

# Multiple Births Midwife Standard

RCN guidance for midwifery and nursing

CLINICAL PROFESSIONAL RESOURCE

Parents  
Midwife  
Twins  
Midwife  
Twins  
Chorionicity  
Standard  
Preterm birth  
Continuity of care  
Dizygotic  
Multiple births  
Parents  
Neonatal care  
Multidisciplinary team  
Triplets  
Mental health  
Screening  
NICE  
Monozygotic

# Acknowledgements

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The Elizabeth Bryan Multiple Births Centre, Birmingham City University contributed to the development of this standard.



This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact [corporate.communications@rcn.org.uk](mailto:corporate.communications@rcn.org.uk)

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## Notes

It is recognised that care may be provided by registered nurses and midwives, health care support workers, assistant practitioners, nursing associates, student nurses, student midwives, and trainee nursing associates. For ease of reading, the generic terms ‘nurse’, ‘nursing’ and ‘nurses’ are used throughout this document, unless specified.

The RCN recognises and embraces our gender diverse society and encourages this guideline to be used by and/or applied to people who identify as non-binary, transgender or gender fluid.

The RCN also recognises that not all those born female or male will identify with the same gender nouns, but for ease of reading, use the term woman/women/man/men and where appropriate acknowledge non-binary terms.

# Introduction

Midwives have an essential role to play in delivering and coordinating care for women, partners and families, who are experiencing a multiple pregnancy. The NICE guidelines NG137 (2011, 2019) and NICE Quality Standard 46 (2013) recommend that all women with a multiple pregnancy should be cared for by a nominated multidisciplinary team, consisting of a core team of specialist obstetricians, midwives and sonographers.

In line with this, The Independent Maternity Review (The Ockenden Report) (2022) also states the need for specialist antenatal clinics, a dedicated consultant and dedicated specialist midwifery staffing. It is critical to have a coordinator to ensure continuity of care and this is ideally suited to the role of a dedicated multiple births midwife (MBM). This standard is intended to provide clear direction for commissioners and managers when creating roles, to support best practice and policies in local service provision for women and their families. The skills and knowledge to provide this service will be outlined in the standard.

MBMs may have different responsibilities depending on the maternity unit where they work. The role will differ depending on whether it is a district general hospital or a tertiary level maternity unit; the level of neonatal care available; and whether there is a fetal medicine service/unit onsite; however, this standard can be applied nationally. MBMs should be the lead midwives for the multiple births service in that unit and have a role in ensuring all staff in the unit understand the key principles of care provided for multiple births families. This will include providing training and education for colleagues and ensuring the optimal quality of care to women and their families.

Two recent UK perinatal mortality reports have highlighted specific concerns about outcomes of twin pregnancies. A review of all baby deaths in the UK in 2020, observed that although overall rates of stillbirth had been declining since 2013, the stillbirth rates in twins had continued to rise. There was a 19% increase in the twin stillbirth rate and a 16% increase in the twin neonatal death rate. Compared to singletons, the risk of stillbirth is more than twice as high in twins, and the risk of neonatal death is over three times higher, and the gap between singleton and twin death rates is becoming wider (Draper et al; 2022). Prior to this, the MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and neonatal deaths in twin pregnancies, published in January 2021, (Draper et al., 2021) outlined issues with care provided specifically in twin pregnancies across the breadth of maternity care.

Crucially, key findings were that in just over half of pregnancies, improvements in care may have made a difference to the outcome for the baby and in two-thirds of pregnancies, improvements in care may have made a difference to the outcome for the woman. There was major sub-optimal antenatal care in half of pregnancies and there was major sub-optimal follow-up care for three-quarters of women. MBMs, and those caring for women with multiple pregnancies, should be familiar with the report's recommendations and implement them as described in this standard. Following the publication of the RCN standard (2021), in 2023, Birmingham City University's Elizabeth Bryan Multiple Births Centre, with RCN collaboration, reviewed the distribution and implementation of this standard. The full report can be found here: [open-access.bcu.ac.uk/14705/](https://open-access.bcu.ac.uk/14705/)

The evaluation concluded that for implementation to be successful, multiple births care should be a priority within the context of other work being done to reduce stillbirth, improve maternity safety and consider the impact of health inequalities and socio-demographic diversity. Implementation of this standard has the potential to close the gap between twin and singleton stillbirth and neonatal loss.

# Background

Figure 1.1 Multiple births statistics in the UK for 2022

	England and Wales (ONS London)	Scotland (GRO Scotland)	N. Ireland (NISRA)	UK total
Total maternities	599,023	47,135	20,608	666,766
All multiples	8750	631	295	9,676
Twins	8,619	622	290	9,531
Triplets	128	9	5	145
Quads and more	Not listed	Not listed	Not listed	Not listed
Twinning rate/1000 mats	14.39	13.20	14.07	14.29
Triplet rate/1000 mats	0.21	0.19	0.24	0.22
Multiple birth rate/1000 mats	14.61	13.39	14.31	14.51

Obtained from the Office for National Statistics, General Registry Office Scotland and GRO Northern Ireland.

