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Deans of Health

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leadership in education
and research

Educating the Future Midwife:

Discussion paper on the key future outcomes for registered midwife education

CoDH UK-Wide Future Midwife Advisory Group

November 2017



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1. Introduction

Following an evaluation in 2015, the Nursing and Midwifery Council (NMC) has committed to developing new pre-registration midwifery education standards. This follows a number of reviews of midwifery and midwifery education in different UK countries including *A strategic vision for maternity services in Wales* (2011)¹, *Setting the Direction for Nursing and Midwifery Education in Scotland* (2014)², *A strategy for maternity care in Northern Ireland 2012-2018* (2012)³, *Better Births* (2016)⁴, *Midwifery 2020 – Delivering expectations* (2010)⁵, a UK-wide collaboration which sets out a vision of how midwives can meet the needs of service users in the future, and *The Best Start: A Five Year Plan for Maternity and Neonatal Care in Scotland* (2017)⁶.

Members of the Council of Deans of Health (CoDH) are responsible for educating student midwives who complete their pre-registration education in the UK. Our members are a key collective source of expertise across the UK on how higher education can meet the future requirements of pre-and post-registered midwives.

The CoDH UK-wide Future Midwifery Advisory Group, agreed that a major focus of its work should be to develop a discussion paper on the CoDH's vision of the future midwife and the profession's education requirements.

This paper is presented as a stimulus for debate and we welcome comments from our members and wider stakeholders. Our hope is that it will support our members and inform the NMC's development of new pre-registration midwifery education standards to improve outcomes and experiences of childbirth for women, children and families.

2. Context

2.1. Defining the midwife and midwifery

2.1.1. Definition of the midwife

A midwife is defined by the International Confederation of Midwives (ICM)⁷ as:

'... a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother

¹ Welsh Government (2011), *A Strategic Vision for Maternity Services in Wales*

² Scottish Government (2014), *Setting The Direction For Nursing & Midwifery Education in Scotland*.

³ Department of Health, Social Services and Public Safety (2012), *A strategy for maternity care in Northern Ireland 2012 - 2018*

⁴ NHS England (2016), *Better Births, Improving outcomes of maternity services in England*

⁵ Chief Nursing Officers of England, Northern Ireland, Scotland and Wales (2010), *Midwifery 2020: Delivering expectations*

⁶ Scottish Government (2017), *The Best Start: A Five Year Plan for Maternity and Neonatal Care in Scotland*

⁷ International Confederation of Midwives, available at: internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/

and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.'

2.1.2. Defining midwifery

The definition of midwifery practice according to Renfrew, McFadden, Bastoset et al (2014)⁸ is:

'Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life.

Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families'.

2.2. NMC programme of change for education and standards

The NMC has embarked on an ambitious programme of change for education that includes development of new pre-registration education standards for the future registered midwife, and a new education framework and quality assurance (QA) model.

The Standards for Pre-Registration Midwifery Education were last published in 2009⁹. Since then maternity services have undergone significant change. The new standards present an opportunity to shape and influence the future vision for midwifery and maternity services and the education that underpins it. Work on new standards began in April 2017 and a public consultation on the draft midwifery standards is expected in 2019. Final standards are likely to be published in early 2020.

The new standards are expected to be outcome focused and evidence based to enable midwives to meet future challenges in caring for women and their families in the future.

The ICM (International Confederation of Midwives) has developed standards, competencies and tools which includes [Global Standards for Midwifery Education](#). The documents are intended to guide midwives' associations, governments, regulators and educators in reviewing and improving midwifery regulation and education.

⁸ Renfrew, McFadden, Bastoset al (2014), The Lancet, Volume 384, No. 9948, p1129–1145, available at: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60789-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60789-3/fulltext)

⁹ NMC (2009), [Standards for pre-registration midwifery education](#)

2.3. Factors influencing midwifery practice

Since the standards were last published, changes in demographics and developments in health and social care have influenced midwifery practice. It is vital that learning and teaching reflect these changes and effectively prepare midwives to meet needs of practice both now and in the future. Although curricula have adapted to respond to this, this has been limited due to current standards.

2.3.1. Advances in midwifery education, knowledge and research

A considerable body of evidence exists showing the difference midwifery practice makes to the lives of women, babies and families. Accessible, high quality midwifery care has contributed to better outcomes including reductions in maternal and infant mortality on a national and global scale (Renfrew et al, 2014)⁸.

Midwifery education in the UK has had a significant impact on strengthening the profession and preparing safe, competent and effective midwives. The role of the midwifery educator has also been shown to bring added value to the curricula (MINT, 2010)¹⁰.

The design of midwifery education has evolved and some programmes have become more complex. In the UK, midwifery has been an all-graduate degree profession since 2009 and most pre-registration education programmes are now direct entry. Pedagogical midwifery research (2012)¹¹ has also enabled education to evolve to include simulation, inter-professional education, technology and innovative teaching methods effectively.

Research has been fundamental to the establishment of midwifery as a distinct and autonomous profession that makes a unique contribution to maternity services. World leading midwifery research has influenced policy, service re-design and practice. Impacts of this research are free standing birth centres, midwife led pathways of care and midwife caseload holding for vulnerable women and families (Sandell et al, 2016¹², Brocklehurst et al, 2011¹³).

¹⁰ NMC (2010), The MINT Project, available at: www.nmc.org.uk/globalassets/siteDocuments/Midwifery-Reports/MINT-report.pdf

¹¹ Marshall JE (2012), Developing midwifery practice through work-based learning: an exploratory study, *Nurse Education in Practice* (Special Edition: Midwifery Education) 12, (5) pp 112-118

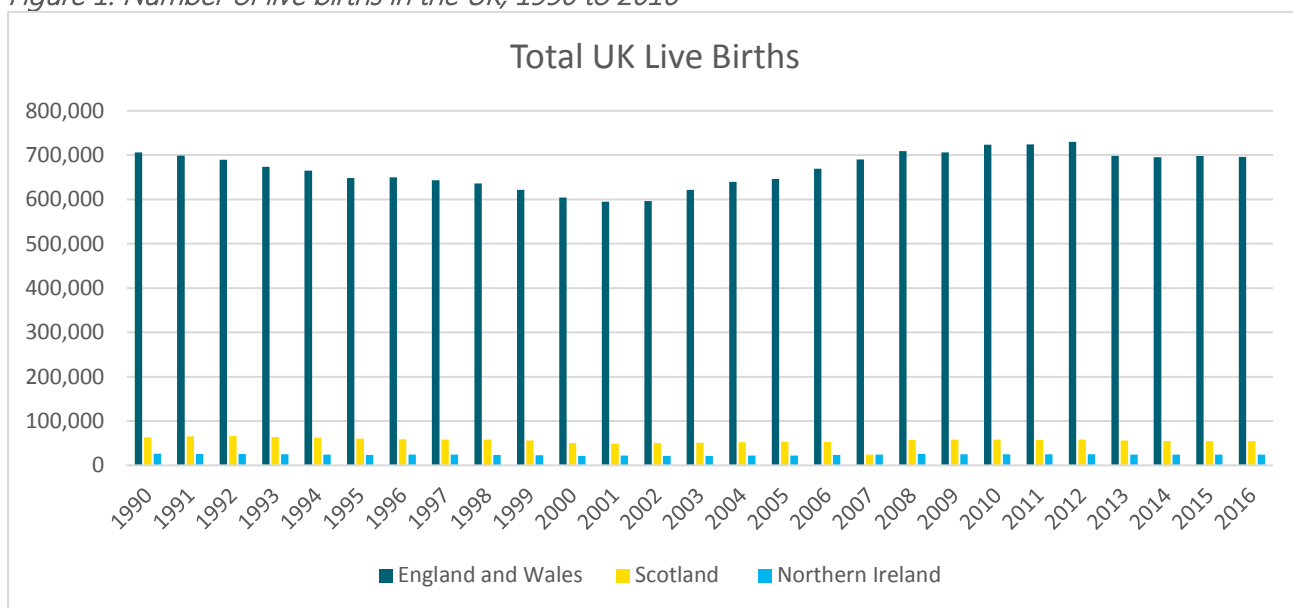
¹² Sandall J, Soltani H, Gates S, Shennan A, Devane D (2016), Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting. Cochrane Pregnancy and Childbirth Group

¹³ Brocklehurst, P. (2011), Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the birthplace in England national prospective cohort study, available at: www.bmj.com/content/bmj/343/bmj.d7400.full.pdf

2.3.2. Profile of those who use midwifery services

Although the number of births in the UK has not changed significantly over the last 25 years, the demographics and clinical profile of women has and that has had an impact on the role of the midwife and midwifery practice (Figure 1).

