

**Royal College of Midwives
and
Nursing & Midwifery Council**

**The Feasibility and Insurability
of
Independent Midwifery in England**

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1	The Brief.....	5
	The Instructions.....	5
	"independent midwifery" – meaning of	6
	Gender Equality	6
2	Methodology.....	7
	Sources of Information	8
	The Advisory Group	8
3	Executive Summary	9
	The Fundamental Issue.....	9
	Executive Key Facts.....	9
	Executive Recommendations.....	11
	Background.....	12
	Sustainable Indemnity/Insurance	13
	Concept of Employed Independent Midwife	13
	Private HealthCare Issues.....	14
	PART ONE	16
4	Insurability - Matters of Law	17
	Shared Responsibility and Apportionment of Blame	17
	Need for Unified Indemnity in Intra-Partum Care	17
	Protection for Non-Intra-Partum Care	18
	NHS Can Claim Against an SEC.....	18
	Time and Cost of Litigation.....	18
5	Liability Risk Explained.....	20
	Exposure to Professional Liability Risk.....	20
	Common Causes of Error.....	21
	Regulation and Control.....	22
	Human Behavioural Risk.....	22
	Stress and Judgment	23
	High Risk/Low Risk Assessment.....	24
	Hospitalisation and Choice.....	25
	The NHS Benchmark and the Issues of Non-Hospitalisation	25
	Miscommunication Between Professionals	26
6	Midwifery - The Intrinsic Risks.....	27
	The Expectation Gap	28
	Education and Training of Midwives.....	29
	Skills and Qualifications	30
	Professional Status	31
	Professional Profile	32
	Clinical Standards, Rules and Regulations	33
	Relationships and Trust.....	34
7	Healthcare Environment Influences	35
	Politics of Healthcare.....	35
	Clinical Negligence Scheme Trust (CNST)	35

8	Risk & Insurance	38
	The Underlying Insurance Problem	38
	NHSLA/CNST	39
	The Current Indemnity Position	40
	Finlay Scott - Policy Review	40
	Compulsory Insurance/Indemnity	41
	PI Insurance Availability for Midwives	41
	Pros and Cons of Commercial Insurance	42
	Warning - Insurance Pitfalls	43
9	Insurable Structures	45
	Insurers' Preliminary Views	45
	PART TWO	48
10	Independent Midwifery - A Solution	49
11	Differences and Sensitivities	50
	What Midwives Do	50
	Differences and Sensitivities	50
	Midwives - Need and Availability	50
	The Advisory Group – Observations and Opinions	51
	Tensions in the Profession	52
	Midwives' Duty of Care	52
	PART THREE	54
12	Independent Midwifery - A Concept	55
	The Objective	55
	Outline of Entity Proposition	56
	A Rationale for Independent Midwifery	56
	The Concerns to be Overcome	57
13	Independent Midwifery- A Protocol	58
	The Rationale for a Protocol	58
	The Rationale for Independent Midwifery	58
	An Outline Protocol	59
	Contract with Access to CNST	60
	Induction/Familiarisation Permissions	60
	Midwifery Standards	61
14	Recommendations	62
15	Credentials	65
	Roger Flaxman	65
	Anthony Barling	65
	Appendix 1 Cost of obstetrics claims	66

1 The Brief

- 1.1 The originating reason for this report is the need of self-employed midwives working alone to find a source of professional indemnity insurance (PII) in the UK insurance market in order to be able to comply with the EU Directive (2011/24/EU) (“Directive”) making insurance compulsory. Several groups of midwives, known generically as “independent midwives” have endeavoured for some years to find insurers willing to underwrite the professional negligence risks associated with independently practised midwifery, without success.
- 1.2 Flaxman Partners Ltd (FPL), who are independent insurance consultants with specialist expertise in professional risk and liability, were introduced to some of these groups in 2008 and in the period up to November 2010 (when this report was commissioned) FPL continued to assist groups of midwives, *pro bono*, in understanding the dynamics that had prevented them from finding suitable insurance, even at any price. It was simply not available from the commercial insurance market or anywhere else.
- 1.3 FPL's several discussions with independent midwives culminated in a recommendation to RCM in 2010 that, in view of the scale of the midwifery demand in the UK and in anticipation of government necessity for NHS cutbacks, it would be an appropriate time not only to carry out a review of the reasons for unavailability of insurance for groups of independent midwives (and/or sole practitioner midwives) but also to address the wider issues concerning the role and scope of midwifery in the UK with the purpose of contributing to a solution to the insurability and defensibility issues. The review was to include the inherent risks associated with midwifery practice.
- 1.4 Our expertise is in understanding, protecting and insuring risks associated with professional practice and practice management in all professions. We have no medical qualification, training or expertise. However, we are familiar with the professional risk profiles of clinical/medical and other recognised and (mostly) regulated treatments, therapies and healthcare practices.
- 1.5 We have, therefore, in order to avoid any misunderstandings, set out our understanding of the subject matter upon which we are reporting and the reasoning for our advice and recommendations.

THE INSTRUCTIONS

- 1.6 FPL was instructed by RCM and NMC, jointly, to explain the reasons for the non-availability of PII insurance to independently practising midwives and to explore a solution in the light of the recommendations in the Scott Report (see 8.20) and the implications of the introduction of the Directive.
- 1.7 FPL understands that, although there are independent midwives throughout the UK, most are in England and the provision of the NHS CNST (indemnity scheme) is not available to independent midwives in England.
- 1.8 It is essential that the reader appreciates that commercial insurers make commercial judgments about cover for claims according to the terms of the policy they have issued and *it must not be assumed that a commercial insurance is an unconditional guarantee* of protection whatever the circumstances. We have included comments on the pros and cons of commercial insurance in the body of the report. The report explains the commercial limitations of insurance policies.

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- 1.9 The report also explains the principles of law concerning midwifery practice (that affects insurability) with particular reference to the interface of midwives with other professionals in the medical field, which is a significant part of the midwifery exposure to allegations of negligence.
- 1.10 **Above all the report is intended to assist** the reader with the facts and information required to be able to make informed decisions about independent midwifery practice, its insurability and the inherent risks associated with midwifery in general and independent midwifery in particular.

"INDEPENDENT MIDWIFERY" – MEANING OF

- 1.11 The term "independent midwife" has evolved, we understand, to refer to midwives practising alone or in groups but not as employees of the NHS, other healthcare organisations or local authorities.
- 1.12 We understand that the term has, in some quarters, become associated with "home birth midwifery" or with other "radical", "alternative" or "experimental" midwifery practices(s). Whilst this report does not attribute "independent midwifery" to this description it must be appreciated that some insurers may do so and hence the reason for making this point.
- 1.13 For the purposes of this report we are distinguishing "independent midwife/midwifery" from "Independent Midwife/Midwifery" or "IM".
- 1.14 The term "independent midwife/midwifery" refers to the status quo, being the midwives described in 1.11 and 1.12 above.
- 1.15 "Independent Midwife/Midwifery" and "IM" refers to a proposed *new concept* of midwife/midwifery practice that would provide a basis for a solution to the insurance/indemnity needs at the heart of this report.

GENDER EQUALITY

- 1.16 It is recognised that a midwife can be female or male. In this report (she) and (her) is intended to denote the equality of gender.

2 Methodology

- 2.1 The brief for this report took into consideration the fact that a midwife's professional clinical activities, particularly those involving the intra-partum process, will only attract commercial insurance or indemnity cover when:
- 2.1.1 organised and controlled in a way that an insurer (or other organisation giving an indemnity) will view the entity as one having strong governance and appropriately professional management, and, specifically, supervision or overseeing of the operational conduct and control and standards of practice (as distinct from the supervision by a Supervisor of Midwives);
 - 2.1.2 there is a clear understanding of the independent midwife's access to NHS resources and premises for reasons of attending with a woman for emergency or specialist intervention services.
- 2.2 We have therefore approached the report by focusing on a potential solution, not just by describing the problem. The report includes a proposal for a potentially suitable structure of an *entity* that would incorporate such governance and which could become acceptable, nationally throughout England, to midwives, women, the Government and the NHS.
- 2.3 We have considered the pros and cons of an alternative provider of maternity services to the NHS, taking into account present political concerns in England about privatising healthcare on the one hand and the opportunities and benefits of being able to improve midwifery for women, on the other.
- 2.4 At the outset we recommended that the RCM/NMC invited a selection of people including clinicians of various disciplines and representatives of organisations with views and expertise on the subject matter to contribute to our research. This became the Advisory Group.¹
- 2.5 The Advisory Group members shared their insights into the issues affecting midwifery and maternity services and their views about a new means of practising without being directly employed by the NHS. We are very grateful for the time they gave us.
- 2.6 We have also taken into account the standards, guidelines and regulations applicable to maternity and midwifery services and the roles of the organisations responsible for accreditation of midwives, employers of midwives and those organisations supplying clinical services.
- 2.7 We have understood the principles behind the CNST and how it works in practice. We are also aware that the present CNST may change its form in due course.
- 2.8 We have taken the opinions on insurability of midwifery and the preferred structures and governance of organisations providing midwifery services from a recognised international insurance broker and from underwriters introduced to us by the broker, all of whom are experienced in the healthcare sector.

¹ See 2.10 below.

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- 2.9 We have not researched midwifery practices and insurance outside England for this review because the principal issues concern English law, English insurance markets and NHS practice in England. We have appreciated that the cost of research overseas (of insurance and indemnity of midwives) is disproportionate to the benefit at this early stage of reporting. The benefits of conducting research in other territories will be greater if the principles set out in this report are accepted as a basis for positive change.

SOURCES OF INFORMATION

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- 2.10.1 Publicly available documents from NHS, professional bodies and other relevant sources.
- 2.10.2 Willis plc (brokers to RCM)
- 2.10.3 QBE Insurance Co
- 2.10.4 AWACS Insurance Co
- 2.10.5 Marketform Insurance Co

THE ADVISORY GROUP

- Cathy Warwick and Louise Silverton, Royal College of Midwives.
- Carmel Lloyd, Nursing and Midwifery Council
- Professor James Walker, Royal College of Obstetricians and Gynaecologists
- Steve Walker and James Mead, NHSLA
- Rona McCandish and Rob Oldham, Department of Health
- Annie Francis and Brenda van de Kooy, IM UK
- Anne Fox, National Childbirth Trust
- Professor Neena Modi, Imperial College, London
- Carole Garrick, Western Sussex Hospitals Trust
- Beverley Beech, AIMS

Where we have mentioned individuals and an organisation with which they are associated we do not imply that they were contributing as representatives of such organisations.

3 Executive Summary

THE FUNDAMENTAL ISSUE

- 3.1 ***This report concerns the current unavailability of PI insurance for "independent midwives" to meet the requirements of EU Directive (2011/24/EU) (the "Directive") which makes insurance compulsory and a proposal for making qualifying indemnity/insurance available***
- 3.2 Midwives wishing to practise alone, or in organised groups ("independent midwives") but NOT as employees of the NHS are currently unable to obtain professional indemnity insurance. Their own attempts and the attempts of others on their behalf to obtain PI insurance, over several years, have failed, for the reasons set out in the body of this report.
- 3.3 The Directive, together with midwives' general acknowledgement that PI insurance is an essential protection for themselves, the woman and the child, has given rise to the commissioning of this report.
- 3.4 The fundamental reason that PI insurance is unavailable is that commercial insurers (as well as specialist medical defence bodies) recognise the very high risk that midwifery presents in the potential for claims alleging negligence by a midwife. The cost of litigation and the awards and settlements arising from litigation involving obstetrics and midwifery (which are often intertwined) are well documented.²
- 3.5 Awards of damages of circa £6m are no longer uncommon and predictions by NHSLA experts foresee awards in excess of £10m in the near future. Sums of this magnitude are too high for an insurer to be able to offer a viable insurance proposition having regard to the number of midwives currently operating independently of the NHS.
- 3.6 This report puts forward a potential solution to enable "independent midwives" to practise, fully protected by insurance. This would be achieved by the midwife becoming an employee of a suitable legal entity regulated for the purpose by the Care Quality Commission (CQC). The entity could be a Social Enterprise Company (SEC); this would meet the objectives of being a sound corporate vehicle which would be an insurable entity in itself (whereas a sole midwife practitioner would not be an insurable entity) and would also address the objections from some quarters to "private healthcare" companies. The SEC would employ the midwives and, as an organisation, deliver their services. The vicarious liability of the employer for its employees is the primary route to obtaining PI insurance. The reasons for this are set out in the report.

EXECUTIVE KEY FACTS

The compulsory insurance requirement

- 3.7 The Directive requiring, amongst other things, *"systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the*

² See Appendix 1.

nature and the extent of the risk, are in place for treatment provided on its territory **will leave midwives unable to practise midwifery unless:**

- 3.7.1 they are employed by the NHS or a fully insured private hospital or other fully insured healthcare organisation;
 - 3.7.2 PI insurance were to become available to “independent midwives”;
 - 3.7.3 the Government introduces a new approach to integrating Independent Midwives³ with the NHS, thereby providing a means of indemnity without the need for private, commercial insurance.
- 3.8 **The effect of the EU Directive's insurance/indemnity requirements** will be to eliminate the availability of an additional (to the NHS) independent midwifery service throughout England and so potentially frustrate the profession's collective aim of improving maternity care and choice for women.

Unavailability of insurance

- 3.9 **The “independent midwife” is not covered by the NHSLA's CNST** (insurance) scheme; moreover there is currently no facility for being able to provide this protection to a midwife or group of midwives even if they are practising as employees of a company or other suitable legal entity. One of the proposals in this report is that this restriction should change so that an organisation contracted to an NHS entity can be given access to indemnity protection as a member of the CNST. The Government has indicated that it will bring forward proposals to enable private providers to obtain this benefit.
- 3.10 **Groups of midwives not employed by the NHS**, currently referring to themselves as “independent midwives”, have been seeking PI insurance from the commercial insurance market since 1994 but, partly because of their self-employed status and partly because of the prevailing legal system in relation to clinical negligence claims in matters of childbirth, commercial insurers have continued to refuse to offer cover. The reasons for this are fully explained in this report.
- 3.11 **After enquiry of the commercial insurance market** in the course of this review, there is currently no evidence of insurers having an appetite for insuring independent midwifery services outside the NHS at all. The reasons for this are fully explained in this report.
- 3.12 **However, if independent midwives were to practise as employees of a formally constituted suitable legal entity such as an SEC** there is a much stronger prospect of obtaining insurance for the entity.

A social enterprise company (SEC)

- 3.13 **Under an "SEC" structure**, antenatal and postnatal care and other non-intra-partum care delivered to NHS, or direct to women, will be insurable by the entity (subject to the entity being regulated by the CQC) without undue difficulty. Intra-partum services require special insurance consideration, for the reasons explained below.