Table by courtesy of The Elizabeth Bryan Multiple Births Centre: [bcu.ac.uk/EBMBC](https://bcu.ac.uk/EBMBC)

England and Wales (2022): [ons.gov.uk/releases/birthcharacteristicsinenglandandwales2022](https://ons.gov.uk/releases/birthcharacteristicsinenglandandwales2022)

Northern Ireland: [nisra.gov.uk/statistics/births-deaths-and-marriages/births](https://nisra.gov.uk/statistics/births-deaths-and-marriages/births)

Scotland: [nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2022/list-of-data-tables](https://nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2022/list-of-data-tables) (Table 1.01b)

Multiple pregnancies and births are associated with more complications (see figure 1.2) for both mothers and babies with resulting higher rates of mortality and morbidity (NICE, 2011, 2019). The *National Maternity and Perinatal Audit* (NMPA) report (2020) identified that approximately 3% of all babies are born from multiple pregnancies and that multiple pregnancies carry an increased risk of adverse maternal and neonatal outcomes.

Multiple pregnancy is recognised as the greatest complication of assisted conception treatments including IVF and there is an international consensus that the aim of all fertility treatment should be the birth of a single, healthy baby (Braude et al., 2006 and HFEA, 2020). This is further exacerbated by the emerging evidence that the public and some health care professionals are unaware of the extent of risk and/or the practical, psychological and financial impact of multiple births on families (Burlingham et al., 2023, Scoats et al., 2018).

Evidence-based high quality clinical care during pregnancy, birth and after birth are essential for the best physical and mental health outcomes for mothers and babies. Equally important is the emotional and psychological support for families throughout childhood.

**Figure 1.2 NICE Guideline NG137 (NICE 2019) identifies why multiple pregnancy carry higher risks:**

- Multiple pregnancy is associated with higher risks for the mother and babies.
- Maternal mortality associated with multiple births is 2.5 times that for singleton births. The risk of preterm birth is also considerably higher in multiple pregnancies than in singleton pregnancies, occurring in at least 50% of twin pregnancies.
- The significantly higher pre-term delivery rates in twin and triplet pregnancies result in increased demand for specialist neonatal resources.
- Risks to fetuses depend on the chorionicity (number of chorionic [outer] membranes) and amnionicity (number of amnions [inner] membranes) of the pregnancy.
- Feto-fetal transfusion syndrome, a condition associated with a shared placenta, can occur in monochorionic pregnancies and accounts for approximately 20% of stillbirths in multiple pregnancies.
- Additional risks to the fetuses include intrauterine growth restriction and congenital abnormalities.

NICE, 2019: [nice.org.uk/guidance/qs46/chapter/Introduction](https://www.nice.org.uk/guidance/qs46/chapter/Introduction)

**Zygoty, chorionicity and amnionicity**

Understanding zygoty (how genetically identical and non-identical twins, triplets and higher order births arise), chorionicity and amnionicity are critical to ensuring appropriate, effective and high quality care is both offered and agreed with the woman (and her partner) (NICE, 2019, section 1.1). [nice.org.uk/guidance/NG137](https://www.nice.org.uk/guidance/NG137)

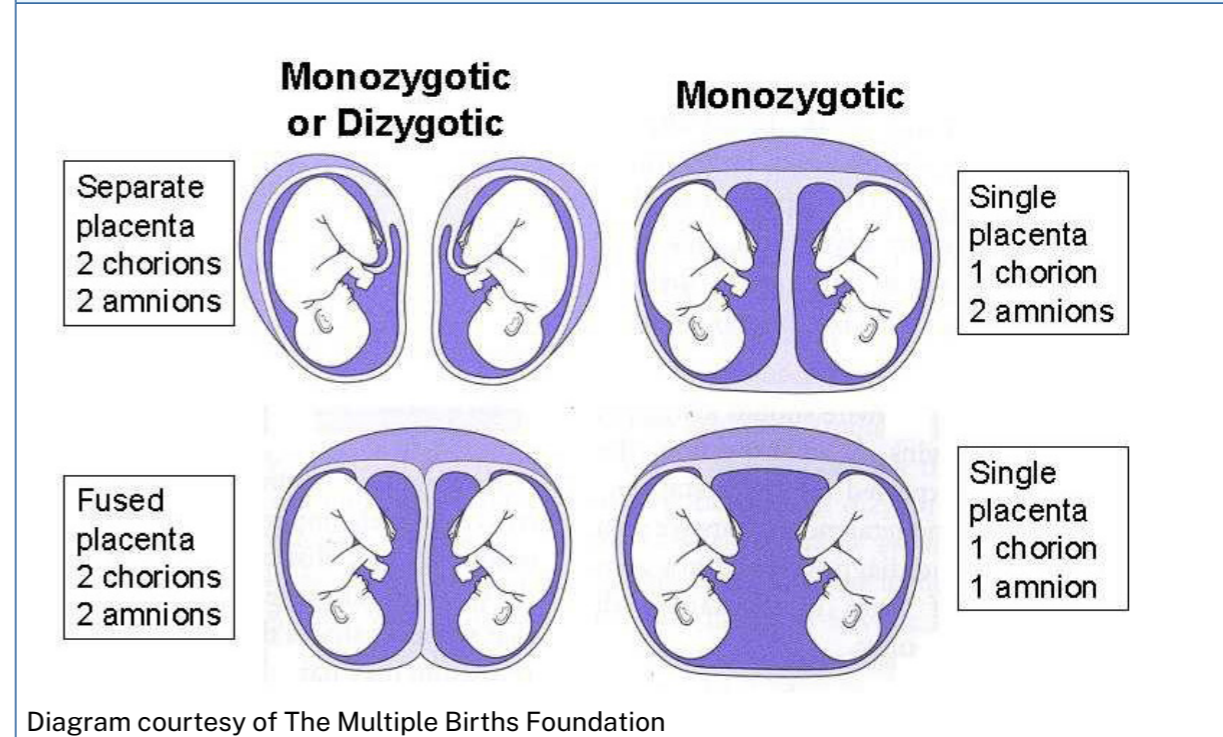
**KEY MESSAGE:** All care pathways should be based on the chorionicity and amnionicity as described in the NICE Guideline 137 and be implemented as soon as a multiple pregnancy is confirmed by ultrasound scan (NICE, 2019).

