

CORE PRINCIPLES TO REDUCE CURRENT VARIATIONS THAT EXIST IN
GRADING OF MIDWIFERY PRACTICE IN THE UNITED KINGDOM

HIGHLIGHTS

- Core principles to enhance reliability of grading midwifery practice were agreed
- Standardisation may alleviate grade inflation and enhance quality assurance
- Grading performance in the context of professional behaviour may focus decisions
- The term 'clinical practice' resulted in a shared understanding in midwifery

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INTRODUCTION

This paper presents the second phase of a national study investigating practice assessment in midwifery. The first phase comprised a scoping study which explored the interpretation and application of the United Kingdom (UK) regulatory body standards, particularly focusing on grading of practice (Anonymised, 2016). A wide range of interpretation leading to a variety of approaches was evident in this earlier phase, raising concerns about reliability and equity of practice assessment in programmes leading to registration as a midwife. The second phase therefore sought to achieve consensus on a set of core principles with the aim of promoting greater consistency nationally in the application of the professional standards. A participatory action research process was taken which comprised two stages: a questionnaire followed by face-to-face discussion, using a Mini-Delphi approach.

Although this study focused on the 55 higher education institutions (HEIs) delivering pre-registration midwifery programmes in the UK, the core principles which were developed will also have resonance with practice assessment approaches internationally as well as across other professions.

BACKGROUND

The World Health Organisation (WHO, 2009) set global standards for the initial education of professional nurses and midwives, including the requirement for a balance between theory and practice components of the curriculum to be demonstrated. The International Confederation of Midwives (ICM, 2013) stipulates that sufficient practical experience should be included in midwifery programmes to attain, at a minimum, the ICM essential competencies for basic midwifery practice. These principles are incorporated in curricula across the globe; for example, the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2014) requires an equal theory-practice ratio and the Midwifery Council of New Zealand (accessed 2017) stipulates a 55% proportion of practice. The 28 member states of the European Union are similarly required to provide a balance of theory and practical preparation in midwifery programmes (European Parliament, Council of the European Union, 2005). The Nursing and Midwifery Council (NMC) in the UK – currently still part of the EU – more specifically stipulates that a minimum of 50% of the programme must be based in practice. Direct hands-on care must be graded and therefore contribute to the academic award (NMC, 2009). This process must be undertaken by midwives who have received specific preparation and regular updating – termed ‘sign-off mentors’ (NMC 2008; 2009).

Other professions nationally and internationally – for example osteopathy, psychiatry, physiotherapy, medicine, nursing, social work and pharmacy - have a similarly strong focus on practice and its assessment (Abbey, 2008; Briscoe et al., 2006; Clouder and Toms, 2008; Dalton et al., 2009; Davis and Ponnampereuma, 2009; Fisher et al., 2011; Fothergill Bourbonnais et al., 2008; Hadfield et al., 2007; Hay and O’Donoghue, 2009; Manning et al., 2016; Seldomridge and Walsh, 2006).

Assessment of practice determines whether potential registrants have embraced the requisite core clinical and practical skills as well as concept-based components such as communication, attitudes, knowledge, team-work, reflection, problem-solving, critical thinking, decision-making and self-awareness which are essential to their professional practice (Cassidy, 2008; Oermann et al., 2009; Sharpless and Barber, 2009). A European study exploring graduate employability highlights the need for this combination of skills (Andrews and Higson, 2008).

The tools and approaches used are therefore fundamental to the process of practice assessment, but the complexity of developing ones which are consistent, reliable and valid is challenging (Briscoe et al., 2006; Fisher et al., 2011; Seldomridge and Walsh, 2006). Mallik and McGowan (2007) published a scoping exercise of nursing and found a range of discrepancies in approaches, as did Lauder et al's (2008) commissioned study in Scotland. Johnson (2008) considered the desirability of grading practice in competence-based qualifications, and reliability of this process has also been questioned (Cleland et al. 2008; Gray and Donaldson, 2009). London (2008) and Hay and O'Donoghue (2009) debated whether standardisation in assessment could in fact be achieved.

METHODS

Aim:

This second phase of the study sought to identify a set of core principles for grading of practice in midwifery. The aim was to enhance reliability of assessment by reducing variations which had been identified in the first phase.