³ See 14.0 below

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- 3.14 **The reason for intra-partum services requiring special consideration** is fully explained in this report. In brief, the intra-partum period is regarded by insurers as the time of highest risk (of a negligent act, error or omission). It is envisaged by insurers that a midwife practising in a hospital environment at the time of birth (intra-partum period) will be practising alongside other NHS employees and that, in the event of an incident that later gives rise to a claim of negligence by the woman or the child, there will be a reason to seek to apportion blame between the NHS personnel and the midwife (who is not an NHS employee).
- 3.15 A midwife who is not employed by the NHS is *not permitted to work* in a NHS hospital and so if an "independent midwife" takes a woman in her care to an NHS hospital the NHS staff must take over and that leaves the "independent midwife" only able to observe, but not to continue to care (professionally) for her woman. One of the reasons for the NHS rule concerns (lack of) insurance. The "independent midwife" is not covered by the NHSLA's CNST.
- 3.16 **This is important. It is envisaged that** an IM (a midwife employed by an SEC) will from time to time take a woman needing NHS treatment to an NHS entity, most likely at the time of imminent birth, and therefore it is important that the IM (employed by the SEC) can practise (continue to care for the woman) with the confidence of full insurance protection. There is no realistic prospect of commercial insurers offering to cover this risk unless an entity such as an SEC is commissioned by the NHS to provide services including the intra-partum period. This would enable an insurance protection to be put in place with the backing of the CNST scheme.
- 3.17 This report concerns the feasibility of achieving an insurance solution that works for the NHS, the NHS LA and the commercial insurance industry in such a way as to enable the concept of independent midwifery to become a reality.

EXECUTIVE RECOMMENDATIONS

- 3.18 To carry out a feasibility study of an employing entity (SEC) based upon the recommendations in this report.
- 3.19 To consider the benefits of seeking comparisons with midwifery practice and indemnity/insurance in other European countries (and subject to the same EU Directive).
- 3.20 An urgent review of midwives' understanding of "Duty of Care". This is discussed fully in the report.⁴ The review should be published by RCM/NMC to improve a contemporary understanding of its real meaning, intentions, implications for liability and disciplinary action.
- 3.21 Promote "Independent Midwifery" as a means of improving insurability.

⁴ See 11.15 below.

Background

- 3.22 Currently, independent midwives⁵ who take private commissions from women to provide one-to-one care in the maternity period are operating without insurance cover. Irrespective of the new obligations of the EU Directive this is a problem for the expectant mother, the child and the midwife because none of them are protected if anything goes wrong.
- 3.23 This leaves the "independent midwife" vulnerable and unprotected in the event of a claim at a later date. Also if the NHS is involved in the care of the same woman, as is likely to be the case, this puts the "independent midwife" at risk of the NHS legal system if a claim is addressed to the NHS. This is because the NHSLA would be required to apportion blame and so the "independent midwife" would be at risk for the cost of defending herself, without insurance because it is not available.
- 3.24 Ideally a woman engaging an "independent midwife" would expect (her) to be able to access NHS facilities when needed and take an active part in continuing to care for her (the woman).
- 3.25 This is not possible at present partly because of the indemnity system adopted by NHSLA and CNST and the independent midwives' exclusion from access to it. The CNST does not (and currently cannot) extend to any party not connected by an NHS member of the CNST. Self-employed midwives are the only group specifically excluded from the NHS indemnity scheme.
- 3.26 **The solution to this problem lies in two places:**
- 3.26.1 with the Government in creating access to the CNST (or its successor scheme)⁶ for contractors providing directly commissioned NHS services;
 - 3.26.2 with midwives in creating a new concept of "Independent Midwifery"⁷ that is compatible with the legal and political necessities of defending a claim against midwives *that insurers can agree to* and the Government/NHS can adopt.
- 3.27 The essential of "independent midwives" is to practise in close association with NHS maternity services and so be able to refer any deviations from the norm for specialist or emergency treatment by the NHS. This means that there is a need to overcome the current restrictions of access to the CNST so that a midwife practising on NHS premises is fully protected, equally in all respects, with NHS-employed midwives. **This requires special CNST regulations – currently unavailable - to be in place for the midwives.**
- 3.28 In summary, this solution would require midwives who wish to practise independently of the NHS to *be employed under a contract of service* with a suitably competent employer. This can, in theory, be any private company but

⁵ See 1.12 above.

⁶ See Healthcare Environment Influences 7.0, below.

⁷ See Independent Midwifery - A Concept, 12.0, below.

the politics of "private medicine" may point to a Social Enterprise Company (SEC) being a more acceptable vehicle in the minds of the public and Government.

SUSTAINABLE INDEMNITY/INSURANCE

- 3.29 This, in turn, requires a suitable and sustainable form of indemnity/insurance provision that can overcome the real commercial impediments that currently exist with both the current CNST access limitations and potential commercial insurances⁸.
- 3.30 Insurance of medical practitioners is regarded by the entire insurance industry as high risk. Commercial insurers offering cover to medical practitioners do so in the knowledge that if the claims experience deteriorates beyond a commercially profitable level, they can simply withdraw further insurance. This has happened on several occasions in the last ten years.
- 3.31 This leaves the medical practitioner in a serious quandry because when the insurance ceases they have no protection against past acts that may result in claims in the future. Professional indemnity insurances are based upon the principle that they pay claims made during the period of the insurance in respect of negligent acts errors or omissions that occurred in the past (known as Claims Made Insurance Policies).
- 3.32 Furthermore, commercial insurers restrict the cover in their policies to suit their own underwriting rules. This means that there is no such thing as a "fully comprehensive" insurance (or, to put it another way, an insurance that covers everything and all eventualities). This is not achievable anywhere at any time from commercial insurance; there are always terms and conditions that restrict coverage.
- 3.33 Consequently, any solution to the need for insurance by "independent midwives" must take into account the inherent restrictions and weaknesses of commercial insurance. This is dealt with in more detail in 8.0, below.

CONCEPT OF EMPLOYED INDEPENDENT MIDWIFE

- 3.34 Insurance of a legal entity, a business, is generally easier to obtain than insurance of individuals or groups of individuals. The reasons for this are various but, essentially, a business is regarded by insurers as having measurable, sustainable substance and to be governed by laws that give insurers protection and an assurance of a certain level of due diligence and management. In short, it is not possible to regulate the conduct of an individual or group of individuals (such as "independent midwives") in the same way as it is possible (but not, admittedly, always achieved) to regulate a business entity governed by legal constraints and regulations.
- 3.35 Insurance of a legal entity such as an SEC would be insurable. By creating the concept of the Independent Midwife (IM), the hopes and aspirations of midwives wishing to practise outside the NHS (for the reasons given and reported in this report) could become a reality.
- 3.36 Independent Midwifery:

⁸ See Warnings - Insurance Pitfalls at 8.36 below.

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- 3.36.1 would become a newly recognised concept that conveys a professionalism and sustainability of competence and reliability upon which future commissioners of midwifery services can rely and the Government and the NHS can accept as a suitably qualified provider of midwifery services;
- 3.36.2 would be delivered by a suitably constituted legal entity, regulated by the CQC that employs midwives. (It is axiomatic that there must be a vicarious relationship between the entity provider of midwifery services to NHS and the midwives for which the provider is responsible. In our opinion, and from our research, this is not debatable. Self-employed midwives will not be acceptable to Government or to insurers.)
- 3.37 A Protocol for "Independent Midwifery" should be agreed by RCM/NMC such that it meets the standards required and also benefits midwives wishing to participate in an Independent Midwifery provider company ("the Protocol").
- 3.38 The Protocol should take into account the key critical requirements of an insurer⁹ (whether commercial or Government related) so as to be fully prepared to take advantage of the outcome of current discussions by Government of the benefits of utilising independent providers.
- 3.39 Given that these objectives can be realised then insurance/indemnity ought to be available from a contemporary insurance source because the risk management, risk mitigation, supervision, management and operating controls would be available to reassure an insurance underwriter that there is a commercially viable proposition to offer.
- 3.40 This report now continues to examine and expose the dynamics, the strengths and the weaknesses of the status quo for midwifery from the insurance and liability points of view.
- 3.41 The next stage would be to prepare a Protocol for Independent Midwifery which we describe in 13.0 below and test this with the insurance market and its legal advisers.

PRIVATE HEALTHCARE ISSUES

- 3.42 We are aware, at the time of writing (Summer 2011), of the prevailing mood of Government towards introducing private companies to improve patients' choice and of the push back by some interested parties in Government and the NHS who wish to maintain the status quo.
- 3.43 This must be taken into account when considering the proposal in this report because a significant distinction has been made between the proposals for, and intentions of, *midwifery* practice in England and the proposals for and intentions of *other kinds of treatment and care*. The risks to insurers are entirely different and require special risk management considerations.
- 3.44 The tension between the protagonists and antagonists for private treatment creates in itself a risk factor for midwives. Where a woman is referred to the NHS after receiving private treatment the woman may not always receive a

⁹ See Insurable Structures 9.0, below.

warm welcome from those who are antagonistic to private healthcare. Insurers are aware of this and this is a contributory reason for their reluctance to offer insurance.

The distinction

- 3.45 Childbirth, we were reminded, is a natural event where the benefits of ensuring the health and wellbeing of the woman and baby outweigh the politics of all other "private medicine". The implied distinction is that in other medical matters the patient's requirement is to be made well from a condition of illness or injury with the associated political implications of being able to buy preferential treatment. This is not so for maternity care.
- 3.46 We were reminded, also, that prevention of illness and birth defects (or the maintenance of wellness) in childbirth are of direct benefit to everyone in society and almost everyone in society will at some time benefit from the expertise and support of a health-promoting midwife. Accordingly, it is suggested by contributors to our research that reducing the acknowledged burden on the NHS associated with childbirth costs and shortages of midwives is therefore now feasible and desirable.

Part One

Part One concerns the legal and insurance aspects that need to be understood in relation to current midwifery practice and a potential Independent Midwifery solution.

The reader is intended to use this as a means of reference for understanding the legal and economic aspects that regulate the viability and effectiveness of insurance.

4 Insurability - Matters of Law

- 4.1 **The crux of insurability of Independent Midwifery is in managing the defensibility in law of a midwife that is not practising within the NHS.**
- 4.2 Claims for negligence involving midwives very often include claims against other (NHS) practitioners who also played a part in the treatment of or advice to a woman during the term of pregnancy.
- 4.3 Where all the (clinical and other) parties are employed by the NHS the defence of the allegations are dealt with by the NHSLA and all parties are indemnified (insured) by reason of their respective employer's membership of the CNST Scheme.
- 4.4 **However, the independent midwife is not and would not be protected by the NHSLA/CNST and so would be at risk of a claim by the NHSLA for apportionment of blame.** Insurers would have to bear the cost of defending the midwife, separately, amongst the complex, and often contradictory, evidence of closely associated clinical and medical practitioners, most of whom are protected by the NHSLA, and who may (be encouraged by lawyers to) seek to apportion blame to a midwife in order to protect their own reputation. This is a typical situation in clinical negligence litigation.

SHARED RESPONSIBILITY AND APPORTIONMENT OF BLAME

- 4.5 Why does this matter? It is our understanding that it would be unusual if the midwife is the only health professional encountered by the woman for the entire period of her pregnancy. The woman is likely to be seeing a GP and will attend clinics for blood tests, screening and for other reasons from time to time. The relevance of this is that more than one person who owes a Duty of Care to the woman may be involved with that woman during the period of childbirth as well as the attending midwife/ves.
- 4.6 Consequently, in the event of a claim against the clinical services interfacing with the woman, the contribution of not only the midwife but also all the other clinical parties will, of necessity, have to be examined in law in order to establish a) the primary causation¹⁰ of liability and b) contributory proportions of liability as between the responsible parties.

NEED FOR UNIFIED INDEMNITY IN INTRA-PARTUM CARE

- 4.7 Consequently, *it is essential that IMs are indemnified by the NHS* in respect of work carried out under a commissioned NHS contract. This would be achieved by the SEC¹¹ having a contract with the commissioning body that gives access to the CNST. That arrangement would leave only the work carried out by the SEC for parties *other than under the NHS contract* to be covered by commercial insurance. This would be more commercially attractive to insurers.

¹⁰ Causation = "causal relationship between conduct and result". That is to say that causation provides a means of connecting conduct with a resulting effect, typically an injury..

¹¹ See Independent Midwifery – A Protocol 13.0, below.

PROTECTION FOR NON-INTRA-PARTUM CARE

- 4.8 Commercial insurance cover for an SEC would be required in respect of any services the SEC offers to women, privately or to other healthcare providers. Every SEC would need relevant commercial insurance cover for its own activities including PI insurance.
- 4.9 It is important to recognise that any advice or service given by an IM (and therefore vicariously the SEC) is vulnerable to a claim for negligence and that because of the nature of the structure and infrastructure of the NHS it is more likely than not that an IM will interface with NHS facilities and personnel, even outside actual intra-partum processes.¹²
- 4.10 This could bring the SEC into a claim conflict with the NHS where the matter is not the subject of the protection of an NHS contract with the SEC. It is a matter that will require careful risk assessment in each case and this is the reason for CNST protection to be made available for SECs delivering contracts to the NHS.

NHS CAN CLAIM AGAINST AN SEC

- 4.11 Commercial insurers recognise that the NHSLA clinical negligence scheme's experience and resources are such that they are world-class experts in defending NHS employees. This means that any insurer of an Independent Midwife /SEC can *expect* a claim to be made against them by the NHS, even if only to test the strength of the midwife's defence. It is the duty of the NHSLA/CNST to make recoveries from contributory negligent parties wherever they can.
- 4.12 Consequently, the commercial insurers will expect to pay a significant sum in the defence of claims even where liability may not be, eventually, proven. This will cause commercial insurance to be expensive. That cost can only be reduced by "joined up" indemnity with the CNST, in respect of NHS contract work. This will require carefully negotiated contracts and indemnities between the contracting NHS units and the SECs.
- 4.13 It is a fact of life that where there are insurance monies available to professionals, lawyers will recommend their client to sue for it. This is one of the negative consequences of professionals being insured but it is universally so and it is not a good reason for the professional to remain uninsured.

TIME AND COST OF LITIGATION

- 4.14 Litigation in the UK is based upon an adversarial process, one of the unintended consequences of which is that lawyers and insurers run up huge costs and expenses, very often disproportionate to the damages payable. Evidence of such costs is available from the NHSLA data¹³ published each year.

¹² See Miscommunication 5.50, below.

¹³ See Appendix 1.

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- 4.15 The nature of this type of litigation is that it can run on for years whilst liability is being established and the quantum of loss/damage (future care/habitation costs) is being calculated as the nature of the damage to the child develops.
 - 4.16 The financial stakes in medical litigation are usually very high. The possibility of a single claim of £6m or more requires the insurer to use top-flight specialist clinical negligence lawyers and the costs of both the specialist lawyers and forensic experts needed to defend a claim will typically run into sums of several hundreds of thousands of pounds and sometimes more.
 - 4.17 Typically the claimant will then have to instruct equally top flight specialist lawyers and the combined costs escalate at alarming rates. This is an unattractive *risk* to a commercial insurer unless they are able to charge premiums to meet the cost.
 - 4.18 However, if the operating protocol of IMs via SECs is sufficiently robust and well risk-managed there is a strong possibility that insurers would be able and willing to offer protection at commercially viable premiums.

5 Liability Risk Explained

This section is intended to explain what is meant by liability risk and the perceived exposure of midwives to allegations of negligence associated with the practise of midwifery.

