Nursing & Midwifery Council

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Midwives in Teaching

THE MINT PROJECT

Annex 5.1
Annotated Bibliography of Context Literature

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INTRODUCTION

This is a literature review, in the form of an annotated bibliography for the MINT (Midwives in Teaching) Project. The MINT project is an evaluation of the contribution that midwife teachers bring to midwifery, particularly in the context of outcomes for women and their families. The project is led by the University of Nottingham, and is being carried out in collaboration with four other universities in the United Kingdom. The project is funded by the Nursing and Midwifery Council. The purpose of this document is to provide a synopsis of the current context in which midwife teachers are operating. Primarily, policy documents are reviewed, and some peer-reviewed literature has also been included.

The design of this review is the result of a joint effort by the members of the MINT Project team. The team initially decided that the review would consist primarily of grey literature. This decision was made as a strong policy focus was wanted for the background of the project, and also to limit the amount of literature that was reviewed. The team consists of midwife, nurse and social science academics, and midwife educators and managers. Members of the University of Nottingham team, and the university collaborative site leads contributed recommendations of what to include in the review. There was considerable overlap in the recommendations from various team members, thereby validating inclusion. However, it must be noted that this review is not exhaustive and cannot be classified as 'systematic'. After the last ten years of grey literature was reviewed, it was decided that some peer-reviewed articles and relevant but older reports should be included. Keywords for searching were suggested by team members. The resulting search terms are below:

Search Terms

1.(MM'Education,Midwifery')or(MM'Education,NurseMidwifery')AND(AB'midwif*teach*') or (TI 'midwif* teach*')

2. (MM 'Education, Midwifery') or (MM 'Education, Nurse Midwifery') AND (MH 'Teachers') or (MH 'Faculty-Student Relations') or (MH 'Faculty Role') or (MM 'Mentorship') or (MM 'Clinical Supervision')

As it was out of the scope and time frame of this review to be exhaustive, two databases (CINHAL and MEDLINE) were searched using the terms above. The results were limited to publications within the last ten years, as midwifery education has changed significantly in recent history, and literature relating to the current practice is relevant to the purposes of the MINT project. Abstracts and titles of the search results were reviewed for inclusion based on relevancy to the objectives of the MINT project. This review is in the form of an annotated bibliography. Grey literature will be listed first, by year of publication, starting from the most recent. Then, peer-reviewed articles will be listed in alphabetical order. The last section of this document is a list of suggested further sources of information, from the documents included in this review.

0.1 GREY LITERATURE

0.1.1 Midwifery 2020 UK Programme (2010). *Midwifery 2020: Delivering expectations.* Edinburgh, Midwifery 2020 Programme.

Reviewed by: Professor Diane Fraser

Overview

This report, launched in September 2010 and available with supporting reports on www.midwifery2020.org., is the outcome of a unique UK-wide collaboration commissioned by the four Chief Nursing Officers. The focus was on how midwives and midwifery can make the greatest contributions to the health of women and their families in the next decade and beyond. The aim of the programme was to identify and consolidate the achievements midwives have already made and to identify future changes needed. The key objectives were to:

- Review the current and developing role of the midwife
- Scope and describe current and future models of midwifery service provision
- Scope current midwifery education and consider its fitness for purpose
- Identify current and future career pathways for midwives
- Maximise midwives' capacity and capability in developing and delivering research-based practice
- Scope the role of maternity support workers/maternity care assistants (MSWs/MCAs)
- Consider ways of supporting and retaining midwives

Five work stream working groups produced detailed reports to address these objectives and the key messages from these reports are presented under the following nine headings:

- Meeting women's needs
- The midwifery workforce
- Developing the midwife's role in public health

- Measuring the contribution midwives make
- Supporting midwives
- Developing a contemporary image of midwifery
- Educating midwives
- Developing midwives
- Maximising midwives' influence

Relevance

The particular relevance of this report is the challenge for midwife teachers to recruit and prepare student midwives to meet and deliver the expectations set out in Midwifery 2020. They need to ensure newly qualified midwives (NQMs) have the capability, personal qualities and competence to:

- Give women and their partners a safe, positive and life enhancing experience of childbirth and parenting (p22)
- Be the **lead professional** for women with no complications (p23)
- Be the **coordinator of care for all women** (p23)
- Be knowledgeable about health and social care needs in the local community (p26)
- Provide seamless maternity services between community and hospital settings (p26)
- Be advocates for improving health and wellbeing (p26)
- Delegate and supervise the work of MSWs/MCAs (p31)
- Work in a range of settings (p34)
- Promote and enhance the management of normal births (p34)
- Coordinate and provide care in high-risk and complex pregnancies and along the whole of the maternity pathway (p34)

To achieve the above a key message states that:

> *'There should be a sufficient critical mass of midwifery educationalists with the capacity to deliver the curricula and provide support to students in practice settings across large geographical areas' (p35)*

This also requires there to be:

- a system of CPD passports to avoid repetitive learning (p37);
- closer partnership working between HEI and service providers (p40);
- opportunities in developing research and research-based practice (p40);
- lecturing staff to maintain their clinical credibility in midwifery practice (p41)

0.1.2 Nursing & Midwifery Council. (2009) Standards of Proficiency for pre-registration midwifery education.

Reviewed by: Marion Louki

Overview

This is a newly updated publication which details the standards of education and training required for pre-registration midwifery education programmes. The guidance ensures that education programmes are designed to prepare students to practice safely and effectively, and that they can assume full responsibility and accountability upon registration.

Relevance

Much of this document comprises lengthy documentation of essential skills clusters which relate to achieving the NMC standards which are broadly split into four domains: effective midwifery practice; professional and ethical practice; developing the midwife and others; and achieving quality care through evaluation and research. Whereas a large proportion of the categories listed under these domains could be achieved by observation, and practice in real-life maternity settings alone, the overriding feel of the document is the underpinning requirement for evidence-based practice and critical reading. This is where the

unique contribution of midwife teachers is essential in the provision of these specific analytical skills. In addition, the document is explicit in the requirement that the application of theory to practice in the academic learning environment must be undertaken by a midwife teacher.

Quotes

The minimum academic level for entry to the midwives' part of the register has changed to degree level since September 2008 and the theory to practice ratio is no less than 50% practice and 40% theory.

> *'The programme must have a variety of learning and teaching strategies...the application of theory to practice in the academic learning environment must be undertaken by a midwife teacher' p.16*

> *'Student midwives should be supported in both practice and academic environments. . . there is an expectation that midwife teachers will have contemporary experience in order to support learning and assessment in both academic and practice learning' p.15*

> *'. . . and this may take a variety of forms including: Acting as a link tutor; Supporting mentor development and updating; Having a part-time clinical role; Supporting clinical staff in their professional development in practice; Being involved in practice development to support the evidence base from which students draw; or Contributing to practice based research.' P.15*

Standard 13 of the document highlights the primary focus of the pre-registration programme is to ensure safe, effective practice when supporting women in normal childbirth. Standard 15 relates to assessment which is designed to confirm that the student has theoretical knowledge as well as practical skills and attitude to achieve entry to the register. A range of assessment strategies are advised to assess these skills to include at least one unseen examination, and the guidance is specific in that both midwife teachers and mentors shall be involved in the assessment of the student's ability to enter the register.

0.1.3 Care Quality Commission Website. (http://www.cqc.org.uk/) Accessed October 2009.

Reviewed by: Dr. Tania McIntosh

Overview

This website provides information about the Care Quality Commission (CQC) which is the regulator of all health and adult social care in England. The CQC is responsible for 'Improvement of care services and ensuring meeting of common standards. Monitoring, inspection, reviews and dissemination. Enforcement powers: fines and public warnings.'

Relevance

This website may not appear to be specifically relevant to midwifery teachers/education, however the CQC conducts large scale and authoritative surveys into what women actually want from maternity services. In addition if their inspections find that the practice environment is not satisfactory then midwife educators could be assumed to have a responsibility to audit the appropriateness for student midwife placements.

0.1.4 NHS Quality Improvement Scotland (2009). Pathways for Maternity Care. Edinburgh: NHS Quality Improvement Scotland

Reviewed by: Mary Vance

Overview

The pathway for normal maternity care is a strand of the Keeping Childbirth Natural and Dynamic (KCND) programme. The programme facilitates ongoing risk assessment and ensures evidence-based care by the appropriate professional for all women accessing maternity care across Scotland. The ethos of the pathway is that pregnancy and childbirth are normal physiological processes and unnecessary intervention should be avoided. One of the key principles of the

pathway for normal maternity care is the right of pregnant women to be provided with current evidence-based information and to be involved with decisions regarding their care and that of their baby. The pathway is the first in a series of pathways for maternity care.

Relevance

This document does not have an impact in relation to the MINT project as it does not address explicitly any of the key objectives, however the document impacts the pre-registration midwifery curriculum in Scotland as it outlines the pathway for normal maternity care in Scotland. It also demonstrates the importance of student midwives being well grounded in normality and having a sound evidence-base for their learning.

