National Council for the Professional Development of Nursing and Midwifery

An Evaluation of the Extent and Nature of Nurse-Led/Midwife-Led Services in Ireland

April 2005

National Council for the **Professional Development** *of* **Nursing** *and* **Midwifery**

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

Mission Statement of the National Council

The Council exists to promote and develop the professional role of nurses and midwives in order to ensure the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

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Foreword

The National Council for the Professional Development of Nursing and Midwifery is pleased to publish this report which has evaluated the extent and nature of nurse-led/midwife-led services in Ireland.

As part of the National Council's ongoing contribution to the professional development of nursing and midwifery in Ireland, this report highlights the increasingly significant role nurses and midwives are playing in the Irish health care system. The diversity and multiplicity of the services would suggest that nurses and midwives are able to respond to patient/client need in a flexible and appropriate manner, allowing the development to occur within a multidisciplinary context. To date these initiatives have been driven by service need and a desire by nurses and midwives, both at senior and clinical levels to improve the quality of the patient/client care.

The findings from this report identify areas where nurse-led/midwife-led services have been developed and emerged in response to an identified gap in service. This service need was identified in different ways, but perhaps the most important method of identification was asking the patient/client what type of service they wanted and in what manner did they want it to be delivered. As the Health Service Reform Programme continues to be implemented new ways of working will be identified.

The National Council would like to sincerely thank all those nurses and midwives who took the time to fill out the questionnaire or attended the focus groups. Without their help and expertise this report would have been impossible.

In addition, my thanks are due to my colleagues, Kathleen McLellan, Head of Professional Development, Christine Hughes, Jenny Hogan who led this research, Mary Farrelly and Georgina Farren, Professional Development Officers.

Yvonne O'Shea
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Introduction

The introduction of a health service reform programme within the Irish healthcare system combined with changing epidemiological and demographic patterns are providing challenges to the traditional delivery of health care. To this end the National Council has undertaken a study to identify the extent and nature of nurse-led/midwife-led services in Ireland. This will provide a baseline to review the potential of such services to support healthcare delivery in Ireland. International experience indicates that such services can add value to the system meeting patient/client and population health need.

It is important to stress that nurse-led/midwife-led care is delivered within the context of a multidisciplinary/partnership approach. No one healthcare professional should or indeed could provide all the care that patients/clients may need over the span of a lifetime. All healthcare professionals work within the scope of their own competency, having the ability to recognise boundaries and knowing when to consult with other professions.

This research identifies the drivers and barriers to date within the Irish healthcare system for nurse/midwife-led care. Utilisation of the research results, the literature and international experience provides the template for a business plan approach which can be utilised by service to develop nurse/midwife-led care in appropriate settings.

The terms of reference for the study were as follows:

- To examine the literature pertaining to nurse-led/midwife-led care services
- To identify the extent of nurse-led/midwife-led care services in Ireland
- To make recommendations on future areas for developments for nurse-led/midwife-led care in Ireland

There are many differing definitions of nurse-led/midwife-led care and for the purposes of this study the following definitions as outlined by the National Council will be used:

Definition of nurse-led care

Nurse-led care is distinct from nurse-coordinated or nurse-managed services. Nurse-led care is provided by nurses responsible for case management, which includes comprehensive patient/client assessment, developing, implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients/clients will be referred to nurse-led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires enhanced skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practising at an advanced level and may be working in approved specialist or advanced practice roles[1] (National Council 2003).

Definition of midwife-led care

Midwife-led care has been defined by the Cochrane protocol as "the context of care where 'the midwife is the lead professional in the planning, organisation and control of the care given to a woman from initial booking to the postnatal period' (RCOG 2001). Within these models, midwives are, in partnership with the woman, the lead professional with responsibility for assessment of her needs, planning her care, referral to other health professionals as appropriate, and for ensuring provision of maternity services"(Hatem et al 2004).

Methodology

The methodology employed for this study consisted of focus groups, an extensive questionnaire and a literature review. The focus groups were facilitated and scribed by members of the executive of the National Council and were analysed using a content analysis approach. The questionnaire was sent to all directors of nursing and midwifery in Ireland. The questionnaire

[1] An advanced level of practice indicates that the nurse has taken on an expanded role within his/her scope of practice, inclusive of any additional training and education required.

was based on the National Council's definition of nurse-led/midwife-led care. The data from the questionnaire was double entered into an SPSS database and analysed accordingly. A random sample of practice nurses were contacted to ascertain the extent of practice nurse-led services that they offered. Finally a national and international literature review was conducted and the relevant Irish policy documents were consulted for reference to nurse-led/midwife-led services.

The report is structured as follows:

Chapter one provides an overview of the literature from a national and international perspective and from the relevant Irish policy documents that support the introduction of nurse-led/midwife-led services.

Chapter two presents the findings from the questionnaires. Respondents to the questionnaire who indicated that they had nurse-led/midwife-led services within their organisation were invited to participate in the focus groups.

Chapter three presents the findings from the focus groups.

Chapter four sets out the conclusions and a framework for establishing nurse-led/midwife-led services.

CHAPTER ONE
Literature Review

The development of nurse-led/midwife-led services in Ireland has been influenced by three factors: health policy, the changing nature of the practice environment and the need to develop services that meet patient/client needs at a local level. The aim of this section is to give an overview of the relevant contemporary policy (and others) documents that make reference to the concept of nurse-led/midwife-led care in Ireland and to examine the international nursing and midwifery literature pertaining to nurse-led/midwife-led care or services.

Irish policy documents

Report of The Commission on Nursing: A Blueprint for the Future (Government of Ireland 1998)

The Commission on Nursing made recommendations for the development of nursing and midwifery in Ireland, many of which have now been implemented. The Commission envisaged that its recommendations would facilitate the development of the role of the nurse and the midwife and the science (and art) of nursing and midwifery in a rapidly changing healthcare environment. Whilst the Commission admitted that its recommendations would not be a panacea for all ills, with a large degree of foresight, it envisaged that structural changes would take place which would enable the profession to grow and that changes in education would influence shifting role boundaries (pp 50-51). These structural changes have manifested themselves in the Health Service Reform Programme (HSRP) announced by the Minister for Health and Children in 2003. The impact of the HSRP on nurse-led/midwife-led services will be detailed below.

Quality and Fairness - A Health System For You (DoHC 2001)

Quality and Fairness (Irish health strategy) forms the context within which nursing and midwifery development will occur. Nurse-led/midwife-led services underpin the four guiding principles of the health strategy (equity, people-centredness, quality and accountability) as nurses and midwives will be adapting to the diverse and changing health needs of society generally and of the individuals within it. Nurse-led/midwife-led services will empower patients/clients to be active participants in decisions relating to their health. Nurse-led/midwife-led services will also be offered to patients/clients at the right time, in the right place and by the right healthcare professional.

The Health Strategy also identified that the health service will have the right people, with the right competencies, in the right numbers, organised and managed in the right way, to deliver the goals and objectives of the Health Strategy (p.121). The Health Strategy refers to care delivery improvements which could emerge as nurse-led/midwife-led services, and in some cases these have already begun to.

'Minor injury units will be established to ensure appropriate treatment and management of non-urgent cases and advanced Nurse Practitioners (ANPs) (Emergency) will be appointed in acute hospitals. ANPs diagnose and treat certain groups of patients independently within agreed protocols' (p.106).

Primary Care: A New Direction (DoHC 2001)

The Primary Care Strategy did not specifically explore the role of nurse-led/midwife-led services in the primary care setting, nevertheless nurse-led telephone advice and triage with appropriate decision and support systems were identified as integral to a twenty-four hour primary care service.

Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products Project

The Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products Project is a joint initiative currently being managed by An Bord Altranais and the National Council. The Steering Committee will make recommendations based on the results and analysis of the research conducted as part of the focus groups, the needs assessment survey, the exploration of need survey with stakeholders and the pilot study for collaborative prescribing. The Review and the Steering Committee's recommendations are set to further the agenda and guide the way for greater discussion and subsequent action by the government and health service providers in the introduction of nurse/midwife prescribing. A progress report was published in December 2004 and is available on the National Council's website www.ncnm.ie . The final report will be completed in June 2005.

Report of the National Task Force on Medical Staffing (DoHC 2003a)

The 'Hanly' Report, as this is more commonly known, identifies services that should be provided in local hospitals. These include nurse-led minor injury units for an extended day (e.g. 8am to 8pm, depending on the volume of cases). It recommends that patients should be triaged either to treatment on site for minor injuries, treatment by a general practitioner, or transferred to a major hospital as required. The report alludes to the role that the clinical nurse specialist and advanced nurse practitioner can play in providing nurse-led clinics. Stating:

'the CNS role is already well defined and is in keeping with the task force's concept of utilising the skills of health professionals to best effect' (p.93)

The task force sees considerable benefits in the planned development of new roles and Table 1 outlines the areas requiring further development identified in the Hanly Report.

Table 1: Potential nurse-led services identified in the Hanly Report (DoHC 2003a)

CLINICAL AREA	DESCRIPTION OF SERVICE
Minor injury clinics	Run by ANPs who assess, diagnose, treat in accordance with protocols, refer and discharge. They ensure that the patient receives the correct intervention from the appropriate person at the right time.
Pre-assessment clinics	ANPs have a key role in pre-assessment of patients undergoing elective day and in-patient procedures. Registered nurses also have a role in assessing patients not requiring a general anaesthetic.
Heart failure clinics	ANPs and CNSs have a key role in the management of 'at risk' patients following discharge until stabilised.

The Hanly Report makes recommendations that are in keeping with the philosophy of the Commission on Nursing. Consequently, the scope for enhancing the roles of nurses and midwives should be further explored with a view to identifying how such enhancement could be implemented. Hanly acknowledges that appropriate education, training and protocols are required to enhance roles. The opportunities for nurses and midwives to enhance their scope of practice and to be innovative and creative in the delivery of patient/client care are clear.

Report of the National Task Force on Medical Staffing: The Challenge for Nursing and Midwifery - A Discussion Paper (DoHC 2003b)

Following the publication of the Hanly Report the Nursing Policy Division in the Department of Health and Children published a response. The discussion paper outlines what it terms 'critical success factors' for the development of nursing and midwifery. These include: management of change, partnership, leadership, education and professional development, competence and clinical guidelines. The report states that there is considerable potential for nurses and midwives to further enhance the development of high quality patient-centred care and to influence positive patient care outcomes. The discussion paper identifies a range of possible developments for nursing and midwifery elicited from nurses and midwives in acute, psychiatric and midwifery settings; these include nurse-led admission, discharge protocols, nurse-led minor injury clinics, pre-assessment clinics, midwife-led antenatal clinics and midwife-led labour ward care.

