INTERVIEW WITH KATE NEWSON ABOUT DIRECT ENTRANT MIDWIFERY

Kate Newson is the Director of Midwifery Services for Tower Hamlets Health Authority. She is also the Chair of the Midwifery Committee of the English National Board for Nursing, Midwifery, and Health Visiting, and a member of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. MIDIRS' director, Marianne Scruggs, interviews her about issues surrounding the uptake of Direct Entrant Training.

Marianne: Kate, there has been the possibility of schools taking up direct entrant courses for a long time and yet there are only two direct entrant courses in the country. Do you have any idea why this might be?

Kate: No, I don't really know. We need to be aware that even the people who advocate it haven't taken it up. Maybe one reason is that we have only recently sorted out the 18 month post registration course, and that probably has taken up much of the tutor's time. But we have to ask ourselves whether while people publicly support it, perhaps some lack the motivation to implement it?

Marianne: Perhaps tutors (and health authorities) are put off by the costs of implementing a Direct Entrant course. After all, they won't produce midwives as quickly as an 18 month course. Wouldn't a DE course cause an expensive gap between the time DE midwives started to train and when they finished?

Kate: The financial arguments for not transferring to DE courses are very thin. Some people think that if they started a DE course they would have a three year gap before they produced any midwives - because it takes three years to train them. But it obviously doesn't work like that in reality because if you are doing an 18 month course when you first started training Direct Entrants, those students would be running through, producing midwives in 18 months. So the maximum gap you would have is 18 months and that is if you are going to go straight from 18 months to total direct entry. But if we change to supernumerary status for direct entrants, and students aren't on the wards at all, then you could keep running the 18 month courses for a bit longer, so maybe you would have a gap as little as one year in the production of your next set of student midwives. Normally schools have gaps of six months, so it's really just a six month hiatus - and that's if you transfer completely. Other people have looked at schemes that do 18 month and three year courses intermingled but that can get very difficult.

Marianne: What's involved in setting up a Direct Entrant course?

Kate: The major undertaking is preparing a programme and getting all the experience - which involves a lot of negotiation with the general school, and they are under a lot of pressure themselves to create the ideal learning environment for student nurses, at the same time as cutting down the numbers of their students. You also have to re-educate staff to be able to provide adequate support for new students who don't have a nursing background. Plus, you will probably have to get additional funding for the implementation of it.

Marianne: Where would the money come from?

Kate: At the moment, it would come from their own district or region.

Marianne: Is there a problem with the curriculum or is the existing curriculum adequate?

Kate: The three year programme curriculum is quite new, and is working very well. It came out at the same time as the 18 month programme. I think what people were worried about in the past was that the curriculum was very prescriptive, but now tutors are being asked to be imaginative. As long as it is within the broad framework as set out by the ENB, there can be a great deal of variation within that.

Marianne: Are there any schools now seriously looking at the possibility of setting up DE courses?

Kate: I think about three have approached the Educational Officers of the ENB.

Marianne: It would obviously be cheaper to train people for three years than four and a half. Won't this encourage Health Authorities to promote direct entrant courses?

Kate: At present the total four and a half year training may not be paid for by Health Authorities because usually health authorities don't train student midwives who were their own student nurses. So, effectively they only train them for 18 months. And the two sets of money come out of different budgets, so it's not seen as a four and a half year collective. The other factor to consider is that we don't follow that through. Some midwives train and then go back into nursing. Some authorities might see a nurse with a midwifery qualification as a plus, say on their gynaecology wards.

Marianne: If you were a tutor wanting to get help in setting up a direct entry course, where would you go and what kind of help do you need?

Kate: The best thing to do would be to contact on the Education Officers at the Board, and they would help you and also put you onto one of the two schools now running DE courses. I think the Education Officers would be very positive right now to anyone who wanted to set up a DE course.

Marianne: Kate Newson, thank you.

THE ENGLISH NATIONAL BOARD WILL BE MAKING A PRESENTATION ABOUT DIRECT ENTRANT MIDWIFERY TO REPRESENTATIVES OF THE MIDWIFERY PROFESSION FROM 1:30 - 5:00 PM ON 3RD SEPTEMBER AT THE ENB. WATCH MIDWIFERY PRESS FOR DETAILS.

THE FUTURE OF MIDWIFERY EDUCATION By Kate Newson

Director of Midwifery Services Tower Hamlets Health Authority

The recently published documents concerning the future of nursing and midwifery education are to be welcomed. Much criticism has surrounded the education of nurses and midwives for many years, the professionals themselves being the most vociferous in their comments.

