently about the relative benefits of universalist compared to targeted approaches within maternity services. While targeted approaches claim to provide support to those most in need, need nevertheless also exists among groups of women living in non-deprived, and consequently non-targeted, circumstances. Targeted approaches will therefore not address inequalities – an approach that addresses the needs of all women in a proportionate way is required.

The determinants of good health and of inequalities are complex. Understanding what is needed to support good health – including access to good health services, adoption of a healthy lifestyle and good living and working conditions – helps develop an understanding of why inequalities in health exist. But health inequalities are "wicked" problems,[11] which means that by definition, there are no simple solutions.

Health is an enormous, complex concept within which health care services play a small but very significant part. Smaller still is the contribution of maternity services within health care services. This provides a perspective on how the NHS and maternity services have an important role to play, but only as part of a much wider approach that includes a range of factors, agencies and actors, as Fig. 1 shows.

Fig. 1 Public health requires all of these factors and agencies to play in ...



[11] A "wicked" problem has been defined as: " ... one for which each attempt to create a solution changes the understanding of the problem. Wicked problems cannot be solved in a traditional linear fashion, because the problem definition evolves as new possible solutions are considered and/or implemented." (Source: http://cognexus.org/id42.htm)

Midwives need to think of the wider context in relation to inequalities. In particular, they need to think about:

- the unique role of the NHS: the NHS has a small but vital role in addressing inequalities through offering women a gateway for access to universal, high-quality, equitable care and support
- the unique role of maternity care services: health care is in itself health-improving
- the unique role of the midwife: there are key issues over which midwives have control, including: providing continuity of carer, which is particularly important for vulnerable women; communicating and providing information appropriate to women's needs; and ensuring women's experience of care is equitable and the care provided is appropriate to their needs.

Investing in upstream work with women to reduce inequalities, increase access to services, promote health and intervene early provide tangible benefits not just for women and their babies, but also for budgets. It has been estimated that such interventions could save NHSScotland £5.4 million in the short term and £131 million per annum over the medium term.

In moving forward on this agenda, midwives should consider:

- how robustly they currently address social problems presented by the women and families in their care
- the role of the midwife in socially complex pregnancies
- the unacceptability of current inequalities in care delivered to women
- the need to embed assets-based approaches in midwifery practice.

General discussion in groups

Pregnancy and childbirth are essentially public health issues that have direct impacts on the long-term physical and emotional well-being of women and their families. It is recognised that while some women may not be vulnerable when they enter maternity services, they may well be vulnerable by the time they exit <u>unless</u> midwives perform their core business well – which includes taking a public health approach.

There needs to be a culture shift and greater understanding of the impact of health inequalities within midwifery, but not at the expense of the core role of the midwife. This is about "midwives for midwifery" – midwives cannot do everything, and there are people in teams within service settings who are better-placed to deliver public health interventions than midwives. It is important for midwifery to define exactly what it can and cannot deliver.

Midwives should celebrate and share successful outcomes of their public health role to raise awareness among the public and services of the important impact they can have. Sound monitoring systems based on those outcomes should be developed, and midwives should also consider how to capture their public health role through workforce measurement tools. It must be recognised, however, that while midwives may have an important role to play in promoting public health, they are not necessarily experts in public health approaches – they require support, advice and education to support their public health role.

Following on from this, there is a need to identify the kind of public health and health inequalities education midwives need and then to plan education delivery appropriately to ensure greatest impact from the resource available: for instance, it would be wasteful to provide two education opportunities for midwives on smoking cessation and responsible drinking if one common course on brief interventions may suffice. It is suggested that the greatest return for investment on public health education for midwives would be through offering it to community midwives as a priority.

All midwives should be taught about factors that influence social change, and midwives should be enabled to participate in multi-disciplinary training on public health. There is also a perception of a need to include public health in the undergraduate midwifery programme, but it is recognised that it will be a challenge to integrate public health within what is an already crowded curriculum.

It is worth considering whether it would be effective to create designated midwives who would focus on the public health role within midwifery services, but the potential impact of this on fragmenting care delivery would need to be recognised.

Currently, public health is not always seen as a priority for maternity services. Midwives say they want more time to focus on public health in their engagement with women and families, but that time is a challenge, given the many other issues and priorities midwives face. Consequently, there is a view that midwives only have time to touch on public health issues in a superficial way.