An Explorative Study into the Expansion of Nursing and Midwifery Professional Roles in Response to the European Working Time Directive (MWHB 2003)

The nursing and midwifery planning and development unit in the (former) Mid-Western Health Board published the findings of a research study which explored the possible development opportunities for nursing and midwifery in light of the European Working Time Directive (EWTD). Thirty-eight focus groups were conducted and all grades of staff welcomed the opportunity to explore professional development possibilities stemming from the introduction of the EWTD. The findings indicated that:

1. enhancement of nursing and midwifery practice should involve a multi-disciplinary/-professional approach and involve all stakeholders
2. role development, with autonomy and decision-making capacity should be assured
3. appropriate support structures must be included.

Some key areas for development were suggested by focus group participants. These include:

1. nurse-led pre-assessment units
2. nurse-led admissions with the possibility of an out-of-hours triage service
3. nurse-led clinics in wound management/tissue viability, diabetes, heart failure, continence promotion, asthma, pain management and dermatology
4. nurse-led out-patients
5. nurse discharge planning
6. minor injuries units
7. nurse-led counselling, e.g. family therapy, cognitive behavioural therapy, etc.
8. total management by midwives of normal pregnancy and labour
9. intravenous cannulation, venepuncture, male catheterisation as part of role development
10. competency-based education and training for all role development.

Throughout the focus groups, nurses and midwives highlighted the need for more nurse-led/midwife-led services. They stressed, however, that any new developments must be supported by appropriate education and training and must be protocol-driven. The report can be downloaded from the National Council's web site at www.ncnm.ie.

The Scope of Nursing and Midwifery Practice Framework (ABA 2000)

The scope of nursing and midwifery practice in Ireland refers to the range, roles, functions, responsibilities and activities, for which a registered nurse or midwife has the education, competence and authority to perform. Furthermore, the scope of practice framework states that nurses and midwives are autonomous in the practise of nursing/midwifery. In order to practice autonomously nurses and midwives require authority to use their professional judgement in fulfiling their responsibilities. The nurse or midwife is accountable for his/her practice. This means that the nurse or midwife is accountable for decisions he/she makes in determining his/her scope of practice. This includes decisions to expand or not to expand his/her scope of practice (p. 21). The framework document also highlights that where expansion of practice has been considered most successful, guidelines, protocols or policies have been developed collaboratively with reference to legislation and research based literature where available.

The Scope of Practice Framework highlights the principles and values which underpin role development and expansion. It is a critical document around which nurses and midwives in Ireland have the facility to develop their role within an agreed framework.

Empowerment Narratives (DoHC 2003c)

Empowerment Narratives (2003) were complied and edited by the 'Meaning of Empowerment Sub-Group of the Empowerment of Nurses and Midwives Steering Groups – An Agenda for Change'. This publication demonstrated by means of exemplars how nurse and midwives as empowered people, have greater control over achieving the goals of the organisation, and how they can develop into confident and effective professionals. The Empowerment Narratives include details on nurse-led/midwife-led services which include:

- Nurse-led wound clinics
- "Bug busting"
- Nurse-led pre-operative screening clinic
- Activities nurse
- Substance abuse service
- Breast feeding hospital initiative
- Domino and hospital outreach home birth service
- Community-based nurse-led parentcraft
- Acute community day hospital and homecare service
- Home-based treatment team
- Community-based counselling initiative.

The details of each of these services, the project outline and the contact details of the individuals involved in the development are all outlined in the report. The report is available on the Department of Health and Children's web site at: www.dohc.ie

Framework for the Establishment of Advanced Nurse/Midwife Practitioner Posts, (National Council 2004a)

The National Council has developed a definition and core concepts for the role of the advanced nurse/midwife practitioner and it determines the requirements for nurses and midwives to be accredited as advanced nurse/midwife practitioners. To date a growing number of ANP posts[2], have been developed by services and approved by the National Council. The posts established reflect service need in the specific areas and their development has required creativity and leadership on behalf of all those involved.

Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts Intermediate Pathway (National Council 2004b)

The National Council has developed a definition and core concepts for the role of the clinical nurse/midwife specialist, and it has determined the criteria for nurses and midwives to be approved as clinical nurse/midwife specialists. In January 2004 the National Council published the findings from an extensive research study entitled An Evaluation of the Effectiveness of the Clinical Nurse/Midwife Specialist. Following this publication, the National Council reviewed its CNS/CMS Intermediate Pathway document (2001) to reflect the research findings. The Evaluation of Effectiveness study outlined the critical areas for development and also described a process for the future development of the CNS/CMS role at local, regional and national level.

Summary

From reviewing the above documents it can be seen that recognition and support for nurse-led/midwife-led change and development is gradually increasing. Nurses and midwives are making an increasingly vital contribution to the health of population and to population health, the expansion of practice of all nurses and midwives and the advent of the clinical nurse/midwife specialist and the advanced nurse/midwife practitioner are testament to this. The Scope of Practice Framework provides the foundation for all nurses to advance and develop their practice.

Nurse-led care: A Review of the Literature

Introduction

A search for literature on Medline, Cinahl and the Cochrane database was conducted using the terms 'nurse-led', 'nurse led', 'nurse-led services', 'nurse led services', 'nurse-led care', 'nurse led care', 'nurse-led evaluation' and 'nurse led evaluation'. The search results revealed a huge volume of articles. In order to give some coherence to this volume, the literature was looked at from an 'area of practice' perspective, the aim being to demonstrate the extent of the growth of the concept of 'nurse-led' into health care and the issues that have arisen as a result of this growth. Table 2 outlines the extent of the areas of practice where nurse-led services have developed.

Table 2: Nurse-led services identified in the literature

•	nurse-led palliative care services	•	nurse-led cervical screening services
•	comparing nurse-led services to medical-led services	•	nurse-led counselling service
•	nurse-led out-patient services	•	nurse-led cystoscopy services
•	nurse-led fracture referral service	•	nurse-led wound assessment services
•	nurse-led osteoporosis clinic (regional)	•	patient satisfaction with nurse-led services
•	NHS direct – nurse-led telephone triage	•	nurse-led walk in centres
•	nurse-led pain management intervention	•	nurse-led diabetes care
•	nurse-led community services	•	outcomes from nurse-led services
•	nurse-led care for children with asthma	•	nurse-led rapid response services
•	nurse-led hypertension clinics	•	nurse-led in patient units
•	nurse-led cardioversion clinics	•	practice nurse-led management of acute minor illness
•	nurse-led secondary prevention clinics (coronary heart disease)	•	

[2] To date 15 ANPs in emergency, 3 in cardiothoracic, 1 in cardiology, sexual health, rheumatology, breast care and primary care have been accredited.

It is evident from the literature that nurses are now beginning to measure the impact of their interventions on health care in order to demonstrate the efficacy of their interventions (National Council 2004a, National Council 2004b, Horrocks et al 2002, Garvican et al 1998, Hall-Smith et al 1997, Mackintosh and Bowles 1997). Forster and Young (1996) in a systematic review of whether the nurse practitioner working in primary care can provide care equivalent to that provided by doctors, concludes that patients are at least as satisfied with care at the point of first contact with nurse practitioners as they are with that given by doctors.

Richardson and Cunliffe (2003), in an article identifying the reasons for the accelerated development of nurse-led services, suggest that changes in health policy and the modernisation of health services give opportunities to reconsider and challenge traditional health care roles and professional boundaries. The need to provide nurse-led services and expand the nursing role can be seen as innovative and creative ways of re-balancing the workforce-demand mismatch caused by the EWTD. Finally, and perhaps more importantly, Richardson and Cunliffe identify that pressures to improve quality and ensure value for money have made healthcare professionals think about their roles and about new ways of working.

The proliferation of articles and the wide range of nurse-led services are self-evident. Most of the articles are concerned with evaluating and auditing the impact of the nurse-led service. The majority of authors state that proper educational preparation, clinical support and medical 'buy in' are crucial for the successful implementation and sustainability of nurse-led services. Table 3 illustrates nurse-led studies that have examined the impact of the nurse-led intervention from an outcomes perspective. The type of outcomes and the authors are included.

Table 3: Types of outcomes, methods and sample numbers of nurse-led evaluations

OUTCOMES	AUTHORS	METHODOLOGY (M=)	SAMPLE NUMBERS (N=)
Cost effectiveness of nurse-led services	York et al (1998)	M= RCT	N=103
Reduced hospital re-admissions	Blue et al (2001)	M=RCT	N=165
	Madge et al (1998)	M=RCT	N=201
Clinical effectiveness of nurse-led intervention	Mac Lellan (2004)	M= Pre-test-post-test	N=800
	Fitzmaurice et al (2000)	M=RCT	N=224
	Denver et al (2003)	M=RCT	N=102
	McHugh et al (2001)	M=RCT	N=98
	Rando (2000)	M=Client satisfaction	N=46
	Twinn & Cheng (1999)	M=Case Study	N=50
	Mackintosh & Bowles (1997)	M=Two Stage Baseline Survey	N=100 & 106
	Williams et al (2002)	M=Literature review	
Decreased hospital admission	Campbell et al (1999)	M=RCT	N=1343
Improved health	Campbell et al (1999)	M=Two Stage Baseline Survey	N=71 & 141
	Leveille et al (1998)	M=RCT	N=201
Improved quality of life	Harrison et al (2002)	M=RCT	N=192
	Gallagher (1999)	M=Audit	N=43
	Smith et al (2002)	M=Survey	N=100
Increased length of hospital stay	Griffiths et al (2001)	M=RCT	N=175
	Wilson -Barnett et al (2001)	M=Literature Review	N=N/A
Patient perceptions	Wiles et al (2003)	M=RCT & Qualitative	N=246
Improved patient satisfaction	Dobson (1999)	M=Project management approach	N=Not given
	Sutcliffe (1999)	M=Survey	N=N/A
	Roxborough (2000)	M=Audit of Service	N=Not Given
	Pritchard & Kendrick (2001)	M=Survey	N=1900
Comparison with medical services for improved quality of life and patient satisfaction	Moore et al (2002)	M=RCT	N=203
	Miles et al (2003)	M=Survey	N=282
	Cox & Wilson (2003)	M=Literature Review	N=N/A
	Bostrom et al (2003)	M= Two-centred descriptive design	N=46
	Delamere (2004)	M=Survey	N=200
Impact of nurse-led clinics on reducing waiting times	Currie, et al (2003) Roxborough (2000)	M=Prospective Audit	N=83

Nurse-led services in specialised areas

There is scant published evidence of nurse-led services for people with intellectual disabilities (ID); that identified was concerned with physical healthcare. It has consistently been reported that people with ID have more medical disorders than their peers (Van Schrojenstein Lanteman-de Valk et al 2000, Mencap 2004) and that they experience difficulties in accessing appropriate health services (Kerr et al 1996, National Disability Authority 2004), particularly people with ID living in the community (Marshall et al 2003a). One Irish study (Walsh et al 2000, cited by Walsh et al 2004) concluded that health checks for people with ID living in a residential setting did not take place "at the levels appropriate for this population and fell short of the frequency suggested for the general population in Ireland" (Walsh et al 2004, p289).