My own view has been fairly consistent. Since the mid-1970's, I have been one of the greatest advocates of direct entry midwifery, believing that the dual qualification of SRN/SCM could, on occasions, inhibit the practice of midwifery, detract from the care of the woman and contribute to a decline in the midwifery profession.

The concept of an increasing band of direct entry midwives has gained increasing popularity even amongst the upper echelons of the profession. Strangely, though, this has not been reflected in the number of direct entrants, either in training or qualifying. Paradoxically, in fact, as enthusiasm for the concept grows, the two training schools for direct entrants appear to be facing an increasingly precarious future. The reasons for this are obviously many and varied and may be as a result of local, political and professional difficulties rather than a reflection on the training offered.

Despite the apparent vulnerability of the direct entry scheme though, the ENB education and training document strongly supported the concept of this method of training for the midwives of the future. Indeed, not only did the Board support the concept of direct entry midwifery, it also suggested that other branches of the nursing profession may wish to follow the midwifery example.

Whilst acknowledging the advantages of direct entry into the various areas of nursing, the Board also recognised that professional isolation was unnecessary. Many areas of shared knowledge exist within all the groups concerned. It was from this concept of shared knowledge that the notion of a core curriculum was developed. With the publication of the RCN document, "A New Dispensation", the term common core curriculum was to become in many circles synonymous with 'foundation course'. This was and is an extremely unfortunate misunderstanding, as it has led to a great deal of confusion and in some cases, suspicion amongst midwives.

The term, common core curriculum, was used in the Board's document to encompass the shared knowledge that would be common to all nursing/midwifery/health visitor courses. It was proposed that the shared knowledge areas would be clearly identified in each course in order that shared learning facilities could be used if appropriate. In practice, this could mean that nurses, midwives and health visitors could come together during training for certain subjects; it was thought that this would be particularly likely in the first year of training. It is important to stress that this shared learning would not lead to a generic qualification but would prevent unnecessary repetition if a RN (registered nurse) decided to train as a midwife.

In financial and educational terms, this has obvious advantages. The ENB document therefore offered to midwives the educational opportunity for which they had been searching.

1) It supported the concept of direct entry and suggested that the student would be supernumary for the first two years of training.
2) RNs would still be able to train as midwives, although it was implicit that this would be the least common method of entry into the midwifery profession.
3) The identification of the common core curriculum would enable small and geographically isolated schools of midwifery to combine with nearby schools of nursing and have a shared learning experience for the appropriate parts of the midwifery curriculum.
4) The flexibility of the Board's document still allowed for the establishment of Regional Schools of Midwifery where desired.

Contrary to this approach, the RCN consultative document was far more prescriptive. The authors of the document advocated the implementation of a foundation course in nursing lasting two years, which would be followed by a year of specialisation. The element of choice or intelligent application was removed in these proposals. All students, regardless of their chosen career, would undertake the two year nursing foundation course. In many ways, this document epitomised the fears that some midwives had had for many years. Midwifery would become a specialisation of nursing and no more. For obvious reasons this document has not been received enthusiastically by the majority of midwives.

If the ENB proposals are accepted, then midwives will have achieved a great deal in terms of the previously stated aims, and the future should look bright. The reality, though, may not be quite as cheerful as one would expect. The midwifery profession now faces its greatest challenge. It has always been assumed that there are a large number of mature students who would welcome the chance to train as midwives and that these individuals would, in fact, make better midwives than their dual qualified counterparts. It has also been argued that with students forming part of the work-force, their learning opportunities are reduced. There are many questions though that will need to be answered -

1) In the event of direct entry training being more readily available, will the number of mature direct entrants be available to take the places?
2) Even if an adequate number of mature entrants are available, will they be prepared to enter the profession when a salary is no longer paid? A grant or bursary seems more likely for the future students.
3) Will the tutors and clinicians be able to ensure that supernumary status does not leave the student feeling isolated and distant from the midwives working in the practical situation?
4) If the students are allocated to individual midwives during their periods of practical experience, are we prepared, as a profession, to ensure that the midwives chosen for this particular role are of an optimal standard?
5) In the future, will a midwife training in this way and given the opportunities of self-development implicit in the proposals be prepared or able to cope with the constraints of the present-day institutions?
6) If, as seems likely, the answer to question (5) is "no", are we, the midwives of the '80s, prepared to make the necessary changes that will enable the midwives of the '90s to practise in a confident and fulfilled way.