Although knowing the chorionicity is essential for the clinical management of multiple pregnancies, zygoty is equally as important for the parents and multiple birth children in the longer term and this can be underestimated by professionals (Criag et al., 2018 and Yelland et al., 2018). Midwives have a key role to play in ensuring parents have accurate information and need to have a clear understanding of the different physiological processes around the developments of zygoty, chorionicity and amnionicity.

It is also clinically important to be aware that same sex multiples who are dichorionic may also be monozygotic.

When fetuses share a placenta (monochorionic) there is a greater risk of complications particularly with feto-fetal transfusion syndrome which affects about 20% of monochorionic pregnancies. Screening for fetal abnormality is more complex in all multiple pregnancies and it is critically important that women are fully informed about the risks of implications of all screening and diagnostic procedures depending on chorionicity and zygoty (Nice, 2019, Guideline 137 Section 1.4).

**Figure 1.3 Placentation of twins**



**Multiple pregnancy and assisted conception**

Although best practice is to aim for a single healthy baby, with all fertility treatments, there will inevitably be some multiple pregnancies. Obstetric and medical history, conception and social circumstances are essential details to be taken at the initial/booking appointment with the midwife. The conception may be a result of the use of anti-oestrogens or ovulation induction using gonadotrophins, as well as IVF.

The pregnancy may be a result of a surrogacy arrangement. The woman may be carrying a child conceived from the use of the commissioning parents own eggs and sperm or donated eggs and sperm. Any specific needs of transgender parents and/or single parents will also need to be considered. Same sex couples may be the commissioning parents.

Many people choose to have treatment outside the UK where clinical practices and standards vary widely. Women are more likely to have more than two embryos replaced and multi fetal pregnancy reduction offered or undertaken if multiples are conceived. Women are often older and may have other medical conditions which pose an even greater risk for their health alongside a multiple pregnancy.

The HFEA (2020) has information on this in its *Information for patients* section at [hfea.gov.uk](https://www.hfea.gov.uk)

The national standards set by NICE (2019) provide clear evidence-based quality statements (see figure 1.4) for all multiple pregnancy care and should form the basis for care provision.

#### Figure 1.4 NICE Quality Statements for QS46 – multiple pregnancy: twin and triplet pregnancies

[nice.org.uk/guidance/qs46](https://www.nice.org.uk/guidance/qs46)

The quality statements for QS46 on *Multiple pregnancy: twin and triplet pregnancies* outline eight key standards to support best practice:

- 1: determining chorionicity and amnionity
- 2: labelling the fetuses
- 3: composition of the multidisciplinary core team
- 4: care planning
- 5: monitoring for fetal complications
- 6: involving a consultant from a tertiary level fetal medicine centre for women with a higher risk or complicated pregnancy
- 7: advice and preparation for preterm birth
- 8: preparation for birth.

## 2. The role of the multiple births midwife

The role of the multiple births midwife (MBM) is to co-ordinate the continuity of care and support women (their partners and families) with a multiple pregnancy. All multiple pregnancies have a higher risk of complications for mothers and babies, some being more complex than others, for example triplets and higher order pregnancies, monochorionic pregnancies and pregnancies to mothers with other health conditions.

The MBM, as part of the multidisciplinary team, will play a key co-ordinating role in ensuring women are allocated to the appropriate care pathway, and working with the multidisciplinary team to meet the woman's needs.

In order to achieve this, the midwife should:

- have knowledge and skills, which includes understanding all aspects of effective care for women expecting a multiple pregnancy during the antenatal, intrapartum and postnatal period through to discharge to community care
- develop and enhance their own clinical skills to provide the care required
- lead and develop services working with the nominated multiple births multidisciplinary team (as defined by NICE) to ensure continuity and consistency of care. This is particularly important when liaising with the colleagues working in other areas eg: neonatal, mental health services, safeguarding and social care and health visitor services
- ensure the continuity of care is shared and maintained between different hospitals and health care professionals (including health visitors both antenatally and postnatally) and especially when care may be transferred out of the unit or immediate area
- support and lead a culture that embraces a better understanding among health care professionals of the needs of women (partners and family) with a multiple pregnancy
- contribute to the structure of local and regional guidelines, policies/protocols and data collection locally and regionally
- understand the needs of grieving and bereaved parents where one or more fetus or baby may not survive. Have the knowledge and skills to support women through the pregnancy, working with bereavement midwives and referring for counselling and other local and national support services as required. All health care professionals should have knowledge about the complexities of bereavement in a multiple pregnancy, including the health visiting service. Health visitors may be known to the family already if they have other children
- develop and maintain positive working relationship with other health care professionals. These will include midwives, obstetricians, sonographers, the neonatal team, health visitors and those defined by NICE as the enhanced team such as dietitians, physiotherapists and perinatal mental health specialists. Further relationships should be encouraged with the wider network in the trust/health board, other maternity units, general practice services (GPs and practice nurses) and community services
- provide clinical supervision for others, presenting case studies and learning from practice. Contribute to updating and continuing professional development (CPD) for all midwives, obstetricians and other colleagues in the local trust/health board
- audit own practice and establish learning opportunities from lessons learnt, record clinical statistics and outcomes.