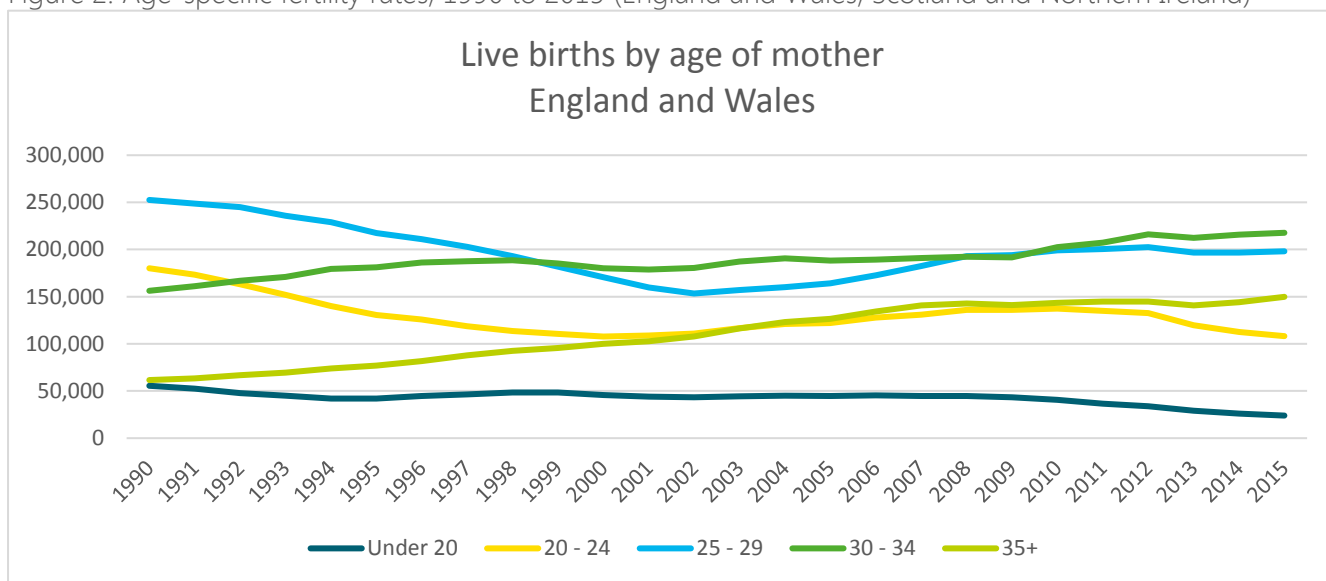
Figure 1: Number of live births in the UK, 1990 to 2016



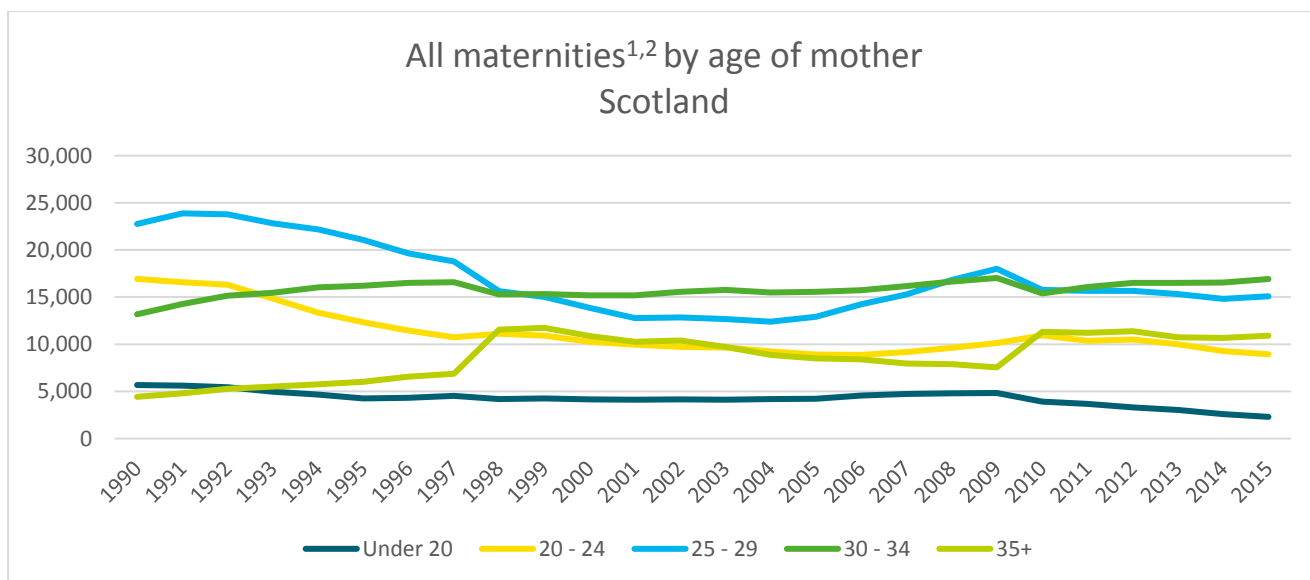
Data source: [Office for National Statistics](http://www.ons.gov.uk) (England and Wales), [IDS Scotland](http://www.nrscotland.gov.uk) (Scotland), Northern [Ireland Statistics and Research Agency](http://www.nisra.gov.uk) (Northern Ireland)

More women are starting their family later in life and this has led to an increase in assisted conception and multiple births (see figure 2 for age-specific fertility rates in each of the UK countries). Increased maternal age is also associated with an increased risk of pre-existing morbidity and developing pregnancy-related complications.