British authors have identified the role of learning disability nurses in nurse-led health screening and health promotion activities relating, for example, to obesity (Marshall et al 2003b) and attendance at general practitioner clinics in the community (Martin et al 2004). While it is not clear that their role and functions fully match the definition of nurse-led services stated by the National Council, it is clear that nurse-led health screening of and health promotion activities among people with ID form a vital component of an integrated, multidisciplinary and cross-sectoral approach to ensuring that this client group receives high-quality and appropriate healthcare.

Given the wide range of settings in which nurses in Ireland work with people with ID and of specialist areas in which clinical nurse specialists work (National Council 2003), nurse-led services that may develop in the future need not necessarily be restricted to the area of health screening and assessment. It is also necessary that roles relating to these services should be developed following consideration of the advantages and disadvantages of medical and social models of ID service provision, and in accordance with the principles of inclusion.

Some literature exists relating to nurse-led mental health care. Evaluative research undertaken indicates mixed findings. For example a randomised controlled trial comparing acute ward care with mental health liaison nurse-led care (including assessment, direct interventions and liaison support) for medically ill older patients in the North of England found that the intervention group were less depressed at 6-8 week follow up although overall no differences were found in general health scores (Baldwin et al 2001). The authors suggest that services which focus on particular patient groups or disorders are more likely to be effective. Nurse-led case management for patients presenting with deliberate self-harm in Accident and Emergency was compared with routine nurse management in a randomised controlled trial in the United Kingdom, and no significant reduction in the overall admission rate was found (Clarke et al 2002). A comparison of nurse-led self-harm assessment service to individuals who self-harm in Cardiff suggested no difference between the service provided by a mental health nurse and psychiatrist, concluding that, an expansion of the nursing role in this area would not lead to a decrease in the quality of the service provided (Griffin 2001).

Descriptions of nurse-led mental health services exist in areas such as liaison (NIMHE 2005), sexual health and mental health (The Northern and Yorkshire Regional NHS Modernisation Programme 2005) and urgent/crisis referrals (Tummey 2001). However, it is often difficult to elicit the extent to which services described are nurse-led as opposed to being nurse provided.

The relative lack of literature on nurse-led services in mental health care may be a reflection of the generally low level of evaluative research carried out on nursing interventions coupled with an issue of some services which are nurse-led failing to be defined as such.

Nurse-led care in older people services have emerged in the literature in a number of areas. A nurse-led fast track system introduced in an emergency department has empowered emergency nurses using new care pathways to directly refer high-risk elderly patients thus supporting a higher standard of care for this group (Davies-Grey 2003). Nurse consultants in the United Kingdom are leading falls clinics, wards and caseloads both in hospital and primary care (Clegg and Mansfield 2003).

Diverse areas of nurse-led care for children are developing. In response to the increase in the incidence in asthma, nurse-led clinics are showing a positive impact on quality of care (Gallagher 1999). A nurse-led intervention improved the management of urinary tract infections in children, was valued by doctors and parents, and may have prevented some renal scarring (Coulthard et al 2003). In the case of children receiving chemotherapy nurse-led assessment of children has resulted in fewer delays and improved care (Boyer and Whiles 2004).

An increasing emphasis in primary care over the last decade has resulted in a proliferation of nurse-led services being offered to patients/clients by practice nurses. Areas such as acute back pain, epilepsy, acute minor illnesses and diabetes management have been introduced (Pritchard and Kendrick 2001, Mills et al 2002, Breen et al 2004, Kinealy et al 2004).

Midwife-led Care: A Review of the Literature

Introduction

In the industrialised world, there are two conflicting models of maternity care. The basis of the psychosocial approach is that childbirth is 'natural' and that the majority of women can have a normal safe childbirth without medical intervention. The traditional biomedical approach is based on the idea that childbirth is only normal in retrospect and that 'normal' childbirth requires medical supervision to ensure safety for the woman and her baby. International developments in the maternity services so that the individual needs of women are more central to the provision of care have gained momentum in recent years (Winterton Report 1992, DoH 1993). These initiatives recommend a lead role and greater responsibility for midwives in the provision of maternity care and support the development of packages of midwife-led care in which midwives provide care throughout the antenatal, intrapartum and postnatal period.

In recent years in Ireland there has been a debate amongst stakeholders regarding choice for women in the models of care available in childbirth. It appears that women wish to have access to more care options regarding childbirth which include flexibility in accessing services, natural birth, midwife-led care and the development of community services (DoH 1997, DoHC 2001a). Maternity care consumer groups such as Irish Childbirth Trust, Home Birth Association, the Association for Improvements in the Maternity Services (AIMS), Midwifery Birth Alliance, La Leche League of Ireland and Baby Milk Action Ireland have raised awareness about choice and control in pregnancy and childbirth. Midwives have indicated that they are cognisant of, and willing to be responsive to, women's needs and many are now actively seeking opportunities to practise midwifery within settings that provide autonomy and alternative choices for models of maternity care (Commission on Nursing 1998, An Bord Altranais 2000).

The World Health Organisation (WHO 1999) has also acknowledged midwife-led care as 'the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and recognition of complications'.

International literature: Midwife-led care

Various models of midwife-led care have been established in order to achieve a women-centred service which would include continuity of care and the provision of increased choice and control over their care for women and their partners. These include team midwifery models where a team of midwives provide care to a group of women throughout the antenatal, intrapartum and postpartum period, 'case-load' midwifery in which midwives carry their own personal case-load and a midwife-run antenatal clinic. There are a number of articles which discuss policies, protocols, guidelines, booking and exclusion criteria for midwife-led care (Campbell et al 1999, Walker et al 1995). There is also a substantial amount of audit and research examining outcomes in terms of neonatal and maternal morbidity and obstetrical intervention rates (Waldenstrom and Turnbull 1998, Campbell et al 1999, Hatem et al 2004). At a psychosocial level women who have availed of midwife-led care expressed increased satisfaction with their childbirth experience, felt better prepared for parenthood as they had better support and advice and experienced less postnatal depression (Biro et al 2003, Watts et al 2003). Not only have women expressed increased satisfaction with their maternity care, but also studies indicate that midwives' job satisfaction has increased as midwife-led care facilitates midwives to use their midwifery skills more appropriately and enables them to practice in an autonomous manner (Todd et al 1998, Saunders et al 2000).

Table 4: Types of outcomes, methods and sample numbers of midwife-led evaluations

OUTCOMES	AUTHORS	METHODOLOGY (M=) & SAMPLE NUMBERS (N=)	
Increased maternal satisfaction	Walker et al (1995)	M= interview	N= 38
	Turnbull et al (1996)	M= RCT	N= 1299
	Hundley et al (1994)	M= RCT	N= 2844
	Shields et al (1998)	M= RCT	N= 1299
	Byrne et al (2000)	M= RCT	N= 201
	Hodnett et al (2001)	M= Cochrane Review	
	Morgan et al (1998)	M= Survey	N= 469
	Biro et al (2003)	M= RCT	N= 1000
Decreased intervention rates	Harvey et al (1996)	M= RCT	N= 194
	Waldenstrom et al (1997)	M= RCT	N= 1860
	Waldenstrom & Turnbull (1998)	M=RCT	Review of 7
	Saunders et al (2000)	M=RCT	N= Unknown
	Biro et al (2000)	M= Mixed	N= 1000
Increased breastfeeding rates	O'Connell and Cronin (2002)	Descriptive analysis	N= N/A
Increased job satisfaction	Todd et al (1998)	M= Survey	N= 92
	Saunders et al (2000)	M= Mixed	N= Unknown
Increased cost-effectiveness	Young et al (1997)	M= RCT	N= 1299
	Harvey et al (1996)	M= RCT	N= 194
	Villar et al (2004)	M= Cochrane Review	N= N/A
Increased continuity of care	Waldenstrom et al (2000)	M= RCT	N= 1000
	Hodnett (2001)	M= Cochrane Review	N= N/A
	Homer et al (2002)	M= Survey	N= 1089

Midwife-led care in Ireland

In 1994 a Report on the Mother and Infant Care Scheme recommended that a pilot domiciliary service scheme be established (DoH 1994). On foot of this the health boards set up an Expert Group on Domiciliary Births to review the current provision of maternity care and recommend developments which would facilitate more choices for women (Expert Group 1998). This resulted in the establishment of a number of pilot schemes in midwife-led care, two of which were hospital-based, the other being community-based. Of these pilot schemes The National Maternity Hospital Domino and Outreach Home Birth Service commenced in 1999 and has been evaluated very positively (Women's Health Unit 2001). An evaluation of the other pilot sites is being conducted at present.

In 2001, in response to consumer demand for a midwife-led service, an integrated hospital and community midwifery service was developed in the (former) South-Eastern Health Board, an evaluation of which is currently being undertaken. Following the recommendations of the Kinder report (Kinder 2001), two midwifery-led units were established in the (former) North-Eastern Health Board. Booking-in of women for maternity care in these units commenced in June 2004, the first baby being born in the midwife-led unit in Cavan on 30th December 2004. Following the successful implementation and evaluation of these units, further pilot sites in this region may be an option for consideration (Comhairle Na nOspideal 2003).

The Report of the National Task Force on Medical Staffing (DoHC 2003a) suggest that this is a time of significant potential for midwives. The Challenge for Nursing and Midwifery Discussion paper (DoHC 2003b) highlighted the high potential for midwife-led clinics and it was clear that midwives themselves felt that they delivered a very specific package of care. It was suggested that the establishment of more midwifery-led clinics would offer women holistic and continuous care as well as providing a "best value for money" service.

CHAPTER TWO
Findings from the Questionnaire

Methodology

A total of 306 questionnaires were sent to all the directors of nursing services in Ireland. Of these, 147 were returned completed giving a total response rate of 48%. Of the 20 questionnaires sent to the directors of midwifery services in Ireland, four were returned giving a response rate of 20%.

