



The Future Midwife Project

An AIMS response to Nursing and Midwifery Council's consultation

AIMS is pleased to contribute to the current consultation on the new draft standards of proficiency for midwives and draft standards for pre-registration midwifery programmes. We have today completed an online survey response (for members of the public responding on behalf of a charity/advocacy group), and have flagged in that response that our detailed comments have been submitted by email. This is because the format of the survey did not easily accommodate our comments.

AIMS draws on its understanding of the UK maternity services and on our work supporting birthing women from across the UK (for nearly 60 years) to respond to this consultation. AIMS has also benefited from the recent webinars on this issue hosted by the NMC, as well as from regional events hosted by other stakeholders, to develop our understanding of the purpose and positioning of these draft standards..

Our response to the consultation sets out the detailed views of AIMS on the two documents included in this consultation: first, we comment on the draft 'standards for pre-registration midwifery programmes' and second we comment on the draft 'standards of proficiency for midwives'.

We would be happy to respond to any queries about our comments. Queries should be addressed in the first instance to our response coordinator, Jo Dagustun via email: jo.dagustun@aims.org.uk

We agree that these standards will represent a key resource for all maternity service stakeholders and we very much look forward to seeing the finalised standards later this year.

AIMS The Association for Improvements in the Maternity Services

There for your mother. Here for you. Help us to be there for your daughters.

May 7, 2019

1. AIMS comments on 'Standards for pre-registration midwifery programmes'

Page 5: There is a reference to the key role of the lead midwife for education (LME). We would like to see more clarity around the governance of this arrangement here. Where is it set out what knowledge and skills that LMEs should have? How does the NMC ensure that LMEs have this knowledge and skill and carry out their roles appropriately?

- Page 8: In the context of the UK policy direction that prioritises the roll-out of continuity of carer models of care, it is very important to AIMS that prospective midwifery students show awareness of the role of the midwife, but this requirement does not seem to feature in the current draft. Add to para 1.1: “demonstrate an understanding of the role and scope of practice of the midwife, including the range of working patterns that midwives work.”
- Page 11: 3.3 - The reference to ‘the range of hours’ should be extended to include ‘and working patterns’.
- Page 11: 3.5 - The current ‘all students should experience’ formulation is too vague and needs revising, as it does not specifically ensure that students will have the experience of supporting, as named midwife, a small number of women throughout the pregnancy/birth/postnatal (appropriately supervised by their mentor), which AIMS believes is a vital component of midwifery education. It might be useful to introduce the concept of caseholding here. We also believe that this clause should set out a minimum number of women that students should support in this way: we suggest 3 as a student, and 3 more in the preceptorship period[1].
- Page 12: 4.4 - The term ‘numeracy’ in this context (and elsewhere in the documentation) seems overly narrow. Can this term please be defined, and checked to ensure that it includes a focus on understanding statistics, as midwives need - as is clear in other parts of the draft documentation - to be able to interpret research results and to explain them to women in order to support informed decision making, and a solid ability to work with statistics is often key to that.
- Page 15: 3 (c) and (d) - When translating European legislation which refers to human beings, would it be possible to use a gender neutral term (eg “their” instead of “his”), or at the very least avoid the use of the masculine (replacing ‘his’ with ‘his/her’)?

2. Standards of proficiency for midwives

- Page 7: Please note that some hyperlinks are missing here. For example, the penultimate paragraph refers to a document entitled ‘Realising professionalism: Standards for education and training’ but no hyperlink is provided.
- Page 9: 1.4 - Please amend “enable evidenced-informed decisions in partnership with women” to “providing evidence based information to support women’s decision making”. This would better reflect the law around this key issue. Women make the decisions about their bodies and births, not midwives, and these documents should provide absolute clarity on this point.
- Page 10: 1.15 - The formulation ‘to decline consent’ makes no sense - please revise. Additionally, we would like to see midwives being explicitly trained to provide appropriate care and support where women decline assessments and interventions, and suggest that this outcome should be added to this list. (We suspect that agreed care pathways for such situations are often under-developed.)
- Page 10: 1.20 - We agree with this clause, but it would seem important for the NMC to have confidence that all employed midwives are able to access appropriate mechanisms

provided by their employer for this purpose. How will the NMC satisfy itself that this is the case?

