

Midwifery Panel
held at 14:00 - 17:00 on 8 February 2023
at Microsoft Teams

Meeting notes

Attending		
Name	Role	Organisation
Agnes Agyepong	Lay member	Founder and CEO of Global Black Maternal Health Institute
Angela Graves	Head of School of Healthcare, University of Leeds	Council of Deans of Health
Anna van der Gaag	Midwifery Panel Chair	Visiting Professor, University of Surrey
Caitlin Wilson	Chair	Consultant Midwife Network, Royal College of Midwives
Jacqueline Dunkley-Bent	Chief Midwifery Officer	NHS England
Janice Sigsworth	Director of Nursing	Imperial College Healthcare NHS Trust
Justine Craig	Chief Midwifery Officer	Scottish Government
Karen Jewell	Chief Midwifery Officer	Welsh Government
Leigh Kendall	Lay member	Maternity campaigner and communications expert
Mary Renfrew	Professor Emerita	University of Dundee
Natalie Whyte	Lay member	Services User Representative National Maternity Voices, Midlands
Nicky Clark	Chair, Lead Midwife for Education Strategic Reference Group	University of Hull
Sascha Wells-Munro	Deputy Chief Midwifery	NHS England

	Officer	
Wendy Olayiwola	National Maternity Lead for Equality	NHS England and NHS Improvement
Tracey McCormack	Director of Midwifery and Gynaecology	King's College London
Ruth May	Chief Nursing Officer, England	NHS England and NHS Improvement
Observers and guest speakers		
Margaret McGuire	Registrant Council Member	NMC
Claire Johnston	Registrant Council Member	NMC
David Warren	Chair	NMC
Salone Sodini	Student Midwife	Shadowing Jacqui Williams
Dr Bill Kirkup	Guest Speaker	Lead for the Independent investigation into maternity and neonatal services in East Kent
NMC attendees		
Andrea Sutcliffe	Chief Executive and Registrar	NMC
Edward Welsh	Executive Director Communications and Engagement	NMC
Verena Wallace	Senior Midwifery Adviser (Policy)	NMC
Jacqui Williams	Senior Midwifery Adviser (Education)	NMC
Anne Trotter	Assistant Director Professional Practice	NMC
Jasmine Bailey	Senior Special Projects Officer	NMC
Maddie Elder	Policy Manager	NMC
Noita Sadler	Assistant Director Stakeholder Engagement	NMC

Gabi Jones	Stakeholder Engagement Manager	NMC
Apologies received		
Gill Walton	Chief Executive	Royal College of Midwives
Dale Spence	Midwifery Officer	Department of Health, Northern Ireland
Gwendolen Bradshaw	Emeritus Professor	University of Bradford

Papers

- Agenda
- Notes of meeting held 2 December 2022

Agenda items covered

- 1 Welcome from Chair
 - Anna van der Gaag welcomed everyone to the meeting, including observers.
 - The Chair thanked colleagues joining the meeting for the first time and those deputising for panel members.
- 2 Matters arising from notes of December's meeting
 - The Chair confirmed with members that they were satisfied the notes from December's meeting were an accurate representation of the discussions held.
- 3 NMC Update
 - Andrea Sutcliffe gave an overview of the NMC's recent work to respond to pressures within health and care and how the NMC has been supporting midwifery and nursing professionals. Links to news stories and updates are being shared monthly with Panel members via the stakeholder newsletter.
- 4 Reflections on East Kent report findings
 - Dr Kirkup was invited to share his reflections on his independent review of maternity and neonatal services at East Kent.

- Dr Kirkup touched on a number of areas:
 - Key themes identified by the investigation: a lack of respect for some women and colleagues; a blame culture where people who spoke up were disciplined; a failure to listen to some women; a failure to learn when something went wrong; very poor team working between and within professional groups and a lack of common purpose.
 - Two hundred and two families came forward in East Kent, but this is likely an underestimate of the numbers impacted. The negative impact on these families of their experiences and the lack of empathy they were shown is significant and long-lasting. We owe it to them to make changes as a result of this investigation.
 - There were eight separate opportunities for the unit and Trust to recognise what was happening, over several years, and each was missed. An example of this is where external bodies had identified an issue such as bullying but not followed it up.
 - The investigation opted not to give operational recommendations because there are already many of these. There have been a number of major investigations since the Morecombe Bay inquiry and none appear to have led to any significant change, showing that operational recommendations may not be working.
 - For this reason, the report instead identified four high level areas for action: 1) monitoring safe performance – finding signals among noise; 2) standards of clinical behaviour – technical care is not enough; 3) flawed teamworking – pulling in different directions; 4) organisational behaviour – looking good while doing badly.
- Dr Kirkup then took questions and reflections from Panel members. Questions covered a range of themes:
 - Panel members expressed their thanks to Dr Kirkup for joining them, and there was widespread agreement that the investigation's approach and its recommendations was helpful.
 - There was agreement that acting now, and sustaining change, is vital.
 - There was discussion around how soft intelligence, which was missed in East Kent, can be used more effectively by the wider system in order to identify risks.
 - There was a query about how representative the families who came forward were of maternity service users in the locality more generally. Dr Kirkup outlined that the investigation did not claim that they were representative, nor was the investigation concerned with finding a representative sample. They wanted to hear sufficient views to develop a good picture of what had happened. Discrimination did not come through

as a theme that contributed to the issues in East Kent when the investigation team spoke to people about this.

