

Future midwife: Consultation response document

November 2019

Introduction

Background

Our Strategy 2015-2020 set out our ambition to be a dynamic, forward looking regulator.

In 2016 we began a programme of work to reform nursing and midwifery education to make sure that our standards for education and our proficiencies enable better safer care, are outcome-based, proportionate, flexible and future-focussed.

As part of this programme of change our Council approved the development of a new suite of pre-registration education standards. These were to be comprised of new outcome focussed standards for the delivery of education and training that would apply to all approved education institutions (AEIs) and practice learning partners delivering all NMC approved programmes. These standards were also to include a new approach to student learning and assessment. Taken together with new standards of proficiency for the professionals that we register, these standards set out the future requirements for safe and effective nursing and midwifery education and practice in the UK.

In 2018 we published the first sets of new standards for education and training and proficiencies for nurses and nursing associates:

1. Part 1: Standards framework for nursing and midwifery education
2. Part 2: Standards for student supervision and assessment
3. Part 3: Programme standards
 - Standards for pre-registration nursing programmes
 - Standards for pre-registration nursing associate programmes
 - Standards for prescribing programmes
 - Standards for return to practice programmes (2019)
4. Future Nurse: Standards of proficiency for registered nurses
5. Standards of proficiency for nursing associates

Part 1 and part 2 apply to all AEIs and their practice learning partners which deliver pre-registration midwifery education programmes

In the next stage of our review we developed new Standards for pre-registration midwifery programmes and new Standards of proficiency for midwives. This document focusses on the evidence sources, engagement and consultation activities that fed into the development of these new standards.

Design principles

We agreed design principles with our stakeholder partners for our new Standards of proficiency for midwives and Standards for pre-registration midwifery programmes, our intention is that our new standards should:

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

Why we're developing new standards for the future midwife

Our previous midwifery standards were published in 2009. The context in which midwives are working is continuously evolving with changes in demographics, health profiles and birthing choices of women. Our standards for what midwives need to know and do need to evolve and be informed by these changes, to ensure that they are able to practice safely and effectively at the point of registration.

Evidence sources and initial engagement

We regularly review all our standards and guidance. This section sets out the key evidence sources that informed development of the draft midwifery proficiencies and midwifery programme standards for public consultation. The responses to the consultation and how they further informed the new standards are addressed later in this document.

Scoping work for this project began with identifying and analysing key reports and research that had been published, examining strategies for the delivery of midwifery care across the four countries of the UK, and thought pieces made recommendations for the education of midwives of the future.

We also commissioned the University of Dundee to undertake major evidence reviews on the needs of women, babies and families; the development of standards; and effective education. This work was based on the best current evidence including the Framework for Quality Maternal and Newborn Care published in The Lancet Series on Midwifery (2014). www.thelancet.com/series/midwifery

Early engagement with key stakeholder organisations occurred in 2017. This included discussions with the Royal College of Midwives, the Council of Deans of Health and the Royal College of Nursing Midwifery Committee; meetings with key medical Royal Colleges including the Royal College of Obstetricians and Gynaecologists, the Royal College of Anaesthetists, the Royal College of General Practitioners and the Royal College of Physicians; meetings with advocacy groups; a series of Future Midwife workshops across all 4 countries; and focus group discussions with midwifery leaders including heads and directors of midwifery, practising midwives, newly qualified midwives, student midwives and educators including lead midwives for education.

To assist in the development of the standards, we brought together a group of midwifery and maternity experts, other health and care professionals and service user representatives in a Thought Leadership Group. The role of the group was to oversee the drafting of the new proficiency standards, acting as a sounding board to develop consensus and providing scrutiny of and advice to inform our proposals. We also conducted a round of stakeholder engagement events in 2018, including a series of Future Midwife round table discussions and workshops with educators and clinical midwives. The draft standards were considered by our Midwifery Panel who advised the Council on the suitability of the standards and the process that had been undertaken to develop them, before the Council approved the draft standards for public consultation.

As part of our engagement with women and families, we also ran a survey on experiences of midwifery care for women and families. The objective of this survey was to directly engage with women and families on the subject of midwifery care and provide a mechanism for these groups, and other seldom heard groups, to feedback directly to the NMC. The survey was promoted using targeted Facebook advertising and was open December 2018 - January 2019. More than 500 people responded.

Consultation

Between February and May 2019, we undertook a public consultation on our draft midwifery proficiencies and programme standards. An external agency, Pye Tait Consulting, were commissioned to run the consultation exercise on our behalf, to run a series of focus groups during the consultation period and to independently analyse feedback from the consultation and give us the data required to produce this report.

In the consultation, we put forward ambitious proposals that reflected the knowledge, proficiency and skills necessary for registration as a midwife.

In the consultation, we sought views on:

- draft *Standards of proficiency for midwives*
- draft *Standards for pre-registration midwifery programmes*

We initiated a wide-ranging social media campaign to support the launch of the consultation. We also used targeted Facebook and LinkedIn advertising to promote the consultation to women, their partners and families and seldom heard groups to encourage as many people as possible to take part.

There were four versions of the consultation survey tailored for different audiences:

1. Midwives, student midwives, educators, employers and related organisations
2. Other health and social care professionals
3. Members of the public, advocacy groups and charities
4. Easy read survey for people who have literacy and/or learning difficulties

This document gives an overview of our proposals and how we've refined our standards as a result of information, both qualitative and quantitative, gathered during consultation and through engagement.

Responses to our consultation

We received 1,636 responses to the consultation on the draft standards of proficiency: 407 from midwives, including 68 student midwives; 117 responses from organisations; 54 from other health and social care professionals; and 1058 from members of the public, including 6 responses to the 'easy read' version. There were 36 narrative responses by way of letter or email from people or organisations who chose to respond in that way rather than completing the online consultation survey.

We received a total of 490 responses to the consultation on draft standards for pre-registration midwifery programmes which was targeted at midwives and organisational stakeholders only: 407 responses to this consultation were from midwives, including 68 student midwives, and 83 responses were from organisations, of which 46 were from organisations with an educational or academic background.

