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Neighbourhood Midwives: the making of a midwifery mutual

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About Annie Francis

Annie is the CEO and one of the four founders of Neighbourhood Midwives, an employee owned, midwifery social enterprise based in London. Before embarking on this latest and most challenging journey of her midwifery career to date, Annie was an independent midwife for fifteen years, providing individualised midwifery care to women in South London. She is a passionate advocate for increasing the range of alternative choices available for both women and midwives and believes that innovation and real change has to come from challenging the *status quo*, not accepting it.

In 2006, a group of independent midwives were invited to meet with Christine Beasley, who was then Chief Nursing Officer at the Department of Health. I was at that meeting and we were told that the Labour government had decided to make professional indemnity insurance a mandatory requirement for all health care professionals. This decision followed concern expressed in parliament that some dental patients, who were suing their orthodontist, had no absolute right of redress in law. The reason for our meeting was because of all the groups that were affected, independent midwives (IMs) were the only ones who would be unable to access insurance at all. We were left in no doubt that to save the future of independent midwifery we either had to find a solution or stop practising. Thankfully, we were offered support from the Department of Health to explore some different possibilities.

Over the past eight years, the road to implementation of mandatory professional indemnity insurance (PII) has been a torturous one, with many twists and turns. The proposed legislation for midwives is encapsulated in an amendment of article 12 under the Nursing and Midwifery Order 2001:

"*12A.—(1) Each registrant who practises as a nurse or midwife must have in force in relation to that registrant an indemnity arrangement which provides appropriate cover*" (Health Care and Associated Professions (Indemnity Arrangements) Order 2013).

It will be implemented through an EU directive and is expected to be in place from July/August 2014.

Fast forward several years from that initial meeting and there have been a number of different responses to PII that have resulted in a range of options for independent midwives. This article is about one of those options — a new and innovative organisation called Neighbourhood Midwives.

Although accessing insurance was a problem, for a number of us it also represented an opportunity to think about how PII could be used as further leverage to bring the model of independent midwifery into the NHS so that women could access it free at the point of need. We decided to put together a proposal which was known as the NHS Community Midwifery Model (NHSCMM) (Francis & van der Kooy 2004). There was a great deal of interest and

enthusiasm for our proposal and it was officially launched on the 19 April 2005 at the joint IMA/MIDIRS conference on sustainable caseloading.

Early discussions, which had taken place with the Department of Health and the government, were focused on how we could become a social enterprise, that is, an organisation which reinvests any surplus back into improving care. This type of organisation would be an alternative provider of midwifery services to the NHS which would then enable us to have access to the Clinical Negligence Scheme for Trusts (CNST) for insurance. During this phase we successfully applied for a grant from the DH Social Enterprise Investment Fund, or SEIF, and were hoping to set up a pilot to test out the concept in Kent. So far, so good. However, one of the many things we have learnt over the years is that nothing is as simple as it first appears.

There were endless delays and setbacks, none of which seemed to make much sense to us because they were usually as a result of a bigger political picture in which we played no part. This is still true today of course, but we have grown well used to it by now and regard it as par for the course. The eventual outcome though, was that the proposed solution of IMs joining the CNST scheme was kicked into the long grass because of complex issues about how the exact mechanism would work for some of the bigger organisations.

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It became clear that, if we were to make any real progress, we would need to turn to the commercial insurance sector again to see what, if anything, we could achieve there.

After a number of meetings and discussions, the NMC and RCM agreed to commission a report about the feasibility of accessing insurance for independent midwives. The Flaxman report (Flaxman Partners 2011) spelled out the reason for the reluctance of underwriters as a group to offer an insurance product to IMs. Their main conclusion was that self-employment within the health care profession was now fraught with difficulties. Harold Shipman is the most infamous example of what could happen when an individual works alone — even with, already considerable, regulatory checks and balances in place. A self-employed midwife, working on her own and offering intrapartum care at home, was way beyond the comfort zone of the risk-averse insurance industry.

That left us with the option of exploring some form of employment if we wanted to continue on this route. After much deliberation we eventually had our eureka moment — employee ownership! What if we became the 'John Lewis' of midwifery, a mutual, or co-operative organisation in which midwives would all be employees and owners too? It felt like a perfect compromise.

