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Response to the RCM State of Midwifery Education 2023 report

by the

UK Network of Professors in Midwifery and Maternal and Newborn Health

We welcome the RCM State of Midwifery Education 2023 report, and the wider contribution the RCM makes to the education of midwives. We recognise that quality education can reduce maternal and newborn mortality and morbidity as well as improving the student experience [WHO, 2019, Framework for Action: Strengthening Quality Midwifery Education for universal Health coverage].

The RCM report provides an opportunity to generate discussion in relation to some of the challenges facing the profession including the pre-registration education of midwives, midwifery academics and clinical teachers. The UK Network of Professors in Midwifery and Maternal and Newborn Health seeks to contribute to this discussion, offering additional context, suggested actions towards achievement of the RCM recommendations and contributing to the strong collective voice that will be required to achieve positive change.

Our responses to the seven recommendations are as follows:

Report Recommendation: *Universities take steps to attract and retain high quality midwifery educators, such as offering competitive salaries and supporting professional development.*

Response: Higher Education Institution (HEI) salaries have not kept pace with salaries in the NHS. NHS Agenda for Change salaries plus enhancements means that new careers in higher education are not financially equitable with the NHS. This has created barriers to recruitment to the higher education sector. The pay differential can be considerable. The RCM report cites an average £1K starting salary between a Band 6 midwife and a lecturer. However, in practice the drop in salary is likely to be much greater once unsocial hours payments are included. Further, many midwives will have advanced in their clinical careers beyond Band 6 before considering working in the higher education sector. As higher salaries within HEIs generally depend on doctoral level qualifications, research grant success, teaching qualifications and experience, and publications rather than clinical experience, these midwives are realistically likely to face a considerable pay drop on entry to HE. It is difficult to get a clear understanding of the problem as there is variation in NHS pay between UK countries and wide variation in pay banding and role definitions and expectations between HEIs across the UK.

The report highlights a concerning drop in the number of midwives in academia with master's degree, doctorate or teaching qualifications. This is a additional barrier to increased salaries. Universities have to abide by their respective equal opportunities/recruitment policies and can find it difficult to provide a rationale to remunerate staff without postgraduate qualifications to the level that midwives might find attractive.

Most universities support professional development for employees. This can often focus on individuals securing teaching qualificationsas the number of educators with a teaching qualification is an important HEI metric. Support for different types of doctoral education may also be available, in full or in-part, plus academic support to apply for external funding for

educational doctorates, doctorates by research and, more rarely, clinical doctorates. We anticipate therefore that subsequent RCM reports will show increasing numbers of midwives in academia with the higher level qualifications that HEIs require, this will take time. There are examples of excellent practice however, there is wide variation between HEIs.

Universities should be encouraged to pay higher salaries in recognition of clinical expertise. If they are to be encouraged to pay relatively higher salaries for midwife educators an incentive may be that they receive a higher tarrif for undergraduate midwives (discussed below).

We recommend that the RCM collaborates with representatives of other similarly affected professions (the College of Radiographers, Royal College of Occupational Therapists, Chartered Society of Physiotherapy, Royal College of Nursing) to explore ways of advocating for recognition of clinical experience/ expertise and securing appropriate remuneration. The issue of funding clinical staff working in HEIs has been addressed successfully for medical staff. The solution used in that case may provide a model that could be transferred to midwifery.

There are long standing HR issues to be resolved between HEI and NHS and provide for the possibility of joint NHS/HEI funded posts. Arrangements would include support for study leave to achieve additional qualifications. This would enable career mobility and flexibility as midwives would be able to move between NHS and HEI roles developing teaching skills and research involvement while maintaining clinical skills and salaries (currently being addressed by NHSE). The RCM can be influential, in particular, through its NHS networks, to create stronger terms, conditions and managerial arrangements for midwives undertaking joint appointments.

Achieving these changes will require sustained external pressure from regulators and professional bodies (ie RCM) as well as internal pressure from senior HE and NHS staff (Director of Midwifery, Medical Director, NHS Chief Exec) to require HEI HR and NHS HR to work together to find and implement sustained solutions.