- ⊖ There was discussion of a culture that ignored those who tried to highlight and tackle problems, which pervaded external partners too, and the challenge of turning this around. Dr Kirkup reflected that after his report into failings of care at Morecambe Bay he told the system not to think that these issues couldn't happen in their service,
- Member panel members reflected on partnership working between professionals and women was a key way to embed and sustain improvements, and that this has been an important part of making improvements at Cym Taff Morgannwg University Health Board.
- There was discussion of how cultures impact on students and new staff members.
- There was reflection on the NMC's role, and the role of regulators more broadly in promoting professional behaviours and multidisciplinary team working, as was the opportunity to promote a learning culture through regulatory processes.
- Andrea Sutcliffe reflected on the NMC's role in supporting improvement:
 - The NMC's strategy sets out its role to regulate, support and influence, and there is a wide range of work that sits beneath this that will help make a difference.
 - The NMC sets standards for education and practice, and many of the issues identified by the investigation are addressed by fully implementing these standards. Therefore, it is vital the NMC and partners make sure implementation is happening.
 - ⊖ The NMC is implementing changes to its pre-registration standards, which include plans to ensure midwifery students experience different leadership and team working during their placements.
 - The perception that the NMC will remove someone's PIN for making a single clinical mistake is false. The NMC is here to assess if professionals are fit to practise in the future, and to do this will consider context, whether there is insight into what happened, meaningful feedback to people impacted, and work done to strengthen practice.
 - Promoting professional behaviours through the Code is key, and we are looking to do more to communicate what's expected and ensure that professionals understand this.
 - Encouraging more and improved multidisciplinary team working is important and the NMC is working in collaboration with the General Medical Council (GMC) to promote professional behaviours in

multidisciplinary teams via our Employer Link Service (ELS) and local engagement.

- The Midwifery Panel is part of our influencing role. We engage across all four countries, partners, educators, women who use services and those who advocate on their behalf.
- We want to use our influencing role to ensure people work in safe and inclusive environments, and to encourage people to embed that cultural change. A key moment for this will be our review of the Code in 2025.

5 Update on the work of National Maternity Voices

- Natalie Whyte presented on the work of National Maternity Voices (NMV), outlining their approach to collaborating with people who use services to co-produce local services.
- Panel members reflected on the importance of local co-production in service design and quality improvement.
- There was discussion on the learning of NMV on what good listening looks like and how this can be shared to promote more effective listening between professionals and women.
- There was reflection on the role of health visitors in sharing the experiences of women who have recently used maternity services, and who may be at a point of reflection at the point at which they engage with a health visitor.
- There was discussion around the need to proactively engage with a range of diverse voices and experiences, to ensure their needs are met by their maternity service and the professionals within it.

6 Update from our Senior Midwifery Advisers

- Jacqui Williams and Verena Wallace presented an overview of their recent work as the NMC's Senior Midwifery Advisers. This included work on Standards for pre-registration programmes with supporting information, upcoming updates to the Practising as a Midwife in the UK document, joint work with the GMC on sodium valproate.

7 Exploring whether the regulation of advanced practice is needed

- Anne Trotter updated on the work to review whether regulation of advanced practice is needed, including the early headlines from the research report:
 - Advanced practice is ill-defined internationally.

- Nurses and midwives report that advanced practice roles are more established in some settings than others.
- Advanced practice in midwifery is less well established and less well defined. It is often identified as a role to lead on managing the care of women with additional and complex needs.
- There is a lack of robust data on patient safety outcomes in relation to advanced level practice either in the UK or internationally.
- Overall, professionals are in favour of regulating advanced practice, but think it needs to be sufficiently flexible to permit innovation.
- The independent reports will be published soon, and the findings of this and our ongoing engagement will inform the options taken to Council later in the year.
- Panel members shared their reflections on this work:
 - The panel welcomed this work taking place and the complex areas and questions it is considering. The panel was pleased that advanced midwifery practice is being considered as part of this work.
 - The differences in how advanced practice is defined in midwifery and nursing roles was explored.
 - There was discussion of the risks in this work of considering advanced midwifery as advanced technical practice, and tasks that could be delivered by midwives instead of doctors. A view was expressed that the work should consider how to define, describe, measure, evaluate and ensure quality for advanced midwifery.
 - The need to consider what the impact on women and people who use services of regulating advanced practice was raised.

8 Closing remarks

- The Chair closed the meeting with a short summary of the themes of listening, understanding, and taking action that came through the presentations and discussions. The Panel were reminded that the next meeting will be online via Microsoft Teams, on Wednesday 21 June, 10:00 – 13:00.

Future meetings:

- Wednesday 21 June 2023, 10:00-13:00
- Wednesday 4 October 2023, 14:00-17:00
- Thursday 14 December 2023, 10:00-13:00