Participants and ethical considerations:

The grading of practice study was unanimously initiated by the Lead Midwives for Education United Kingdom Executive Group (LME-UK) – representing all 55 HEIs delivering pre-registration midwifery programmes nationally (Way, 2016). A sub-group of five experienced midwifery academics with a shared interest in and track record of publication on practice assessment formed the research team, while all LMEs were invited to participate throughout the study. Ethical considerations relating to informed participation and option to withdraw were addressed. The LME-UK group was kept fully apprised of the progress of the study, via JISCMail (a national academic mailing service which facilitates discussion, collaboration and communication within the UK academic community) or at the regular professional meetings. These forums also provided the opportunity for all the lead educationalists to contribute their views and responses to questionnaires and discussions, indicating their consent; they could similarly opt not to respond. Provision was made for those who had not been able to attend meetings to view draft outcomes and add their own comments. All data collected were anonymised on receipt by the lead researcher, prior to circulation to the other members of the study team for member-checking.

Design and data collection:

The collaborative nature of the LME-UK group enabled participatory action research to be undertaken in two stages. Friere (1970) and Denscombe (2010) suggest this

approach as an appropriate methodology to solve a particular problem in a progressive manner, enabling production of guidelines for best practice. A Mini-Delphi or Estimate-Talk-Estimate (ETE) approach (Green et al., 2007) enabled draft statements to be consulted on through use of a questionnaire in stage one and face-to-face discussion in stage two, until consensus on terminology was achieved.

Stage one: The findings from the first phase of the study (Anonymised, 2016), in which a wide range of interpretation and application of the NMC standards had been demonstrated, were initially shared and discussed with LMEs at one of their meetings. This resulted in development of 12 draft statements (*Tables 1-4*) which were designed to capture what appeared to have been positive aspects and address variations. The statements were next circulated electronically as a questionnaire to the participants so that they could rate their views on these, using a Likert scale. Only four options were provided: strongly agree, agree, disagree and strongly disagree – a method adopted by Garland (1991) to encourage participant decisions. The questionnaire provided an opportunity for qualitative comments to expand on the quantitative data. Responses were received from 29 of the 55 institutions represented (52.73%).

Stage two: Following cross-checking by the study team, the collated data and suggested revised statements were shared at an LME-UK Executive Group meeting later in the year at which 32 members (58.21%) were present. Those statements which had not already achieved consensus were discussed further by the attendees. Adjustments were made until consensus was reached. The set of principles was subsequently circulated to the entire LME membership via JISCMail to enable those

who had not been present to contribute their views. A few indicated approval and no objections were raised. A set of 11 core principles was therefore agreed as final (*Table 5*).

FINDINGS

To facilitate presentation, the data from both the questionnaire (stage one) and the outcomes of the Mini-Delphi discussion (stage two) have been combined under the relevant headings. The 12 draft statements are indicated in *Tables 1-4*, having been categorised according to the ratings responses in stage one:

1. Consensus – in which 100% agreement was indicated in both stages (*Table 1*);
2. Staged consensus – in which strong support was indicated in stage one and consensus achieved in stage two (*Table 2*);
3. Minor modifications – in which statements were supported in stage one, but minor adjustments were needed in stage two (*Table 3*);
4. Controversial – in which responses in stage one were more mixed, and more extensive discussion was needed in stage two (*Table 4*).

Responses indicating ‘strongly agree’/ ‘agree’ have been combined, as have ‘strongly disagree’/ ‘disagree’ in presenting the findings from stage one. The final revised statements which formed the set of core principles may be seen in *Table 5*.

1. Consensus:

Category 1: CONSENSUS	a)Clinicians should be involved in developing and monitoring assessment tools/ processes	b)Sign-off mentors should be given clear verbal and written guidance on the assessment tool and	c)The full range of grades available should be encouraged	d)The correlation between qualitative comments and grade awarded should be clearly demonstrated
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		criteria for grading the level of performance/ competence		
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Table 1: Draft statements in category 1 (consensus)

Four of the 12 statements achieved consensus in stage one (100% agreed/ strongly agreed; n = 29), so were ratified in stage two and remained as shown in *Table 1*.

Qualitative comments included:

- “Clinicians were not just able to shape the tool to ensure that it was workable but took ownership and championed the tool and therefore implementation of the tool was very successful” (1a)
- “On line there are options for additional help points” (1b).