A further barrier to retention of midwifery teaching staff is that many HEIs continue to offer teaching only contracts in particular to staff without a PhD or research track record and this is likely to include most midwives entering HEIs. This can be unattractive / a disincentive to attracting and retaining midwifery educators and may slow career progression. Teaching only contracts also disadvantages midwifery research and will impact REF2028.

Report Recommendation: *Academic assessor: student (AA:S) ratios are no greater than 1:19 to ensure effective support is provided and students meet the required standards.*

Response: A student: staff ratio that ensures effective education and support for our next generation of midwives is imperative. The bedrock of sustainable, safe and personalised maternity care is well trained and well supported students, educated by well funded and well supported staff with enough time to engage with and undertake research and practice and time to actively and creatively engage the students with the fundamental principles and implications of midwifery as a philosophy, an art, and a science.

The detail of the design of each pre-registration midwifery programme is unique [*an observation cited within the RCM report*] and the <u>overall</u> staff student ratio required to deliver

each programme will therefore vary. The contributions to student learning from a range of staff from different disciplines delivering different aspects of the programme needs consideration. For example, it could be a subject specialist librarian who teaches students about information searching, retrieval, storing. Furthermore, students also have access to a wide range of student services including learning resource centres and on-line provision, study skills support, careers information and guidance, counselling etc. all of which needs to be funded from the student fee.

While multi-disciplinary learning and teaching from subject specialists is very valuable, the focus of all learning needs to relate to becoming a midwife. Responsibilities for the curriculum design, implementation, and evaluation must always reside with the midwifery lead.

Some professions such as physiotherapy and occupational therapy have a SSR for profession specific teaching and this helps protect the profession specific teaching workforce. It will perhaps also be helpful to focus on the responsibilities of the academic assessors and ensure they are able to fulfil all academic assessor standards as determined by the NMC. Programme approval processes provide a good opportunity to explore this and ensure the programme has a viable level of staffing with the appropriate expertise. If it is felt that the approval process is not delivering on this perhaps the RCM could bring this to the attention of the NMC and ask for the approval process to be reviewed.

Universities report that current funding for domestic students is inadequate and it is common for domestic student tuition costs to be cross-subsidized by international student fees. It is challenging for universities to increase the income generated through midwifery student fees. The numbers of midwifery students accepted into HE pre-registration programmes is restricted by the availability of clinical placements, and the by the commissioned level of student midwife numbers in Scotland. This limit on the number of students impacts the potential income earned by HEI in offering midwifery education programmes.

Higher tariffs for student midwives may be a solution. A review of the Office for Students banding that provides additional income to HEIs that deliver high cost programmes, such as midwifery, is timely as the current pre-registration programme is more intensive to deliver given the increase in academic assessor role and specialist curriculum content.

The Office for Students implement the banding payable to HEIs multiplied by number of student per cohort to enable HEIs to appoint appropriately trained academics to deliver the programme.

The RCM has a role as a pressure group to influence Government to increase the high-cost programme banding of midwifery pre-registration. The RCM, NMC and CoDH all have a role to play to effect some influence.

Without high tariffs, universities may argue that an improved student:midwifery staff ratio was unaffordable. These issues must be addressed to avoid the risk that pre-registration midwifery education becomes financially non-viable for some HEIs.

Report Recommendation: *Protected time is created within staff workloads to enable academic assessors, practice assessors and students to connect across academic and clinical settings.*

Response: Universities should ensure appropriate, fair, equitable and transparent workload allocations. In making this recommendation the RCM could undertake to explore the workload allocation approach adopted by universities. This may expose the pressures being experienced by midwifery staff in HE. Most research or dual intensive universities are working within Athena Swan principles. With workload models there are usually principles around percentage time for teaching, admin, service and research. However, many academics report that they are working beyond their capacity and workload allocation (see UCU publications on this). This is a sector wide problem.