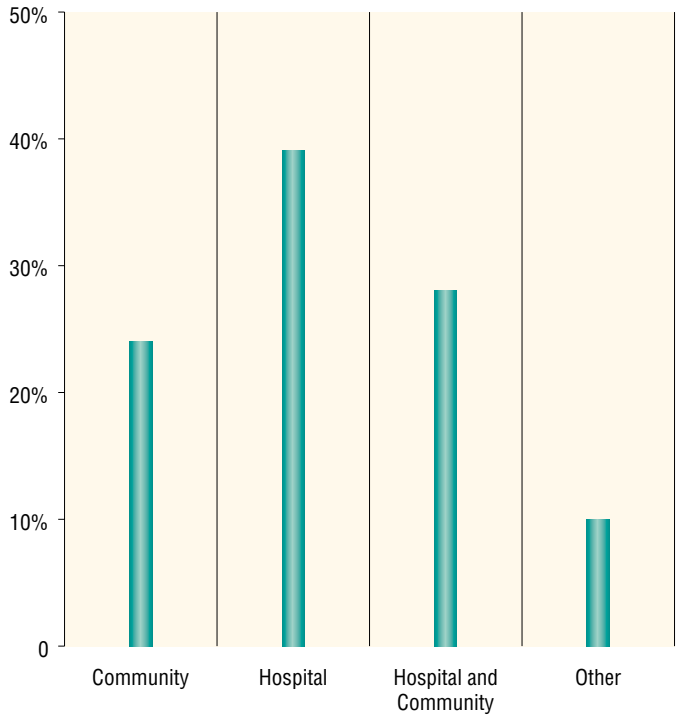
Questionnaire design

The questionnaire design was based on the definition of nurse-led/midwife-led care as outlined by the definitions provided on page 7. The aim of this was to identify if services were actually nurse-led or midwife-led as opposed to being nurse-run or midwife-run or nurse-managed or midwife-managed. The questionnaire was also designed to elicit from respondents the type of nurse-led/midwife-led service provided, if any. The questionnaire also aimed to elicit at what grade the nurse/midwife running the service worked, and to what level they were educated. A further aim was to discover from whom the nurses/midwives running the service could receive referrals and to whom they could refer. Finally the questionnaire asked respondents to indicate if they audited the service and if they were planning to introduce nurse-led/midwife-led services in the future. Full details of the questionnaire are available in Appendix 1.

Demographics

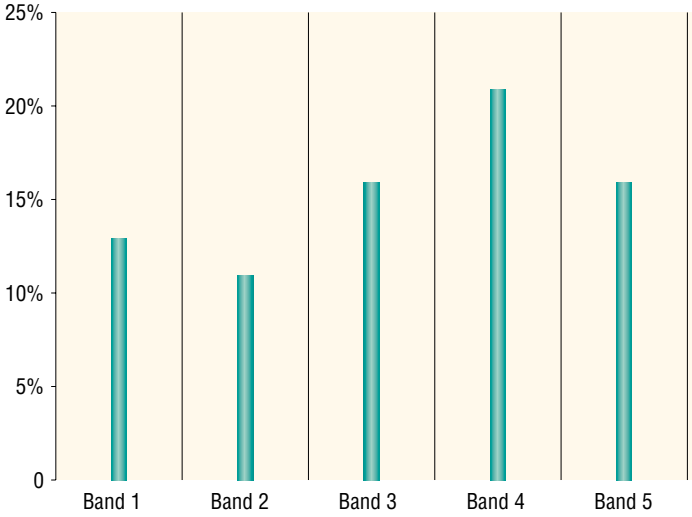
Each respondent was asked to identify the care setting in which they were working or employed. Of respondents to the questionnaire, 24% were from a community setting, 39% from a hospital setting and 27% came from both hospital and community setting. The remaining 10% of services which did not 'fit' the criteria included in this response were areas such as the blood transfusion service, the prison service, nursing homes, community nursing units, residential services for persons with intellectual disability, day centres and hospices (see Figure 1).

Figure 1: Care setting of respondents



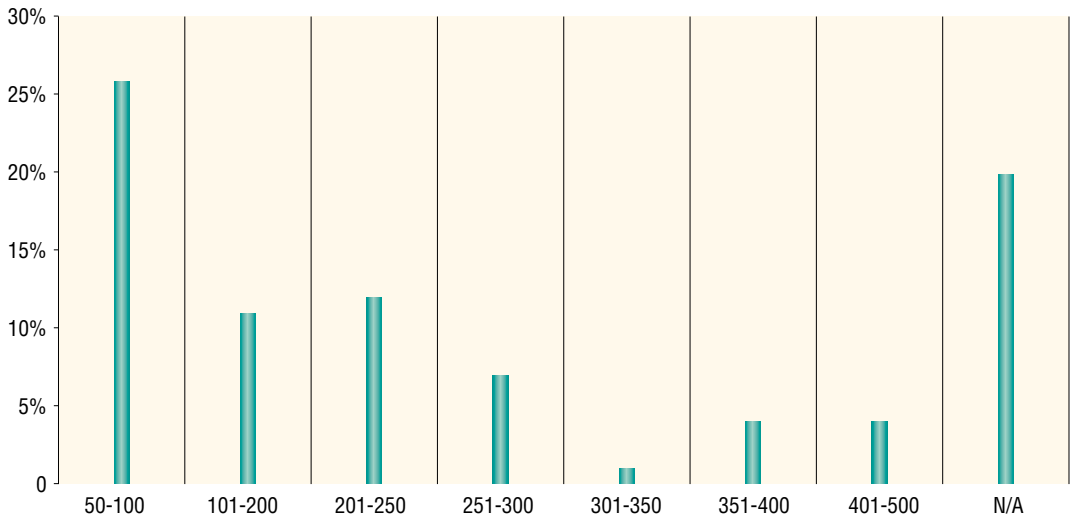
Each organisation was then asked to identify to which hospital band they belonged: 22% indicated that they did not belong to any banding system. The band that was represented most frequently was band 4 at 21%; bands 3 and 5 were the next highest with 16% respectively, band 1 was represented at 14% and finally band 2 was represented by 12% of respondents. Figure 2 demonstrates the bands.

Figure 2: Hospital bands



Each respondent was asked to supply the number of beds in their organisation, taking into account that some services do not have 'beds' per se. Figure 3 demonstrates the majority of beds per organisation: 20% of respondents to the questionnaire did not have beds and over 25% of respondents had between 50-100 beds.

Figure 3: Number of beds per organisation



Of the respondents to the questionnaire, 47% stated that they provided nurse-led or midwife-led services, whilst 50% stated that they did not have nurse-led or midwife-led services (3% were missing values). A small number of questionnaires had accompanying letters stating that they could not fill in this question as they did not fit the criteria.

Question five asked respondents to identify their nurse-led or midwife-led services and to estimate how long each services had been established. Out of a total of 147 responses, 69 (47%) claimed to have nurse-led/midwife-led services; of these, 44 (30%) fitted the criteria for nurse or midwife-led care as indicated by the National Council (see page 7) , and the remaining 25 (17%) did not fit the criteria. These criteria were determined by the definition of nurse-led care and midwife-led care given on page 7. Table 5 outlines the type of services and the number of years established.

Table 5: Type of nurse-led/midwife-led service and number of years established[3]

TYPE OF SERVICE	YEARS ESTD.
Adult tissue viability clinic	7
Adult pre-assessment day-care	4
Adult renal transplantation services	2
Adult haemocomatosis services	2
Adult pre-admission elective orthopaedics	2
Admission/discharge planning	3-4
Advanced nurse practitioner - Accident & Emergency service	1-5
Alzheimer unit	3
Assessment and case management in day hospital	3
Asthma and COPD – practice nursing	1-6
Asylum seekers	2
Behavioural therapy	10
Blood collection clinics	2
Breast and cervical screening - practice nursing	1-6
Bone densitometry estimation	3
Cardiac rehabilitation	5
Care of older person	34
Case management	4
Case manager home subvention	1-10
Child health screening	20-34
Cognitive behavioural therapy	5-8
Colposcopy services	10
Community alcohol & substance misuse counselling services	7-8
Community midwifery	6
Community programme (mental health)	18
Continence assessment and management	4-28
Continuing care	Not specified
Convalescence care	3-15
Cryotherapy – practice nursing	Not specified
Coronary heart disease – practice nursing	1-6
Day care services	8-20
Deliberate self-harm liaison nurse	2
Dementia care services	6
Developing care plans	4
Diabetes – including practice nursing	3
Disability service – assessment of needs	34
Ear care- practice nursing	1-6
Early transfer home scheme	2
Extended care	20
Family therapy services	4
Family planning – practice nursing	1-6
Foetal assessment	4

TYPE OF SERVICE	YEARS ESTD.
Generic counsellor: day services	3
Haemodialysis treatment	9
Heart failure	2-3
Home care	15
Hospice day care	11
Hypertension – practice nursing	1-6
Immunisation – adult and paediatric - practice nursing	1-6
Lactation	5
Leg ulcer clinic	1-4
Lymphoedema clinic	7
Men's health – practice nursing	1-7
Midwife-led clinic	6
Midwifery-led unit	6 months
Midwives' clinics	15
Minor injuries A & E	3
Occupational health	5
Oncology services	3
Outreach clinics	3
Paediatric cystic fibrosis clinic	14
Paediatric/Adult diabetes services	14/5
Paediatric endocrinology	9
Paediatric respiratory services	7
Paediatric/adult dermatology	7/2
Paediatric urology	7
Palliative care	1-14
Parent craft classes	6-25
Patient assessment	4
Postnatal care	15
Primary care wound clinic	5
Rehabilitation services	2
Residential services	50
Respiratory nurse clinic	3
Respite care	3-10
Respite care (crisis)	8
Respite care (planned)	8
School screening	34
School service	20-30
Substance abuse service	Not stated
Therapeutic aphaeresis service	8 months
Travellers' service	10
Travel health – practice nursing	1-4
Urodynamics	3
Wound care including leg ulcer management – practice nursing	1-6
Women's health – practice nursing	1-6

[3] Where the years are in multiples, more than one organisatiom provides this service.

Respondents to the questionnaire were asked to identify if the nurse-/midwife-led service was able to admit or discharge their patients/clients. The caveat to this question was that admit or discharge can mean admission or discharge to hospital or to another health care institution or from the episode of care that the nurse or midwife was providing (see appendix 1 for the questionnaire). Figures 4 and 5 outlines the percentages of services, which had nurse-led/midwife-led services that were able to admit or discharge. A large percentage (54%) of respondents to the questionnaire who had nurse-led/midwife-led services were not sure if patients could be admitted or discharged into or across services.