Despite this, midwives can consider how to make better links to agencies such as social care and community services to ensure public health issues are identified and addressed. Midwives in some areas lack confidence in managing social issues and should be turning to appropriate professional colleagues for support. Evidence-based models (such as Sure Start) and pathways can also support midwives in achieving this, and these models and pathways should be mainstreamed within maternity services. Awareness of Getting it Right for Every Child approaches should be increased among midwives, and outreach strategies with the third sector should be developed.

In addition, there is significant interest among midwives in the co-production approach to care, which advocates professionals working in strong partnerships with communities to develop community approaches to, for example, support women who are breastfeeding

Midwives' interventions normally have a very rapid impact, so it is important for midwives to recognise that there are few "quick-fix" solutions for public health issues. They therefore need to develop a mindset that recognises the value of interventions that promote longer-term benefits for women and their babies.

At NHS board level, public health funding should be cascaded to maternity services. New models for public health should complement the Early Years Framework, and the nationally developed vulnerable families pathway should be implemented.

Appropriate time should be allocated for antenatal appointments to include public health advice and consultation.

National action: top priorities

- Promotion of a culture shift towards public health within midwifery, but not at the expense of the core role of the midwife.
- Identification of the kind of public health and inequalities knowledge, skills and attitudes required by midwives.
- Development of an effective infrastructure for communication with social care and community services.
- Mainstreaming of evidence-based models (such as Sure Start) within maternity services.
- Adoption of co-production approaches to care.

Local action: top priorities

- Implementation of public health education at local level for midwives, prioritising community midwives.
- Cascading of funding for public health to maternity services.
- Implementation of the nationally developed vulnerable families pathway.
- Development of roadshows to further promote the Early Years Framework to midwifery services.
- Appropriate time allocated for antenatal appointments to include public health advice and consultation.

Education and research: introduction[12]

Scotland has recently published guidance on the development of clinical−academic research careers in nursing, midwifery and the allied health professions[13] which focuses on the need to develop a critical mass of clinical−academic researchers at each level of the NHS career framework. While this is not easy to achieve in a small profession like midwifery, it is nevertheless considered central to making progress in this area.

Clinical−academic research careers are about midwives combining research with practice (rather than opting for one route or the other), facilitating knowledge transfer and supporting an evidence-based practice culture. There is a well-recognised gap between the availability of research output and individual practice: clinical−academic roles aim to reduce that gap by increasing the uptake and impact of research in practice settings. Evidence suggests that when the role is appropriately designed and described and where support is provided for the post-holder, the sum of combining practice and research exceeds the component parts.

[12] This summary is based on a presentation given by Gwendolen Bradshaw, Head of the Division of Midwifery and Reproductive Health, University of Bradford, and Bob Parry, Associate Director, NHS Education for Scotland.
[13] NES (2011) *National Guidance for Clinical Academic Research Careers for Nursing Midwifery and Allied Health Professions in Scotland.* Edinburgh: NES. Access at: www.nes.scot.nhs.uk/about-nes/publications/national-guidance-for-clinical-academic-research-careers-for-nursing-midwifery-and-allied-health-professions-in-scotland

The introduction of clinical−academic research roles requires a managed process to plan, implement and evaluate the impact and a high level of visible organisational management support. There is also a need to:

- address human resource issues around, for instance, contracts and pensions
- encourage a positive and responsive work-based culture
- ensure appropriate research supervision and clinical mentorship
- promote strong partnerships between health boards and universities.

Key questions around clinical−academic research careers include the following.

- How can the gap between research output and practice uptake be reduced?
- How can collaboration between researchers and research programmes be promoted at international level?
- How can work-based cultures be supported to become receptive to research-led change?
- How will clinical knowledge and skills be developed alongside the development of research skills?
- Who will spot "talent", and how?
- How will talented clinical researchers be retained?
- Who will determine research priorities?
- How will research-informed and enhanced teaching be facilitated?

Continuing professional development (CPD) in midwifery needs to link explicitly to developing the safety, quality and effectiveness of practice. It is important to be able to demonstrate enhanced quality of care as a direct result of midwives' engagement with CPD activity. In the current economic climate, opportunities for midwives to engage in CPD activity supported by resources from their employer are likely to be reduced (contracts for CPD in England, for instance, are being cut by 25% over the coming year), although a certain element of employer responsibility is recognised. It will therefore be even more important for midwives to identify their developmental needs and to demonstrate the impact on the quality of services they provide as a result of the CPD activity in which they are supported to take part.