It should be made clear that many organisational responses were based on feedback from a large number of people. For example, organisations such as the Royal College of Midwives and a number of NHS Trusts and Health Boards based their responses on the feedback they had received from their own members or employees in response to

consultation exercises or calls for evidence they carried out to inform their own formal responses to our consultation.

In addition to the consultation we ran a programme of engagement activities across the UK. We organised:

- Fourteen workshop events in seven cities, in all four countries of the UK
- Visits to maternity units and universities around all four countries to take views from midwives in practice and midwifery students
- Presentations on our consultation at a range of events
- Joint events with stakeholders including the Royal College of Midwives, the Council of Deans of Health, the Royal College of Nursing, the Lead Midwives for Education, the Northern Ireland Practice Education Council and the Association of Radical Midwives
- Two roundtable events to hear feedback from advocacy groups, other health and care professionals and their representative organisations
- Exhibitions at conferences around the country to raise awareness of the consultation and draft standards – an example of this was an exhibition stand at the London Maternity Festival, which was attended by over 700 midwives, student midwives, educators and members of the public
- Four webinars that targeted educators, midwives and interested groups and organisations
- Two Twitter chats, one hosted in partnership with the Council of Deans of Health and the other hosted by ourselves, to take views from people who were unable to attend an event in person
- Qualitative engagement with seldom heard and underrepresented groups, such as the travelling community, women with learning difficulties, women with cancer, women who are HIV+, asylum seekers, refugees and the LGBT+ community.

We are grateful to everyone who responded to the consultation and who participated in our focus groups and stakeholder engagement events.

As part of our consultation activity we carried out an ongoing equality and diversity impact assessment (EQIA), which sought to ensure our activities and proposals promoted good relationships and did not disadvantage any group. We also took the needs of Welsh language speakers into account in all aspects of our engagement and consultation, receiving two responses to our consultation in Welsh.

Following the consultation and the independent analysis of the findings, it was important to consider these findings in order to refine our standards and decide on any proposals made during the consultation and engagement that we could take forward. We created a small number of groups made up of subject matter experts from a range of midwifery and other healthcare backgrounds. Known as 'consultation assimilation teams' (CAT's), these groups had four country representation and considered some of the key issues that had arisen from the consultation.

Our proposals for the new standards then went through our internal governance processes and final drafting, including legal and 'tone of voice' reviews, before going to our Council for final decision and approval. Council approved the new standards on 3rd October 2019.

Structure and contents of this document

We've divided this document into separate sections. These sections focus on our proposals regarding:

1. *Future midwife: Standards of proficiency for midwives*
2. *Standards for pre-registration midwifery programmes*

Each section sets out in turn:

- the rationale for our proposals and draft standards as issued for consultation
- high level feedback from the consultation and engagement
- rationale for amendments to draft standards made after the consultation

Future midwife: Standards of proficiency for midwives

Rationale for our draft standards

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers to ensure that standards remain contemporary, fit for purpose and reflect good practice.

The draft standards were developed through an extensive and rigorous process of evidence review and engagement. They were intended to reflect current best national and international evidence on the health, well-being, needs, views and preferences of women, new-born infants, partners and families. They were also intended to be in alignment with the recommendations of government reviews of maternity services and midwifery in the four UK countries - England, Northern Ireland, Scotland and Wales.

Over recent years there have been many positive changes in health and social care including increased involvement of women, their partners and families in decisions about their midwifery care, moves to increase continuity of carer and choice for women in regard to place of birth, and a clearer focus on improving the quality of care across the NHS and specifically maternity services. We took into account current and evolving challenges for midwifery and maternity care in the UK, including changing population health profiles which have resulted in more complex health challenges, growing poverty and inequality, a clear need to improve services after birth, women's and children's mental health and well-being, and consideration of workforce challenges in the NHS.

The draft standards recognised the evolving evidence base. As a result, we included an increased emphasis in the draft standards on the role of the midwife in public health and health promotion, understanding social and health inequalities, and improving postnatal care, mental health care, infant feeding and the early stages of building family relationships. The draft standards also aimed to support midwives to provide continuity of care, and to provide safe and effective care in a range of settings including the home, community, midwifery-led units and hospitals. There was also a strong focus on effective working with interdisciplinary and multiagency colleagues to proactively anticipate, prevent, and manage clinical and social complications, and to develop strength and flexibility in responding to stressful situations.

Feedback from consultation and engagement

General feedback

Overall the results of this extensive consultation showed that there was strong endorsement of the draft standards. More than 50% of midwives and healthcare professionals gave positive levels of agreement to every question asked (45 questions in all). Twenty-five of those questions gained greater than 80% agreement. Organisations gave 42 out of 45 questions more than 50% agreement, and 11 questions achieved over 80% agreement.

All respondent categories welcomed the focus on communication, relationships, and kind and compassionate care within the standards. Midwives in particular expressed the highest levels of endorsement for inclusion of these proficiencies.

Organisational responses indicated the highest levels of agreement with the standards' coverage of the midwife's ability to recognise signs of deterioration and compromise and being able to initiate first line management where this occurs. There was also strong agreement with our proposals on midwives effectively communicating and building relationships with all women, their partners and families; providing education and support for women and their partners and families in preparation for parenthood that is tailored to their needs, views and preferences; and being able to safely manage and co-ordinate intrapartum care of a woman and her baby.

The public were strongly supportive of midwives providing safe, kind, compassionate, respectful care that is women and family centred. They also strongly agreed it was very important that midwives, as the lead professional, are able to recognise if women and their babies experience complications and know how to respond effectively, whilst also feeling it was very important that midwives are able to provide care and support in a range of settings, including the home, community, midwife-led units and hospitals.

Overall, these findings from the public responses to the online consultation were consistent with the findings from parallel qualitative research undertaken with the public via a series of focus groups and in-depth interviews.

Charities and advocacy groups were largely positive in their feedback on the draft standards, stressing the importance of clear and open communication, and noting the importance of good cross-team working. They also highlighted the need for tailored care, good communications, continuing professional development and the need for midwives to provide safe, kind, compassionate, respectful care that is women and family centred. In addition, most charities and advocacy groups felt it was very important that midwives are able to work with others and provide care and support in a range of settings.