Figure 4: Services that could admit patients/clients

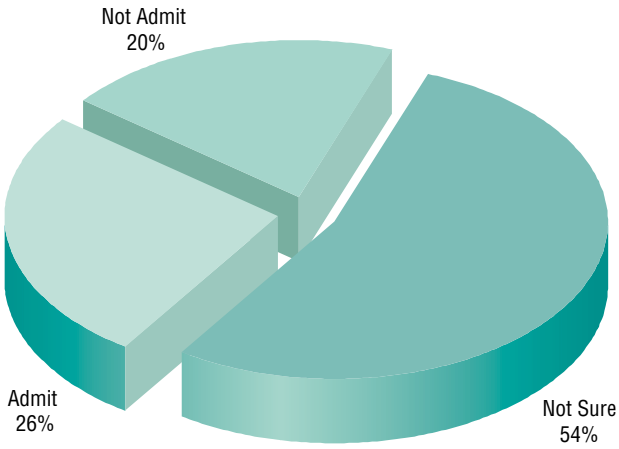
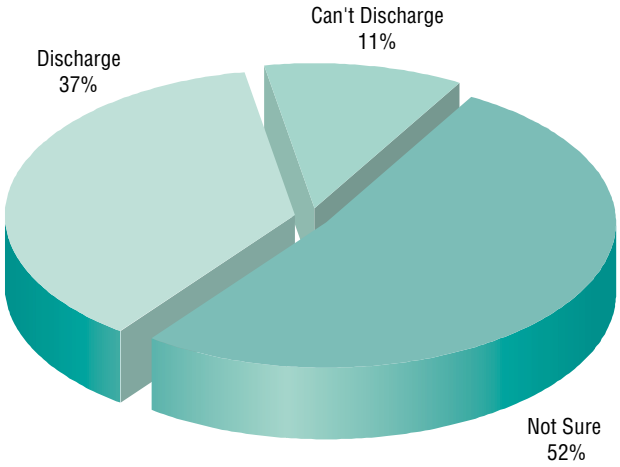


Figure 5: Services that could discharge patients/clients



The following table indicates the health and social care professionals to whom the nurse or midwife providing the nurse-led/midwife-led service can refer.

Table 5: Health and social care workers to whom the nurse/midwife running the nurse-led/midwife-led service could refer[4]

HEALTH CARE WORKER	%
Physiotherapist	33
CNSs/CMSs	30
Occupational therapist	29
Speech therapist	23
Radiographer	7
Community mental health nurse	24
Public health nurse	36
Social worker	33
Psychologist	16
Medical staff	37
GP	43
Consultant	28
No-one	1
Other[5]	15

Table 6 outlines the percentage of respondents to whom the nurse or midwife running the nurse-led/midwife-led service could refer.

Table 6: Health and social care professionals (including patients/clients) who could refer to the nurse-led/midwife-led clinic[4]

HEALTH CARE WORKER	%
Dietician	13
Physiotherapist	20
CNSs/CMSs	20
Occupational therapist	18
Speech therapist	14
Radiographer	4
Public health nurse	31
Community mental health nurse	22
Social worker	22
Psychologist	13
GP	40
Consultant	33
Other medical staff	26
Staff nurses/midwives	24
CNM 1, 2 or 3	22
Self-referrals by patients/clients	24
No-one	1
Other[5]	9

[4] The percentage totals 120%, as some respondents ticked more than one option.
[5] 'Other' included ophthalmology, chaplaincy, transplant co-ordinators, chiropody, etc.

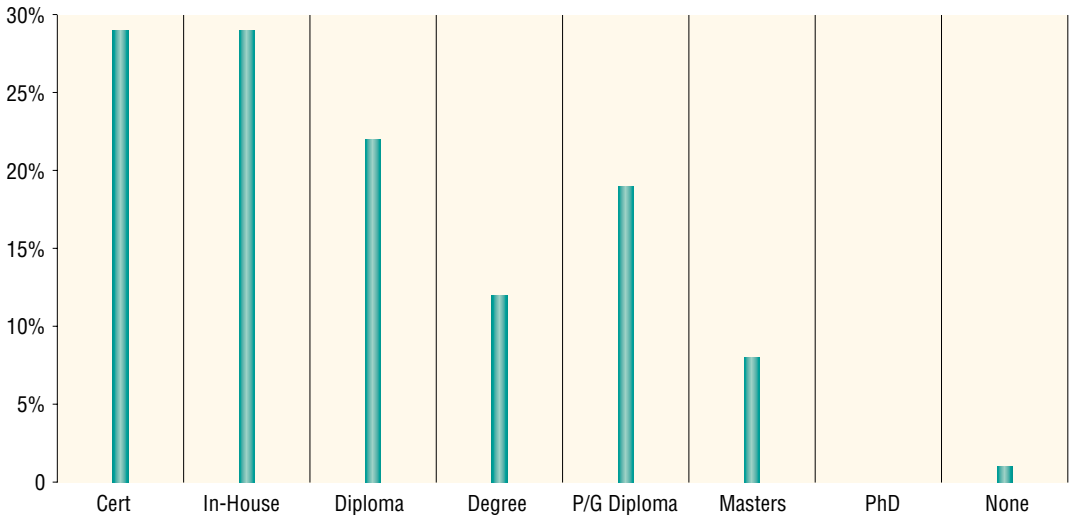
The following table outlines the grade of staff working in nurse-led or midwife-led services. It can be noted that there is a more or less even distribution among staff nurses (25%), clinical nurse/midwife specialists (25%) and clinical nurse/midwife managers (27%). The advanced nurse/midwife practitioner accounts for 2% of services.

Table 7: Grade of staff providing the nurse-led/midwife-led service

GRADE OF STAFF	%
CNM/CMM	27
Staff nurse/midwife	25
CNS/CMS	25
Other	20
ANP/AMP	2
None	1

Nurses and midwives who run nurse-led and midwife-led services were asked to identify the type of education or training they had received in order to prepare them for the role. The following table indicates the type and percentage of education and training that they received. Forty-three per cent stated that they had received training or education to equip them for the role, while nine per cent stated they had received none. Forty-eight per cent stated they did not know if they or their staff had received training and/or education.

Table 8: Type of training and education nurses and midwives received to equip them for the role



Respondents were asked to summarise the type of nurse-led/midwife-led services that they were intending to introduce or develop in the future. Thirty-four per cent were planning to introduce and/or develop nurse-led/midwife-led services in the future and 35% stated that they were not planning to introduce any nurse-led or midwife-led services. Table 9 is an outline of some of those responses.

Table 9: Types of service that directors of nursing/midwifery are intending to introduce in the future

•	Reality and cognitive behavioural sessions with self-referral to a nurse-led community service
•	Day care service for older people
•	Rheumatology
•	ANP in pain management
•	Out-patient cataract nurse-led clinic
•	Incontinence care in the older person
•	Health promotion in the elderly
•	Nurse-led pre-admission assessment service
•	Challenging behaviour
•	Holistic assessment of clients in the community who may require elderly care
•	Nurse-led clinic for clients with enduring mental health difficulties
•	Nurse-led liaison service (Mental health)
•	Nurse-led community detoxification programme
•	Diabetic ANP
•	Nurse-led colposcopy clinic
•	Midwife-led early miscarriage clinic
•	Midwife-led admissions and discharges
•	Tissue viability
•	Nurse-led pain management
•	Midwifery-led clinics
•	Pre-/post-HIV testing sessions
•	Nurse-led palliative care via ANP posts
•	Nurse-led care and case management (community care)
•	Nurse-led falls clinic
•	Nurse-led therapeutic day hospital
•	Midwifery-led ultrasonography service
•	Midwifery-led postnatal clinics
•	Midwifery-led breast-feeding support groups
•	Nurse-led mental health promotion
•	Nurse-led mental health rehabilitation
•	Nurse-led cognitive behavioural psychotherapy
•	Review of home birth services
•	Eating, drinking and swallowing nurse-led clinic
•	Nurse-led glaucoma clinic
•	Nurse-led therapeutic apheresis
•	Nurse-led platelet apheresis
•	Radiation induced toxicities (ANP)
•	Midwifery-led services for healthy women likely to have a normal pregnancy and labour
•	Nurse-led child health primary screening
•	Nurse-led cervical cytology clinics
•	Nurse-led community leg ulcer clinics
•	Nurse-led enuresis treatment clinic
•	Nurse-led child health service

Of respondents to the questionnaire, who indicated that they provided nurse-led/midwife-led services, 65% (n=52) stated that they audited the service they provided while 35% (n=28) stated that they did not. Table 10 illustrates what aspects of the services were audited.

Table 10: Example of audit type

•	Numbers of patients seen by service
•	Numbers of patients seen by nurse
•	Mean waiting time to be seen by nurse
•	Registration time to time seen by nurse
•	Triage time to time seen by nurse
•	Registration time to time departing the service
•	Consumer satisfaction survey
•	Demographic profile of service users
•	Numbers of new referrals on a monthly basis
•	Number of visits to the service
•	Geographic area of residence of service user
•	Referring consultant
•	Type of referral
•	Reason for referral
•	Numbers of review visits
•	Location of contact[6]
•	Type of care delivered at each episode
•	Diagnostic reason for referral
•	Most common diagnostic group
•	Average number of visits per month
•	Busiest months
•	Details of procedures carried out
•	Numbers of patients discharged per month
•	Re-admission rates
•	Length of stay
•	Impact of nurse-led service on patient/client knowledge of own disease
•	Preferred time of day for intervention

[6] This refers to whether the patient was seen in their own home, the out-patients department or as an in-patient or other.

Some of the audit findings were used to compile an annual report which the nurse or midwife running the service used to identify further areas for development. For example, one of the reports stressed that service provision could be improved with the development of written agreed multidisciplinary referral guidelines and discharge criteria.

Discussion

It is evident from the results of the questionnaire that there are already many developments in nurse-led/midwife-led care in Ireland. The diversity and multiplicity of the services would suggest that nurses and midwives are able to respond to patient/client need in a flexible and appropriate manner. These developments have taken place in a multidisciplinary working environment and reflect a certain level of multidisciplinary collaboration and co-operation. To date these initiatives have been driven by service need and a desire by nurses and midwives, both at senior and clinical level to improve the quality of the patient/client care. It is also evident that as these services develop they are being audited and measured for clinical effectiveness and patient satisfaction. These developments can only increase and maximise the therapeutic potential of nursing and midwifery for patients and clients. What is also evident is that nurses and midwives have been leading some of these services for many years, and some such services have only recently been established. How these services were established and what kind of barriers and benefits were accrued are now discussed in light of the findings of the focus groups.

