



**Title. A discussion paper: Do national maternity policy reviews take account of the education and training of the future midwifery workforce? An example from England**

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## Background

The provision of maternity care has received considerable global attention in recent months, not least related to the Lancet series (Maternal and Child Nutrition 2013, Midwifery 2014, Maternal Health 2016), and a priority within the United Nations (UN) Sustainable Development Health and population stream (<http://www.un.org/sustainabledevelopment/health/>). In the United Kingdom (UK) there have been country focussed reviews of maternity service. In Northern Ireland (The Regulation and Quality Improvement Authority 2017), their review is focused on ensuring quality, safety and evidenced-based practice; in Scotland (Scottish Gov 2017) the aim is to ensure every mother and baby gets the best possible care from the health service and Wales is embarking on their review having not been refreshed since 2012. England has recently published the outcome of their review with the vision for maternity services to become safer, more personalized, kinder, professional and more family friendly (National Maternity review 2016).

The World Health Organisation and International Confederation of Midwives set the global standards for the training and education of student midwives (WHO 2009, WHO 2013; ICM 2013) with a view that these will be adopted and embedded at a national and, or regional level. It is evident that there is a difference of interpretation of these standards across different countries (Luyben et al 2017). Education standards are usually set by the competent authority or professional body. However a balance is needed in enabling the local workforce to meet the needs of a local population versus a set of national standards that provide the skills and competence for a newly qualified midwife to work anywhere within the applicable country or further afield.

Common to all curricula is that student midwives spend a proportion of their programme in clinical practice. In this environment, clinical practitioners who may or may not have an academic background, such as a mentor or clinical supervisor, are influential in student learning. The pre-registration midwifery

curriculum has often been the driver of change. However, current theory and evidence-based care is not always experienced by students in the clinical setting. Reconciling the theory practice gap is often laid at the door of the educational institution where students recount that what they are taught in the classroom is not necessarily the reality of the clinical work they 'see and do'. This view may need to change with the clinical environment assuming more responsibility in incorporating evidence quickly into everyday practice. One way of effecting this change is to ensure a good working relationship between the education provider and colleagues working in clinical practice. In the UK the last time any substantive update to the pre-registration midwifery standards took place was in 2009 (NMC 2009). Amongst other changes, the revised standards raised the academic attainment to degree level as well as emphasising continuity, choice and control within the philosophy of education ensuring woman- and family-centred care was embraced. However, as seen above maternity policy reviews have taken place since this date across the four countries of the UK, without the comparable update in national standards.

#### CASE EXAMPLE: Better Births Review

The national maternity services review for England, commonly known as *Better Births*, (2016) highlighted several areas to be addressed with a timescale that ranges from now until 2020. The current students on midwifery pre-registration degree programmes in England will be qualified midwives by 2020, which indicates an urgent need to review the content of current programmes to ensure the key benchmarks are met through education. This is a factor applicable to programmes internationally where education of the future workforce needs to keep step with any new government health policy that is implemented. It should therefore be ensured that when standards are set they will be flexible enough to meet the changing needs of the population midwives work with as well as policy updates as and when they happen. This paper explores some of the key actions of the review in England to highlight potential

implications for education of student midwives and raises questions for discussion as an example to other educators globally as they face similar situations.

### **Personalised care (Section1 of the review)**

The first part of the review identifies that women should have a personalised plan of care that will be addressed throughout pregnancy and be a tool that can be updated as and when is necessary with the aim to ensure women receive the most appropriate care for their needs. Often in the UK care planning is limited in midwifery and relates particularly to those with more complex needs (e.g. NICE 2013). Women may be allocated to a maternity pathway that is deemed 'low' or 'high' risk and will then stay on this pathway with limited review to incorporate changes in her pregnancy. This has the potential to limit movement between pathways.. Women may create their own 'birth plan' in early pregnancy (Whitford et al 2014) or later in the pregnancy that may not be referred to again by the midwife (and then reluctantly) until labour.

### **Implications for education**

Personalised care planning is not a new concept and has often been referred to as woman centred care. Students may be well rehearsed in the theoretical underpinning of personalised care but may not often see its application in practice alongside the reviewing, updating and adaptation of plans according to need. Research identifies that clinical staff do not always support women to write or use plans they have created or recognise their preferences (Whitford et al 2014). A recent study also highlights that women have concerns about making formal 'plans' for birth and that any planning tool should not be formulaic or standardised but truly personalised and individual (Divall et al 2017).

Crucial to the implementation of personalised care is the understanding of true informed choice which is raised in points 1:2 and 1:3 of the review (2016). It highlights the need to ensure women are able to make personal decisions around their care, but there has been much ambiguity about what informed

choice is. For example, whether it is based on narrow or defined choices that only the maternity services want to offer or true choice (Walker 2005), place of birth being a case in point.

Students will need to learn skills across theory and practice around facilitation that includes listening and counselling appropriately as well as empowerment of the women in their care. These are often regarded as 'soft skills' which may be lost in the academic requirements of education institutions (McIntosh et al 2013). Students will mainly learn communication skills in practice, and this is positive if the midwives demonstrate 'best practice' (Hughes & Fraser 2011) and the students then mirror these practices in the future. It is of more concern if what they see and hear does not match the expectations of the review.