The new standards

The details of the consultation responses that fed into our considerations, the outcomes of those considerations, the changes made as a result and the rationale for making those changes are outlined below under a range of subject headings.

Universal care

Our intention was that the draft standards would adequately prepare midwives to practise across the whole continuum of care for both women and newborn infants, to strengthen women's own capabilities and to clearly articulate the appropriate knowledge and skills for universal midwifery care.

In the consultation, respondents were asked a series of questions about whether and to what extent the draft standards of proficiency and their associated midwifery skills gave enough detail to enable newly qualified midwives to provide universal care for all women, newborn infants and families.

The answers received were overwhelmingly positive. Over 70% of midwives and other professional respondents agreed or strongly agreed with each question statement, and over 70% of organisational respondents agreed or strongly agreed with 18 of the 23 question statement posed (and over 50% agreed or strongly agreed with the other 5).

In addition, members of the public, charities and advocacy groups were asked a series of questions seeking to identify what they thought was important to ensure future midwives could deliver safe and effective midwifery care. Again, a clear majority of these respondents felt that all the identified activities and skills were very important to providing safe and effective midwifery care.

Overall, 92% of the public and 88% of charities and advocacy groups felt it was very important that midwives provide safe, kind, compassionate, respectful care that is women and family centred; 79% of the public and 71% of charities and advocacy groups felt it was very important that midwives can provide care and support in a range of settings; 86% of the public and 77% of charities and advocacy groups felt it was very important that midwives are able to recognise if women and their babies experience complications and know how to respond; and 75% of the public and 77% of charities and advocacy groups felt it was very important that midwives are able to communicate well and build relationships with mothers, parents and families.

Comments that accompanied the responses from all sources echoed the sentiment that the standards provide comprehensive cover of the skills required, however, some respondents felt there was not enough focus on 'normal birth' and voiced concerns about a broadening of the midwife's role. Some respondents also expressed an opinion that the added responsibility being put on newly qualified midwives in these draft standards was too great.

Post consultation consideration largely agreed that the draft standards clearly articulated the role of the midwife in providing care for all childbearing women, infants, partners and families, and adequately prepared midwives to optimise normal processes across the whole continuum of care for both women and newborn infants. It was, however, felt that there was a need to further strengthen the definition and role of the midwife and to place this firmly and centrally within the standards.

The final version of the standards therefore ensured that the role and scope of the midwife in the 21st century as a provider of skilled, knowledgeable, respectful and compassionate care for all women, newborn infants and their families across the continuum was embedded throughout the document.

The introduction also now clearly describes how the standards reflect the Framework for Quality Maternal and Newborn Care (Lancet 2014). Skills are now contained in the new Domain 6 for extra clarity rather than as detailed lists at the end of individual domains. The removal of these detailed lists ensures greater flexibility and future proofing within the standards, as well as helping to improve the readability and clarity of the document.

Additional care and recognising complications

Our intention was that our new standards would not only articulate the role of the midwife as lead professional for midwifery care for women and babies and adequately prepare midwives to optimise normal processes across the whole continuum of care, but also to enable them to anticipate, prevent, recognise and manage safely and effectively situations that may arise across the continuum due to the onset of complications and/or additional care needs.

Increasingly, women accessing maternity services are older and may have additional social, physical and mental health needs which may require additional midwifery and multi-professional care. Our new standards sought to emphasise that midwives are ideally placed to anticipate and to recognise any changes that may lead to complications and additional care needs. Equally when such situations arise, our new standards sought to clarify that the midwife is responsible for recognising these and for immediate response, management and escalation, involving, collaborating with and referring to interdisciplinary and multiagency colleagues.

As part of the consultation, respondents were asked a series of questions about whether and to what extent the draft standards of proficiency and their underpinning skills would enable newly qualified midwives to deliver the required care for women, newborn infants and families in situations where additional care may be necessary.

The answers received from midwives and other professional respondents were strongly supportive of the contents of the draft standards; those from organisations were moderately so, although in every case there was a majority that supported our proposals.

In addition, members of the public, charities and advocacy groups were asked how important they thought it was that midwives, as the lead professional, are able to recognise if women and their babies experience complications and know how to respond effectively. 86% of public respondents and 77% of charities and advocacy groups thought this was very important.

Many respondents of all categories gave positive endorsements to the draft standards, saying the standards anticipated the changing nature and conditions of midwifery practice. Others, however, felt that despite the seemingly fulsome nature of the draft standards and underpinning skills, there was still scope for more to be included.

Comments from the public acknowledged the midwife's role as the lead professional and that midwives should have the skills needed to recognise any problems that may arise and act appropriately. If a midwife is able to recognise complications, it keeps the woman calm and relieves stress. Compassionate aftercare and midwives being non-judgemental about pain relief were also suggested as matters for possible inclusion in the new standards.

A central theme emerging from the comments made by charities and advocacy groups was that in their belief midwives are best-placed to recognise any complications as they have the closest contact with woman and baby; it was noted that births which require little intervention occur often, and that midwives should be educated and trained to recognise complications and, importantly, to know when to ask for help.

Comments from the public, charities and advocacy groups also focussed on the need for safety to be a top priority, given the complex nature of pregnancy and labour, and emphasis should be placed more on professional expertise.

The RCM recommended revisiting as to whether all of the skills contained in the draft standards were required at the point of registration.

Post consultation consideration concluded that the draft standards generally reflected the scope of care for women and newborn infants with complications and/or additional needs. There were however concerns that students would not always have exposure to some skills as they were related to conditions which are rarely seen.

As a result, the final version of the standards more clearly highlighted the role of the midwife in recognising complications and taking action to manage them. The standards recognise that midwives are ideally placed to recognise any changes that may lead to complications, and are responsible for any immediate response to and first line management of such complications in collaboration with interdisciplinary and multiagency colleagues.