Page 11: 1.21.1 - More clarity around this standard seems necessary, given that new research is being undertaken constantly and new research reports are published regularly. It would seem fair, therefore, to put some limits around minimum expectations in this area. For example, is there an expectation that practising midwives would be familiar with evidence beyond that collated in local, NICE or Royal College guidelines? What mechanisms should be available for midwives to support their ability to access current best evidence? Is the NMC satisfied that appropriate mechanisms exist? Please define 'current best evidence'.

Page 11: 1.21.6 - We are very surprised that 'women's role in decision making' should be considered a challenging and contentious issue in itself. Is this more of an issue of how well maternity services enable women to make informed decisions and to then support those decisions? The example might then be phrased as follows: "... the ability of the maternity services to support and respect women's decisions, ..."

Page 12: 1.21.7 - To access 'appropriate written materials' it is clearly necessary that these materials exist. Is the NMC confident that these materials exist. It does not seem appropriate that individual midwives should have responsibility for their availability, but that this is a task to be undertaken at an organisational level.

Page 12: 1.21.7 - Here and throughout the document it is difficult to follow the text. For example, 'These include ...' lead on to 'use'. Surely this should say 'using', similarly 'checking' rather than 'check', 'avoiding' rather than 'avoid', etc. Also, we are keen to see a specific skill set out in this section around consent, so that we can be confident that midwives are skilled in ensuring that women are comfortable about any physical contact that might be necessary for tests, examinations and interventions that are being offered, and that women feel comfortable to delay or decline such contact.

Page 13: 1.21.15 - This paragraph could usefully clarify that women's decisions need to be respected, and we would also like to see here a reference to the structures in place to support midwives in advocating for the woman in this circumstance/providing such care.

Page 15: Please review the language used here and consider amending 'women who may find it difficult to access services' to 'women whom services have tended historically to serve poorly'.

Page 15: 2.10 - Whilst AIMS appreciates the focus on breastfeeding in this clause, we find the current draft unclear in terms of the absence of any mention of learning outcomes associated with supporting women/babies not breastfeeding.

Page 16: 2.13.2 - Providing there is no change in circumstances, a regular review of a woman's decision in this context sounds strange - could you please look at this drafting again? And whilst we appreciate that such regular reviews are generally well-intentioned, based on our experience it would seem important to include some wording that ensures that such reviews do not simply provide an opportunity for staff to inappropriately (and regularly) seek to pressurise a woman into changing her mind.

- Page 16: 2.13.4 - Whilst clearly well-intentioned, the final bullet point of this clause does not seem appropriate, as it suggests an involvement with local capacity-building/ community development work beyond the scope of the midwife. Surely this is something to be actioned instead at an organisational level, with the midwife's role generally limited to identifying gaps in provision?
- Page 17: In relation to 3.2, please also see comments above related to 1.21.1. Midwives cannot be expected to have immediately critically reviewed each emergent piece of relevant research, so the expectation set out in this clause needs to be more bounded.
- Page 18: 3.10 - Is the second bullet point perhaps better expressed in terms of 'transition to extra-uterine life'? Please define 'very early child development'.
- Page 18: 3.11 - This text is difficult to follow and would benefit from redrafting, for example as it seems to suggest that breastmilk is not fed to a baby in some circumstances via a bottle. To address this, it might be helpful to refer here to expressed and donor human milk explicitly (as is done in the final bullet point of 3.19 and also in 3.21).
- Page 19: 3.15 - The reference to 'midwives exemptions' comes across as jargon to the lay reader. Can this either be better explained in the text or defined in the glossary?
- Page 19: 3.16 - The word dilemmas in this context seems odd: 'issues' might be better.
- Page 19: 3.17 - Please define 'positive outcomes', for both mother and baby.
- Page 19: 3.18 - In the first part of this clause, the list of examples seems oddly chosen: do examples need to be listed here? The formulation 'women themselves will be the best judge of ... may need' reads oddly, and we would suggest that a better drafting of this idea would read: "women themselves hold expert knowledge about their personal strengths [to end, as before]".
- Page 19: 3.19 - 'Integrated assessment' is jargon that needs to be explained/ defined.
- Page 19: It strikes us in reading this text that there is a missing reference here to the need for midwives to demonstrate knowledge and understanding of women's legal rights and human rights in childbirth and the practice of informed consent for any offer of tests, assessments and interventions.
- Page 20: 3.21 - This outcome is potentially problematic, as we would suggest that the provision of such care often goes beyond the midwife's individual responsibility, with many institutional arrangements, procedures and spaces not fit for purpose, for example in terms of providing a care environment in which normal processes can be optimised. How can the NMC assure itself that midwives are well supported by their employing organisations to enable good practice as outlined here?
- Page 21: 3.23.1 - Without a clearer reference to the 'sources' that midwives should consult, this clause seems too vague, and open the individual midwife up to unreasonable expectations around literature-searching. It would be helpful to have a cross-reference here to the infrastructure available to support midwives in this area.
- Page 21: 3.23.3 - It is difficult to interpret the meaning of this clause. Perhaps redraft to read 'Share information in relation to the impact of pregnancy, birth (including different

