

Response to
Nursing and Midwifery
Council – Future midwife
consultation

May 2019



Promoting · Supporting · Influencing



The Royal College of Midwives
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The Royal College of Midwives' response to the Nursing and Midwifery Council – Future midwife consultation

The Royal College of Midwives (RCM) is the professional organisation and trade union that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in professional leadership, representation, education and influence for and on behalf of midwives, student midwives and maternity support workers. We actively support and campaigns for improvement in maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to respond to this consultation. Our response has been informed and shaped by a number of engagement activities we have been involved with across the UK. This has included our staff attending and reporting on a number of listening events held by the NMC and other organisations across all four countries of the UK, including the UK Lead Midwives for Education Executive Group and the Council of Deans of Health with whom we have worked closely during the consultation. We have held a number of external and internal workshops with members and staff including the RCM Leaders Forum (membership includes Directors/Heads of Midwifery, Consultant Midwives and Lead Midwives for Education) and the RCM Student Midwife Forum. We launched an on-line survey for RCM members in April to test some initial findings relating to the look and feel of the standards of proficiency and some key questions regarding the programme standards in particular the length of the programme. We have also drawn on some additional literature and relevant research to support our response.

The RCM have been involved with the development of the draft standard through their membership of the Thought Leadership Group and as a member of the Midwifery Panel, whom has had oversight and provided advice to the NMC Executive and Council. We would like to commend the NMC staff on the substantive and inclusive engagement they have undertaken both in the development of the standards and the consultation. We would particularly like to thank Professor Mary Renfrew for the thoroughness of her work, dedication and leadership.

Our views and recommendations are set out below.

Key messages

1. Overall, the domains, outcomes and skills accurately reflect the definition of midwifery and the quality framework from the Lancet series on Midwifery, they articulate what we would expect that a midwife should know and be able to do at the point of registration.
2. The standards are reflective of the current context in which midwives work and respond to the current policy directives within the UK. There is emphasis placed on optimising normal physiological processes, a stronger emphasis on the midwives role in public health, social care and mental health and on the 'first line' management of complications. They identify midwives as autonomous practitioners and leaders of midwifery care, working as part of a multidisciplinary team across health and social care.
3. The standards are comprehensive, specific and detailed and reflect a strong evidence base taken from the literature and views from a wide range of stakeholders.
4. The RCM welcomes the inclusion of standards that focus on self-care, self-awareness, emotional intelligence and human factors as well as the 'golden thread' running through of the importance of relationship building (women, families, midwives and the multidisciplinary team), safety and quality.
5. In order for the standards to be future-focused and enable innovation we would recommend that the skills list be reviewed. We consider that in their current form they are too detailed, restrictive, task-based and the balance has been tipped too far towards a medical rather than social model of care. In order to enable easy review in response to changing policy and practice we recommend that they are contained in an annexe.
6. The language requires review throughout the document to ensure that the standards contain verbs that are appropriate to the outcome required, are achievable, measurable and use consistent language that is clear.
7. The RCM welcomes the acknowledgement of the role of the Lead Midwife for Education as integral to ensuring high standards of midwifery education. We would recommend that the programme standards also include reference to the role of midwife educators.
8. The standards are more extensive, comprehensive, ambitious and stretching than the current standards. In order to achieve the intended objective that students must be competent, confident and safe at the point of registration the status quo of 3 years pre-registration education and training cannot remain. This should be reconsidered as either a 4 year programme or 3 years followed by a mandated foundation year of supported practice and protected learning time.

Responses to the specific NMC consultation questions

Principles underpinning the standards

Our intention is that the Standards of proficiency for midwives and the Standards for pre-registration midwifery programmes should:

- a) be unambiguous, clear and concise, using consistent language
- b) be accessible to the public
- c) anticipate the likely future conditions for midwifery practice
- d) be appropriate for all four countries of the UK
- e) be evidence informed, taking full account of national and international evidence and data, and the recommendations of key reports
- f) allow for flexible to programme delivery and innovative approaches to programme delivery
- g) have a core focus on the safety, needs, views, preferences and experiences of women, newborn infants, partners and families in all types of settings
- h) draw on a human rights-based approach, promoting equity, diversity and inclusion
- i) encompass and promote multi-agency, inter-disciplinary and team working across a range of settings
- j) be outcome focussed, measurable and assessable, considering what a midwife needs to know and should be able to do, **at the point of registration.**

Q5. Do you agree or disagree that the above principles have been met by the draft Standards

We recognise that these are draft standards and will need extensive proof reading. However, in their current form we do not think that the standards achieve these objectives:

- a) be unambiguous, clear and concise, using consistent language
- c) anticipate the likely future conditions for midwifery practice
- j) be outcome focussed, measurable and assessable, considering what a midwife needs to know and should be able to do, **at the point of registration**

With reference to the style of the document, there is variation in some of the language used. The use of permissive language, for example, 'may', is not usually associated with regulatory standards. There is inconsistency with the use of professional terminology versus more lay terminology. Some tenses need refining, particularly when generating statements from a stem sentence.