0.1.5 Wales Audit Office (2009). Maternity Services. Cardiff: WAG

Reviewed by: Joy James

Overview

This is a report by the Wales Audit Office into maternity services in Wales. This work examines whether the Trusts in Wales are delivering efficient maternity services that result in positive experiences and outcomes for women and their babies. The report concludes that while maternity services are generally appropriate and women's satisfaction levels are relatively high compared with England, practices vary unacceptably and information is generally not well collected.

Relevance

This document provides information on the maternity services in Wales. The Heads of Midwifery Advisory Group (HOMAG) considered some of the information to be inaccurate as more up to date statistics were provided to the Wales Audit

Commission prior to the publication of this report. The report does not consider training, student midwives or midwife teachers and as such there is no clear relevance of this report to the study except for ensuring newly qualified midwives are equipped to provide the midwifery care women expect.

0.1.6 Department of Health, Social Services and Public Safety. (2008) Review of Skill Mix in Maternity Services in Northern Ireland (Final Report) Northern Ireland.

Reviewed by: Maggie Mallik

Overview

Background information: continuing trend of year on year increases in birth rate within Northern Ireland (NI) with special reference to impact of migrant communities with English as their second language. Also continues to be births in NI from mothers resident in the Republic of Ireland (RI).

> *'number of registered births in Northern Ireland has risen from 21,400 in 2005 to 23,300 in 2006 and subsequently 24,451 in 2007' (1.2 p3)*

In March 2007, there were 1,293 midwives (1015.68 WTE) and 102 student midwives. The age profile of midwives indicated that 50% were due for retirement within 10 years. Increasing student commissions will help in a limited way as these are also mature students. Birthrate Plus (Ball & Washbrook,1996) is used in NI for calculating future workforce needs.

The document, taking a lead from Scotland (NHS Education Scotland 2006) and the Royal College of Midwives (RCM 2006), argues for the development of the new role of Maternity Care Assistant (MCA). The NMC advocate that the standards for preparation and development of the MCA should remain under the control of the registered midwife (NMC 2008).

Literature highlights the first structured development of MCA roles from 2005 – 2006 in England in response to the NSF for Children, Young People and Maternity

Services (DoH, 2004). A survey demonstrated an ad-hoc approach to training and development in the field, i.e. there were substantial variations in title, range of activities, required entry level of training and grade. Scotland was more structured in its approach and dividing lines were established that allowed the MCAs to be involved in the assessment of women. However the interpretation, decision making and planning of care remains the responsibility of the midwife. Regardless of the roles tasks to be achieved, the main debate centres around who designs and provides the training of MCAs; the primary argument being for Midwife, ownership, control and responsibility (McKenna et al 2003). Training needs to be linked to National Occupational Standards (NOS) which have been developed for maternity and care of the newborn. In the UK to date, NVQs have not yet been developed that link to these specific NOS standards. The RCM provides a three modular (8 weeks per module) 'Fit for Purpose Programme' based around the competencies required by MCA job descriptions (RCM 2004). However, in Scotland, five areas of core competencies were identified for inclusion in training programmes for maternity care assistants to include : pregnancy, childbirth and the postnatal period; education; clinical skills; baby care and personal skills and competencies (NHS Education Scotland,2006). RGU commenced a work-based learning MCA course in April 2007. A report by Sandall (2007) and the Health Care Commission review of maternity services in England (HCC 2008) highlights the positive impact of the MCA role on services provided to mothers and babies

A mapping of the skill mix for maternity services in NI was conducted through a series of workshops between February and May 2008 before proposals for change were made.

Proposals included:

- Agreeing on a generic job description and roles for Band 2 and Band 3 support workers within acute maternity services. Band 3 posts would have additional

specific roles/competencies that reflected the specific areas of service where the MCA was employed

- Developing a new job description for support roles within community settings both at pre-natal and post natal level. The latter would focus on delivery of an enhanced service (as opposed to a 'lean' service) to provide psychological support and enhance parenting skills particularly for new parents.

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Debate continued on the lack of an NVQ framework to provide the necessary accredited competencies needed by the MCA. In Scotland, the competency framework developed by NES in 2006 is being piloted by a HEI (RGU).

Relevance

This document is not directly linked to the aims of this project. However, it highlights ongoing debates about skill mix in the delivery of quality maternity care and changes in skill mix could affect the quality of learning in practice for student midwives..
The Document provides further context to what is happening in NI around the delivery of quality maternity services. To address the rising birth rate and the concurrent foreseeable manpower shortages because of retirement of up to 50% of the midwifery workforce within the next ten years, there has been this review of how services can be provided. One solution has been increasing the number of pre- registration midwifery students year on year. There are still a substantial number of students completing a shortened pre-registration midwifery programme in an attempt to reduce this anticipated workforce deficit. Whether

shortened programme students take up posts as newly qualified midwives or whether there is more attrition than from the three year programme qualifiers might emerge during this research.

0.1.7 Healthcare Commission (2008) Towards better births: a review of maternity services in England.

http://www.cqc.org.uk/db/documents/Towards better births 200807221338.pdf

Reviewed by: Dr. Tania McIntosh

Overview

This report is a detailed analysis of results of an earlier survey (Women's experiences of maternity care). Data was in collected 2006/07 and a survey of 26,000 mothers carried out in 2007. Section 13 of the report states that women are particularly concerned about informed choices for screening; choice in labour; quality of postnatal support; and cleanliness of facilities.

Relevance

This report is focused on systems, and therefore little information about midwifery care is provided. Education is not mentioned at all, therefore this paper is only relevant to objectives of the MINT project in relation to whether newly qualified midwives have the capability to meet the future needs of childbearing women.

0.1.8 King's Fund (2008) Safe births: Everybody's business. An independent inquiry into the safety of maternity services in England.

Reviewed by: Dr. Tania McIntosh

Overview

This document reports an enquiry in 2007 to look at safety at the time of birth. The report concluded that it was everyone's business; midwives, doctors, support staff, management to ensure safety at the time of birth. It was stated that the majority of births are 'safe' but there is no universally agreed definition for safety.

Relevance

There is nothing specifically mentioned about pre-registration midwifery or teachers as all training mentioned is post-qualification. However newly qualified midwives should be 'safe' practitioners and hence whether they feel competent to provide safe care is of relevance.

0.1.9 Rosser, E and Albarran J (2008) Recruitment and retention of midwifery academics across south west England, Report for SW Strategic Health Authority. Bristol, University of West of England.

Reviewed by: Faye Doris

Overview

This is the report of a study which looked at the recruitment and retention of midwifery academics in the south west of England. This study scoped the workforce and qualifications of midwifery academics employed in HEIs in SW England. It also presented the context influencing the recruitment and retention of midwifery academics. A mixed method approach was used with email collection of biographical data related to midwifery academic staff; face to face interviews/telephone interviews with Heads of Midwifery Education and focus

group interviews with midwifery lecturers. The quantitative data was analysed using descriptive statistics and the qualitative data analysed using thematic analysis. The results were presented under the objectives of the study. They reported the demographics and discussed recruitment, retention and strategies to support increased number of students.

Relevance

This qualitative discussion from the focus group interviews covers many areas that may be relevant to this project. It certainly discusses programme delivery and indirectly contributions made by midwife teachers. There is a tendency to pursue the negative aspects of being a teacher such as workload, time for scholarship rather than the positive contributions.

0.1.10 Healthcare Commission (2007) Women's experiences of maternity care in the NHS in England

Reviewed by: Dr. Tania McIntosh Note: Healthcare Commission ceased to exist 31/03/2009. Functions and role taken over by the Care Quality Commission.

Overview

This is the first survey of maternity services by the Healthcare Commission (HCC). The survey concentrates on the views and experience of service users.

Relevance

There is nothing specifically mentioned about pre-registration midwifery education or the contribution of midwifery teachers in this document. However it is a useful survey on the views of women towards their care, which may have implications for the MINT project.

89% women rated care in labour/at birth as 'excellent', 'very good', or 'good'. Postnatally 12% women said care 'fair' and 8% 'poor. (Pg.2)

82% women said they were spoken to in labour in a way they could understand. (Pg.5)

Half of women gave birth lying down or with legs in stirrups (despite being discouraged by NICE guidelines. Ref: NICE (2007) Intrapartum care: care of healthy women and their babies during childbirth. (Pg.9)

Women were more negative about post natal services than other aspects. They reported lack of consistent advice round infant feeding (23%) and similar rates for practical support and encouragement. (Pg.9)

Majority of women saw GP before booking with midwife. 57% said choice about birth included home.(pg.11)

Two thirds of women felt they were involved in decisions antenatally and during labour.(pg.13)

Information around postnatal care and recovery felt to be less good by women. (Pg.17)

'To have confidence in staff is one of the main things that women want when giving birth' (ref for this statement is DH (2004) National Service Framework for Children, Young People and Maternity Services.) (pg.19)

68% women 'definitely' had confidence and trust in staff caring for them during labour and birth, 27% said they had 'to some extent' despite only 22% having met midwife before labour. (Pg.19)

0.1.11 Hunter B (2007) The All Wales Clinical Pathway for Normal Labour: What are the Experiences of Midwives, Doctors, Managers and Mothers? Swansea University, Swansea

Reviewed by: Joy James

Overview

This is a review of the All Wales Normal Labour Pathway. The report surveys mothers, midwives and doctors views of the use of a pathway to manage normal

labour. The pathway use, its documentation and the various relationships are explored. Recommendations are focused around practice, policy and research aspects. Overall the pathway appears to be working well, it supports midwives decision making and has reduced doctor's involvement in normal labour events. Mothers seem not to see any major change in their care, although do feel supported in labour.