modes of birth) and postnatal care on public health and individuals' short, medium and long-term wellbeing. When referring to a skill of sharing information, here and in the clauses that follow, it would also be useful to clarify with whom a midwife should be skilled in seeking to share such information, perhaps by providing some examples.

- Page 21/22: In 3.23.4, and in contrast to the previous clause 3.23.3, there is no reference to time (eg long term effects), which seems to be an omission. Also in 3.23.4, the formulation 'evidence-informed, clear and meaningful' is used; in 3.23.5, the formulation used is 'clear, accurate and meaningful': consistency here would seem important.
- Page 22: 3.23.6 - This would be better phrased in line with the format used in 3.23.4, and omit the particular example (which could better come later in the document, in 3.23.25).
- Page 22: 3.23.7 - This reads oddly as currently drafted. Perhaps redraft to read 'Share information on the importance of early childhood experiences (during the first three years of a child's life) and family attachment ...'
- Page 23: 3.23.15 - Here and throughout the document, AIMS would prefer 'baby', or 'unborn baby' rather than 'fetus'.
- Page 23: 3.23.15, bullet point 2.8, we would like to see the example here expanded to read "... including previous perinatal loss and other birth-related physical and psychological trauma."
- Page 23/24: 3.23.15, bullet point 3. The word "holistic" is welcome, although we note that much of what follows seems to describe a medical examination. Bullet point 3.2: please define 'vital signs' (see also page 25 where this phrase is used in a more reader-friendly way). Bullet point 3.6: here or elsewhere in this section please add a specific reference to current or potential homelessness, as midwives now have a duty to offer referral on this issue. Bullet point 3.16: this suggests that "conduct speculum examination... preterm labour" is a routine procedure, so some redrafting would be useful here to make clear that it is not. Bullet point 3.17: please define 'venepuncture' or choose more familiar words to describe this process.
- Page 24: 3.23.15, the final bullet point (4) is difficult to read: maybe delete '... needs, views and preferences on ...' and '... , including the wish to attend parenting classes,...' as these phrases do not seem to add to the meaning of the clause. It would seem helpful to add the phrase '(including choice of place of birth)' after 'preparation for birth'.
- Page 24: 3.23.16 Bullet point 4. Please reword or define 'loss from the vagina' and 'show'. (This would also help clarify the subsequent mention of 'loss from vagina' on page 28.)
- Page 25: 3.23.16 cont. Please check whether 'palpitation to assess fetal growth' should be included under the heading 'assessment of progress of labour'.
- Page 26: 3.23.16 cont. Why do we talk about minimising 'the risk of **severe** trauma to the vagina and the perineum'? Surely any trauma should be minimised. It would be more positive to see here a reference to the objective of an intact perineum. In terms of ordering these clauses, it would seem more appropriate to list the episiotomy-related skill below the trauma-minimisation skill. With specific reference to the episiotomy

clause, using the word 'need' in the context of episiotomy seems to silence the issue of the responsibility of staff to gain a woman's informed consent before performing an episiotomy, which we consider highly unhelpful. With reference to fetal distress, please redraft to read 'if fetal distress occurs' (rather than 'when'). Please define 'suturing'.

Please replace "including expulsion of all placental products" with "birthing of the placenta". Define infarcts.

We are not clear on why the calcification of the placenta is listed as an abnormality. Could you please check this point/ amend the drafting here (perhaps by replacing "abnormalities" with "observations").

Page 26: 3.23.17 Consider adding the word 'initial adaptation to *extra-uterine* life...'