The skills underpinning additional care and the recognition of complications have also been reviewed for clarity and achievability with particular emphasis given to the skills required in caring for and supporting women and newborn infants requiring medical, obstetric, neonatal, mental health, social care and other services. Delivering kind and caring bereavement care has also been strengthened, as have some of the skills that may be required in an emergency.

Continuity of care and carer

Continuity of care and carer is a concept that is increasingly reflected in national midwifery strategies across the four countries of the UK and which we similarly sought to reflect in our draft standards. It is a subject regularly brought up in both quantitative and qualitative research. Many regard it as the ideal but are concerned that it may not be happening in practice.

Consultation questions asked to what extent it was agreed that the draft standards gave enough detail about the level of knowledge midwives need to have in order to provide and promote continuity of care and carer; whether the associated underpinning skills gave enough detail to enable midwives to provide and promote continuity of care; and whether the draft standards gave enough detail to ensure that midwives are capable of providing continuity of care and carer throughout the continuum of care across a range of settings.

Responses to consultation from all categories of respondent were generally positive. The inclusion of an entire domain on this area was seen by many as commendable, but also by others as idealistic or even unrealistic, with some respondents stating that 'continuity of care and carer' represents a substantial change to midwifery practice. Other comments highlighted that the standards were predicated on a model of care delivery that does not exist in some parts of the UK. Responses from the public, charities and advocacy groups in particular noted that continuity of care is crucial for mothers to build trust with midwives.

As part of the post consultation review it was considered whether the ethos and philosophy of continuity of care and carer could be made stronger in the standards. There was also recognition that systems and current practice are not ready to fully support continuity of care and carer. Changes are needed and AEs together with practice learning partners will need to think creatively about how to support students with continuity in the future.

The standards of proficiency now make clear that midwives play a leading role in enabling effective management and team working, promoting continuous improvement, understanding and delivering change management and encouraging a learning culture, all of which promote continuity of care and carer. The standards specifically highlight throughout the document the midwife's role as the lead autonomous professional for the care and support of women, newborn infants, partners and families and their role as the accountable coordinator of care. The need to work in partnership with women is also highlighted, as is the need to act as an advocate for women, newborn infants and families and to help identify resources relevant to the needs of women and newborn infants and assist women in accessing these resources.

Interdisciplinary and multiagency working

The draft standards had sought to ensure that interdisciplinary and multiagency practice was embedded throughout the document. This reflects the fact that interdisciplinary and multiagency working is and will continue to be at the heart of safe and effective midwifery practice.

Consultation questions were therefore asked regarding to what extent the draft standards adequately reflected the knowledge and skills required for the future midwife to:

- Identify and escalate concerns related to the physical health and mental well-being of the woman or new-born infant
- Involve, learn and work collaboratively with interdisciplinary and multiagency teams
- Coordinate care with and across the wider interdisciplinary and multiagency teams
- Safely and effectively lead and manage midwifery care, delegating responsibilities when appropriate

Responses were overwhelmingly supportive of the draft standards, with over two-thirds of respondents from every category agreeing or strongly agreeing that the draft standards reflected the necessary requirements. In addition, in a question asked to members of the public only, 74% strongly endorsed the importance of midwives being able to work with other professionals to ensure the needs of women, their babies and families are met at all times.

Charities and advocacy groups in particular were keen to stress the importance of clear and open communication, both between midwives and women and between midwives and colleagues. They noted that good cross-team working was crucial to promote successful outcomes and experiences for mothers and babies alike. Organisations generally felt that the draft standards placed suitable emphasis on the midwife as the lead professional and what is expected for this role in terms of interdisciplinary and multiagency working.

The post consultation review considered these comments and agreed that whilst the general position adopted by the draft standards should be supported, there was potential for lack of clarity regarding the role of the midwife in working with others and across agencies.

The final version of the standards has therefore strengthened our commitment as a regulator to interdisciplinary and multiagency working, and the key role of midwives. This commitment is embedded both in descriptions of the role and scope of the midwife, and the knowledge and skills that must be assessed in order to join the register and exhibited throughout subsequent midwifery practice.

Examination of the newborn infant

The draft standards included content that was intended to reflect the knowledge and skills needed for the future midwife to be able to conduct a full systematic physical examination of the newborn infant.

Consultation questions were therefore asked as to what extent the future midwife should be able to conduct a full systematic physical examination of the newborn infant at the point of registration; and whether the draft standards provided the appropriate knowledge and the skills for the future midwife to safely conduct a full systematic physical examination of the newborn infant.

On the first point, 67% of midwives, 83% of other healthcare professionals and 62% of organisations agreed or strongly agreed that the future midwife should be able to conduct a full systematic physical examination of the newborn infant at the point of registration. On the second point, however, only 49% of midwives, 51% of other healthcare professionals and 43% of organisations agreed or strongly agreed.

Some concerns were voiced about whether this could be achieved within a 3 year degree programme. However, it was acknowledged that several approved education institutions (AEIs) had already successfully incorporated the theoretical and practical components of the physical examination of the newborn infant into their programmes, so it can be achieved. Some AEIs may therefore need to reconfigure their programmes to incorporate this new proficiency as a result.

Having considered all the evidence, it was decided as part of our post consultation deliberations that the physical examination of the newborn infant should be included in the new standards of proficiency for midwives; that the new standards should include both the theoretical and practical components of the examination; that midwives should perform the examination on healthy term newborn infants and this should be made clear in the standards; that the differentiation between the initial assessment of the newborn infant and the enhanced physical examination of the newborn infant should be more clearly articulated; and that the list of skills should be replaced with a more high level approach.

Postnatal care

The draft standards sought to clearly identify and articulate the midwife's responsibilities in delivering safe and effective postnatal care to women, newborn infants and families.

As part of the consultation, questions were asked as to what extent the draft standards adequately reflected the knowledge and skills required to identify and escalate concerns related to the physical health and mental well-being of the woman or newborn infant; to provide education and support for women and their partners and families in preparation for parenthood that is tailored to their needs, views and preferences; and to be able to safely manage and provide postnatal care of women and care of newborn infants.