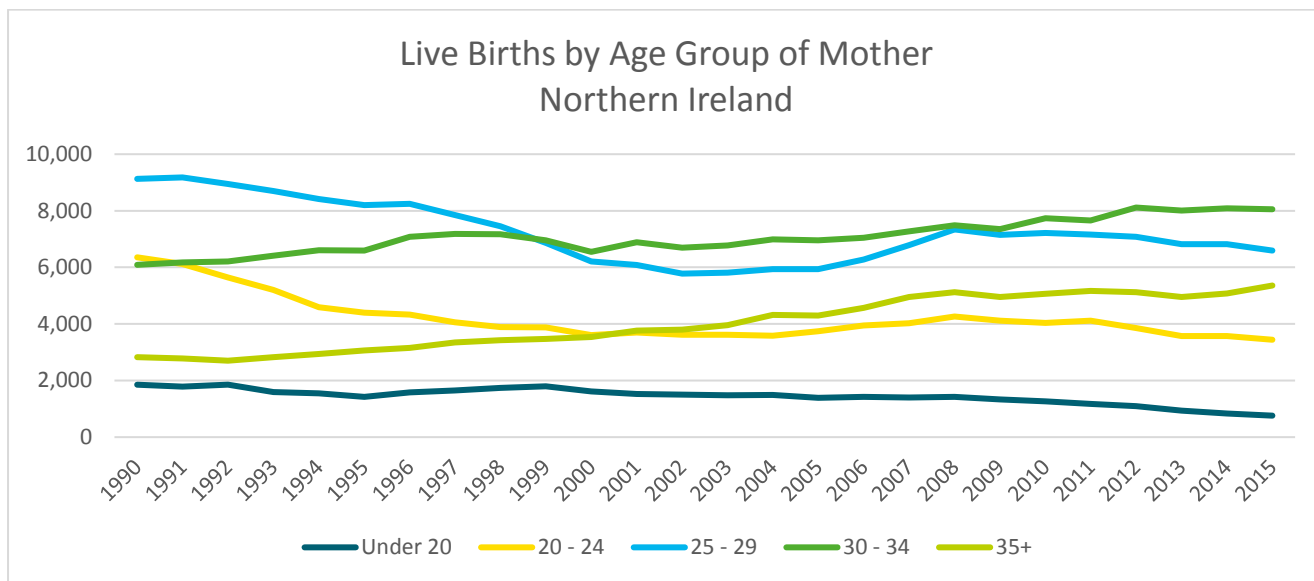
Figure 2: Age-specific fertility rates, 1990 to 2015 (England and Wales, Scotland and Northern Ireland)



Data source: [Office for National Statistics](http://www.ons.gov.uk)



Data source: [IDS Scotland](http://www.idscotland.nhs.uk) (1 - Excludes home births and births at non-NHS hospitals, 2 - Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered)



Data source: Northern [Ireland Statistics and Research Agency](http://www.nisra.gov.uk)

In recent years, social, economic and ethnic diversity has increased, for example the proportion of births in England and Wales to mothers born outside the UK has risen from 11.6% to 27.5% between 1990-2015 ([ONS, 2015, England and Wales](http://www.ons.gov.uk)). Many of these mothers do not speak English as their first language and may require additional support to access and navigate maternity services. The most disadvantaged and vulnerable women and babies in society are the most likely to die or suffer from ill-health¹⁴.

Inequalities adversely affect health across the lifespan. The midwifery role can be powerful in supporting disadvantaged women and managing diversity. Specialist midwifery roles and services for substance misusing mothers and smoking cessation, have been successful at improving outcomes and experiences of care and reducing inequalities. More specialist roles for midwives may have significant benefits for the future health of children leading them into adulthood.

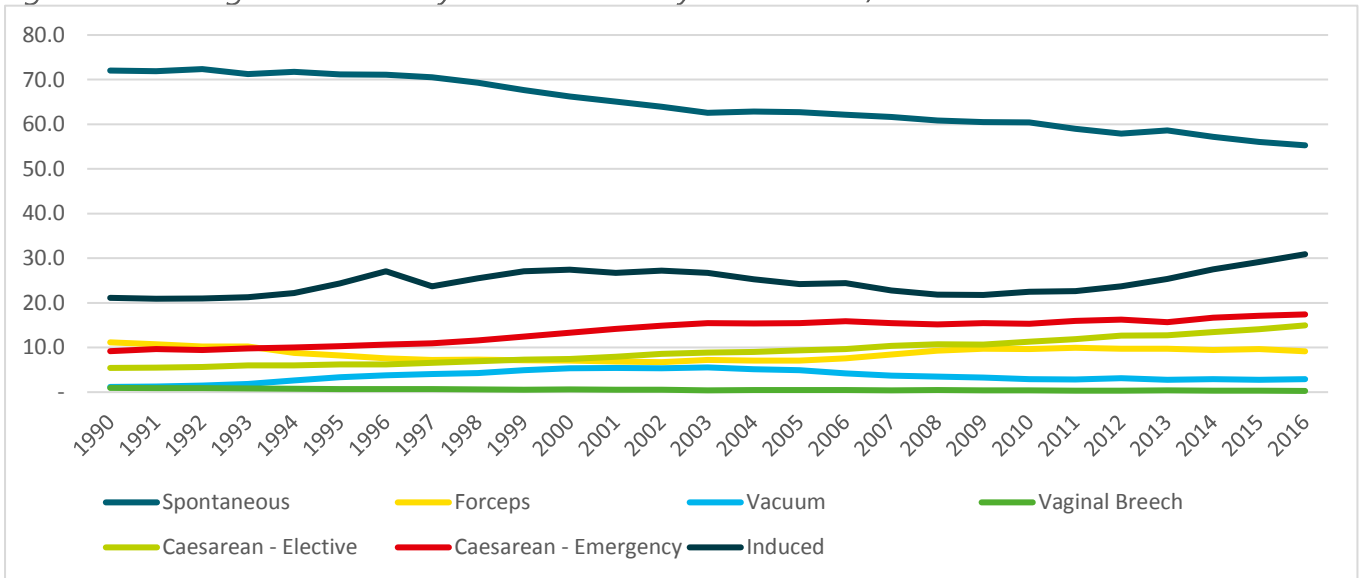
Rates of long term conditions such as diabetes and obesity are also contributing to the increasing demands on midwifery services. In Scotland and England more than one in five (22% and 21% respectively) of pregnant women are obese¹⁵. These conditions put pregnant women at greater risk of complications and problems during pregnancy, which often require higher levels of care and intervention.

There has been an increase in medical interventions during labour as demonstrated by the rising rate of caesarean sections, particularly elective caesareans (see figure 3 for Scotland). There are several factors that influence modes of childbirth including medical reasons and an increasing focus on personalised care and choice. Caesarean sections have an impact on women's experience of childbirth, expectations and future birth choice. Once a woman has had a caesarean birth, there is an increased likelihood of subsequent births by this method.

¹⁴ MBRRACE-UK, [Confidential Enquiry into Maternal Deaths](http://www.mbrpace.org.uk)

¹⁵ RCM (2016), [State of Midwifery Services Report](http://www.rcm.ac.uk)

Figure 3: Percentage of live births by method of delivery in Scotland^{1,2}, 1990 – 2016

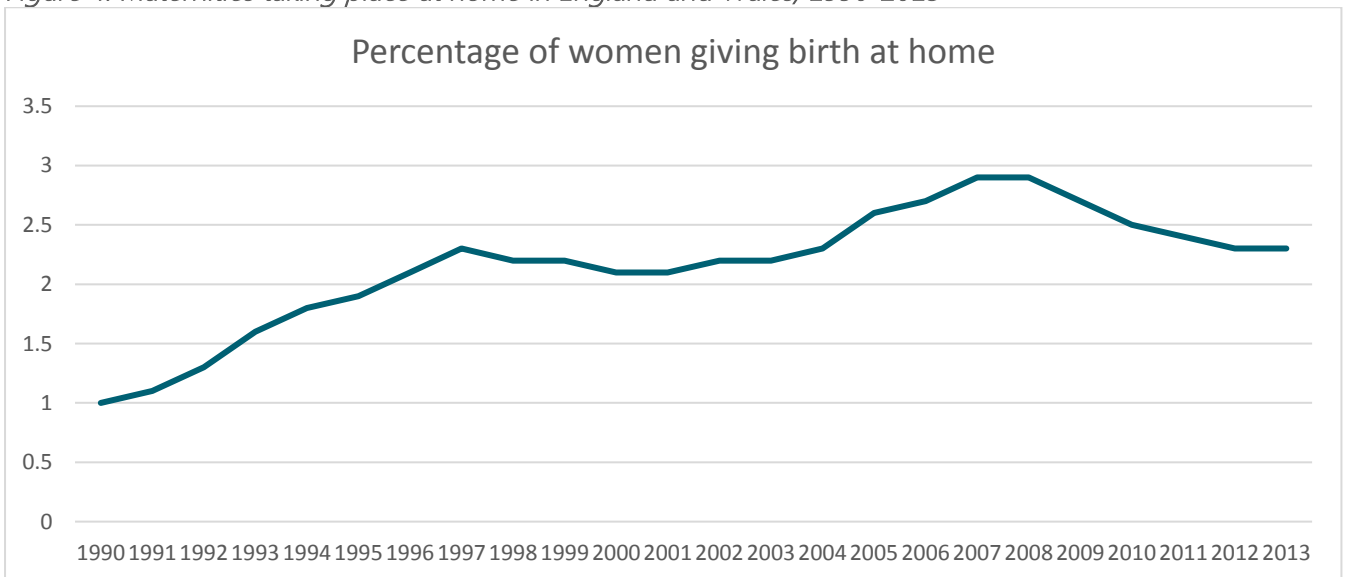


Data source: [ISD Scotland](http://ISDScotland.org) (1 - Excludes home births and births at non-NHS hospitals, 2 - Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered.)