I believe that the answer to the last question is probably the most significant. It is fatuous to believe that a change in training and education alone will bring about the desired changes within our profession. The most significant changes will need to be amongst qualified midwives. We are all prepared to change others - how many of us are prepared to change ourselves?

THE EDUCATION OF NURSES : a new dispensation (1)*

by Sarah Roch Senior Tutor, Princess Anne Hospital, Southampton

In 1979, the Nurses, Midwives and Health Visitors' Act entered the statute book, and the three major caring professions entered a new era of co-operation, linked together by a statutory body - the United Kingdom Central Council (UKCC). This Council's brief was to "establish and improve standards of training and professional conduct for nurses, midwives and health visitors".(2)*

In the knowledge that radical changes in professional education were necessary, and conscious of how imperative it was to "get it right", the Royal College of Nursing set up a truly independent Commission on Nursing Education under the Chairmanship of Dr Harry Judge (Director of the Department of Educational Studies, University of Oxford). The Commission was asked to make recommendations on the future pattern of nurse education, and invited a midwife educator to serve because midwife teachers are actively involved in many forms of nurse education, and to enable midwifery education to be seen in an appropriate context.

The commission received evidence from all specialities (including midwives) and consulted the professions widely. It finally produced a radical and well-researched report detailing imaginative and far-reaching reforms for nurse education, including extremely good suggestions to enable genuine student status, and the proposal that nurse education should come under the aegis of Higher Education in order to improve academic attainment and credibility.

Some interesting manpower research produced a fascinating equation which sought to prove that in the long term, apart from an initial "pump priming" operation, the new system could cost little more than the present format.

The report also makes much of the important fact that if the present system continues, by the mid 1990s, due to inexorable demographic trends, the nursing workforce could cease to function effectively because of lack of recruits in the 18-20 age group.

Midwifery will also face a reduction of applicants in this age range and will need to look to attracting the more mature student.

As the Commission's brief was to examine nurse education, midwifery education was not discussed in detail, but merely looked at in terms of the overall pattern of education for health professionals within the spirit of the 1979 Act.

A major proposal of interest to midwives, involved a direct entry system for all the professional specialties, and the experience of midwifery education in this respect was helpful. It was important for a midwife to be involved when a common core curriculum was under discussion.

For many years the midwifery profession has been advocating an increase in direct entry midwifery education and training, and this document certainly supports that philosophy. The profession has also indicated that the present accepted norm of dual qualification is both expensive and unnecessary, and these proposals also accommodate that concept.

This document is readable and full of useful well-documented information, and should be carefully considered together with the strategies being put forward by the statutory bodies. If the midwifery profession is well informed it will choose its future education strategy wisely.

*References

(1) The Education of Nurses : a new dispensation. (Report of the Commission of Nurse Education) Royal College of Nursing (1985).

(2) Nurses'. Midwives' and Health Visitors' Act (HMSO) 1979.

DIRECT ENTRY MIDWIFERY TRAINING INITIATIVE

A presentation held in London on September 3 by the English National Board for Nursing, Midwifery & Health Visiting

DIRECT ENTRY training should be the predominant feature in the midwifery profession of the future if the mood of those participating in a recent presentation on direct entry training has been gauged correctly.

Organised by the English National Board for Nursing, Midwifery and Health Visiting, the afternoon meeting, held in London on Wednesday, September 3, was attended by nearly 200 teachers, managers and clinical midwives from midwifery training institutions from all over England.

Chairman Mrs Kate Newson opened the proceedings by explaining the background to the decision to hold the meeting. After publication of the English National Board's strategy on education the Midwifery Committee (of which she is chairman) had presented a paper to the Board indicating that there was uncertainty as to where the Board stood on direct entry training for midwives.

This meeting, she said, had been held to hear what the midwifery profession itself felt about direct entry and, also, about the recently published Project 2000.

The first speaker was Miss Sue Downe, now a Staff Midwife at Derby City Hospital. Miss Downe described her own experiences and what she and others had felt "On being a direct entry student midwife".

After graduating from university Miss Downe had gone to Botswana, where she first became involved in midwifery. Her work there had convinced her that her career was to be in midwifery—*not*, she said firmly, nursing, but in midwifery.

On returning to this country she had applied for direct entry training to the Edgware Road and Derby hospitals, both of which had long waiting lists. She eventually got in through a cancellation.

She spoke of the antagonism existing between the direct entry students and the 18-month State Registered Nurses. At Derby they had all sat down one evening and "talked it through", after which things had been for the better. She advised anyone starting mixed training to be "scrupulously fair" and to bear in mind the need for counselling; it was a good idea to get both groups together. Talk to the staff as well, she suggested, to see how they felt about direct entry training.