Relevance - listed by MINT project objective

Identify the various models for delivery of pre-registration midwifery education in the UK This was a research report exploring the implementation of an All Wales pathway of care, as such it does not consider pre-registration midwifery education as a particular aspect.. Within the 'key implications for practice' (p4) education of pre and post registration midwives is mentioned, but only in relation to the need to develop 'clinical judgement' and 'the need for ongoing training and support for all practitioners'.

Evaluate whether these variables affect the quality of care that qualified midwives can provide to mothers and their babies The 'key implications'(p4) of this report have been divided into sections relating to practice, policy making and research. Within the practice section the need for education, preceptorship and ongoing training and support for midwives is highlighted. The report does not go further to suggest models or any particular approach that should be taken. There appears to be little relevance within this document to midwife teacher's role. The highlighting of women's views and their relationship with midwives is interesting but no link has been made to education other than emphasising the need to develop clinical judgement and provide support and ongoing training for new initiatives. The importance of preceptorship, support and training having been emphasised could be linked to pre and post registration education. There are obvious links to the quality of mentorship and ultimately the midwife teachers

role in preparing both the student midwife and midwife mentor in their role as a preceptor.

0.1.12 Department of Health. (2007) Choice Matters 2007-2008: Putting Patients in Control. DH Publications.

Reviewed by: Maggie Cooper

Overview

This publication provides an update on the implementation of patient choice in the NHS since it was introduced at the start of 2006, focusing on the experiences of patients and NHS staff.

Relevance

The document focuses on choice in terms of place for treatment and the process for enabling patients to exercise choice. There is no mention of maternity services specifically or students.

0.1.13 Department of Health. (2007) Maternity Matters Choice, Access and Continuity of Care in a Safe Service. DH Publications.

Reviewed by: Marion Louki

Overview

This document addresses the four national choice guarantees for maternity care in England as underlined by the Government in 2005. These are: choice of access to maternity care, type of antenatal care, place of birth i.e. home, midwifery led or consultant led, and place of postnatal care. The authors recognise the importance of pregnancy and birth being normal life events for most women, and that specialist care should be readily available and of the highest quality. All midwives should have skills and up to date knowledge to know who and when to refer to, and practice must be based on available evidence and clinical guidelines.

There is much emphasis on meeting the needs of whole communities and strategic direction identified at both commissioning and provider levels. The importance of clinical leadership and multidisciplinary working is recognised, as is the provision of opportunities for employment of newly qualified midwives.

Relevance

Maternity Matters highlights that successful implementation of the best possible maternity services requires full engagement of all service providers, including the NMC in setting the curriculum requirement for pre and post registration education. Whilst this document does not have a key impact in direct relation to the objectives of the MINT project, ultimately the nature of pre-registration midwifery programmes may need to be amended to include more comprehensive cover of the health inequalities issues raised.

0.1.14 Hewitt P. (2007) Trust, Assurance and Safety – The Regulations of Health Professions in the 21st Century. London. The Stationary Office.

Reviewed by: Faye Doris

Overview

This publication is the paper presented to Parliament by the Secretary of State for Health, Patricia Hewitt in 2007. It largely looks at medical education but focuses on the regulation of healthcare professions. Chapter 5 looks at education and the role of the regulatory bodies. It does not add to any of the key objectives of the MINT Project but states that:

'Excellence in education is the foundation of professional excellence in healthcare' (p69). It goes on to say that

'The educational process takes individual potential and individual sense of vocation and, through learning, practice, reflection, supervision, mentoring and

examination, builds expertise, confidence and capability and imbues students and trainees with a set of professional values and standards that are expected to meet or exceed throughout their careers' (p69)

Relevance

The link of this document to the project is minimal. It however gives an indication of what 'fitness for practice' or 'purpose' may look like at the end of a midwifery programme as seen in the quotes above.

0.1.15 Redshaw, M., Rowe, R., Hockley, C. & Brocklehurst, P.(2007) Recorded delivery: a national survey of women's experience of maternity care 2006. National Perinatal Epidemiology Unit, pp. 1-96

Reviewed by: Nicole Stephen

Overview

The aim of this review is to document the views of women with recent experiences of maternity care in England. Specifically, new information was needed to compare with a survey done of recent mothers in 1995. The review provides a point of reference on current practice, and a baseline for measuring changes that have recently been implemented. The information was gathered by surveying 4800 women in 2006 who had given birth in a particular week that year.

Relevance

Broadly, this article is relevant to the objectives of the MINT project as it provides some information about student midwives in practice. However, it does not address midwifery education. There is one instance where student midwives are mentioned, with text quotes from study participants. (Please see quotes section below). In addition, sections on communication and interaction with health

professionals, and a section of data about care from midwives may provide useful background information.

Quotes

Quotes from the source regarding the presence of student midwives or doctors during labour and birth:

> *'I had a student midwife but didn't feel comfortable with her. I wanted a qualified midwife but she came in and said she wasn't needed, I requested for her to stay but she didn't.' (Page 44)*

> *'I had a student with the midwife. This was very good as someone was with me throughout labour.' (Page 44)*

> *'I had a midwife on hand throughout my whole labour ...I also enjoyed having a lovely student midwife attend the birth - she was brilliant and I'm glad I was able to allow her to add another birth to her list!' (Page 44)*

> *'More than two-thirds of women always felt confident in the midwives they saw. However, first time mothers were less likely to say they always felt confident about their midwifery care. There was little change in this perception between 1995 and 2006.' (Page 10)*

> *'With regard to relationships with staff and communication there were differences in the way that care was perceived. Women from these groups were less likely to have felt that they were treated with respect and talked to in a way that they could understand by one or more members of staff during pregnancy, labour and birth and postnatal care.' (Page 11)*

> *'All health care is about more than the technical aspects of treatment. Good care meets the needs of people as individuals, including their needs for encouragement, information and reassurance.' (Page 12)*

> *'Among the lessons for health professionals working in maternity care and policymakers, the quantitative and qualitative responses emphasise the importance of: – listening to women as an integral part of care, particularly those in labour – remembering and learning from what women say they take away with them – treating women as individuals with kindness and respect – continuing to ask women about their views and listening to what they have to say about their care, locally and nationally.' (page 81)*

0.1.16 Welsh Assembly Government (2005)National Service Framework for Children, Young People and Maternity Services. Cardiff: WAG

Reviewed by: Joy James

Overview

This document considers the health and wellbeing of individuals in Wales from pre-conception to their eighteenth birthday covering not only primary and secondary care for the child but also considering the role of the maternity services. Six standards identified lay down key actions for named organisations in relation to child and family centred services, access to services, quality of services, health promotion and well-being, parenting and safeguarding children. This document is meant to work alongside another document in this review - 'Designed for Life' and makes reference to it.

Relevance

This document does not have direct relevance to the objectives of the MINT project except in relation to whether newly qualified midwives have been equipped to contribute to the health and wellbeing of childbearing women and their families.

0.1.17 Welsh Assembly Government (2005) Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century. Cardiff: WAG

Reviewed by: Joy James

Overview

This document continues the work recommended in the 2001 document 'Improving Health in Wales' and aims to set targets for the following 10 years that achieve a 'world class healthcare and social services' (foreword) that develops a culture of reablement utilising user groups to define changes needed. It focuses on all aspects of population health and illness prevention and is not specific to maternity services however, the document points to the NSF for Children, Young People and Maternity Services published after this paper.

Relevance

Very little is referred to in relation to education except that there will be the funding of more nurses (and within that terminology it is assumed that that includes midwives) to be educated.

0.1.18 Department of Health (2004) National Service Framework for Children, Young People and Maternity Services. Change for Children: Every Child Matters. DH Publications.

Reviewed by: Marion Louki

Overview

Standard 11 of this document provides a framework for establishing clear standards for the promotion of health for children, young people and maternity services. It promotes flexible services which are appropriate for the needs of pregnant women whilst supporting the normal physiology of birth and effective multiagency interaction.

There is specific reference to meeting the needs of vulnerable and hard to reach women and their families, such as teenagers, the homeless, asylum seekers and travelling women. Care pathways place the woman, her partner, and her child at the focus of care, and should also be tailored to needs to include conditions such as HIV, drug users and those experiencing domestic violence or mental health issues.

Relevance

Whilst this document does not have a key impact in direct relation to the objectives of the MINT project, the most relevant aspects were where the unique contribution of midwife teachers could be linked and are included in Box 3 'What Women Want' p. 27 as follows

> *To have confidence in the staff providing care; To have one-to-one care throughout labour preferably from a midwife they have met in the pregnancy; To receive personalised care and be treated with kindness, support and respect; A pleasant and safe birth environment; To receive adequate information and explanation about their choices for childbirth (p.27).*

In addition, it is stated that staffing levels and competencies should comply with Clinical Negligence Scheme for Trusts standards.