- 5.1 **What is risk?** It is the term used by insurers to describe the probability and chance of something happening that will trigger a claim under an insurance policy. It also embraces the cost to the insurer of meeting the claim.
- 5.2 The risk to an insurer is a combination of the probability and chance of it happening and the cost outcome. In the context of this report it means the probability and chance of a midwife being found legally liable, in whole or in part, for a negligent act error or omission.

EXPOSURE TO PROFESSIONAL LIABILITY RISK

- 5.3 **What does exposure to risk mean?** This describes the things that the insurer foresees as likely to cause a claim to be made under the policy.
- 5.4 It is important to know what *insurers perceive* as risk because it provides the basis for managing the risk.
- 5.5 **Three perceived prime exposures to risk emanate from Independent Midwifery.**
 - 5.5.1 The first concerns the perception that Independent Midwives prefer achieving an intervention-free birth.
 - 5.5.2 The second concerns the midwife's relationship with (her) woman.
 - 5.5.3 The third concerns the midwife's relationship and permitted role at the time of entering NHS premises in anticipation of accessing intervening medical help.

Intervention-free preference

- 5.6 We have been told, on several occasions, of the methods employed by some midwives to encourage their women to experience a completely natural, intervention-free birth. The implication is that some midwives risk delay in intervention in circumstances for which they could be reasonably criticised.
- 5.7 If a midwife is practising independently of any other person or authority (practising alone) the risk of unreasonable delay is increased by the unavailability of any person or authority to recognise potential for errors of judgment arising from the criteria in 5.11 below, in time to take preventative de-risking action. We know from experience and from medical negligence solicitors that "too late" referral for intervention care is a *primary* cause of negligence claims.

Relationships

- 5.8 The second prime exposure to risk concerns the relationship between the woman and the midwife. If the woman is difficult to deal with and/or reluctant to accept advice a midwife can be tempted or intimidated to disregard ordinary

professional judgment in order to get the woman to cooperate. This concerns the Duty of Care¹⁴ of the midwife and is discussed in detail below at 11.15.

Unfamiliarity with NHS facilities and staff

- 5.9 The third prime exposure to risk is a visiting independent midwife being unfamiliar with the personnel and resources at the NHS venue to which the woman may have to be admitted at the intra-partum stage. Insurers and lawyers would say that it is essential that a midwife is familiar with the surroundings when using medical facilities. We are told that midwives are sometimes unfamiliar with the environment and the people they are working amongst and, more worryingly, some regular hospital staff resent the intrusion of a visiting midwife and can make things difficult. Insurers will not accept this risk.
- 5.10 We have understood from our research and enquiries that there can be professional jealousies and tensions arising between midwives within the NHS and those operating outside it. We are also aware that tension can exist between midwives and other medical practitioners in clinical environments that cause additional stress to the midwife which can easily be transferred to the woman in her care. This is probably the most vexing aspect of the risks associated with midwifery. It can best be dealt with by Protocols controlling midwives who work in NHS premises only occasionally.¹⁵

COMMON CAUSES OF ERROR

- 5.11 The nature and extent of that scope for failing, despite the regulations, codes of conduct, guidelines, systems and procedures, is determined, for example, by any one or combination of the following:
- 5.11.1 fundamental experience;
 - 5.11.2 up-to-date experience;
 - 5.11.3 physical alertness, fitness;
 - 5.11.4 tiredness;
 - 5.11.5 disillusionment with working conditions;
 - 5.11.6 temperamental (un)suitability to the work of a midwife;
 - 5.11.7 (un)willingness to absorb training and continuing professional development advice, information and recommendations;
 - 5.11.8 the influences of the working environment, including lack of leadership;
 - 5.11.9 bullying, intimidation;
 - 5.11.10 lack of respect for others;

¹⁴ Duty of Care 11.15, below.

¹⁵ Permissions 13.25, below.

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- 5.11.11 loss of self-esteem;
 - 5.11.12 lack of resources;
 - 5.11.13 poor management;
 - 5.11.14 overstretch between too many women at any one time;
 - 5.11.15 (un)suitability and availability of assistance;
 - 5.11.16 relationships with other staff and especially when operating in hospital or midwife-led units at the time leading up to, during and immediately after childbirth.

REGULATION AND CONTROL

- 5.12 The midwifery profession is governed by regulations and codes of conduct which are designed to help the midwife maintain a consistent level of professionalism and that includes, of course, professional judgment.
- 5.13 The regulations and codes of conduct that govern the discipline of midwifery are known to be comprehensive and the combined reports of RCOG and the three other Royal Colleges (RCM, RCPCH and RCoA) entitled Safer Childbirth (2007) and Standards for Maternity Care - Report of a Working Party (2008) are acknowledged by everyone with whom we have spoken in the course of preparing this report as being fundamentally fit for purpose and generally acknowledged by the medical profession. The importance of clear and universally acknowledged practice disciplines and standards of care are a pre-requisite for providing a defence in law to a claim alleging negligent practice and so their continued application and enforcement are a pre-requisite for an insurer.
- 5.14 However, insurers and lawyers know very well, from actual experience, that human behaviour cannot be successfully regulated by rules, guidelines, systems and procedures alone. Consequently, despite the regulations and guidelines there is scope for a midwife to misjudge, miscalculate, fail to observe or otherwise do or omit to do something that leads either directly or indirectly to an allegation of causing damage by negligence.
- 5.15 For example, it is an acknowledged fact that from time to time a maternity unit will be under stress with too many women and too few staff and in those situations a midwife may compromise (her) professional judgment just to cope with the situation.
- 5.16 From a legal, and therefore a risk, point of view it presents one of the most significant risks to the midwife and midwifery practice. It can be very difficult to evaluate judgment in hindsight to separate the responsibilities of the midwife from other clinical personnel. The cost of having to do this is a significant concern to insurers because they have to bear the cost.

HUMAN BEHAVIOURAL RISK

- 5.17 **Experience has proven that it is not possible, in midwifery or in any other professional or quasi-professional discipline, to regulate the conduct of human behaviour by regulations, codes of conduct, guidelines, systems and procedures alone.**

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- 5.18 In fact, experience of insurers of all professions has shown that an overburden of systems and procedures **can actually diminish the professional's respect for them and they therefore become bypassed, ignored, overridden or treated as a tick-box requirement with no real attention to the purpose of the procedure or process. In short, in practice they often do not meet fit for purpose standards.**
- 5.19 These dynamics are true of professionals in all other disciplines as well as clinical or medical. People who are capable of achieving high standards of educational qualification are often reluctant to work in an environment where their qualification, status, age, experience and judgment are not recognised.
- 5.20 People unable to actually leave their job for reasons of income, pension and limited job opportunity elsewhere can become radical, disaffected and careless as to the compliance with regulations and rules. It can lead to inter-professional hostility and unnecessary or unwarranted risk taking.
- 5.21 In the course of our research and enquiries we have learned of the frustrations that midwives express about working within the NHS where the system of work deprives them of the opportunity of providing the full scope of care for a woman throughout her pregnancy, for which they have been trained.
- 5.22 We recognise that there are, of course, midwives who are content, efficient and successful in the NHS system and so this vindicates the view that midwives' individual personalities, experience and personal aims and objectives play an important part in their professional lives and the outcome for women.
- 5.23 This report is primarily concerned with midwives operating *independently* of the NHS and from our research we have concluded that there are midwives who believe they are characteristically better suited to working independently than to working within the NHS system.
- 5.24 From the point of view of professional risk, midwives working within the NHS system are at least supervised by the NHS' extant controls, systems and processes at their place of work. It is reasonable to presume that, by the very nature of the National Health Service structure and hierarchy and it being an employer with vicarious liability for its employees, that there is a discernible and measurable level of supervision at any given time. Even if this is not universally true of all NHS units the NHS will defend its employees against allegations of negligence along with defending its own position.
- 5.25 This is not so for midwives working independently of the NHS and so it is essential that Independent Midwives are able to demonstrate that they are aware of and are actively managing and monitoring their exposures to risk; otherwise, they will be uninsurable and also may not have a defence of their actions in a court of law.

STRESS AND JUDGMENT

- 5.26 In assessing whether or not a midwife was negligent lawyers will carefully examine, with the benefit of perfect hindsight, the professional judgment of the midwife. The law compares the judgment of one professional in a given situation with the judgment of other comparable experts in the same field.
- 5.27 It is recognised that stress causes professional judgment to be tested to its limits and so an inherent risk for midwives is failing to exercise that judgment with the skill and care ordinarily to be expected when under stress.

HIGH RISK/LOW RISK ASSESSMENT

- 5.28 Connected with professional judgment is the matter of assessing a woman as high risk or low risk. Awareness of the dynamics of determining a woman's level of risk prior to birth is an essential part of determining the midwife's exposure to risk.
- 5.29 We are told that midwives are trained to a level that enables them to determine the health status of a woman, recognise the signs and symptoms of ill health or other complications that may lead to the need for interventions around the time of birth and also whether a woman is capable of giving birth under midwife-led care.
- 5.30 Even in circumstances where there are no complications that require intervention we have been advised that midwives always need to be aware of changes in condition of a woman and, in particular, changes that result in a woman no longer being assessed as "low risk"¹⁶. Such a change is likely to bring about the necessity for referral to appropriate specialist care by other healthcare experts and the ability to have ready access to NHS resources. It is, we are told, equally possible that a woman's risk status during pregnancy can fall from high to low risk.
- 5.31 We have heard, consistently, from the Advisory Group, and this is supported by our observations throughout our research and enquiries, that hospital birth for a well woman is not in itself a necessity. We have been led to understand that some 30% of births would fall into the category of "low risk" and would remain so and it would be safe for these births to be at home (subject to the precautions for availability of emergency intervention) or in a midwife-led facility.
- 5.32 However, we are also clear from the discussions with experts in the course of our review, that it is not possible for a midwife to determine in advance that complications will not ensue even in the most healthy appearing woman.
- 5.33 Consequently, it is evident to us that for any woman other than "low risk" there is an implied necessity for the birth to take place in hospital or in a closely connected or co-located childbirth environment whereby transfer to a fully equipped medical unit can be achieved with minimum disruption and delay, i.e. a very few minutes.
- 5.34 We are told that there are some women who are high risk in the antenatal period but change to a low risk as the pregnancy progresses. The risk can change up and down. Therefore, constant monitoring is a crucial aspect of risk control.
- 5.35 A woman being attended by any midwife or other healthcare professional (i.e. not a private doctor or private midwife) might reasonably expect that she can initially elect not to go to hospital for a birth but, in the event of urgent need for medical attention, the attending midwife will nevertheless get her to hospital. In the case of an independent midwife it is, of course, not as simple as that.

¹⁶ "High risk" and "low risk" are expressions consistently used by people to whom we have spoken.

HOSPITALISATION AND CHOICE

- 5.36 The independent midwife has no authority to practise within the NHS but the woman may not understand this. The NHS will provide the emergency care but may not allow the woman's midwife in. ***The outcome of this argument leads inexorably to the question of what is in the public's best interest?***
- 5.37 From a legal point of view there is logic that says if the NHS makes available a hospital facility for every woman's childbirth then the woman cannot complain if she elects not to use it. This, of course, is a disputable assertion but it is an issue that needs to be more closely examined from the pragmatic viewpoint of the gap between the extremes of home birth and hospitalisation as a norm.
- 5.38 There is of course also the "social event" aspect of childbirth and it is important to balance the risk between the woman's enjoyment of the social event and the wisdom of safe medical practice.
- 5.39 Consequently the "hospitalisation lobby" gains power in the logic that if every birth is hospitalised there can be no delay and therefore the cost of claims and litigation is theoretically diminished. This has not proven to be the outcome. The number and value of claims from hospitalisation has not proven the case for hospitalisation, in itself.
- 5.40 A principal driver for modern midwifery has been giving women choice in the place and manner of their childbirth experience. The press tends to make a point of identifying home delivery and radical practices as synonymous.
- 5.41 The most common counter-argument to this "ideal" is that a women who needs emergency medical attention is deprived of this facility if she is not in a hospital environment at the time of birth.
- 5.42 However, we see these as two extremes between which there is a sound basis for safe childbirth practice.
- 5.43 It is appreciated that some women do not wish to have a baby in hospital, that others are ambivalent and that others still would not think of having a baby anywhere else but in hospital. We understand that it is the primary duty of a midwife to take into account the woman's wishes and, within the bounds of (her) experience, competence and Duty of Care, to attend the woman in the way (she) requests subject at all times to proper assessment of the risks associated with her pregnancy.
- 5.44 This imposes upon the midwife an absolute duty to assess, monitor and keep assessed the woman's condition to determine whether there is any prospect of a need for intervention at the time of birth, basing that opinion upon the criteria laid down in relevant clinical guidelines and codes of conduct.

THE NHS BENCHMARK AND THE ISSUES OF NON-HOSPITALISATION

- 5.45 A midwife who attends a woman throughout her term and attends and assists in the delivery of a healthy child without intervention *could* be regarded as "a perfect outcome". Anything less than "a perfect outcome" implying the potential for consequences in litigation.
- 5.46 England's governing society has created medical facilities in the NHS designed to significantly reduce the risk of a woman experiencing childbirth difficulties that result in harm to the child.

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- 5.47 With few exceptions in England there will be no reason why a woman cannot get to, or expect to be able to get to, an NHS hospital or birth clinic so as to reduce the risk of complications at the time of birth.
- 5.48 Consequently, a midwife attending a woman away from a hospital or birth clinic and who does not anticipate the risk of the need for intervention and so does not plan for making available the emergency intervention facilities is, by definition, at risk of an allegation of professional negligence.
- 5.49 **In other words, because the NHS facilities are there for all, for the prime purpose of making childbirth as safe as possible, any non-use of those facilities will beg the question (in law) as to why they were not used.** That is a prime litigation approach to establishing blame and liability and a risk that midwives must always take into account.

MISCOMMUNICATION BETWEEN PROFESSIONALS

- 5.50 What does this mean? Midwives and obstetricians in particular amongst other clinical practitioners operate with different philosophies of care and there is much scope for misunderstandings. The legal consequences of non-communication and/or mis-communication between professionals is known to be at the root of negligence claims. This problem is serious enough *within* NHS environments but if a non-NHS midwife becomes engaged in care for a woman alongside NHS personnel, the consequences for her can be much more serious if she is not protected in exactly the same manner as are the NHS practitioners.
- 5.51 Consequently, the insurability of Independent Midwives can only be solved by having contractual agreements with the NHS that bring the Independent Midwife into a comparable basis of protection with other NHS employees in the course of defending a claim.