Prejudice against direct entry midwives was now not as strong as it used to be, said Miss Downe, but she warned that it should be borne in mind that direct entry midwives would only be "as good as their course".

She ended by listing some of the strengths and weaknesses of direct entry training. These included: *Strengths:* no sickness module—and direct entrants stay on; training includes relevant data, which makes it cost effective to the NHS (but not, she added, to midwifery); direct entry midwives can practise in the EEC as soon as they qualify; increased time to attain skills; ideal for someone who has no wish to be a nurse. *Weaknesses:* still experimental courses; reduced career prospects (Miss Downe was not convinced that this argument was true); difficult to cope with being a student after coming from life in a university or with experience of working; takes longer to be accepted as a competent practitioner; lack of medical knowledge (this also was refuted by Miss Downe); expensive for midwifery budget.

She summed up her lists by reminding her audience that the majority of direct entry midwives would all want to stay on in midwifery—their chosen career—and, as they were committed, were likely to involve themselves in research and in discussion on issues such as Project 2000.

Although the next speaker was listed as Miss Young, it was in fact Mrs D. McDonald, Senior Midwife Teacher, Wolverhampton School of Midwifery, who took the floor. She began her talk on "Preparing the ground" by asking a question: "Why prepare for a three-year course?". And then proceeded to answer it, for the benefit of those present. At Wolverhampton, she said, where they had been preparing for some years to introduce direct entry training, they believed in what they were doing—they felt that the time was right and that there was a need for such a course. There was no shortage of applicants and, said Mrs McDonald, it was good for the profession.

She acknowledged that they were treading virgin ground. From the start they had proceeded cautiously, using guidelines from the (then) CMB and the ENB. She described how they had formed a committee and had gone on a fact-finding mission to the then two schools running three-year courses. Lines of communication had been set up with other midwifery schools and feasibility studies carried out. The next step had been to develop a curriculum, deciding on its philosophy and the clinical content of the course.

It had taken six full months to plan the courses but there was reward in the enthusiasm shown in the ward chosen to take direct entrant students. Now, she said, the curriculum plan was nearly finished, having been approved in principle by the English National Board. The target date for the start of the course was late 1987 or 1988. There would be a yearly intake of eight students.

Mrs McDonald was immediately followed by Miss M. Young, Senior Midwifery Tutor at Derby City Hospital. Also speaking to the theme of "Preparing the ground", Miss Young emphasised that Derby was a very different proposition to Wolverhampton. In Derby they had been training direct entrants for 50 years—although she admitted that she did not know such a scheme existed when she applied for her post!

She explained that Enrolled Nurses had been dropped from the hospital and that there were only SRNs and direct entrant midwives (a decision in which she had not been involved).

In providing direct entry training, Miss Young said that backup from existing staff was very necessary. She conceded that preparation of staff was perhaps not always as good as it should be, for it had to be recognised that direct entry training was very heavy on tutors' time. She found direct entry students enthusiastic and questioning; many, she thought, knew more about the profession than the trained staff.

Long Waiting Lists

She emphasised the necessity for "other people to take up the need for direct entry training". There were long waiting lists of—mostly—young women eager to take up midwifery as a career. Often she found that by the time she got round to writing to applicants when there were vacancies they would have moved on or got other work. She had gone through as many as 100 names to get eight—this was a terrible loss of potential midwives.

Miss Young did not believe that teachers should be pressed to take direct entry students. It was better to get over any problems by discussion, confrontation and talking them through. "I firmly believe", Miss Young concluded, "that direct entry is the way we should be going".

This first part of the programme ended with questions and answers, in which concern about the shortage of tutors was very evident.

The latter half of the afternoon was entitled "The way forward" and the two speakers were Miss Ruth Wilday, Director of Nursing Services (Midwifery), Birmingham Maternity Hospital, and Dr E. R. D. Bendall, Chief Executive Officer, English National Board.

As RCM members know, Miss Wilday is a witty and innovative speaker and she took the theme of "The way

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MIDWIFERY SEMINAR
JUNE 15, 16, 17, 18
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forward" to imply a journey through direct entry training with its purpose being meditation on the next move: the training needs of a student with no previous experience, developing programmes to meet the needs of that student and of the manpower needs of the service in the most efficient and cost effective way.

Using pictures of road signs to illustrate her talk Miss Wilday guided her audience through a maze of traffic warnings and other hazards to journey's end and its four-way signpost to: Research; Teaching; Clinical practice; and Management.