We question whether these standards enable midwives of the future to be true midwifery practitioners i.e. skilled in the basics and what it means to be a midwife and be the professional experts in the practice of normal midwifery or will they become a 'Jack or Jill of all trades'? Will they widen the theory-practice gap in the initial years as services catch-up with the evidence base and policy initiatives, for example, continuity of carer?

Within each of the domains we have identified where improvements could be made in order that the stated principles can be realised.

Q6. Do you agree or disagree that the principles of equality, diversity and inclusion are appropriately embedded in the draft standards of proficiency for midwives and the standards for pre-registration midwifery programmes?

Agree.

Standards of proficiency for midwives

Q7. The draft standards of proficiency set out specific knowledge and associated skills for each domain. Do you think that there's enough detail in each domain about the level of knowledge midwives need to have?

Domain 1: Being an accountable and autonomous midwife

We would suggest that the title includes the word 'professional' to reflect outcomes 1.2, 1.5, 1.14, 1.18.

1.4 Overall there is little mention of digital records nor much elsewhere in the document (see 1.21.4); if the intention is to 'future proof' this document this is a significant omission. We suggest that the proficiencies need to include an understanding of the role digital technology plays in the delivery of care in supporting communication, continuity, safety, quality, person-centred care and strategic development of services. Concurrently this would need supporting with the midwife understanding their role in relation to excellence in the digital world of record keeping in relation to security, accuracy, information sharing with colleagues, information sharing with women, principles of GDPR etc. We do not think that 1.21.4 "Keep effective records... etc." covers the requirements sufficiently.

1.5 Suggest moving this outcome further up the list so that it is more obvious.

1.12 We have several concerns with this paragraph:

It is unclear what "legal status" is in this context as someone can have many different legal statuses at one time. We suggest that this phrase is removed. If the intention is to consider someone's immigration status, place in the criminal justice system or nationality, then it should be stated explicitly.

We suggest adding 'physical health' as it can make women just as vulnerable as mental health and not all physical health ailments will be covered by "disability".

We suggest adding 'abuse' to "violence" to encompass the full spectrum of the way women are made vulnerable through relationships – linking to the Home Office definition¹ which all four countries accept.

1.15 This needs to go further. We suggest adding that the midwife needs to 'understand the importance of informed consent'; that it underpins all interventions and procedures. Midwives need to know *why* consent is important, not just show the ability to seek it from women.

1.16 Midwives should have skills like numeracy, literacy etc. not only for their midwifery practice, but also to have an understanding that women and families who lack these skills may interact with maternity services differently than those who do.

1.19 We question whether this statement about the "professional need to maintain a healthy lifestyle" is best addressed in these proficiencies. This relates more to staff wellbeing and health in their workplaces.

¹ <https://www.cps.gov.uk/domestic-abuse>

1.20 "...seeking and responding to support and feedback from women, families, and colleagues..." We suggest adding 'stakeholders' to this list so as to capture Maternity Services Liaison Committees (MSLCs) / Maternity Voices Partnerships (MVPs), other women's support groups and other NHS organisations.

Domain 2: The midwife's ability to provide and promote continuity of care

We would recommend that the title for this domain is reviewed for two reasons. Firstly, the title does not reflect the full scope of the content e.g. 2.3, 2.6, 2.10, 2.12 etc. Secondly, it is one approach to structuring midwifery care and, it puts at risk attempts to future proof the proficiencies as patterns of care evolve. In addition, will it disadvantage those students who will not or cannot experience Continuity of Carer; their experience and learning in other models of care should be reflected in the proficiencies. We would suggest a title that reflects the broader concept of the organisation of midwifery care and the midwives role in working in differing systems of care.

The emphasis on continuity throughout however is important and should be retained. There should also be reference to the promotion of social capital and building relationships as this is an important often-overlooked element of the continuity models. It is not just about the one to one relationship with a woman and midwife but her emerging as a mother into her community and building new relationships within that.

2.2 Include multi-agency working.

2.3 This outcome as currently written doesn't make sense, suggest remove "and the provision of midwifery and maternal newborn care and the health services", include "and consider the impact ..."