### Continuity of care and carer in the context of multiple pregnancy

When considering multiple pregnancy and birth, continuity of care from the core multiple births team and other health care professionals involved is essential and facilitates the same standard of care for everyone. One midwife may not be able to provide effective continuity of care. However, as the lead midwife in the care of an individual woman, the MBM should be the co-ordinator of care. They may not be providing day-to-day care but will have oversight of the care pathway. This will enable the lead midwife to oversee consistency and a seamless care pathway throughout the journey for the woman, her partner and family. The structure of care provided may differ across the UK. **Figure 2.1** outlines the maternity care strategies throughout the UK.

The essence of continuity, and the expectation for all women, is of seamless maternity services which work effectively between community and hospital settings. Such a care philosophy should also support families to have a positive pregnancy, birth and postnatal experience, regardless of complexity and/or complications.

Midwifery 2020 (DH, 2010) described the co-ordinating role of the midwife:

“For almost all pregnant women, the midwife is the conduit for care throughout pregnancy, labour and the postnatal period. Whilst the midwife is expert in the normal, they also provide a pivotal role in co-ordinating the journey through pregnancy for all women. Whilst the lead professional may change during a pregnancy, the co-ordinator of care stays the same, providing the continuity that women want.”

#### Figure 2.1 Maternity care strategies across the UK

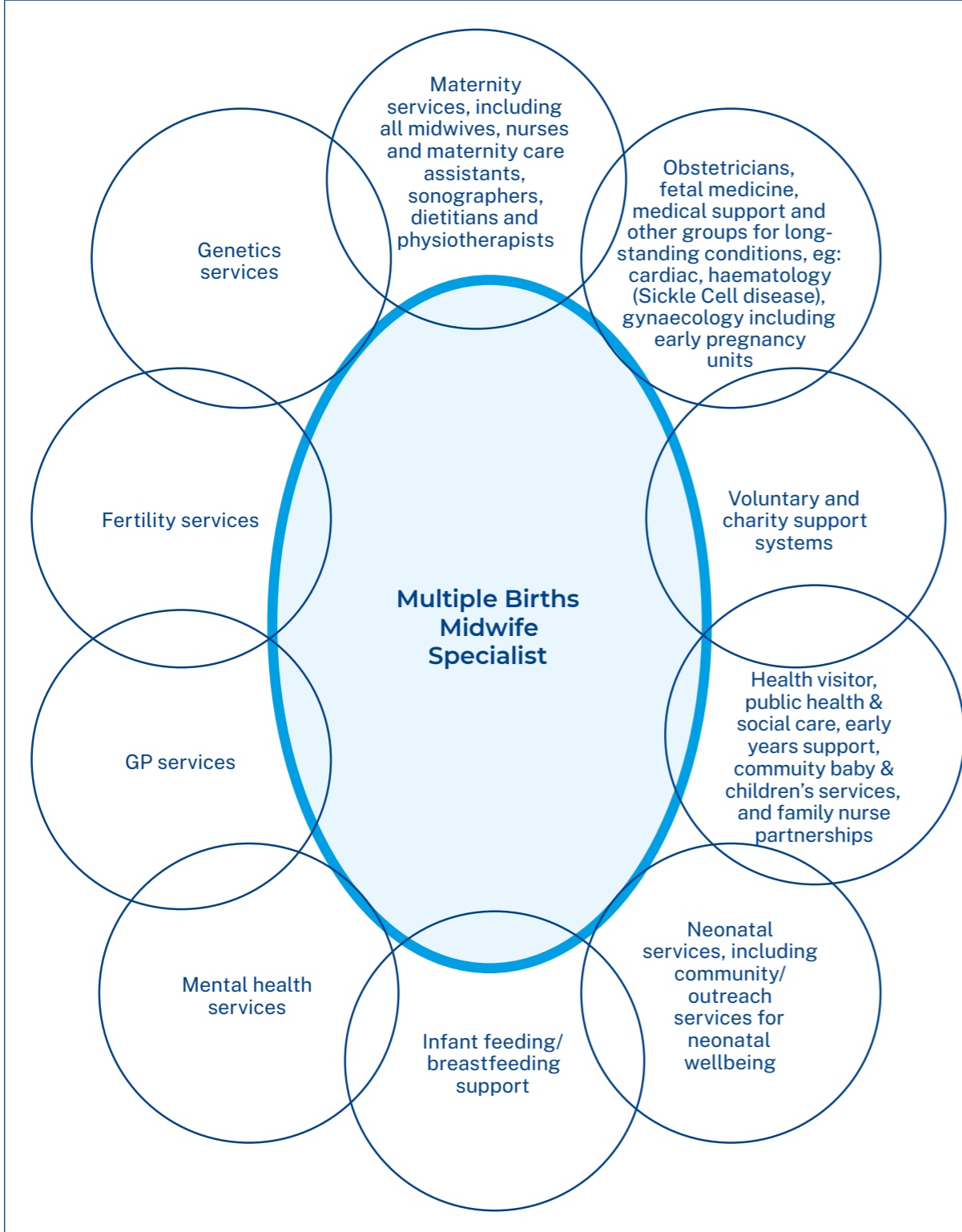
- England: Three year delivery plan for maternity and neonatal services (2023): [england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/](https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/)
- Wales: A Five Year Vision (2019): [gov.wales/sites/default/files/publications/2019-06/maternity-care-in-wales-a-five-year-vision-for-the-future-2019-2024.pdf](https://gov.wales/sites/default/files/publications/2019-06/maternity-care-in-wales-a-five-year-vision-for-the-future-2019-2024.pdf)
- Scotland: Best Start (2017): [gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/](https://gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/)
- Northern Ireland: (currently developing a new maternity strategy) A maternity strategy for Northern Ireland 2012-2018: [health-ni.gov.uk/articles/maternity-strategy-northern-ireland-2012-2018](https://health-ni.gov.uk/articles/maternity-strategy-northern-ireland-2012-2018)