CHAPTER THREE
Findings from the Focus Groups

Three focus groups were held with nurses and midwives from the services who had indicated in the questionnaire that they would be willing to discuss issues surrounding the establishment of their nurse-led/midwife-led service. The focus groups were held in Sligo, Cork and Dublin and a total of 26 nurses and midwives participated. The profile of the attendees was mostly assistant directors of nursing and midwifery and clinical nurse/midwife managers.

Evolution of nurse-led/midwife-led services

Several themes emerged from the focus group discussions, such as factors leading to the evolution of the nurse-led/midwife-led services, barriers to their success and the benefits to patients/clients. These are now discussed.

Service need and patient/client demand

The overarching reason for the establishment of nurse-led/midwife-led services was service need. This need was identified in various ways, for example, patients/clients were asked what kind of service they wanted. This led to the establishment of evening diabetic clinics, leg ulcer clinics and evening lactation and midwife-led ante-natal clinics. Out-of-hours services that were responsive to patient/client need were successfully introduced as a direct consequence of requests from the patient/client.

'out of hours service, responsive and flexible to service need'

Changing demographics

Changing demographics, population trends and unhealthy lifestyles were cited as reasons why new services were introduced. The need for more patient/client education and general health promotion were other factors that were considered important when establishing nurse-led/midwife-led services.

'the need to educate patients, patients come in under the medical model and go home with no education, no understanding of their illness, but now nurses are educating, and have more time to talk and promote the patients own well being'

Reduction of waiting times

The need to reduce patient/client waiting times and to provide a rapid access service was identified as a priority in some areas. The need to utilise the CNS/CMS role to its maximum potential led to the establishment, in some areas, of nurse-led/midwife-led clinics, allowing the CNS/CMS to assess, plan, treat, discharge and/or refer on.

'nurses took ownership (for developing nurse-led services) themselves, went off and trained and identified the need and pushed ahead, good pioneers'

Patient/client choice

Midwife-led ante-natal and foetal assessment clinics were established when a gap in the existing services was identified, the aim being to give women a choice regarding their pregnancy pathway.

'a lot of the midwifery-led service has come from professional development, increasing confidence thanks to education and literature'

Continuity of care

Nurse-led clinics for enduring mental illness were set up because it was identified that there was poor continuity of care for clients and clients were seeing a different healthcare professional at each episode of care. Nurse-led early intervention clinics were established as early intervention in enduring mental health has become accepted as best practice.

Factors critical to the establishment of nurse-led/midwife-led services

Accurate data

The factors critical to the successful implementation of nurse-led/midwife-led service included, identification of service need from an empirical perspective. This meant that evidence needed to be collected and analysed, the service need identified, a business case written and presented in an informed manner to senior managers.

'research it properly and show the need – make a business case and sell it to the managers/establishment competing for resources'

Collaboration

Looking at international best practice and using it to support the business case was seen as essential. Once the proposal became embedded in the service plan the factors that became important included: communication, collaboration and education. Collaboration from the medical staff and senior nursing staff was seen as crucial for the proposal to succeed.

Role definition

Clarification of new roles was seen as essential for the service to succeed; where there was lack of clarity about the role, resistance to the introduction of the service increased. Education of the relevant health care personnel about the new service was deemed essential if the service was to succeed.

Desire to change

Motivation, commitment and a desire to change hospital/service culture were cited as important factors when attempting to drive change. Having a vision for how services can be improved was cited as critical to successful implementation.

'I went into the director of nursing with an idea and was given the go ahead'

'there is another way forward'

'be willing to embrace change'

Finally, having the appropriate person with the appropriate level of knowledge and the appropriate expertise to lead the service was seen as essential from a clinical perspective.

Barriers to establishing nurse-led/midwife-led services

Financial constraints

In many instances the barriers to establishing nurse-led/midwife-led services were the inverse of the factors that were deemed essential to their establishment. However, participants at the focus groups identified some other concerns about setting up this type of service. Not least of these were financial resources. Participants agreed that it was often difficult to get 'development monies'; in many instances services had to be developed out of existing resources. Finance for professional development of staff was also difficult to access. Participants suggested that nurses and midwives preparing to lead nurse-led/midwife-led services need to have the necessary and appropriate education and/or training.

Lack of accurate data

A lack of Irish research and audit data was cited as an obstacle, as were a lack of availability of baseline demographic data and a lack of access for audit training and education.

Prescribing difficulties

The lack of authority to prescribe was cited as a barrier, although participants did acknowledge that this was being addressed. Participants nevertheless suggested that the lead-in time, and the time it will take to build a cohort of nurses and midwives who can prescribe will continue to be a barrier for the foreseeable or medium term future.

Location of service

The location of the nurse-led/midwife-led service was a consideration for participants. It was considered crucial that the service location must have an accessible, reliable and effective public transport system and be close to other amenities such as a pharmacy and for easy referral to other health care professionals. A 'one stop shop' type of service was considered the ideal scenario for the patient/client journey to be as seamless as possible.

Referral mechanisms

Poor mechanisms for referring patients/clients to and from the nurse-led/midwife-led service was cited as a barrier. Referral pathways and clear and unambiguous criteria for the reason for referral needed to be established and agreed by all the health care professionals involved in the service.

Risk taking

Lack of a 'risk taking' attitude to developments and a leaning towards medical dependency were regarded as further obstacles to developing nurse-led/midwife-led services. It was thought that a lot of nurses preferred to work 'alongside' medical staff rather than as autonomous individuals. Some of the participants felt very strongly that nurses and midwives use the scope of practice as a means to declare what they can't do rather than what they can.

Trade union factor

Participants expressed the view that the trade unions were, in some instances, concerned with financial remuneration for expanding the scope of practice rather than professional development opportunities. However, in some other instances the help of the trade unions in driving an agenda for change was seen as advantageous.

Clerical support

Finally, the lack of clerical support, especially for collecting and entering data for audit purposes, was seen as a considerable obstacle.

The benefits to the service and/or the patient/client of nurse-led/midwife-led care

The benefits to the patient/client included: increasing the continuity of care, patient's/client's being able to spend more time at home (assuming this was their preferred location), increased support in the community, relieving the burden on the acute services, improved symptom control, increased cover 'out of hours' and increased support after discharge. Patient/client compliance with medication and better education of patients/clients were seen as positive benefits.

The benefits to the service obviously overlapped with benefits to the patient/client on the basis that if the patient/client receives a satisfactory service then the service itself feels the overall benefit or effect. Direct measurable benefits to the service included better efficiency, improved patient/client journey, more individualised care, reduction in readmission rates, developing shared areas of expertise, disseminating and publishing the same. The streamlining of documentation was cited as a benefit as it reduced duplication and prevented the patient's/client's from telling their story over and over again to different health care professionals.

'people are voting with their feet, enquiries to join the service are increasing, word of mouth: people are coming back to book in'

All of the benefits to the service and to the patient/client that were identified in the focus groups were not merely anecdotal; most of the services has measured the effect the nurse-led/midwife-led care was having on the users and on the service by audit or questionnaire. Finally, job satisfaction and greater autonomy for staff were cited as associated benefits from the service.

Discussion

It is clear that nurse-led and midwife-led services currently available are wide-ranging, flexible and patient/client-centred. However, taking into account the recommendations from the Hanly report and the international literature, there is more scope for further development of these services to develop in Ireland. Nurse-led/midwife-led care could and should be developed in areas such as emergency, primary care, care of the older person, pre-assessment clinics, pain management, out-patient clinics, ante-natal care, 'total midwifery' care. With the proper educational and structural supports nurse-led and midwife-led services have great potential to expand within the framework of national policy. Service need would appear to be the single most important factor when the concept of nurse-led/midwife-led care was being considered.

CHAPTER FOUR
Conclusions and Framework for Establishing Nurse-led/Midwife-led Services

Conclusion

The expectations and demands of patients/clients receiving healthcare and healthcare services are shifting. Changes in the provision of healthcare are having an impact on the demands made on the healthcare providers, and have resulted in shorter stays in acute services, quicker access to hospital services and greater emphasis on the importance of providing community care. A significant factor in support of such changes is the creative use of nursing and midwifery expertise and a more effective utilisation of nurses and midwives experience and skills.

A culture of innovation, a desire to change and a motivated workforce are pre-requisites to any organisational change. If any of these factors are absent the process could be protracted and the desired outcomes may not be achieved. A proactive and strategic approach to the development of nurse-led/midwife-led services can ensure that services are developed in a flexible, innovative and creative manner to meet the evolving needs of patients/clients using the health services.

Increasingly, nurses and midwives are required to enable and co-ordinate care and liase across acute and community boundaries. New models of care are being developed that require all clinical and health and social care practitioners to challenge traditional professional boundaries. Important changes are taking place in the public's expectations and perceptions of the health services.

This research study has identified the extent and type of nurse-led/midwife-led services that are currently available in Ireland. It is evident that nurse-led/midwife-led services are continually being developed and refined by nurses and midwives who want to improve the quality of patient/client care. What is also evident is that these nurse-led/midwife-led services have evolved because of a gap in the service or because the service was not meeting the expectations of the patient/client. This can be evidenced by the introduction of evening and out of hour's clinics that suit the patient/client and not necessarily the health care professional delivering that service.

It is evident that depending on location and type of service nurse/midwife-led care can be delivered by nurses at generalist, specialist and advanced practice level. For those providing the clinical care it is critical that the clinical leadership is provided at the appropriate level. Ongoing professional development needs of the nurses and midwives delivering nurse-led/midwife-led services should be supported by the organisation.

As part of the questionnaire, each respondent was asked to indicate whether their organisation was considering developing any nurse-led/midwife-led services, and if so, to outline what they might be. Table 11 outlines their responses for future development of nurse-led/midwife-led care. This is not an exhaustive list as it reflects the views of those who responded to the questionnaire; there are many other areas that may not have been considered.

The diversity and multiplicity of the services would suggest that nurses and midwives are able to respond to patient/client need in a flexible and appropriate manner, allowing the development to occur within a multidisciplinary context. To date these initiatives have been driven by service need and a desire by nurses and midwives, both at senior and clinical level to improve the quality of the patient/client care. It is also evident that as these services develop they are being audited and measured for clinical effectiveness and patient satisfaction.

The development of nurse-led/midwife-led services in a structured collaborative manner will support the emerging health service needs. Nursing and midwifery competencies will be maximised, contributing to responsive delivery of care. Patients/clients will benefit from innovative and creative systems for delivering care.