2.5 Include 'in all settings'.

2.9 "access to food": this is implicitly included in health and wellbeing, so can be removed.

2.10 Reword - replace "protection" with 'protecting the rights of women....'

Domain 3: Universal care for all women, newborn infants and families

3.5 In many maternity services, parent education is no longer provided by midwives and therefore may be difficult for the student to achieve, suggest replace "demonstrate" with 'have knowledge of'.

3.9 Suggest replace "epigenetics" with 'genomics' – there is no mention of this new science within the standards. Genomics will have a significant impact on population health and the personalisation of care and treatment over the next decade², we strongly recommend that relevant outcomes and skills are included within these standards.

3.14 This is something that even doctors struggle with on a regular basis. We suggest this is narrowed to 'commonly administered' medicines.

3.20 We have difficulty in understanding what the intended outcome is here, we recommend that it is reviewed and reworded.

² <https://www.genomicsengland.co.uk/about-genomics-england/>

3.22 Suggest move to Domain 1 alongside 1.6, 1.7 & 1.8.

Domain 4: Additional care for women, newborn infants and families with complications and/or further care needs

There is quite a lot of repetition in this domain and because of the level of detail it makes it more noticeable when things are missed. Consideration should be given to the appropriateness of having long lists of what should be achieved – is there a way to explain these conditions/contexts in the round so midwives will be equipped to recognise any and all of these when caring for women? There is also a need to define what is meant by “prevalent”.

Social vulnerabilities need to be more prominent within this section. Women can be socially isolated for many reasons – asylum seeking, homeless, substance misuse, non-English speaking, trafficked - and this is not clear across all the sections – see for example 4.3, 4.9.

If the lists in this section are retained, our suggested amendments are as follows (see also skills) :

4.1 Move raised BMI into clinical complications rather than further care needs as BMI often leads to clinical complications.

4.2 Additional complications to consider include: thalassaemia, HIV, morbidity following caesarean section, cord complications to include true knots.

4.4 Include sepsis and A-B-O and rhesus incompatibility.

4.5 Include poor positioning leading to painful attachment.

4.9 Include tocophobia and perinatal loss to include women who have a child removed at birth, acknowledging their ‘bereaved status’ and resultant vulnerability.

Domain 5: Promoting safe and effective care: the midwife as colleague, scholar and leader

5.3 & 5.2 need to come before 5.1

5.4 Need to include reference to understanding compassion micro-skills/methodologies.

5.5. ‘Quality of care’ is mentioned twice, we suggest two separate outcomes:

Understand the relationship between safe staffing levels, appropriate skill mix and the safety and quality of care.

Recognise risks to public protection and escalate concerns appropriately and in line with local/national escalation guidance/policies.

5.10 ‘improvements’

5.11 Remove ‘the ability to develop’.

First bullet point – remove ‘strategic planning’, we consider that this is outside the scope of a midwife at the point of registration, this is a more senior level outcome and would only develop with experience.

Second bullet point: include reference to Professional Midwifery Advocates/Clinical Supervisors.

5.12 Remove 'compassionate'

5.14 Remove 'and disseminate'

5.17 Reword - 'Demonstrate positive leadership'

5.18 This would be quite challenging at the point of registration, we suggest this outcome is modified to state: 'Support students and maternity support workers in the provision of midwifery care, promoting reflection and providing constructive feedback'.

Q8 Do you think that the associated skills expressed in each domain are at the right level of skill?

Most of the feedback we have heard relates to the level of detail of the skills set and whether this is appropriate. Whilst it provides clarity and sets out the breadth of the scope of midwifery practice it also runs the risk of promoting a superficial, task-orientated 'tick box' approach to assessment.

We are also concerned that lists will restrict rather than giving freedom for innovation and future-proofing. Although these are very reflective of the current situation and responsive to some of the current policy (though more so in some countries than others), the question remains, what will midwifery and maternity services look like in 5-10 years time? Will the standards be able to respond as flexibly to changes in policy and service delivery as they have done in the past? We would recommend that the skills lists are moved into an annexe so that they can be amended/updated more easily should this be required.

In our response, we have commented in detail on the skills and how they are expressed. We would recommend that there is a re-assessment as to whether all of the skills are required at the point of registration. There is a view that some of the skills listed are too advanced and go beyond what would be expected of a midwife at the point of registration; too content specific or repetitive.

