Council of Deans of Health

The voice of UK university faculties for nursing, midwifery and the allied health professions

Nursing and Midwifery Council - Future midwife consultation

Council of Deans of Health written submission – May 2019

The Council of Deans of Health welcomes the opportunity to contribute to this important consultation. The Council represents the 85 UK university faculties engaged in education and research for nursing, midwifery and the allied health professions.

Key messages

1. Women, newborn infants, partners and families and their care, needs, views, preferences and experiences must be at the heart of these new standards. The regulation of midwives must also assure the quality, safety and efficacy of care from both a regulatory and educational perspective. Universities are committed to delivering high quality education which ensures public protection.

2. The Council welcomes the fact that these standards recognise the accountability and autonomy of registered midwives and their role as the lead professional and provider of continuity of care and carer.

3. The Council welcomes domain 5, which asserts the importance of the midwife as a colleague, scholar, and leader in promoting safe and effective care. In particular, the focus on ongoing engagement with evidence and research is especially positive.

4. In order to ensure that these standards remain future-focused, they should be rebalanced by reducing their list-based and task-focused nature. This is especially the case for domains 2, 3, 4 & 5. This would allow them to be more flexible and better meet the needs of service users and practice over the next decade whilst ensuring public protection.

5. Specifically, there is a need for a greater focus in the standards on the dynamic nature of the role of midwives as providers and promoters of continuity of care and carer for all women across a range of settings; of the role of midwives in behavioural change, including in relation to public health; and of the role of midwives as leaders, and consumers and producers of evidence and research.

Responses

Principles underpinning the standards

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

The Council agrees with the acceptance of the modifications outlined below in future questions.

The standards do have a core focus on the safety, needs, views, preferences and experiences of women, newborn infants, partners and families. They do also draw on a human rights-based approach. In general, the standards are accessible to the public and appropriate for all four nations of the UK. The Council welcomes the fact that the standards are evidence-informed, particularly via the influence of the Lancet Series on Midwifery, which is evident.

In order to ensure that these standards remain future-focused, they should be rebalanced and made more dynamic by reducing their list-based and task-focused nature. This is especially the case for domains 2, 3, 4 & 5. This would allow them to be more flexible and better meet the needs of service users and practice over the next decade whilst ensuring public protection.

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 programmes?

Agree. For example, this is indicated in standards 1.6, 1.7, 1.12, 1.15, 2.3, 2.7, 3.1, and 3.18.

Feedback on Draft Standards of Proficiency for Midwives

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

Domain 1: Being an accountable and autonomous midwife

Agree, with the caveats below.

The Council particularly welcomes standards 1.13 and 1.21.5, which will enable students to develop skills of self-reflection, which is important for maintaining professional standards and revalidation.

Standard 1.12 refers to 'legal status', but it is unclear what this refers to. If this refers to the immigration status of a service user, then this should be clarified.

Standard 1.15, which is focused on the informed consent of women, contradicts standard 1.17, which states that an account of all care given should be available for review 'by the woman, her partner and family and by all professionals involved in care.' This should be reworded to ensure that information is only provided to those individuals that a woman consents to having access. A midwife has an important role not only in demonstrating the ability to seek informed consent, but also in understanding why this is important.

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

Agree, with the caveats below.

Domain 2 should be renamed: 'The midwife's ability to provide and promote continuity of care and carer in health and care systems.'

The use of the term 'first line management' could be seen to conflict with the role of the midwife as the lead professional across the care continuum. This term should be reconsidered in light of this potential conflict, especially as this term does not reflect the diverse settings that midwives practise in. However, any reconsideration of this term should not deprioritise safety.

Standard 2.3 is an awkward fit in the sequencing of these standards and should be located after standard 2.6.

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

Agree.

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

Agree.

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

Agree, with the caveats outlined below.

The Council strongly welcomes the commitment to the understanding of current research (standard 5.13) and lifelong learning (standard 5.15) in these standards. However, a more dynamic sense of the role of midwives as leaders, and consumers and producers of evidence and research needs to be incorporated into these standards.

Standard 5.4 refers to 'strength-based approaches', but if this term is to be used then the definition should be incorporated into the standard to increase clarity.

8. Do you think that the associated skills expressed in each domain are at the right level of detail?

Domain 1: Being an accountable and autonomous midwife

Agree, with the caveats outlined below.

Standard 1.21 starts with the phrase: 'at the point of registration'. This should be removed as it is repetitive, as all standards are expected to be met at the point of registration. This is the case throughout all domains.