Table 11: Areas for future development of nurse-led/midwifery-led services

NURSE-LED SERVICES IN GENERAL NURSING
minor injury services
pain assessment
care of the elderly services
out patient clinics in wound care
telephone triage
pre-assessment clinics (pre surgery)
heart failure clinics
clinics in tissue viability
clinics in continence promotion
clinics in asthma
clinics in dermatology
nurse-led discharge
palliative care services
osteoporosis clinics
community services
hypertension clinics
cardioversion clinics
secondary prevention clinics (coronary care)
cervical screening services
cystoscopy clinics
walk in centres
diabetes care
holistic/alternative therapies care
NURSE-LED SERVICES IN INTELLECTUAL DISABILITY
health screening (with specific groups, e.g., the older person with ID, people with severe and profound ID, children with complex needs)
health promotion (e.g., relating to obesity, exercise)
behaviour management
mental health assessment
advocacy for people with ID attending mainstream health and mental health services
MIDWIFE-LED SERVICES
total management of normal pregnancy
midwife-led domino care
midwife-led outreach home birth service
midwife-led units
NURSE-LED SERVICES IN PSYCHIATRY
counselling – family therapy
counselling – cognitive behavioural therapy
addiction service
rehabilitation service
attention deficit hyperactivity disorder service
bereavement service
deliberate self-harm service
affective disorders service

Framework for establishing nurse-led/midwife-led services

Introduction

Taking into account the findings of this study, national policy documents and the international literature the following is a recommended framework for organisations or services intending to introduce nurse-led and/or midwife-led services in the future.

New models of care require a review of the competencies and skills of nurses and, midwives and, where appropriate, expansion of practice. When identifying areas for expansion of practice, frameworks exist to support this:

- Scope of practice (ABA 2000a)
- Code of conduct (ABA 2000b)
- ANP/AMP framework (2nd ed) (National Council 2004a)
- CNS/CMS frameworks (2nd ed) (National Council 2004b)
- ABA guidelines for midwives (ABA 2001)

Underpinning these frameworks are evidence-based protocols and multidisciplinary integrated care planning. Examples of their use to support nurse-led/midwife-led care include areas such as medication management, referrals to the multidisciplinary team, requesting of tests and admission and discharge of the patient/client.

It is recommended that a business plan approach is adopted to aid the development of nurse-led/midwife-led services. The following provides a template to assist this. Organisations should utilise this in conjunction with their own internal processes.

Preparing a business case for the introduction of nurse-led/midwife-led services

In developing the business case the following four principles should be adhered to:

1. The outcome for the patient/client is the top priority.
2. The service to be provided will be demonstrably cost-effective.
3. The service model or care delivery model will be based on evidence relating to the needs of the specific population and/or the caseload.
4. Models of evidence-based best practice will be adopted.

A project management approach to develop the business case should be utilised. This entails identifying stakeholders, establishing a project team and setting targets to be achieved within a stated and agreed timeframe. Members of the project team should be chosen according to their particular area of expertise, ensuring that a multidisciplinary and/or interdisciplinary approach is adopted. Finance and human resources departments can provide expertise, as they have the required knowledge. A total systems approach will achieve results more successfully and effectively.

The content of the business case should include:

- Service needs assessment
- Human resource implications, including an analysis of the skills and competencies that will be required
- Financial analysis
- Non-financial analysis
- Evidence and risk
- Implementation plan

The following section provides a template for a business case. If the organisation has its own template, this should be used. There is no single 'right' outline, format or content list when writing a business plan. The content needs to be credible, accurate, logical and succinct.

Template for a business case

Proposition or summary

A statement of the new service that is being proposed should be written at the early stages. This should briefly detail the new service and anticipated benefits to the service. The statement should be written with the target audience in mind.

Context

Include a brief statement about why the proposed change really matters to patient/client care and the organisation. The geographic location affected by the proposition (or not) should be addressed and the organisational context outlined.

Service needs analysis

This section needs to demonstrate the need for the new service. How the new service will impact on patient/client care should be outlined. Provide details of current service provision, current activities, client/patient need and gaps in service in order to demonstrate what the impact on patients/clients will be. This information could come from the following sources:

Service data

- current activity levels
- current waiting list figures
- results of audits
- caseload analysis
- population demographics particular to the service
- epidemiological data available and particular to the service, including mortality and morbidity rates at local, regional, national and international levels.

Information

- Hospital In-Patient Enquiry (HIPE)
- National Cancer Registry
- Public health information systems
- Central Statistics Office
- Local health statistics

Health and social policy documents and reports[7]

- Evaluation of the Irish Pilot Programme for Health Care Assistants (2004)
- Health Strategy – Quality & Fairness - A Health System For You (2001)
- Cardiovascular Strategy (1999)
- Cancer Strategy (1996)
- Primary Care Strategy (2001)
- Palliative Care Strategy (2001)
- AIDS Strategy (2000)
- National Breastfeeding Policy (1994)
- National Health Information Strategy (2004)
- The National Health and Life Styles Survey (2003)
- Research Strategy for Nursing and Midwifery in Ireland (2003)
- Acute Hospital Bed Capacity – A National Review (2003)
- Health Statistics (2002)
- Long Stay Activity Report (2001)
- Effective Utilisation of the Professional Skills of Nurses and Midwives (2001)
- European Home and Leisure Accident Surveillance System Report for Ireland (2002)

Include a statement of service overview and activity analysis, indicating the level of service currently provided, followed by the projected level of service that will be provided by the introduction of the new service.

[7] All of these reports are available on the Department of Health and Children web site www.dohc.ie

Financial analysis

This is a critical section of the business case. Accurate data must be provided in relation to the scale of new service, i.e. new posts, resources, etc. Utilise the assistance of the finance department in the organisation.

Estimated costs split between:

- Non-recurring (one-off) costs: project management, equipment, recruitment, initial training and evaluation, changes to accommodation, 'pump priming' and continuing costs, salaries etc.

Estimated savings:

- Estimated savings can be more difficult to identify than costs. Identify ways of doing things differently. Look at what the organisation is currently spending which is often very different to what is budgeted and what could be saved over time.

Look for the savings in staff costs such as:

- Reduced use of agency and locum staff, reduced staff turnover and from reducing multiple visits by the patients/clients to hospitals, less complaints, less paperwork.

Timing:

- An analysis of costs and savings over the relevant financial years. If unsure, make an estimate.

	2004-5	2005-6	2006-7
Non-recurring costs			
Continuing costs			
Savings			

Non-financial impact

- Quantify the likely impact of the change on key performance areas such as quality, reduced waiting times, increased patient/client satisfaction and clinical performance indicators.

Human resources implications

The Health Strategy recommends having the right person with the right level of knowledge and the right expertise to lead the service from a clinical perspective. In many cases a business proposal will be about re-engineering the way in which people work and maximising the potential available competencies. To this end a good business case should include the competencies and skills that will be required to deliver the proposed service. This should include the level of decision making expected and the level of autonomy.

The availability of education to ensure the required competencies and skills is a necessity. The business case will therefore need to identify educational needs within the organisation. These may be delivered 'in-house', by the centres for nurse education, third level institutions or other means. Agreements with the education providers should be outlined along with the cost implications associated with fees, replacement costs and time.

Evidence and risk

- Detail how the proposed change will work. Give examples of small-scale tests or history of success elsewhere. Also include potential risks and contingency plans to prevent them.

Quality improvement information

- Provide evidence from the international literature – demonstrating the efficacy (or otherwise) of similar services
- Outline patient/client expectation of the service
- Outline the perceived contribution of the new service to patient/client care
- Discuss what the introduction of a new service will bring to the organisation that was not already there
- Review and critically compare other similar services within the region or nationally
- Discuss how the introduction of the service will be monitored. It is important to collect baseline data for comparative purposes

Implementation plan

- Outline the timeframe for delivery of the new service from approval of business plan to initiation of new service. Use Gantt charts as appropriate.
- Discuss the business plan with key decision makers in your organisation prior to finalising it.
- Submit the business plan to key decision makers as appropriate.
- Make recommendations for inclusion in the regional or local service plan if appropriate.

Summary

Most business plans require review and amendments as they go through the formal review processes by key decision makers and stakeholders. Be prepared for this and be open to new suggestions. It takes time to prepare, submit and get approval for a business plan – remain committed to the justifications for the new service and clearly articulate the vision which will improve patient/client care. Utilise all opportunities with key stakeholders and decision makers to promote the business plan.

Many factors such as the ageing population, population increases, changing ethnic composition and increasing urbanisation will affect the requirement for nursing and midwifery services and specialisation within health services in the future. This framework has indicated the types of information and sources of evidence that will be required when a new service is being proposed. The HSRP and other national and regional strategies and policies, regional demographic and epidemiological profiles and local requirements based on service need are the foundation of any proposal.

All new services must have an evaluation strategy built in to assist the process of continuous quality improvement and to ensure that the service fits the patient/client need. This evaluation should be as holistic as possible, incorporating the views of patients/clients and communities. The introduction of any new service will have implications for the wider system of working and cannot be considered in isolation.

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APPENDICES
Appendix 1: Nurse-led Questionnaire

National Council for the Professional Development of Nursing and Midwifery

Nurse-led Care QUESTIONNAIRE

Address details

Dear A Another

The National Council for the Professional Development of Nursing and Midwifery is undertaking a research study to establish the extent of nurse-led services in Ireland.

Nurse-led care is distinct from nurse coordinated or nurse-managed services. Nurse-led care is provided by nurses responsible for case management, which included comprehensive patient/client assessment, developing, implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients/clients will be referred to nurse-led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires increased skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practicing at an advanced level and may be working in specialist or advanced practice roles. (National Council 2003)

To this end I would be very grateful if you or a nominated colleague would complete this questionnaire.

If you have any questions concerning the content, please don't hesitate to contact me on 01 882 5314.

Please return the questionnaire in the FREEPOST envelope provided.

Yours sincerely

Jenny Hogan
Professional Development Officer

Respondent's Details **No: N0282**

Prefix First Name

Surname

Title

Organisation

Address

If any of the above details need to be amended please fill out the fields below.

Prefix First Name

Surname

Title

Organisation

Address

Nurse-led Care QUESTIONNAIRE

Q1: In which of the following care settings does your organisation/service belong?

Community ☐ Hospital ☐ Hospital & Community ☐

Other (please specify) _____

Q2: To which of the following bands does your organisation/service belong to?

Band 1 ☐ Band 2 ☐ Band 3 ☐ Band 4 ☐ Band 5 ☐

Other (please specify) _____

Q3: How many beds are there in your organisation/service?

50 -100 ☐ 101-150 ☐ 151-200 ☐ 201-250 ☐ 251-300 ☐ 301-350 ☐

351-400 ☐ 401-500 ☐ More than 500 ☐ Not applicable ☐

Q4: Do nurses provide a nurse-led service? (see covering letter for definition of nurse-led care)

Yes ☐ No ☐ Don't know ☐ **If you have ticked No or Don't know please skip to question 16**

Q5: If you ticked yes to question 4 please detail each service you consider to be nurse-led and how many years has it been established?