6 Midwifery - The Intrinsic Risks

- 6.1 **This section explains the intrinsic risks associated with midwifery; the expectation of the woman and the skill and experience of the midwife. These are the elements of midwifery practice that are at the root of the professional discipline and which would form the basis of an investigation into an allegation of negligence.**
- 6.2 Midwifery differs significantly from other healthcare disciplines, such as physiotherapy, osteopathy, dentistry, chiropractic and chiropody. The difference is that childbirth is not, by definition, an illness or condition that is being remedied. Rather, it is a condition of presumed wellbeing with the attendant risks associated with deterioration from that state.
- 6.3 In other words childbirth concerns a defined period in which a woman requires preparation for an event that is presumed to be a healthy and natural process. The midwife's role is to use professional skill and care in ensuring that the woman remains well and detects any signs or symptoms of potential "unwellness" and to either manage them or bring them to the attention of more specialist medical advice.
- 6.4 The skill and experience of diagnosis and the decision to take what action and when is the prime skill of the midwife. These decisions are often taken in isolation from other medical care. It is commented upon by almost every person we have encountered in our research and enquiries that the decisions made by a midwife in the circumstances of diagnosis and recognition of complications are crucial to the mother's and baby's outcome. Insurers recognise this too.
- 6.5 Consequently, a (normally healthy) woman's (general) expectation could reasonably be described as that a midwife will take care to ensure that her baby will be delivered safely, without undue delay, in good health, and the mother will recover from the childbirth without ill-effect. This is a high level of expectation, in which the consequences of failing to meet the expectation are known to be potentially multi-million-pound compensatory damages.
- 6.6 As mentioned above, the role of the midwife is to specifically recognise the potential for the need for intervention by other and differently qualified practitioners and manage (her) professional advice and the expectation of the woman accordingly. This gives rise to the need to interface with other professionals and the time that this is most likely to occur is during the intra-partum process to enable smooth escalation when complications arise.
- 6.7 This is a critical time for the wellbeing of the mother and baby and one that is the primary focus of the risks associated with midwifery. Cause and reason to make a complaint that may lead to a claim of negligence against a midwife is largely a matter of the perception of the claimant (or her partner, family or friends).
- 6.8 This means that when the expectation of the woman is not met there is a greater chance of a claim.

THE EXPECTATION GAP

- 6.9 Whenever expectation is not met there is a potential for a complaint leading to litigation. **This is the “expectation gap”**. In practice there are many things that can occur during a birth that cause no damage to mother or baby or which arise other than due to negligence by healthcare professionals but complaints/claims may be lodged nevertheless. Under an insured scheme of indemnity these would *have to be* notified to the insurers.
- 6.10 Closing the expectation gap entirely is *impossible* but narrowing the gap is achieved by setting clear parameters of expectation from the outset. It will be important for future IMs to demonstrate to insurers how they will achieve this.
- 6.11 One of the objectives of some IMs is to be able to offer a one-to-one relationship throughout the term and beyond. The overarching objective for the IM is to take a woman through the entire term of childbirth and deliver a natural birth, without intervention.
- 6.12 For those women whose expectation and choice is entirely met by the objectives of intervention-free and therefore, probably, home birth, the midwife offering that service is, on the face of it, the woman's ideal.
- 6.13 At the start of providing care to a woman who wants to have a home birth the midwife must make the woman aware that it is only possible following a satisfactory risk assessment. If the risk changes then the woman must be advised again.
- 6.14 However, it is inevitable that some women will not be aware of or willing to admit the true risks of a home birth "ideal" and the midwife may find it difficult to persuade the woman to accept (her) professional judgment leading to the woman not being willing to use the medical facilities of a hospital when things start to go awry. The risk is that when the ideal expectation is not met it will almost certainly escalate to a claim. The midwife's judgment will be severely scrutinised in these situations.
- 6.15 Furthermore, insurers are concerned that the "ideal" exposes IMs to being *encouraged* by the woman to continue alone and unsupported by medical facilities when this is not in the best interests of the woman. This must be taken into account in any future protocol or solution.
- 6.16 Insurers believe that some independent midwives take it upon themselves to continue alone and unsupported by medical facilities when this is not in the best interests of the woman. IMs employed by an SEC will be under the stewardship of the employer and so will reduce the likelihood of unwittingly falling into the traps of the expectation gap.

EDUCATION AND TRAINING OF MIDWIVES¹⁷

- 6.17 A midwife is a person who has successfully completed a midwifery education programme, duly recognised in the country in which it is located, and has acquired the requisite qualifications to be registered to practise midwifery (see ICM 2005)¹⁸. Once on the register, a midwife may provide care throughout the childbirth experience (this includes the antenatal, intra-partum and postnatal periods) and practise in any setting including the home, community, hospitals, clinics or health units.
- 6.18 The NMC looked at the education and training requirements of midwives to allow entry to the midwife's part of the Nursing and Midwifery Council (NMC) register and professional practice of midwifery. The NMC is required by the Nursing and Midwifery Order 2001 to establish and maintain a register of qualified midwives in the UK and to set the standards for pre-registration midwifery education.¹⁹ These standards are guided by the international definition of a midwife and the current requirements of the European Directive 2005/36/EC.²⁰
- 6.19 All programmes leading to registration as a midwife in the UK have to be approved by the NMC and are provided by approved education institutions (AEIs). These programmes prepare students to practise safely and effectively and assume full responsibility, autonomy and accountability for their practice at the point of registration. Since 2008, all programmes in the UK are required to be delivered at a minimum of first degree level. For non-registered nurses, these programmes are at least three years in length. There is also provision for NMC registered nurses (adult) to undertake a shortened programme of at least 78 weeks in length.
- 6.20 The theory to practice ratio of education programmes is required to be no less than 40 per cent theory (normally centred within a university setting of the AEI) and no less than 50 per cent clinical practice in partner providers to the AEI. The clinical practice component is required to be in direct contact with the care of women and their babies in a variety of settings and throughout the 24-hour, seven day period so that students develop an understanding of the needs of women and their babies throughout this time. This contact is under the supervision of a midwife and students are supernumerary.
- 6.21 As part of their education and training, students are expected to develop skills and experience in providing care and support to a group of women from early pregnancy until care by a midwife is complete. This may take the form of holding a supervised caseload.

¹⁷ This section has been contributed to by the Nursing and Midwifery Council.

¹⁸ The international definition of a midwife – adopted at the international Confederation of Midwives Council meeting in Brisbane, Australia 19 July 2005. See What Midwives Do 11.0.

¹⁹ Standards for pre-registration midwifery education, Nursing and Midwifery Council 2009.

²⁰ European Union Directive -The Recognition of Professional Qualifications 2005/36/EC Article 40.

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- 6.22 On completion of the programme students must demonstrate competence in:
- 6.22.1 Sound evidence-based knowledge of facilitating the physiology of childbirth and the newborn, and be competent in applying this in practice.
 - 6.22.2 A knowledge of psychological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this in practice.
 - 6.22.3 Use of appropriate interpersonal and communication skills to support women and their families.
 - 6.22.4 Skills in managing obstetric and neonatal emergencies, underpinned by appropriate knowledge.
 - 6.22.5 Being autonomous practitioners and the lead professional to women experiencing normal childbirth and being able to support women throughout their pregnancy, labour, birth and postnatal period, in all settings including midwife-led units, birthing centres and the home.
 - 6.22.6 Being able to undertake critical decision-making to support appropriate referral of either the woman or baby to other health professionals or agencies when there is recognition of normal processes being adversely compromised.

SKILLS AND QUALIFICATIONS

- 6.23 Midwives are more highly skilled and qualified than is generally appreciated by the public or by the insurance industry.
- 6.24 This is an important factor in the context of *risk profile* because the perception of insurers would be that if midwives are better skilled and qualified than they had appreciated then it does not bode well for the profession, based upon the continuing losses and the historical claims experience emanating from midwifery practice. As already mentioned, it is acknowledged the known losses are those arising from obstetrics and gynaecology, *including* midwifery, because there are no separate statistics for midwifery alone but that does not help the midwifery case for insurance protection.
- 6.25 In the absence of separate reliable statistics (and we believe there are none) the corollary, from an insurer's point of view, would be that they would not expect the outcome of loss and cost to be any different.
- 6.26 In other words, even imposing more controls on midwives would not persuade insurers to accept the risk because they are of the opinion that a midwife is, alone or with others, exposed to a claim of the same proportions as an obstetrician. This view can only be changed if a deliberate decision is made to separately record midwifery litigation and claims.
- 6.27 From our research, *and in the context of insurability*, there does not appear to be any need for imposing more clinical controls or more learned skills upon midwifery practice. There is no evidence known to us that midwifery skills, generally, are anything but of the highest order. Standards for Maternity Care - Report of a Working Party 2008 were produced by the four Royal colleges

(RCM, RCOG, RCPCH and RCA) and published by the RCOG and these are consistently referred to and utilised.

- 6.28 ***We would also add that, from a risk and risk management point of view, there is a case for arguing that there may already be too many controls and restrictions and that there is a diminishing return on their value and effectiveness. This is not a subject for this report but we recommend it could usefully be explored in more detail for the benefit of best practice.***²¹

PROFESSIONAL STATUS

- 6.29 The NMC rules state that it is the responsibility of every practising midwife to enable the monitoring of (her) standards and methods of practice and to enable inspection of her/his records and equipment and any premises by a supervisor of midwives and local supervising authority in the council. Each practising midwife is required to have a named supervisor of midwives.
- 6.30 From our discussions with members of the Advisory Group it is apparent that this was an important feature of the supervision of midwives and that such supervisors are able to provide continuing support and guidance. There is a requirement for each midwife to meet the supervisor at least once a year for the purpose of “statutory supervision”. An additional layer of supervision is provided by the Local Supervising Authority Midwifery Officer who oversees the standards of supervision in the officer’s area.
- 6.31 We have also noted that there are a number of reviews of the state of midwifery and the future of midwifery. We note that these are detailed, interesting and strong documents. So far as we can see they amount to “thought leadership” but it was not clear to us how the recommendations in these documents would feed into changes of practice, governance, or training, in practice.
- 6.32 It appeared to us, admittedly from a limited number of interviews, there is a sense of uncertainty, amongst midwives generally, about their place in clinical care. The difficulties and tensions that we talk about elsewhere in this report are relevant to our review. In terms of risk awareness and risk management dissonance and misalignment will impede midwives in the workplace from achieving the best outcomes for women because they may feel threatened, not respected, over-ruled and contradicted by those seeking to impose their own professional opinions at the expense of those of the midwife.
- 6.33 Consequently in the interests of assisting independent midwives in obtaining insurance/indemnity cover generally, midwives should be assisted in being recognised for the skills and professionalism they bring, particularly in connection with the supervision of normal births.
- 6.34 The role they can play in difficult births, particularly in observation skills and expertise required in the more difficult situations should also be promoted and recognised as a key value of midwifery and the part that a midwife plays in clinical care.
- 6.35 At the same time, midwives need to be acutely aware of the limits of their skills and abilities. As the NMC Rules and Standards states, midwives should not

²¹ Human Behavioural Risk 5.17, above.

seek to provide care for which they have not had training or for which they are not competent.

- 6.36 A renewed approach to defining the midwife's role in clinical care should enable obstetricians and midwives to be more consistently able to work together as a team with appropriate trust and respect for their respective complementary skills and expertise.
- 6.37 This is an issue of leadership at all levels and by all clinicians, i.e. including in the overall management of midwives, their human behaviours and attitudes. See also Common Causes of Error and Human Behaviours, above.
- 6.38 These aspects of a midwife's practice are carefully watched by insurers because they come to light in claims. They naturally tend to forge the views of the insurers about midwifery and its place in clinical care and this forms their basis of judgment about insurability.

PROFESSIONAL PROFILE

- 6.39 It is important that the true professionalism of midwifery is effectively presented to both the users of midwifery services and the stakeholders in the success of midwifery practice in the future. The rationale for this is that the defence of a professional is based upon the skill and care exercised at any given time and if the midwife, albeit technically qualified, does not present a professional image it will undermine the confidence of others who work with or rely upon the midwife and give a court of law cause to question the midwife's professional skill and competence.
- 6.40 The current perception of a midwife is (she) is susceptible to subjugation to other clinical professionals who regard themselves as more qualified, more skilled or simply more important than a midwife. This creates a "defensive" status for midwives to overcome and this perception of themselves can also harm their defence in the course of giving evidence in the course of litigation.
- 6.41 The following are some of the comments we received about "professionalism" and midwifery practice:
 - 6.41.1 *"(Some) midwives do not want to face realistic facts; they want to be idealistically philosophical. That is not good for women or for them. They must be part of a well-organised professional team.*
 - 6.41.2 *Why not treat midwives as trusted professionals?*
 - 6.41.3 *There is a lack of joined-up thinking between obstetricians and midwives.*
 - 6.41.4 *Midwifery doesn't require NASA skills and practices but it does require CORGI consistency of practice.*
 - 6.41.5 *Midwives do not hold themselves in the esteem they deserve having regard to their skills and training.*
 - 6.41.6 *It is unprofessional for a midwife not to tell the mother she is not insured and has no emergency facility standing by.*
 - 6.41.7 *Midwives must be clearer about the boundaries they work within.*

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- 6.41.8 *Midwives are the professional eyes and ears of obstetricians and must be able to identify deviations from the norm, very quickly, and act upon them even more quickly.*
 - 6.41.9 *If midwives were encouraged to "fit in the team" the outcomes would be better for all.*
 - 6.41.10 *Is "midwife" the correct term for them now? Perhaps "obstetric nurse?"*
 - 6.41.11 *(Some) midwives do not find out enough about their patient and then get surprised and find it difficult to extract themselves (from a situation).*
 - 6.41.12 *Midwives are often deterred from asking for help for fear of criticism for asking.*
 - 6.41.13 *Midwives who are "one to one" pick up on even the tiny changes that make all the difference.*
 - 6.41.14 *Would like to see more midwives doing "low risk one-to-one (childbirth)" in the NHS.*
 - 6.41.15 *Independent midwifery is really "caseload" midwifery.*
 - 6.41.16 *The emotional issues of women in pregnancy are scarring; one-to-one caseload midwifery would reduce the incidence of post-natal suicides and depression.*
 - 6.41.17 *42% of women using NHS services suffered emotional distress; this is due to insufficient midwives attending the woman pre-birth.*
 - 6.41.18 *(Some) midwives do not appreciate the speed at which problems escalate; they leave things too late, wanting to do it themselves.*
 - 6.41.19 *(Some) midwives try to "normalise" births when there is a real need for additional medical attention. Working more closely with obstetricians would help them overcome their need to do that.*
 - 6.41.20 *There is a profound difference between (a midwife) advocating against intervention and advocating to minimise intervention.*
 - 6.41.21 *"Albany" midwives failed. I rest my case.*
 - 6.41.22 *Delay in escalation is a key failing of midwifery.*
 - 6.41.23 *Most of the issues causing damage are due to failing to identify key markers due to lack of knowledge and skill.*
 - 6.41.24 *Most cases are failures at intra-partum."*

CLINICAL STANDARDS, RULES AND REGULATIONS

- 6.42 We have no expertise to comment on, in any way, the clinical standards or regulations governing the clinical competence of properly trained and qualified midwives. If anything we are surprised that there is *so much* detail and wonder whether this has the effect of de-skilling professional midwives by allowing

them to rely solely on ticking the boxes for compliance and thereby reducing their reliance upon professional judgment and training.

- 6.43 Whilst this is primarily a matter for clinical expertise it has a bearing upon an insurer's assessment of risk. It is well known in the insurance industry that overregulation and reliance upon tick-box processes creates a separate stream of risk on the one hand and rarely prevents accidents, errors or omissions on the other.