Standard 1.21.6 states that there is a need to 'reflect on and debate topics that are seen to be challenging or contentious such as women's role in decision-making…' This should not be seen as a challenging or

contentious issue and this reference should be removed, especially as registered midwives should act as advocates for the rights of women at all times.

Standard 1.21.7 includes a reference to 'clarification techniques.' It is unclear what this means, and this should be clarified.

Standard 1.21.12 refers to 'difficult conversations'. This reference should be removed and the standard should only refer to sensitive issues. This standard also refers to ethical dilemmas, but 'loss and bereavement, and breaking bad news' are not ethical dilemmas. The reference to 'loss and bereavement' is better captured by standard 1.21.3.

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

Agree, with the caveat outlined below.

Standard 2.13.4 refers to identifying 'local resources relevant to the needs of women and newborn infants … and where such services do not exist work with communities and agencies to promote their establishment.' Students should be exposed to this, but it maybe difficult for all students to be assessed as competent in this standard in practice.

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

Agree, with the caveats outlined below.

There needs to be a more dynamic understanding of the role of midwives in behavioural change, including in relation to public health. For example, standard 3.23.2 embraces a list-based version of public health promotion and prevention. This standard also refers to the permissive 'may include.' Regulatory standards should either be a requirement or not included. This further calls into the question the need for such detailed lists in these standards.

Standard 3.23.2 refers to 'sexually transmitted diseases.' This should be changed to 'sexually transmitted infections.'

Standard 3.23.6 refers to the impact of bed sharing on breastfeeding, but this is a more complex issue that is impacted on by a range of factors and the reference to bed sharing should be removed.

Standard 3.23.11 refers to 'antimicrobial stewardship'. This should be changed to a more accessible term.

Standard 3.23.14 refers to 'injection equipment.' This term should be clarified.

Standard 3.23.15 refers to the assessment of fetal growth twice. The second time should state 'assessment of fetal growth by other measures.'

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

Agree, with the caveat outlined below.

Standard 4.12.6 refers to skills including 'urinary catheterisation of bladder for women.' This should be reworded to state: 'urinary catheterisation of bladder for women and wider care.'

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

Agree, with the caveat outlined below.

Standard 5.19.7 refers to 'e-alerts'. This may be too prescriptive a standard in light of the potential changes to technology over the next decade. A more dynamic understanding of digital literary and engagement is needed for these standards to be fit for purpose.

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

Yes. A full systematic examination of newborn infants should be made more explicit. For example, standard 3.23.17 should refer to this examination taking place 72 hours after birth.

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

N/A.

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. Read as a whole, the draft standards can be seen to inter-relate and build on one another in terms of the knowledge, skills and behaviours expected of a midwife at the point of registration.

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?

Agree, with the caveats outlined below.

The current standards embrace a list-based and task focused version of professional midwifery practice. This will not allow the necessary flexibility to ensure that the standards are fit for purpose for the professional practice of the next decade. Where appropriate, lists should be removed from standards to ensure that they are broad enough to be fit for purpose in a decade's time, whilst ensuring public protection.

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

Agree, with the caveats outlined below.

The Council welcomes the focus in the draft standards of proficiency on continuity of care and carer, which is provided via domain 2. We also welcome that the midwife is acknowledged in standard 1.5 as the 'lead professional for the midwifery care and support of women and newborn infants throughout the whole continuum of care.'

However, more focus on the range of settings that a midwife may be working in is needed, including the dynamic nature of the role of the midwife working across boundaries. The language in the standard focuses too much on a distinction between hospital and community settings and this needs to be rectified.

Q14. Provide kind and compassionate women and family centred care?

Agree. For example, this is indicated by standards 1.7, 1.9, 1.21.10, 3.20, 4.11, and 4.12.9.

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

Agree. For example, this is indicated by standards 1.8, 1.9, 1.21.4, 1.21.7, 1.21.8, 1.12.9. 1.21.11, 1.21.16, and 2.13.1.

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

Agree. For example, this is indicated by standard 3.23.24.

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, with the caveats outlined in Q13.

The Council welcomes the focus in the draft standards of proficiency on continuity of care and carer, which is provided via domain 2. We also welcome that the midwife is acknowledged in standard 1.5 as the 'lead professional for the midwifery care and support of women and newborn infants throughout the whole continuum of care.'

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. For example, this is indicated by standards 1.21.6, 1.21.11, 2.12, 3.1, 3.2, 3.3, 3.23.2, 3.23.3, 3.23.5, and 3.23.7.

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

Agree. For example, this is indicated by standards 3.5, 3.23.8, and 3.23.15, However, it must be noted that not all women have such a choice to make. All service users need to be encouraged to adopt a healthier lifestyle, but some may not have this choice.