To become an MBM, the midwife should:

- have experience of practice in all areas of maternity care including fetal medicine
- demonstrate understanding, ability and confidence to implement/apply NICE standards, and other relevant national guidance
- have been educated to/working towards Master’s level academic study and display Master’s level thinking and decision making
- understand embryological and fetal development and the physiological development of multiple pregnancy

- be competent and confident in managing and caring for women and their babies, including understanding the potential that complications specific to multiple pregnancy may occur. This includes the complexity of screening and diagnosis of abnormalities and selective feticide and a clear understanding of referral mechanisms and follow up
- have a knowledge of the wider social and psychological factors for women and their families with multiple pregnancies. This should include understanding the emotional impact and increased risk to perinatal mental health
- understand the ethical and legal issues associated with reproduction including fertility technologies, multifetal embryo reduction and termination of pregnancy and surrogacy
- have a clear understanding of the diversity of the multidisciplinary team that may be involved in the care, and be responsible for co-ordinating the care pathway, including timely and sufficient information sharing and referral (**see figure 2.2**)
- continue to develop their understanding of how to provide culturally safe care for all groups, particularly those who may not have easy access to services (for example, the Gypsy/Roma/Irish Traveller community, asylum seekers and individuals who are not registered with a GP) and consequently do not experience the same health outcomes as the rest of the population
- take account of the specific issues of inequality in maternity services affecting Black, Asian and other minority ethnic women and families who are at risk of poorer physical and/or mental health outcomes
- ensure recording of ethnicity is complete and accurate and ensure ready access to high quality interpreting services and translated and audio format health promotion materials.

Figure 2.2 The multidisciplinary network



**Different expertise, complexity and practice**

There are different levels/points of complexity and consequently different levels of practice required to best support women with a multiple pregnancy, birth and postnatally. Each MBM's role should be defined to reflect their level of practice and the context of their care provision.

There should be a minimum of two MBMs in every maternity unit who can provide care to ensure continuity for all women throughout the service provision.

**All midwives**

Every midwife should have some understanding of the management of multiple pregnancies. They should be familiar with local guidelines which should be based on implementing the NICE standard (NG137 and QS46) and the care pathways. They should know how to refer to the specialist multiple births team and what information and support to provide to women until the first appointment with the MBM. The role of every midwife continues throughout pregnancy, birth and postnatally, for example, if an MBM is not available when a woman may present with concerns; they should also be familiar with the need to escalate issues to the specialist team.

**Multiple births midwife**

The MBM will have additional knowledge and skills including formal education in the management and implications associated with multiple pregnancies and births.

They are responsible for co-ordinating the care of women with a multiple pregnancy/birth, working closely with colleagues in the nominated multiple births multidisciplinary team (as defined by NICE) and wider health care teams.

These MBMs may also be working in a service which includes a fetal medicine unit, and may be undertaking scanning and informing and supporting women considering complex decisions such as multi-fetal embryo reduction and selective feticide.

Figure 2.3 The multiple births midwife should be competent or working towards being able to:

- provide excellent midwifery clinical care, including counselling and psychological support
- take account of the woman's (and her partners) needs, choices and aspirations
- use tools to audit and evaluate practice and drive quality improvement
- enhance their own and colleague's education
- consider the need for research including identifying research priorities to further enhance practice. Actively participate in multi-centre research
- understand the local and political landscape where care is set, including local service providers' priorities to ensure active engagement in commissioning and provision
- be an inspiration and source of knowledge for others
- network effectively to enhance and disseminate good practice.

## 3. Multiple births midwife: skills and knowledge

The role of the MBM demands a range of defined clinical skills and knowledge alongside management and leadership experience and insightfulness. They may be leading and/or co-ordinating care.

All midwives will be familiar with the standards set out by the NMC in *Practising as a Midwife* (2021), *Standards of Proficiency* (2019) and the *NMC Code* (2018).

The standards of proficiency required of midwives are divided into domains:

- being an accountable, autonomous, professional midwife
- safe and effective midwifery care: promoting and providing continuity of care and carer
- universal care for all women and newborn infants
- additional care for women and newborn infants with complications
- promoting excellence: the midwife as colleague, scholar and leader
- the midwife as a skilled practitioner.