2.3.3. Policy changes and service reconfiguration

The context and setting in which midwives practice has changed over the years. Now a minority of women give birth at home in the UK (see figure 4 for England and Wales). Most midwives work in obstetric units where the care tends to be specialist and obstetric led, providing care to women and babies with complex and/or rare medical conditions. UK maternity policy promotes choice about where women can give birth. With growing evidence to suggest that for many women it is safe and there are advantages to giving birth outside an obstetric unit we are already seeing a change in clinical practice driven by women’s choices¹³.

Figure 4: Maternities taking place at home in England and Wales, 1990-2013



Source: [Office for National Statistics](http://OfficeforNationalStatistics.org)

More recently, government policy across the UK has attempted to shift the focus of maternity care away from secondary care to more community based care for healthy women. The National Maternity Reviews in both Scotland and England⁴ highlight the importance of continuity of care and continuity of carer by midwives. Research has consistently found that maternity continuity of care models improve outcomes and women's satisfaction¹².

Given the perennial tension between available resources and population needs, it is likely that the future midwife will practise within significantly different maternity systems, influenced by emerging models such as value based healthcare.

2.3.4. Changing roles of women

Women's lives have changed alongside societal changes. The NHS has not always developed services that reflect and are responsive to women's roles and responsibilities in modern society. There have been many policies with recommendations and rhetoric but these have not always translated into services that meet women and their families' needs and expectations. Many women still receive fragmented care though new models of care are being explored to enable better continuity. Midwifery education must support midwives to be perceptive, flexible, innovative, creative, critical thinkers to work in transforming services that are appropriate and inclusive to maternity service users' needs and their preferences.

2.3.5. Midwifery workforce

The midwifery workforce is predominately female and many work part-time. Most midwives work in the NHS. The midwifery workforce across the UK is ageing, a 2016¹⁶ report by the Royal College of Midwives (RCM) on the state of midwifery services identified that a high proportion of the midwifery workforce is aged 50 or over – across the UK by country the percentage of midwifery staff aged 50+ is: England 33%, Scotland 41%, Wales 35% and Northern Ireland 40%. Within the next 10 years around a third of midwives will be nearing retirement.

In recent years, the number of places on pre-registration midwifery programmes has been relatively stable. With demands on midwives rising due to the increase in birth rates and growing complexity, there is a clear need to ensure that there are sufficient numbers of newly qualified midwives entering the profession, there are sufficient educators both in practice and AEs to teach student midwives and sufficient provision of post-registration education to foster retention of the current and future midwifery workforce. The CoDH is closely monitoring the impact of recent university funding reforms in England on healthcare student numbers across the UK.

A 2017 RCM survey¹⁷ about the health, safety and wellbeing of midwives working in education revealed that over a third of midwives that took part in the survey said they wish to leave their organisation in the next two years. A shortage of midwife lecturers to educate the next generation of midwives will worsen the shortage of midwives working in practice.

¹⁶ RCM (2016), [State of Midwifery Services Report](#)

¹⁷ RCM (2017), [Survey results about the health, safety and wellbeing of midwives working in education](#)

2.4. Routes into registered healthcare professions

Widening participation and access to higher education are at the fore of the political agenda. There is also an expectation within education that learning will become more flexible and responsive to workforce and employer needs. Other health care professions have seen the introduction of new degree apprenticeship routes into professional registration. Further guidance is available on the CoDH website. This is a significant development of the future health and social care workforce. At the time of writing a level 6 degree apprenticeship for midwifery is being explored.

In 2005, maternity support workers (MSWs) were introduced to the maternity team. They work under the supervision of midwives who delegate to them midwifery and non-midwifery tasks. They are not a regulated profession and do not have a nationally agreed job description, set of competencies or training. It is feasible that in the future the role may be developed into a midwifery associate and a formal pathway created leading to registration as a midwife.

2.5. Funding of health higher education

From 2017 new students on most midwifery pre-registration courses in England have access to the standard student support package of tuition fee loans and support for living costs, rather than getting a bursary. With the introduction of tuition fees, there is potential for student demography to change and widening participation to become a more challenging agenda. Students are likely to be more discerning in their choice of university, career and value for money.

The other countries making up the UK are watching the impact of the recent funding reforms carefully. All three countries still have a government led commissioning system and eligible students can apply for a bursary and have their tuition fees paid. Any future midwifery standards will need to consider the complexities of mixed funding models across the UK.

2.6. Models of care

Maternity care across the UK is built on a common set of principles of safe, high quality, accessible care. However, as health is a devolved matter midwifery policy and practice vary between the four countries of the UK. Despite there being no single model of service delivery across the UK, such as midwives being the first point of contact for pregnant women, there are many commonalities. Most healthy women who are at low risk of obstetric complications are offered midwife-led care during the childbirth continuum. Those women who do not fall into this category will, in addition, be cared for by an obstetrician and other health care professionals based on need. Even when women are receiving obstetric led care, midwives still provide of the care and are frequently the coordinators of care. Some midwives work between hospital and community settings both in rural and urban locations to maintain skills and promote continuity of care/r, but this is not common practice.

In the UK, there are four places to birth; home, obstetric unit, freestanding midwifery units (FMU) which are situated in a community setting, and alongside midwifery units (AMU), situated alongside an obstetric labour ward. Not all four options are accessible and available in all regions and to all women. Currently, most births take place in a hospital setting (RCM, 2016).

In all models of midwifery care the vital component is that they promote the woman and her family at the centre of care with the midwife building and sustaining effective relationships.

2.7. Globalisation

Technology and travel have made it easier to connect with others across the world. This means midwives can learn more easily about maternity services and roles in other countries. Higher education is one of the UK's major exports and many AEs deliver contracts overseas, supporting countries that are looking to develop the roles of midwives, exchanging knowledge to build a new professional cadre. UK based midwifery education is viewed as the 'gold standard' overseas, and UK midwives can practice with limited need for conversion of their education in many countries.

There is increasing recognition of the benefits of internationalisation for student midwives during their education programmes. Education has a role in equipping midwives to learn more about diverse needs and culturally sensitive care. The benefits of outward student mobility for student midwives have been highlighted in a report produced jointly the CoDH and Universities UK International (2017)¹⁸. For example, a 2017 study¹⁹ of an Erasmus exchange programme between UK and Maltese student midwives found that students valued the opportunity of undertaking study and midwifery practice in another culture and healthcare system, extending their knowledge and development of clinical competence and confidence. By the end of the programme they felt they had become more independent and empowered to facilitate developments in practise when they returned to the UK.