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

Agree. For example, this is indicated by standards 4.1, 4.2, 4.3, and 4.4.

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

Agree. For example, this is indicated by standards 1.4, 1.21, 1.21.1, 1.21.2, 1.21.4, 1.21.11, 2.13, 3.2, 3.3, 3.19, 3.20, 3.21, 3.23, 3.23.1, 3.23.4, 3.23.13, 3.23.16, 3.23.20, 3.23.21, 3.23.22, 3.23.23, 4.6, 4.7, 4.8, 4.10, 4.12, 4.12.6, 4.12.12, 5.3, 5.8, 5.19, 5.19.2, and 5.19.17.

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

Agree. For example, this is indicated by standards 1.21.6, 1.21.11, 1.21.16, 2.10, 2.13.4, 3.3, 3.11, 3.13, 3.19, 3.21, 3.23.2, 3.23.5, 3.23.6, 3.23.10, 3.23.15, 3.23.17, 3.23.18, 3.23.19, 3.23.24, 3.23.25, 4.5, 4.8, 4.12.4, 4.12.8 4.12.10, 4.12.11, and 4.12.12.

Q19. Identify and escalate concerns related to the health and mental well-being of the women or newborn infant?

Agree. For example, this is indicated by standards 1.21.7, 1.21.14, 3.3, 3.6, 3.13, 3.15, 3.23.15, 4.1, 4.2, 4.3, 4.5, 4.7, 4.8, 4.12.4, , 4.12.6, 4.12.8, 4.12.10, and 4.12.11.

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. For example, this is indicated by standards 1.12, 1.21.10, 1.21.16, 1.6, 1.7, 1.9, 1.12, 2.3, 2.13.4, 3.1, 3.4, 3.6, 3.12, 3.13, 3.17, 3.18, 3.22, 3.23.2, 3.23.15, 3.23.16, 3.23.17, 3.23.18, 3.23.20, 3.23.21, 3.23.22, 3.23.24, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.8, 4.9, 4.12.4, 4.12.6, 4.12.7, 4.12.8, 4.12.9, and 4.12.10,.

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

Agree. For example, this is indicated by standards 1.12, 2.3, 2.7, 2.9, 2.13.4, and 3.23.2.

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

Agree. For example, this is indicated by standards 3.5 and 3.23.8.

Q23. Involve, learn and work collaboratively with multi-disciplinary and agency teams, such as social workers, nurses, obstetricians, GPs

Agree. For example, this is indicated by standards 1.21.14, 2.11, 2.13.5, 2.13.8, 3.23.21, 4.8, 4.9, 4.11, 4.12.1, 4.12.4, 4.12.7, 4.12.8, 4.12.9, 4.12.10, 4.12.11, 4.12.12, 5.6, 5.17, 5.19.1, 5.19.2, 5.19.3, and 5.19.4.

However, these standards should include a greater focus on opportunities for multi-disciplinary and interprofessional learning to better mirror the realities of practice. For example, we would recommend a strengthening of standard 5.6 in light of this.

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

Agree. For example, this is indicated by standards 1.21.14, 2.11, 2.13.6, 2.13.7, 3.19, 3.21, and 4.12.6.

However, these standards should include a greater focus on opportunities for multi-disciplinary and interprofessional learning to better mirror the realities of practice.

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

Agree. For example, this is indicated by standards 3.9, 3.19, 3.21, 3.23.12, 3.23.15, 3.23.16, 3.23.17, 3.23.18, 3.23.19, 3.23.21, 3.23.22, 3.23.23, 3.23.24, and 3.23.25.

Q26. Able to safely manage and coordinate intrapartum care of a woman and her fetus?

Agree. For example, this is indicated by standards 2.13.0, 3.19, 3.21, 3.23.12, 3.23.15, 3.23.16, 3.23.22, 3.23.24, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, and 4.12.6.

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

Agree. For example, this is indicated by standards 4.6, 4.12.5, and 4.12.6. However, this should not only be about first line management, but be expanded to include recognition of risk factors and complications.

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

Agree. For example, this is indicated by standards 1.21.7, 1.21.14, 4.7, 4.12.6, and 4.12.8.

Q29. Safely and effectively lead and manage midwifery care, involving multi-disciplinary [sic] and multi-disciplinary colleagues and delegating responsibilities when appropriate?

Agree. For example, this is indicated by standards 5.1, 5.6, 5.17, 5.19.1, 5.19.2, 5.19.3, and 5.19.4.