RELATIONSHIPS AND TRUST

- 6.44 It is evident to us from several sources that there is an undercurrent of non-cooperation, lack of trust and some bullying in the maternity environment. The reasons for this are fundamentally those of professional respect (or lack of it) on the one hand and human behaviour patterns on the other. This is not unique to midwifery but the difference, and hence the importance in this case, is that these dynamics will often occur at a time of crisis for the woman or baby and therefore the outcome impact can be considerably more damaging, if not fatal, than if it was occurring in, for example, a financial, commercial or other industrial environment where life is not at risk.

7 Healthcare Environment Influences

POLITICS OF HEALTHCARE

- 7.1 It is clear from our review and discussions with interviewees that, within current UK politics, there is a continuing dialogue about privatising healthcare, including, by implication, the "sub-contracting" of maternity healthcare services from the NHS to willing and suitable providers. They will not be willing to offer or contribute to a solution unless there is a clear and demonstrable pathway for the safe and sustainable integration of midwifery services with existing NHS healthcare resources and services.
- 7.2 From the insurer's point of view there must be "joined up" co-operation between companies (SECs) providing the services of midwifery in an NHS environment, including, amongst other things the SEC's Independent Midwife attending an NHS hospital with a woman. There will have to be a clear contractual relationship between the NHS commissioner, the hospital/maternity units and the corporate provider of maternity services. The reason for this concerns, primarily, the legal practicalities of defending claims and is dealt with elsewhere in this report.
- 7.3 Assuming there is a political will to allow IMs to be one of the classes of service providers to the NHS then the midwifery profession's next task is to design a suitable Protocol.

CLINICAL NEGLIGENCE SCHEME TRUST (CNST)

- 7.4 The CNST is the NHS "indemnity insurer", managed by the NHSLA in England. It protects its members (mainly NHS Trusts) and (vicariously) their employees against allegations of negligence. The relevance of the CNST to this review is that it does NOT cover midwives not working for the NHS and there is currently no means by which it can do so.
- 7.5 Consequently, an independent midwife is not permitted to practise (continue to assist and support her woman) when attending NHS premises, partly for reasons of no CNST protection.
- 7.6 This is a significant problem in dealing with matters of risk and insurance and any solution for the insurance of Independent Midwives must address and deal with this issue to ensure there is "joined up" indemnification for midwives working at NHS premises where other personnel are protected by the CNST.

CNST - its role and future implications

- 7.7 In the course of our research and the presentation of this report we have assisted Baroness Cumberlege in putting a question to the House concerning making available CNST protection to providers of contracted-in services to the NHS as members (of the CNST) in their own right.

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- 7.8 In July 2011 a question was put to the House: *To ask Her Majesty's Government what is the mechanism for IMUK²² to ensure their members are able to join the CNST or its equivalent?*

Earl Howe responded:

- 7.9 *"Non-National Health Service bodies, including IMUK, cannot currently join the Clinical Negligence Scheme for Trusts as members. In future, we intend to make NHS clinical indemnity arrangement available to all providers of NHS acute, community and mental healthcare, which includes independent midwives that wish to work within the NHS. We will publish proposals in due course."*

Description of the CNST

- 7.10 The CNST is a unique fund providing some protection for its members, the hospital trusts, who pay an annual contribution as annually assessed by the NHSLA, the administrators of the CNST.
- 7.11 The CNST is a "discretionary fund". This means that the NHSLA can exercise its discretion as to which claims to pay, how much and when.
- 7.12 This is different from an insurance which is a pre-defined contract of indemnity that will only pay strictly in accordance with its terms and conditions.
- 7.13 The CNST is only available to NHS parties and, by agreement, to parties given special access to the CNST via contracts with NHS parties who are members of the CNST.
- 7.14 To date there has been no contract available to providers of midwifery services.
- 7.15 The inherent weakness of the CNST is that a member that decides to leave the CNST will cease from that moment to receive any further monies at all, even in respect of matters that are outstanding and ongoing.
- 7.16 This means that the member is tied into the CNST for all time unless it can find another means of "providing for" its potential liability (provisions), i.e. for claims known and pending. Some members have provisions of tens of millions of pounds and until now there has been no alternative means of making those provisions.
- 7.17 We understand from our enquiries that the level of annual funding to the CNST is in need of substantial upward review and that the future of the CNST is under consideration if an alternative means of funding the members' potential liabilities can be found.
- 7.18 An alternative to the CNST has recently been launched (May 2011) by a group of insurers willing to underwrite the risk of the NHS trusts according to the actual risk they present. Early indications are that more than 40 Trusts are showing interest and that they have been advised that premiums are likely to be less than their annual contributions to the CNST. It is not yet known if maternity services will be covered and, if so, on what terms. It might be

²² An organisation of independent midwives.

possible as part of a Trust's overall programme but is unlikely as a stand-alone midwifery practice.

- 7.19 The mechanics of this new arrangement are not relevant to this report but the implication is that there could be an insurance market that would be prepared to consider underwriting a scheme for independent midwives, in due course. However, in our opinion this is unlikely for the reasons set out in this report.
- 7.20 Early enquiries into the new insurance facility have established that the effect of the new insurance available to the Trusts as an alternative to the CNST would not change the need for IMs working for that Trust to have a contract with the Trust in order to access any indemnity for the protection of IMs.
- 7.21 The implications of indemnity/insurance being provided by a commercial insurer instead of the CNST "fund" are several and important. We explain these under Risk and Insurance - Pros and Cons of Commercial Insurance.²³

²³ See Pros and Cons, 8.29 below.

8 Risk & Insurance

THE UNDERLYING INSURANCE PROBLEM

- 8.1 **The perception of the insurance industry is that a lone midwife attending a birth can easily make a mistake that can result in multi-million-pound damages. Although multi-million-pound damages are the exception rather than the rule, the cost of defending and paying such claims in an adversarial litigation environment has driven commercial insurers away from taking the risks.**
- 8.2 The principal reasons for the commercial insurance market rejecting the insurance of (self-employed) independent midwives are:
- 8.2.1 The perceived high risks associated with the intra-partum process.
 - 8.2.2 The extreme vulnerability of midwives to allegations of negligence by women and by other medical practitioners facing claims themselves, seeking to apportion blame to a midwife.
 - 8.2.3 The legal complexities and costs of defending midwives against allegations of negligence.
 - 8.2.4 The amount of the damages/awards typically associated with damaged babies.
 - 8.2.5 The absence of any legal entity to employ and control the operational and performance of Independent Midwifery services (as distinct from the supervisory controls of the NMC).
 - 8.2.6 The absence of uniform standards for Independent Midwifery practice, currently outside the NHS.
 - 8.2.7 Insufficient numbers of independent midwives to charge a sufficient but affordable premium.
- 8.3 Commercial insurers perceive the risk presented by midwifery in the same light as they do that of obstetrics and gynaecology (they lump these plus midwifery together in their statistics) which are known for being the highest cost to the NHS in terms of clinical litigation and awards of damages. There is no current means by which claims in each specialist area can be separated out and analysed to create a reliable risk profile for midwives alone.
- 8.4 Anecdotally, the perception of insurers is that individual awards connected with obstetrics and gynaecology and maternity/midwifery services are now expected to be > £6m per award and rising. NHSLA²⁴ has remarked that there is a realistic prospect of individual awards regularly breaking the £10m barrier in the foreseeable future.
- 8.5 Data concerning past NHSLA claims costs is set out in **Appendix 1**.

²⁴ Steve Walker, CEO NHSLA.

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- 8.6 A London Health Trust in its Board minutes in 2006 reported that a typical British maternity unit with about 3,000 births per year can expect two "brain damage" cases in an average year.
 - 8.7 Until 1994 insurance was available via the Royal College of Midwives for all its members. Due to claims relating to midwives in independent practice, since that date insurance has remained unavailable to self-employed midwives despite repeated and ongoing attempts by RCM, and brokers on its behalf, to persuade the insurance market to offer it.
 - 8.8 Insurers are acutely aware of the costs of defending medical negligence claims and, for the reasons mentioned above, they have concluded that independent midwives, in particular, are uninsurable.

NHSLA/CNST

- 8.9 The CNST is a unique method of "pay as you go" discretionary indemnity protection for its (circa 500) participating members. The CNST is recognised by the NHSLA and Government as a "not ideal" system but it has served a purpose. It may, however, change its form and its provisions if something more suitable becomes available.
- 8.10 We are aware of and fully understand the real financial and legal complexity of providing funding for past and future liability settlements. We also recognise that there will be pros and cons in any new arrangement for providing for liability settlements. There is no simple and inexpensive solution for this.
- 8.11 Moreover, the transfer of the risk and responsibility to commercial insurers would not solve all the problems of insuring midwifery practice and indeed could bring about financial risks and problems of its own.
- 8.12 It is likely that any changes to the CNST will have to reflect its current "not ideal" status and also to cater for Foundation Trusts and the move towards encouraging private resources to complement NHS delivery of services. Both of these pose significant and different problems for the CNST concerning the financial provisions of the "liability tail"²⁵ of any member of the CNST that decides, for whatever reason, to leave the CNST. This is not a matter of specific concern to the midwifery profession or a matter for detailed explanation in this report but it goes to the very root of financing its long term costs of and provisions for the liability of the NHS arising from negligence.
- 8.13 These changes may of themselves influence a reappraisal by the commercial insurance market of the profitability of insuring private medical services and if so this could open up the opportunities for insurance of midwifery. Whilst there is no foreseeable sign of this at the time of writing one can never say "never" in matters of insurance markets.
- 8.14 However, if CNST protection does not become available for midwives (in the manner proposed in this report) commercial insurance may still *not* be able to provide *the same* comprehensive level of protection as would the CNST offer

²⁵ The liability tail is the ongoing liability of the CNST member for claims that have been made prior to the date a CNST member leaves the CNST but which remain outstanding and not settled or paid. All of such claims revert to the sole liability of such CNST member.

its members and so, once again, **this report recommends caution should be exercised when adopting commercial insurances in medical malpractice** because they are not guaranteed forever at the terms the insurers may offer at the outset.²⁶

- 8.15 The future of Independent Midwifery depends upon being able to protect the woman and baby from the inevitable occasional errors and omissions of the practice of midwifery and provide a remedy, should this occur.

THE CURRENT INDEMNITY POSITION

- 8.16 Midwives practising outside the NHS or a private healthcare organisation (e.g. self-employed midwives taking private clients whether for home birth or placing reliance for intervention and emergency care upon NHS or private hospital facilities) are not insured for professional negligence either by the commercial insurance markets or by the NHS (CNST) and presently cannot obtain PI insurance from either the commercial insurance market or from the NHSLA's CNST.
- 8.17 Midwives employed within the NHS have protection (under CNST or the equivalent in the devolved administrations) but not their own PI cover and midwives in employment are covered by the RCM's policy.
- 8.18 Midwives working for private healthcare organisations are [presumed to be] protected by an indemnity or insurance cover provided by their employers.
- 8.19 Midwives who are supplied to the NHS by agencies (bank midwives) are covered by the NHS indemnity scheme.

FINLAY SCOTT - POLICY REVIEW

- 8.20 Finlay Scott, Chair of the Indemnity Policy Review group (June 2010) (FSR) says at Recommendation 20: "In relation to groups for whom the market does not provide affordable insurance or indemnity, the four health departments should consider whether it is necessary to enable the continued availability of the services provided by those groups; and, if so, the health departments should seek to facilitate a solution."
- 8.21 This report is particularly concerned with the feasibility of insurance or indemnity²⁷ for midwives (as defined) and with contributing to a solution facilitated by the health departments. It is one of the purposes of this report to start the process of finding a solution by analysing the insurance and indemnity-related dynamics of the feasibility for a solution.
- 8.22 The FSR also says at para.16: "*From the outset, there was an important distinction to be drawn in how the condition of registration could be met. For employees in the NHS or independent sector, it was intended that they should be able to satisfy the condition of registration by dint of the corporate cover that arises from an employer's vicarious liability for the acts or omissions of*

²⁶ See also above at 1.8.

²⁷ The difference between insurance and indemnity in this context is that the former is a contract by a third party insurance company to indemnify the insured against loss whilst the latter is merely a reference to a means of "indemnifying" by means other than a commercial insurance company.

employees. As a result, personal cover, from a defence organisation, trade union or other body, would not be required in relation to practising as an employee. Personal cover would only be required in relation to self-employed practices."

- 8.23 This comment is helpful in that it recognises the inherent value of a vicarious liability status that is engendered by an employer organisation for its employees' errors and omissions.

COMPULSORY INSURANCE/INDEMNITY

- 8.24 A woman utilising the services of a midwife in England may reasonably be expected to rely upon the quality of the service provided as being at least consistent with that available from the NHS and could reasonably be expected to assume that any service that is provided in England is the subject of an indemnity or insurance protection at least as reliable as that provided by the NHS.
- 8.25 Protection against the consequences of negligent midwifery, by insurance or another suitable means, is recognised as being in the public interest and the public will assume all medical practitioners are insured. That in itself is a problem for currently practicing independent midwives.
- 8.26 If a midwife is to practise in England, independently of the NHS, there is a strong case to support compulsory indemnity by insurance or other suitable means. That is borne out by the sentiments expressed in the Finlay Scott report and the references made therein to Government initiatives that recognise the public interest reasons for requiring healthcare practitioners to be insured or otherwise indemnified. The Directive will require such cover.
- 8.27 **In our professional experience, in dealing with a wide range of professionals in various disciplines, and the impact of their negligence upon their clients (whether services are given for consideration or otherwise), there is no plausible reason to challenge a recommendation for protection of women and children, by insurance or other suitable means of indemnification.**

PI INSURANCE AVAILABILITY FOR MIDWIVES

- 8.28 We have consulted three leading PI Medical Malpractice insurers²⁸ via Willis plc, worldwide insurance brokers, following which we can confirm:
- 8.28.1 PI insurance from the commercial insurance market for the full midwifery service, *including* the intra-partum process will remain unavailable to *self-employed* independent midwives for the foreseeable future.
- 8.28.2 PI insurance from the commercial insurance market for midwifery services *excluding* the intra-partum process, may be available to self-employed independent midwives although we have not found any evidence of its availability and do not expect it to be available for *self-employed* midwives for the foreseeable future.

²⁸ QBE Insurance plc; AWAC syndicate at Lloyd's; Marketform at Lloyd's.

- 8.28.3 PI insurance from a commercial insurance market *may* be available to *employed* midwives operating within a suitable legal entity (See Independent Midwifery - A Protocol 13.0) providing midwifery services but with limitations that are likely to *exclude home birth and any intra-partum practice* UNLESS provided in connection with an NHS contract which gives access to indemnity via the CNST or its successor, with a private hospital or clinic that provides an indemnity as part of the contract.
- 8.28.4 **NB1.** If the latter, care must be taken to establish whether the private hospital/clinic insurers would retain a (subrogatory)²⁹ right of recovery (of insurer's settlement of the claim) against the midwifery service provider and /or the midwife in person.
- 8.28.5 **NB2.** There are reasons why commercial PI insurance could present more of a problem for Independent Midwives than is realised. This concerns the continuity and reliability of supply (of insurance) and this is explained in this report.