In deciding which skills to retain and which to remove it may be helpful to assess the frequency with which a midwife in their day to day practice would be required to use these skills, some of these skills are extremely rare, for example, insertion of a naso-gastric tube. Studies that have assessed skills retention has identified that skills are lost very quickly unless repeated frequently, in a review of 19 published studies on CPR and AED skills retention investigators found that, on average, 66% of people could not pass a skills test just three months after instructor-led training and approximately 90% failed after 12 months. We therefore caution against including skills that are unlikely to be repeated on a regular basis and are not essential core skills such as basic life support.

Domain 1: Being an accountable and autonomous midwife

In relation to information sharing there is little emphasis on non-biased information; there is mention of evidence based information (1.21.1) and reflecting on difficult topics (1.21.6) but there also needs to be acknowledgement of ones' own position in relation to the evidence. Similarly, the importance of understanding the woman's own perspective on 'material risk' and what safety and good care looks like. In 1.21.7 there is low-level 'responding to cues' type information, however there is little on actively seeking out and respecting the woman's perspectives on her care. In light of the recent Montgomery v Lanarkshire Health Board Supreme Court ruling this needs to be made more explicit.

1.21.3 There are a number of legislative requirements, including Codes, all of which are assumed to be covered in 1.2 so it is unclear as to why this legislation is singled out above all others, if this is retained then it would be necessary to specifically name all other legislative requirements.

1.21.6 We question whether, in 10 years time, will these still be the contentious issues in midwifery? In order to future-proof, we suggest removing this list of examples and state the importance of midwives recognising and responding appropriately to contentious issues and understanding how they play out in the media, across society at large, and can be interpreted and acted upon by individual women and families.

1.21.11 & 1.21.12 These two skills are a bit muddled. 'Breaking bad news' isn't an ethical dilemma, and bereavement is then covered again in the next skill 1.21.13. Suggest reworking this into two different points and leaving bereavement to the next point:

- Demonstrate the ability to conduct conversations about issues and decisions related to sexuality, pregnancy, childbirth, the newborn infant, mother-infant relationships and other familial relationships, that are informed by current evidence.
- Engage and empathise with women and families in difficult conversations, including conversations with a moral or ethical dimension.

1.21.15 Suggest adding 'supporting her to exercise her autonomy at all times' after the words "clinical guidance". This is where the earlier point made about a woman's human rights needs reinforcing.

1.21.16 We suggest adding sexuality and pregnancy to this list, as above. There are cultural dimensions to these too.

1.21.18 'Well-being' and 'wellbeing' is used interchangeably throughout this document, choose one format and use this consistently throughout.

1.21.5 How would this be assessed, can thoughts and feelings be measured? Suggest remove "on own thoughts and feelings around..."

Domain 2: The midwife's ability to provide and promote continuity of care

2.13.3 '...and newborn infants together' With whom? It isn't clear if that is with other health care professionals or the woman.

2.12.4 Should this skill be in Domain 1 as relates to Outcome 1.12 ? Remove "intimate partner" as violence can be by anyone in or close to the family not just the partner. In the second bullet point '...where such services do not exist...' this would be a challenge a midwife at the point of registration. Although this is a laudable aim it is outside of a midwife's scope of practice. For example in England, these are services provided by Local Authorities and funded by Public Health England, where the decision making sits entirely out of the midwife's hands. We suggest the word 'support' would be more appropriate.

Domain 3: Universal care for all women, newborn infants and families

3.23.2 We advise caution in the use of lists in this context. In our view the stem is sufficient and the list, which is permissive, should be removed. We would recommend use of the RCM Stepping Up to Public Health Model³ as an approach to facilitating conversations with women about public health issues.

3.23.5 Include the needs of the women who know they are going to bottle feed as they will require appropriate preparation in the antenatal period.

3.23.6 There are a number of factors which impact on breastfeeding – bed-sharing is just one of many, suggest remove this particular reference, or alternatively, include all factors.

3.23.11 Amend to ‘understanding antimicrobial and antibiotic resistance and applying the principles of antimicrobial stewardship’

3.23.14 Move 4th bullet to become 2nd. Include ‘Understand and act in accordance with the standards/guidelines for medicines management set by local and national organisations’.

3.23.15 “Assessment of fetal growth” is stated twice (see top of page 24).

3.23.16 Page 25, reword “need for assistance with mobility” to ‘encourage to mobilise with explanation as to the advantages of positioning in labour’.

Page 25 Substitute “including excitement, joy, anxiety, apprehension, fear” with ‘range of emotions’- this avoids emphasising particular emotions (three negatives to two positives) at the expense of others. This skill is duplicated on page 26, bullet point 5 which seems unnecessary.