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

a. optimising normal processes

Agree. For example, this is indicated by standards 3.3, 3.13, 3.15, 3.23.15, 4.1, and 4.2.

b. managing common symptoms

Agree. For example, this is indicated by standards 3.3, 3.13, 3.15, 3.23.15, 4.1, 4.2, 4.3, 4.5, and 4.8.

c. anticipating and preventing complications

Agree. For example, this is indicated by standards 4.3, 4.5, 4.8, 4.12.4, 4.12.10, and 4.12.11.

d. responding to women's health and mental well-being needs

Agree. For example, this is indicated by standards 3.3, 3.6, 3.13, 3.15, 3.23.15, 4.1, 4.2, 4.3, 4.5, 4.8, 4.12.4, 4.12.10, and 4.12.11.

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. For example, this is indicated by standards 3.14 and 3.23.12.

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

Agree. For example, this is indicated by standard 3.15.

c. understand and apply the principles of midwives' exemptions

Agree. For example, this is indicated by standards 4.12.6 and 3.15.

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

Agree. For example, this is indicated by standard 3.15.

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

Agree. Newly qualified midwives should be able to undertake both an initial physical examination of the newborn infant as well as the full systematic physical examination taken within 72 hours. This will help to ensure that these standards are more future-proof.

We note that Newborn and infant physical examination (NIPE) guidelines operate in England, but other nations in the UK use other guidelines and this flexibility should be upheld by these standards.

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

Disagree. This should be made more explicit within the standards. This would likely be best placed at standard 3.23.17.

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

New standards of proficiency and education may lead to consideration of the regulation of maternity support workers, especially in light of the development of Health England England's 'Maternity support worker competency, education and career development framework.' The education sector stands ready to engage in these conversations for the benefit of women, newborn infants, partners, families, and students.

Feedback on Standards for pre-registration midwifery programmes

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

Agree.

However, on page 12 of the draft programme standards, standard 4.6 states that approved education institutions should: 'ensure that there is equal weighting in the assessment of theory and practice'. This is accompanied by a note that states: 'Weighting in this context means equal value is given to the assessment theory and practice [sic]'. Due to the holistic nature of assessment across both theory and practice, it would be better if standard 4.6 stated: 'ensure that there is equal consideration given to the assessment of theory and practice.'

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

Yes.

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

Allow individual education providers and partners to decide the optimal length. This should be in line with the minimum number of years and hours set by European Union legislation.

Most providers are likely to continue to provide pre-registration midwifery programmes at a minimum of three years and 4,600 hours, especially as some providers are already delivering programmes which have content close to the proposed standards. However, providers who want to deliver programmes across a longer and more flexible time period should be allowed to.

Employers also have a central role in ensuring ongoing staff development and the embedding of knowledge, skills and behaviours in professional practice. Preceptorship is critically important, and work should be undertaken to increase the consistency of preceptorship across the four nations of the UK. Consideration should also be given to the preparation and ongoing support of the existing workforce in order to support students in practice education settings.

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?

All of the factors are important in preparing midwifery students for registration. For different students some factors may be more important than others.

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

N/A.

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

It is positive to see the focus on leadership and scholarship within the standards of proficiency which should extend to emphasising opportunities for midwifery educators to lead for the benefit of students, the education sector, and professional practice as well as women, newborn infants, partners, and families.

The education sector, amongst others, needs to be made aware as soon as possible if the implementation of new midwifery standards of education and proficiency will lead to changes to the Standards Framework for Nursing and Midwifery Education.

On page 19 of the draft programme standards it states that training is to be dispensed under the appropriate supervision, including 'supervision and care of at least 40 pregnant women'. This should be reworded to 'women in labour.'

Impact Assessment

Q41 Age

These standards are anticipated to have an impact on this protected characteristic.

Q42 Disability

These standards are anticipated to have an impact on this protected characteristic.

Q43 Gender reassignment/Trans

These standards are anticipated to have an impact on this protected characteristic. The Council is concerned that the standards do not fully incorporate the needs of transgender individuals, especially in the language used in the standards. There should be more focus on the needs of non-binary individuals and the pronoun choice of all individuals.

Q44 Marriage and civil partnership

These standards are anticipated to have an impact on this protected characteristic.

Q45 Pregnancy and maternity

These standards will have an impact on this protected characteristic.

Q46 Race/Ethnicity

These standards are anticipated to have an impact on this protected characteristic.

Q47 Religion or belief

These standards are anticipated to have an impact on this protected characteristic.

Q48 Sex

These standards are anticipated to have an impact on this protected characteristic.

Q49 Sexual orientation

These standards are anticipated to have an impact on this protected characteristic.

For more information contact:

Josh Niderost, Senior Policy and Public Affairs Officer, josh.niderost@cod-health.ac.uk