PROS AND CONS OF COMMERCIAL INSURANCE

- 8.29 Insurance is a contract governed by strict rules and policy wording that defines what will and will not be paid, and how. The Medical Defence Union is an insurance-based scheme; the Medical Protection Society is a discretionary-based scheme, as is the CNST.
- 8.30 There are pros and cons for each method of protection. They are not the same.
- 8.31 The advantage of a discretionary-based scheme is that it is governed by people who have a direct and discrete interest in the parties protected, often by the model of a "mutual insurance pool".
- 8.31.1 The cost is not subject to market competition but to the discretion of the managers of the scheme.
- 8.31.2 The claims are subject to scrutiny and decision by the manager's lawyers.
- 8.32 The disadvantage is that there is no hard and fast rule as to what can be paid and it is sometimes said that it is not equally fair to all.
- 8.33 The advantage of an insured scheme is that the cover is in writing, certain and to be interpreted off the page.
- 8.33.1 The cost is subject to market competition.
- 8.33.2 The claims are subject to scrutiny and decision by the insurers' lawyers.
- 8.34 Other significant dynamics of an insured scheme include:

²⁹ To subrogate/subrogation: The legal right of an insurer to take over the rights and remedies of the insured party so as to recover such monies as they have paid out in a claim.

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- 8.34.1 The premiums could rapidly escalate after two or three years when claims begin to evolve. History shows, typically, a doubling and trebling of premiums over three to five years and rarely any fall back to lower premiums.
 - 8.34.2 There is a foreseeable risk that insurance can in itself, in the future, restrict practice (the USA experience).
 - 8.34.3 Midwives would be selected by insurers according to several selection profiles including, of course, claims history. This would leave some midwives with more expensive premiums and put some at risk of not being able to afford any cover at all. This could also lead to a midwife being put out of business at a future renewal date and left without any run-off (past liability) insurance. A list of underwriter's questions is set out later in this section.
 - 8.34.4 Insurers would decline to accept some midwives because of their "track record".
- 8.35 A midwife losing insurance protection or voluntarily ceasing to buy insurance (and therefore ceasing practice) would have no run-off protection for the six or seven years following cessation). This is a problem for the woman given the protracted nature of clinical negligence cases.

WARNING - INSURANCE PITFALLS

- 8.36 Commercial insurance is a complex contractual instrument and, once it has been obtained, it can be summarily withdrawn at short notice (most commonly at renewal, without advance warning) and without reason. Medical malpractice insurances of all kinds are vulnerable to summary withdrawal of commercial insurance and experience has been proven that this is particularly true for insurance of midwives. Typically, this is most likely to happen between three and five years after inception of a new scheme of insurance when claims experience begins to show that claims exceed premiums by too high a margin.
- 8.37 Another risk of commercial insurance is that premiums can escalate alarmingly and without warning so as to become unaffordable. This could imperil the organisation employing midwives, an individual midwife and, of course, the woman. Withdrawal of cover would severely imperil an employing entity and could also expose midwives to personal risk because, in the absence of insurance to protect the employing entity, there is nothing to prevent the employing entity being sued nonetheless and this may cause the employer to be less protective of the employee's interests.
- 8.38 There is, theoretically, no reason why a midwife should not be sued personally (in the knowledge that there is no insurance) but unless there are assets available to pay the costs and damages most lawyers would not advise a client to pursue this option. However, personal feelings (of a claimant) can sometimes override commercial wisdom and this can result in a trial of the midwife just to make a point.
- 8.39 There is no automatic entitlement to insurance and no insurer is obliged to offer it. Consequently, commercial insurance must be robust and secure in all respects from the outset and purchasers of commercial insurance must take exceptional care to research and compare commercial insurance quotations and to understand the security and expertise of the insurers offering the cover. .Once the insurance is in place the insured (the entity and the employees)

must remain vigilant as to the manner in which they practise and also how they promote and present themselves as professionals. Over-optimistic advertising and over promising can give rise to grounds for alleging negligence when the expectation has not been met.³⁰

- 8.40 Changes in practice methods and standards must be notified to insurers because if they are not the insurer may argue there has been non-disclosure of material information and so decline to honour the claim. This kind of thing is rarely appreciated by medical buyers of insurance but it is a key aspect of the contractual agreement between insurer and insured and can have a devastating consequence if this occurs at the time of a claim.
- 8.41 The purpose of this warning is to alert the reader to the fact that commercial insurance is not the panacea for all ills. Careful consideration should be given to the benefits of Government-based protections if they can be made available as these will be more likely to meet the complex needs of the midwifery profession. However, a carefully planned and executed combination of commercial insurance and Government indemnity is achievable and may prove to be the most successful outcome.

³⁰ See also The Expectation Gap 6.9.

9 Insurable Structures

- 9.1 **This section describes a proposal for an entity for the delivery of maternity services that would, subject to the detail and negotiated terms and conditions, be insurable by commercial insurers.**
- 9.2 After consultation with insurers, lawyers and the Advisory Group, midwives wishing to practise outside the NHS should do so by means of a suitable legal entity. Whether the organisation to which they are contracted is a limited company, a social enterprise company (SEC) or a community interest company does not really make any difference to an insurer; what matters is that there is a suitable legal entity that can be presumed to carry on in perpetuity and take vicarious responsibility for its employees and that will be presumed to be able to arrange run-off cover.³¹
- 9.3 Such an entity would need to have a strong commercial and clinical governance structure of at least the strength described in the CNST standards for midwifery-led maternity units.
- 9.4 The entity would need to impose rigorous standards and controls and provide regular training and competence reassessment of its PAYE midwives.

What is required from an insurance point of view?

- 9.5 The following guidance is drawn from discussions with brokers and insurers and its purpose is to guide the reader as to what would be expected by insurers before they are able to offer insurance protection.

INSURERS' PRELIMINARY VIEWS

Governance

- 9.6 The insurers would want to see:
- 9.6.1 strong management leadership;
 - 9.6.2 effective corporate governance;
 - 9.6.3 effective clinical governance;
 - 9.6.4 sound financial strength;
 - 9.6.5 effective risk management protocols;
 - 9.6.6 co-operation with insurers in risk management and monitoring;
 - 9.6.7 rigorous employee selection;
 - 9.6.8 annual review for competence.
- 9.7 The structure should be appropriate for the services offered whether acting for private clients or midwifery services under contract to NHS organisations.

³¹ Insurance against the liabilities outstanding at the time of the entity's cessation of business.

Underwriting concerns

- 9.8 **Insurance underwriters have expressed some of their general concerns about the insurance of midwifery. These are set out for information of the reader.**
- 9.9 The high legal costs incurred by both a claimant's and defendant's solicitors; how these can be reduced by negotiated settlements in preference to full litigation.
- 9.10 The implications for insurers of the Jackson Report on Costs Before an Action. The proposals which are being introduced are likely to reduce an insurer's outlay on claimants' legal costs by curtailing success fees in Contingency Fee Agreements between solicitors and their clients. However, the right for defendants' costs to be paid by unsuccessful claimants is also to be limited in most cases. It remains to be seen if fewer claims will be brought in respect of marginal 50/50 cases.
- 9.11 Legal aid for clinical negligence cases is expected to be removed. However the impact on claims remains uncertain.
- 9.12 The risk of being sued by the NHSLA (a Subrogatory³² Rights Action) or "joined in an action" by the Claimant on the recommendation of the NHSLA.
- 9.13 How the NHS would allow interface between independent midwives and its own staff in matters of intra-partum process where there is likely to be a contributory liability element to the claim.
- 9.14 The Duty of Care owed under the NMC rules in caring for women for whom they are responsible in an emergency situation. The emergency may have been created by the woman herself who does not wish to go into hospital despite having been advised in clinical terms that the level of risk to her and the baby is above acceptable levels for a home birth.
- 9.15 The role and legal status of a midwife attending with a woman at an NHS hospital at which she is not employed.
- 9.16 The nature and extent of home birth and the controls governing it.
- 9.17 The nature and extent of other roles of a midwife that do not include the intra-partum process.

Assessment of risk

- 9.18 Insurers have expressed concern about several aspects of risk that they will review carefully in the assessment of any proposal for insurance. These are not exhaustive but are a good basis for the reader to understand the overarching principles.
- 9.19 We will take into consideration the following:
- 9.19.1 Assessment of individual midwives by:

³² To subrogate/subrogation: The legal right of an insurer to take over the rights and remedies of the insured party so as to recover such monies as they have paid out in a claim.

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- (i) years of experience post qualification;
 - (ii) source of training;
 - (iii) ongoing professional development
 - (iv) language/communication skills;
 - (v) protocols and processes followed;
 - (vi) proximity to hospital and other medical emergency facilities;
 - (vii) working relationship with obstetricians;
 - (viii) cultural overseeing of practice standards and the operational controls of employed midwives (as distinct from Statutory (clinical) Supervision by NMC);
 - (ix) nature and structure of employer organisation;
 - (x) keeping of records and ability to make contemporary notes of judgment and decisions;
 - (xi) re-examination and/or competency re-assessment.

9.20 No action needs to be taken with regard to these observations. They are simply included here to illustrate the thoughts of the underwriters contributing to our research.

Part Two

Part Two concerns an appreciation of the fundamentals of midwifery and Independent Midwifery.

We have included these because the outcome of an insurable solution entirely depends upon a common agreement of the underlying principles of the proposed concept of Independent Midwifery.

10 Independent Midwifery - A Solution

- 10.1 Given that it is not possible to obtain insurance for midwives practising alone, this part of the report addresses the feasibility of a solution that *would* enable midwives to practise independently (of the NHS).
- 10.2 From our research and enquires we have learned that:
- 10.2.1 It is generally agreed that it is in the best interests of women, of Government and of the NHS that there are sufficient midwives available to meet demand and that they are entirely consistent in terms of quality and reliability wherever and however they practise.
 - 10.2.2 There is general support for a concept of Independent Midwifery as outlined in this report.
- 10.3 We can envisage practical solutions that will enable independent midwifery to operate safely, integrated with NHS services, in such a way as to make available a sustainable indemnity insurance protection.
- 10.4 The solution will depend upon the willingness of Ministers and the NHS to allow a joined-up access protocol for independent midwives to deal with the emergency and specialist intervention of a woman's needs in the intra-partum phase of childbirth, in particular, and the interface controls and responsibilities between midwifery providers and NHS services and resources, in general.
- 10.5 Any midwifery service ought to be of a specification and quality standard no less than is provided by the NHS. Anything less than this would be uninsurable.³³
- 10.6 The most reliable and practicable method of providing an independent midwifery service would be to engage and train midwives as employees of a stand-alone legal entity³⁴. The legal entity would be more easily insurable because of its intrinsic substance, its ability to pay a premium, manage its services and people and because it will have vicarious liability for the acts and omissions of its employees – clinical, administrative and management.
- 10.7 A suitable legal entity could be a Social Enterprise Company (SEC) and/or a Community Interest Company (CIC). We have looked into the feasibility of this and we envisage creating a specialist SEC/CIC protocol for integration with NHS services. The SEC/CIC would be regulated by CQC to ensure the regulation and maintenance of NHS standards of care and practice.
- 10.8 This report proposes a solution that integrates NHS and independent midwifery and so maintains the benefits of NHS facilities and expertise whilst simultaneously creating more midwifery availability to enhance the choices for and access to care for women.

³³ Presenting a risk profile for which commercial insurers are unable or unwilling to offer terms.

³⁴ A suitable legal entity capable of employing midwives.

11 Differences and Sensitivities

WHAT MIDWIVES DO

- 11.1 The International Confederation of Midwives agreed a definition of what a midwife does as follows:
- 11.1.1 A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.
 - 11.1.2 The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the post-partum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
 - 11.1.3 The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.
 - 11.1.4 A midwife may practise in any setting including the home, community, hospitals, clinics or health units.
 - 11.1.5 Adopted by the International Confederation of Midwives Council meeting, 19th July 2005, Brisbane, Australia.
 - 11.1.6 Supersedes the ICM "Definition of the midwife" 1972 and its amendments of 1990.

DIFFERENCES AND SENSITIVITIES

- 11.2 We have been made aware, from the interviews we undertook in preparing this report, of a wide range of differing opinions and sensitivities in and around midwifery practice, within the NHS and in Government as well as by practising midwives themselves. We have taken these into account.
- 11.3 Each of the following issues has a bearing upon the outcome of a practical Independent Midwifery solution to meet the objectives of this review. We have taken these matters into consideration and comment upon them as appropriate.

MIDWIVES - NEED AND AVAILABILITY

- 11.4 There is an evident and accepted need for more midwives to be able to practise in England. **The RCM believes there is a shortage of over 4,000 midwives (RCM Statement 22 March 2011). For the purposes of this**

report, and after consultation with the Client, it is agreed that there is a prima facie case for a commercial “market” for Independent Midwifery in England.

- 11.5 The NMC confirm that the actual registrations of midwives for 2011/12 are 40,337 registrations, of whom 36,100 have given notice of intention to practise, leaving 4,237 presumed to be available for practice but expressing no current intentions.
- 11.6 We understand they are potentially available for a “return-to-practise” programme and re-engagement as practising midwives. The shortfall in the numbers of practising midwives could therefore be reduced from this pool if the midwives could be encouraged to return to practice and this is a view consistently expressed by interviewees contributing to this report.
- 11.7 It was reported to us that some of the available non-practising midwives would be enthusiastic in a “return to practice” programme to bring them up to modern midwifery professional standards provided that the system of work was attractive, safe, insured and entirely supported by the principal regulators and stakeholders. It is also reported to us that many of these midwives would not be attracted to returning to work within the NHS because it does not allow them to practise one to one with the woman.