In addition, the public, charities and advocacy groups were asked how important they thought it was that midwives can identify and support women and babies who may have an increased risk of mental and physical health problems; and how important they thought it was that midwives can help women, their partners and their families prepare for parenthood in a way that takes into account their needs, views and preferences.

Overall the responses were positive, with over 70% of midwives, other healthcare professionals and organisations supporting the content of the draft standards in this area. In addition, 80% of the public and 82% of charities and advocacy groups felt that it was very important that midwives can identify and support women and babies who may have an increased risk of mental and physical health problems; whilst 54% of the public

and 62% of charities and advocacy groups felt that it was very important that midwives can help women, their partners and their families prepare for parenthood in a way that takes into account their needs, views and preferences.

Responses from the public acknowledged that support in preparing for parenthood is helpful, but some respondents felt that midwives need to remain non-judgemental and provide information and support to the woman and their family to inform the choices they make.

Charities and advocacy groups noted the important role that midwives play in recognising and understanding mental health issues in women and acknowledged the supporting role that midwives can play in this regard as they can build up a relationship based on trust, particularly with respect to vulnerable mothers. Such groups also stated that it was important that women, partners and families were able to make sufficiently informed choices.

Post consultation consideration of the responses led to the conclusion that whilst the standards as put forward for consultation had clearly articulated the appropriate knowledge and skills needed to deliver postnatal care, there was a need for a separate standard relating to situations where a baby is taken into the care of social services. With 1 in 4 women having pre-existing mental health conditions, gaining exposure to pre-existing conditions is already a reality of the current demographic. In terms of serious emerging complications, however, students are rarely exposed to these. It is important therefore for universities to use creative approaches to teaching and learning in these areas.

The final version of the standards has therefore been strengthened in a number of areas. This includes references to the role that midwifery support workers and others can play in the delivery of postnatal care, and the need to continue providing postnatal care to a woman when her baby is taken into the care of social services, and the need to provide emergency safeguarding in situations such as where the woman has been the victim of violence or abuse.

Infant feeding

The midwife's role in providing help and advice with regard to infant feeding is a subject area that was embedded throughout the draft standards. The standards contained outcomes and skills on a range of issues under the wider subject area of infant feeding, based on the working assumption that the standards of proficiency must reflect the knowledge and skills needed to inform and support a woman in her choice of feeding method.

As part of the consultation exercise professionals, organisations, members of the public and charities/advocacy groups were all asked to what extent the draft standards adequately reflected the knowledge and skills required for the future midwife to provide information and support for women's choice of infant feeding.

In response to this question 87% of midwives and healthcare professionals and 72% of organisations agreed or strongly agreed. 78% of members of the public and 74% of charities / advocacy groups felt it was very important that midwives provide information and support for women's choice of infant feeding during pregnancy and after birth.

The public took a keen interest in the subject of infant feeding. Irrespective of the feeding method chosen, public respondents noted that midwives should be well educated and trained to be able to offer informed, evidence-based support, to provide information in a non-directive and non-judgemental manner, and to respect the choice made by the mother.

Charities and advocacy groups stated that midwives should provide support and advice which is non-directive and non-judgemental, and that midwives should respect the choices made by mothers on infant feeding. Mothers should also be made aware of all support available to be able to make informed decisions.

Many responses from the public, charities and advocacy groups highlighted the experience of individual mothers who felt that "breast is best" was forced upon them whether they chose to breastfeed or not. It was noted that mothers who choose not to breastfeed should still receive non-judgemental support from their midwife.

Post consultation consideration of all feedback and evidence confirmed that the draft standards had in the main clearly articulated the appropriate knowledge and skills the midwife needs to deliver care in infant feeding, including issues such as breastfeeding and formula feeding, for healthy babies and small/sick babies, and the public health/health promotion aspects as well as the care aspects of infant feeding.

However, it was felt that some of the terminology used should be reviewed for clarity and ease of understanding. It was also felt that the standards should emphasise that there are a range of feeding options for women, with greater emphasis on the role of the midwife in supporting infant feeding when the mother and infant have returned home.

The final version of the standards therefore gave a stronger emphasis on the range of infant feeding options available to women to choose from. The standards also now more strongly emphasise the infant feeding support that should be provided to mothers once they have returned home, and the need to take cultural contexts and traditions into account. The skills associated with infant feeding have been streamlined and as with all skills are now contained within Domain 6.

Medicines and prescribing

The draft midwifery proficiencies set out to ensure that in future newly qualified midwives will have greater competence and confidence in the management and administration of medicines, including greater knowledge of pharmacology. They should as a result be in a stronger position to move on and obtain a prescribing qualification if they wish to do so.

Responses were generally supportive of the proposed standards. Over 65% of midwives and other professional respondents agreed or strongly agreed with each statement put before them. The same was the case for organisational respondents with one exception - only 44% of organisational responses agreed or strongly agreed with the proposal regarding progressing to a prescribing qualification, with 33% disagreeing.

Both the Council of Deans of Health and the RCM largely agreed with our proposals in this area, however, the RCM did comment that being capable of the safe and effective management and administration of all medicines might be too much for a newly qualified midwife to achieve, and that perhaps this statement should be modified so that it referred to 'commonly administered medicines' or 'midwives exemptions medicines'.

Post consultation review of this feedback led us to conclude that whilst respondents were largely supportive of what the draft standards were aiming to achieve, in some instances the proposed wording was not strong enough, and that the structure of the standards was confusing.

As a result the skills associated with medicines management, administration and prescribing have been streamlined and are now contained within a specific section of the new Domain 6. The skills now contain a more enhanced focus on the need to be able to safely supply and administer medicines under 'midwives exemptions', placing an emphasis on the need for midwives to ensure that they keep themselves updated regarding any changes to the list of medicines that are 'exempt'.

Equality, diversity and inclusion

Our draft standards were drafted with an appreciation of our commitment to equality, diversity and inclusion (EDI) in all aspects of midwifery practice.