	TITLE OF SERVICE	YEARS ESTABLISHED
Service 1		
Service 2		
Service 3		
Service 4		
Service 5		
Service 6		

Q6: Do the nurses who run nurse-led services have the following? (Please tick according to service as above)

	TOTAL RESPONSIBILITY FOR CASE MANAGEMENT	COMPREHENSIVE ASSESSMENT PATIENT/CLIENT	PROVIDE CLINICAL LEADERSHIP
Service 1	☐	☐	☐
Service 2	☐	☐	☐
Service 3	☐	☐	☐
Service 4	☐	☐	☐
Service 5	☐	☐	☐
Service 6	☐	☐	☐

Q7: Do nurses who run nurse-led services admit their patients/clients?

(Admit can mean, admission to hospital or to another health care institution)

Yes ☐ No ☐ Don't know ☐

Q8: Do nurses who run nurse-led services discharge their patients/clients?

(Discharge can mean from any healthcare institution or from the episode of care that the nurse was providing)

Yes ☐ No ☐ Don't know ☐

Q9: Please tick to whom the nurses running the nurse-led clinic can refer to:

Dietitian	☐	Community mental health nurse	☐	Consultant	☐
Physiotherapist	☐	Public health nurse	☐	No-one	☐
CNS's/CMS's	☐	Social worker	☐	Other (please specify)	
Occupational therapist	☐	Psychologist	☐		
Speech therapist	☐	Medical staff	☐		
Radiographer	☐	GP	☐		

Q10: Please tick from whom the nurse running the nurse-led clinic can receive referrals from;

Dietitian	☐	Community mental health nurse	☐	CNM 1,2 or 3	☐
Physiotherapist	☐	Social worker	☐	Self referrals from patients/clients/relatives	☐
CNS's/CMS's	☐	Psychologist	☐	No-one	☐
Occupational therapist	☐	GP	☐	Other (please specify)	☐
Speech therapist	☐	Consultant	☐		
Radiographer	☐	Other Medical staff	☐		
Public health nurse	☐	Staff nurses	☐		

Q11: Are the nurses who run nurse-led services working as either:

(You may tick more than one where the service is provided by more than one nurse)

1. a staff nurse	☐	4. a clinical nurse manager	☐
2. a clinical nurse specialist	☐	5. none of the above	☐
3. an advanced nurse practitioner	☐	6. please specify if not listed above	

Q12: Have the nurses who are providing nurse-led services in your organisation received education or training specifically to equip them to lead the service?

Yes ☐ No ☐ Don't know ☐

Q13: If you answered yes to Q12 could you list the relevant education or training that the individual undertook?

Certificate course	☐	Post graduate diploma	☐
In-house training	☐	Masters degree	☐
Diploma	☐	PhD	☐
Degree	☐	None	☐

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Nurse-led Care QUESTIONNAIRE

Q14: If you have nurse-led services are audits performed?

Yes ☐ No ☐

Q15: Would you be willing to allow the National Council access to the audit reports or summaries of reports?

Yes ☐ No ☐ N/A ☐

Q16: Is your organisation developing any nurse-led services?

Yes ☐ No ☐ Don't know ☐

Q17: If you ticked yes to the previous question could you give a brief outline of the services under development?

Q18: Does your organisation/service have a patient/client advocacy group?

Yes ☐ No ☐ Don't know ☐

Q19: If you answered yes to Q18 would you be willing to discuss this at a later date with the National Council regarding access to patient/client information?

Yes ☐ No ☐ N/A ☐

Q20: Phase two of the research will consist of focus groups with organisations that are providing nurse-led care. If you or your service providers would be interested in taking part in these focus groups please tick the relevant box.

Willing to take part in focus groups ☐

NOT willing to take part in focus groups ☐

National Council for the Professional Development of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

All information in this questionnaire will be treated confidentially.
Many thanks for taking the time to fill out this questionnaire.

6/7 Manor Street Business Park, Manor Street, Dublin 7.
Telephone: 01 882 5300. Fax: 01 868 0366.
Email: conference@ncnm.ie Website: www.ncnm.ie

APPENDICES
Appendix 2: Midwifery-led Questionnaire

National Council for the Professional Development of Nursing and Midwifery

Midwifery-led Care QUESTIONNAIRE

Address Details

Dear A Another

The National Council for the Professional Development of Nursing and Midwifery is undertaking a research study to establish the extent of midwifery-led services in Ireland.

Midwifery-led care has been defined by the recent Cochrane protocol as "the context of care where 'the midwife is the lead professional in the planning, organisation and control of the care given to a woman from initial booking to the postnatal period' (RCOG 2001). Within these models, midwives are, in partnership with the woman, the lead professional with responsibility for assessment of her needs, planning her care with her, referral to other health professional as appropriate, and for ensuring provision of maternity services".[1]

To this end I would be very grateful if you or a nominated colleague would complete this questionnaire.

If you have any questions concerning the content, please don't hesitate to contact me on 01 882 5314.

Please return the questionnaire in the FREEPOST envelope provided.

Yours sincerely

Jenny Hogan
Professional Development Officer

[1] (Hatem M, Devane D, Fraser WD, Hodnett ED, Sandall J, Soltani H. Midwifery-led versus other models of care delivery for childbearing women (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 1, 2004. Chichester, UK: John Wiley and Sons, Ltd.

Respondent's Details **No: M0008**

Prefix First Name

Surname

Title

Organisation

Address

If any of the above details need to be amended please fill out the fields below.

Prefix First Name

Surname

Title

Organisation

Address

Midwifery-led Care QUESTIONNAIRE

Q1: In which of the following care settings does your organisation/service belong?

Community ☐ Hospital ☐ Hospital & Community ☐

Other (please specify) _____

Q2: To which of the following bands does your organisation/service belong to?

Band 1 ☐ Band 2 ☐ Band 3 ☐ Band 4 ☐ Band 5 ☐

Other (please specify) _____

Q3: How many beds are there in your organisation/service?

50 -100 ☐ 101-150 ☐ 151-200 ☐ 201-250 ☐ 251-300 ☐ 301-350 ☐

351-400 ☐ 401-500 ☐ More than 500 ☐ Not applicable ☐

Q4: Do midwives provide a midwifery-led service? (see covering letter for definition of midwifery-led care)

Yes ☐ No ☐ Don't know ☐ **If you have ticked No or Don't know please skip to question 16**

Q5: If you ticked yes to question 4 please detail each service you consider to be midwife-led and how many years has it been established?

	TITLE OF SERVICE	YEARS ESTABLISHED
Service 1		
Service 2		
Service 3		
Service 4		
Service 5		
Service 6		

Q6: Do the midwives who run midwife-led services have the following? (Please tick according to service as above)

	TOTAL RESPONSIBILITY FOR CASE MANAGEMENT	COMPREHENSIVE ASSESSMENT PATIENT/CLIENT	PROVIDE CLINICAL LEADERSHIP
Service 1	☐	☐	☐
Service 2	☐	☐	☐
Service 3	☐	☐	☐
Service 4	☐	☐	☐
Service 5	☐	☐	☐
Service 6	☐	☐	☐

Q7: Do midwives who run midwifery-led services admit their patients/clients?

(Admit can mean, admission to hospital or to another health care institution)

Yes ☐ No ☐ Don't know ☐

NATIONAL COUNCIL FOR THE PROFESSIONAL DEVELOPMENT OF NURSING AND MIDWIFERY

Q8: Do midwives who run midwifery-led services discharge their patients/clients?

(Discharge can mean from any healthcare institution or from the episode of care that the midwife was providing)

Yes ☐ No ☐ Don't know ☐

Q9: Please tick to whom the midwives running the midwifery-led clinic can refer to:

Dietitian	☐	Community mental health nurse	☐	Consultant	☐
Physiotherapist	☐	Public health nurse	☐	No-one	☐
CNS's/CMS's	☐	Social worker	☐	Other (please specify)	
Occupational therapist	☐	Psychologist	☐		
Speech therapist	☐	Medical staff	☐		
Radiographer	☐	GP	☐		

Q10: Please tick from whom the midwive running the midwifery-led clinic can receive referrals from;

Dietitian	☐	Community mental health nurse	☐	CMM 1,2 or 3	☐
Physiotherapist	☐	Social worker	☐	Self referrals from patients/clients/relatives	☐
CNS's/CMS's	☐	Psychologist	☐	No-one	☐
Occupational therapist	☐	GP	☐	Other (please specify)	☐
Speech therapist	☐	Consultant	☐		
Radiographer	☐	Other Medical staff	☐		
Public health nurse	☐	Staff midwives	☐		

Q11: Are the midwives who run midwifery-led services working as either:

(You may tick more than one where the service is provided by more than one midwife)

1. a staff midwife	☐	4. a clinical midwife manager	☐
2. a clinical midwife specialist	☐	5. none of the above	☐
3. an advanced midwife practitioner	☐	6. please specify if not listed above	

Q12: Have the midwives who are providing midwifery-led services in your organisation received education or training specifically to equip them to lead the service?

Yes ☐ No ☐ Don't know ☐

Q13: If you answered yes to Q12 could you list the relevant education or training that the individual undertook?

Certificate course	☐	Post graduate diploma	☐
In-house training	☐	Masters degree	☐
Diploma	☐	PhD	☐
Degree	☐	None	☐

PTO

Midwifery-led Care QUESTIONNAIRE

Q14: If you have midwifery-led services are audits performed?

Yes ☐ No ☐

Q15: Would you be willing to allow the National Council access to the audit reports or summaries of reports?

Yes ☐ No ☐ N/A ☐

Q16: Is your organisation developing any midwifery-led services?

Yes ☐ No ☐ Don't know ☐

Q17: If you ticked yes to the previous question could you give a brief outline of the services under development?

Q18: Does your organisation/service have a patient/client advocacy group?

Yes ☐ No ☐ Don't know ☐

Q19: If you answered yes to Q18 would you be willing to discuss this at a later date with the National Council regarding access to patient/client information?

Yes ☐ No ☐ N/A ☐

Q20: Phase two of the research will consist of focus groups with organisations that are providing midwifery-led care. If you or your service providers would be interested in taking part in these focus groups please tick the relevant box.

Willing to take part in focus groups ☐

NOT willing to take part in focus groups ☐

National Council for the Professional Development of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

All information in this questionnaire will be treated confidentially.
Many thanks for taking the time to fill out this questionnaire.

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