Technology will probably play an increasingly important role in the delivery of CPD activity as we move forward, particularly for practitioners in remote and rural areas.

In relation to specialist and advanced practice, it is important to have:

- clear roles and expectations
- good employer practices, with support for the acquisition of appropriate educational underpinning for practice
- an evidence-based approach through which practitioners can demonstrate ongoing competence.

Midwifery 2020 outlines the possibility for midwives to specialise along all levels of a continuum from "novice" to "expert" practitioner status, with opportunities to specialise or to adopt a more "generalist" role. Any defined specialism needs to reflect the needs of the group of women who are being cared for. Midwives who do

“specialise” may choose to move from one area of “specialist” interest to another during their career. A sound educational underpinning for specialist practice is necessary, although the academic level of the preparation may vary. For advanced practice, *Midwifery 2020* stated that educational preparation should be pitched at Master’s level. It is possible to have an advanced practitioner working in either specialist or generalist roles. Promoting normality will always remain paramount.

Key questions in relation to specialist and advanced practice include the following.

- How can opportunities for midwives to develop their skills be created in economically challenging times?
- What models of care can best facilitate a range of career pathways?
- How can midwives be supported to access educational opportunities that are linked demonstrably to enhancing the quality of midwifery care?

General discussion in groups

There is a need for an overarching midwifery research agenda that reflects primarily the needs of women and midwives and from which large multi-centre research studies can grow. The overarching research strategy should be reflected in, and supported by, research strategies developed at local level that support the initiation of strong, local, collaborative research projects. NHS boards and universities should work closely together to identify these local research priorities and devise plans to address research issues locally (there may be advantages in adopting regional approaches to this process).

Local links at NHS board level should be identified to feed into the recently established Royal College of Midwives’ (RCMs’) research group. This would help in identifying key research areas relevant to practice.

There are concerns among midwives on the potential impact on research capacity and capability of reducing the number of midwifery education providers in Scotland. Universities and NHS boards are urged to monitor this situation very carefully.

A national structure for clinical−academic careers, with all relevant human resources issues resolved, is needed to grow the cohort of research-capable and practice-orientated midwives. The medical profession may offer a good model on the development of posts jointly funded by NHS boards and universities. A timebanking system, through which academics and practitioners are credited time for the hours they spend working in each others’ environments, is recommended as a means of supporting joint appointments.

Students should be supported by universities and NHS boards to embrace lifelong learning approaches and consequently broaden their horizons for developing future practice. NHS boards should work with universities to identify potential midwifery leaders early and support them through into practice.

National action: top priorities

- Development of an overarching midwifery research agenda.
- Development of a national structure for clinical−academic research careers.

Local action: top priorities

- Development of midwifery research strategies at local level that reflect national priorities and local needs; there may be advantages in adopting regional approaches to this process.
- Development of local links at NHS board level to feed into the RCM research group.
- Adoption of a timebanking system to support joint appointments.

3. Moving forward

A comment from the event organisers, who included representatives from NHS Education for Scotland and the Scottish Government

The *Delivering the Midwifery Landscape* event formed part of a process of gathering intelligence to feed into the Maternity Services Action Group (MSAG) on what the midwifery contribution to delivering the *Refreshed Framework for Maternity Care in Scotland* might be. Participants raised many points for local and national action, the most prominent of which are addressed below.

Leadership is key to taking Scotland's midwifery services forward, but it was clear from discussions at the event that there is a perception of a lack of midwifery leadership, power and influence at the highest levels. This perception exists despite many of the participants at the events having been able to access a range of leadership development programmes and initiatives. We believe it would therefore be most sensible to focus effort in this area on transforming and translating the leadership development activity midwives have undertaken into practical actions.

RCM UK Board for Scotland has indicated a willingness to support Scottish Government to develop initiatives in this area, and a proposal will go forward to the Framework Implementation Group of the MSAG. Related work that has been taken forward with midwives in England may provide indications of how such initiatives should develop.

As a first step, there could be value in conducting a mapping exercise to benchmark existing midwifery leadership against the National Leadership Standards for NHSScotland.[14] An approach will be made to the National Leadership Unit[15] to review options in this area.

Improvement methodologies, such as lean methodology and the Releasing Time to Care initiative, show much promise in supporting maternity services in key quality areas such as rapid access to services and ensuring continuity of carer. Initiatives are being planned to promote and embed these kinds of approaches within maternity services nationally.