The following standard has taken account of these existing NMC standards to define the specifics of the MBM.

It is recognised that this is a developing role and that not all MBMs will come with the full skill set required to fulfil all components outlined here. Nevertheless, they should have a personal development programme and timeframe to achieve the standard appropriate for their role.

### 3.1 Clinical practice skills

- Be able to provide evidence-based, competent and confident care to women with multiple pregnancy during antenatal, labour and postnatal care, including effective handover to infant care and related services.
- Have an expert knowledge of multiple pregnancy, management options and effectively signpost to other services or support groups.
- Understand the importance of monitoring both mother and babies during pregnancy, intrapartum and postnatally.
- Facilitate midwife-led clinics, face-to-face, home visits and telephone and online services for clinical decision-making conversations and care provision.
- Be able to provide information to the woman and her partner about expectations for antenatal, labour and postnatal care, which is appropriate to individual women's specific educational needs.
- Be able to deliver parent education through the antenatal and postnatal period for the woman (her partner and family).
- Be able to assess the mental health and wellbeing of both parents and acting/referring accordingly. Be able to undertake consultations independently, including assessment, history taking, physical and psychological assessment.

- Support women's choices for example regarding antenatal screening assessments (of mother and fetus/s) and regarding feeding their infant(s).
- Provide compassionate care to pregnant women:
  - o be able to communicate with women and health care professionals at all levels, in primary, secondary care and tertiary care demonstrate excellence in written, verbal and telephone skills, including documentation
  - o be skilled in having challenging conversations and delivering difficult news
  - o empower women to make the choices they feel are right for them as individuals
  - o empower and educate families to make informed decisions, to be aware of their choices and care options
  - o ensure women and their partners understand the benefits, risks and choices available for safe effective care and that women can articulate their decisions including possible outcomes
  - o be able to obtain informed consent and provide advice on planned care and women's choices
  - o be able to impart unexpected and possibly unwelcome news sensitively and effectively and provide necessary emotional support, and referral to counselling if required.
  - o understanding and champion robust transfers of care and communication with other health care professionals within the maternity service where they are working and in other external units to ensure continuity of care.
- Be a non-medical prescriber or work within patient group directives (PGDs) and have knowledge of drug regimens and side effects, including complementary therapies.
- Demonstrate empathy and compassion, whilst also undertaking information giving, counselling and support and know when to refer to the appropriate services. This should include providing information and support and referral to counselling services as needed, for example: bereavement midwives, Improving Access to Psychological Therapies (IAPs) and applying the National Bereavement Care pathway.
- Undertake referrals both to other professionals and local support groups.
- Ensure the woman has contact details for the MBM and can make contact if problems develop or issues need clarifying.
- Demonstrate appropriate record keeping skills, in line with this specialist role, including those related to Care Quality Commission (CQC) or equivalent services' requirements.
- Utilise technology as appropriate to enhance practice and service provision and evaluation.



### 3.2 Leadership skills

- Be the woman's advocate, and the central contact for women.
- Can work independently as an autonomous practitioner as well as part of the multidisciplinary team and be organised in the practice environment.
- Be actively engaged in service development, commissioning and provision of complex care pathways.
- Be actively engaged in establishing and leading national standards such as NICE standards.
- Be aware of the value and costing of the service by looking at the impact of the MBM on service users; for example, by user satisfaction ratings, number of consultations, caseload outcomes, number of women seen and numbers contacted.
- Be responsible and accountable for ensuring that the service complies with the reporting mechanism for monitoring and reporting clinical outcomes, such as the CQC.
- Work in collaboration with senior colleagues to challenge behaviours that undermine equality and diversity adhering to Human Rights Act, trust policies and other relevant local and national policies/guidelines.

### 3.3 Ultrasound skills

Some MBMs may include ultrasound skills as part of their role, however, it needs to be balanced with all the other elements of the role. This part of the role should include:

- undertake a Consortium of Accredited Sonographic Education (CASE) programme of training for ultrasound in early pregnancy or similar
- perform ultrasound scans in accordance with safety guidance and utilise guidelines such as those produced by NICE to contemporary practice
- understand imagery and interpretation of results
- communicate findings effectively to the woman (and her partner)
- produce a clinically accurate and useful report that will enhance overall care
- maintain professional development within this specialised area.

The Society and College of Radiographers (SCoR) and British Medical Ultrasound Society (BMUS) have published guidance on professional ultrasound (2023). Public Health England (2017) and the SCoR (2017) advise on the need for practitioners to meet agreed criteria before undertaking first trimester and fetal anomaly screening.