It is not possible, in a brief report, to take readers through the whole "journey". Among the points made by Miss Wilday were that she believed direct entry for midwives to be a matter of urgency—she pointed out that its preparation took a minimum of two years. Forward planning would include discussion with all those involved—your immediate boss, the education officer at the ENB, the CNO, general manager, health authority and, most certainly, your clinical colleagues.

There was not just one way to achieve direct entry, said Miss Wilday. One had to accept that resources were not the same in different health authorities and there was the time factor to be considered. She listed some of the "needs" for this journey. Residential accommodation alone was a major undertaking. Then there were "communications"—the most important part of the journey—keeping people up to date, participating in curriculum development. She suggested the use of tapes, a bulletin or newsletter. What about "finance"? What was needed for direct entry? Some resources were "shareable" but there would always be an initial outlay. Direct entry was cheaper in the long run but initially it was expensive. She set out the financial resources to be considered: pay for tutors, student midwives' salaries/grants for three years. Other, less obvious, considerations were interview expenses; audio equipment, books and magazines; lecture/index/examination fees; travel costs; telephone; uniforms; education budget for tutors.

After all this, Miss Wilday said, the question to be asked was: "Do you believe this journey is really necessary today?"

Project 2000

Dr Bendall, the final speaker of the afternoon, said that there was a feeling that the majority of midwives were in favour of direct entry and she disclosed that funding for its extension was "in the pipeline". Referring to Project 2000 she acknowledged that midwives thought that a major problem lay in the Common Foundation Programme. She asked them to remember that "There is good in common establishment", citing shared libraries, audio-visual equipment and buildings. There was, she admitted, trouble when you started applying commonality in all specialties—e.g. nutrition. However, midwifery was not the only specialty with a problem.

Dealing with some of the criticisms that had been voiced following publication of Project 2000, Dr Bendall pointed out that it was envisaged that the Common Foundation Programme would take *up to* two years rather than the full two years so often quoted. She begged midwives not to be "overly defensive". There were admirable strengths in midwifery but some schools were too small.

Referring to the suggestion that students should be supernumerary Dr Bendall said that this was the "biggest single change" that the professions could need. Speaking of the possibilities for the professions in the future she warned that "the only thing that would stop us is if we shoot ourselves in the foot by not considering each other".

After this contribution it was perhaps inevitable that during the question-and-answer session that followed there was much discussion about the purpose of Project 2000.

The afternoon's proceedings were summarised by Chairman Kate Newson, who asked: "Why haven't we prepared for direct entry?" Was there, she wondered, a commitment to the system? A decision, too, had to be made on Project 2000. Should midwives decide to take on their own profession and go their own way it was an "incredible responsibility". If, in a few years' time, it became clear that they had chosen wrong it would, she warned, be the fault of the midwives, not the nurses or the health visitors or anyone else.

Listening to the afternoon's speakers and the debate, she had heard issues raised which she had not previously thought of. She urged those present to go back to their places of work, to talk over the afternoon's discussions with their colleagues. And then, having talked and made their own decisions, to let the ENB know what those decisions were. The outcome would depend on the response from the midwifery profession.

Wendy Savage : on birth

"On the other hand there is the pessimistic view (of labor), which says that no labour is normal except in retrospect. But at the other end are people who say that everything is normal, unless something goes wrong.

"Pregnancy is not an illness: it is a very important part of a couple's life together. It is very important to allow a woman to feel in control, rather than taken over by the doctor, by the hospital, by the system.

"If you're not careful, you could label almost the whole population of women having babies as of high risk.

"Men are onlookers, bystanders, who have a feeling that they have got to do something about the pain and the birth which is progressing.

"Women, on the other hand, understand that it is a very important function and that there are worse things in life than pain."

Midwives chronicle & Nursing Notes Nov'86.

'Project 2000 : A new preparation for practice" is the United Kingdom Central Councils consultation document on Nurse Education & Training. See M.C.&N.N July for further information.

Birth G[illegible]e Vol 3 No2

A STUDY TO INVESTIGATE AND PROMOTE

THREE YEAR (DIRECT ENTRY) MIDWIFERY TRAINING.

Brief description of project final draft

The Project

The study will seek to identify the advantages/disadvantages of three year midwifery training programmes, establish the reasons for the lack of courses, and document problems/solutions met in their development. Together with data compiled from relevant recent research, this information would enable more informed decisions to be made about the development and promotion of such programmes. The Department of Educational Studies at the University of Surrey is carrying out work between the beginning of April 1987 and the end of March 1988. The proposed plan is as follows:

1. Literature survey.
2. Postal questionnaire surveys of Regions, Districts, midwifery schools, and potential applicants for three year training.
3. Follow up visits and interviews to add further depth to the information gathered in the postal surveys.
4. Feedback of results.