Page 27: 3.23.17 cont. For the systematic physical examination of the newborn, this section could be clearer that the midwife's role is to recognise possible issues rather than to diagnose (eg heart, hips)

Page 28: 3.23.18 This final bullet point of this clause seems to be about assessing a woman's needs in the context of the social support available to her, and it would be good to say this if so. Please define reciprocity in the glossary.

Please define safeguarding. It would be helpful if this definition included a clear explanation of what is to be understood by this term which clarifies the scope of safeguarding and also highlights how potential reportable safeguarding concerns may be averted by the midwife offering appropriate support.

Page 30: Heading: it is not at all clear what 'optimising' means in this context (and elsewhere in this section)? It would be clearer to say 'supporting' or 'protecting'.

Page 30: 3.23.21 - The opening paragraph is missing 'the ability to' at the end (see also other openings in Section C). Bullet 1: the phrase 'as needed' here is problematic: what does this mean? Who decides whether such contacts are necessary? Bullet 2: add 'with' after 'relationship'.

Page 30: 3.23.22: Bullet point 1: This section seems to be about the '*physical* environment', so it may be worth clarifying that; consider adding a reference to appropriate lighting.

Bullet point 5: we find the language here odd eg "identify optimal positions". We would prefer a formulation along the following lines: "supporting the women to find positions for labour and birth that work best for her"

Page 31: Bullet point 1: amend to read "Ensure access to adequate food and drink, and encourage...[to end]".

Page 31: Bullet point 2: the use of the verb 'toileting' seems odd (and infantilising) in this context. Can this be phrased differently?

Page 31: Bullet point 5: whilst the drafting of this clause here seems helpful in general, we are mindful of the way in which women are still coached to push and hold their breath inappropriately, and so we wonder the text could in some way further work to discourage such practice?

- Page 31 Bullet point 6: whilst we understand the understanding of birth physiology to which this clause refers, we note that 'birth' might be a more user-friendly term than 'expulsion' in this context.
- Page 31 Bullet points 7, 12 and 13: it would be helpful to include the notion of women's decision-making and the practice of informed consent in these bullet points .For example, in bullet point 7, we are concerned that the current drafting here works to silence the need for informed consent and we suggest replacing "... undertake episiotomy if indicated ..." with "... undertake episiotomy if indicated and informed consent is given ... "
- Page 31: Bullet point 9: The term 'positive time' is not clear. Perhaps make this a new bullet point, linking to the UNICEF UK BFI standards where protected uninterrupted time of at least an hour is suggested.
- Page 31: Bullet point 11: Please check whether the reference to a hat reflects best evidence. We are not aware of any evidence that hats should be used routinely.
- Page 31: Bullet point 14: We would like to see a subtle change of emphasis here, which would be signalled by replacing language around the skill of offering '**delayed** cord clamping' with language around the skill of 'protecting the baby from the **premature** clamping of the cord'.
- Page 31: Bullet point 15: The phrase 'as soon after birth as possible' is problematic, as we are concerned that this might lead to undesirable behaviour, for example in which staff seek to rush a mother/baby dyad to achieve or 'tick off' a first breastfeed.
- Page 31 Bullet point 16: Again, we are concerned that this language may unintentionally work to normalise and justify examinations undertaken without consent. Please extend the sentence to read "and after informed consent is obtained".
- Page 31: Bullet point 19: Is there any reason why this text can't refer to eating and drinking (rather than 'food and fluid intake')?
- Page 32: 3.23.24: Bullet point 1, delete 'and additional opportunities as needed'. Bullet point 2: insert 'Encourage' before listen[ing] and respond[ing]'.
- Page 33: 3.23.25: Bullet point 2: Include mention of evidence-based advice on bed sharing here or elsewhere in this section (rather than on p22 - see above).
- Page 34: Please check whether the word 'essential' ought to appear twice on this page and also on page 35.
- Page 34: Please check this text: shouldn't the reference to disability be under further care needs and not under clinical complications?
- Page 35: Bullet point 1, line 5: is the use of the term 'malpresentation' here absolutely necessary? We would prefer a more neutral term such as unusual or atypical .We are also keen for breech birth not to be categorised here as a malpresentation, so in the context of the current wording would like to see 'and breech birth' rather than 'including breech birth'. (We also have a query about whether midwifery skills around breech birth should fall under domain 3, rather than domain 4.) Line 7: we are concerned that this wording around problems with the cord might act to reproduce

misunderstandings of unproblematic cord presentations. Omitting 'including cord round the neck' would seem to avoid this possibility.