¹⁸ Council of Deans of Health and Universities UK International (2017), [*Outward Student Mobility for nurse, midwife and AHP students*](#)

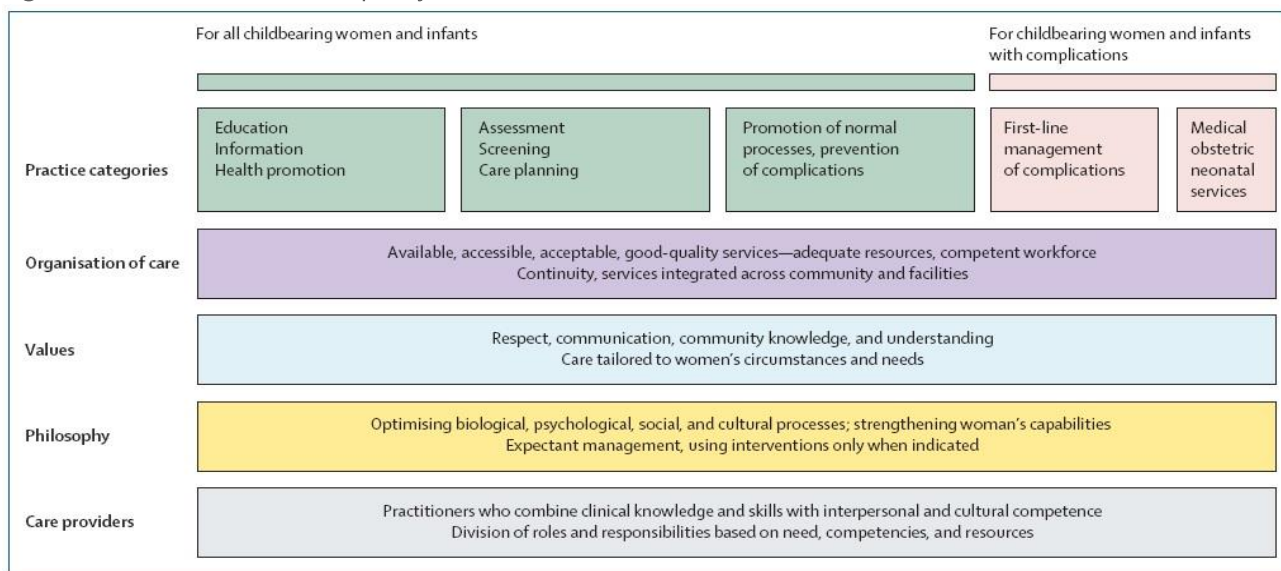
¹⁹ Marshall JE (2017), Experiences of student midwives learning and working abroad in Europe: the value of an Erasmus undergraduate midwifery education programme, *Midwifery*, 44 (2017) pp7-13.

3. Future outcomes for pre-registration midwifery education

This section of the paper outlines the CoDH’s initial views on the key outcomes of future registered midwifery education. We have grouped our thinking around the Lancet framework for quality maternal and newborn care. The framework (Figure 5) has been developed for all childbearing women and infants and outlines the care they should expect across all types of pregnancy, labour and birth, and postpartum regardless of where the birth takes place. It sets a basis of what midwifery practice should be and is a guide for midwifery education.

3.1. The framework for quality maternal and newborn care

Figure 5: The framework for quality maternal and newborn care



Source: [The Lancet](#) (2014)

3.2. Practice categories

3.2.1. Education - competent graduate professionals

Since 2008 the minimum academic level for entry onto the midwifery part of the NMC register has been degree level. Midwifery will continue to be delivered by graduate professionals. The MINT study (2010)¹⁰ highlighted the value of midwifery education being designed and delivered by midwives with subject specialism.

At the point of registration, all student midwives must be able to demonstrate the professional qualities, skills, knowledge and behaviours expected of the registered midwife, regardless of the education pathway leading up to registration. We should also aspire for them to demonstrate graduate attributes such as scholarship, global citizenship and lifelong learning. Midwives of the future must have intellectual

autonomy, inquiring minds, numeracy and communication skills, and ethical and social understanding if they are to be employable and successful in their careers (Barrie, 2004)²⁰.

3.2.2. Information giving, public health, safeguarding and health promotion

Given the policy commitment to reducing health inequalities in the UK and the focus on maintaining health and preventing disease, midwives must further enhance their public health role. They are likely to play a key role in assessing the health and social needs of populations and communities and delivering the public health agenda. Research has demonstrated that appropriate care and support during pregnancy affects the health and wellbeing of women and babies, not just in childhood but into adulthood. An example of this is perinatal mental health services which can provide the optimal start in life for newborns.^{21,22}

Enabling self-care and self-management, supporting women and families to make healthy choices and taking increased responsibility for their own health and well-being will be key increasingly important. Pregnancy is noted as a window of opportunity and there are opportunities for teachable moments that may support behaviour change (2010)²¹. Key health challenges for midwives to manage include obesity, alcohol and drug misuse, and sexual health.

3.2.3. Care planning

Midwives will increasingly support the vision of more personalised and relational care. This means care centred on the needs and decisions of women, her baby and family. Every woman can expect a personalised care plan which has been co-designed with her midwife and other health professionals, which sets out her decisions about her care and is updated throughout her pregnancy, birth and the postnatal period. Midwives will ensure that women are provided with unbiased, appropriate individualised information in a timely manner and based on the most up to date evidence. It must also be culturally and socially sensitive. Midwives will promote continuity of care, liaising closely with other services to ensure that care is joined up.

3.2.4. Prevention and management of complications

Midwives are currently the lead care provider for physiological/normal childbirth while being able to expertly recognise deviations from normal criteria and take appropriate action. The midwife's current role is to assess, monitor, detect, refer to appropriate professionals, co-ordinate, liaise with others, keep contemporaneous records and practise as an effective member of the multidisciplinary team when complications occur. They recognise signs of a deteriorating woman and act, managing the situation within their scope of practice. When these complications occur women still require the vital relational role that the midwife offers and where appropriate may continue to be the co-coordinator of care. With increasing demand, complexity and pressures on the medical workforce, it is reasonable to expect that in the future midwives will become more responsible for managing risk, minor morbidities and some complications of pregnancy, such as urinary tract infections, previous caesarean section and pregnancy

²⁰ Barrie S (2004), A research based approach to generic graduate attributes policy. Higher Education Research and Development. 23(3): 261–75

²¹ Phelan S (2010), Pregnancy: a 'teachable moment' for weight control and obesity prevention. American Journal of Obstetrics and Gynaecology. Vol. 202 Iss. 2 (2010) p. 135.e1 - 135.e8

induced hypertension (no proteinuria) without the need to refer to others. Educational programmes will have to adapt to adequately prepare midwives for this responsibility, e.g. more pharmacology and pathophysiology.

3.3. Organisation of care

Available, accessible, acceptable, good-quality services—adequate resources, competent workforce

Continuity, services integrated across community and facilities

The Lancet (2014), p. 4

3.3.1. Innovation and entrepreneurialism

Due to changes in health and social care, future midwives will work in new ways and possibly in new roles. Midwives will need to think differently and come up with creative solutions to address future challenges. For innovation and entrepreneurialism to continue to grow there is a need for strong leadership, encouragement, and the relevant resources within the profession.

3.3.2. Digital skills

Digital technology has transformed the way we live our lives. Health care technology is expanding fast as people become increasingly interested in using digital tools to manage their health and wellbeing.

A report (2016)²² published by the Nuffield Trust states that 75% per cent of the UK population go online for health information and 50% use the internet for self-diagnosis. More than 165,000 health-related apps are on the market.