Page 25 Pain relief needs to include reference to alternative therapies. Although we are not expecting midwives to be able to use these at the point of registration they should have a knowledge and understanding of their use, advantages and disadvantages, in order to support women.

Assessment of maternal and fetal health in labour and monitoring progress needs to include reference to understanding the mechanism of labour.

3.23.17 Page 26 We question whether wording of the last statement under the first bullet point is correct. Is the baby able to “...respond to the mother’s cues for food, love and comfort” just after birth?

3.23.17 Page 27 Systematic physical examination - although detailed this does have omissions, for example, there is no mention of:

- mouth - include checking for sucking reflex
- fingers and toes - include identification of single palmar crease and its significance
- evidence of Mongolian blue spot and its relevance

Rather than a lengthy list we would suggest using an overarching term or terms, such as body systems, to cover any and all of the assessments that may be required here.

³ <https://www.rcm.org.uk/media/3165/stepping-up-to-public-health.pdf>

3.23.18 Reword the statement relating to pain and pain management – it is inappropriate to have a list here. Pain is what the woman says it is, there are many different ways in which it can manifest in the postnatal period. The more important point is listening, recognising and responding when a woman complains of pain.

3.23.18 We question what does the midwife do if these community facilities such as “access to shops” are not available as is often the case in remote and rural areas? We think this is out of the midwife’s scope and should be removed.

3.23.19 & 3.23.25 There is quite a lot of repetition across these two skills sets in relation to infant feeding.

3.23.21 The verb ending is wrong for each of the bullet points that follows ...’skills include:’ Should be ‘arranging, promoting, providing etc. rather than “arrange, provide, promote”?

3.23.22 As above.

3.23.23 It would be helpful to include the essential elements of the Avoiding Term Admissions to the Neonatal Unit (ATAIN) programme here ⁴. This includes the importance of keeping mother and baby together and avoiding unnecessary separation and the early recognition and management of respiratory symptoms, hypoglycaemia and jaundice.

Domain 4: Additional care for women, newborn infants and families with complications and/or further care needs

4.12.6 Reword - ‘respond to a woman complaining of pain’

Should intravenous cannulation be a pre or post registration skill?

Reword - ‘and/or midwives exemptions medicines’

Reword - ‘bladder care including catheterisation’

Reword - ‘appropriate tests, including blood sampling...’

Last bullet point is the same as first bullet point of 4.12.8 – are both required?

4.12.8 Remove –“insert, manage and remove oral/nasal/gastric tubes”

“Assist” may be the wrong verb to use with the procedures listed at the end of this section. For example, with caesarean section emphasis should be placed on the midwives role in supporting the woman and her partner throughout the operation, receiving the baby, assessing its condition and promoting skin to skin etc. rather than ‘assisting’ which could be interpreted as ‘assisting’ the surgeon. It is the role of the junior doctor/scrub nurse/MSW to ‘assist’ the obstetrician/anaesthetist whilst the midwife focuses on supporting the woman and her partner and undertaking the necessary observations/assessments during the procedures.

4.12.10 We question whether support for women who are receiving treatment for substance misuse fits under mental ill health?

⁴ https://improvement.nhs.uk/documents/764/Reducing_term_admissions_final.pdf

In this section the lists risk missing out essential points. As before, we suggest an overarching statement or umbrella terms may be a better way to cover it all. If the list remains, we suggest considering:

- Not all caesarean sections incisions are closed with sutures – some have staples/soluble sutures. Need to include safe removal of drains, cannula, urinary and epidural catheters.
- Is de-infibulation of FGM included earlier, would all students across the UK be able to achieve this?
- Include support for women and families who have had a baby removed (top of page 41)
- Include harvesting of colostrum
- Additional care for the newborn infant should also include ‘recognise’
- Jaundice needs to include reference to breast feeding jaundice, physiological and haemolytic.

Domain 5: Promoting safe and effective care: the midwife as colleague, scholar and leader

Overall, these skills are not as well developed as those in the other domains. They need to be more dynamic rather than operational and task-focused. There is more detail required in relation to the skill set required to work effectively in multidisciplinary teams. Delegation, which needs to be safe and effective, would warrant its own skill set. There is also more detailed required regarding the midwife’s knowledge of research methodology and its application.

5.19.3 This whole sentence assumes that at the point of registration a midwife can supervise other new, junior team members as well as the wider multidisciplinary team. We would not expect this of a midwife at the point of registration as they require support themselves, we therefore suggest removing “managing and supervising”. Should be ‘maternity and/or healthcare support workers’

5.19.5 Review this tense, it should be ‘seeking...; taking action...; identifying...; demonstrating...’

5.19.6 Reword - ‘Demonstrate engagement in ongoing professional development opportunities’, remove the examples as these are repetitive and do not reflect the range of learning opportunities now and in the future.