- Page 35: 4.3 - We doubt whether "sequelae of" is necessary here, as we would suggest that the knowledge and understanding referred to here needs to be of birth trauma generally and not just its sequelae.
- Page 35: 4.4, bullet point 2: see previous comments - please amend 'Adapation to life' to read 'Adaptation to extra-uterine life'
- Page 36: 4.5 - Under clinical complications, we would like to see explicit mention of breast and nipple thrush.
- Page 36: 4.7 - The mention of 'shoulder dystocia' here (under clinical complications for the woman) is confusing, as it suggests that we are referring to the woman's shoulder. Please also look again at the reference here to breech: as before, we suggest amending the text to read "undiagnosed malpresentation **and** breech"
- Page 37: 4.9 - There is a lack of clarity with the use of the word 'prevalent'. What are these complications/interventions/ conditions - where might they be listed? How will the midwife assure herself that she is updated on all of these?
- Page 38: 4.12.3 - Please define 'digital communication formats'.
- Page 39: Please include an entry for SBAR in the glossary. See also earlier comments re the use of the term 'midwives' exemptions' (p19). The term 'emergency scribe sheets' is jargon best avoided (or defined).
- Page 40: "assist with caesarean section; elective, planned, and emergency": it would be clearer just to have planned and unplanned. What is the distinction sought between elective and planned?
- Page 41: Please check the desirability of the phrase "hand express breastmilk" as this seems to exclude using a breastpump. Add a reference to supporting parents to store/ give stored breastmilk.
- Page 42: 4.12.10 Bullet point 2, replace 'drugs and' with 'drugs on'. Bullet point 4 seems out of scope in this section given the wording of the introduction. 4.12.11: As before, the use of the term 'optimise' is not clear: does this mean 'support'?
- Page 43: 4.12.12 Under additional care, bullet point 2, replace 'negative factors' with 'issues that might be impeding effective feeding'; replace 'pacifiers' with 'dummies'; bullet point 3, remove '(formula)'; bullet point 4: be more explicit if this point is about unwell/ premature babies
- It would seem appropriate for the bullet point around identifying and addressing tongue-tie and lip-tie as soon as baby is born to be near the top of this list.
- Page 44: 5.2 - We are surprised that this list does not include potential safety concerns, otherwise this is assuming something has to first go wrong before effective action is taken.

- Page 48: Companion: this seems to be an unnecessarily limited role definition - why does it not extend into the pregnancy and postnatal periods (both in this definition and also across the document more generally)?
- Page 48: Continuity of Carer or relational continuity of care: to align with Government policy, this definition needs to be updated, drawing on the language used by the NMPA or the NHS Long Term Plan to more specifically focus on the key role of the named midwife, with the rest of the team providing an essential (but essentially different) back-up role.
- Page 49: Fetus: see comment related to this term on page 23 above. We would prefer to see the term 'unborn baby' being used instead of fetus, and fetus being defined as the unborn 'baby' rather than 'offspring'.
- Page 49: Informed consent: please redraft this definition. Informed consent is not just 'seen as' an important link between evidence-based care and human rights. It IS the crucial link between these things.
- Page 49: Human factors: an expanded definition here would be helpful, perhaps drawing on the National Quality Board Concordat (eg "The principles and practices of Human Factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, a Human Factors approach offers ways to minimise and mitigate human frailties, so reducing medical error and its consequences.")
- Page 50: Woman: Please review this definition which doesn't quite make sense. Perhaps a better form of words would be: "We have used the word woman in this document, as this is the way that the majority of those who are pregnant and having a baby will identify. It is important for midwives to acknowledge, however, that not everyone having a baby will identify as a woman."
- Page 50: Safety: we note that there is no glossary entry for safety in a maternity care context. There are points in the document where the phrase 'physical and emotional safety' is used but it might be worth reviewing the use of the word in the document to see whether a broader definition should be offered (for example, encompassing psychological, spiritual and cultural safety).

[1] We recommend that a separate document covering standards for preceptorship period is included within the Future Midwife programme.