Technology has increasingly been adopted across a range of midwifery practice. Medical technology has brought numerous changes in pregnancy and childbirth and in some cases, has led to safer more effective care, but its overuse has also contributed to significant rises in unnecessary intervention. Technology is used in clinical management and health records, diagnostics and assessment in pregnancy, monitoring and pain management during labour and in birth practices. As health and social care becomes more technologised, the skills to appropriately use and develop these new ways of working will be part of the expectation for registered midwives. Opportunities to develop innovative methods of support, advice and provision of information to women using social media is set to grow (2017)²³.

There are also opportunities to consider the contribution that technology can make to developing innovative and flexible delivery models of healthcare education. These may involve technology based interactions such as telehealth.

²² The Nuffield Trust (2016), [The Digital Patient: transforming primary care?](#)

²³ McCarthy R Choucri L Ormandy P Brettell A (2017), Midwifery continuity: The use of social media. *Midwifery*. 52,34-41

3.3.3. Promoting safe and high quality care

Registered midwives will continue to act in the best interests of women, children and their families and prioritise their needs. They will embrace and lead the patient safety and continuous improvement agenda within healthcare. They need to have methodological expertise in this area, data collection, analysis and change management skills.

Managing women's expectations and feedback to improve services is key. Midwives will continue to elicit and act on feedback from women and their families of the care they have received. They need the ability to assess risks to safety and quality of care and can take appropriate action to manage risk.

Midwives are required to maintain knowledge and skills and update in these to accommodate new innovations and technology and to sustain the ability to provide evidence-based care. Registrants are expected to engage in a range of continuing professional development (CPD) activities to deliver safe, contemporary midwifery care and to maintain their registration with NMC through the triennial revalidation process.

3.4. Values

Respect, communication, community knowledge, and understanding

Care tailored to women's circumstances and needs

The Lancet (2014), p. 4

Midwives will ensure that those receiving care are treated with dignity, respect and compassion. They will promote collaboration and treat women as active and equal partners. Care will be centred on the woman and her family, and women should be offered choice and unbiased information. Midwives will recognise and respect cultural difference and diversity, acting in ways that embeds equality, diversity and inclusion throughout midwifery practice.

3.4.1. Women and family centred care

Midwives will continue to offer holistic care for mothers and babies during pregnancy, birth and beyond within their scope of practice. This care will increasingly be provided by multi-professional teams, working across settings. Midwives will be required to have a good knowledge of local health and social care needs; they will have a role in identifying families at risk and will be able to respond proactively to the needs of pregnant women and their family across the whole maternity pathway.

Student midwives will need to be prepared to become advocates to promote and improve the health and social wellbeing of women, children and families. In practice, midwives will need to have a strong and influential professional identity, ensuring that midwifery contributes effectively to strategy and policy at domestic and international level. This will require them to embrace change and future professional challenges, take leadership responsibility, act as ambassadors for the profession, and influence regulatory, political, societal and organisational change.

Student midwives must be given opportunities to get involved in the care of women along the continuum of maternity care through a diverse range of case-holding placements. The placements enable student midwives to gain experience of the provision of holistic integrated midwifery care with real midwifery scenarios that they would encounter as a registered midwife. This would also support policy recommendations for continuity of care(r) supported by midwives.

3.4.2. Leading and coordinating midwifery care

Midwives are autonomous practitioners able to lead and coordinate midwifery care, make referrals, and supply and administer some medicines. The UK CNO's report, *Midwifery 2020 (2010)*⁴, outlined two distinct roles for midwives:

- Lead professional

'The role of lead professional is to plan, provide, and review a woman's care, with her input and agreement, from initial antenatal assessment through to the end of the postnatal period. In most circumstances, a midwife would take the role of lead professional for all healthy women with straightforward pregnancies. For low-risk women, midwife-led care reduces admission to hospital and results in significantly less intervention during birth.'

- Coordinator of care

'For almost all pregnant women, the midwife coordinates her care throughout pregnancy, labour and the postnatal period. The midwife is expert in the normal, but also provides a pivotal role in coordinating the journey through pregnancy for all women, ensuring they are referred to health, voluntary and social services when appropriate and that holistic care is provided to optimise each woman's birth experience regardless of risk factor. Whilst the lead professional may change during a pregnancy, for example to the obstetrician when necessary, the coordinator of care remains the same, providing the continuity that women want.'

As the number of people with multiple conditions and vulnerabilities increases, future midwives can expect to manage and deliver more complex care across the continuum within multi-disciplinary teams across health and social care (see 3.2.4). Midwives will need to have higher level and clinical leadership skills in this type of maternity care. Midwives will need to be highly adaptable with advanced clinical leadership skills in these new models of care.

Midwives are likely to have an increasing role in managing maternity support workers, requiring appropriate delegation and supervision of tasks. They will manage and deliver care and will negotiate and problem-solve in a range of environments. The critical thinking skills and judgement required to delegate safely and effectively will become increasingly important and this will need to be reflected in standards for pre-registration midwifery education.

3.4.3. Communication and interpersonal skills

Strong communication and interpersonal skills are integral to effective midwifery care. This includes active listening skills, the use of a range of verbal and non-verbal communication methods taking account of

cultural sensitivities, language and communication needs, building rapport with maternity service users and communicating effectively with other health and social care professionals.

Midwives will require the ability to respond and adapt to changing situations, they will need confidence and judgement to act assertively and raise concerns when appropriate. Information about care is shared with women and their families and between professionals now.

3.4.4. Multi-professional team work and inter-professional education

Registered midwives will continue to work as part of the maternity care team and will often lead these. They work closely with other registered health and social care professionals such as neonatologists, GPs, obstetricians, anaesthetists, health visitors, public health practitioners, dieticians, physiotherapists, paramedics, social workers and mental health teams. They also work with the non-registered workforce such as maternity support workers and maternity care assistants. *Better Births*⁴ recommends that: 'Those who work together should train together.' Multi-professional learning should be a core part of all pre-registration training for midwives so that they understand and respect other roles, skills and perspectives. Multi-professional training should be a standard part of continuous professional development, both in routine situations and in emergencies⁴. This simulated learning needs revisiting using the current evidence base to develop this type of learning to maximise skills development that are sustainable.

Inter-professional education (IPE) should be meaningful and related to practice. For example, it should be developed within practice areas such as maternal mental health where midwives, mental health nurses, social workers, doctors and pharmacists work together in practice to support women with mental health challenges. Education can be delivered around relevant scenarios and problem – solving exercises used to illustrate key areas where disciplines need to focus to support seamless care.

There are many examples of universities currently supporting IPE. For example, student midwives train alongside operating department practitioners (ODPs) to enhance team working during obstetric emergencies. Mental health student nurses are taught alongside student midwives and in some cases, offer peer learning for them.

The School of Nursing and Midwifery and School of Medicine at Queen's University Belfast, developed and piloted an inter-professional education initiative in 2014 (2017)²⁴. The collaboration introduced concepts of normal labour and birth to fourth-year medical students, led by final-year midwifery students. An evaluation reported positive benefits of inter-professional education and subsequently both schools have committed to embed it within their curricula.

3.4.5. Recognising global midwifery practice

Working within an increasingly connected world means that future registered midwives are likely to encounter a range of global issues more frequently (such as female genital mutilation (FGM), anti-microbial resistance and the impact of migration) as well as expecting to work in other countries. Awareness of some of these trends and themes will provide an important context in which midwives

²⁴ Anderson et al (2017), Enhancing inter professional education through low fidelity simulation. *British Journal of Midwifery* 25(1) p52 - 58.

practice and support their ability to be proactive and innovative in the future. A recommendation to strengthen this would be increasing access to student electives and learning with students visiting from overseas. All midwifery programmes should recognise the global context of which midwifery is part of and how their role can help address these many challenges such as addressing health inequalities.