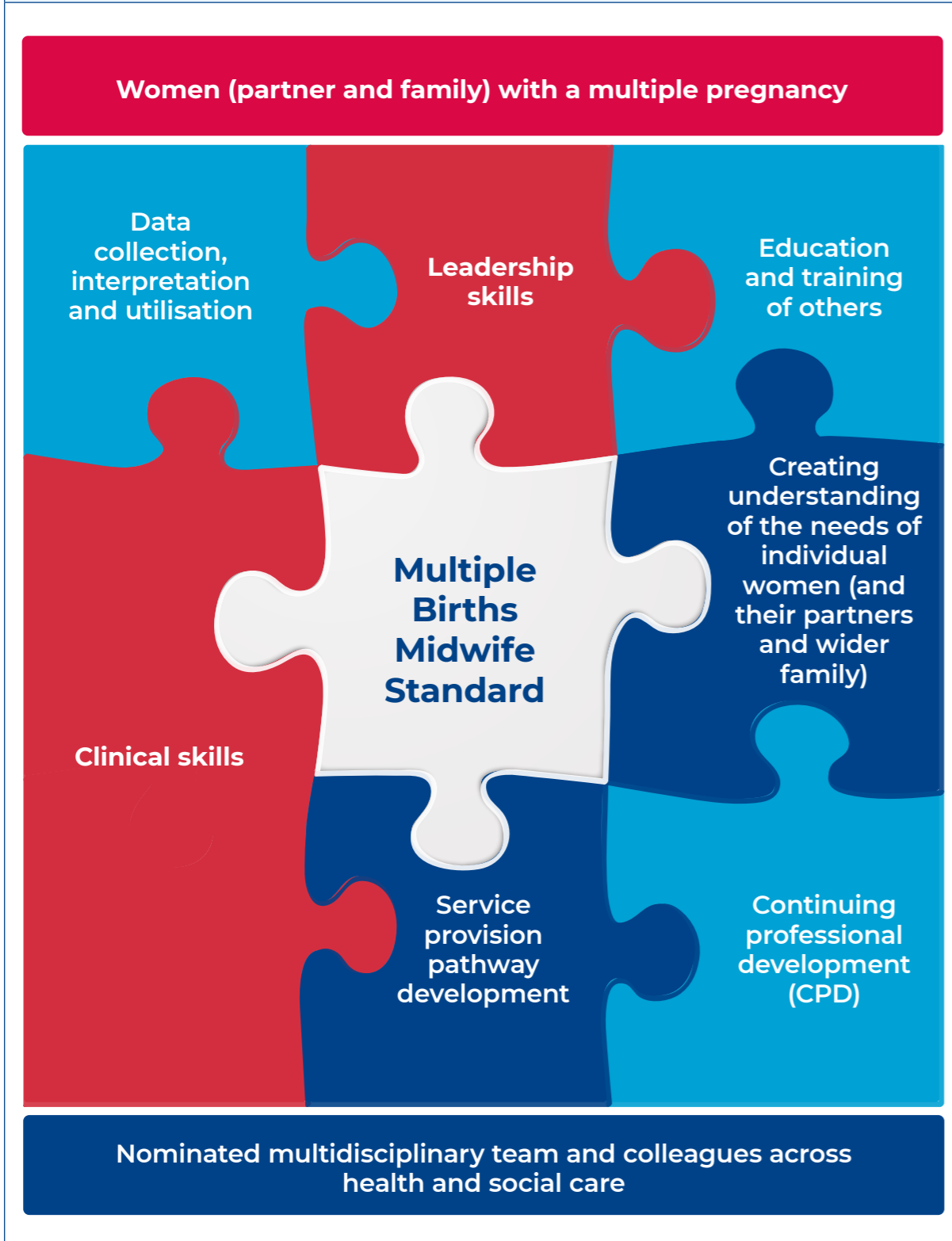
The MBM who works in ultrasound should be aware of their scope of practice, in particular, recognising and reporting deviation from the norm, including anomalies not related to the pregnancy (ISUOG, 2016) and appropriate referral as necessary.

### 3.4 Service provision/pathway management/ co-ordination

- Working with the multidisciplinary team to co-ordinate the care for all women with a multiple pregnancy until discharge of the mother and babies. Multiples are more likely to be admitted to a neonatal unit and the MBM would facilitate co-ordination of the care for discharge of the mother with the neonatal team. Some babies may be in hospital several days or weeks after the mother is discharged from midwifery care. Equally, not all babies will be going home to the woman who birthed them, such as with surrogacy arrangements.
- Designing and monitoring care pathways to ensure a streamlined service in all areas of care, including the co-ordination of services, appointments and referrals to other services.
- Liaising and working with support groups.
- Working with Maternity Voices Partnership or equivalent service user organisations.
- Collecting and analysing data to demonstrate service effectiveness, clinical outcomes, mortality and morbidity and to create own centre audit and research data.
- Service evaluation, including women's views (and their partners) on the care they have received.
- Inform, engage in, and use research in practice.
- Information technology skills should incorporate use of databases, protocols, literature searching, audit, questions, research, word processing and spreadsheets (such as Microsoft Word and Excel packages), this should also include online platforms such as MS Teams and Zoom.
- Have an awareness of the impact of social media on women's (and partner's) knowledge and/or expectations, including liaison with the unit's social media team.

## 4. Education and personal development

Figure 3 Overview of a multiple births midwife standard



The level of education needed for the role is at Master’s level with evidence of Master’s level thinking and problem solving.