We met with Baxendale, an employee owned company who support other organisations wanting to become employee owned and immediately discovered shared values and a common purpose. After a great deal of work together, from project management to legal and financial support, they became our investors and, following their invaluable support and input over the past two years, we have slowly but steadily, worked through what this embryonic new organisation would look like.

Having adopted co-ownership as our employment model, we then set about putting together a comprehensive governance framework with midwifery focused guidelines. This included a full set of care pathways, policies and processes, financial forecasts and IT requirements, all built into a five year business model. This mammoth task achieved the first and most pressing requirement — that of full insurance. We then successfully applied for Care Quality Commission (CQC) registration. In 2012, Neighbourhood Midwives Ltd (NM), the UK's first and only employee owned, midwifery social enterprise was born.

During this period of development, the initial premise of us contracting into the NHS was still our preferred route and what we had originally set out to achieve. However, we now found ourselves in a very different political landscape. The coalition government, its austerity measures and the 2012 Health and Social Care Act have, between them, created a deeply challenging set of circumstances for the NHS. We were faced with a new reality — that the likelihood of us being able to get a contract while the NHS was undergoing such huge re-organisation was now more remote than ever.

The other difficulty we had was that, as a new 'start-up' business, NM was unable to demonstrate the outcomes, such as higher rates of normal births, fewer interventions and greater satisfaction amongst women, which we passionately believed we could achieve and for which there is plenty of evidence (Sandall *et al* 2013). So, we went back to the drawing board and took the decision to launch as a self funded service, which meant women would pay us directly. That way, we could begin to test out all our processes, recruit our midwives and build our database of outcomes. It also meant that the overall business model was strengthened as the additional revenue would help support the eventual NHS work done at tariff.

We think of this phase in our development as 'campaigning through delivery': all women should have the choice of a positive experience of childbirth with a midwife they know and trust. Just as midwives should have the option of an alternative, holistic way of working (more in tune with how midwives used to practise, when based in the community, but in a 21st century context). Ultimately, for us, this means NM being commissioned to work within the NHS.

And so, in July 2013 NM launched in South East London after almost two years of planning and preparation. To date we have ten midwives based across London and the surrounding areas and have had almost 50 babies born. We have learnt a great deal over the past ten months, not least how to be endlessly adaptable and flexible in the face of constant challenges. However, the most exciting discovery is the potential that employee ownership has to bring about transformative change in midwifery through the development of a positive, shared culture of genuine partnership and support.

Since the Mid Staffs enquiry there has been a great deal written about the dysfunctional culture that can develop within hospitals and there has been a concerted effort to encourage more compassionate, kinder and individualised care. Although there is obviously the need for regulation and the management of risk, if there is too much rigidity in the structures that support a system, it can create repetitive and inflexible behaviour which in turn can become an expectation that everyone must conform (Martin 2010).

If conformity is valued above quality, then a blame culture may develop in which an individual midwife who argues for a more flexible approach, or wants to support a woman choosing to step outside of a 'guideline', may be seen as a troublemaker, or subversive. She may be either bullied into conforming or eventually give up and leave the profession, adding to the ranks of qualified midwives who have chosen not to practise. Mavis Kirkham (2007) describes the hierarchical and rigid power structure within the NHS in which a technical and managerial climate pervades. Actions and interventions that can be measured count for more than what she describes as the essence of midwifery — the less visible or measurable care embodied in relationships.

It is not surprising then that midwives may struggle in this environment to hold on to a philosophy of care and compassion, a philosopy that has usually brought them into the profession in the first place. But, if a rigid and conformist culture is part of the problem how do we change it? The independent review of staff engagement (GOV.UK 2013), which launched in October 2013 and reported its results in April 2014, was an attempt to come up with some of the answers.

One of the options it considers is the increased use of employee ownership. There are a handful of these already operating within the NHS and social care sector having used the 'right to request' or the 'right to provide' mechanisms (Cabinet Office 2011) to spin out of the public sector. They are frequently held up as exciting examples of proactive and innovative change within the public sector (Big Society Awards 2014), so why not try it within midwifery?

NM originally adopted the idea of employee ownership as a pragmatic decision, but we have since discovered through living it that it is so much more than that. The ongoing challenge within midwifery is how to provide a nurturing, relationship-based, high quality and safe level of care to women without sacrificing a midwife's own health, well-being and family life. By making midwives owners within their own business, we give them greater responsibility and autonomy and a thriving partnership culture that supports innovative provision of 24/7 individualised care in a way that works for everyone.