0.1.19 Welsh Assembly Government (2002) Delivering the Future in Wales: A framework for realising the potential of midwives in Wales. Briefing Paper 4. Cardiff: WAG

Reviewed by: Joy James

Overview

This is one of a series of briefing papers developed by WAG under the title of 'Realising the Potential'. The document while published by WAG was developed by the Heads of Midwifery Advisory Group (HOMAG) in Wales. This document

provides the direction to build upon for existing good practice in further developing a maternity service that meets the strategic goal of 'Realising the potential: A strategic framework for nursing, midwifery and health visiting'. The WAG strategy for nursing, midwifery and health visiting was launched in July 1999 under the title of 'Realising the potential'. There were five supporting aims: 1. Improving the environment of care 2. Ensuring high quality of service for all 3. Encouraging independent reflective practice 4. Developing existing and new career pathways 5. Demonstrating the value of midwives.

The document is developed around underpinning values of:

- women centred care
- maintaining normality
- developing the role of the midwife,
- improving quality care
- maintain standards

Relevance

There is no mention of midwife teachers. Educationalists are mentioned in relation to their involvement as an observer in the Heads of Midwifery Advisory Group (HOMAG) (p10). Newly qualified midwives are mentioned in relation to the need to ensure post-registration development of mentors (p8). This mentions the need for structured mentorship programmes that provide support and encouragement to identify their training needs. This document provides direction in relation to quality of care, standards of midwifery practice and services delivery/development. There is no substantial mention of midwifery education, midwife teachers and student midwives.

0.1.20 Department of Health, Social Services and Public Safety (2002) Developing Better Services: Modernising Hospitals and Reforming Structures. DHSSPS, Northern Ireland

Reviewed by: Maggie Mallik

Overview

This document, published post the setting up of Northern Ireland (NI) Assembly, is a review of Acute Care Services via hospitals in NI. Other complementary documents address primary and community care. The main aim is to modernise the services in a time of peace in NI. Service models need to get the balance right between providing competent specialist teams in larger acute hospital centres alongside up-to-date services being also accessible at local levels for clients.

> *'The vast majority of people will be within 45 minutes, and everyone will normally be within one hour of emergency care and consultant-led maternity services' (No 8 p9)*

At the time of the report (2002), with a population of 1.7 million in NI, 13 hospitals provided maternity services; the average number of deliveries per hospital being between 450 and 5000 per year

Changes included a proposal for nine large acute hospitals and seven local hospitals, keeping the majority of units which were already in existence; however services and administrative structures for delivery of health and social care to be reorganized. Local hospitals to provide pre and post natal care and women should be less than an hour away from a consultant led unit.

> *'Consultant maternity in-patient services will be provided on 9 sites. The development of midwife-led maternity units will be encouraged alongside consultant-led units, and 2 standalone midwife led units (one in the east and one in the west of NI) will also be piloted.' (12,p9)*

It was recognized that a significant increase in staffing would be needed over the 9 years for implementation with an average of up to 25% increase for all health

care professionals by 2010.

Relevance

The report, in its recognition of the need for modernization of services, acknowledges the contribution that students make to service and also the more stringent standards set, covering the degree of supervision, the specific nature of the work undertaken by trainees and facilities for study available, by professional standard-setting bodies (2.21 & 2.22 p17).

There is a reference to 'Managed Clinical Networks' as a new way forward in balancing the needs of service users (p21) with collaboration and movement across all sectors to provide the best possible service.

For maternity care, the proposal advocates a concentration of the services but with midwife led units as stand alongside units for low risk births. Two pilot 'stand alone ' midwife led units to be provided with good transport links to a Consultant led service.

Administrative reform proposals advocated a slimmed down infrastructure that would be more cost effective with one strategic regional health and social care authority, one consumer representative body and reduction in the number of individual Trusts.

Key changes to maternity services:

- Reduction in the number of Consultant led maternity units
- Development of midwifery led 'stand alongside' and two pilot 'stand alone' units
- Recognition of the need for an increase in professional numbers but recruitment to midwifery education programmes not specifically referred to in the report

The proposals in this document were made seven years ago so it is necessary to

find follow up documents which will give some indication of progress in making the changes recommended.

0.1.21 Scottish Executive (2002) Expert Group on Acute Maternity Services: Reference Report. Edinburgh: Scottish Executive

Reviewed by: Mary Vance

Overview

This report is a comprehensive, evidence based, reference document. It describes the background to the evolution of maternity services and service provision (in 2002), identifies the appropriate criteria for care within the different care locations, identifies the skills and competencies required by the maternity workforce, and provides the evidence to enable the provision of a comprehensive acute maternity service in Scotland. The remit of the Expert Group on Maternity Services (EGAMS) included the identification of innovative approaches to training and education for maternity professionals.

Relevance

This document does have a minor impact in relation to the MINT project as it addresses a few of the key objectives of the MINT project as shown below. While the report does not address the contribution of midwife teachers, models for delivery of pre-registration midwifery education in the UK are addressed briefly: 'There are a number of academic institutions in Scotland which provide undergraduate courses in medicine and midwifery and there are some examples of shared learning by medical and midwifery students (e.g. Dundee). Currently a limited number of institutions also provide an 18 month shortened midwifery course for registered nurses '(p.58)

The report does not evaluate whether these variables affect the quality of care that qualified mid- wives can provide to mothers and their babies. However the

report does explore the development and maintenance of skills and competencies of maternity services staff. For example:

> *'Maternity services staff should be given appropriate support, training and education to maintain the appropriate skills and competencies to ensure that appropriate care may be given within the different levels and locations of intrapartum care' (p. 8)*

> *'..., there is a paucity of evidence to identify midwives' competence in caring for at risk or ill women during the pregnancy episode and professionals within both groups highlighted the importance of all midwives being able to recognise and care for 'ill' women during their pregnancy episode. This was considered particularly important for midwives working in isolation or in remote units' (p. 58).*

> *'It is important that maternity care professionals receive the education and support required to ensure sufficient confidence in the decision-making process about providing intrapartum care and referral when appropriate...There should be multi-professional maternity courses for midwives, GPs, paramedics and other appropriate healthcare professionals, especially for those working in remote and rural areas '(p. 66).*

> *'Confidence and decision making skills will be enhanced if professionals (midwives, obstetricians, paramedics and where relevant GPs) are equipped with the necessary skills and competencies, have the professional backup and resources to support their role irrespective of demographics. The importance of a team and multi-professional approach to education, training and service provision on a local and regional basis was emphasised as being crucial...As well as providing the appropriate courses to meet professional needs, innovative ways of maintaining skills and competencies are advocated' (p.67-68)*

> *'It has been recognised that multidisciplinary teams are critical to the delivery of maternity care - the opportunities for multidisciplinary training and development need therefore to be maximised' (p.74).*

0.1.22 Scottish Executive Health Department (2001). A Framework for Maternity Services in Scotland. Edinburgh: Scottish Executive

Reviewed by: Mary Vance

Overview

The framework sets out the clear local action required so that NHS Boards and other agencies can make sure that maternity services are appropriate to the needs of the people and geography of Scotland. It recognises that there are

specific issues that impact on service provision in remote and rural areas. The Framework is also a benchmark for the Scottish Executive to assess implementation of local strategies and action plans, and monitor progress.

Relevance

This document does not have an impact in relation to the MINT project as it does not address any of the key objectives. However the document has and continues to have an impact on the pre-registration midwifery curriculum in Scotland as it outlines the focus of Maternity Care in Scotland. A number of actions in relation to the training/education of midwives are identified. For example: Principle 5 Maternity services should provide parent education programmes that address normal pregnancy and the treatment of complications developing during pregnancy. A comprehensive health promotion programme and opportunities for discussion about the effects of parenthood on relationships should be offered. (P.11)

Local Action The CRAG recommendations on Parent Education (April 1995) should be the basis for development of local parent education programmes, but they should also incorporate: training for midwives, health visitors and other professionals to equip them with the knowledge and educational skills needed to provide quality parent support and education (p.43)

Principle7 Maternity services should make sure that women's circumstances are assessed holistically and that social and psychological needs are identified and managed appropriately. (P.11)

Local Action NHS Trusts should make sure that all professionals receive training and support in:

- identification, sensitive assessment, communication skills and support for women who are victims of past or ongoing domestic violence in line with 'Preventing Violence Against Women, an Action Plan for the Scottish Executive'

- child protection issues
- identification, screening, referral and support of women who have or are at risk of developing postnatal depression and other mental illness in a non-stigmatising way
- monitoring and support of women with particular needs such as pregnant schoolgirls, unsupported women, women from minority ethnic communities, women in prison, asylum seekers and refugees and women with severe social problems such as homelessness or alcohol/substance misuse.