THE ADVISORY GROUP – OBSERVATIONS AND OPINIONS

- 11.8 The following remarks evidence a wide range of views amongst the medical profession but mostly point to a genuine desire to improve the outcomes by better attention for women.
- 11.8.1 *"It is Government policy that women be given choice of where they give birth. However, given the current constraints on capacity in the NHS, the range of choices is not always complete.*
- 11.8.2 *Most midwives believe in the benefits of one-to-one care "in the field" but this is not available to midwives working in the NHS.*
- 11.8.3 *Most midwives aspire to achieve this (individual care) but, given the number of women that have to receive care and the way in which care by the NHS is organised, continuity of individualised care is hard to achieve. Therefore, some midwives opt to practise outside the NHS, caring for a defined group of clients with whom they plan care and provide continuity of support.*
- 11.8.4 *There are some women for whom the NHS does not provide a suitable care model to address their needs and experiences and therefore seek the services of independent midwives.*
- 11.8.5 *They would bring women to the NHS for necessary intervention and/or emergency treatments with the attendant benefits of knowing the woman and thereby immediately complementing the more specialist services available at the place of intervention/treatment.*
- 11.8.6 *All women want and benefit from continuous care, especially for a first child.*

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- 11.8.7 *A policy of one woman to one midwife is in the best interests of the woman and will lead to healthier and safer childbirth outcomes and will also save the NHS money.*
 - 11.8.8 *Continuity of antenatal care and support by a known midwife will enable the women to be well prepared for labour and may assist in the improvement of a birth outcome.*
 - 11.8.9 *Continued care in the postnatal period may reduce postnatal trauma, depression and suicide.*
 - 11.8.10 *There is a body of opinion within the medical profession and some midwives that there is a general presumption in the NHS that childbirth is necessarily a hospitalisation event and that one of the benefits of Independent Midwifery would be to safely relieve the cost and time pressure on the NHS, with particular reference to the reduction in elective Caesarean section births.*
 - 11.8.11 *There are a range of opinions held by the public as to where the safest place to give birth is.*
 - 11.8.12 *Women should be given more choice as to where they give birth, including hospital midwifery-led units, dedicated birth centres and home birth for low risk women where there are suitable and safe conditions to do so.*
 - 11.8.13 *Women may start out low risk and later become high risk but this is often not recognised by the woman or the midwife."*

TENSIONS IN THE PROFESSION

- 11.9 We are aware that there are different attitudes to midwifery practice and that although all midwives are bound by the same NMC rules, standards and practice, the methods employed within those boundaries are many and varied.
- 11.10 There is a real fear of "radical" midwifery practice.
- 11.11 The level of practical clinical support and oversight and monitoring in independent midwifery has been inconsistent and proven to be unreliable.
- 11.12 Some NHS practitioners and managers do not believe there is any necessity for midwives to practise anywhere other than in the NHS.
- 11.13 Some NHS and some non-NHS doctors and midwives believe it is dangerous for a woman to give birth anywhere other than in a fully equipped medical environment.
- 11.14 There exist professional tensions between clinical personnel in all disciplines and midwives for reasons of differences in professional judgment.

MIDWIVES' DUTY OF CARE

- 11.15 The reality of legal liability and the insurability of midwifery is not widely understood by the midwifery profession. There is an insurability risk factor in this misunderstanding and so we comment on it in detail.

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- 11.16 It became clear to us in the course of our interviews that the concept of a midwife's "Duty of Care" is widely misunderstood. Some midwives understand Duty of Care to mean they have a duty to care for a woman in whatever way the woman expresses her wish at the time. It is frequently interpreted as being an obligation to do, or not to do, something in accordance with the *woman's express wishes or demands* but it takes no account of whether it would otherwise be consistent with good practice. We do not know why this view exists but it is a real and present danger and should be addressed, irrespective of this report, without delay.
- 11.17 The correct position is that midwives must at all times and under all circumstances act in accordance with professional obligations and judgment and not do something that is inconsistent with or contrary to professional training, integrity or which could not be justified at a later date as consistent with good practice and sound professional judgement.
- 11.18 We understand, for example, that a midwife has no authority to remove a woman from where she is being attended to (e.g. from home to hospital) and that midwives sometimes use this as a reason for doing whatever the woman demands even if it would be against the midwife's usual best judgment to do so. This misconception of the Duty of Care should be addressed without delay.
- 11.19 We are told by way of another example that midwives are sometimes required to attend a woman who has not followed the professional advice given by the midwife, another midwife or other doctor or healthcare professional. Nevertheless, the midwife has an obligation to provide care and, we understand, this causes some midwives to follow the demands of the woman, against their own professional judgment, because it is the only way they can get the woman to cooperate. This is a serious conundrum for the profession because the legal position in the event of a claim for damages is likely to be at odds with the humanitarian aspects of dealing with a situation such as this.
- 11.20 This can lead to consequent legal problems for the midwife who has not properly understood her legal obligations and what is really meant by the Duty of Care. In some cases employment problems result because the care given is suboptimal and in breach of an employer's policies.
- 11.21 Another misunderstanding concerns home births. Home birth is often associated with "radical" midwifery practice. It polarises attitudes in medical circles and is an unhelpful distraction away from the benefits of carefully planned and monitored non-hospitalised childbirth as an acceptably safe practice under the right conditions.
- 11.22 If there is a sound clinical case for home births it should be made publicly available information so that a woman can easily make an informed decision and do so without imperilling the professional reputation of a midwife who has to deal with the complexities of Duty of Care in home birth situations.

Part Three

Part Three concerns a concept, a protocol and a potential solution for insurable independent midwifery.

Insurers and other stakeholders not closely associated with midwifery will continue to hold views and perceptions that influence their willingness to lend to, insure and support Independent Midwives (IMs) and so it is important that the profile of independent midwifery and IMs is entirely positive, sustainable and sufficiently closely allied to NHS practices and resources such that it stands the test of being a merited complementary resource as distinct from a rival competitive private practice.

12 Independent Midwifery - A Concept

- 12.1 We envisage that Independent Midwifery could become an established concept for providing maternity care working in conjunction with NHS.
- 12.2 It would engage midwives wishing to practise in the "community" as distinct from under the direct employment of the NHS and providing flexibility to both commissioners and midwives.
- 12.3 It would assist NHS midwives and maternity services in the development and promotion of Choice for Women, enabling this to become a normal concept of childbirth but doing so within an operating protocol that retains the integrity of NHS practice, midwifery learning and knowledge. The experience of the NHSLA to guide and influence the future of midwifery practice both in and out of hospital and similar clinical environments will be of great assistance.
- 12.4 Above all else the operating protocol must be capable of standing up to the rigorous tests of law and established evidenced-based practice.
- 12.5 The protocol put forward in this report is based upon the "wish list" deriving from the broad range of interested parties contributing, directly and indirectly to this review.
- 12.6 It also takes into account our knowledge and expertise in the subject of professional risk and liability, the legal, commercial, economic and practical aspects as well as the insurability of professional risk.

THE OBJECTIVE

- 12.7 Midwives are primarily concerned with being able to practise their skills for the benefit of women, giving them a choice of childbirth environment and providing reliable continuity of care throughout the pregnancy and childbirth experience.
- 12.8 There is *no overriding* objective for being able to:
 - 12.8.1 provide home birth services;
 - 12.8.2 provide private midwifery services.
- 12.9 It is recognised, however, that some midwives will want to do so.
- 12.10 This protocol is more specifically aimed at the following:
 - 12.10.1 Recovering the unused professional skills and services of qualified midwives who have left the midwifery profession but would like to re-engage with it.
 - 12.10.2 Midwives who prefer to work independently of the NHS cite reasons of :
 - i. home and family commitments;
 - ii. flexibility of work/life balance;
 - iii. providing a continuity of care throughout the pregnancy and childbirth experience;

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- iv. providing a specific part or parts of the care throughout the pregnancy and childbirth experience but excluding the intra-partum. Midwives would need to be fully up to date and able to practise across the whole maternity pathway. Management of the end of antenatal care and the start of postnatal care will need to be a careful documented process.

OUTLINE OF ENTITY PROPOSITION

- 12.11 The principal objective will be to scope a practice protocol for midwives with particular focus on antenatal and post-partum services for the support and wellbeing of women and with a special and separate protocol (optional for midwives) concerning intra-partum services for each of low risk and high risk women.
- 12.12 The services of midwives will be controlled and supervised by the overarching operating company/ies that will have vicarious responsibility and accountability for employed midwives.
- 12.13 The services of midwives would be available to:
 - 12.13.1 Commissioners of NHS services requiring scalable services from time to time. This means that the requirement for midwifery may be more or less at any one time according to the volume and profile of childbirth and so the demand for independent midwifery services to cope with the volume. Demographics determine the childbirth rate at any given time and the commissioners may find they have periods of need for additional services.
 - 12.13.2 Private individuals where the IM has access to a private hospital or clinic or NHS hospital by way of a pre-contracted service.

A RATIONALE FOR INDEPENDENT MIDWIFERY

- 12.14 Midwifery, in common with all other professional disciplines, includes practitioners with different specialist skills, differing preferences for working environment and differing temperaments and experience suited to focusing on particular kinds of women; for example, young mothers, immigrants, women with existing health difficulties, and much more.
- 12.15 Women will benefit from access to midwives that can best meet their needs and it is feasible to meet that need if more midwives, with diverse attributes, are available in the community but not specifically hospital based.
- 12.16 Shortages of midwives exist in identified parts of England and there is a known appetite of PCTs to consider outsourced maternity care services to address their shortage or particular requirement.
- 12.17 There may be some financial advantage to a flexible deployment recognising that it is the NHS that has to ensure 24/7 availability of backup.

THE CONCERNS TO BE OVERCOME

12.18 These include:

12.18.1 quality of practitioner;

12.18.2 clinical oversight and audit of standards of practice;

12.18.3 objections to "privatisation" of healthcare;

12.18.4 public interest protection and indemnity;

12.18.5 loss of control by NHS;

12.18.6 conflicts of interest;

12.18.7 failures of other maternity/childbirth initiatives.

12.19 We have taken into account each of these concerns. They are of relevance to insurers and other stakeholders as well as to the envisaged employer organisation itself.

12.20 Our conclusion is that it is possible to overcome each of them by means of establishing an operating protocol.

13 Independent Midwifery- A Protocol

THE RATIONALE FOR A PROTOCOL

- 13.1 Insurability of midwifery, whether by commercial insurers or via the CNST (or its successor), will depend upon the risk profile of midwifery in the independent sector.
- 13.2 Risk profile means the combination of:
 - 13.2.1 the vulnerability of midwives to errors and omissions and claims resulting therefrom on the one hand; and
 - 13.2.2 the defensibility of the actions, judgments and decisions of midwives, on the other.
- 13.3 The principal risk to midwives is an allegation of negligence in the intra-partum process, which includes the monitoring, advice and treatment of the woman in the antenatal period.
- 13.4 It is acknowledged that there is a necessity for a midwife to recognise when medical intervention may be necessary for a woman and to ensure that the woman reaches appropriate medical care *in good time*. This brings the midwife into direct working contact with other medical practitioners and, in legal and insurance risk terms, this creates an even more complex situation when a claim is brought following a birth. The complexity arises from determining the responsibility of each relevant contributing party at the relevant time both pre, during and post the birth.
- 13.5 The principal weakness of a midwife's legal position concerns the history of the woman leading up to an intervention being required by another healthcare professional. The next most vulnerable legal position is the decisions made, or not made, in the delivery room, for which the midwife alone can be held responsible. These are a matter of fact in each case and the insurers are dependent upon the protocols, procedures and written records of evidence that will support a defence in a court of law. Very often the evidence is incomplete or absent because note-making is by definition dependent upon the midwife's diligence and judgment.

THE RATIONALE FOR INDEPENDENT MIDWIFERY

- 13.6 For the purposes of this report the rationale for Independent Midwifery (as stated to us) is to allow qualified midwives to practise outside the NHS but within the framework of a suitable legal entity which is able to contract with the NHS to provide midwifery services on a one to one caseload basis..
- 13.7 The reasons for midwives not wishing to be NHS-employed concern flexibility of work/life balance and the contractual/working time requirements of being an NHS-employed midwife.
- 13.8 The intended benefits to women of more midwives available on a one-to-one caseload basis include better care, better monitoring, more choice for women and improved outcomes for all.

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- 13.9 The implication is that Independent Midwifery will focus primarily on providing midwifery services through one midwife (with an alternate for cover) on a caseload basis and/or a pathway specialist basis "in the field" as distinct from being solely based at an NHS premises.
- 13.10 Assuming this rationale to be true the insurers of Independent Midwifery will require evidence of a protocol that will be no less comprehensive than that of midwives working in the NHS. In fact, the insurers will need to be satisfied that the Protocol for Independent Midwifery will be substantially robust and stand the tests of critical scrutiny in a court of law. This means that it must withstand the tests of medical expert witnesses called to testify on best practice.
- 13.11 Accordingly, the protocol (which may include exclusion criteria for the circumstances in which care *cannot* be provided) should focus upon those aspects of midwifery practice that are most difficult to deal with from the legal and insurability points of view. This includes, in particular, the intra-partum process carried out in conjunction with other medical practitioners at an appropriately equipped NHS maternity unit.
- 13.12 There is a shortage of midwives in parts of England and if the insurance/indemnity issues can be solved it could enable the return to practice of midwives who have left the NHS and would prefer the Independent Midwifery model.
- 13.13 In turn this would make possible the creation of a model of employment for midwives, by bodies other than the NHS, that will be flexible, accepted by the Government and the NHS and more able to develop care that will offer choice to women and allow "one-to-one midwifery" more scope for development.

AN OUTLINE PROTOCOL

- 13.14 A suitably regulated employing legal entity is the crux of a safe and sustainable platform for Independent Midwifery.
- 13.15 In theory, any private company could be a suitable employing legal entity. However, having regard to the politics of private medical services we recognise the already mooted benefits of a Social Enterprise Company (SEC) and/or a Community Interest Company (CIC), both of which are distinguished from private healthcare companies by the nature of their aims and objectives and controlling interests.
- 13.16 For the purposes of this report *only*, we will refer to the employing legal entity as the SEC.
- 13.17 It is essential for Independent Midwives (IMs) to be *employed* and not self-employed. Part-time employment under a contract of service is included in the term *employed*. A contractual arrangement will ensure full vicarious responsibility of the employer for the employee and is a keystone of the Protocol and the insurability/indemnification solution.
- 13.18 The SEC will be regulated (currently) by the Care Quality Commission (CQC).
- 13.19 As insurance cover in the commercial market is not available to midwives for the full care pathway, the SEC would need to tender for contracts from NHS commissioning bodies that will give IMs the ability to carry out intra-partum processes in respect of NHS contracts and to gain access to CNST if/when possible.

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- 13.20 Furthermore, the SEC would be able to contract with private hospitals to provide access to insurance cover for IMs caring for women under such a contract.
 - 13.21 The primary purpose of the SEC will be to provide qualified, competent IMs for caseload contracts, special function pathway contracts and such other special needs as the commissioning body may have from time to time.
 - 13.22 The status of the IM will be such that it will include working in an NHS "unit" of equal standing with an NHS-employed midwife when required to do so, under contract. It is envisaged in particular that this will include the IM taking a woman under care, as part of a contracted-in service, to an NHS unit and continuing to care for the woman on NHS premises with full indemnity rights.

CONTRACT WITH ACCESS TO CNST

- 13.23 The Protocol requires there to be a contract with the commissioning body which gives access to CNST protection. At present this contract is not available.
- 13.24 The terms of the SEC's contract with a commissioning body is a crucial aspect of the insurability of the SEC if cover for intra-partum care is required (the SEC buys the insurance; the midwives will not need insurance themselves).

INDUCTION/FAMILIARISATION PERMISSIONS

- 13.25 Typically, a NHS midwife will be trained to care for women in a delivery unit and operate the equipment, use the resources available and interface with other medical staff and assistants.
 - 13.26 Typically, however, an IM may be less familiar than an *in situ* employed NHS midwife with:
 - 13.26.1 the delivery room and its resources;
 - 13.26.2 the full-time personnel working in the birth suite;
 - 13.26.3 the availability and access to emergency procedures and personnel including undertaking mandatory training;
 - 13.26.4 the intra-partum process, if lacking in recent practical experience.
 - 13.27 Accordingly, the risk factor will be determined by the *actual* experience of the midwife and evidential familiarity with the birth/delivery facilities.
 - 13.28 In order to ensure effective control of an IM on NHS premises it is suggested that the Protocol requires that each IM shall be given a "permission" by each NHS "unit" that the SEC contracts to use, entitling the individual IM to practise there.
 - 13.29 The "permission" will simply be an attestation that the IM has passed a familiarisation and induction process at each unit. This will provide a first-class level of risk management and be a useful contribution to a defence in law.
 - 13.30 In the event that an IM does not have the relevant permission the IM will not be permitted to "practise" as a midwife in the relevant "unit". The IM can only
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remain "in attendance". The incentive will be for the SEC to ensure its IMs are fully trained and hold relevant "permissions".