3.5. Philosophy

Optimising biological, psychological, social, and cultural processes; strengthening woman's capabilities

Expectant management, using interventions only when indicated

The Lancet (2014), p. 4

3.5.1. Knowledge and evidence-based practice

Safe and effective care is underpinned by a knowledge base drawn from research and evidence-based practice. Future midwives will need to have a sound understanding of research methods, and the ability to assess and apply findings from relevant studies, whether carried out by midwives, obstetricians, scientists, sociologists, psychologists or other researchers, to inform and strengthen effective midwifery practice.

Midwifery education should embed knowledge of research methods and enable students to apply research theory to practice including ethical consideration. All midwives should be able to critically appraise research to assess its quality and value and to have the confidence to understand and evaluate research studies. Education should empower students and midwives to have confidence in both critiquing research and generating new knowledge to inform and enhance practice. Midwifery education should also promote valid and sustainable pathways for midwives to pursue postgraduate research careers. Research is vital to support developments in midwifery practices and improve experiences for women. Therefore, the future of midwifery necessitates an increasing number of midwives acting as principle investigators and having clinical research careers. Midwifery pre-registration programmes need to expose midwives to research careers offering long term joint clinical academic pathways linked with practice and academic institutions.

3.6. Care providers

Practitioners who combine clinical knowledge and skills with interpersonal and cultural competence

Division of roles and responsibilities based on need, competencies, and resources

The Lancet (2014), p. 4

3.6.1. Newborn physical examination

Research published in the British Journal of Midwifery (2017)²⁵ argues that the full neonatal examination on healthy term babies should become part of all pre-registration midwifery programmes. Traditionally the full newborn infant physical examination (NIPE) has been performed by medical practitioners, however

²⁵ British Journal of Midwifery (2017), Including the newborn physical examination in the pre-registration midwifery curriculum: National survey, Volume, No. 1, p26-31

in recent years, opportunities have allowed midwives to train to become NIPE practitioners. This has enabled midwives to widen their scope of practice and enhance their role. Currently 13.7% of UK midwives are NIPE practitioners, and there is wide variability in the number of examinations they undertake. Putting the NIPE into the pre-registration curriculum would increase the number of midwives able to perform the NIPE, help reduce workload pressures on the current workforce, and provide continuity of carer for women and babies. It would also embed the NIPE as part of standard midwifery practice, avoiding it being seen as an 'enhanced' role. Careful consideration would have to be given to how the existing workforce could be prepared to support students developing these skills in practice and how this could be fitted into an already full curriculum, but there are already examples of this being done successfully in the UK.

3.6.2. Postnatal care

Postnatal care for mothers and their babies is an important aspect of continued maternal care. It is a time when women can experience major psychological and social change. Midwives and maternity support workers will continue to deliver community based postnatal care providing advice and support on breastfeeding, mothers' emotional wellbeing, and the management of health issues in women and their babies after birth.

The National Maternity Review (2016)⁴ clearly advocates for better postnatal and perinatal mental health care as there has been a historic underfunding and provision in these two areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family. Postnatal care must be resourced appropriately with women having access to their midwife (and where appropriate, obstetrician) as they require following the birth of their baby. Those requiring longer care from the midwife should do so with follow-up in designated clinics.

Continuity of care supported by the midwife in the postnatal period would help to sustain breast feeding and more timely detection of any changes in the mother's mental health. The midwife will also be involved in the transfer of ongoing care to health visitors and other health and social care professionals, typically around 10 days after birth. However, for women who remain healthy during the weeks following birth, the future midwife should have the knowledge and skills to undertake care up until and including the 6-week postnatal physiological examination that include contraceptive advice.

Midwives will need to have a flexible approach to provide this, working across various settings and providing care to women with a variety of needs.

4. The wider system and education framework

4.1. Duration and design of programmes

- Programme length

The direct entry midwifery pre-registration degree programme is currently a minimum of three years. The new standards can be expected to 'raise the bar' of practice in the future and more elements (e.g. prescribing theory) are likely to be brought into pre-registration education. In the future, programmes may need to be longer to accommodate this and the level of theory and practice needed to adequately prepare midwives for future practice. The decision on programme duration would of course need to consider several factors including the political landscape of higher education funding, the impact of the UK's withdrawal from the European Union on programme hours, and workforce and placement capacity across the UK.

Currently the midwifery pre-registration shortened programme is 3000 hours, which is approximately 85 weeks. This programme length may need to be realigned in order to consider the elements of adult nursing that are transferable whilst ensuring that the components of the long programme which prepare a midwife for her future role are fully addressed, therefore two years may be more realistic.

- Practice hours

Greater flexibility in the allocation of programme hours is required. The current prescribed programme requirements are defined within the Mutual Recognition of Professional Qualifications 2005/36/EC (MRPQ Directive)²⁶. This directive requires the training of midwives to comprise of at least 4600 hours in theoretical and practical training with at least a third of time in clinical training. The NMC requirements are for 50 percent theory (2300 hours) and 50 percent practice hours. Although the full implications of the UK's withdrawal from the EU are yet to be understood, there is an opportunity to consider whether the UK should remain within the directive and the relative risks and opportunities of opting out of its provisions.

We believe the required 100% achievement of the 2300 clinical hours for student midwives in practice should be removed. The requirement is arbitrary, it prioritises clinical practice over theoretical knowledge. This would create more opportunity for a focus on competence compared to hours and allow more flexibly delivered programmes.

- Inter-professional learning

Student midwives should be encouraged to learn with other healthcare professionals to understand their roles and working practices. Inter-professional learning should be a mandatory, evidence based component of educational programmes at pre-registration level, particularly in areas where multi-professional working is essential e.g. mental health and complications during birth and pregnancy.

- Grading of clinical practice

²⁶ The recognition of professional qualifications laid down in Directive 2005/36/EC enables the free movement of professionals such as nurses and midwives within the EU

Grading of practice is a current NMC requirement for midwifery education programmes. Assessment of practice must be graded and signed off by a sign-off mentor. The grades achieved contribute to the outcomes of the final academic award. The midwifery sign-off mentor is an experienced clinician who has undertaken additional academic preparation. As research has shown^{27,28} there is widespread variation in the application of current NMC pre-registration midwifery education standards which has led to challenges in achieving consistency of grading practice in pre-registration midwifery programmes.

There is a need to revisit the rationale for grading of practice informed by the evidence base. The development of new pre-registration midwifery standards is an opportunity to address some of these challenges. To support this the CoDH would welcome a national midwifery practice assessment tool.

- Programme elements

The new standards should be competency based and outcomes focused and equip newly qualified midwives with the knowledge, skills and professional behaviours they need when they join the register. Programmes will be developed in consultation with local service providers, service users, students and others who are key partners in the future education of midwives.

We suggest that education and training for the new-born physical examination should be included in the new standards as this would enable all midwives across the UK to carry out screening tests on healthy full-term babies shortly after they are born. We also believe peri-natal mental health should be key areas of focus in the new standards.

The new standards should re-consider the requirement for student midwives to complete a set number of birth and practice skills. Instead, they should support a competence based, outcomes approach.

To prepare the future midwife for lifelong learning and the various career pathways of the profession, the standards should also reflect students developing core skills in facilitating the learning of others, leadership, management and research with placements being arranged for them to work alongside university academics, leaders and managers and researchers as role models.

4.2. Accreditation of prior learning (APEL)

There is currently no accreditation for prior learning in midwifery (APEL) for the long pre-registration programme in midwifery and candidates are required to have completed 12 years of secondary education. The shortened programme permits admission with advanced standing for those who are registered as an adult nurse.