5.19.7 Remove e-alerts and research summaries for reasons stated above.

5.19.8 This is more appropriate than what 5.19.3 says earlier.

Q9. Are there any knowledge or skills missing? If yes, please outline which ones.

We have included omissions in our response to Q8.

Q10. Are there any knowledge or skills that do not need to be included? If yes, please outline which ones.

We have made some suggestions to the skills which could be removed in our response to Q8.

Q11. The five domains in the draft standards are intended to inter-relate and build on each other and should not be seen separately. Do you think the draft standards do this?

Agree. The draft standards can be seen to build on one another and are inter-related.

Q12. Our intention is to set standards that prepare the future midwife to practise now and towards 2030. Do you think the draft standards are sufficiently future focused?

We have identified in our responses above where we consider that the outcomes or skills are not sufficiently future-focused and have made some alternative suggestions.

Q13. Provide safe and effective midwifery care across settings for all women, newborn babies, partners and families?

Agree.

Q14 Provide kind and compassionate women and family centred care?

Agree.

Q15. Effectively communicate and build relationships with all women, their partners and families?

Agree.

Q16. Promote, support and encourage close and loving relationships between women, their partners, families and newborn infants?

Agree.

Q17. Be capable of providing continuity of care and carer throughout pregnancy, birth and postnatally in a range of settings including the home, community, midwife-led units and hospital?

Agree.

Q18. In relation to the future midwife's role in public health, to what extent do the draft standards adequately reflect the knowledge and skills required for the future midwife to:

a. understand and recognise the public health needs of local communities and individual women

Agree.

b. provide education and support to women, their partners and families on healthy lifestyle choices

Agree.

c. identify women, fetuses and newborn infants who may have an increased chance, or risk, of a health disease or condition

Agree.

d. enable and support women to make and evidence-based, informed decision about their own health and care and that of their newborn infant throughout pregnancy, birth and beyond

Agree.

e. provide information and support for women's choice of infant feeding

Agree.

Q19. Identify and escalate concerns related to the health and mental wellbeing of the woman and newborn infant?

Agree.

Q20. Recognise mental, physical, social, cultural and spiritual needs and preferences of women to be able to provide information and support to women and their partners, families and newborn infants?

Agree.

Q21. Understand and recognise social and health inequalities and how to mitigate them through evidence based midwifery care?

Agree.

Q22. Provide education and support to women and their partners and families in preparation for parenthood that is tailored to their needs, preferences and values?

Agree.

Q23. Involve, learn and work collaboratively with multidisciplinary and agency teams, such as social workers, nurses, obstetricians, GPs?

Agree. It should be emphasised that this should be relevant and meaningful. We are aware that there are exemplars of good practice but we are also aware that in some institutions, this is just a tick box exercise and the students understanding and knowledge of multidisciplinary and multiagency working is poor.

Q24. Coordinate care with and across the wider multidisciplinary and multiagency teams, such as the health visitor, GP social worker, to arrange seamless transfer of care when midwifery care is complete?

Agree. But, similar to the response provided in Q23 this needs to be meaningful and reflective of the realities of practice.

Q25. Provide care that optimises normal processes and recognises deviations from these in women, fetus and newborn infant?

Agree.

Q26. Able to safely manage and co-ordinate intrapartum care of a woman and her fetus?

Agree.

Q27. Recognise signs of deterioration and compromise and is able to initiate first line management where this occurs?

Agree.

Q28. Respond effectively to deteriorating and emergency situations, including urgent escalation to others?

Agree. This should include referral.

Q29. Safely and effectively lead and manage midwifery care, involving multidisciplinary and multidisciplinary (should this be multiagency?) colleagues and delegating responsibilities when appropriate?

Agree.

Q30. Able to safely manage and provide postpartum care of women and care of newborn infants, including...

a. optimising normal processes

Agree.

b. managing common symptoms

Agree.

c. anticipating and preventing complications

Agree.

d. responding to women's health and mental wellbeing needs

Agree.

Q31. In relation to the future midwife's role in the safe management and administration of medicines:

a. demonstrate knowledge of pharmacology and the ability to recognise the positive and adverse effects of medicines

Agree.

b. be capable of safe and effective management and administration of medicines

Agree.

c. understand and apply the principles of midwives exemptions

Agree, however students should also be capable of safe and effective management and administration of midwives exemptions medicines, under the direct supervision of a midwife as stated in the guidance provided by the Medicines and Healthcare products Regulatory Agency⁵.

d. have the knowledge to progress to a prescribing qualification following registration

Agree.