2. Staged consensus:

Category 2: STAGED CONSENSUS	a)Academic staff should provide opportunities to support sign-off mentors in their decision-making about a student’s competence/level of achievement	b)A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) would be helpful for all programmes to incorporate, standardising the measure of competence/ performance in midwifery practice across the UK
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Table 2: Draft statements in category 2 (staged consensus)

Statements 2a and 2b (*Table 2*) had been strongly supported but not achieved consensus in stage one. These were, however, upheld in the Mini-Delphi discussion in stage two.

Statement 2a: In stage one, 90% (n = 26) had agreed and none disagreed, however 7% (n = 3) just made a comment or did not respond; one of these indicated neutrality. Qualitative comments noted that sign-off mentors had become skilled at making appropriate judgements, and assessment methods such as tripartite

meetings (involving the student, sign-off mentor and educationalist) could facilitate this. Consensus was achieved in stage two that this principle should be upheld.

Statement 2b: Results from the questionnaire showed 86% (n = 25) agreement, 4% (n = 1) disagreed and 10% (n = 3) just made a comment or did not respond.

Qualitative comments acknowledged that a common set of grading criteria would be best practice, but some respondents wondered whether it was achievable. On discussion in stage two, consensus was reached that a third phase of the study would seek to develop a generic grading matrix.

3. Minor modifications:

<p>Category 3: MINOR MODIFICATIONS</p>	<p>a)Assessment tools should explicitly state that a judgement is being made about the <i>performance</i> and not the <i>individual student</i></p>	<p>b)Academic staff should moderate sign-off mentor grades/ comments either in person at a tripartite or triad meeting or as a follow-up activity of the documentation <i>(Note that this statement was subsequently excluded as already covered in final core principles 8 and 11 – see Table 5)</i></p>
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Table 3: Draft statements in category 3 (minor modifications)

The above two statements were supported by the majority of respondents in stage one (90% agreed/ strongly agreed; n = 26), but were discussed further in stage two.

Statement 3a: Some of the qualitative responses in stage one had suggested that when attributes such as over-confidence, personal hygiene and behaviour were being assessed, the *performance of the individual* was being judged. In discussion at the meeting in stage two, further clarification was thought necessary. This principle was therefore amended to:

*“Assessment tools should explicitly state that **performance** is being objectively measured against marking criteria which include knowledge, skills*

and personal attributes in the context of professional behaviour, rather than a subjective judgement on the student her/himself.”

Statement 3b: In stage one, although there was 90% support for this statement, 7% (n = 2) disagreed and 3% (n = 1) stated neutrality. Qualitative comments supported moderation for quality assurance, however it was noted that this could be challenging. In stage two, it was agreed that statement 2a (*Table 2*), which had already achieved consensus, would also facilitate this purpose. Later discussion about statement 4c (*Table 4*) similarly comprised elements of statement 3b. It was therefore agreed that statement 3b (*Table 3*) was superfluous to the set of final core principles.

4. Controversial:

Category 4: CONTROVERSIAL	a) Specific grades or symbols should be awarded for 'pure' practice, rather than pass/ refer, and these should reflect a continuum of development	b) If a practice module comprises other components, the 'pure' element should be a minimum proportion.	c) If non 'pure' practice elements are incorporated into a practice module, a clinician should participate at some point in the assessment or moderation process of other components together with academic/s	d) There should be a minimum credit weighting applied to practice modules throughout all midwifery programmes (<i>Note that this statement was subsequently excluded in the final core principles – see Table 5</i>)
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Table 4: Draft statements in category 4 (controversial)

The four remaining statements (*Table 4*) attracted more varied responses in stage one. These required more extensive discussion in stage two to address differing interpretations.

Statement 4a: Although 72% (n = 21) had agreed with the ethos of this statement in stage one, 21% (n = 6) disagreed and 7% (n = 2) just made a comment or did not respond. One respondent noted that some clinical skills (such as administration of injections) could be assessed as pass/ refer rather than graded as they were either safe or unsafe. Another stated that a single grade for practice was appropriate providing parameters were clear that if one proficiency was failed, then the grade must be a referral/ fail – complying with the NMC (2009) requirements. Not all respondents were clear about what was meant by ‘pure’ practice. Some stated that there was no such thing, as practice required underpinning knowledge as well as skills. The study team – along with many of the group members present – had understood this term to mean “direct hands-on care” as stated in NMC (2009, p21). Consensus was achieved that statement 4a would be adjusted to refer to ‘clinical practice’ as this appeared to have a common meaning to all present, and was in fact preferred to the NMC terminology:

“Specific grades or symbols should be awarded for clinical practice rather than pass/ refer, reflecting a continuum of development and meeting requirements of the NMC Standards.”*

(*currently termed by NMC as ‘direct hands-on care’ - *Standard 15 of ‘Standards for pre registration midwifery education’ – NMC, 2009*)

Statement 4b: Participants had been asked to indicate the suggested minimum proportion if they agreed with this statement in stage one. Fifty-five percent (n = 16) had agreed, 17% (n = 5) disagreed and 28% (n = 8) just made a comment or did not respond. Qualitative comments in the questionnaire again indicated some confusion about the term ‘pure’ practice. One respondent noted that her understanding was

that practice should only be about practice, with no theoretical component, and should be assessed by clinicians. Another argued that even though theory and practice modules were assessed separately, theory underpinned practice and vice versa, so all modules were really covered by both. For those who agreed with statement 4b, proportions ranged from 20% - 80%, with 50% of those indicating a figure (n = 6) suggesting 50% of the module mark. Modification in terminology was agreed to reflect statement 4a, and consensus was achieved on a minimum of 50% weighting. This principle was therefore amended to:

“If a practice-based module includes elements other than clinical practice, it is recommended that the credit weighting for these additional elements should not exceed 50% within that module.”*

Statement 4c: Again, 55% (n = 16) had agreed with the principle in stage one, 24% (n = 7) disagreed and 21% (n = 6) made a comment or did not respond; one of these indicated neutrality. Two participants noted that clinicians may be used in viva voce or OSCEs (Objective Structured Clinical Examinations). The ‘neutral’ respondent suggested that some flexibility should be demonstrated if the academic was closely linked to practice. As for statements 4a and 4b, respondents had found the term ‘pure’ practice controversial. It was agreed by the participants in stage two to support the ethos of the statement, but to provide more scope for flexibility in application. The term ‘pure’ practice was therefore removed, and a broader principle was agreed through consensus:

“Quality assurance of grading of practice (ie: monitoring of inter-rater reliability) should be undertaken collaboratively by academic staff and clinicians experienced in assessment.”

As previously stated, the ethos of this amended statement also covered the principle of statement 3b (*Table 3*).

Statement 4d: In stage one, 72% (n = 21) agreed with this statement, 14% (n = 4) disagreed and 14% (n = 4) just made a comment or did not respond. Participants were asked to indicate the minimum suggested weighting if they agreed. Responses ranged from 30% to 80% with the majority (53.3%) suggesting a proportion of 50% of the practice module. One further respondent had just noted 'high' and another stated they were 'unsure'. Qualitative comments in the questionnaire inferred that HEIs may be reluctant to implement a weighting.

There was extensive discussion about statement 4d in stage two. Some participants suggested that a direct interpretation of the NMC requirement for a minimum of half of the programme to be practice-based would naturally translate to a 50% weighting. Although others upheld this general principle, they noted that there were diverse ways of managing this aspect during curriculum development and highlighted the challenges of institutional constraints. Some concerns were raised about grade inflation and the impact that increasing the proportion of credit weighting for practice could have on the overall mark profile. Most participants were, however, positive about the increased emphasis on practice which grading provided. Consensus was not able to be achieved. It was agreed to continue to be mindful of this matter, although the statement itself was excluded from the final set of core principles.

Core principles:

The final core principles for grading of practice in midwifery programmes were ratified when no objections were raised by the members of the group who had been unable to participate in the Mini-Delphi discussion in stage two, following electronic circulation (*Table 5*). It was agreed to add core principle 1 to set the scene, as this was key to practice assessment in the NMC Standards (2008; 2009):

1. The NMC requires clinical practice* to be assessed by clinicians with due regard.
2. Clinicians should be involved in developing and monitoring practice assessment tools/ processes.
3. Sign-off mentors should be given clear verbal and written guidance on the assessment tool and criteria for grading the level of performance/ competence.
4. The full range of grades available should be encouraged.
5. The correlation between qualitative comments and grade awarded should be clearly demonstrated.
6. A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) will be developed to enhance standardisation of the measure of competence/ performance in midwifery practice across the UK.
7. Assessment tools should explicitly state that performance is being objectively measured against marking criteria which include knowledge, skills and personal attributes in the context of professional behaviour, rather than a subjective judgement on the student her/himself.
8. Academic staff should provide opportunities to support sign-off mentors in their decision-making about a student's competence/ level of achievement.
9. Specific grades or symbols should be awarded for clinical practice* rather than pass/ refer, reflecting a continuum of development and meeting requirements of the NMC Standards.
10. If a practice-based module includes elements other than clinical practice*, it is recommended that the credit weighting for these additional elements should not exceed 50% within that module.
11. Quality assurance of grading of practice (ie: monitoring of inter-rater reliability) should be undertaken collaboratively by academic staff and clinicians experienced in assessment.