(P.45) Principle 9 Maternity services, including obstetric and neonatal services, should provide a fully integrated childbirth service responsive to the needs of mothers and their new-born babies. (P.47) Local Action Regular multi-disciplinary in-service training sessions on the management of high risk labours including cardiotocograph interpretation should be attended by all professionals involved in delivering care during childbirth; (p.50) Principle 10 One-to-one midwifery care should be given to women during labour and childbirth in order to make sure they have individualised attention and support, preferably with continuity of carer. (P.50)

Local Action All professionals directly involved with care during childbirth should be given appropriate neonatal resuscitation and immediate care training; (p.51) Principle 15 Maternity services should promote, support and sustain breastfeeding. Women should be informed of its' benefits, while being supported in their chosen mode of infant feeding. (P.58)

Local Action All maternity units should adhere to the principles of the UNICEF/WHO Baby Friendly Hospital initiative through structured programmes of education and support for mothers and professionals; An Infant Feeding Adviser should be appointed in each NHS Board area to support women and to raise breastfeeding rates through the education and training of health professionals;

(p.58)

Principle 17 There should be a comprehensive, multi-professional, multi-agency service for women who have, or are at risk of, postnatal depression and other mental illness. (P.59)

Local Action NHS Trusts should make sure that training programmes are developed and implemented for professionals incorporating the identification, screening and support of women who are at risk of developing postnatal depression; (p.59)

Principle 20 Maternity services should be tailored to the needs of the individual woman. Services should be provided by multi-disciplinary and multi-agency teams with a clear understanding of professional roles to maximise the quality and comprehensiveness of care, ensuring safety for both mother and baby. (P.64)

Local Action

- NHS Trusts should make sure that the principles of change management meet the training and education needs of professionals before implementing re-engineered services;
- The Royal Colleges, United Kingdom Central Council, National Board for Nursing, Midwifery and Health Visiting for Scotland and educational establishments must make sure that the education and training that professionals receive in Scotland is of a level to ensure accreditation elsewhere in the world;
- The Royal Colleges and the National Board for Nursing, Midwifery and Health Visiting for Scot- land should address the need for joint training of pre-registration medical, midwifery and nursing students engaged in providing maternity care. NHS Trusts should do the same for post-registration students. (p.64)

Principle21 Maternity services should agree arrangements for both inutero transfer and the transfer of a recently delivered mother and/or her new-born baby to a linked secondary or tertiary unit. (P.65)

Future work to be undertaken

- The Royal Colleges, the National Board for Nursing, Midwifery and Health Visiting for Scotland, the Scottish Council for Postgraduate Medical and Dental Education and the Remote and Rural Areas Resource Initiative should consider the appropriate multi-professional, multi-disciplinary skills necessary for practice in remote and rural areas to develop appropriate training packages;
- NHS Boards should develop links to facilitate short-term professional exchanges between urban and rural areas so that the skills of all clinicians are maintained and updated;
- The Universities, the Scottish Council for Postgraduate Medical and Dental Education and the National Board for Nursing, Midwifery and Health Visiting for Scotland should consider the need for undergraduate medical, midwifery and nursing students to experience the challenges of maternity service provision in a remote and rural setting;

0.1.23 Wallace, M (2001). The European standards for nursing and midwifery: information for accession countries.

Reviewed by: Dr. Tania McIntosh

Overview

The entire document is designed for states seeking to join EU and sets out directives relevant to nursing and midwifery. The directives are principles of legislation which are implemented by national law (usually in a specific time frame, i.e. 2-3 years). To allow midwifery qualifications to be recognised, and used, across Europe. Midwifery directives are 80/154/EEC (describes titles and qualifications which reach minimum EU standards) and 80/155/EEC (describes

minimum acceptable training programmes). The minimum acceptable training programme is:

> *'. . . at least three years of practical and theoretical studies' (18 months if nurse trained).*

It is stated that teaching must include obstetrics and gynaecology, ethics and professional legislation, physical and social environment of patients, however nothing is specifically mentioned about who should provide the teaching. It is important to note that the original directive said

> *'4. Member States shall ensure that the institution training midwives is responsible for the coordination of theory and practice throughout the programme'*

Relevance

This document is relevant to the MINT project as it lays down training requirements for midwifery education, but makes no comment about who should deliver them in theory setting. However it does specify that clinical trainers should be suitably qualified.

0.2 OLDER REPORTS BUT RELEVANT TO THIS PROJECT

0.2.1 Day C, Fraser D, Mallik M (1998) The Role of the Teacher/Lecturer in Practice. Research reports series number 8. London, ENB.

Reviewed by: Professor Diane M Fraser

Overview

This 18 month study explored and described the role of nurse and midwife lecturers in the practice learning environments. The different ways in which the role was carried out is mapped and the ways in which being employed by universities impacts on academic and clinical credibility, competence. The study also identifies the management of best practice models. Included are three tentative models as strategic options for managing the practice curriculum, suggestions for the preparation of and support of lecturers in their role and ways in which lecturers might maintain their clinical competence.

Relevance

This report has direct relevance to the MINT project because at least 50% of the pre-registration programme is spent in practice settings and midwife teachers have overall responsibility for managing this part of the curriculum as well as the learning that takes place in the university setting. Although it includes all four branches of nursing as well as midwifery, all five 'fields' displayed a convergence of perceptions and beliefs about the practice role of the 'link lecturer'. What was also evident was the enormous variation in what was provided by link lecturers and whether the universities managed this aspect of the lecturers' role.

Lecturers from all fields believed the practice role is important in supporting the clinical learning environment and in enabling 'reality-based' teaching in the classroom. Time to fulfil the role was of concern as generally classroom teaching,

marking and moderation, administration and personal/professional development took priority. Overall they believed the role needed strengthening through better organization and management systems to enhance their clinical credibility. Students' experiences of contact with lecturers when in the practice setting was highly variable, from no contact, to working with or seeing the lecturer weekly. Students across all fields believed that their lecturers should give their mentors support and visit at regular pre-arranged times to discuss their progress. Some of these visits should include private discussions with them and their mentors. They did not think lecturers should carry out formal assessments with them in practice but that they should be involved to ensure a fair system was in place and that standards were maintained. Student midwives particularly valued the increased input by lecturers during their first year as for the three year programmes students, it helped them adjust to health care settings.

Mentors were particularly positive about the role when they had regular visits and the lecturer was highly visible in the practice areas. Overall they valued the 'link' role highly and wanted it to be developed further with more frequent visits of longer duration. The following are some of the recommendations in the final section of the report (pp123-125):

- Implementation of an effective model for the role of the lecturer in practice requires a strong, overt and on-going systematic commitment from the university to manage and audit practice education.
- Preparation programmes for lecturers should recognize the special nature of practice education for health care professionals, induction programmes should provide structured support.
- Since practice contexts change over time, ongoing provision for managed continuing professional development support should be available.

- Institutions are funded to provide lecturers according to the type of placements and need for equitable support for practice education and development.
- There is no evidence that SSRs should be adversely adjusted as there is evidence that even with them most lecturers are unable to spend 20% of time in practice settings.
- Education institutions to give priority t setting up a system for the strategic management of the practice role.
- Without professional development in the area of practice, consortia representatives and case study respondents believe that university as well as practice-based teaching will soon become outdated, therefore work is needed to resolve the difficulties and tensions surrounding the nurse and midwife lecturer role.

0.2.2 Fraser D, Murphy R, Worth-Butler M (1998). Preparing Effective Midwives: an outcome evaluation of the effectiveness of pre-registration midwifery programmes of education. Research reports series number 9. London, ENB.

Reviewed by: Professor Diane M Fraser

Overview

This study reviewed three-year midwifery programmes including following a cohort of newly qualified midwives during their first year of practice. The findings of this study made suggestions for improving recruitment and selection, the structure of the curriculum, the appropriateness and robustness of assessment schemes, the preparation and support of assessors, the role of the teacher in the assessment process and the ideals of midwifery programmes alongside the realities of what it was like for students in the maternity services. An assessment

matrix was also produced to assist universities in monitoring the robustness of their own assessment schemes.

Relevance

This study has direct relevance to the MINT project as it made suggestions as to how midwife teachers could improve the competence and confidence of newly qualified midwives. Some of the suggestions have been implemented in UK universities and the MINT project will be able to explore which of these continues to be effective and whether, even if effective, have been sustained. The following were recommended in the final section of the project (pp 115-118):

- Prospective students to be given insight into the realities, challenges and experiences of being a student midwife
- In recruitment to pay particular attention to personal qualities such as confidence, communication skills, attitude
- Importance of integrating theory and practice from the outset
- Enabling students to develop the skills for problem framing and re-framing
- Enable students to learn specific skills earlier in a structured learning context
- Reconsider the appropriateness of progressing from simple to complex and health before illness, given what students will encounter in practice
- Include a period of consolidation at the end of the programme to enable students 'to be a midwife', to develop management skills and gain confidence for the transition from student to midwife
- Develop strategies for monitoring the quality of assessment in the practice setting
- Midwife teachers to be more proactive in relation to learning and assessment in the practice setting through a partnership approach
- Assessment schemes designed that will not allow 'the borderline' student to 'slip through the net'

- Midwife teachers to meet with named assessor and student at least once during each assessment/allocation period (a tripartite' process) – not just when problems arise
- Newly qualified midwives to receive a short period to 'settle in' to being a midwife, labour ward support needed for three year and shortened route qualifiers
- Effectiveness of curricula monitored as to whether they have enabled newly qualified midwives to develop management skills and to participate in caring for women with complications
- Supervisors of Midwives to monitor the effectiveness of induction programmes for new midwives, especially those on 'bank' or agency shifts and who those who are particularly lacking in confidence.

