MIDWIVES IN TEACHING – THE MINT PROJECT

EXECUTIVE SUMMARY

Background

The Nursing and Midwifery Council (NMC) commissioned the MINT project in order to evaluate midwifery education. In particular the study was required to investigate the contribution and impact of midwife teachers on care provided by students and newly qualified midwives to mothers and babies.

A resourcing requirement for Approved Education Institutions (AEIs) that there should be one midwife teacher for every ten midwifery students (1:10 SSR) was established by the English National Board (ENB) almost 20 years ago. There has been little evidence that this ratio has a direct influence on quality education and the ability of students and newly qualified midwives to provide quality care. However many Lead Midwives for Education (LMEs) believed a SSR of 1:10 helped them retain a sufficient midwife teacher resource when they were a small profession in very large universities. The study was therefore needed to inform the NMC's forthcoming review of pre-registration midwifery education standards.

The overarching aim of the project was to evaluate ***whether midwife teachers bring a unique contribution particularly in the context of outcomes for women and their families.***

Project objectives, design and management

The project was carried out by the University of Nottingham in collaboration with four other universities: Glamorgan (Wales), Kingston/St Georges (London), Plymouth (south-west England), Robert Gordon (north-east Scotland); and support from Queen's University (Northern Ireland). The fieldwork took place between spring 2009 and autumn 2010. Project objectives were to:

1. Identify the various models for delivery of pre-registration midwifery education in the UK.
2. Gather information about the specific contributions made by midwife teachers.
3. Evaluate whether these variables affect the quality of care that qualified midwives can provide to mothers and their babies.

4. Determine the value brought by midwife teachers regardless of the model of education provision.
5. Develop quality indicators to demonstrate the value brought by midwife teachers.

The study was designed in three phases:

Phase one was a survey approach with on-line questionnaires to all UK LMEs, midwife teachers and each region's Local Supervising Authority Midwifery Officers (LSAMOs).
Phase two was a case study design in six universities and the participants included LMEs, programme managers, midwife teachers and senior students from the three year and shortened programmes. .
Phase three was a prospective diary study where newly qualified midwives recorded their experiences and the influence of their student programme on their effectiveness as midwives.

Findings

The report presents the project findings in six sections as follows:

Main report - a synthesis of findings from all phases and all project participants and conclusions.
Annex One – An annotated bibliography of the context literature
Annex Two – Lead Midwives for Education and Programme Leads
Annex Three – Midwife Teachers to Pre-registration Midwifery Programmes
Annex Four – Senior Student Midwives (three year and shortened)
Annex Five – Newly Qualified Midwives, Preceptors and Supervisors of Midwives.

Conclusions

Pre-registration programmes produce newly qualified midwives who are fit for practice. There were no differences between the competence of those exiting from three year and from shortened programmes.

The synthesis of the findings indicates that the student and newly qualified midwife participants valued the roles of midwife teachers, especially where they taught most of the curriculum, facilitated the application of knowledge to midwifery practice, provided good personal tutor support and were visible and credible in practice. This was especially important to support mentors as well as

students through tripartite discussions and to ensure equity and reliability of support and assessment.

The models of curriculum delivery most valued included: small group interprofessional learning that were scenario or problem based; simulation exercises to develop dexterity, speed and confidence in a range of skills and emergency situations; caring for a few women throughout the childbearing continuum (caseload holding) and having a variety of practice placements to include normality and complexity and different ways of working.

Teachers reported that they had a very heavy university based teaching load and this often detracted from the amount of time they could spend supporting practice learning. Time for personal development, scholarship and research was also limited and some teachers spent much of their own time compensating for those activities they could not cover in their contracted hours.

The findings also indicate that newly qualified midwives are perceived to be competent in delivering care to mothers and their babies in normal pregnancy and childbirth and to able to respond safely in determining priorities when women and babies have complex needs. The newly qualified midwives particularly valued the role of the midwife teacher in supporting them to acquire the skills to deal with a variety of common situations, and in helping them to become self-sufficient in knowledge acquisition through training in the techniques for evidence based practice and research evaluation.

It was clear that the transition to qualified professional was a particularly challenging period, the newly qualified midwives sometimes lacked confidence in their abilities. They needed to mentally rehearse skills and decisions, they were sometimes not as fast as they felt that they should be in pressurised situations. Having sympathetic support from senior colleagues was important in helping them to maintain their confidence in these circumstances.

Not all aspects of midwifery education that were particularly valued by newly qualified midwives were evident in all AEIs, but where they occurred they included having midwife teachers who kept their teaching real by being up to date and visible in practice, having a range of learning experiences in different maternity services or acute hospitals, acquiring skills in a controlled or simulation environment and being allowed to become more autonomous during the final months of their programme by mentors who ‘let go’ to enable them to learn the whole role of the midwife.

Implications and recommendations

The results draw attention to some key aspects of the midwife teacher's role that are highly valued. However, it is apparent that the role is complex with many demands, and that to be able to fulfil these, sometimes competing demands, requires teamwork and some specialisation within the teams. These demands include being credible in practice, maintaining scholarship and research, supporting personal students and being involved in curriculum design and most of its delivery. Criteria to assess a sufficient critical mass in the midwife teaching resource to meet these complex demands cannot be reduced to a fixed SSR for each provider of midwifery education. Those with an apparently good SSR might need an even better ratio if the provider is small and individual teachers attempt to teach the whole curriculum or have a large number of or geographically distant practice sites. Small numbers of midwife teachers in a university are not able to cover the complexity of the midwife teacher role, sustain academic and clinical credibility and enable the development of midwifery research.

It is therefore recommended that each provider of undergraduate pre-registration midwifery education has a critical mass of midwife teachers. Only then will the team as a whole be able to undertake the midwife teacher's core role and then differentiate roles between them to ensure that corporately they advance midwifery as well as being effective educators.

Instead of the NMC setting a SSR for each provider of pre-registration midwifery programmes a set of quality indictors is therefore proposed in chapter four of the main report.

The criteria for critical mass that could be applied to midwife teaching teams should focus on an AEI having a robust resource allocation model that can be shown to support clinical and academic credibility for staff; teachers being visible and immersed in practice (including tripartite monitoring of practice assessment); students able to practise and receive feedback on core skills in a controlled or simulation environment; an effective personal tutor support scheme; and a core of research active staff.

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July 2011