Table 5: Core principles for grading of practice in midwifery programmes

(*currently termed by NMC as 'direct hands-on care' - *Standard 15 of 'Standards for pre registration midwifery education'* – NMC, 2009)

DISCUSSION

The first phase of the national study identified a wide range of interpretation and application of regulatory body standards for practice assessment in pre-registration midwifery programmes (Anonymised, 2016). This second phase therefore sought to enhance consistency, particularly focusing on the grading element of the process. A level of standardisation was welcomed by many respondents. It was suggested that this would help programme teams to address queries about grade inflation as well as enhancing quality assurance.

Consensus was achieved on a set of core principles (*Table 5*). It is considered that the chosen methodology facilitated this outcome. Participatory action research in two stages provided an opportunity for LMEs from all the institutions to contribute to problem-solving and decision-making through individual responses and group discussion. Although response rates were limited to 52.73% and 58.21% respectively, different institutions were represented in both stages. All members of the group had the opportunity to participate, and all were invited to make comments on the final set of core principles.

A strength of the questionnaire was the absence of a 'neutral' option in the Likert scales. Although there is some controversy about distortion of results in this approach, others argue that it reduces social desirability bias (Garland, 1991).

Respondents had still been able to state that they were 'neutral' in their qualitative comments but had only chosen to do so on three occasions, providing a rationale for this view. Decisions of ranking were therefore predominantly decisive in stage one, and the detailed discussion which followed in stage two enabled further exploration.

Although it could be viewed as a weakness of the questionnaire design to have used the terminology 'pure' practice, the resultant controversy generated very productive discussion in stage two. This highlighted the differences in interpretation of what proportion of 'direct hands-on practice' was needed to form the assessed element of practice in programmes. The approach to practice not being "restricted to the provision of direct care only" reflects the stance in ANMAC (2009, p4), which was further broadened in their 2014 Accreditation Standards. The opportunity to deliberate the meaning and emphasis in stage two of the study resulted in an improved and shared understanding. This was an important outcome, having the potential to alter approaches to future programme development. The fact that the preferred term 'clinical practice' was embraced by participants and achieved consensus is of note. This may inform future educational standards both nationally and internationally.

As in the first phase of the study, the issue of grade inflation was again raised, due to the requirement for practice to contribute to academic credits (NMC 2009). Gray and Donaldson (2009) also noted this phenomenon, as did a number of other studies.

Paskausky and Simonelle (2014) found that 98% of student nurses in a study group of 281 received a clinical grade higher than their exam. Of these, 90% achieved B+ or greater, and the authors suggested this was indicative of grade inflation. This

corroborated the findings from an earlier study (Scanlan and Care, 2004), in which 4,500 student nurses' clinical grades were analysed. Similarly, 90% received a B+ and above, with 60% at A or A+. In the final placement, almost 80% were A or A+. A study of 204 American nursing students found that 95% of students were awarded practice grades of A or B, and only 5% a C (Seldomridge and Walsh, 2006). In the same country, a psychiatry survey noted that 20-30% of students' academic profiles were affected by grade inflation in clinical assessments (Briscoe et al., 2006).

Scanlan and Care (2004) proposed that this could be harmful to the profession.

Donaldson and Gray's systematic review (2012) cited a number of papers which contradicted this, however, suggesting that grading could enhance and motivate students' performance in practice. In the first phase of this study the LME-UK group was overall positive about the impact of grading on degree classification, as this demonstrated that practice was valued (Anonymised, 2016). Various 'moderating influences' had been introduced in midwifery programmes to ameliorate this effect.