The application for APEL from those wanting to access the long programme are expected to increase within the context of higher education funding changes and student demographics. It is recognised that many potential student midwives have significant learning from previous education, work or life experience. To ensure the midwifery profession remains accessible to applicants from a wide range of

²⁷ Fisher M, Bower H, Chenery-Morris S et al (2017), A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom, *Nurse Education in Practice*, 24 (2017) pp 99-105

²⁸ Fisher M, Way S, Chenery-Morris S et al (2017), Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom, *Nurse Education in Practice*, 23 (2017) pp 54-

backgrounds we would support a review of APEL to enable potential students to APEL onto the long pre-registration midwifery programme.

4.3. Prescribing

The review of the standards is an important opportunity to discuss the future of midwifery prescribing, and the skills and exposure to prescribing practice within pre-registration midwifery education. At present, midwives can supply and administer medicines in the course of their professional midwifery practice under Medicines Act exemptions. Medicines not included in the midwives' exemptions list require a prescription from an authorised prescriber. Student midwives may administer medicines listed on the midwives' exemptions list, excluding controlled drugs, under the direct supervision of a registered midwife. Exemptions are different from prescribing. Midwives can only prescribe if they have successfully completed an accredited prescribing course. Midwifery prescribing has enabled midwives to extend their scope of practice which has benefited women by enhancing continuity and access to timely and appropriate health care.

There is potential to extend midwifery prescribing further, making it an integral part of the role and pre-registration programmes, as has been effectively introduced in other countries such as in New Zealand. The development of the new UK wide midwifery education standards should consider whether to include prescribing, the skills (including pharmacology knowledge, ability to do calculations, safe drug administration) and exposure to prescribing practice within pre-registration midwifery education. On registration, newly qualified midwives should have the theoretical underpinning to prescribe within the midwifery scope of practice but would need to undertake additional training to become practicing independent prescribers. The new standards are an opportunity to consider whether midwives should be prescribers and whether they should be prescribers earlier in their career. The introduction of prescribing into pre-registration would require workforce developments to ensure educators and mentors have the required skills to teach and champion safe and effective prescribing.

4.4. Simulation and clinical skills

Midwifery education programmes must continue to have a variety of learning and teaching strategies. Practice learning must involve direct contact with women and babies, across a range of settings throughout the programme. The use of simulation to support the acquisition of clinical skills is an important component of learning and teaching strategies. AEs want to see greater flexibility in the number of hours that will count in the new standards. However, simulation must not replace clinical placements and its use should be spread across the programme duration. The quality and precision of simulation hours should be part of the approval and monitoring on approved education programmes.

4.5. Practice education

With students spending much of their midwifery pre-registration degree in a practice learning environment, the transformation of practice education lies at the heart of delivering any future vision for pre-registration midwifery education. Practice must work collaboratively with AEs to provide optimal support that is consistent, fair, and prepares students for practice as a midwife. Practice support is essential to minimise attrition. Practice education has a powerful influence on the formation of professional identity, on the future career choices of newly qualified midwives and on the attitudes and expectations that they carry into their practice as registered midwives.

The challenges for the delivery of effective practice learning are deep, and constitute one of the greatest threats to the successful delivery of any new standards. These challenges include:

- Resources: funding, the lack of value placed on education/mentorship of qualified staff;
- Variability of placements and lack of placement capacity in some important settings;
- Focus on 'input' measures and the hours in practice rather than learning in practice.

Any changes to the standards must therefore be looked at in the round with improving practice learning, reflection on mentorship and the role of those who supervise practice education, and work on the range and quality of practice placements available.

4.6. Learning and assessment

The NMC has proposed new requirements for learning and assessment which would have implications for the future of midwifery education. If the proposals are accepted, support and supervision will be separated from the assessment of midwifery students. New practice assessor and practice supervisor roles would be developed. The current Standards to support learning and assessment in practice²⁹ (SLAiP) would most likely be withdrawn.

Learning and assessment in clinical placement is a key competent to the development of student midwives. The MINT Project¹⁰ concluded that midwife teachers should be involved in the preparation, ongoing support and quality monitoring of mentors and that tripartite meetings between the mentor, student and midwife teacher were valued and important in ensuring consistency in the assessment and progression of students.

Protected time for preparing and updating mentors, as well as undertaking student assessments, is vital for midwifery education. Clear expectations and support mechanisms for midwifery mentorship need to be developed between placement partners and AEs. These should be articulated in the standards of proficiency as an understanding of the principles for effective mentorship should be an outcome of the final year of the pre-registration programme for midwives, which would then lead into the post-qualification preceptorship period.

4.7. End point assessment

There is uncertainty about the future QA model. AEs are unclear what mechanism the NMC will apply to ensure future education programmes continue to meet its standards and that risks are managed effectively.

The NMC is actively considering a common assessment for entry onto the NMC register for nurses and midwives. If the NMC continues to approve midwifery education programmes in the future, any decision to introduce a common assessment would need to be based on careful assessment of the advantages

²⁹ NMC (2008), [Standards to support learning and assessment in practice](#)

and disadvantages of such assessment. One risk would be the additional burdens and costs for students, and delayed entry to the register.

4.8. Preceptorship and point of registration

As educators, we support preceptorship for nurses and midwives. This is particularly relevant if the pre-registration programme remains three years long. Preceptorship offers newly qualified midwives the opportunity to gain confidence, to consolidate their learning and to become familiar with their new responsibilities. We would like to see a formal preceptorship/internship/foundation year which is compulsory for all newly qualified midwives. To make this a reality, AEs and employers need to work closely and we would want involvement with the NMC and RCM. Preceptorship needs to be clearly defined, designed, monitored and resourced.

There is a connection between a formal preceptorship year and the point at which a newly qualified midwife is entered onto the NMC register. There is scope to consider whether the point of registration should remain the same (currently on successful completion of a degree programme) or if it should be different in the future. Options that should be considered include moving the point of registration to completion of preceptorship or giving new midwives provisional registration during preceptorship leading onto full registration at the end of preceptorship. Full consideration would need to be given to the full implications of a change to the point of registration.

4.9. Lead Midwife for Education

There is need for strong leadership in midwifery education. Currently the lead midwife for education (LME) supports the development, delivery and management of midwifery education programmes. The role and functions of LMEs is set out in the NMC's Standards for pre-registration midwifery education (2009) and Education & Registration Rules (2009). The role is a current requirement for approval of education programmes.

The role should be reviewed to ensure it is required and if so remains fit for purpose and is future proofed. Due consideration must be given how to meet some of the existing challenges of the role such as lack of role consistency and demonstrating added value though a reliable evidence base^{30 31}.

³⁰ Marshall JE and Furber C (2017), Who will educate and prepare the midwives of the future? The crisis in midwifery education in the United Kingdom, MIDIRS Midwifery Digest (September) 27;3, pp TBC IN PRESS

³¹ Marshall JE (2015), The power of the lead midwife for education (LME); the role, function and challenges, MIDIRS Midwifery Digest, 25 (1) pp 11-14

5. Next steps

The CoDH welcomes the NMC review of the standards, as a timely and relevant piece of work. We would like to see an outcomes focused set of standards and approach to their implementation and delivery.

As the single voice of the UK education faculties for midwifery, the CoDH is a key stakeholder in the process of developing new standards. The NMC's programme of change for education is ambitious and our role as the CoDH is to always consider implications for implementation and to be a critical and constructive partner to the NMC. Employers, other health and social care professions, service users and students also have a key role to play in the standards development and implementation.

Post-registration and CPD are key considerations to the NMC's work. The NMC, AEs and others will want to ensure that the new standards can be supported by the right resources including up-skilled education and practice leaders. As a Council, we are keen to support a NMC led review of future post-registration education for midwives and nurses.