Given that, as set out in Part 2: Standards for student assessment and supervision [NMC 2018], it is a requirement that approved education institutions, together with practice learning partners ensure that:

- 6.8 practice and academic assessors receive ongoing support to fulfil their roles
- 9.4 the nominated academic assessor works in partnership with a nominated practice assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies
- 9.5 academic assessors have an understanding of the student's learning and achievement in practice
- 9.6 communication and collaboration between academic and practice assessors is scheduled for relevant points in programme structure and student progression
- 10.3 they receive ongoing support and training to reflect and develop in their role
- 10.4 they continue to proactively develop their professional practice and knowledge in order to fulfil their role

It is essential that these requirements and assessor responsibilities are factored into the workload model. How the above is achieved is for each institution to determine in conjunction with pre-registration programme leaders, practice learning partners and the respective LME. LMEs can ensure that these standards are met as part of the programme approval process.

Report Recommendation: *When there is a lack of diversity among teaching staff, a recruitment plan is developed to reflect the diversity of staff, students, and the people they care for.*

Response: We strongly support the need for greater ethnic diversity in the NHS and HEI workforce reflective of the communities we serve. One option could be provision of a recruitment plan as a condition of programme approval. However, this may create a serious challenge in a context where recruitment to HEIs, and in particular recruitment from some communities, is already difficult. Innovations should go beyond trying to attract and retain midwives from marginalised communities. There are examples internationally of innovations to address HE access and success for students, and to attract, retain and develop academics from marginalised communities. For example, at Griffith University, Australia, a *whole of*

workforce pathway approach is used. Students from marginalised communities are provided with an integrated programme commencing prior to application to HE to ready applicants for tertiary education and extends through to graduation and employment. As part of this programme, academics from these same communities are recruited and developed with their primary role to support the students from their community in theoretical and clinical learning environments. As a profession we need to consider all options to address the lack of ethnic diversity in the academic and clinical midwifery workforce through a wider lens.

Report Recommendation: *Secondment or joint appointment opportunities are offered between health Boards/ Trusts and universities, ensuring improved partnership working and successful succession planning into midwifery education and research.*

Response: We agree that this is critical for ensuring integration between education, practice and research. Previously these arrangements have been difficult to implement given differing HR, pension, remuneration arrangements in individual cases. However, in England this approach is part of the Long Term Workforce Plan, so there may be opportunities to advance this agenda in future. There is also a (little known) clause in the NHS pension arrangements that provides for anyone moving from the NHS to HEI to remain in their NHS pension scheme providing they are 'research active' and this may be useful in overcoming some barriers.

There is a very clear process for doctors. Medical schools have special conditions that enable staff to remain within NHS pensions. 20% VAT is charged for secondment between NHS and HEIs for non medical professions. We need to highlight examples of good practice and to raise the profile of successful models so that they can act as an incentive / source of guidance for others, for example https://www.catch.ac.uk/training-careers/other-healthcare-professions/case-studies-other-health-professions

On a cautionary note, individuals holding joint appointments report burnout is an issue in trying to meet expectations of two organisations including administrative load of working across two organisations. Careful integration of the joint appointment roles seems to be key to avoiding this risk.

Report Recommendation: *Regular meetings are arranged between university (including the Lead Midwife for Education) and NHS strategic leadership to monitor midwifery programmes and address concerns from either organisation as early as possible.*

Response: The reference to NHS strategic leadership is not clear in this recommendation. Typically LMEs meet with Directors of Midwifery in Trusts. Some LMEs also sit on boards of local maternity and neonatal systems within the ICS. These arrangements can, and should, be assessed through programme approval processes. It is essential that appropriate arrangements are in place for the effective delivery and evaluation of any peer-registration programme. There are a number of relevant NMC standards governing this area including as follows:

Part 1: Standards framework for nursing and midwifery education [NMC 2018]

- 2.1 There are effective governance systems that ensure compliance with all legal, regulatory, professional and educational requirements, differentiating where

appropriate between the devolved legislatures of the United Kingdom, with clear lines of responsibility and accountability for meeting those requirements and responding when standards are not met, in all learning environments.