In order to meet the expectations of provision of true choice, students need to increasingly be able to understand the reading and application of evidence to practice. This is already a requirement of midwifery curricula (NMC 2009:7). The enabling of informed decision making however also requires a depth of understanding of ethical principles of consent, personal choice and human rights (Schiller 2016). This will also need to be underpinned by reference to the law and how this impacts on women's needs and responses. In clinical practice students will need to be able to facilitate the woman to make choices in an unbiased way (Houghton et al 2008). It is recognised that students and midwives may carry 'biased' views due to previous experience. Therefore maintaining a culture of reflection on self and one's practice should be encouraged and supported widely, to enable students to recognise where bias is present and in order to meet the needs of individual women in their care. Modelling of such reflection should be demonstrated within the culture of midwifery practice, with midwives given increasing opportunity to explore practice situations alongside students.

#### **Digital care planning (section 1.2 and 5.3 of the review)**

The *Better Births* review highlights the use of digital care planning tools and a culture of electronic records as important. The aim is for women to have continuous access to their health records and the latest relevant evidence and information. A national electronic record for maternity care in England has been discussed and planned for some considerable time and this review may now make it a reality. Scotland has set an example of being the first UK country to have a National hand-held record (available from [http://www.healthcareimprovementscotland.org/our\\_work/reproductive\\_maternal\\_child/woman\\_held\\_maternity\\_record/swhmr\\_maternity\\_record.aspx](http://www.healthcareimprovementscotland.org/our_work/reproductive_maternal_child/woman_held_maternity_record/swhmr_maternity_record.aspx)). In contrast, across England around 60% of maternity trusts use the records created by the Perinatal Institute (available from <http://www.preg.info/>) who have now created an app. It is yet to be seen when this becomes a reality nationwide.

#### **Implications for education:**

It is already expected that students will learn the importance of record keeping but ensuring this is within a digital culture should be addressed within programmes early on. Being able to understand and reflect on concepts of the law that underpin digital data collection that includes confidentiality will be a requirement. A particular barrier to supporting students with this type of learning in the UK is the lack of access universities have to the digital media that the NHS uses. In many areas universities and other academic learning environments are at the forefront of developing digital media and current health services are often behind, which also provides complications when educating students. More collaboration with resources would help to ensure that learning matches the reality in practice.

#### **Understanding of choice and the personal maternity care budget (section 1.3 of the review ).**

Currently funding in the NHS is available for women to choose different providers for antenatal, labour and postnatal care. In recent years funding for services has been devolved from central government to

local organisations, still accountable to government, but are given the freedom to commission various types of maternity care to meet the needs of the local population. *Better Births* has moved this one step further by stating that women should have a NHS Personalised Maternity Care Budget to enable them to be in control and exercise their own choices of where they attend for care. It has been highlighted that this will require wide organisational and cultural change (Glendinning et al 2013). It is yet to be seen whether the reality of the care budget proposed will remain in the services or how much choice and control women will be given over the spending on their needs. The context behind the review relates to current situations where women wish to have particular forms of care yet NHS services are unable to provide it. For example, in the area of home birth, where this was not available locally, women could opt to fund independent providers of continuity of care services instead.

#### **Implications for education:**

Students will require increased understanding of the principles of a personal maternity care budget and the role of a midwife in this provision. As this is a new concept in England which was be piloted in 2017, it is difficult to know how and when this will become an integral part of the student learning. The principles of a personalised budget are not difficult to teach as this is an aspect of maternity services in New Zealand, but the necessary experiential learning to underpin cultural change can only happen from and with others in practice as they learn together. It is therefore important for practice and education to work together and learn from each other during this time of implementation.

#### **Discussion**

The purpose in writing this paper was to illustrate that, when changes are made to national policy regarding maternity services and care, those who educate students need to be responsive to the requirements and collaborate with practice, in order to prepare students to enter the workforce as competent and confident practitioners. We recognise we have not provided pointers to designing



curricula, but to demonstrate that any wide reaching change to service, needs to be inclusive of the workforce of the future. This includes developing students and also those supporting them in practice. As indicated earlier in the paper, students may experience a mismatch between the theory and clinical experience (Lake & McInnes 2012) and it is vital to bridge this divide in order to ensure change is effective.

In the UK the review of the NMC standards of midwifery education is currently underway (NMC 2018) with the aim to future-proof the standards to meet the prospective demands on midwives in practice. Increasing complexity in the health and wellbeing of childbearing women and advances in technology have occurred since the previous standards were published and therefore are not necessarily reflected in the current education standards. The opportunity to adapt to change may have been limited. We have highlighted the importance of any national midwifery education standards to be flexible enough to address the rapid changing maternity and global environment. There is evidence that some creative curriculum development processes, such as including all stakeholders from an early stage, enables a more responsive programme (Sidebotham et al 2017).

On a global stage different political policies will impact maternity education locally. In order to provide a more consistent framework and equity in midwifery standards that all follow, it could be argued that the focus of education should move toward the Lancet and ICM standards recommendations globally (Luyben et al 2017). In turn the global standards should influence local education policy with support from education providers. Until this is implemented, the theory practice gap will remain and student midwives will be entering the workforce lacking in preparation for the role.

## **Conclusion**

In conclusion it is important that any authority responsible for setting national or local midwifery education standards ensures they are set at a level of principle so they have a shelf life that facilitates

the rapidly changing needs of the workforce. In addition, midwifery educators and those who support students in practice need to be in an environment where they can effectively work together. This, in turn, will enable midwifery students to learn within a contemporary curriculum, with the aim of what they learnt, being seen in practice.

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