Participants commented on the value of using a range of modes of assessment to reduce the impact of practice grading on overall academic profile as well as to enhance reliability and validity. Seldomridge and Walsh (2006) similarly recommended the use of multiple methods for a more robust assessment. This approach was also supported in the multi-professional longitudinal study by Fisher et al. (2011), which explored a range of practice assessment methods and tools. Core principle 10 (*Table 5*) recommends that modes other than 'clinical practice' should not attract more than half the credits within practice-based modules. This reflects the value of a multi-method approach, which could have the benefit of reducing grade inflation whilst maintaining the emphasis on practice itself.

This study also recognises the importance of involvement of clinicians in the development and monitoring of practice assessment tools and processes (core principle 2, *Table 5*) - essential to promote understanding and ownership as well as ensure quality. The importance of providing clear guidance is also highlighted (core principle 3). Other literature supports this approach (Bennett and McGowan, 2014; Black et al., 2013; Briscoe et al., 2006; Fisher and Webb, 2008; Fisher et al., 2011; Gainsbury, 2010; Heaslip and Scammell, 2012; Paskausky and Simonelle, 2014; Scanlan and Care, 2004; Seldomridge and Walsh, 2006).

The first phase of this national study highlighted that grading appeared to empower sign-off mentors to more effectively determine fitness to progress or enter the register as a midwife (Anonymised, 2016). Their increased confidence in the grading process enabled them to exercise discretion in using the full range of marks to either reward excellence or identify failing students. Clinicians value their role as professional gatekeepers – most taking the accountability of assessment very seriously (Fisher et al., 2011; Moran and Banks, 2016), despite this requiring courage in the face of worrying opposition at times (Black et al., 2014; Hunt et al., 2016). In stage two of this phase of the study, there was an interesting discussion relating to the objective measurement of *performance* in the context of professional behaviour (comprising knowledge, skills and attitudes) against a set of marking criteria, rather than it being a judgment on the student him/herself – resulting in core principle 7 (*Table 5*). If this focus is emphasised, it may assist clinicians to be more objective and courageous in making their decisions – especially if supported by

academics (Black et al., 2014; Jervis and Tilki, 2011; Royal College of Nursing, 2016; Rutkowski 2007).

The findings from this study support continuation of grading of practice, despite its challenges. Donaldson and Gray (2012) similarly conclude that it is beneficial. Chenery-Morris (2014) suggests that the process of grading is more important than its contribution to an academic award.

Maxted et al. (2004) suggested the need to develop new methods of assessment with known validity, reliability and predictive power. Donaldson and Gray (2012) recommended the use of rubrics to enhance reliability and reduce grade inflation. Core principle 6 (*Table 5*) was agreed as an outcome of this study. The third and final phase will therefore comprise development of a common set of grading criteria suitable for use throughout all midwifery programmes and with any practice assessment tool. This rubric will consist of qualitative comments to indicate levels of performance in practice, attracting scoring appropriate to individual institutions. Participation will be sought from a wider range of stakeholders, to include clinicians and students. Consideration will also be given to the inclusion of other professions.

CONCLUSIONS AND RECOMMENDATIONS

In contrast with the assertions that standardisation in assessment may not be achievable (London, 2008; Hay and O'Donoghue, 2009), this study has demonstrated – through collaborative consultation - that variations in approach can be reduced.

A series of stakeholder meetings is currently taking place in the UK prior to NMC consultations on draft standards to replace the existing regulatory requirements for pre-registration education in midwifery (NMC, 2009) and nursing (NMC, 2010), as well as practice learning and assessment (NMC, 2010). Published findings from the first phase of this study have already been disseminated to the regulatory body. It is anticipated that the principles identified in this paper will also contribute to the evidence informing these standards. The generic nature of many of these principles may also enable transferability to other professional programmes internationally where practice assessment is fundamental to registration.

The study group on behalf of the LME-UK Executive Group therefore suggests the following recommendations:

1. Midwifery programmes nationally should incorporate the agreed core principles into curriculum development as far as possible within the context of individual institutional constraints. Other programmes nationally and internationally may also choose to consider applying some or all principles to their own programmes.
2. Where integration of these principles is proving more challenging due to institutional constraints, the results of this study and subsequent publications may be used to support rationale at internal validation events.
3. The NMC will continue to be kept updated with the study findings and publications to contribute to the evidence-base for the new educational standards.

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CONFLICT OF INTEREST STATEMENT

None of the authors has any financial or personal conflict of interest with other people or organisations which could bias this work.

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