This is an independent University-based project and as is customary confidentiality will be maintained.

Background

There has been a recent surge of interest in the three year (direct entry) midwifery training and representatives of the midwifery profession have expressed a commitment to the principle. The English National Board for Nursing, Midwifery and Health Visiting identified the need for a study to investigate and promote the development of such programmes; the Department of Health and Social Security provided funds and the Department of Educational Studies at the University of Surrey was commissioned to do the research.

People

Research Teams
Nancy Radford (Research Officer, Dept. Ed. Studies, University of Surrey)
Anne Thomson (Midwife Teacher, part time secondment to the project)
Dr Brian Salter (Research Consultant to the project)
Betty Fitzgerald (Project secretary)

An Advisory Group provides the team with specialist information and guidance:
It is chaired by:
Dr M. Pope (Deputy Director, Dept. Ed. Studies, University of Surrey)

Members:
Miss M. Aynsley (Senior Midwifery Tutor, Newcastle and member of ENB Midwifery Committee)
Miss C. Hallworth (Senior Midwifery Tutor, Watford and member of ENB Midwifery Committee)
Mrs J. Leeks (Administrative Officer, Dept. Ed. Studies, University of Surrey)
Mrs K. Newson (Director of Midwifery Services, Tower Hamlets and Chairman of ENB Midwifery Committee)
Dr J. Prince (Nursing Officer, Research, DHSS)
Miss A. Stewart (Professional Officer, Midwifery, ENB)
Mrs V. Tickner (Director of Education, RCM)

Enquiries about the project should be sent initially to Mrs B. Fitzgerald, Dept. Ed. Studies, (Block AA), University of Surrey.

COMPUTER AIDED LEARNING

Computer aided learning (CAL) is defined as learning about computers whilst using the technology, this in both the form of software and techniques available.

At a meeting of the English National Board on 11th November 1986, the Board received and agreed a framework for the development of computer assisted learning for nurses, midwives and health visitors. The Board further agreed that consultation with Directors of Nurse Education, approved Midwife Teachers, EAGs and colleges preparing nurse tutors should be undertaken before the document was submitted to the DHSS for possible funding.

These consultations took place during February, March and April 1987, and in general the response was favourable, agreeing that the Board should take an initiative in developing CAL.

As a result of the consultative process, the ENB document on CAL was revised. The document as it stands considers the problems of the poor quality of available software, the current state of CAL in nursing/midwifery education, the strategic framework for the introduction of CAL, the options available and the estimated cost.

The ENB planned to approach the DHSS for funding in June 1987. In September 1987 the design of courseware will begin and in June 1988 the training of the teachers will start. In September 1989 the evaluation will be implemented and in June 1990 the project is due to be completed.

Taken from the minutes of the 75th meeting of the ENB, held on 9th June 1987.

DIRECT ENTRY TRAINING: A POTENTIAL FUTURE OR A VIABLE PRESENT?

Soo Downe, Midwife

The RCM has expressed its support (1). The ENB is sponsoring research into its potential (2). The UKCC has shown significant interest in its development (3).

Why, therefore, is direct entry midwifery training still only offered in one training school in the country?

According to an exploratory study (4) run in 1985 most tutors polled felt that the following were the main issues preventing the establishment or re-establishment of such courses:

1. Lack of tutors.
2. Lack of applicants.
3. Lack of finance.

In an attempt to seek the views of those presently involved in direct entry training on this subject, three people were approached.

Miss Marion Young is the Senior Tutor at Derby City Hospital School of Midwifery, the only school in the UK presently running the three year training. She agreed that the chronic lack of tutors in midwifery at present is a major reason for the inability of schools to run such a course. In fact many senior tutors have visited Derby, having shown an interest in the training. They have left expressing enthusiasm; but some appeared not to have sufficient back-up from other tutorial staff. This is after all not so surprising when one considers the extra work needed by tutors intending to run the course; work requiring not only extra hours on the wards and in block teaching clinical and theoretical skills, but also time at home investigating aspects of nursing that may have long been relegated to distant memory. Before all this comes the many hours of course planning for submission to the ENB for ratification.