Q32. Should the future midwife be able to conduct a full systematic physical examination of the newborn infant at the point of registration?

We have heard mixed views with regard to this. Currently there are some educational institutions where the students meet this requirement and others where it is partially met with the students completing the theory component pre-registration and the practical component post-registration. To some extent the inclusion of the full systematic examination is related to the length of the programme, if this was to be extended to 4 years then this should be included otherwise we would recommend that the theory is completed with the pre-registration programme and the practice component completed post-registration.

Q33. Do the draft standards the appropriate knowledge and skills for the future midwife to safely conduct a full systematic examination of the newborn infant?

No, there are omissions, the standards should include the detailed assessment criteria outlined in the Public Health England Newborn and Infant Physical Examination (NIPE) Programme Handbook⁶.

Q34. Do you have any other comments about the draft standards that you would like to make?

All comments have been included in our responses above.

Standards for pre-registration midwifery programmes

Q35. The draft programme standards propose that midwifery programmes provide an equal balance of theory and practice learning using a range of learning, teaching and assessment strategies such as the use of simulation and technology. To what extent do you agree or disagree with this approach?

Agree, however it would be helpful to have clarity as to what is meant by practice. Our view is that as midwifery is such a strongly relationship based profession in order to develop the necessary skills, direct interaction and hands on care with women and their families is required. This is in contrast to the more technical professions such as surgeons where the development of the fine motor skills required is enhanced through the use of simulation and technology. Thus, in midwifery, the use of simulation and technology should be counted as theory and practice is counted as direct hands on care.

⁵ <https://www.gov.uk/government/publications/rules-for-the-sale-supply-and-administration-of-medicines/rules-for-the-sale-supply-and-administration-of-medicines-for-specific-healthcare-professionals>

⁶ <https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook/newborn-and-infant-physical-examination-screening-programme-handbook>

Q36. Should the NMC work with others to support the development of a standardised, national practice assessment document?

Agree. There are already agreed regional assessment documents such as the Pan London Practice Assessment Document. The UK LME Executive Group would be able to assist in moving this work forward towards a nationally agreed document.

Q37. What do you think the minimum length of the programme should be, to prepare the future midwife to meet the proposed new standards of proficiency at the point of registration?

We consider that it is hugely ambitious to expect students to become competent, confident and safe in all the proficiencies (outcomes and skills) as described in the consultation documents in 3 years and there is a risk that the student will be set up to fail. There is a general acceptance that additional time is required. However, for varying reasons, principally financial, there is little appetite from governments, education and practice placements providers and student midwives themselves to extend the programme to 4 years. A 4 year programme is our preferred option and we would have liked to see some hypothetical modelling in the consultation using the 4 year programme in Ireland⁷. A longer programme aligns with the European Midwives Association and International Confederation of Midwives intentions of moving towards a 5 year programme within Europe and internationally (personal communication). The alternative and perhaps pragmatic solution would be a 3 year programme followed by a mandated foundation year with supported practice and protected learning time such as that provided to newly qualified doctors in the UK. We recognise this poses a dilemma for the regulator as it can only determine requirements for pre-registration education programmes however, we would strongly recommend that the NMC works with the 4 UK governments to support this option.

Q38. Which factors do you think are most important in preparing the future midwife to meet the new standards of proficiency at the point of registration?

These are wide ranging and more evidence is needed on the education outcomes and their impact on the workforce providing education and training for students. We are concerned about the capacity and sustainability of the practice and education workforce, arising from its aging profile (60% of the education workforce are over 50) and reduction in staff to cut costs both within education and practice settings. There are vacancies across education and practice and the salaries in the education sector have not kept pace with the NHS thus making it a less attractive career choice for experienced midwives. As student numbers grow in response to government policies across the UK, high quality education experiences are increasingly difficult to provide. It is also a challenge in some areas to ensure student midwives have adequate exposure to normality and are able to provide midwifery care to women with a wide range of needs and in a variety of settings. As we have stated earlier in the response, some students will struggle to gain experience in different settings and with a diverse population of women.

We think there are significant implications for practice placements providers:

- a) Will there be sufficient practice supervisors and assessors with the future midwife skills to support and assess students on the new programme?