Midwives must have a real say in how to create a more fulfilling work/life balance for both themselves and their colleagues. Enabling and supporting midwives to come up with creative solutions to managing that balance is encouraged within an organisational culture that listens to and respects every member's opinion and trusts each midwife to take individual responsibility for her own practice.

"After all these years of effort, it remains our ambition and goal to be commissioned to provide our unique service within the NHS"

True caseload models work best when there are no clocking on and off times, when a midwife arranges her work schedule to fit in with her life, as well as meeting the needs of the women she is caring for. So if an evening visit compensates for a morning off to watch your child's school assembly, that's fine. On call is manageable because you can have a protected 24 hours off each week, plenty of holiday to recharge your batteries and an organisational commitment to a sustainable caseload. We use a buddy system, so if you have a special anniversary or family birthday, you can arrange to divert your phone to your partner for the evening and let your women who are due know the details through a simple text. The buddy system and team support ensures that after being up all night at a birth your midwife partner will see your women the next day, safe in the knowledge that you will do the same for them.

At NM we have a flat hierarchy throughout the organisation. Yes, there are different roles amongst us but we don't have managers in the traditional sense. There is a central management team, who take responsibility for the business strategy, finance, HR, audit etc, but there is a place on the board for an employee director, voted in by her colleagues. There is also an expectation that each and every employee, as an owner of the business, takes a full and active role in the development and growth of the whole organisation, sharing in and contributing to the vision and social aims outlined within our constitution.

The model of employee ownership also promotes genuine clinical autonomy for the midwife, enabling her to develop and enhance her full range of skills within a supportive culture, but underpinned by a robust governance framework which has been developed in line with national guidance. Individual midwives also take responsibility for contributing to the regular updating of our guidelines and policies. All of this helps to create a more nurturing culture and recognition of the balance between taking responsibility and giving support.

"When I finally went into labour at 7am, I was holding my baby girl within 2.5 hours after a beautiful home birth and I truly believe a large part of that had to do with the fact that I could be so relaxed because they made me feel so safe"

None of this can be taken for granted though and needs to be constantly nourished and grown through flexible, open and transparent communication channels via weekly team meetings and our monthly NM days. These gatherings must always involve food — usually a shared lunch, and might also include a reflection on a current issue, or a midwife taking on responsibility for a particular aspect of training and updating and then 'booking a slot' to share her learning with everyone else.

The definition of the word 'midwife' is 'with woman' — and the entire *raison d'etre* of NM is to enable and support a midwife to be just that — with a woman throughout her childbearing experience, a skilled practitioner who she knows and trusts. After all these years of effort, it remains our ambition and goal to be commissioned to provide our unique service within the NHS. We now passionately believe that employee ownership could be the key that finally unlocks the barriers that have proved so resistant to change.

Case study

Amy Fanton, who gave birth to Scarlett at home in October 2013, was cared for by Neighbourhood Midwives.

"*My first birth was relatively straightforward from a medical perspective. It was traumatising emotionally and left me sceptical of my body's ability to birth without intervention, fearful that I wouldn't be able to cope through a normal labour, and afraid of the hospital setting. As soon as I knew I was pregnant with my second child, I knew I wanted to try for a natural birth.*

During the antenatal period, Annie Francis and Tina Perridge were amazing at helping me work through these fears and anxieties so that during the labour I was able to just let go. By the time my labour was imminent, I was completely at peace with the possibility that I might end up in the hospital setting I had previously been so fearful of, because I knew I could 100% trust their judgment and expertise. When I finally went into labour at 7am, I was holding my baby girl within 2.5 hours after a beautiful home birth and I truly believe a large part of that had to do with the fact that I could be so relaxed because they made me feel so safe. During the labour they were nothing short of brilliant — calm, soothing, loving, positive motherly energy, helping me get back in control when I started to struggle, but also knowing exactly when to stand back and let nature take its course. The monitoring they did was so gentle and unobtrusive that most of the time I wasn't even aware it was occurring. They were perfect guides through a challenging, but beautiful experience that I will treasure for the rest of my life. They were my epidural, and then some (and definitely my husband's sedative!)."

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