As part of the public consultation, respondents were asked to state to what extent they agreed or disagreed that the principles of EDI were appropriately embedded in the draft standards of proficiency for midwives and the standards for pre-registration midwifery programmes. They were also asked to provide any comments on the potential impact of our standards on people who share specific protected characteristics.

In responding to the consultation, 88% of midwives and other healthcare professionals and 81% of organisational responses agreed or strongly agreed that the principles of EDI were appropriately embedded in the draft standards. In comments, the majority of these respondents expected a positive impact from these standards, however, there was also a call for more emphasis generally on EDI issues.

A central theme arising from the responses from the public was the vulnerability of people with protected characteristics and the importance of the right language being used. Charities and advocacy groups discussed the role that midwives can play in supporting mothers with mental health issues and/or with learning disabilities in particular.

Post consultation consideration of this feedback led us to conclude that the draft standards did enable midwives to provide care for all women and newborn infants taking into account the protected characteristics, and that the principles of equality, diversity and inclusion are suitably incorporated in the draft standards, but that this could be further enhanced in both documents.

It was felt, for example, that not all newly qualified midwives fully understand protected characteristics and human rights legislation, and that as a result Domain 1 should have a specific stand-alone standard requiring knowledge and understanding of the protected characteristics and the relevant equalities and human rights legislation.

As a result, the final version of the standards has been refined to ensure that there are more prominent references to the promotion of human rights; to compliance with equalities and human rights legislation; to providing non-discriminatory care and challenging discriminatory behaviour; to acting as an advocate on behalf of the disadvantaged; and to the need to be able to identify and address signs of unconscious bias both in oneself and in others.

Format and structure of the Future Midwife proficiencies

One of the NMC's key design principles for all of its standards and other documents is that they should be unambiguous, clear and concise, using consistent language not only within documents but across documents, and that they should be accessible to the public.

We therefore asked consultation respondents to state to what extent they felt our design principles had been met.

The feedback was largely positive, with 80% of midwives and other professional healthcare respondents and 60% of organisational respondents agreeing or strongly agreeing that the design principles had been met. Some respondents felt however that the length of the standards may affect public accessibility, whilst others felt there was unnecessary ambiguity, repetition and excessive detail within the document.

Public feedback was that whilst the document was comprehensive and fairly clear there was some unnecessary duplication. Women and families who receive care from midwives in particular suggested that it would be useful for members of the public to have access to a simpler version of the standards to make it more accessible.

It was suggested that methods such as the greater use of sub-headings to break up the text, the reduction of repetition, reducing the reliance on lists and the greater use of annexes may help the document meet the design principles more fully and become more accessible.

As a result, the final version of the standards was restructured. The extensive use of detailed lists of skills have been removed which has improved the overall presentation

of the document and the new Domain 6 hosts a significantly refined set of midwifery skills that provide clarity on the midwifery associated skills for each domain and avoid repetition and over-use of lists.

Standards for pre-registration midwifery programmes

Rationale for proposed draft standards

Our draft *Standards for pre-registration midwifery programmes* set out proposals for NMC approved pre-registration midwifery education programmes.

Student midwives must successfully complete an NMC approved pre-registration midwifery programme in order to meet the *Standards of proficiency for midwives* and to be eligible to apply for entry onto our register. In order to deliver the new proficiencies effectively, it was necessary to ensure that that our new education programme standards were aligned to the requirements necessary to deliver the proposed new proficiencies.

In addition it was necessary to ensure that the structure of the proposed new standards mirrored that already in place for other recently published education standards for nursing, nursing associates and prescribing programmes. This was to ensure consistency of outcome and that our standards met our design principles and the requirements of our education framework. It would also ensure that they could be quality assured effectively using our new quality assurance framework which is now in place.

Public safety and future focus was central to the development of the draft new programme standards for midwives. Student midwives will be in contact with people throughout their education and it's important that they learn in a manner and environment that keeps people in their care safe. It is also necessary to ensure that the standards meet the educational requirements of students not just now but for years to come. Our proposed education standards were drafted with all of these requirements in mind.

Feedback from consultation and engagement

General

As with the Future Midwife draft proficiencies, there were strong overall positive findings to the draft standards for midwifery education. Some 80% of midwives and 71% of organisations agreed with the proposed 50/50 balance of theory and practice learning; 82% of midwives and 75% of organisations responded positively to the proposed support for the development of a standardised national practice assessment document; and there was a similarly strongly held view that simulation should not replace practice learning but should instead be seen as something to support and supplement learning in practice placement scenarios. A range of views were also expressed on programme length and the role of the lead midwife for education (LME).

Midwives and organisations responding to the consultation were also asked which factors they thought were most important in preparing the future midwife to meet the new standards of proficiency at the point of registration.

The quality of teaching and learning was most frequently selected by midwives (79%), followed by quality of supervision and assessment (74%) and range of practice learning opportunities (58%).

Organisations most frequently included range of practice learning opportunities in their top three (81%), followed by student recruitment and selection (77%), and quality of supervision and assessment (58%).

Many midwives also commented that they were reassured that the content and structure of current programmes were broadly reflective of the content of these standards, whilst others praised the comprehensive content and clear and concise language used in the proposed new standards.

The new standards

The details of the consultation responses that fed into our considerations, the outcomes of those considerations, the changes made as a result and the rationale for making those changes are outlined below under a range of subject headings.

Length and structure of programme

The length and structure of pre-registration midwifery degree programmes has been a running feedback theme throughout our engagement. This has been due not only to concerns about whether it is feasible to fit everything required of the modern midwife into a three year / 4,600 hours degree programme, but also concerns about the confidence levels of newly qualified midwives and the impact this lack of confidence can have on their ability to deliver safe and effective midwifery care at the point of registration.

Our draft standards proposed that all pre-registration midwifery programmes must meet the equivalent of the minimum programme length of three years set out in Article 40(1) of Directive 2005/36/EC; and that only where a student is already registered with the NMC as a nurse level 1 (adult) can the programme be shortened to no less than 3000 hours (18 month programmes) or 3600 hours (two year programmes).