⁷ <https://www.nmbi.ie/nmbi/media/NMBI/Publications/midwife-registration-programmes-standards-requirements.pdf?ext=.pdf>

- b) What will be the impact of workforce challenges, according to the 'Closing the Gap' report this will pose a threat to the delivery and quality of care over the next 10 years⁸ (ref Closing the gap)?

And for education providers:

- a) Will there be sufficient teachers and capacity within the teaching workforce to support students?
- b) Is there capacity/resources to cope with more flexibility in approaches to teaching and learning e.g. access to simulation laboratories?
- c) Do students have exposure to the breadth and depth of midwifery research particularly in institutions where the midwifery research profile is less evident?

Q39. Is there anything else that we need to take into account? If so please state.

3.1 Remove - "midwifery" before students.

3.5 "a number of women" is a bit loose - we recommend that a minimum number is stated.

3.7 a) is a must do b) is optional, not sure of the relevance of this for midwives as most of the medicines required in day to day practice are specified in a).

Q40. Do you have any general comments about the draft Programme Standards that you would like to make?

These standards appear to have taken in very different approach and are much more 'light touch' in comparison to the proficiencies. They are not as comprehensive as previous programme standards for midwifery education, in particular, how they describe the role of the Lead Midwife for Education and there is no mention of the role of midwife educators/teachers.

There is international consensus on the importance of midwifery leadership in education⁹ and the fundamental importance of midwifery educators to the quality of midwifery and the future of the profession¹⁰.

The Midwives in Teaching report¹¹, commissioned by the NMC, identified the key quality indicators for midwifery education and specified the requirements of the midwife educator role that include:

- The midwife teacher team is clinically and academically credible
- The midwife teacher team has an understanding and knowledge of all practice placement areas
- Midwife teachers are 'highly visible' and easily accessible in all the main student practice placement sites and good communications are maintained with more remote locations
- Midwife teachers are involved in the monitoring practice assessment of student competence and mentor/assessor consistency through tripartite discussions

⁸ <https://www.health.org.uk/sites/default/files/upload/publications/2019/Closing-the-gap-key-areas-for-action-overview.pdf>

⁹ https://www.who.int/hrh/nursing_midwifery/educator_competencies/en/

¹⁰ [https://www.midwiferyjournal.com/article/S0266-6138\(16\)00021-8/fulltext](https://www.midwiferyjournal.com/article/S0266-6138(16)00021-8/fulltext)

¹¹ <https://www.nmc.org.uk/globalassets/siteDocuments/Midwifery-Reports/MINT-report.pdf>

- All students have a personal tutor who is a midwife teacher and can monitor their professional and academic progress and development

We would recommend that these requirements are explicitly stated within the standards for midwifery programmes. We would also recommend that statement on the Lead Midwife for Education (page 8) is divided into two sections. The first section, to identify the requirement to appoint an LME, to notify the NMC of that appointment and for the LME to be the strategic lead for midwifery education and to advise on all matters relating to midwifery education both within the AEI and externally. The second section, to outline their role in supporting declarations of health and character for students.

There is a view that the selection, admission and progression section is a little weak, the expectation should be more than “having capability”.

The equal partnership between education providers and their practice placement partners needs to be stated more clearly within these standards. We are aware that there are a number of partnerships that work extremely well and student experience is good, however, are some that are less good and the student learning experience is poor.

Impact Assessment

Q41. Age

Q42. Disability

Q43. Gender reassignment/Trans

Q44. Marriage and civil partnership

Q45. Pregnancy and maternity

Q46. Race/Ethnicity

Q47. Religion or belief

Q48. Sex

Q49. Sexual orientation

The Standards of proficiency and Standards for midwifery programmes are wide ranging and have the potential to impact on all the protected characteristics stated above. We would recommend that a full equality impact assessment needs to be carried out on the final documents, there are risks of an equality impact on students, educators, practice supervisors and assessors as well as women and their families.

We have highlighted potential equality impact on the following protected characteristics throughout our response, age, disability, gender reassignment, marriage and civil partnership, race, religion or belief and sexual orientation. For example, in the principles section we talk about accessibility and taking a human rights approach that promotes equality, diversity and inclusion. Under Domain 1 we highlight, disability and Domain 3 vulnerable women e.g. asylum seekers. In Domain 1 there is reference to sexual orientation – is it also worth adding in gender reassignment and marriage and

civil partnership just so that all the protected characteristics that could relate to relationships are covered? We also wonder if it worth adding in religious considerations when cultural dimensions are considered in 1.21.16. We also raise the ageing age profile of the workforce.

Ongoing monitoring and review as the new standards are implemented, will also be required.

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