- 2.5 adopt a partnership approach with shared responsibility for theory and practice supervision, learning and assessment, including clear lines of communication and accountability for the development, delivery, quality assurance and evaluation of their programmes

Part 2: Standards for student assessment and supervision [NMC 2018]

- 1.4 there are suitable systems, processes, resources and individuals in place to ensure safe and effective coordination of learning within practice learning environments

Report Recommendation: *Registered midwives use the Nursing and Midwifery Council (2019) Standards of proficiency for midwives when planning their continuing professional development as part of revalidation to demonstrate their own competency and be able to support and supervise midwifery students.*

Response: We support this recommendation. We understand that the NMC will be reviewing its approach to revalidation. When this project commences it will be important to engage in the consultation process in order to influence and shape the way forward for midwives.

Additional observations

1. The data concerning qualifications on page 5 does not capture the percentage of staff studying for masters degrees. This information would be helpful in gaining a more detailed understanding of the overall position.
2. It is clear that the age profile is changing and this is concerning. It is good to have this situation highlighted in the report [Page 7].
3. The data concerning the ethnicity of educators is difficult to interpret because the reader is not given the detail in relation to the response rate for this question. Does this include all staff contributing to programme delivery or just the midwifery educators? [page 7]
4. The section on midwifery educational leadership states that 8% of Deans or Associate Dean level posts are occupied by midwives. The appropriate percentage should vary relative to span of professions and role. For example, leadership positions in Schools of Nursing and Midwifery or Midwifery should have greater percentage of midwives in leadership positions than at College/ Faculty/ Institute level which may include many more different professions. Leadership percentage should be proportionate.
5. Almost 60% [59%] of LMEs are members of strategic management groups within universities. This seems to be a positive finding as there are often large number of professions represented in typical health/social care faculty structures. However, the reason for their membership is not clear. More information about the management and governance structure of each institution is needed to truly understand the contribution and impact the LME is making in relation to the functions of the LME as set out in Part 3: Standards for pre-registration midwifery programmes [NMC 2019].

6. It is reported that 29% of LME's were not asked to complete the FOI request. Some institutions may have a central team who's responsibility it is to respond to FOI requests. As a result, we don't know if the data returned is disputed by the LMEs who were not involved, or if the LMEs requested to be involved and were refused.
7. The RCM calls for midwives to be represented at university Board/ senior management or strategic team (as they recommend for NHS Trust Boards). We strongly support the aspiration for midwives to be appointed to Dean, Deputy Dean, Vice principal and other senior levels within academia based on merit. Pathways for senior academic progression should be made clearer and midwives supported and mentored to achieve these roles. It would be useful to provide examples of midwives in these very senior roles.
8. There is a reference to the requirement for LMEs to manage a team of professionals but this is not set out in the new standards. The central focus of the LME role is related to academic standards and academic quality including the student experience. Additionally, the LME may be required to contribute to the design, development, implementation, evaluation and quality assurance of midwifery programmes. Contributions at strategic and operational level on matters relating to midwifery education are central as the role of the LME. Determining how this happens at local level, in keeping with local management and governance structures needs to be agreed locally. It will also depend on whether the LME holds responsibility for programme leadership as well as the LME role. A shared understanding of the role of the LME is essential and the RCM may be able to assist with this. Perhaps the RCM can advise LMEs when negotiating and determining the LME aspect of their role locally. The LME Forum will be a vital source of guidance on these matters as LME role holders will have all manner of additional responsibilities. In summary, whilst the LME role is similar across universities, the overall contribution of the LME will vary from university to university and the remuneration and workload remission will also vary accordingly. We recommend that the RCM advocates for a more clearly defined role for the LME.
9. The focus on the student experience within the report was useful as it highlighted some key areas of concern such as high levels of attrition. It would be helpful to see the HESA [Higher Education Statistics Agency] data for student midwives to provide a more detailed and fuller picture.