- 13.31 "Permissions" should be subject to "regular" review and renewal (period to be agreed).

MIDWIFERY STANDARDS

- 13.32 These would be the same as currently existing, subject to any modifications recommended by the NMC and, in relation to the SEC, the CQC.

14 Recommendations

ADVISE MIDWIVES

- 14.1 RCM to formally advise independent midwives:
 - 14.1.1 of the risks to themselves associated with practising alone devoid of any fall-back medical support;
 - 14.1.2 of the fact that a self-employed midwife is uninsurable for the reasons explained in this report;
 - 14.1.3 a midwife could be sued personally and lose her home and her future livelihood as well as her midwifery qualification if she practises without insurance, once it is mandatory;
 - 14.1.4 of the risks to the woman and baby associated with practising alone devoid of any fall-back medical support;
 - 14.1.5 that obtaining consent from a woman to practise without insurance and/or and without access to an NHS hospital does *not* protect the midwife in law from any claims that may ensue.
 - 14.1.6 a midwife cannot contract out of her legal liability for loss or damage arising from bodily injury to a third party i.e. (a woman or child).

PUBLIC INTEREST- FOR INSURANCE

- 14.2 Consider whether it is against the public interest to permit a self-employed midwife to practise without insurance, irrespective of the legal requirement that may come into force.

PROMOTE MIDWIFERY TO IMPROVE INSURABILITY

- 14.3 Currently the risks are too great for insurers to accept “independent midwives” as a class of insured.
- 14.4 The changes required to enable an insurer to underwrite the risks are considerable and, in our opinion, cannot be achieved without a sea change of relationship between the midwifery “profession” and the NHS which controls and maintains the infrastructure for medical and surgical technology, medical and surgical treatment, hospital care and the emergency services that are a pre-requisite for enabling the interventions required for safe childbirth.
- 14.5 We recommend that this will only be achieved by creating a means by which NHS contracts for “Independent Midwifery” can be let by NHS commissioners.
- 14.6 At the time of writing our report we understand there is an increasing possibility that Government will encourage the outsourcing of services. Maternity services are in demand in some areas and so there is a *prima facie* case for creating a deliverable service by means of an SEC, or similar. We recommend that midwives wishing to practise outside the NHS are encouraged to pursue this avenue by means of an SEC (see 3.13,above).

PERCEIVED BENEFITS

- 14.7 The resource of midwives potentially available to meet the increasing needs of women and to meet the cost reductions by the NHS are, we believe from our research, ready and willing to play a specific part in supporting the childbirth process in England and in doing so:
- 14.7.1 bringing more caseload capacity to the profession by employing more independent midwives "in the field";
 - 14.7.2 promoting the professional skill of being the eyes and ears of the obstetricians "in the field";
 - 14.7.3 increasing the continuous care and wellbeing of women in childbirth;
 - 14.7.4 reducing the failure rate of detecting the need for intervention;
 - 14.7.5 eliminating the incentive for a midwife to take a risk by non-referral;
 - 14.7.6 providing a secure and consistent platform for encouraging and training new midwives to "work in the field";
 - 14.7.7 establishing reliable benchmarks and statistics for non-hospitalised childbirth;
 - 14.7.8 ensuring that a woman can rely upon the NHS and all of its services without compromise or delay;
 - 14.7.9 reducing the risk of inter-medical practitioner dispute and consequent litigation;
 - 14.7.10 reassuring the various medical practitioners, including midwives, of the full and equal support of the NHSLA in defending allegations of fault or negligence;
 - 14.7.11 enabling midwifery support workers to become an integrated part of the maternity care service and freeing midwives to be the professional practitioner;
 - 14.7.12 providing the right people in the right place at the right time;
 - 14.7.13 complementing but not competing with the resources of the NHS hospitals and maternity units.
- 14.8 The King's Fund report published in 2011 entitled "Staffing in Maternity Units" ISBN: 978 1 85717 609 4 makes recommendations for "*getting the right people in the right place at the right time*". The report deliberates comprehensively on the appropriate methodologies and proportionate risks and benefits of change but does not, understandably, address the issue from the point of view of risk in the context of professional liability and indemnity against allegations of negligence.
- 14.9 We recommend that the sentiments of "***getting the right people in the right place at the right time***" is the precursor to a concept of childbirth that will achieve the challenge of safety, quality care and cost savings with the additional benefits of choice for women and continuous care for women. This

will employ qualified and trained midwives for what they are best at and prefer doing; being the ears and eyes of the medical professionals specialising in obstetrics and gynaecology whose value is at its best in the specialist centres around the country.

14.10 "Independent Midwives" should be employed by a suitable legal entity (see above) and specifically recruited to work "in the field" as distinct from NHS hospital midwifery units, their principal purpose being to provide the specialist professional level of care for women for which a midwife is specifically trained.

14.11 "Independent Midwives" may elect to work in specific pathways or parts of a pathway to suit their own interests, circumstances, work/life balance and reflect their experience and desire for learning and the development of their career.

FEASIBILITY STUDY

14.12 To carry out a feasibility study of an employing entity (SEC) based upon the recommendations in this report.

EUROPEAN COUNTRIES COMPARISON

14.13 To consider the value and benefits of seeking comparisons with midwifery practice and indemnity/insurance in other European countries (and subject to the same EU Directive).

DUTY OF CARE

14.14 An urgent review of midwives' understanding of "Duty of Care". This is discussed fully in the report.³⁵ The review should be published by RCM/NMC to improve a contemporary understanding of its real meaning, intentions, implications for liability and disciplinary action.

³⁵ See 11.15 above.

15 Credentials

ROGER FLAXMAN

- 15.1 My business address is 68 Lombard Street London EC3V 9LJ. I am currently Managing Director of Flaxman Partners Ltd, professional risk and insurance consultants and insurance claims advocates.
- 15.2 I qualified in 1981 as an Associate of the Chartered Insurance Institute (ACII). I am now a Chartered Insurance Practitioner and an accredited member of the Academy of Experts, a CEDR³⁶-accredited mediator and CEDR International Panel member.
- 15.3 This report is based upon my experience as a broker in the London insurance market from the period 1969 to 1999 and from 1999 to present, as an insurance consultant (and with effect from January 2005 as an FSA-authorised insurance intermediary) to professional bodies, professional firms, corporations, societies and associations on matters of corporate and professional risk, liability and insurance.
- 15.4 I am also an adviser on risk and insurance practice to the British Insurance Brokers' Association.
- 15.5 I have practised as an expert witness to the courts since 1999.

ANTHONY BARLING

- 15.6 My business address is 68 Lombard Street London EC3V 9LJ. I am currently a director of Flaxman Partners Ltd. I qualified as a solicitor in 1974 and practised until 2009. My main expertise was advising clients involved in commercial transactions. I was Managing Partner of Finers Stephens Innocent for 6 years from 2000 and I have been a trustee of charities, not-for-profit organisations and NED of an NHS trust.

³⁶ Centre for Effective Dispute Resolution

Appendix 1 Cost of obstetrics claims

The figures shown below are reproduced from the publicly available statistics of the NHSLA Fact Sheet 5.

There are no statistics specifically identifying negligence by midwives. Midwifery claims are included within the Obstetrics figures.

Cost of obstetrics claims PAID in 2010/11

CNST Damages	CNST Defence Costs	CNST Claimant Costs	CNST Total Paid
185,578,557	14,290,453	34,975,081	234,844,091

Number of obstetrics claims notified in 2010/11 = 801 (most of the payments of these claims will not be made for between 5 and 10 years)

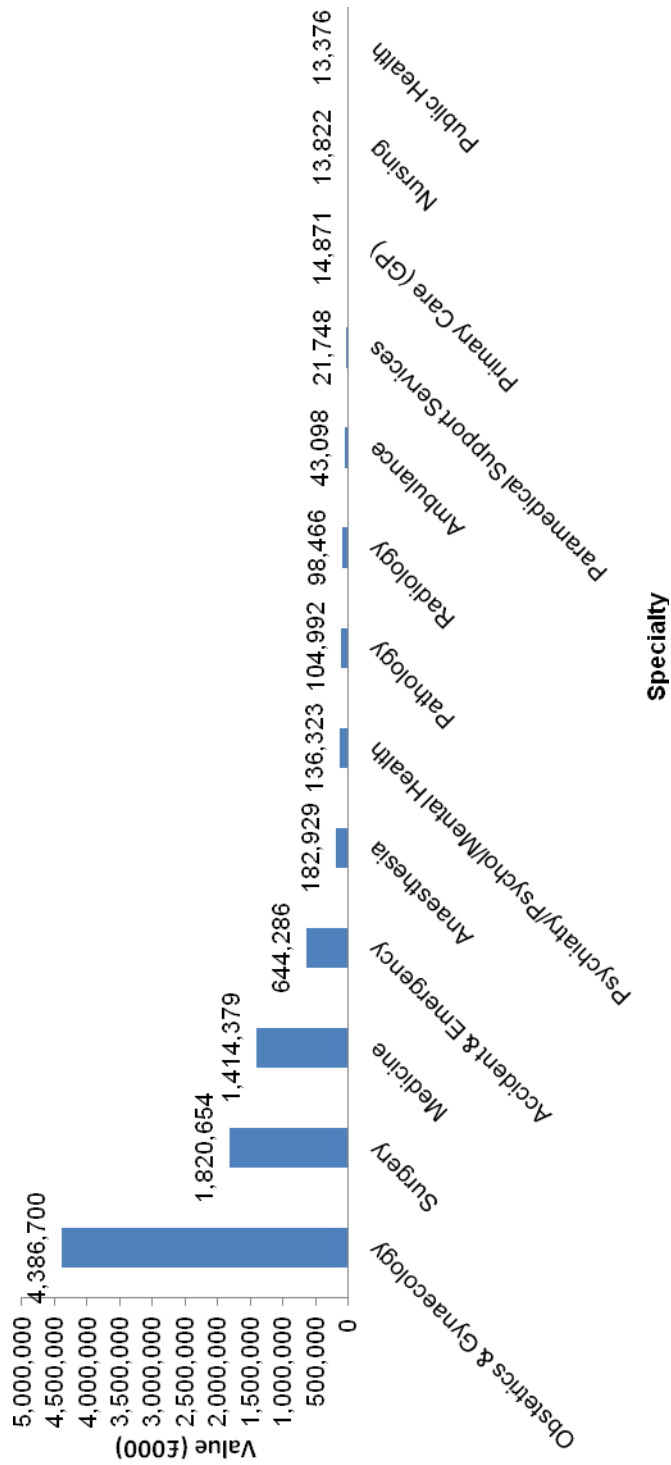
The growth of claims can be seen from the figures below showing the £ value of claims paid in each year since 1999.

10/11	09/10	08/09	07/08	06/07	05/06
£'000	£'000	£'000	£'000	£'000	£'000
729,072	650,973	614,342	456,301	424,351	384,390

04/05	03/04	02/03	01/02	00/01	99/00
£'000	£'000	£'000	£'000	£'000	£'000
329,412	293,384	175,277	*201,869	22,521	4,783

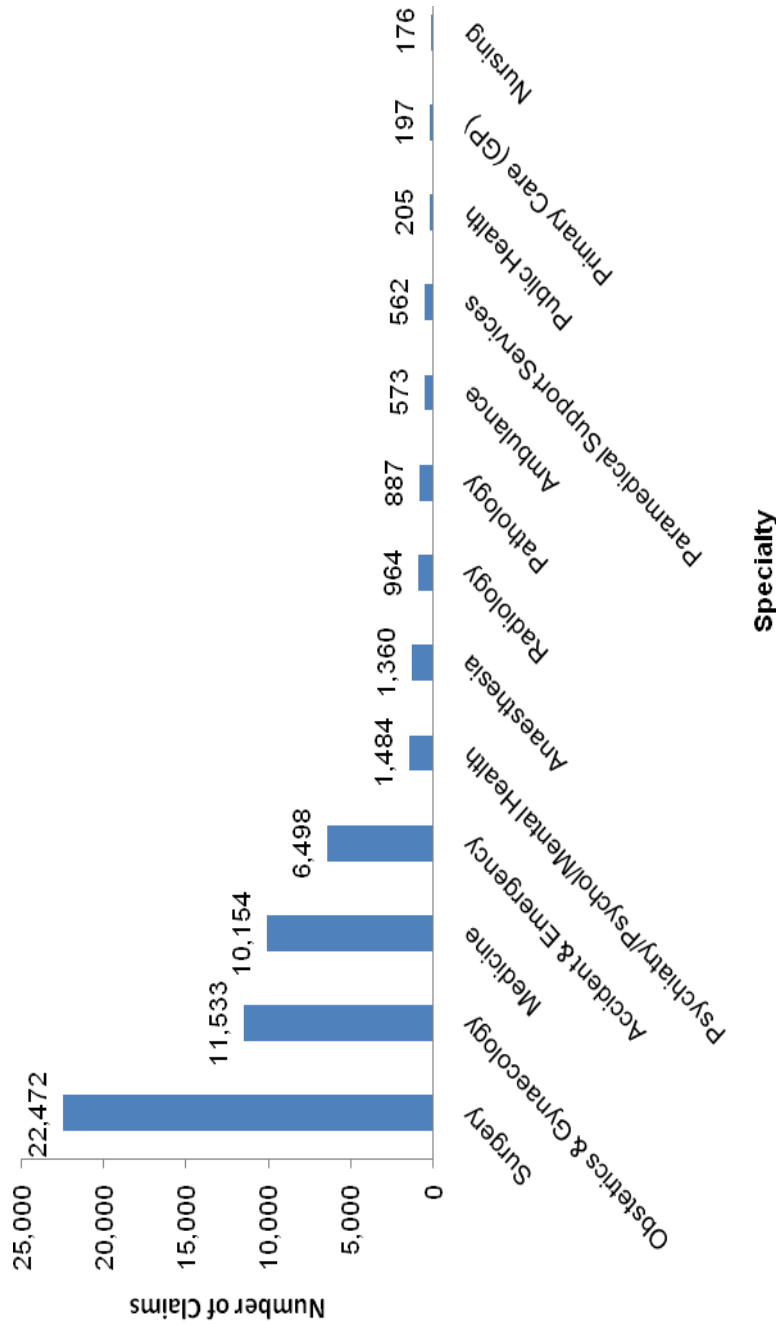
Total value of reported CNST claims by specialty as at 31/03/10

(since the scheme began in April 1995, excluding “below excess” claims handled by trusts)



Total number of reported CNST claims by specialty as at 31/03/10

(since the scheme began in April 1995, excluding "below excess" claims handled by trusts)



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