0.3 PEER-REVIEWED ARTICLES

0.3.1 Briscoe, L. & Lavender, T. (2009) Exploring maternity care for asylum seekers and refugees. British Journal of Midwifery, 17(1) 17-23.

Reviewed by: Joy James

Overview

This document is an evaluation of a longitudinal exploratory multiple case study that sought to explore the experiences of maternity care of three asylum seekers and one refugee with a view to provide better maternity services resulting in a lessening of the increased risk of mortality of these groups. The authors suggest that maternity care givers are failing the needs of these client groups and say that:

> *'improving the way that maternity care givers engage with asylum seekers and refugees may be facilitated by the theory of transformational teaching' (p. 20).*

The authors go on to suggest that this could be achieved in pre and post registration midwifery education by increasing the levels of critical thinking and reasoning.

Relevance

This document implies that the needs of these client groups are not met because practitioners are ill equipped to undertake the task and that a better means of communication and empathic and cultural sensitivity achieved through reflection was needed to improve outcomes in these groups .

0.3.2 Davey, M., Brown, S., & Bruinsma, F. (2005). What is it about ante- natal continuity of care giver that matters to women? Birth, 32(4):262- 271.

Reviewed by: Joy James

Overview

This document addressed whether continuity of care giver influenced women's experience of maternity care by an anonymous population-based postal survey

Relevance

The content is not relevant to MINT Objectives except in relation to the NMC Standards where it is suggested that student midwives experience caseload practice.

0.3.3 Field, D. (2004) Moving from novice to expert - the value of learning in clinical practice: a literature review. Nurse Education Today,24 (7):560-565

Reviewed by: Nicole Stephen

Overview

This article is a literature review of nursing education in the UK, in relation to the Fitness for Practice Report (UKCC 1999). Specifically, this article discusses mentorship and practice teachers. While it is about nursing, many of the concepts seem to be applicable to midwifery education, hence its inclusion in the review. Many of the concepts in the literature review are related to the interview with the Nottingham Programme Lead, and may be relevant to concepts from other Programme Lead interviews.

Relevance

This article provides the theoretical underpinning of mentorship and the role of practice teachers in nursing and midwifery education, therefore it may provide background material for the project as well as supporting material to data collected.

Quotes

Benner's (1984) model, describing the potential development of nursing expertise as progressing through five stages from novice to expert, and identifying nursing competencies, remains influential in British nursing education. (P.1)

The uncritical adoption of Benner's (1984) 'From Novice to Expert' approach promoted the development of 'reflective' approaches to nursing as the new mantra for nursing education in the 1990s. The significant role that reflecting in and on practice still takes within nurse education should be seen against the background of responsibility for much of students' clinical education and all of the clinical assessment being devolved to ward mentors who vary in quality and commitment, nurse teachers being based in higher education and losing clinical expertise and the convenience of 'reflective essays' as a proportion of the 'academic words' tied to practical assignments. (P.2)

To reflect in reasonable depth and to begin to acquire the levels of nursing practice learning described by Benner (1984), the student requires an adequate practice placement, and stimulating dialogue with an excellent mentor with a good basis of theoretical knowledge, who in turn requires senior support. These are not always in place, and whilst the reflective approach can be used to relate theory to practice and practice to theory, much student reflective work remains superficial. Clearly the key to progressing from novice to expert is excellent mentor support, otherwise the nursing student may make defective assumptions based on inadequate personal reflections. (P.2)

There is strong evidence (Corlett, 2000) of a discrepancy between classroom theory and the learning which takes place in the clinical area. (P.3)

Corlett et al. (2003) tested three factors in learning: preceptors teaching relevant theoretical areas within the higher education setting, collaboration between service and education providers on lesson content and better sequencing of theory and practice showed no difference in students' theory or practice scores according to the way in which all the factors were varied. Corlett et al. (2003) however did suggest that the type of placement that students complete at different stages in their preparation may be more important than close sequencing of theory with practice. (P.3)

Landers (2000) also specifically suggested that by participating in practice, the practice educator has the potential to provide learning opportunities for the kind of application, analysis and synthesis of information which gives students an understanding of what nursing is about. However, it needs to be acknowledged, that as a nurse who may have to work in a variety of settings with different types of clients, the practice educator may be clinically and academically competent, but lack the clinical expertise of the mentors they are supporting. (P.4)

Illustrations of the efficiency type of knowledge which is developed in and from practice is provided by Sloboda (2001). He identifies that the expert has recognised the microstructure of the task, and describes the economy of effort and fluency of actions evident in expert performance. Working in clinical practice areas the practice educator has the opportunity to witness or develop similarly effective short cuts, but whereas the practice educator may include these in defined stages of practice teaching, not all mentors have analysed their work stages in order to be able to do this.(p.4)

He [McCormick (1999)] therefore recommended valuing practice knowledge more highly and recommended teaching it in its own right. Nursing procedures, which may initially be taught in university 'clinical skills laboratories' require more

varied and complex skills than can be taught in classrooms. (P.4)

The practice environment and the student's mentor are thought to be significant in this process, as the student seeks to endure conceptual knowledge with personal meanings from practice. (P.5)

Lauder et al. (2003) suggested that a student's metacognitive strategies involving the monitoring of and reflection on personal learning will help to build cognitive schemata of theory and practice knowledge. However, their work was with experienced qualified nurses, and even these nurses needed considerable help to develop these learning strategies. (P.5)

Significant research by Cahill (1996) on student nurses' experience of mentorship in practice revealed that teaching and learning activities were seen as taking place after the 'work' (patient care) was completed, thus illustrating the significance of 'time' for mentoring. Learning and patient care were thus seen separately, with one being a reward for the other. It is possible to infer from Cahill's(1996) findings that students may not perceive when they are learning practically in clinical settings, and might be referring to 'learning experiences and help' in terms of academic assignments and the formulation of clinical learning objectives. Implicit within Cahill's (1996) research might be the notion that mentors were failing to explicitly connect clinical nursing knowledge with academic knowledge, theories and research. This may be a fruitful area for further development as tradition-ally it is the professional educators who have been blamed for a theory/practice divide. (P.5)

Research by Corlett (2000) suggested that students perceive classroom based theory teaching as being 'idealistic and decontextualised'. (p.6)

Clearly the practice educator, who belongs to both the clinical and educational worlds, is ideally placed to promote the relation of theoretical knowledge to practice and to reduce 'that function of time' referred to by Corlett (2000).

Equally important in relating theory to practice and coaching excellent practice

outcomes is the mentor. (P.6)

0.3.4 Hughes, D.(2004) The mentoring role of the personal tutor in the Fitness for practice curriculum: an all Wales Approach. Nurse Education in Practice,4, 271-278.

Reviewed by: Nicole Stephen

Overview

This paper discusses the mentoring role of the personal tutor in pre-registration nurse education. It explores the concept of mentorship as well as its application to the Fitness for Practice curriculum. Specifically it highlights the role that personal tutors play in promoting reflection in practice as well as the potential consequences of student/tutor conflict. This article is specific to nursing education, not midwifery however the concepts discussed in this article appear to apply to both fields.

Relevance

This paper is relevant to the MINT project objective 'Gather information about specific contributions made by midwife teachers'. While this paper relates to nursing education, there is detailed information about the role of the personal tutor, which also exists in midwifery education. In three focus groups, the students discussed the mentoring role of the personal tutor, and its relevance to their education.

Quotes

Similarly, the process of mentorship as defined by the Welsh National Board (2001), is one that also facilitates learning opportunities, supervises and assesses students in the practice setting. Terminology frequently used to describe a mentor includes teacher, supporter, coach, facilitator, assessor, role model and

supervisor (p.2)

The personal qualities of a mentor, and the nature of the relationship between the mentor and student are central to the success of the mentorship process (Pulsford et al., 2002), and from the literature it can be surmised that the attributes of a good mentor include: Trust, openness, generosity of time (Quinn, 2000). Knowledgeable, approachable, motivated to teach, good communication skills (Darling, 1986). Patient, kind, good listener, sound practitioner, academic nurse, good teacher (Davies et al., 1994). (P.2)

In contrast, a qualitative study of effective mentoring by Gray and Smith (2000) indicated that students quickly lose their idealistic view of their mentor and over time develop an insight into the qualities of a poor mentor. Poor mentors were identified as promise breakers, lacking in knowledge and expertise, unapproachable and intimidating to students. (P.2)

The mentoring role is defined by Lloyd-Jones et al. (2001):

- Supports student in the clinical area and acts as a role model
- Facilitates the learning experiences on placements
- Undertakes clinical teaching and assesses the student's practice (p.2)

Whilst emphasizing the difference between theory and practice, Benner (1984) recommended that it was the role of experienced nurses in the clinical environment to facilitate the transition from novice to competent practitioner. (P.3)

This theory–practice gap now dominates approaches to preparing students for their future role, and with increasing emphasis on work-based learning, one of the many strategies de- signed to support students is supervision (Spouse, 2001). (P.3)

Within Higher Education (HE), it is usual to differentiate between the terms 'teacher' and 'mentor'. Quinn (2000) defines the term 'mentor' can as a

relationship between a tutor and a student that includes a range of functions, other than formal teaching and assessment, that support students through their progression of study. (P.3)

According to Phillips (1994), the concept of the 'personal tutor' is one that has evolved over time in Colleges of Nursing and Midwifery Education with little apparent active planning or formality although nurse teachers have always been personal tutors in different guises and to varying degrees with individual and groups of students. Although the personal tutor is a well-established role, its interpretation appears to be more coherent since the inception of the new curriculum. (P.3)

The All Wales Assessment of Clinical Practice document (NAfW, 2002c) details the multi- faceted role that the personal tutor must adhere to and although not exhaustive, this includes:

- Preparing each student, prior to their first and subsequent clinical placements by explaining the importance and process of clinical outcomes.
- Providing tutorial support by organizing and facilitating personal tutorial discussions that focus on clinical experiences.
- Providing individual support for students who are experiencing problems of failing to make progress in clinical practice and/or academic programme.
- Discussing with link tutor, issues that students have highlighted in relation to their clinical placement.
- Discussing with students, reflective entries, supporting evidence and relevant documentation within the portfolio.