It is the difficulties inherent in this aspect that concern Dorothy McDonald, Senior Tutor at New Cross Hospital School of Midwifery, who is presently involved in trying to set up a DE course. She emphasises the time involved for tutors who often work long hours out of officially paid time endeavouring to construct a viable course. She has been called upon to provide not only the unfamiliar detail of DE training, but also to investigate the logistics of creating a College of Midwifery in which to house it and other midwifery courses. This request, from the ENB, has led to her being asked at local level to provide five potential plans, with costings! Surely this is not a tutor's responsibility, and, if they continue to be required by local managers to furnish such detailed information, most tutors will never undertake the venture. Dorothy McDonald feels that the ENB should encourage whatever viable schemes tutors manage to present, taking into consideration the fact that tutors understand the day-to-day politics of their local situation. They are thus in the best position to judge the optimum involvement of the resources, (structural and human) at their disposal. Tutors who wish to run the course are clearly dedicated, seeing it as a major step forward for midwifery. However, such tutors are themselves only human, and are also a limited resource. Should they really be expected to put so much spare time and energy into planning and setting up a course alone? Theoretical support is not enough without expert back-up and practical encouragement.

Perhaps the formal creation of a tutors' curriculum group at national level, either through the ENB or the RCM would pool acquired knowledge so that the wheel isn't constantly re-invented. Such a group, with regional input, would also provide the support needed by many tutors planning DE courses.

There is also the problem of Unit General Managers (UGMs) not understanding the long-term financial investment of DE training. As Miss Young reiterated, they prefer a course producing midwives every 18 months rather than one doing so every three years. Such a preference does not take into account the rate of attrition among midwives with nurse's training.

This problem is compounded by the fact the in many regions there is no separately earmarked budget from Region for midwifery education. It is devolved only from Unit level and thus has to battled for at that level. If Regions are to encourage DE training they must earmark money specifically from Regional level to the Units.

Miss Young commented that often a tutor interested in the training who contacts the ENB is then referred to her. She feels that such tutors may not be getting much directive information from the ENB.

Miss Stewart, Professional Officer of the ENB, points out that the ENB is not really in a position to offer an opinion or to advise and direct midwifery tutors on the subject until the results of the current University of Surrey research are available. As she says, the ENB is supportive in principle, as demonstrated by the recent DE training presentation run by the Board (5). All representatives attending were followed up, resulting in more interest and activity a propos the training.

Hopefully the massage is reaching UGMs and tutors as a result of such enterprises.

Miss Young emphasises that curriculum planning should actually be easier now than previously since the ENB have dropped many of the rigid criteria previously insisted upon for course planning. Such changes may well incline keen tutors to apply themselves seriously to preparing a course.

The theoretical support for DE training is indisputable, and widespread. Practical application of this support appears to be stalemated. The waiting list of direct entry applicants at Derby continues to run in the hundreds at a time when we are bemoaning the imminent loss of the eighteen year old 'training pool'. To lose such a resource of enthusiastic and dedicated potential midwives is short-sighted to say the least. We who support DE training can only continue to press for resolution of the stalemate as soon as possible.

References

1) Report of the RCM Council Working Group on the Role and Education of the Future Midwife in the United Kingdom. October 1986. From: The Royal College of Midwives

2) Research underway through the University of Surrey, Department of Educational Studies. Contact: Nancy Radford, Research Fellow.

3) Project 2000: The Final Proposals. January 1987. Section 10. From: the UKCC.

4) Summary of recent survey assessing midwifery training schools' attitudes to DE midwifery training. MIDIRS Pack No.2 1986.

5) Direct Training Initiative. Report of the ENB presentation held at the Royal Society of Medicine, 3rd September 1876. In: MIDIRS Pack No.3 1986.

An original article commissioned for MIDIRS.

SETTING UP A MIDWIFERY DEGREE COURSE

Australian Journal of Advanced Nursing has blished a paper which aims to provide midwives, icators and nurses interested in curriculum velopment with an understanding of the losophical, educational and psychological foundations a college-based midwifery programme. This is done describing the experience of setting up a midwifery degree course at the Lincoln Institute of Health Sciences, Melbourne, Victoria. The authors aim to share the knowledge which they gained through the process of curriculum design, innovation and implementation. Hence the planning of the course, its history and the course programme are all described.

dzik L. Mastery learning for midwifery: a college-based course. Australian Journal of Advanced Nursing, vol 3, no 2, c-Feb 1987. Copies can be supplied (under the terms of the Copyright Act). Send 50p and an A4 SAE to Sue wkins at MIDIRS.

Midwifery training boost

EAST Cumbria Health Authority has secured approval from the English National Board for the training of midwives for the next three years in the Cumberland School of Midwifery.

This will permit the first intake of students into a new school jointly funded and organised by East and West Cumbria Health Authorities.