The MBM needs to have specialist knowledge relating to twins, triplets and quads, in particular:

- different types of twins, triplets and more, and care pathways
- managing triplet and quad pregnancies
- importance and relevance of chorionicity to care provided
- multi-fetal embryo reduction
- screening for fetal abnormality and complexities in multiple pregnancies
- recognising complications and make appropriate referrals
- understanding and advising on risks including pre-term birth
- providing additional antenatal care and specialist antenatal education to meet the specific needs of women and their partners with multiple pregnancies
- intrapartum care to meet optimal outcomes for mothers and babies.
- postnatal care provision will be both a role of co-ordinating care as well as clinical practice. This should take account the possible need for enhanced postnatal care/visits based on individual requirements
- infant feeding support to ensure choices are explained and appropriate support available, taking account of the UNICEF Baby Friendly Principles (2017)
- liaising with neonatal unit staff, and awareness of the potential complications in order to support the parent/s, including having clear knowledge of local neonatal pathways and thresholds for transfer
- bereavement support will include links with bereavement care midwives and counsellors as well as knowing how to provide ongoing support during pregnancy/ birth/postnatal care. This includes good communication with other agencies, such as awareness of support available for those who may experience neonatal loss
- assessing mental health and wellbeing of both parents and acting/referring accordingly
- assessing social circumstances and liaising with other professionals antenatally to prepare for any potential difficulties
- be competent and confident in educating colleagues on multiple pregnancies and birth.

This should include:

- physical examinations of multiple babies/advanced physical assessment skills/ consultation skills
- communication skills (modules specific to multiple pregnancy to include counselling, breaking bad news)
- non-medical prescribing

- ultrasound skills
- leadership, including political and economic leadership
- presentation skills and teaching/education skills
- safeguarding of adults and children
- feeding support
- bereavement support.

MBMs may also wish to consider [RCN credentialing](#) to demonstrate their competence at this [advanced level of practice](#) (RCN, 2023) including:

- maintaining NMC registration
- managing their own support effectively for supervision, mentoring/buddying, using other networks, including their professional midwifery advisor (PMA) and/or clinical supervisors
- demonstrating development of the role, including self-audit, publications and a research profile
- maintaining an awareness of, and actively engaging with, local and national maternity policy drivers around multiple pregnancy service provision.

## 5. Conclusion

Midwives may not come with a full range of skills to meet this standard and so this publication is intended to provide a pathway for career enhancement through specialist practice and advanced level practice.

The MBM is a key and unifying role within the specialist multiple births multidisciplinary team. It presents an exciting career option for midwives to develop specialist knowledge and skills. It also creates the potential to move into areas including research and influencing service provision for women and families with multiple births at regional and national levels.

The 2023 evaluation of the distribution and implementation of this standard concluded that for implementation to be successful, multiple births care should be a priority within the context of other work being done to reduce stillbirth, improve maternity safety and consider the impact of health inequalities and socio-demographic diversity.

The NICE guidance sets the evidence base for clinical care and working towards achievement of these standards nationally should be a goal of all service providers. This is an opportunity where midwives can really make a positive difference to the experience of women and their partners at a potentially vulnerable and stressful time in their lives.

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## 7. Further resources

Association of Early Pregnancy Units (AEPU)  
[aepu.org.uk](https://www.aepu.org.uk)

Antenatal Results and Choices (ARC)  
[arc-uk.org](https://www.arc-uk.org)

BLISS for babies born premature or sick  
[bliss.org.uk](https://www.bliss.org.uk)

BLISS (2015) *Bliss Baby Report: Hanging in the balance*. London: BLISS.  
<http://files.bliss.org.uk>

British Association of Counselling and Psychotherapy (BACP)  
[bacp.co.uk](https://www.bacp.co.uk)

British Fertility Society (BFS)  
[britishfertilitysociety.org.uk](https://www.britishfertilitysociety.org.uk)

British Infertility Counselling Association (BICA)  
[bica.net](https://www.bica.net)

Elizabeth Bryan Multiple Births Centre  
[bcu.ac.uk/ebmbc](https://www.bcu.ac.uk/ebmbc)

European Society of Human Reproduction and Embryology  
[eshre.eu](https://www.eshre.eu)

HFEA website for info about infertility  
[hfea.gov.uk/treatments](https://www.hfea.gov.uk/treatments)

Miscarriage Association  
[miscarriageassociation.org.uk](https://www.miscarriageassociation.org.uk)

Pregnancy Sickness Support  
[pregnancysicknesssupport.org.uk](https://www.pregnancysicknesssupport.org.uk)

Royal College of Nursing  
[rcn.org.uk](https://www.rcn.org.uk)

Royal College of Midwives  
[rcm.org.uk](https://www.rcm.org.uk)

Royal College of Obstetricians and Gynaecologists  
[rcog.org.uk](https://www.rcog.org.uk)

Sands – Stillbirth and neonatal death charity  
[sands.org.uk](https://www.sands.org.uk)

The Ectopic Pregnancy Trust  
[ectopic.org.uk](https://www.ectopic.org.uk)

Twins Trust  
[twinstrust.org](https://www.twinstrust.org) and [twinstrust.org/healthcare-professionals.html](https://www.twinstrust.org/healthcare-professionals.html)

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## RCN quality assurance

### Publication

This is an RCN practice guidance. Practice guidance publications are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

### Description

Midwives have an essential role to play in delivering and co-ordinating care for women, partners and families, who are experiencing a multiple pregnancy. These standards are intended to provide clear direction for commissioners and managers when creating roles to support best practice and policies in local service provision for women and their families. The skills and knowledge to provide this service are also outlined in the standards.

**Publication date: September 2024 Review date: September 2027**

### The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact [publicationsfeedback@rcn.org.uk](mailto:publicationsfeedback@rcn.org.uk)

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