Respondents were asked what they thought 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, and were provided with a variety of options as to the preferred optimum minimum programme length to choose from, with an opportunity to comment as to the reason for their choice.

Consultation responses were mixed with none of the proposed options receiving an outright majority of approval. It was the case, however, that more midwives supported

the programme remaining a minimum of three years (48%) rather than four years (38%); whilst more organisational respondents supported a minimum four year programme (42% of educators and 46% of employers) rather than three years (26% of educators and 31% of employers).

Where respondents commented, there were general comments across the range of respondents about the impact on students, particularly from a student finance point of view, of an increase to a four year programme, as well as comments about the impact on the workforce of having to wait four years rather than three years before students could qualify and join the workforce.

The Council of Deans of Health proposed that individual education providers and their partners should be allowed to decide the optimal length of their programmes, taking into account the minimum requirements set by the EU, whilst the RCM felt that it was hugely ambitious to expect students to become competent, confident and safe in all the proficiencies as described within four years, and that a minimum four year programme was their preferred option. They also suggested that an alternative and perhaps pragmatic solution would be a three year programme followed by a mandated foundation year.

One English based education provider suggested that students should be provided with a range of options regarding programme length (in terms of years and weeks per year of study, not the total hours to be undertaken) – in particular they felt an option of four years study of 35 weeks a year would help students who were mothers to spread the programme over a longer period of time and enable them to balance study and home responsibilities. However, an employer representative organisation strongly supported three year programmes – they had concerns about the impact of four year programmes, including workforce supply pipeline issues, increased costs to students and an increasing need to rely on agency/bank staff to backfill vacancies as a result.

After considering this evidence and further discussion, the NMC has decided to keep the minimum programme length of three years/4600 hours and options for shortened programmes as stated in the draft standards that went out for consultation. It is accepted that there were genuine concerns about some elements of the proposed new proficiencies being achieved with a three year programme. However, it was also accepted that there were genuine risks in terms of financial impact on students and student attrition rates if a minimum four year programme became mandatory. By stating a minimum length, AEI's are not prevented from innovating and offering a programme which extends beyond three years if they wish to. Indeed, the proposed standards were seen as a potential opportunity for AEIs to rethink their pre-registration midwifery programme curricula and to reconfigure their programmes in order to accommodate the new proficiencies.

The final version of the standards therefore restates the standards regarding programme length as initially proposed.

Theory / practice split

The draft standards proposed that AEs and their practice placement partners must ensure the midwifery curriculum provides an equal balance of 50 percent (2,300 hours) theory and 50 percent (2,300 hours) practice learning using a range of learning and teaching strategies. It was also proposed that they must ensure that there is equal 'weighting' in the assessment of theory and practice.

Consultation responses were generally supportive of our proposals, with 80% of midwife responses and 71% of organisational responses strongly agreeing or agreeing with the proposed wording. It was suggested by some respondents, however, that greater clarity could be achieved by deleting of the word 'weighting' as this could have a specific meaning in an academic context e.g. it could mean 'academic credits'. The use of words such as 'consideration' or 'value' or 'importance' instead was proposed.

Further post consultation consideration of feedback led us to conclude that the standards as worded provided sufficient flexibility for structuring the programme across the curriculum and across the duration of the programme.

The final version of the standards therefore retains the proposed 50/50 split between theory and practice learning. The reference to 'weighting' has been removed from the final version of the standards. This is to ensure clarity, but also because it was felt to be implicit throughout these standards and indeed other NMC education standards that theory and practice learning are considered to be of equal value.

Simulation

The draft standards proposed that AEs and their practice placement partners must ensure technology-enhanced and simulated learning opportunities are used effectively and proportionately to support learning and assessment, especially where clinical circumstances occur infrequently but where a proficiency is nevertheless required. Respondents were asked to what extent they agreed with these proposals.

Consultation responses were generally in favour of our proposals, with 80% of midwife responses and 71% of organisational responses strongly agreeing or agreeing with the proposed wording. Midwives in particular acknowledged the value of simulation for scenarios which may occur infrequently. Some respondents however asked for clarity on where simulated learning hours should sit - in practice learning or within the theory element.

In particular the RCM commented that it would be helpful to have clarity as to what is meant by practice. It was their view 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, and that as such, simulation and technology enhanced learning should be counted as 'theory' and only direct hands-on care should be counted as 'practice'.

After further consideration of the evidence and responses, it was agreed that AEI's and practice learning partners should have flexibility to decide how simulation is used in teaching, learning and assessment and how simulation is incorporated into the curriculum within the confines of EU law. The EC Directive 2005/36 permits simulation to be used as part of the clinical practice training in certain specified circumstances where clinical scenarios happen infrequently, and therefore there are limited opportunities for students to practice in the real life situation. These are breech deliveries, episiotomies and initiation of suturing. In addition, in order to count towards practice hours, the training must 'take the form of supervised in-service training in hospital departments or other health services approved by the competent authorities or bodies.' There was some discussion about adding a numerical value to the amount of simulated learning that could be permitted, however it was concluded this was not outcome focussed, preferring to leave this as a flexible option across theory and practice.

The final version of the standards therefore state that programme providers must ensure that technology-enhanced and simulated learning opportunities are used effectively and proportionately to support learning and assessment, including where clinical circumstances occur infrequently and a proficiency is required. A clear definition of what constitutes 'simulation' and 'simulated learning' was also included within the glossary.

The role of the lead midwife for education

The requirements of the lead midwife for education (LME) are set out in the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 ('the Registration Rules').

Within the draft standards, we included text about the LME, providing high level guidance on the role. The guidance did not form part of the standards as this would not align with what is in our legislation and Rules. This information was intended to support the guidance in the current 'Practising as a midwife in the UK' document.

<https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/practising-as-a-midwife-in-the-uk.pdf>

There were numerous written responses to the consultation from individuals about our reference to the lead midwife for education, with many arguing that the role needs strengthening and articulating more clearly within the new standards. A high proportion of these comments called for a greater emphasis on lead midwives for education having a strategic role particularly in respect of quality assurance and managing risk which was believed to have been overlooked in the draft standards.