There are clear indications from the event of the need for project work in relation to midwives' roles in public health. One such project could look at the relevant education implications, building on the strong existing public health education base in midwifery education to transform theoretical underpinnings into practical actions in maternity services. Innovative models of education that have been used in dentistry and pharmacy may be translatable to a midwifery context to support this work, and NES is considering options.

A second area of work would be aimed at clearly articulating the role of the midwife in public health, again building on the strong base of work that has been carried out in this area to enable midwives to understand their public health functions more clearly and to enact them effectively in practice.

[14] Access at: www.scotland.gov.uk/Publications/2009/10/29131424/0
[15] See: www.nes.scot.nhs.uk/about-nes/educational-development/national-leadership-unit

Event participants eagerly supported the benefits of clinical−academic research careers and the need for centres of excellence for research and education in midwifery. We are mindful that the Scottish Government review of midwifery education has recently commenced, and suggest that issues around clinical−academic research careers and centres of excellence should be taken forward to inform the review.

We also note the difficult issues around human resources in relation to clinical−academic research careers, which are addressed in the *National Guidance for Clinical Academic Research Careers for Nursing Midwifery and Allied Health Professions in Scotland* document. As a general principle, we will continue to promote more integrated working between NHS boards and Scotland's universities.

While the call for participants for local links to be identified at NHS board level to feed into the recently established RCM research group to help in identifying key research areas relevant to practice is very much to be welcomed, we believe the initial need is to strengthen links between boards and the Nursing, Midwifery and Allied Health Professions Research Unit (NMAHP Research Unit).[16] It is clear that the RCM research group and the network it is creating will have a key role in this.

There is clear synergy between the key issues that emerged from the event – the need for clear leadership to drive improvement methodologies to enhance effectiveness and quality, the focus on the public health elements of the midwifery role and the need for excellence in education and research to support high-quality, effective care – and the *Healthcare Quality Strategy for NHSScotland*. Measures taken to advance the issues raised by event participants will be progressed within the wider workstreams being developed to achieve the Quality Strategy's three quality ambitions for NHSScotland of safe, effective and person-centred services.

This report could not reflect all of the wide-ranging and dynamic discussion that took place on the day, but has attempted to gather some of the key points as they were reflected in feedback from participants. These messages will now go forward to inform the process of implementing work under the auspices of the *Refreshed Framework for Maternity Care in Scotland* and *Midwifery 2020: Delivering Expectations*.

In closing, we wish to thank Ros Moore, Chief Nursing Officer for Scotland, for opening the event and for continuing to support the ongoing debate on the future of midwifery in Scotland, and to all those who helped to organise and deliver the event.

[16] See: www.nris.gcal.ac.uk/

Annex 1. Summary of national and local priorities

Leadership	
National priorities	**Local priorities**
• The creation of a midwifery appointment at government level. • Support for the wider implementation of existing leadership standards and frameworks. • The development of centre of excellences to promote midwifery leadership through education and research.	• Midwifery leaders better utilising direct access to executive nurse directors. • The development of a supported career framework for midwife leaders. • Implementation of national leadership standards and frameworks. • Protected time for leadership development and the provision of mentorship and support opportunities for leaders. • The head of midwifery in every unit providing professional, in addition to managerial, leadership.
Public health and health inequalities	
National priorities	**Local priorities**
• Promotion of a culture shift towards public health within midwifery, but not at the expense of the core role of the midwife. • Identification of the kind of public health and inequalities knowledge, skills and attitudes required by midwives. • Development of an effective infrastructure for communication with social care and community services. • Mainstreaming of evidence-based models (such as Sure Start) within maternity services. • Adoption of co-production approaches to care.	• Implementation of public health education at local level for midwives, prioritising community midwives. • Cascading of funding for public health to maternity services. • Implementation of the nationally developed vulnerable families pathway. • Development of roadshows to further promote the Early Years Framework to midwifery services. • Appropriate time allocated for antenatal appointments to include public health advice and consultation.
Education and research	
National priorities	**Local priorities**
• Development of an overarching midwifery research agenda. • Development of a national structure for clinical−academic research careers.	• Development of midwifery research strategies at local level that reflect national priorities and local needs; there may be advantages in adopting regional approaches to this process. • Development of local links at NHS board level to feed into the RCM research group. • Adoption of a timebanking system to support joint appointments.