Additional roles and responsibilities of the personal tutor are outlined by Neary (2000) and include the following activities:

- Encouraging reflective practice to aid the relationship between theory and practice

- Providing academic support in the process of academic assignments
- Maximizing learning opportunities and advising on learning activities
- Participating in the preparation of placement mentors(P.4)

. . . personal tutors possess certain attributes to facilitate tutor/student relationships and include self- awareness, trust, acceptance and respect for the student, empathetic understanding, credibility and retaining individuality by being one's natural self. (P.4)

. . . part of the personal tutor role is to act as a 'bridge' between what is taught in school and what happens in clinical practice. In facilitating this, the tutor must possess clinical skills to enhance credibility and should acknowledge that what is taught in school is sometimes different to what happens in practice. The role also has historical and literary associations concerning both pastoral and authority associations (Richardson, 1998). (P.4)

Introducing students to reflective practice goes some way towards preparing them for clinical supervision after registration, and in order to facilitate reflective groups, Claveirole and Mathers (2003) profess that lecturers require skills similar to those of a good clinical supervisor, which include reflection, supervisory and facilitative skills. (P.4)

There are weaknesses and prejudices in all mentoring systems and the conflict of dual roles of mentor and assessor is just one of many debated issues in the School, with some lecturers believing that befriending students impacts on the learning process and consequently effects progress. Phillips (1994) emphasizes further weaknesses and cites Lewis's (1998) belief that personal tutors may find difficulty in resisting temptation to ensure that all of their own personal students successfully complete educational programmes. He also fosters the belief that students may reject the support offered by the personal tutor for fear of being labelled as weak or perceived not to be coping. (P.5)

The use of a portfolio is a dynamic positive means to show that a student is

developing knowledge and competence (UKCC, 1990), and to encourage students to engage in life- long learning, a portfolio offers an ideal vehicle for reflection whilst providing evidence of achievement (Priest and Roberts, 1998). (P.5)

Teachers with their own unique personality may perceive and carry out their personal tutor responsibilities in an individual way (Phillips, 1994). However, there are pitfalls that are often associated with the expectations of both parties, a lack of understanding of the true nature of the personal tutor role and an emphasis on limited aspects of the overall learning process. (P.5)

The role of the personal tutor can be perceived to be both demanding and fulfilling, although Charnock (1993) recognises that for some lecturers the demands are too great, and a degree of detachment is preferred due to the continuing extended role. He also recognises that this view should be respected, and the diversity that this role offers adds to the richness of the educational experience. (P.6)

Anecdotal evidence suggests that the workload of the personal tutor has dramatically in- creased since the introduction of the new curriculum, primarily its extensive documentation, however there is no evidence to support this. It is also too soon to identify if the theory– practice gap, previously identified with the Project 2000 curriculum, is narrowing. (P.7)

0.3.5 Kenny, G.(2004) The origins of current nurse education policy and its implications for nurse educators. Nurse Education Today, 24 (2):84-90

Reviewed by: Nicole Stephen

Overview

This document addresses the changes that occurred with the publication of the Fitness for Practice policy and their implications for UK nurse educators within higher education. It provides insight into the economic and societal barriers that

nurse (and midwife) educators have to contend with. The excerpts may be helpful for background sections, and to set the context of the MINT Project. The author argues that as Fitness for Practice policy has been adopted, holism has been sacrificed. She states that 'in a modern healthcare context education can no longer be advanced solely on the premise of scientific rationality/skills as a means of preparation for the workplace. What is required is equality of contribution, which necessitates that holism, can be reinvested with power and influence.'(P.2)

Relevance

This article is relevant to the objectives of the MINT project, as it addresses the policy that guides the education of nurses and midwives. It is useful as it puts nurse education in historical context. However, it is largely a criticism of the system. Also, it is about nurse education, and does not address issues specific to midwifery education. However, it provides several interesting points about the role of nurse educators, which seem to be applicable to midwifery education.

Quotes

In the process of these reforms [Fitness for practice], nurse educators were marginalised and portrayed a negative light. (P.1) Fitness for Practice (UKCC, 1999) acknowledged the impact that social forces would have on the nursing profession and care delivery. What is absent from the analysis is acknowledgement of the impact it would have on nurse educators. Lack of recognition of this reflected how nurse educators were caught between the two convergent and powerful discourses of politics and economics. The political discourse at the time was that higher education in the UK needed to be brought from the margins of society into mainstream educational provision for the greater societal good (Barnett, 1994). Nurse educators' links with higher education in the UK made them susceptible to the criticism that they were remote from the needs

of service providers (Camiah, 1996). The economic discourse articulated that society needed a skilled nursing workforce to deliver the modernisation agenda of the NHS. Service providers believed that nurses with skills were not being produced. Consequently nurse educators were perceived as failing to teach technical skills (Corbett, 1998). The position of educators was further weakened by the perception that they were motivated by
their ideological preferences rather than the needs of the NHS (Humphreys, 1996). These discourses enabled the more powerful social actors of government and service providers to ensure that their interests and intentions set the agenda for social change in nurse education.

One of the ways that this could be achieved is through revisiting the nature and role of nurse educators. This requires a radical departure from the Fitness for Practice (UKCC, 1999) perspective of seeing educators as passive objects of external steering, to a model that portrays nurse educators within a higher education context as active actors who respond to external demands from collectively sustained values (Ylijoki, 2001). (P.2)

A shift in the perception of the function and nature of nurse education necessitated a shift in how educators were perceived by education managers and policy makers. The changing claims upon educators in the UK was evident through the 1980s and 1990s as they moved from being trainers of nurses in schools of nursing to striving to adopt the mantle of university academics. Educators needed to be reclaimed so that they could provide value for money in nurses who were fit not just for award and registration but also for purpose and practice. (P.3)

An economic competency based view of education makes the student the consumer and education the product to be received. The potential for role conflict is high as nurse educators attempt to align demands of individual student support within an educational culture that is economically driven (Gidman et al., 2000).

(P.3)

Current debates taking place within the Nursing and Midwifery Admissions Services (NMAS) are looking at ending specific educational requirements for entry into pre-registration nursing (Pearce, 2003). This could result in a potential student nurse population that is not equipped with the academic skills to meet the demands of scholarship within HE. Student needs are having to be met in an environment that requires educators to also be responsible for reducing attrition from nurse preparation (DoH, 2000), and being required to improve placement opportunities and qualities of experience (English National Board, DoH, 2001a, 2001b). (P.4)

Nurse education is unusual within HE in that it is funded directly by the NHS. Consequently nurse education is expected to be highly responsive to service provider's needs. The purchasing power of education consortia's creates the potential that a narrow skills-based, competency-based approach could hold sway in the commissioning and planning of education. (P.4)

Nurse education has to be employment focused because it has to produce competent nurses. (p.5)

The origins of current nurse education policy and its implications for nurse educators remain an integral part of care delivery educators must be active in setting the agenda for education. This is a model that seeks to go beyond the narrow vision in the report of returning to clinical areas to refresh forgotten practical skills (English National Board, DoH, 2001a,b). Service providers would like to see nurse educators physically present on the ward teaching skills. Higher education is unlikely to allocate time to release educators to return again to the historical roles of clinical tutor. Between the two dynamics educators need to assert and identify themselves how best they can contribute to the cause of holism through the use of scholarship. (P.5)

The transformation of the nurse educator away from the narrow passive role

implied by the Fitness for Practice (UKCC, 1999) portrays nursing academics as public intellectuals whose responsibility is not only to service providers but also to students, colleagues and the wider community (Nixon et al., 2001). This wider community must acknowledge the global community of which nurses and nurse educators are an integral part. For full and effective engagement on a global level nurse educators will have to articulate their nursing knowledge and value their healthcare practices. This is crucial if the dangers of exporting unhelpful models of education are to be avoided in the context of globalisation. (P.6)

0.3.6 Mansell I, Bennett G, Torrance C, Fairbairn G. (2002) The role of the nurse lecturer in the supervision of students' essays, projects and assignments: results on an all Wales questionnaire survey. Nurse Education Today,22(7):511–517.