Post consultation consideration of feedback concluded that we should add a new standalone section on the LME in the Standards for pre-registration midwifery programmes, incorporating all the requirements of the NMC Registration Rules related to the LME into the standards; that the role should be clearly defined and that such a

definition should be included in a glossary and/or supporting information; that a requirement should be added to the standards that the AEs must liaise with the LME on all matters related to midwifery education; that a footnote confirming the LME or his/her designated midwife substitute must have current registration with the NMC should be added to the standards; and that we should expand the LME section in the *'Practising as a midwife in the UK'* document.

As a result the final version of the standards now more clearly provide for the LME role. Further additional material about the LME has also been included within the document, reflecting the importance of this role in midwifery education.

User testing

In addition to appointing Pye Tait Consulting to independently analyse the consultation responses, we commissioned another external agency, Blake Stevenson, to 'user test' our proposals for future midwife proficiencies and the midwifery programme standards. Groups of key stakeholders tested our proposals to check that they were workable, deliverable, accessible, measureable and could be assessed locally to ensure we will be able to undertake quality assurance of education programmes effectively. Although not required to do so comments on the content of actual standards were also given.

With regard to the Future Midwife standards of proficiency, user testers generally liked what the draft standards said on universal care, but on additional care and recognising complications, feedback was more mixed. Some user testers felt that the draft proficiencies focused too much on uncommon aspects of the role and should be stripped back. However, other user testers liked the detail as they felt midwives are treating more and more women with pre-existing conditions, and that the standards were formalising what they are already doing. Some user testers also stated that some of the skills and outcomes listed were more suited to a preceptorship programme.

On pre- and postnatal care, user testers also felt that there were a few areas where there could be more information or guidance, including preconception care and the mental health and wellbeing of both the mother and partner.

Feedback from user testers relating to equality, diversity and inclusion within the standards was that there was nothing in the draft standards that was specifically discriminatory or non-inclusive. However, some user testers felt that the language was lightly worded, non-specific and could be more overtly inclusive. User testers also broadly welcomed the proposals on medicines and prescribing.

With regard to the draft Standards for pre-registration midwifery programmes, on programme length user testers generally stated that the proposed new standards would be achievable within a three year programme, however, some user testers from A&EIs expressed concern that it would be difficult to achieve the standards required via the shorter programme for registered nurses.

User testing feedback on the theory/practice split was also largely positive. Where concerns were voiced, the most common points of concern were the lack of guidance over the equal split between theory and practice and the need for more clarity as to how the 50/50 weighting applies.

On simulation, some user testers questioned whether simulated practice should count towards theory and/or practice hours. Those who were familiar with the nursing standards explained that they are very clear on how simulated learning can be used, but guidance is required as to what is acceptable in the midwifery programme standards too.

Finally, there was also concern voiced by AEI user testers that the role of the LME had been diluted in the new standards.

The feedback from user testing was considered alongside the responses to the consultation and all other evidence captured during the engagement and consultation process, and fed into the post consultation decision making processes regarding the wording and structure of the new standards, addressing wherever possible the concerns raised by user testers and ensuring that the new standards were workable, deliverable, measureable and could be assessed locally.

Council decision on length of programme and further work being undertaken by the NMC

In taking our decision regarding the retention of the three year minimum period for a pre-registration midwifery degree programme, we acknowledge that although the responses to the consultation did not definitively support an increase in the length of the programme, some groups of stakeholders remain concerned about the preparation of newly qualified midwives. However, different perspectives remain regarding whether the issues of concern would be resolved by increasing the length of the education programme, or by improving the management of the transition from student to qualified midwife once qualified.

In the absence of a strong evidence base or widespread consensus, our recommendation was therefore to retain the current regulatory arrangement in relation to programme length, i.e. that AEIs and their practice learning partners must design and deliver programmes which are sufficient to ensure that students meet the proficiencies required for registration by the end of the programme. AEI's have the opportunity to decide on the length of the midwifery programme to achieve that, as long as it is no less than the *minimum* length of three years, which is currently required by EU legislation. AEIs may choose to run a longer programme if they wish to, but that is a decision for them to take and is not mandated by us.

The current approach supports the ambition to set outcome focused standards, to avoid creating unnecessary or disproportionate barriers for those seeking to join the professions we regulate.

Although we do not recommend a change to the current arrangements for programme length for the reasons stated, we acknowledge that there is consensus that the first year following initial registration is a critical period for the newly qualified midwife (NQM) and that preceptorship needs to be taken seriously. Although we cannot mandate preceptorship, we have committed to work with the four countries to agree the principles which underpin good preceptorship and seek support for the implementation of those principles across the UK. This approach has been discussed with, and has the support of all four country CNO's and the CMO in England. We will publish these principles in this area at the time of the launch of the midwifery standards in January 2020.

We are also committed to a programme of evaluation to establish how all our standards are being implemented and in establishing what improvements may be needed in the future. This will be commissioned by NMC and outputs and outcomes will be overseen by an advisory group of relevant stakeholders and will report into Midwifery Panel and Council. This approach for midwifery would be consistent with the WHO action plan on Strengthening Quality Midwifery Education (WHO 2019) which sets expectations for continuous review and evaluation to adjust programme length, structure and content as necessary if required.

Summary

Our consultation and engagement activities during the development of our new education standards were productive and successful, with significant numbers of people, members of the public, nurses and midwives, students and organisations taking part both to co-produce and express their views on our proposals. In addition, the volume of responses from midwives to the consultation were reflective of the number of registrants in each of the four countries of the UK.

It is only through the expression and analysis of those views, in whatever form they are made and received, that we can develop and enhance our standards. This in turn ensures that our standards for nursing and midwifery education and our proficiencies are the best they can be, with patient safety, public protection and person-centred care at their core.

We would like to thank everybody who participated in any of our consultation and engagement exercises. We could not have successfully developed these new standards without their input and enthusiasm.

We would also like to place on record our particular thanks to Professor Mary Renfrew and Professor Gwendolen Bradshaw for their work in helping us to develop the new standards.