Nine student midwives will be recruited every six months and the first intake is on 11th May.

There are many qualified nurses in Cumbria who are eager to do midwifery training, and for this reason the majority of students, for the next year or so, will be recruited locally, with one trainee from Yorkshire.

This will of course create vacancies for newly-qualified general nurses during the period of training.

Miss Champion, Senior Midwife Teacher, who led the team which gained approval for training, said: "Both East and West Cumbria are committed to the success for this project and there has been excellent co-operation and great enthusiasm from all concerned.

"We hope that with the introduction of the new training school we will be able to train and retain an adequate supply of midwives with the aim of maintaining and improving the quality of service to mothers in East and West Cumbria."

Reproduced with permission from the Cumberland and Westmoreland Herald, 21 March 1987.

Midwifery college planned

A PROPOSAL to set up a College of Midwifery in conjunction with Newcastle and Northumberland has been supported by North Tyneside Health Authority.

The authority had set up a working group to discuss the rationalisation of midwifery training after agreeing there were four options to consider:

- Retain the status quo — This left North Tyneside without any input into midwifery training and was not supported.
- Combine Newcastle and North Tyneside — This was welcomed by North Tyneside but left Northumberland out on a limb.
- Combine North Tyneside with Northumberland — Because of long standing problems in Northumberland, this was not acceptable.
- Combining North Tyneside, Newcastle and Northumberland to form a College of Midwifery — This was preferred.

District personnel manager and nurse adviser, Mrs Jean Turner, was involved with the working group. She said it would take a year to agree training systems and set up the college.

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WNB

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APRIL 1987

MID 87/001
Circular

POST BASIC CLINICAL STUDIES - SHORT COURSE IN OBSTETRIC ANAESTHESIA/ANALGESIA FOR MIDWIVES OUTLINE CURRICULUM NUMBER WNB 4

The Board has recently approved the Short Course in Obstetric Anaesthesia/Analgesia for Midwives: Outline Curriculum Number WNB 4 which will be a Statement of Completion course for experienced midwives and/or nurses currently involved or working in an obstetric theatre/delivery suite.

The aim is to further educate and train the midwife or nurse in aspects of obstetric anaesthesia/analgesia and in neonatal resuscitation.

The course, which is of 15 days' duration (minimum) may be planned on a block or day release basis integrating theoretical and clinical instruction throughout.

Copies of the Outline Curriculum will shortly become available from the Board's offices price £1.15 each including postage and packing. Cheques and postal orders should be made payable to the Welsh National Board. Despatch is on receipt of payment except for Training Institutions and Health Authorities which will be sent an invoice upon delivery.

Any enquiries regarding this circular should be addressed to Mrs Ruth Davies, Professional Officer (Midwifery), at the Welsh National Board's offices.

Midwives in short supply

Call for rethink on direct entry training scheme

Reporter Caroline Milburn this week looks at the problems facing local midwifery services and how one midwife copes with the rigours of her daily round.

COPING with a shortage of midwives is a constant headache for the director of midwifery services at Heath Road Hospital in Ipswich, where 3,000 babies are born each year.

"I can never remember a time when I wasn't worried about there being not enough midwives," says Elizabeth Fern.

The national shortage of midwives has led to a situation where Ms Fern says she could easily find room in her budget to employ ten more.

But while the need is there, the numbers of qualified applicants are not. As with many professions in Britain which are suffering a shortage of skilled workers, many of the answers can be found in training. But a further problem for midwifery is the low pay traditionally associated with female occupations.

Ms Fern, with 20 years' experience in the profession, says the lack of candidates coming forward is directly related to the current training structure and low pay.

"Most applicants must go through three years of general nursing training before going on to complete a further 18 months of midwifery training. And they just aren't paid enough. A staff midwife gets paid the same as a staff nurse, starting on £6,457 and rising to £7,750."

The long, intensive study and training period puts many potential candidates off, but the alternative path into the profession, a three-year direct entry course, operates in only two British cities.

Ms Fern along with many other midwives, sees her profession as separate yet complementary to nursing, and says an increase in the number of direct entry courses could solve the staffing crisis.

"Direct entry courses would attract women of mixed backgrounds and mixed ages and it's much cheaper to train people for three years as opposed to four and a half."

Ms Fern also sees another advantage over general nursing training: "Midwives from these courses are orientated to well-women as opposed to coming up through a channel where you are dealing with sick people and where there is a tendancy to then associate pregnancy with illness.

"Three quarters of women have their babies without complication and three quarters are delivered with the midwife being the only senior person present," she says.