Reviewed by: Nicole Stephen

Overview

This article reports on a study of nurse lecturers supervision of student's academic work in Wales. The results of the study demonstrate the amount of time that lecturers invest in the supervision process. The authors emphasize the multi-faceted nature of the lecturers role.

Relevance

This article is highly relevant to the objectives of the MINT project as it addresses three of the five project objectives: 2. Gather information about specific contributions made by midwife teachers; 4. Determine the value brought by midwife teachers regardless of the model of education provision; 5: Develop metrics to quantify the value brought by midwife teachers. The methods included semi-structured interviews, and a questionnaire developed from the results of the interviews to survey nursing and midwifery lecturers across Wales. This article

demonstrates a similar approach to the content of the focus group interviews with the midwife teachers in the MINT project..

Quotes

Over the past decade there have been many changes within nursing and midwifery education and the lecturers' role has become increasingly multi-faceted. Camiah (1998) argues that activities relating to teaching and learning form only part of the role which also includes managerial, clinical, research and scholarly activities. All of these activities demand time, and it has become increasingly necessary for lecturers to rationalise time spent on some activities in order to make time for others. (P.1)

Armitage & Rees (1988) suggest that supervision consists of two roles; the personal role and the task role. The former includes the provision of emotional support and encouragement, whilst the latter largely consists of assisting the student in the completion of course work. (P.1)

The demographic profile of the respondents suggests an experienced and well-qualified work- force with the majority of respondents having experience of lecturing in the former schools of Nursing and Midwifery prior to the move to Higher Education. Camiah (1998) argues that these changes have significantly changed the role of the nurse teacher, she further suggests that nurse teachers now have far greater pressures, including the need to be both clinically credible and research active. However, whilst this may be the case the findings of this study suggest that a great deal of time and effort is being given to the supervision process. (P.5)

If the aspirations of fitness for practice (UKCC 1999) for a competent practitioner able to plan and deliver holistic care in a changing world of health and social care are to be realised then the ability of students to study independently, develop critical thinking and writing skills are fundamental. (P.7)

0.3.7 Raisler J, O'Grady M, Lori J. (2003) Clinical teaching and learning in midwifery and women's health. Journal of Midwifery and women's health,48(6):398.

Reviewed by: Nicole Stephen

Overview

This is a literature review of clinical teaching strategies in midwifery. Based on the literature review the article goes on to discuss the challenges in clinical teaching, responsibilities of the education program, students, and mentors, and finally contains several suggestions for clinical teaching in midwifery.

Relevance

This article provides good background material about clinical teaching. It is relevant to the aims of the MINT project however rather than focusing on midwife teachers, it is based on mentoring and the exploration of that role. Also, this article provides an American perspective, which limits its relevance to the MINT project as the context for midwifery is different in the UK. However, on page 3 there is a box outlining expectations and responsibilities in clinical teaching which may provide a good basis for a preliminary comparison to our findings.

Quotes

Students face multiple stresses that affect their clinical experience, including time and financial pressures; long commutes; juggling responsibilities for family, work, and school; insufficient time to study; and, for some, the role change from expert nurse to novice midwife or APN. (Pg.1)

Faculty in research-intensive universities face increasing pressure to publish and secure re- search grants, leaving less time available to work with students and preceptors. Candidates for tenure may be discouraged from engaging in more

than token clinical practice. As teachers move further from practice, their ability to support and evaluate the clinical learning process may be compromised (pg.2) Some education programs have created a Clinical Coordinator position to link the academic program and clinical sites more effectively. The Clinical Coordinator has a key role in recruiting and retaining preceptors and clinical sites and arranging student placements. S/he may also provide teaching and learning resources to faculty and preceptors and supervise clinical activities. This multifaceted role requires clinical and academic competence, creativity, flexibility, and good communication skills. (Pg.2)

0.3.8 Thompson, J. (2002) Competencies for midwifery teachers. Midwifery,18(4):256– 259.

Reviewed by: Nicole Stephen

Overview

This article presents an individual's view about the basic competencies required of midwife teachers. The author is from the US, but has taught and practised midwifery internationally. This is an opinion paper, rather than a research article. However, it presents some useful concepts in midwifery education.

I propose that persons learning to be midwives need appropriate role models who are competent midwifery practitioners themselves, and who share this midwifery philosophy and way(model)of discipline is that the only qualification needed to providing care for women and childbearing families. (P.2)

Relevance

This article is highly relevant to the aims of the MINT project, however it may not be useful as it is not based on research. While the author has much experience in midwifery and midwifery education, one person's view may not be sufficient evidence to merit inclusion in the literature review.

0.4 RECOMMENDED SOURCES FOR FURTHER READING

Reviewers suggested the sources below for further reading, as they may have relevance to the objectives of the MINT project.

0.4.1 Grey Literature

- Nursing & Midwifery Council (2009). Standards of Proficiency for pre-registration midwifery education.
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- RCM (2004) Prepared to care: fit for purpose programme: Preparation of maternity care assistants. RCM; London
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- Rosser, E and Albarran J (2008) Recruitment and retention of midwifery academics across south west England, Report for SW Strategic Health Authority. Bristol, University of West of England.

There is a good reference list that can be pursued. Particular reference is made to the Strategic Learning and Research Committee (StLaR) (2004) Developing and sustaining a world class workforce of educators and researchers in health and social care, http://www.stlar.org.uk

- Department of Health (2007). Maternity Matters Choice, Access and Continuity of Care in a Safe Service. DH Publications.
- Making it Better: For Mother and Baby (2007) • National Perinatal Epidemiology Unit: Recorded Delivery: A national survey of women's experience of maternity care 2006 (2007)
- Department of Health: National Service Framework for Children, Young People and Maternity Services (2004)
- Redshaw M, Rowe R, Hockley C, & Brocklehurse P. (2007) Recorded delivery: a national survey of women's experience of maternity care 2006. National Perinatal Epidemiology Unit. pp. 1-96
- 'Every Child Matters: Change for Children in Health Services', the 'National Service Framework for Children, Young People and Maternity Services' (the NSF)
- Department of Health. (2004) Choosing health: making healthier choices easier. London: DH Publications.

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- Department of Health (2003) Maternity and Neonatal Workforce Group Report to DH Children's Task force. London: DH Publications.
- Department of Health (2004) National Service Framework for Children, Young People and Maternity Services. Change for Children: Every Child Matters.
- Department of Health. (2003) Delivering the best: Midwives contribution to the NHS Plan. Welsh Assembly Government (2002) Delivering the Future in Wales: A framework for realising the potential of midwives in Wales. Briefing Paper 4. Cardiff, WAG.

Being seven years old this document has been superseded by a number of reports. The document mentions reports that have probably been reviewed or are even older and as such may not be relevant today:

- Audit Commission Report (1997) First class delivery: improving maternity services in England and Wales Abingdon. Audit Commission Publications
- SNMAC (1998) Delivering our future: Report by the Standing Nursing and Midwifery Advisory Committee February 1998
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- Fleming V, Poat H, Curzio J. (2001) Competencies of midwives with single or dual qualifications at the point of registration in Scotland. Midwifery. 17(4). p295-301.
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- Maggs C, Rapport F (1996) Getting a job and growing in confidence: the dual experience of newly qualified midwives prepared by the pre-registration route. NT-Research. 1996. Jan./Feb. 1(1). p68-78.

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Peer-reviewed articles

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- Carlisle, C., Luker, K., Davies, C., Stilwell, J., Wilson, R. (1999). Skills competency in nurse education: nurse managers' perceptions of diploma level preparation. Journal of Advanced Nursing 29 (5), 1256-1264.
- Spouse, J. (2001). Bridging theory and practice in the supervisory relationship: a sociocultural perspective. Journal of Advanced Nursing33 (4), 512-522.

- Hughes, S. (2004) The mentoring role of the personal tutor in the Fitness for practice curriculum: an all Wales Approach. Nurse Education in Practice, 4, 271-278.
- 'Following the recommendations of the FFP report (UKCC, 1999), the UKCC (2000) published revised standards for the preparation of teachers of nursing, midwifery and health visiting.'
- Gray M.A., Smith, L.N. (2000). The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. Journal of Advanced Nursing 32 (6), 1542–1549.
- Jarvis P., Gibson, S. (1997). The Teacher Practitioner and Mentor in Nursing, Midwifery, Health Visiting and the Social Services, second ed. Nelson Thornes, Cheltenham.
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- Chow F.L.W., Suen, L.K.P. (2001). Clinical staff as mentors in pre-registration undergraduate nursing education: students' perceptions of the mentors' roles and responsibilities. Nurse Education Today 21, 350–358.
- Neary, M. (1997). Defining the role of assessors, mentors and supervisors: Part 2. Nursing Standard 11 (43), 34–38.
- Price, B. (2002). Gaining the most from your tutor. Nursing Standard 16 (25), 40–44.

- Priest H., Roberts, P. (1998). Assessing students' clinical performance. Nursing Standard 12 (48),
- 37-41.
- Pulsford D., Boit K., Owen, S. (2002). Are mentors ready to make a difference? A survey of mentors' attitudes towards nurse education. Nurse Education Today 22, 439–446.
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